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American Dental Association

ADA American Dental Association

211 East Chicago Avenue
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Supplement Two to Annual Reports and Resolutions

128th Annual Session

Las Vegas, Nevada

October 10-15, 1987

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Report of President

Dr. Joseph A. Devine

To begin my report, let me tell you first one of the most important things I learned this year: nobody does this alone. I'd like to take this opportunity to introduce to you the finest support team a president could have. These are my friends, my family members and my peers and colleagues who have made it possible for me to spend this year, on your behalf, representing the profession of dentistry both here and abroad.

As those of you who know me well might suspect, this is not going to be your typical outgoing president's report. Most of you have been here before and you know that this is the president's last chance to tell a large and captive audience about all the wonderful things he accomplished during his term of office.

I'm not going to do that. I have prepared a written report, as the *Bylaws* require, that will be distributed to you following this meeting of the House and that will go to the reference committee for consideration. And that report contains my recommendations and even a proposed resolution or two for you to consider.

But at this time I'd like to speak to you candidly about the issues that I think are the most important ones we face right now, the issues that will have the greatest impact on our collective future. First, I'd like you to look at your watch. This isn't going to be a long speech, but what I want you to keep in mind is that one of our most powerful tools in addressing the problems we face is time. Remember that—time.

Now I'd like you to take a coin out of your pocket. The second tool we have that we must use wisely and appropriately to address these issues is money. And that is my theme for this report: time and money.

First let's talk about money. I need you to assist me in a simple test. Take that coin in your hand and hold it like this, right up to your eye, very close. Now close the other eye and look up here at me on the platform. You can't see what I've got in my hand up here, because you're holding that coin so close to your eyes.

I hope that's a nickel you're holding, because five cents has a very special significance. As you may remember, some years ago a tremendous battle was fought over a five-cent withhold, at the time of the beginning of the development of the concept of dental service corporations. We lost that battle and, as a result, we lost the edge in the marketplace. And over the years we've lost control of the service corporations. All over the question of a nickel.

What I'm holding here, what you can't see because you've got your eye on a nickel, or a dime or a quarter, is a $100 bill. Now let me give you some interesting information about this $100. If this was $100 of net income of the average general dentist in the United States today, about three cents of it would go to the American Dental Association for his or her national dues. If that dentist is a specialist, he or she would pay about two and a half cents of $100 to the ADA.

Now that's not very much. And yet for five years now the House and the Board have spent a considerable amount of time arguing about the dues. And that issue has been my single ongoing concern about this Association. I do not believe our members are as concerned about the amount of the dues as they are concerned about for what the dues are spent. And the reason they are concerned is because we, the governing bodies of this Association, the Board and the House of Delegates, have not done a good job of communicating to our members what is done with their dues.

It's a very simple fact: the closer you are to the headquarters office, the better you understand the process. For example, if you surveyed the members who complain about how the dues are spent, you will find very few of them have served on the councils or committees of the Association. The volunteers who've had a chance to be involved, who've actually seen how the system works, appreciate and understand the process.

It seems like every year we come to this meeting and the House demands that the budget be cut. And I think you, the delegates, demand this because your constituents at home are asking for it, because they don't understand how the budget is being used.

And it seems like every year the Board responds to those demands with a proposal to cut costs by eliminating programs, because that's the only way left to cut expenses. And then the House says, "No, this is someone's program, we can't do away with this." And it's the same old impasse.

If you're not satisfied with the budget the Board has brought to you this year, you probably won't ever be satisfied—that's how good it looks. You will see that although the reorganization plan the House authorized last year eliminated very little in the way of agencies or programs; it did allow us, with the expert advice of Dr. Ginley, to streamline the Association dramatically, reducing costs and bringing you a budget that should make you very happy. By the time I finish here today, I hope you will not be satisfied with it; I hope that I will have convinced you to spend some money.

And I hope that if you choose to spend some additional money in the next year, you will do it differently from the way these things have been handled traditionally. Please don't add a program or activity in such a way that it becomes a permanent structure. You can add a program and not change the *Bylaws*. And when that program has served its purpose, it can be terminated and those monies used for new priority activities.

One of our problems is that we do not relate cost to value. My mother used to tell me there are a lot of people who know the price of everything and the value of nothing. Please listen to my suggestions for some new programs and activities for next year; discuss them in the reference committees and here on the floor of the House and decide if you agree or disagree that these are important things we

should be doing. If you agree and you choose to fund them, that's fine. If you disagree and choose not to fund them, that certainly is your prerogative. But I want to be sure you have the opportunity to make those decisions.

And if you want to add even more programs or services, then you must find more money. Last year I stood up here and did everything but cry to get this House to approve a dues increase. And what was that heated debate about? It was over eight dollars. I don't believe that's appropriate. I think it's your responsibility to find a way to pay for the things you want, the programs and activities your constituencies tell you they want.

But is money the only issue? John Bomba told you two years ago that we are educated professionals, too intelligent to try to solve our problems by throwing money at them. I would add that it takes more than money; it takes time, as well. We can successfully manage any problem we face, with enough time and money. Our problem is that we start too late. We don't give ourselves enough time to address our problems. I want to address three critical issues, and I'm going to talk about them making no attempts at prioritization. It's your job, as delegates to this House, to establish this Association's priorities.

But I will emphasize what I think are the most important factors about these issues—I think that's my job. I will warn you that some of my ideas have price tags; I ask you not to think of them as requests for money but as requests for a program and activity that will serve our members.

The first issue we must address is hygiene, and I will ask you to remember that my remarks reflect my opinions and my judgments and not Association policy. If you survey the average state legislator in any state where hygiene legislation has been proposed, his or her impression would be that 100% of the hygienists in that state support unsupervised practice. Now, we know that is not the case. We know there is a significant population of hygienists who are very happy with the status quo, for the simple reason that they work for an employer who is fair and who compensates them with the salary, the benefits and the incentives they feel are adequate.

And salary, benefits and incentives are the key words. The issue for the hygienists has never been, and it still is not, supervision. Their issues have been and are employer/employee relations, wages, benefits and career advancement.

We know that the issue is one of health and safety of the public and unless we are successful in conveying our message to the legislators, the public's health will suffer.

The problem we face is that the vocal minority that is pressing forward for unsupervised hygiene really represents, we estimate, at most roughly one-third of the hygienists in this country. At the moment, no one is speaking for the rest of them. And I suspect that the leadership of the vocal minority doesn't enjoy the total, 100% support of all those it claims to represent.

So what the Board is recommending is that the state dental societies consider creating a membership category for those hygienists who are interested in being a part of organized dentistry, those who want to belong to a professional—not a political—association.

So I urge you to consider forming a membership category in your state for the auxiliaries, including the dental assistants, the lab technicians and the office managers. Help make them part of the team, give them the benefits, give them opportunities for professional education and encourage them to belong to your Association.

Think of the professional advantage inherent in retaining this very valuable member of the dental team. We can see a steep drop in the number of people entering hygiene, and many areas suffer an acute shortage of hygienists.

Do not misinterpret my meaning; improving our relationships with hygiene does not mean I support the goals of that vocal minority. I am resolutely opposed to unsupervised practice for hygienists. Hygienists who support that concept want to become dentists by legislative act, without going through the same intensive, professional training we did. And if you want to permit a secondary level of dental care, you're certainly moving in the right direction if you permit unsupervised hygiene.

The second critical issue we face is prepaid dentistry, which is rapidly becoming preplanned dentistry. What is at issue here is our most basic right as health care providers: the right to diagnose and to plan treatment. As I traveled through the country the past few years, you may remember me telling you how important it was on behalf of the patient that no one be allowed to interfere with our right to diagnose and plan treatment. For indeed it is the patient who is at risk. And you must understand that no one is going to protect our patients, if we do not.

Let me tell you something very unsettling, something I heard from a very reliable source high in the insurance industry: many of the major carriers would like to get out of the health insurance business. Why? Because it's the most complex and costly of all the insurances; carriers either have huge losses or very limited profits. Basically they remain in the health insurance arena because they don't want to lose the life and pension business of their major clients. So don't look to the carriers for compassion. They are not selling health insurance because they're worried about the health of your patients; they're selling health insurance in the hope of making a profit and retaining the good will of their life and pension insurance clients.

I think it's important that we find some way to explain to the American public that alternative dental benefit plans based on cost savings may well mean a complete change in the type of dental care received, not simply a lower fee for the dentist.

Why am I concerned? From the anecdotal material I've gathered, I don't think I'd ever want to be a capitation dentist. Working under that kind of system must frequently create conflicts with your obligation to the patient. In the worst case scenario, every procedure provided is likely to be paid for out of your income. It would be a terrible thing every time you look at a patient to think, "If I provide treatment, it's going to lower my profits or even put me in a loss position." I can't tell you how many times I have talked to young dentists who are trapped in a capitation plan and who tell me that they want out of that system.

And what about specialty care in capitation dentistry? Is the patient with the abscessed tooth going to be referred to an endodontist and will the capitation dentist pay for that service out-of-pocket? Is he then going to have the patient back, to post and crown that tooth? That's a serious question.

Where do we stand right now? There are two givens in the marketplace at this time. First, any entrepreneur, any insurance company, any union, that develops a dental plan

and promises a population of patients, regardless of the level of payment, regardless of the method of payment, regardless of restrictions and exclusions, will sign up dentists very quickly. The second given in the marketplace is this: if you design a program that the dentists like, that the dentists think is wonderful and which all the dentists want to participate in, it is not marketable to large employers in sufficient numbers. Direct reimbursement is a classic example of this.

Now don't leave this room and say the president of the American Dental Association is against direct reimbursement. But the president of the American Dental Association believes in reality, not idealism.

If you talk to a group of dentists and say, "We have this plan in which patients have freedom of choice," the dentists will say, "That's good." Tell them, "We have this plan where you don't have to fill out claim forms and the patients just pay you," and the dentists will say, "That's good." "And further," you say, "in this plan there's no limitation on the treatment, no restrictions, all treatment is covered." And the dentists would say, "That's good."

Well, last year Dr. Kobren and Dr. Ginley went to a meeting with the major purchasers of health care and made all those same statements. And the purchasers said, "That's bad, because it flies in the face of managed care." Simply stated, they couldn't trust a concept that lacked controls. At that time, our program was too new and we had insufficient numbers and historical data to refute their criticisms.

The message was loud and clear: direct reimbursement is not going to be, for large companies, a viable alternative to the major trends of change in delivery systems. Our market for direct reimbursement is the small to medium company. Of course, that's about 80% of the business community, so we have a lot with which to work.

Direct reimbursement is an important program for us and it is one that is becoming more successful all the time: we have 20 states now actively involved in their own direct reimbursement programs.

Look at the experience of our colleagues in Texas. They made a realistic appraisal of the dental benefits marketplace and they decided they had to do something. But they were willing to admit that the necessary expertise in this area does not lie with our member dentists. They knew they had to go into the marketplace and sell something. So they hired experts to help them design and market a program, a program that's been fairly successful.

I have asked some of the Texas delegates to testify at the reference committee, not to sell you their program but to inform and educate you, to help you decide if you want to follow a similar course.

In other words, do you want to become more actively involved in the marketplace? There are three things I think we can do to strengthen our presence in the marketplace. And I think this House of Delegates should have the opportunity to determine if the Association should take the steps necessary to put us on the right track.

Now notice: I said this House of Delegates. Not the Councils, not the Committees, and not the Board of Trustees. To my mind, there are some issues that should go directly from the president to the House and that's what I'm going to give you.

Last year the House passed a resolution that says the ADA should "...engage in an aggressive program to educate prospective purchasers to the advantages of dental benefit programs that are compatible with private practice, fee-for-service dentistry and freedom of choice...." So far, so good. That resolution goes on to say that "...in this effort, promotion of the direct reimbursement model is preferable, but other models may be acceptable."

That's the problem, right there, and that's the first thing I think we ought to consider doing. The language is explicit about direct reimbursement but we need to be more specific about the "other models" that are also acceptable.

The second area is our purchaser contact program. If this House adopts new language for a policy on educating prospective purchasers, as I hope it will, we will need to put together a program to do that. I am suggesting that our program be expanded to 200 purchaser contacts in the coming year.

I want the Association to know how many companies have dental benefit plans, how many union contracts are coming up for renewal and how many companies and unions are looking for different dental plans when those contracts are up for renewal. We need to get this information and use it in a timely fashion.

When our staff and Council members go out to talk to a purchaser, we need to be able to talk about programs in which they're interested. You and I know the big unions don't want to hear about direct reimbursement—but they're beginning to look long and hard at IPAs, where they can negotiate directly with the dentists. So whatever type of program the Association and the purchaser want to discuss must be open to what is probable. I have no problem with that and you shouldn't, either.

The third area on which I hope you will act has to do with the future and adoption of an active program to continue the purchaser contact program in a major way. That may mean hiring professionals to work with prospective purchasers.

I am asking you to direct the appropriate agency of the ADA to develop a plan to build a network of professionals to reach plan purchasers. This program would be developed in 1988 with a report back to the 1988 House of Delegates.

I am sending these recommendations in resolution form to the reference committee, together with budgets, and I am asking you to consider them carefully (see Appendix—Resolutions 87, 88 and 89). We need to take action on these matters so we don't have to wait to get help to our members, to provide them with assistance. If there is one thing they need to know it's that their professional organization knows what's going on out there in the marketplace and isn't sitting on its hands wondering what to do about it.

We've pinched our nickels so thin that the Indian is riding the buffalo. If we want solutions, let's start paying for them. That's why I've come directly to you. It's your call, so think about it carefully.

Last year I told you the single most important activity facing this profession was the study of alternate delivery systems. You are aware of where we stand with that. You have a report that details the protocol, the things that are expected to come from such a study. As you have probably heard by now, the ADA submitted a research proposal for a

comprehensive study of dental care under all reimbursement mechanisms to the Kellogg Foundation. In addition, we submitted a second proposal to study the oral health care of patients who receive treatment under all reimbursement mechanisms.

Our petition to the Kellogg Foundation to fund these studies was rejected, because our protocol emphasizes research and Kellogg's guidelines emphasize demonstration projects. In its rejection of our funding request, however, Kellogg agreed that the study is important and recommended that we send our proposal to other foundations with more specific interest in what we want to accomplish.

A broad spectrum of research such as has been proposed is absolutely necessary if we are to move forward in this area. Although it goes beyond the language of Resolution 51-H adopted by last year's House, directing the Board to develop a protocol for the study of capitation dentistry, there are some excellent reasons for us to take this broader, more comprehensive view.

If we limit our study to capitation, to what can we compare the results? Without comparative data, without studying all forms of dental care under all forms of delivery, the results of a capitation study would be meaningless.

We are the national association of dentistry. We are the voice of our profession. As such our obligation to provide factual, unbiased and accurate information can never in any way be compromised by gut reactions and emotion, no matter how we may feel, no matter if we are eventually proved right!

Alternative benefit plans have had a major impact on both patients and dentists. Speculation about the type, quality and appropriateness of care provided under various dental reimbursement systems remains unanswered and can no longer be ignored.

Dental care provided under CDOs, HMOs, IPAs, capitation, self-funded/third-party administered and fee-for-service programs must be objectively evaluated, away from the dental community; and the information resulting from those studies should be made available to the government, to the plan purchasers, to employees and to the dental profession.

The research proposal we submitted to Kellogg is a direct result of the interest expressed in alternative payment arrangements expressed by Congress, consumer organizations and sponsors of dental benefit programs. The effects of such arrangements, both positive and negative, upon the delivery of dental care have not been measured in a systematic way in a representative population. Therefore, I am placing before this House a resolution expressing the Association's support for and commitment to this most important study. I submit to you that this study will be the single most significant contribution to the purchasers, recipients and providers of dental care in the coming decade.

I want you to know that I fully support the resolution submitted by the Council on Dental Care Programs, and I fully support the recommendation of the Board regarding funding these critical research activities. But let me remind you again, we are talking about both time and money. Too often I hear people saying, "Well, it's a good idea, but we can't afford it. We'll have to wait, because it costs too much money."

With all due respect to the Council, I do not think we can afford to wait until 1988 to undertake this kind of study. So I am including with my report a resolution for your consideration that would allow the Board to expend $500,000 to begin the research process (see Appendix—Resolution 90). This is not nearly all the money we would need—but it would be enough to get us going. I urge you to consider authorizing this expense, to get the process underway immediately.

Another activity in this area that I want to talk to you about is a concept that I think is practical and innovative and is one the members will like.

If a significant patient population in my home town was faced with the need to decide on an alternate delivery system to preserve its dental health benefits, I would not be able to provide it with information or materials to make that decision. We—the ADA—have no such patient education or patient awareness materials that talk about the benefits and the disadvantages of various delivery systems.

Without definitive research, the ADA is precluded from making meaningful statements about the delivery of dental care under the various systems. In contacting a well-known public relations agency on this subject, I was told, and I quote, "Without consumer research, as well as research among dentists...it would be impossible to mount a public information campaign that would stand up to media scrutiny...."

I was further told that to proceed in this area the ADA should "commission research (to study) the advantages of the various systems now available," because "you cannot base a public relations campaign on a 'hunch' no matter how firmly that hunch is believed... ." In conclusion, the agency said, "Only after full-scale research is conducted and evaluated can we then develop (an appropriate message)."

Remember that we are talking about both time and money. Yes, a program such as this program would cost money—but it would be money well spent. In this case, the more critical issue is time. We cannot afford to wait for a crisis. We need to be sure that study is undertaken and that research is completed, so that we have solid data on which to build an effective public awareness campaign.

We cannot presume that the people who are going to make changes in the delivery systems will wait until we are ready, and will honor our timetable. We have no such commitment, no such promise.

The way the system worked in the past was for the House to say, "Yes, we want you to begin to prepare something. But we want to see it next year. Don't actually do anything until we've had a chance to approve it—again." So an entire year elapses. We come back to you with a refined concept and then, too many times, the House says, "No, we want to change this, we want to change that. We don't want to pay for this, we don't want to pay for that."

All of which is fine and all of which falls within your authority, presuming that in the meantime, some bellwether group such as the auto industry in Detroit has not changed the delivery concept entirely and several million people have been forced into a delivery system that may not be in their best interest and that may put dentists in a situation in which their conscience must battle with their need for financial security.

I'm asking you to protect your most basic right, the right to diagnose and the right to plan and recommend treatment

to your patients, to do that in the most ethical manner possible, to do that by expending your members' money in their best interest and to hire the very best people available to do the very best job we can in the marketplace.

How about it? What do you want to do? Do you want to be active and save your rights? Or do you want to be inactive and save your money?

The last critical issue facing the profession that I want to discuss with you today is intraprofessional relations. And once again I'm asking for a little audience participation.

I'd like to ask all the general dentists to stand up. Not the family dentists, not the cosmetic dentists, not the porcelain dentists, or whatever terms there are. Just the general dentists, please stand up.

Now let's have all the specialists in this House of Delegates stand up. And let's take a look too at the slides on the video monitors that show you other interesting facts and figures about specialists and general practitioners in the ADA. But is it really important what the percentages are? I don't think so. Numbers are not critical. Attitudes are.

We are talking about a serious problem, the problem of intraprofessional relations and the ongoing saga of the fragmentation committee. I have to tell you it's been a severe disappointment to me that I couldn't make some headway in this area during my term. Although I certainly never dreamed that we would be able to solve this problem in one year, I did think we'd be able to get a better start on it, and I'm not sure we have, even with the combined efforts with the fragmentation committee of 1986 and this year's intraprofessional relations committee.

One of the things that made our profession respected and admired by our patients has been the outstanding relationship between the generalist and specialist. Our situation is one that is very different from that in medicine, and in the past, at least, it worked very well: our patients have been well served.

Statistics will show too that the dentist who refers is usually a very successful dentist, because he gains the confidence of his patients in indicating that he admits, willingly, his limitations and does everything he can, including referring, to assure that his patients have the very best care. I want to quote a very famous dentist who said on this topic: "The ADA will defend, to the limit of its resources, your right to practice to the limit of your ability. But that's where it stops. At the limit of your ability." By the way, that's a quote from one of my previous speeches.

I want to share with you what I've told our graduating students when I've had the privilege of addressing commencement exercises during the past year. I tell those new dentists that their relationships with the specialists are critical.

The primary obligation of that relationship, in my judgment, lies with the specialists, and not with the generalists. It is their responsibility to share their professional expertise with their generalist colleagues, to help them understand the limits of their abilities.

I think the best trained dentists are the ones with the most postgraduate education. The one who understands the specialty treatment the best is also, I believe, the best referring dentist in point of numbers. I guess for the balance of this discussion I'll seem to be picking on the orthodontists. That's not deliberate; it simply stems from the fact that most of the comments I hear on this subject and in the press seem to focus on the discussion between generalists and orthodontists.

I felt that before I could make these comments, I had an obligation to do at least some basic research. And I decided I would find out if, in fact, general dentists are doing more orthodontics than they did in the past. The answer to that question, based on our research, is a simple no. Then I said, is the problem that there are more orthodontists watching the general dentists do the same amount of orthodontia?

My research turned up statistics that apply to all the specialties. Total freshmen enrollment, from its highest point in the 1970s until 1985, showed a reduction of 1,458. We went from 6,301 freshmen in 1978 to an enrollment of 4,843 in 1985. During that same period, first-year enrollment in the specialties dropped from 1,237 in 1978 to 1,209 in 1985, a drop of only 28 in the specialties as opposed to a drop of 1,458 in the total freshmen enrollment.

It would seem from this that we are rapidly developing a disproportionate share of specialists. I'm not recommending any changes in that; but I think we have to recognize that this growing number of specialists may be a factor in our current situation.

Also during that time 42% of all dental graduates pursued some form of education beyond the doctoral degree, another statement of fact that tells us more dentists are receiving more advanced training. It's obvious that with more advanced training, those dentists are attempting more complicated procedures. That leads to yet a still smaller population of patients to be referred to the specialists.

Sometimes I hear discussion that there should be some kind of a rule that only those dentists with specialty training should be allowed to undertake certain procedures. Is it possible to establish rules at the national level to regulate practice? Is this something that the ADA should consider as policy? I think not. Only individual state practice acts can attempt to do that. And I'm really not sure that you want to do that.

Our real problem here is the breakdown of the referral process, a process that has served the public very well, that has given us the reputation of being caring, has given the patients the assurance that they will receive the most expert care available.

Maybe the specialists should adopt this simple motto: "If you won't send me any cases to start, don't send me any cases to finish." That would apply to the oral surgeon who is continuously asked to remove root fragments, to get a tooth out of a sinus, to stop some bleeding, whatever the complication is. The oral surgeons do this willingly for dentists who support them morally and financially, by recommending them further treatment and referring their patients routinely.

The endodontists cannot make their living taking your instruments out of canals. The periodontists, the orthodontists all are not anxious in this litigious society to assume cases that already present some kind of a problem and at the same time assume the risks with the referring dentists.

I think too the generalists are entitled to say to the specialists, "If you won't tell me what cases I should start or should not start, how should I decide?" It's up to the specialists to be more generous in sharing their expertise and specifically to explain the things to avoid. They need to help the general dentists understand the things to look for,

to prevent the problem before it occurs, rather than asking the specialists for help after the problem develops.

Where do we go from here? The Board and staff seek your guidance as to how you would like to approach this problem. My personal judgment is that this is a very serious problem that affects the profession and the type of care we deliver. The proper relationship between the generalist and specialist is one of the single most important factors in this profession.

I promised you that I wouldn't keep you long and I'm running out of time—I'm only sorry that I can't talk with you in detail about many of the positive things that happened during the year.

For instance, Dr. Dave White's outstanding idea with the PAC-clinician program. You know that I'm very dedicated to the political action concept. And this program of working with outstanding clinicians who volunteer freely to give their time to bring new dentists into the political fold has proven to be an effective idea.

Another issue that depends more on time than on money is how we handle the problems of infectious disease and infection control. I think Dr. Saddoris and his successors will find that this will be the biggest issue in years to come. There will be more press, more concern, more correspondence with our members and more changes in how we practice dentistry.

We still have problems with recruitment and retention. I think the House has to help determine what it thinks is a realistic percentage of the members of this profession that will ever be members of the American Dental Association. We're making some progress, but we need to be realistic: we will never get all the dentists in this country to belong to the ADA. Let's accept that now, while acknowledging at the same time that this is an ongoing concern that deserves your attention at the state and local, as well as the national, levels.

I have been honored this year to serve as your president. You have trusted me with that responsibility and I appreciate it. You have hosted and entertained and honored Mary Margaret and me beyond our wildest dreams, and we appreciate that.

In closing, let me ask you to look again at that coin I asked you to take out. It says, "In God we trust." Sometimes I think we should add "And in damn few others."

So I'm going to ask you a final favor. Trust Jim Saddoris. Trust your Board. Trust Tom Ginley and your staff. In short, trust the process, because I can tell you, from first-hand experience, that it works. And remember, "If you want to be treated like a doctor, you have to behave like a doctor." God loves you all and so do I.

Resolutions

The resolutions and accompanying background statements appear in the Appendix of this report.

Appendix

Purchaser Contact Program

Background: The President believes that the Association should launch a purchaser contact program to assist plan purchasers in designing dental benefit plans for their employees that will preserve the patient's freedom of choice of dentist, and utilize the fee-for-service dentistry preferred by the profession.

The Association should be in a position to know which major company/union contracts are up for renewal, and whether consideration of a change in dental benefit plans is likely to be part of the contract negotiations. It is also important for the Association to be able to identify those companies which are considering instituting dental benefit plans for the first time, as well as those companies that are considering dual options and alternative dental benefit plans.

The currently budgeted purchaser contact program allows for 30 visits to employers during 1988. The President would like to see this program expanded to 100 visits to purchasers during 1988. Outlined below are the anticipated costs involved in adopting a purchaser contact program:

1. Volunteer travel, 70 × $400	$28,000	
Staff travel, 70 × $400	28,000	
Volunteer per diem, 70 × $140	9,800	
Staff meals and lodging, 70 × $125	8,800	
		$74,600
2. Survey of companies and unions		
Program costs: survey, mailing, and tabulating	$25,000	
Additional temporary staff	15,000	
		$40,000
3. Actuarial consultants	$50,000	
		$50,000
Total Cost of Program for 1988		$164,600

The President offers the following resolution for consideration.

87. Resolved, that the Association launch a purchaser contact program that will permit up to 100 purchaser contacts during 1988, and be it further

Resolved, that the 1988 budget be increased in the amount of $164,600 to fund the program, and be it further

Resolved, that the Board of Trustees charge the appropriate Association agency with responsibility for implementing the program.

Future Promotion of Fee-For-Service Dentistry and Freedom of Choice of Provider

Background: There is a strong need for the Association to explore the feasibility of hiring a team of professionals to reach plan purchasers on a full-time basis. Council members cannot devote the amount of time necessary to make this a full-time program and it may not be permissible for in-house staff to be hired for such a program.

Clearly, the members are waiting to see what direction their Association will take in actively putting into practice the long-standing policies of fee-for-service dentistry and freedom of choice of provider.

The Council's 1988 budget does not include development of this new program. The anticipated costs include the following:

1. Subcommittee meetings:	
Volunteer travel, 3 members × 2 meetings = 6 × $400	$2,400
Volunteer per diem = 6 × $140 × 2 days	1,700
Meals for subcommittee and staff (lunches = 18 × $10)	200
	$4,300

Therefore, the President recommends the following resolution:

88. Resolved, that the Association direct the Council on Dental Care Programs to develop a full-time program to reach plan purchasers to promote the Association's policies of fee-for-service dentistry and freedom of choice of provider, and be it further

Resolved, that the Council develop an appropriate budget for the program and report back to the 1988 House of Delegates, and be it further

Resolved, that the 1988 budget of the Council on Dental Care Programs be increased by $4,300 to cover the cost of developing the program.

Education and Prospective Purchasers of Dental Benefit Programs

Background: The Association has long supported promotion of the concept of direct reimbursement to dentists, patients and plan purchasers. During the past three years, the Association has developed an impressive campaign to fulfill this mandate. As we have accumulated data and experience with this concept, it has become quite evident that some segments of the purchasing community do not consider direct reimbursement acceptable. Among the various reasons are that direct reimbursement does not fit the mold of managed care. Some purchasers believe that lack of controls will result in overtreatment and program abuse. Still other purchasers believe that utilization review is crucial to a benefit plan.

The Association is currently working with a very well-known actuarial firm and is developing data to assist plan purchasers to better understand direct reimbursement, and to make accurate cost projections in order to compare a direct reimbursement program to their current dental benefit plans.

In order to assist those plan purchasers who do not wish to consider direct reimbursement plans for their employees, the President recommends that the following resolution be adopted:

89. Resolved, that Resolution 58H-1986 (*Trans.*1986:515), Education of Prospective Purchasers of Dental Benefit Programs, be amended by deleting the second resolving clause and substituting therefor the following:

> **Resolved,** that in this effort, promotion of direct reimbursement, independent practice associations, and any other model which encompasses fee-for-service dentistry and freedom of choice, is encouraged by the Association.

so that the amended policy shall read as follows:

Resolved, that the Association engage in an aggressive program to educate prospective purchasers to the advantages of dental benefit programs that are compatible with private practice, fee-for-service dentistry, and freedom of choice, and be it further

Resolved, that in this effort, promotion of direct reimbursement, independent practice associations, and any other model which encompasses fee-for-service dentistry and freedom of choice, is encouraged by the Association.

Development of a Protocol to Study Capitation Programs

Background: The President agrees with the Board of Trustees (Report 9; Worksheet: 555) and the Council on Dental Care Programs (Appendix C of Report 9; Worksheet: 572) that the comprehensive study of dental care provided by U.S. dentists under all forms of reimbursement mechanisms is of major importance to plan purchasers, the government and consumers. Further, the President believes that the proposed study is so vital to the profession that it should begin as soon as possible. Therefore, the President recommends adoption of the following resolution:

90. Resolved, that the Board of Trustees is authorized to spend up to $500,000 to fund Phase One of the study, as outlined in the budget (Appendix B) attached to Board Report 9.

Notes

Supplemental Reports and Resolutions

Notes

Council on Dental Care Programs

Supplemental Report 1: Response to Resolution 60-1985 Regarding Customary Fee

Background: Resolution 60-1985 (*Trans.* 1985:586) was referred back to the Council on Dental Care Programs for further study by the 1986 House of Delegates (*Trans.* 1986:506). The membership's concern with the application of the Association's definitions of "usual, customary and reasonable (UCR)" dates back to 1979. In reviewing the background of the problems resulting from the application of UCR, two things become apparent: (1) the issue is far from new, and (2) its implications for the profession and its patients are of major importance.

The definitions of UCR, adopted in 1973 (*Trans.* 1973:665), were directed to the Council on Dental Care Programs by Resolution 85H-1980 (*Trans.* 1980:558), which instructed the Council to study the definitions in order to "...clarify such terms, update and justify their existence..."

The disparities in UCR plans had caused increasing problems for members and their patients, especially as the number of dental benefit plans increased. In 1981, the House adopted Resolution 29H (*Trans.* 1981:576), which directed the Council to survey major insurance firms and service plans to determine the methodologies, including definitions of relevant terms, used in calculating benefits in UCR plans.

Early in 1984, the Academy of General Dentistry approached the Council asking for assistance in resolving some of the problems members were having with UCR plans. The Academy believed at that time that the problems were due to language contained in the Association's definition of "customary fee," which allowed separate reimbursement levels for specialists and general practitioners for providing the same or similar services, due to the phrase "dentists of similar training and experience."

The issue went to the 1985 and 1986 Houses of Delegates and in both instances the House referred the matter back to the Council for further study (*Trans.* 1985:586; 1986:506).

Subcommittee to Study Customary Fee: From the outset of its study of the issues, the Council established that the "victims" in this controversy are the patients and that dentistry's commitment to resolving the problem and protecting patients' rights would have to be strong and uncompromising. Following the 1986 House of Delegates, the Council Chairman appointed a special Subcommittee to Study Customary Fee to thoroughly review the issue. During the Subcommittee's first meeting it was determined that focusing on "customary fee" alone would not solve the problem. The Council Chairman approached the Board of Trustees at its February 1987 meeting to request that the Council be permitted to expand the study to include the definitions of "usual" and "reasonable" with "customary." The Board agreed to the Chairman's request.

The Subcommittee recognized that in order to find a solution that would be meaningful and would have a long-range effect, its study of the situation must be divided into two phases. The first phase would identify current applications and abuses of the Association's definitions by the insurance industry and review these definitions for their applicability in light of the current administrative environment. The second phase will formulate and implement an organized and methodical series of action steps to address the specific problems identified in phase one.

Phase One

Insurance Company/Service Corporation Use of Definitions of Usual, Customary and Reasonable: Two studies on the use of definitions by insurance companies and service corporations, conducted by the Washington State Dental Association in 1980 and by the Council in 1981, show conclusively that the Association's definitions of UCR are not used by insurance companies or service corporations. Following these studies, the Council made a concerted effort to have the Association's definitions accepted and used. This effort did not succeed and, unfortunately, the profession has been bitterly divided over language that has no bearing on the problems members are experiencing due to the applications of the definition of "customary."

Apart from some Delta Dental plans, insurance companies and service corporations do not maintain separate fee profiles, so the divisive issue of specialists receiving a higher reimbursement level than general dentists for providing the same service is without widespread foundation.

The Council noted that for the duration of the heated debate that has taken place on this issue over the past two years, the insurance company and service corporation representatives (with whom it meets on a regular basis) never volunteered the information that they had their own definitions of UCR and did not use the definitions developed by the Association.

The Council has received complaints from members—both specialists and general practitioners—who have received a variety of reimbursement levels for the same service and who practice across the street from each other, in the same town and some even in the same office. It quickly became obvious to the Subcommittee that the real problems with disparate reimbursements are caused by the methodologies used by insurance carriers to calculate fee levels on which benefits are determined.

Research showed that the Association's language in its "customary fee" definition urging consideration of "socio-economic area of the metropolitan area or other socio-economic area" was, at best, being inconsistently factored into the various methodologies and, at worst, was being completely ignored. Some companies consider the state as a whole, making no distinction between urban, suburban and

rural communities; others divide states into quadrants; some into regions; and still others use a finer delineation by zip codes.

The methodologies used by insurance carriers to calculate fee levels on which benefits are based are considered proprietary by the industry. This is contrary to the Association's contention that UCR is a viable system, provided plan purchasers and employees are thoroughly informed about these methodologies. The privacy currently enjoyed by the insurance industry has resulted in an additional problem for members and their patients, that is insurance carriers are informing patients that their dentists have charged above the UCR fee levels for their areas. As a result, members stand accused before their patients with absolutely no way to refute the insurance carriers' claims.

The Health Insurance Association of America (HIAA) states that commercial insurance companies update their fees regularly, either on a semiannual or annual basis. However, there is no regulation in any state requiring that the latest fee data be used to determine benefits or for selling new plans. In addition, insurance companies use a variety of combinations of UCR. For instance, some use "reasonable and customary," some use "usual and reasonable" or "usual and customary," and others use all three, or all three consolidated into one definition.

With as many variables of definitions and methodologies plugged into the insurance carriers' individual formulas, it is easy to understand why members and patients receive such widely disparate reimbursement levels for the same procedures.

The Council believes that resolving the problem will require major surgery rather than a band-aid. Determining an equitable method for calculating fee levels on which benefits are based is crucial and requires that:

1. criteria and corresponding methodology be developed by the Association for acceptable UCR plans to include, but not be limited to, the following:

   —fee data updated quarterly;
   —fee data collected only from fee-for-service plans;
   —a statistically significant sample size must be used as a minimum base;
   —data must be based on ADA codes;

2. the criteria and methodology must be approved by the insurance commissioner in each state;

3. the criteria and methodology must be made known to the purchaser and patients;

4. limitations on benefits attributable to the application of UCR determinations be described on a patient's Explanation of Benefits notification by the statement: "Any difference between the fee charged and the benefit paid is due to limitations in your dental benefit plan contract," or a statement of similar intent;

5. insurance commissioners have the authority to alter and correct such inequities as:

   —division of geographic boundaries;
   —fee update periods;
   —artificial screening systems;

   and any other inequities that may be identified.

The Subcommittee has studied the Association's current definitions of "usual, customary and reasonable." It agreed that "customary" is the mathematical structure used by insurance companies and service corporations to control "usual and reasonable." The Subcommittee also agreed that "usual and reasonable" are within the control of dentists, but that "customary"—where the real mischief is being created for the profession and its patients—is completely outside the control of the profession.

The definitions used to explain concepts in dental benefit plans will be acceptable to the profession only if they reflect what is actually taking place. The Council has suggested that "usual" represents the fee most frequently charged by the dentist; "reasonable" represents the fee charged by a dentist, that is modified by special medical or dental complications or unusual circumstances; and "customary" represents a fee level that is arbitrarily determined only by an insurance company or service corporation administrators.

The Council believes that a successful solution to this issue will result in a unified profession, and therefore recommends the adoption of Resolution 75, which is presented at the end of this report.

Phase Two

The fact that this study of "customary fee" involves an important consumer issue requires that the Council reach far beyond the resources of the Association and dental profession for solution. Based on the adoption of the above definitions by the 1987 House of Delegates, the Council will proceed to Phase Two of this study and pursue the following activities:

—hire an actuarial consultant to work with the Council to develop guidelines for use in determining appropriate criteria and methodologies for calculating fee levels on which benefits are decided;
—work to develop model regulations to bring about consistency in the criteria and methodologies and their application in the various states;
—develop a legislative initiative on a state-by-state basis that would implement the criteria and the methodologies; and
—create an agenda to work with insurance carriers to gain cooperation in standardizing the definitions, criteria and methodologies.

A final report and recommendations will be submitted to the 1988 House of Delegates.

Resolution

75. Resolved, that the following definitions of usual, customary and reasonable fees be adopted:

Usual fee is the fee which an individual dentist most frequently charges for a specific dental procedure.

Reasonable fee is the fee charged by a dentist for a specific dental procedure which has been modified by the nature and severity of the condition being treated and by any medical or dental complications or unusual circumstances, and therefore may differ from the dentist's "usual" fee or the benefit administrator's "customary" fee.

Customary fee is the fee level determined by the administrator of a dental benefit plan from actual submitted fees for a specific dental procedure to establish the maximum benefit payable under a given plan for that specific procedure.

and be it further

Resolved, that the current definitions of usual, customary and reasonable fees (*Trans.* 1973:668; 1981:574, 575) be rescinded.

Council on Dental Care Programs

Supplemental Report 2: Update on Recent Council Activities

Direct Reimbursement Promotional Activities

Education of the membership continues to be a cornerstone of the Association's efforts to promote direct reimbursement. Between May 1 and September 30, the following presentations for members were given:

—one direct reimbursement presentation at a constituent's annual session;
—three 1-hour presentations on marketing direct reimbursement to component societies;
—one half-day session on direct reimbursement at the Association's Management Conference; and
—one hour presentation as part of a panel discussion on dental benefits sponsored by a constituent society.

In addition, an article on Association support for constituent society promotion of direct reimbursement was published in the *ADA News*.

In response to Resolution 76H-1985 (*Trans.*1985:570), the Council has increased its assistance to constituent and component societies. The following activities were completed between May 1 and September 30:

—preparation of a manual on marketing direct reimbursement, including Association resources and sample budgets, advertisements and print materials;
—training of newly hired direct reimbursement staff for a constituent and for a component dental society; and
—production of three booth displays for direct reimbursement, suitable for use at trade shows, conventions and employer expos.

The Council continued to provide assistance to constituent and component societies in the form of incentive funding for the development of new direct reimbursement campaigns. Societies receiving funds from May 1 to September 30 are:

Utah		$2,373.00
Cleveland		883.00
Northern California		630.00
South Carolina		3,426.00
	Total	$7,312.00

The total incentive funds allocated thus far from the 1987 budget is $23,250, distributed among eight societies.

The marketing efforts of constituent and component societies, as well as that of the Association, will be greatly enhanced by the availability of software produced in-house by Association staff and available for purchase by employers beginning September 30, 1987. The system will run on an IBM-PC and will be tested by Minute Lube, a division of Quaker State in Utah with a direct reimbursement plan covering 2,500 individuals, and by a school district in Indiana with 100 employees and their dependents.

In addition to testing the software, these employers and others have agreed to allow the Association access to their cost and utilization experiences. The acquisition of current, accurate data is vital to the development of a meaningful data base for direct reimbursement. Staff has used the information received on costs and designs of direct reimbursement programs to better advise prospective employers of the costs they may anticipate when converting to direct reimbursement.

As the Association expands its purchaser contacts to reach larger and more sophisticated multistate employers, there is a need for concrete actuarial support in addition to experiential data. For this reason, the Council has contracted with Milliman & Robertson, an actuarial firm with access to national data on dental charges and utilization. By the end of the year, the firm will have developed a rating formula and trained Council staff in projecting direct reimbursement dental costs based on several variables including: plan design, number of employees and dependents, region of the country, type of company, previous dental coverage and employee demographics such as sex and age.

Contact with multistate employers has been a priority of the Council this year, and staff has met with representatives of a General Motors component and General Electric. Information has also been sent to benefits personnel at companies such as UniRoyal, Frito-Lay, TWA and Toyota. This year, the Council's Dental Benefits Conference featured speakers from Yale University, Dow Corning Corporation and Lubbock County School System, discussing their successes with direct reimbursement dental programs for their employees. Staff will reach more employers this fall and next year as they take the booth displays to national conferences and conventions of employers. Two such exhibits are slated for the fall of 1987 and seven are scheduled for 1988.

Employers are also being contacted with information on Flexible Spending Accounts and their place in dental benefit programs. The Council has developed an insert page for the direct reimbursement kit which explains the concept of a flexible spending account and how one is especially effective when combined with a direct reimbursement dental plan. The Council has also produced a brochure on flexible spending accounts which more generally explains the concept and how the use of a flexible spending account stretches the dollars of a patient because dental care may be paid for with nontaxable monies.

Peer Review Activities

The Association first formally recognized the peer review concept for dentistry when policy on dental society review committees was adopted 17 years ago (*Trans.*1970:25,485;

1971:485; 1976:865). Since that time, other policy statements that speak to various aspects of the peer review process have been adopted: peer review of radiographs and other treatment records (*Trans.* 1971:524); use of peer review mechanisms by third parties (*Trans.* 1972:668); exemption from liability for peer review committee members (*Trans.* 1973:656); review of dental practice by the profession (*Trans.* 1975:658); merging of responsibilities of grievance and peer review committees under functions of a single entity—the peer review committee (*Trans.* 1977:904); dental society cooperation in resolving interjurisdictional peer review cases (*Trans.* 1979:624); constituent society member cooperation with peer review procedures (*Trans.* 1980:576); and constituent societies conforming their peer review systems to Association recommended actions (*Trans.* 1981:573).

Although those policies that have been adopted more recently (the last one being adopted in 1981) speak most clearly and directly to the peer review process, policies adopted much earlier do not fully reflect the peer review process as it currently functions. Although other policies have been adopted that correct omissions or otherwise supplement earlier policy, the Association's policy framework for peer review appears somewhat incohesive.

Council Activities: The Council, consistent with its *Bylaws* responsibility, has assisted constituent and component dental societies and peer review committee chairmen and members in implementing peer review procedures, improving on existing functions and dealing with specific questions or problems. This assistance has been provided through on-site peer review assistance programs to constituent societies, available resources for dental societies conducting their own training sessions, dissemination of printed material, compilation and maintenance of data on peer review, and ongoing correspondence and telephone communication.

In the time that the Council has been monitoring nationwide peer review activity and actively assisting the profession in peer review matters, it has seen the process evolve considerably. A peer review mechanism exists in every state, although it varies to a limited extent in the procedural aspects of the process. The most evident differences generally reflect the size of the population, the number of practicing dentists, the geographical considerations, the extent and nature of the dental benefit marketplace, and the perceptions of the dental society and its leadership of peer review as a priority.

The policies that have been adopted to date have enabled the Council to fulfill its responsibilities in a reasonably consistent manner. There are aspects of the peer review process, however, that should be addressed in policy and are not, or that are addressed in existing policy which is no longer timely or appropriate. These include the availability of and access to the peer review process by nonmember dentists, the appropriate role of specialists in peer review, both as reviewers and those being reviewed, and the guidelines and criteria for the composition of the committee and the specific administrative procedures.

The Council firmly believes that the profession has a vested interest in ensuring that the peer review process works efficiently, predictably and objectively. The Council appreciates the fact that all recommended procedures, whatever they may be, cannot be fully implemented in every state and expected to work equally well. Realistically, whatever recommendations are ultimately adopted must allow enough latitude to accommodate the individual characteristics of the state. The basic precepts, however, must be established to encourage some level of consistency and thereby enhance the credibility of the process.

The Council is of the opinion that the ultimate objective of the dental profession is to exercise as much self-regulation as possible by ensuring that dental treatment is reviewed by dentists and that oversights, inadequacies or other problems are remedied. From a more practical and more immediate standpoint, the peer review process currently offers the most accessible and tangible recourse for addressing and resolving problems with dental treatment. It also presents a much more preferable alternative to malpractice litigation, an issue of great concern at this time. Third-party carriers should also look to dentistry's review system as a primary means for addressing problems regarding dental treatment. There is no review mechanism that a third-party carrier can internally implement or otherwise use that can as effectively preserve the integrity of the dentist-patient relationship or that would have as much support from the dental profession. A peer review system that does not function to its greatest potential can only serve to encourage the formation of other review mechanisms, most of which may not be acceptable to the dental profession. Lastly, the value of a well functioned peer review process to the profession's image cannot be underestimated.

Other than the dentist-patient relationship established in the course of dental treatment, there is no one single opportunity that so intimately acquaints the patient with the dental profession. It is to dentistry's advantage to ensure that the peer review process is perceived as consistent, efficient and, most importantly, as credible.

Recommendations: The Council has carefully and extensively reviewed all existing policy on peer review. Those policies which speak to the broader dimensions of the peer review process form the framework and should remain intact. These policies urge dental societies to establish their peer review systems in accordance with the Association's recommendations; mandate member cooperation with peer review procedures; and establish the duty and prerogative of the dental profession to conduct all necessary review of dental practice. Those policies that relate to dental society cooperation in resolving interjurisdictional cases; merging of responsibilities of grievance and peer review committees; urging of dental societies to seek legislative exemption from liability for peer review committee members; and establishing the right of peer review committees to review radiographs are more administrative or procedural considerations and have been incorporated, along with the policy on dental society peer review committees, into the *Guidelines on the Structure, Functions and Limitations of the Peer Review Process* presented as an Appendix at the end of this report. The Council, therefore, recommends adoption of the following resolution.

78. Resolved, that the *Guidelines on the Structure, Functions and Limitations of the Peer Review Process* (Appendix) be approved, and be it further

Resolved, that Resolutions 6H-1979 (*Trans.*1979:624), 91H-1977 (*Trans.*1977:904), 24-1973-H (*Trans.*1973:656), 43-1971-H (*Trans.*1971:524) and 49-1970-H (*Trans.* 1970:25,485) and 21-1971-H (*Trans.*1971:485), as amended by 123H-1976 (*Trans.*1976:865) all of which are incorporated in the *Guidelines on the Structure, Function and Limitations of the Peer Review Process*, be rescinded.

The policy on utilization of the peer review process by third parties was originally adopted in 1972. A revision is suggested to clarify and more accurately reflect the participants in the dental benefits marketplace. For this reason, the Council recommends the adoption of the following resolution.

79. Resolved, that the American Dental Association recommends that all insurance carriers, service corporations, alternative benefit plans and government programs use the dental profession's established peer review process to address issues or disputes concerning dental treatment, as appropriate, and be it further
Resolved, that Resolution 51-1972-H (*Trans.*1972:668), which urges third parties to use constituent or component peer review mechanisms as the primary method to resolve fee disputes prior to threats of litigation, be rescinded.

The existing policies on Professional Standards Review Organizations (PSROs) encourage dental participation (*Trans.*1974:636) and seek to amend the PSRO law to allow dental representation at the national level and the establishment of a PSRO dental component for the review of dental services (*Trans.*1978:499). The PSRO program has been phased out and its enabling legislation was superseded by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). The responsibilities of PSROs have been assumed by the Peer Review Organizations (PROs), which are required to utilize dentists in the review of dental services. Although the language in the Peer Review Organizations enabling legislation regarding dentist membership is similar to the language that was used in the PSRO legislation, there is some latitude to allow for nonphysician members. According to information obtained by the Association's Office of Quality Assurance, however, dental participation in the affairs of most PROs is very limited at this time.

Dentists should participate in PROs, both as members of their governing boards and of the organizations. As individual PROs develop the criteria and standards used in their respective utilization and quality reviews, dentists should be supportive of and actively involved in the development of those criteria. Also, PROs will gradually expand their activities beyond the hospital setting to include review of other than Medicare funded services, including services provided in the private sector. Dentist involvement in the PRO program will become increasingly important. The Council therefore recommends adoption of the following resolution.

80. Resolved, that the Association encourage the constituent dental societies to take action to assure full and equitable participation of dentists as members of the Peer Review Organizations in their respective areas and as members of their governing boards as long as dental services are being reviewed, and be it further
Resolved, that existing policy on dentist participation in Professional Standards Review Organizations, Resolutions 21-1974-H (*Trans.*1974:636) and 95H-1978 (*Trans.*1978:499), be rescinded.

Summary of Resolutions

78. Resolved, that the *Guidelines on the Structure, Functions and Limitations of the Peer Review Process* (Appendix) be approved, and be it further
Resolved, that Resolutions 6H-1979 (*Trans.*1979:624), 91H-1977 (*Trans.*1977:904), 24-1973-H (*Trans.*1973:656), 43-1971-H (*Trans.*1971:524) and 49-1970-H (*Trans.* 1970:25,485) and 21-1971-H (*Trans.*1971:485), as amended by 123H-1976 (*Trans.*1976:865) all of which are incorporated in the *Guidelines on the Structure, Functions and Limitations of the Peer Review Process*, be rescinded.

79. Resolved, that the American Dental Association recommends that all insurance carriers, service corporations, alternative benefit plans and government programs use the dental profession's established peer review process to address issues or disputes concerning dental treatment, as appropriate, and be it further
Resolved, that Resolution 51-1972-H (*Trans.*1972:688), which urges third parties to use constituent or component peer review mechanisms as the primary method to resolve fee disputes prior to threats of litigation, be rescinded.

80. Resolved, that the Association encourage the constituent dental societies to take action to assure full and equitable participation of dentists as members of the Peer Review Organizations in their respective areas and as members of their governing boards as long as dental services are being reviewed, and be it further
Resolved, that existing policy on dentist participation in Professional Standards Review Organizations, Resolutions 21-1974-H (*Trans.*1974:636) and 95H-1978 (*Trans.*1978:499) be rescinded.

Appendix

Guidelines on the Structure, Function and Limitations of the Peer Review Process

The function of a peer review committee is to review matters regarding the appropriateness of care and/or quality of treatment. Peer review committees also may, acting in an advisory capacity, provide for the appropriate review of fees.

Dental societies should establish peer review committees which provide for the review of differences of opinion between a dentist and a patient, or a dentist and a third-party agency. Third-party agencies may include insurance carriers, dental service corporations, administrators of health and welfare trusts, alternative benefit plans, government agencies, and employers who have implemented self-funded and self-administered dental plans.

Requests submitted by a dentist for review of treatment rendered by another dentist should be channeled to that agency which the constituent or component society has determined should review allegations of gross or continual

faulty treatment by a dentist. This could be the judicial committee or committee on ethics, or some combination thereof. It could also be the state board of dentistry.

In all instances, the peer review committee should carry out its responsibilities within a reasonable period of time that makes its efforts effective.

To guide dental societies in establishing peer review committees, consideration of the following principles is recommended.

1. The committee should be established as an official body of the constituent or component society.
2. The committee membership should be composed primarily of general practitioners who have the qualifications and experience to render a considered opinion as to the dental standards of the community, and to have their opinion accepted by the parties.
3. The committee should consider problems submitted by patients, dentists and third-party agencies. Review of problems involving practicing dentists who are not members of the dental society is encouraged.
4. The committee should not be vested with disciplinary authority, but should be able to provide recommendations for remedial action, as appropriate.
5. The committee should utilize standard procedures and forms in obtaining data required for adequate evaluation.
6. The committee should not consider cases in litigation.
7. The committee should establish a policy that parties appearing before it do not have the right to be represented by an attorney.
8. The committee should have the prerogative to appropriately request and review treatment records in cases under consideration.
9. The committee should have a clearly outlined process for dealing with repeat adverse decisions against a practitioner and for handling requests for appeal.
10. Constituent societies should consider whether appropriate liability insurance is required to protect dentists who serve as members of the peer review committee, and the societies sponsoring the peer review activity.
11. Constituent societies should have appropriate statutory protection for immunity from liability for peer review committee members and for confidentiality of records.
12. Information on the purpose, function and availability of the peer review process should be made available to dental society members, the public and other interested agencies.

The following guidelines are suggested to assist dental societies in implementing the foregoing principles.

Organization: The peer review committee should be a permanent committee of the dental society with appropriate status and liaison with related committees. It could be a freestanding committee, or subcommittee of the committee, or council, on dental care programs or other body charged with the responsibility for managing issues regarding dental benefit plans.

Composition: The committee should be composed of dentists who are well respected in their professional community. Terms of the committee should be staggered to ensure continuity of experience. The appointment of a lay person to serve on the peer review committee is encouraged.

The committee should also have as resources specialists who can be appointed on an ad hoc basis. If the dentist being reviewed is a specialist, he/she may require the chairman to obtain a panel of like specialists. Also, if the committee feels the need for additional expertise, specialists may be appropriately appointed. Any additional members appointed on an ad hoc basis should have the same status, for that particular case, as do permanent members of the committee.

Submission Procedures: It is recommended that all requests for peer review be submitted in writing, accompanied by supporting records and other pertinent information, to the constituent or component dental society. All parties to a peer review case should be asked to agree in writing to abide by the peer review committee's recommendation.

In cases involving a third-party carrier, the carrier should first have made an attempt to contact the dental office for clarification on a clerical or claim reporting problem, or to have had its dental consultant contact the dentist on issues involving professional judgment or contract interpretation.

The carrier should notify the patient of a delay in payment of a claim, with further explanation that the claim is pending receipt and review of additional clinical documentation.

Constituent dental societies are urged to cooperate in every appropriate way to resolve peer review cases in which the parties involved reside in different states or in different jurisdictions within the same state. These cases should be given priority consideration for resolution in an expeditious manner.

Mediation: The component peer review committee chairman should appoint one committee member to serve as mediator. All contacts made by the mediator should be carefully documented. The mediator submits a written report to the chairman, either advising that mediation was successful or that it was unsuccessful and further action is necessary.

Committee Review: The committee should be composed of a minimum of three members. If the committee determines that a clinical examination of the patient is necessary, the patient should sign an appropriate consent form and the dentist should be notified. Committee members should have the opportunity to individually evaluate the specifics of the case. The committee's final recommendations should reflect the collective opinion of the members.

Communications and Recordkeeping: The committee should report its decision and recommendations within 60 to 90 days from initiation of the review. The committee should communicate in writing its decision to all parties to the case.

Copies of all documents and records obtained during the review process—including the decision and any

recommendations—must be kept confidential and should be forwarded to the constituent society executive offices. An attorney should be consulted to determine individual state provisions for retention of case records.

Appeal Mechanism: Within 30 days of a component dental society peer review committee's decision, all parties have the right to appeal, in writing, to the constituent dental society peer review committee generally serving as the appellate body. An appeal can be considered if it can be shown that: (a) proper procedure was not followed, (b) information previously unavailable at the time of review has become available or (c) the decision was perceived to have been contrary to any evidence and testimony presented. The decision of the appellate body is final within the peer review context.

Considerations for Peer Review and Dental Benefit Plans: The quality of the dental treatment provided under dental benefit plans is the logical concern of the dental profession and questions regarding that quality are within the purview of the peer review process.

Review of the dental treatment provided under a dental benefit plan should include a determination that the services were performed and that the treatment was appropriate and rendered in a satisfactory manner.

Peer review committees should be able to use all of the following methods, as required, to assess the quality of treatment services:

—follow-up and evaluation of patient complaints;
—review of records for adequate history, treatment plan and recording of services provided; and
—review of appropriate radiographs.

In the course of peer review function, specific deficiencies or problems prevalent in a particular plan may become evident. General information regarding the administrative or other aspects of the plan should be communicated, as appropriate, to the constituent society body vested with the responsibility for monitoring dental benefit plans.

Council on Dental Practice

Supplemental Report 2: Cooperative Continuing Education Efforts Between Dentists and Dental Laboratory Organizations

Background: Since the Association's reorganization, the Council on Dental Practice has continued liaison activities with dental laboratory organizations, subsequent to its own organizational meetings. One means of Association liaison activities would be through continuing education programs at the state and local levels. Both dental and dental laboratory organizations would like to improve communications about such programs. The Association has urged editors to include information in their publications about the dental laboratory industry's continuing education activities along with other issues of interest. The Association has also urged the dental laboratory industry organizations to increase publicity efforts for programs of mutual interest.

Some states have reported existing policies which prevent dental laboratory technicians from attending continuing education courses sponsored by dental societies. The Council believes this is unfortunate since certified dental technicians must complete mandatory continuing education credits to qualify for annual recertification and the National Board for Certification accepts participation in officially sponsored state dental society programs. The Council also believes that some courses sponsored by the laboratory industry are appropriate for the continuing education needs of dentists. Further, the Council believes that the liaison between the profession and the laboratory industry would be promoted and encouraged through such participation and interaction. The Council, therefore, recommends adoption of the following resolution.

Resolution

55. Resolved, that the American Dental Association urge constituent and component societies to establish cooperative arrangements with their counterparts in the dental laboratory industry to promote continuing education courses of mutual interest.

Council on Ethics, Bylaws and Judicial Affairs

Supplemental Report 1: Judicial Proceedings

Background: As noted in its annual report to the House (*Reports*:115), the Council at its May 11-12, 1987 meeting heard the appeals of Dr. Lawrence S. Lipkind of San Francisco and Dr. Thomas O. Ballard of Sacramento, California. The Council rendered its decision in the case of Dr. Ballard on June 22, 1987. The summary of this decision is hereinafter set forth. A complete text of the Council's opinion in this case is available on request to the Council. The appeal of Dr. Lipkind is still under consideration by the Council.

Appeal of Dr. Ballard: Dr. Ballard (Appellant) appealed to this Council from a sentence of expulsion imposed by the Judicial Council of the California Dental Association (CDA). CDA had charged the Appellant with refusal to comply with a reasonable request of a duly authorized committee of the CDA, specifically, refusal to cooperate with a peer review committee. On appeal, Appellant contended that his refusal was based upon his belief that the peer review committee was biased against him. This belief was based upon Appellant's experience with the peer review committee in a prior case. Appellant had requested the CDA to provide peer review through another component society, but CDA did not have any provision for this procedure at that time.

Only the CDA appeared at the oral argument of this case before the Council. In oral argument, the CDA informed the Council that during the course of the appeal, the Appellant negotiated with the CDA regarding the production of records. Subsequently, the records were produced, the peer review proceeding held and a decision rendered in Appellant's favor. On the basis of the cooperation by the Appellant, the CDA recommended a reduction in the penalty imposed. In considering the penalty to be imposed, this Council took cognizance of the fact that the peer review system is an important service provided to the public by organized dentistry. As a dispute resolution procedure, it enables dentists, patients and third parties to resolve their differences in an expedited manner without incurring the expense of legal proceedings. This is especially useful in small claims where the incumbent legal expense otherwise prohibits any resolution. Like all dispute resolution systems, whether in court or out, it is not perfect. The decision maker or makers do not always reach the correct decision. However, it is apparent that if every member with an adverse determination in peer review could place the burden on the system to prove that it was not biased against the individual in a subsequent proceeding, the system would break down. In this regard, the Council noted that had Appellant gone forward in the original proceeding, while the peer review hearing would have taken place within the same component system as his prior case, the hearing panel would have been different. Therefore, the Council found that the Appellant's original refusal to cooperate was not justified. However, in view of the Appellant's later cooperation and the CDA's recommendation, the Council determined to impose the penalty of censure on the Appellant, the penalty to be suspended in lieu of one year's probation. On successful completion of the probationary period, the suspended penalty of censure will be withdrawn and negated.

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

Council on Governmental Affairs and Federal Dental Services

Supplemental Report 2: Update on Council Activities

This supplemental report of the Council updates the status of state and federal legislative and regulatory issues as of September 18, 1987.

Overview of Federal Legislation: The first session of the 100th Congress has been dominated by the need to organize the newly Democratic Senate, the Iran hearings and the controversy over Supreme Court nominee Robert Bork. With regard to health issues, most attention has been directed toward two aspects of benefits legislation—catastrophic coverage under Medicare and mandates on employers to provide certain health benefits to employees.

Catastrophic Health Insurance: The House of Representatives has passed legislation (HR 2470) to limit Medicare beneficiary out-of-pocket expenditures for hospital and physician care to approximately $1,700 a year. A Senate vote on similar legislation (S 1127) has been delayed because of controversy over an amendment to add coverage for prescription drugs. The House bill includes a drug provision.

The legislation does not address nursing home care and other long-term care expenses. The Association urged that dental expenses should count toward meeting the eligibility threshold and, once a beneficiary qualifies for catastrophic protection, dental expenses should be covered. Neither of these changes is included in these bills.

Mandated Benefits: If and when a Medicare catastrophic bill is signed into law, it can be expected that increased attention will be focused on the variety of so-called mandated benefits bills. Senator Kennedy (D-MA) is actively working to build interest in his S 1265 to require all employers to provide a basic benefits package to all employees who work at least 17 hours a week.

A requirement that employers of 20 or more provide catastrophic benefits may emerge as a viable first step in the mandated benefits debate. Ways and Means Health Subcommittee members Stark (D-CA) and Gradison (R-OH) have introduced legislation (HR 2300) to require this.

The Association has presented comprehensive testimony and further background information urging positive incentives rather than federal mandates to help reduce the number of uninsured in this country.

Of further concern in Senator Kennedy's bill is a broad preemption of state laws relating to employee benefits. The provision is intended to override state mandatory benefit provisions. As drafted it also would override state freedom of choice and other similar state laws. The Association has vigorously objected to this preemption provision.

Professional Liability: There will be virtually no federal legislative activity in this Congress with regard to tort reform. The Congress continues to view this as a state matter.

The Senate has passed and the House Energy and Commerce Committee has approved Federal Trade Commission reauthorization legislation (S 677, HR 2897) which includes a requirement that the FTC conduct a comprehensive study of the liability insurance industry, including dental liability insurance.

The U.S. Health and Human Services Department (HHS) recently issued a report on professional liability. The Association had considerable input through participation in meetings of the Department's Liability Task Force and through submission of additional information.

The Department's report emphasizes the multifaceted nature of the liability problem and calls for action involving tort and insurance reform as well as provider and public education. This report acknowledges that legislative activities will take place primarily at the state level.

Medicaid Overlap: The House Energy and Commerce Committee has included in its Budget Reconciliation package (HR 3188) a provision to assure that state Medicaid plans will reimburse for services provided by dentists that are covered when provided by a physician and are within the scope of license of the dentist. An identical provision is to be considered by the Senate Finance Committee as part of its budget deliberations.

Campaign Finance Reform: The Senate has held seven cloture votes attempting to end a mostly Republican filibuster against legislation (S 2) to establish partial public financing of Congressional elections. Each vote failed. It now does not seem likely that the issue will be brought before the Senate until next year at the earliest. The Association, on its own and in conjunction with a coalition of associations and corporations, has been extremely active in opposition to S 2.

Federal Trade Commission: Congress is developing legislation to extend the authorization of the FTC. As noted above, both the House and Senate versions of this legislation would require the Commission to conduct a study of the liability insurance industry. Both bills also contain provisions which could significantly increase notification and procedural requirements that the Commission would have to meet before it could intervene in state deliberations. The Association favors the House approach to these interventionist restrictions. The House bill more specifically defines the procedures that must be followed.

Medicare Fraud and Abuse: President Reagan has signed into law (PL 100-93) legislation to increase the ability of the HHS Department to bar health professionals and providers

from participation in Medicare and Medicaid for conviction of fraudulent practices in those programs.

Appropriations: The House Appropriations Committee has approved a fiscal year 1988 budget for the HHS Department that includes $128 million for the National Institute of Dental Research and an additional $3 million for NIDR activities with regard to AIDS. A separate spending measure, currently pending before the House Subcommittee on Defense Appropriations, will provide funds for the military dependent dental insurance program which became operational on August 1, 1987.

National Health Service Corps: The Senate has passed S 1158 to extend authority for the National Health Service Corps. Included is establishment of a new loan forgiveness authority. The House Commerce Committee has approved a similar bill (HR 1327).

Tax Matters: The Association continues to urge Congress to correct two changes made by the 1986 Tax Reform Act and expand another. The changes would return full deductibility of (1) professional dues and similar expenses for employed dentists and (2) interest paid on student loans. The Association also urges full deductibility of health benefit premium payments for self-employed individuals.

With regard to each of these areas, the Association is working with relevant organizations so that a broad base of support will be provided at the time when tax changes again are considered by the Congress. Congress is expected to continue to resist tax changes through next year.

Peace Corps: The House has adopted legislation (HR 1266) to provide a pilot Peace Corps program to establish and train health service teams, including dentists, to serve in host countries. Similar legislation (S 895) is pending in the Senate.

Tobacco: There continues to be considerable interest in tobacco-related issues. Hearings have been held on proposals to prohibit or severely limit tobacco advertising, to increase excise taxes on tobacco products, to limit or remove special treatment of tobacco products under consumer protection and food and drug laws and to otherwise discourage use of these products.

Although it is unlikely that any proposal more stringent than an increase in the excise taxes could be enacted, the continuing publicity about the health consequences of tobacco products use has been helpful.

Prevention Block Grants: The House has adopted (HR 1861)—an extension of the Preventive Health Services Block Grant authority. Funds from these block grants to the states can be used for fluoridation activities.

Federal Employees Dental Benefits: The Washington Office expects that a member of the House Employee Benefits Subcommittee shortly will introduce ADA-developed legislation to assure availability of dental benefits for all federal employees. Senate sponsors are being sought.

Drug Prescribing Restrictions: The House Energy and Commerce Committee has approved legislation (HR 2168) to prohibit (except in unusual circumstances) physicians, dentists and others from dispensing prescription drugs for a profit. Free distribution of samples would be permitted.

Right-to-Know: Federal rules issued by the Occupational Safety and Health Administration (OSHA) will require dentists and all other employers in the nonmanufacturing sector to inform and train office personnel of the dangers of hazardous substances. The Hazardous Communication Rule, which is being phased-in over the next nine months, preempts existing state and local right-to-know laws. States which have existing OSHA-approved plans would be allowed to continue their enforcement of right-to-know statutes but only after their programs have been resubmitted to OSHA for certification. A key element in the new rule is a September 24, 1987 requirement that manufacturers and distributors of products with hazardous substances must provide purchasers with material safety data sheets (MSDS) which detail the nature and properties of the hazardous substances. The MSDS are to be used by employers as part of mandatory hazardous communication programs that inform workers of the presence of hazardous substances and train such personnel on proper safeguards. Dentists are required to establish in-office hazardous communication programs by May 20, 1988.

Data Bank: A national data bank to collect and dispense information on medical and dentist disciplinary actions will become operational on November 14, 1987 under a timetable set by the Department of Health and Human Services. The data bank, authorized by Congress in 1986 as part of the Health Care Quality Improvement Act (PL 99-660), is to serve as a clearinghouse on adverse decisions affecting hospital privileges, licensure and professional society membership of physicians and dentists. All payments, awards and judgments made by insurance casualty companies in the settlement of malpractice claims must also be reported to the data bank. HHS officials expect to award a federal contract by September 30 to a private organization or association to establish and maintain the data bank.

Infection Control: Mandatory infection control procedures and training programs for health care workers must be instituted under requirements to be issued by the OSHA. This federal agency—established by Congress in 1970 to regulate workplace health and safety standards—has announced that dentists, physicians, hospitals and other health care employers must supply office staff and support personnel with masks, gloves and protective eyewear, as well as conduct in-office educational programs on infection control and barrier techniques. The Occupational Safety and Health Administration will follow guidelines developed by the Centers for Disease Control in implementing the new regulation. OSHA officials plan an October mailing to all health care employers outlining compliance and enforcement procedures.

U.S. Department of Health and Human Services Dental Affairs: A review of dental programs within the HHS has

been authorized by the House Committee on Appropriations. The Congressional directive stipulates that the study shall be conducted by a special committee, comprised of public and private sector representatives, which is to address "...the identification of appropriate goals and priorities in dental health in the areas of research, education, prevention and service."

Of particular importance is the requirement by the House panel that the HHS committee evaluate the need for new organizational and administrative arrangements to improve the effectiveness of Departmental dental health activities. The Association had requested the HHS study in response to Resolution 31H (*Trans.*1986:53) calling for the establishment of an organizational focus for dental affairs within the Department.

Department of State Government Affairs

All but nine state legislatures have adjourned their regular sessions for 1987. Many are still meeting in special sessions called to deal with selected issues of particular urgency. For example, Florida Governor Martinez called a special session of the Legislature to meet in September for the purpose of considering whether to submit the newly enacted sales tax on services to a voter referendum.

Dental Hygiene: A California Superior Court judge recently ruled against the California Dental Association in a case challenging the procedures used to implement an experimental program in independent hygiene practice. The court ruled that the program's administrator, California State University at Northridge, was not a state agency. Thus, the University did not have to comply with procedural requirements that apply to state-run programs.

As of September 15, 14 hygienist-backed bills had failed to pass, three were enacted as introduced and two were enacted with amendments that significantly changed their content. Both dentistry-backed bills relating to hygiene supervision were enacted.

Freedom of Choice: A Delaware State Dental Society bill, requiring employers to offer employees a free choice alternative to closed-panel dental benefits plans, was signed into law in July. Delaware becomes the 15th state to protect patients' freedom of choice.

General Anesthesia and Conscious Sedation: Arkansas, like Indiana, enacted legislation that regulates the administration of anesthesia and conscious sedation by dentists this year. The New Hampshire Board of Dental Examiners adopted an anesthesia permit system under authority of its general rule-making powers.

Mandated Benefits: In May, Minnesota became the first state to mandate benefits for treatment of TMJ disorders. The mandate applies to insurers, nonprofit health service plan corporations and HMOs. Benefits must be paid for treatment provided by dentists, as well as physicians.

Colorado enacted legislation that amends an existing statute mandating benefits for congenital defects in newborns. The amendment lists specific treatments which must be covered under medical or dental insurance policies for treatment of cleft lip or palate.

AIDS: The Ohio State Dental Board proposed rules in May that will, if adopted, mandate infection control in dental offices. The proposed rules require dentists and auxiliaries to:

—be immunized against hepatitis B virus;
—wear gloves, masks and protective eyewear;
—use specific sterilization and disinfection procedures; and
-dispose of contaminated wastes and sharp implements according to state and local environmental laws.

Last year, the Washington State Dental Disciplinary Board issued infection control guidelines which recommend the use of barrier techniques.

In June, the Board of Trustees of the Arizona State Dental Association approved a membership directive which states, "Beginning immediately, all dental treatment should be rendered by utilizing gloves, masks and eye protections in addition to the usual sterilization procedures as prescribed by ADA guidelines." The Oregon Dental Association adopted similar standards to guide its members last year.

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

Commission on Relief and Disaster Fund Activities

Supplemental Report 1: Amendments to the Relief and Disaster Funds "Indentures of Trust"

Background: With the 1986 restructure of the Association, the Commission on Relief and Disaster Fund Activities was increased in number from seven to eight members. The newly composed Commission this year has reviewed the *Indenture of Trust* for the Relief Fund and the *Indenture of Trust* for the Disaster Victims Emergency Loan Fund to ensure that they comport with the directives of the House of Delegates for the 1986 restructure. The Commission had noted several areas in each *Indenture of Trust* that should be amended in order to comply with the directives of the restructure, to be consistent with the Association's *Bylaws* and to be consistent with the Commission's historical practice. These areas are as follows:

1. Introductory paragraph of each *Indenture* refers to seven Commission members. With the restructure, there are now eight members of the Commission.

2. Article III, "Investment of the Trust Property," of the Relief Fund's *Indenture* states (in pertinent part):

> The Trustees shall from time to time, with the approval of the Board of Trustees of the Association, employ an investment counsellor. Such professional counsel shall be either advisory to the Investment Committee in all matters relating to the investment policies and practices of the Trust Property or may be given discretionary authority by the Investment Committee to buy and sell securities for the portfolio *provided that the investment counsel promptly reports to the Trustees* through the Commission on Relief and Disaster Fund Activities Secretary, each purchase and sale of a security as soon as completion of any such transaction is confirmed (emphasis added). The Trustees *shall from time to time select three of their members who* together with the Treasurer of the Association and Chairman of the Commission *shall constitute the Relief Fund Investment Committee.* The Committee shall monitor the activities of the investment counsel and make recommendations to the Trustees on investment programs (emphasis added).

This provision does not comport with the historical practice of the Commission. First, the "investment counsel" referred to in the *Indenture* is the Association's bank, Lake Shore Bank. The bank, of necessity, makes investment buy/sell decisions daily. Those decisions are reported promptly to the Association's accounting department. In addition, a listing of transactions is compiled monthly and mailed to each Commission member. The Commission Secretary receives quarterly reports from Lake Shore Bank, which he promptly provides to the Commission members (the Trustees). It would not be practical, and has never been necessary, to provide the Commission members with reports each time an investment is made, particularly during periods when there is heavy trading activity of 50 or more trading decisions in one year. Therefore, the Commission believes this provision should be amended to reflect the Commission's actual practice.

Second, this provision requires that the Commission establish an investment committee. Each year the Commission complies with this mandate but then votes to act as a committee of the whole, thus eliminating the need for an investment committee. Therefore, as a practical matter, the Commission believes this provision should be amended to give the Commission the discretion as to whether or not a separate investment committee is needed in any given year.

3. Article IV of the Relief Fund *Indenture,* "Grants to Beneficiaries," states in pertinent part:

> Unless and until this *Indenture of Trust* be amended to provide otherwise, grants to beneficiaries shall be made only from investment income heretofore received (when the fund was a fund of the Association) or investment income hereafter received by the Trustees. Provided, however, that sums refunded to constituent society relief funds out of contributions to the American Dental Association Relief Fund may be applied by the Constituent societies to the fulfillment of grants approved by the Trustees.

This provision lacks clarity as to what funds are available to make relief grants to beneficiaries and the Commission is seeking to amend the language, to comport with its interpretation and past practices. The Commission believes that all monies, including, but not limited to, contributions, capital gains and bequests, as well as accumulated interest and dividends, should be available for charitable purposes, with the exception of the initial endowment of the Relief Fund by the Association. This endowment consisted of cash and other securities totaling $670,964.23. Although the Commission is of the opinion that this position reflects the intent of the *Indenture,* the existing provision could be

construed as limiting grant payments to the amount of investment earnings generated in any one year. Such a policy could seriously curtail Commission activities and the ability to offer aid during periods of great need. The Commission believes that its mission is better served by the amended provision, which reaffirms that it has the freedom and latitude to adequately assist those facing difficult financial circumstances.

4. Article VIII of the Relief Fund *Indenture* and Article IX of the Disaster Fund *Indenture*, "Limitation of Liability and Indemnification of Trustees," state as follows:

> No Trustee shall be liable for any loss not attributable to his or her own dishonesty or to the willful commission by him or her of an act known by him or her to be a breach of trust. A Trustee shall not be liable for any wrongful act or omission of any other Trustee, nor of any investment counsellor, agent, attorney or employee of the Trustees. Each Trustee shall be indemnified by the (Fund/Trust) and held harmless by it from and against all claims and liabilities including the reasonable expenses of defending against them, to which he or she may be or become subject by reason of his or her being or having been a Trustee, except liabilities arising out of his or her negligence or willful misconduct.
>
> This provision is inconsistent with the liability and indemnification provision in the Association's *Bylaws* and, therefore, should be amended so that the two provisions are consistent.

Consequently, the Commission recommends, adoption of the following resolution.

Resolution

39. Resolved, that the introductory paragraph of the Relief Fund's *Indenture of Trust* be amended to read as follows:

> This *Indenture of Trust* executed the 30th day of September, 1948, by and between the American Dental Association, a nonprofit corporation organized and existing under the laws of the State of Illinois and having its principal office in the City of Chicago, County of Cook and State of Illinois, hereinafter sometimes called the "Association," Party of the First Part, and the eight duly elected members of the Commission on Relief and Disaster Fund Activities of the American Dental Association, each of whom has subscribed his name hereto, hereinafter called the "Trustees," Parties of the Second Part,

and be it further
Resolved, that the introductory paragraph of the Disaster Victims Emergency Loan Fund's *Indenture of Trust* be amended to read as follows:

> This *Indenture of Trust* is between the American Dental Association as settlor and eight trustees to be appointed from time to time by the Board of Trustees of the American Dental Association. This *Indenture of Trust* shall take effect on November 15, 1972. The Association and the Fund Trustees consent to the stipulation in this paragraph and the following articles of agreement:

and be it further
Resolved, that Article III, "Investment of the Trust Property," of the Relief Fund's *Indenture of Trust* be amended to read as follows:

> That part of the Trust Property which the Trustees deem available for investment shall be invested by them in assets legal from time to time for investment by trustees under the laws of the State of Illinois. The Trustees shall from time to time, with the approval of the Board of Trustees of the Association, employ an investment counsellor. Such professional investment counsellor shall be either advisory to the Investment Committee in all matters relating to the investment policies and practices of the Trust Property or may be given discretionary authority by the Investment Committee to buy and sell securities for the portfolio provided that the investment counsellor periodically reports to the Trustees through the Commission on Relief and Disaster Fund Activities Secretary, regarding purchases and sales of securities. The Trustees may from time to time select three of their members who together with the Treasurer of the Association and Chairman of the Commission would then constitute a Relief Fund Investment Committee. If so selected, the Committee shall monitor the activities of the investment counsellor and make recommendations to the Trustees on investment programs. Otherwise, the Commission as a whole shall monitor such activities.

and be it further
Resolved, that Article IV of the Relief Fund's *Indenture of Trust*, "Grants to Beneficiaries," be amended to read as follows:

> Unless and until this Indenture of Trust be amended to provide otherwise, grants to beneficiaries and administrative expenses shall not be made from the original endowment, but rather shall be made only from accumulated income including, but not limited to, contributions, capital gains, bequests, interest and dividends heretofore or hereafter received by the Trustees. Sums refunded to constituent society relief

> funds out of contributions to the American Dental Association Relief Fund may be applied by the constituent societies to the fulfillment of grants approved by the Trustees.

and be it further

Resolved, that Article VIII of the *Indenture of Trust* of the Relief Fund and Article IX of the *Indenture of Trust* of the Disaster Victims Emergency Loan Fund, "Limitation of Liability and Indemnification of Trustees," be amended to read as follows:

> Each Trustee shall be held harmless and indemnified by the Association against all claims and liabilities and all costs and expenses, including attorneys' fees, reasonably incurred or imposed upon such person in connection with or resulting from any action, suit or proceeding, or the settlement or compromise thereof, to which such person may be made a party by reason of any action taken or omitted to be taken by such person as a trustee in good faith. This right of indemnification shall inure to such person whether or not such person is a trustee at the time such liabilities, costs or expenses are imposed or incurred and, in the event of such person's death, shall extend to such person's legal representatives. To the extent available, the Association shall insure against any potential liability hereunder.

Resolutions

Submitted by Constituent Societies, Trustee Districts and Delegates

Louisiana Dental Association

Development of Protocol for Treatment of AIDS Patients

The following resolution was adopted by the Louisiana Dental Association Board of Directors on July 10, 1987 and submitted on August 24, 1987 by Dr. Vincent N. Liberto, secretary-treasurer, Louisiana Dental Association.

Background: Dental offices and laboratories are risk centers for infectious disease. Pathogens, derived primarily from blood and saliva, are present in the operatory.

Significant cross-contamination occurs in dental offices and laboratories, flowing mainly but not exclusively, from patients to the dental staff. Pathogens can spread from patients' mouths to dental instruments, equipment, surfaces and staff even when infection control protocols are followed closely.

AIDS and other diseases are present in the dental healthcare environment. AIDS is an incurable disease of the immune systems that is almost always fatal.

There is serious concern about the real and present risk of treating individuals with the AIDS virus by members of the dental profession.

36. Resolved, that the American Dental Association develop a definitive protocol regarding the treating of AIDS virus compromised patients in the various dental care delivery systems, including a detailed description of the method by which a typical dental operating suite can be adapted to the best possible risk environment for the dental staff and its patients.

Ohio Dental Association

Hepatitis B and AIDS Testing for Dental Health Care Workers

The following resolution was adopted by the Ohio Dental Association on September 13, 1987 and transmitted by Nancy C. Quinn, executive director, Ohio Dental Association on September 23, 1987.

Background: Board Report 5, Association Activities Regarding Acquired Immune Deficiency Syndrome (*Supplement 1*:291), mentions that several state legislatures are considering bills concerning AIDS testing, and some deal specifically with testing health care providers. Testing is being considered as a way to reduce transmission of this disease. The American Dental Association should take the lead in investigating a voluntary, anonymous testing program for dental health care workers to serve both the public and the profession in the areas of hepatitis B and AIDS infection control in dental offices.

43. Resolved, that the appropriate council of the American Dental Association be directed to fully investigate the practicality of instituting a voluntary and anonymous hepatitis B and AIDS testing program for dental health care workers.

Texas Dental Association

Tax Deductibility of Dues Paid to Professional Dental Organizations

The following resolution was adopted by the Texas Dental Association House of Delegates and transmitted on September 2, 1987 by Mr. Robert E. Caffrey, executive director, Texas Dental Association.

Background: Under the new tax law, salaried dentists cannot deduct the cost of their Association dues unless they exceed two percent of their salary. Since this has a negative influence on the conduct of their professional responsibilities, a change should be made in the tax law to permit these dentists to deduct the full cost of their Association dues. Therefore be it

37. Resolved, that the ADA Council on Governmental Affairs and Federal Dental Services, as a priority item, seek changes in the tax law which would permit salaried dentists to deduct the cost of dues paid to professional dental organizations.

Texas Dental Association

Opposition to Separate Fee Schedules

The following resolution was adopted by the Texas Dental Association Board of Directors and transmitted on September 2, 1987 by Mr. Robert E. Caffrey, executive director, Texas Dental Association.

Background: In reviewing the 1987 *ADA Policies on Dental Care Programs* manual there are many statements of the Association's position on the administration and plan design of dental insurance programs. There are also several different policy statements relating to fees and

reimbursement. Yet, there is no specific statement regarding the issue of whether a plan should pay a specialist more than a general practitioner for the same service. This lack of a position has allowed some Delta plans to discriminate against general practitioners in making payments on services even when the service involved is one that is more frequently done by general practitioners. The Association needs to make a strong statement on this issue. Therefore, be it

38. Resolved, that the American Dental Association is unequivocally opposed to any type of separate fee schedules for reimbursement to general practitioners and specialists for the same or similar services.

First Trustee District

Substitute for Resolution 11

The following substitute resolution was adopted by the First Trustee District and transmitted on September 25, 1987 by Dr. Edwin S. Mehlman, caucus coordinator, First Trustee District.

Background: Insert words "including dentistry" between "benefits," and "should" in the first resolving clause so that the substitute resolution reads:

11S-2. Resolved, that the American Dental Association believes that employer-sponsored health benefits, including dentistry, should be encouraged through the use of positive incentives, and be it further
Resolved, that the American Dental Association does not support employer mandated health benefits.

First Trustee District

Keynote Speaker Honorarium

The following resolution was adopted by the First Trustee District and transmitted on September 25, 1987 by Dr. Edwin S. Mehlman, caucus coordinator, First Trustee District.

Background: The keynote speaker is an important and integral part of the ADA annual session. In the recent past, the typical honorarium has been $10,000. This appears to be a reasonable and prudent sum; however, it is not a line item. Few delegates understand where or how the funds are generated, therefore, be it

62. Resolved, that the honorarium paid to the keynote speaker of the ADA annual session shall be listed as a separate line item in the budget information that is sent to the delegates.

First Trustee District

Commemorative Stamp Honoring Dr. Horace Wells

The following resolution was adopted by the First Trustee District and transmitted on September 25, 1987 by Dr. Edwin S. Mehlman, caucus coordinator, First Trustee District.

Background: The year 1994 marks the 150th anniversary of the discovery of anesthesia by Connecticut dentist, Horace Wells. A commemorative stamp honoring Dr. Wells would effectively acknowledge this pivotal event in medicine and dentistry. The U.S. Postal Service receives 1,000 requests for commemorative stamps, while limiting its issue to 20, annually. The determining factors for selection include consideration of the relative significance of the individual's achievement, and extent of national support for the candidate. Therefore be it

63. Resolved, that the American Dental Association urge the United States Postal Service to issue a Commemorative Postal Stamp, in 1994, to honor Dr. Horace Wells, the discoverer of general anesthesia.

First Trustee District

Treatment Costs of Barrier Techniques

The following resolution was adopted by the First Trustee District and transmitted on September 25, 1987 by Dr. Edwin S. Mehlman, caucus coordinator, First Trustee District.

Background: As new federal regulations and the Centers for Disease Control Guidelines require dentists to use barrier techniques (gloves, masks and glasses) in treating all patients and because these requirements result in decreased productivity and increased costs for both labor and materials, therefore, be it

64. Resolved, that the ADA Council on Dental Care Programs conduct a study to determine the average net loss per dentist in using barrier techniques and be it further
Resolved, that the results of the study be communicated to the American Association of Insurance Carriers with a requirement that these increased costs be reflected in all fee schedules.

First Trustee District

Deans' Statement Opposing Unsupervised Practice by Dental Auxiliaries

The following resolution was adopted by the First Trustee District and transmitted on September 25, 1987 by Dr. Edwin S. Mehlman, caucus coordinator, First Trustee District.

Background: In recent years we have seen a multitude of bills filed in state legislatures across the nation regarding the unsupervised practice of dentistry. Often legislators request input on these filings from areas of academic dentistry. We therefore feel that the deans of U.S. dental schools should enter into a coalition with organized dentistry in our attempts to provide protection for the dental health of the public. Therefore be it

68. Resolved, that the ADA urge deans of the U.S. dental schools to take a stand and issue a strong statement against the unsupervised practice and the fractionation of the "dental team," by hygienists or any other type of dental auxiliary personnel.

First Trustee District

Equitable Dental Benefits for All Military Dependents

The following resolution was adopted by the First Trustee District and transmitted on September 25, 1987 by Dr. Edwin S. Mehlman, caucus coordinator, First Trustee District.

Background: Most third-party dental plans treat all of their insured customers equitably and equally in payments for covered services. There are a few notable exceptions to equal and equitable benefit payments. One such company, Delta Dental Plans of California, the national administrators of the Military Dependents' Dental Program, has published generic booklets for military dependents in every state of the nation which lead the beneficiaries to believe that they will be paid higher benefits if they seek out and utilize a participating dentist.

This is contrary to the intent of the law enabling much needed dental coverage for military dependents. Because there are military installations and personnel in every state, California Delta has unilaterally produced windfall profits for itself from every military dependent who received his/her dental care from local community dentists who choose not to contract to participate in any plan which discriminates against some of the eligible military dependents.

ADA policy, Freedom of Choice of Dentists (*Trans.*1982:548) states:

> **Resolved,** that the ADA request that the federal programs providing for contractual arrangements with civilian dentists for provision of dental service to civilian beneficiaries afford patients freedom of choice of dentists.

This resolution clearly implies that no barriers to freedom of choice, including economic ones, should be thrown up between dependent and free choice of dentist.

ADA policy, Third-Party Fee Schedules (*Trans.*1983:543) states:

> **Resolved,** that the American Dental Association opposes initiatives that encourage the public to select dentists principally on the basis of cost because it considers such arrangements to be a disservice to the public which is interested in securing the best possible dental care for themselves and their families.

This 1983 resolution clearly states that no economic barriers to freedom of choice of dentist be placed between dependents and their free choice of dentist.

ADA policy, Dental Care under Medicaid (*Trans.*1983:584) states:

> **Resolved,** that the American Dental Association initiate and actively support legislative efforts to amend the Medicaid statutes to provide that Medicaid recipients may select a licensed dentist...(and) that there be no discrimination in the payment schedule or payment provision of covered services or procedures when performed by a licensed dentist.

This 1983 resolution clearly speaks against discrimination in both freedom of choice of dentist and equal nondiscriminatory payments for those services.

The Texas Dental Association has been in discussions with Delta Dental Plans of California, the administrators of the Military Dependents' Dental Program and has received a letter stating that benefits will be the same regardless of whether the patient receives treatment from a participating or nonparticipating dentist.

On August 5, 1987, Mr. Robert G. Becker, general counsel, Delta Dental Plans of California wrote to the Texas Dental Association stating:

> ...Thus, in Texas and contrary to the system used (sic-by Delta) in other states, both participating and nonparticipating dentists will be paid on the same basis using allowances up to published tables.

No federal public money should be paid to any company that openly discriminates against some of our citizens.

Should not all military dependents receive the same freedom of choice and freedom from economic coercion that their brethren in Texas receive? Therefore, be it

70. Resolved, that the Board of Trustees of the ADA immediately instruct ADA attorneys to champion the rights of all military dependents by removing the discriminatory payment mechanisms which Delta Dental Plans of California has published and operates, and be it further

Resolved, that the Board of Trustees immediately instruct appropriate councils and Washington lobbyists to introduce necessary actions to prevent Delta Dental Plans of California, or any other dental plan contractor, from promulgating economically coercive or discriminatory rules or regulations which cause equal-federal public premiums money to be paid for nonequal benefits to the beneficiaries.

First Trustee District

Publication on Management of Hazardous Waste

Exclusion of Dentistry from OSHA Regulations

Financial Assistance for Defense and Litigation Related to Management of Hazardous Waste

The following resolutions were adopted by the First Trustee District and transmitted on September 25, 1987 by Dr. Edwin S. Mehlman, caucus coordinator, First Trustee District.

Background: The Resource Conservation and Recovery Act (RCRA), in 1980, was enacted in the present era of rapidly growing federal and state agency regulations of hazardous waste. In 1986, the Environmental Protection Agency (EPA) redirected the focus of regulation to small and medium-sized businesses, including dentistry. The U.S. Occupational Safety and Health Administration (OSHA) has formalized regulations requiring all dentists, as employers, to provide their full staff involved in patient care with protective gloves, masks and eyewear, as well as requiring immediate compliance with the general infection control guidelines recommended by the Centers for Disease Control (CDC) and the ADA. Failure to comply could lead to stiff civil and criminal penalties. In addition, effective May 1988, as an extension of court-ordered "right-to-know" legislation, practicing dentists will be required by OSHA to inform all staff through a written hazardous waste communication program, of any potentially hazardous substances they may be exposed to in the dental practice. Dental amalgam may be interpreted to be hazardous waste, for example, in view of the definitions set forth by the RCRA and the Comprehensive Environmental Response, Compensation and Liability Act (CERCLA).

This summer, the EPA charged a Connecticut-based dental scrap processor with the harmful and improper disposal of dental mercury. The incurred cost of cleanup totaled $432,000.00. The 40 to 50 dentists, both from Massachusetts and Connecticut, who sold scrap material to this processor may share legal and financial responsibility. This case is currently being researched by environmental attorneys for the two state dental associations in defense of the implicated dentists.

Further state legislative action includes the State of Connecticut Department of Consumer Protection's proposed amendment regulating the disposal of hypodermic needles and syringes through only limited and restricted DEP-approved disposal sites.

It is evident from this background that hazardous substance management, protection and education is a present, critical and burgeoning issue confronting dentistry throughout the country. Therefore, be it

71. Resolved, that the Board of Trustees of the ADA charge the appropriate council(s) and committee(s) to review, research and collate all state and federal legislation and regulations governing the management of hazardous substances as related to dentistry, and that their findings and recommendations be published, in pamphlet form, and disseminated to the ADA membership, and that this publication minimally fulfill the OSHA regulations for it to serve as the "written hazardous communication program" for dental staff, and that this publication be mailed to the membership no later than January 1, 1988.

72. Resolved, that the Council on Governmental Affairs and Federal Dental Services, in cooperation with the ADA lobbyist(s) and ADA legal counsel, review the above legislation and regulations for revision and amendment as deemed necessary and appropriate, and to include but not be limited to consideration of the exclusion of dentistry from such legislation and regulation, and that lobbying efforts on behalf of the ADA be initiated in support of said revision and amendment on both the state and federal level.

73. Resolved, that the ADA provide financial assistance to state associations in their research for and defense of ongoing and future litigation regarding the management of hazardous waste.

First Trustee District

Identification of Potential Hazardous Waste Materials

The following resolution was adopted by the First Trustee District and transmitted on September 25, 1987 by Dr. Edwin S. Mehlman, caucus coordinator, First Trustee District.

Background: In late June 1987, 60 dentists in Massachusetts and Connecticut received correspondence from the Boston Regional Office of the Environmental Protection Agency (EPA) notifying them of inappropriate disposal of dental waste material by a particular scrap material refining corporation to which these individuals had sold scrap material. The correspondence, in addition to requesting a response to a rather lengthy questionnaire in compliance with federal laws, specifically indicated that the seller of scrap was equally liable with the refiner, for the replenishment of "superfunds" used to clean up hazardous waste materials.

The refining corporation is bankrupt. Hence, the EPA is looking to the dentists to collect its expenditure. This is unique in the sense that the dentists were neither involved in the refining nor disposal process.

This incident raises national implications and certainly gives rise to cause for concern. Essentially, any dentist unknowingly and unwittingly may become embroiled in a similar situation. Most importantly, this instance points out the absolute need for the American Dental Association to: (1) identify specific hazardous waste materials which are common to dental offices; and (2) develop appropriate protocol for their disposal.

74. Resolved, that the Board of Trustees be requested to direct the appropriate councils of the ADA to identify potential hazardous waste materials which are related to the practice of dentistry and develop appropriate protocol for their disposal.

First Trustee District

Study of Methods to Increase Dental Auxiliary Manpower

The following resolution was adopted by the First Trustee District on October 11, 1987 and submitted by Valerie Donnelly, executive director, Rhode Island Dental Association.

Background: One of the major problems that the dental profession faces in many areas of the country is the growing shortage of dental auxiliary personnel—dental assistants, dental hygienists and dental laboratory technicians. The shortfall is probably due to a variety of reasons which might include: lack of encouragement of the profession to prospective candidates, the economic factor relative to the tuition of a dental auxiliary curriculum, and the economics of loss of earning power while enrolled in a dental auxiliary program. In addition, there are numerous career options now available to potential candidates who previously pursued careers in the dental auxiliary disciplines.

Enrollments in dental auxiliary education programs have been declining steadily during the past five years. This decline is accompanied by a concomitant decline in the number of graduates available. To deal with these downward trends, major efforts must be made to attract candidates to pursue careers in the dental auxiliary fields. These efforts should include development of a SELECT program for dental auxiliaries. Further, it seems appropriate that constituent dental societies in concert with state boards of dentistry make every effort to encourage dental auxiliary personnel, especially dental hygienists, who are inactive to reenter practice.

In the Council on Dental Education's report to the House (*Reports*:98), the Council has identified an approach that it believes could offer the best immediate solution: to study the feasibility of training dental assistants to perform certain functions now delegated only to dental hygienists. Such functions might include a prophylaxis with supragingival scaling and coronal polishing. This approach would not entail creation of an entirely new category of dental auxiliary, with new educational programs and credentialing requirements. Rather, supragingival scaling and coronal polishing could be treated as expanded functions for dental assistants. A survey by the Council's Division of Educational Measurements indicated that in 1985, 18 states already permitted dental assistants to perform coronal polishing, usually based on completion of a short training program in the specific function.

The Council believed that the expanded duty dental assistant approach offers some advantages. For example, those states that are experiencing personnel shortages might enact regulations fairly quickly to permit this additional function for dental assistants, with appropriate training and supervision requirements. The feasibility of delegating these functions to dental assistants will continue to be studied. If appropriate, "curriculum guidelines" for the necessary training programs will be developed.

92. Resolved, that the Council on Dental Education in its study of dental auxiliary education include the need to develop a SELECT program for recruiting students to dental auxiliary programs; identifying ways by which dental auxiliaries who have left the field can be identified and encouraged to reenter practice; reviewing the current educational requirements for the dental auxiliary disciplines; and concluding its study of the feasibility of training dental assistants to perform certain functions now delegated only to dental hygienists, and be it further

Resolved, that the Council implement any of its findings that are consistent with current ADA policy and in addition give a complete report to the 1988 ADA House of Delegates.

First Trustee District

Reference to Previous House Actions

The following resolution was adopted by the First Trustee District on October 13, 1987 and submitted by Dr. Edwin Mehlman, caucus coordinator.

Background: Newly proposed resolutions often refer to past resolutions in the background statement or resolving clauses. It is essential to be able to read the body of the past resolutions in order to intelligently deliberate on these new issues. Therefore be it

97. Resolved, that the text of all resolutions from previous House actions which are referred to in resolutions presently under consideration be included in the background material provided.

Second Trustee District

Study of Continuation of Associate Membership Category

The following resolution was adopted by the Second Trustee District and submitted on September 17, 1987 by Dr. S. Steven Jones, executive director, The Dental Society of the State of New York.

Background: Associate membership in the ADA was developed to accommodate a person "not eligible for any other type of membership in this Association, who contributes to the advancement of the objectives of this Association and has not met the educational requirements for licensure as a dentist anywhere in the United States...."

Constituent societies in which applicants reside are asked to submit letters of recommendation for individuals to the Board of Trustees for associate membership. Such applications do not offer reasons for granting associate membership beyond the applicant's desire to receive ADA publications, to attend meetings, etc. There are no provisions whereby the Association can monitor an associate member to insure that the privileges are not misused.

Moreover, the benefits made available by virtue of associate membership are easily attained by subscription to ADA publications.

Recent requests for recommendation of applicants for associate membership submitted to The Dental Society of the State of New York have been denied due to misgivings engendered by the possibility that applicants might use this membership for their own commercial purpose which may or may not be in the interest of organized dentistry.

The haphazard manner in which this membership category is monitored is best exemplified by the fact that here in New York a licensed dentist is included among the list of ADA associate members.

For such reasons the Second Trustee District offers the following resolution:

45. Resolved, that an appropriate agency of the ADA study the advisability of continuing the category of associate membership.

Second Trustee District

Malpractice Litigation Videocassette

The following resolution was adopted by the Second Trustee District and submitted on September 17, 1987 by Dr. S. Steven Jones, executive director, The Dental Society of the State of New York.

Background: The country's liability insurance crisis that is seriously distorting the orderly practice of dentistry requires concentrated efforts at solutions on the part of the organized profession. Investigation has revealed that the situation can be considerably improved by the institution of education programs for the practicing dentist.

Courses in risk management, instituted by constituents, are created to teach dentists procedures which can tend to reduce the number of malpractice litigations. Insurance companies have welcomed this approach and are granting reductions in premium fees to dentists who take such courses. Additional educational means are needed to augment this educational effort.

One of the most effective teaching instruments developed in recent years is the videocassette whereby educational material can be most effectively presented. The ADA has recognized the efficacy of videocassettes as an educational tool in its professional liability loss prevention program. By the use of professional actors such procedures, as the serving of a summons, the examination before trial, the preparation for trial and a mock trial, can be most effectively portrayed. A videocassette would not only make dentists aware of the causes and ultimate costs of malpractice claims, it would also help dentists weather the trauma of possible litigation by depicting professional liability trial proceedings—all of which would serve as a valuable risk management educational device. Dentists would learn from the presentation of a mock trial just how valuable complete documentation and proper conduct on a witness stand becomes.

As the production of such a videocassette would meet the needs of every constituency within the ADA, the Second Trustee District submits the following resolution.

46. Resolved, that appropriate agencies of the ADA produce a videocassette that would demonstrate the various stages of malpractice litigation, from the serving of a summons, the examination before trial the preparation for trial, and a mock trial.

Second Trustee District

Prototype Hazard Communication Program

The following resolution was adopted by the Second Trustee District and submitted on September 17, 1987 by Dr. S. Steven Jones, executive director, The Dental Society of the State of New York.

Background: The Occupational Safety and Health Administration (OSHA) of the U.S. Department of Labor has announced that an expanded regulation will take effect May 20, 1988, which requires employers to inform their employees about hazardous substances on the job.

Under federal regulation, dentists will be required to maintain a hazard communication program in their offices. (Written program guidelines and information must be kept on file in case of inspection by OSHA.) Office staff must be trained in accordance with the written program, and a record of this training and any protective measures taken by the practitioner must also be maintained. This should include a record of the dentist having made material safety data sheets (MSDS) available to staff. Manufacturers have been required since September 24 to include an MSDS with all hazardous substances.

OSHA has set a maximum fine of $1,000 per violation.

In order to facilitate national conformity and compliance with this regulation which supercedes state and local regulations of similar import, the Second Trustee District offers the following recommendation:

47. Resolved, that appropriate agencies of the ADA create a prototype hazard communication program to include all of the specifications of OSHA, and be it further
Resolved, that this document be made available to member dentists throughout the country in order to aid their compliance with OSHA regulations.

Fourth Trustee District

Dental Benefits for Patients with Congenital Deformities

The following resolution was approved by the Fourth Trustee District and transmitted on September 21, 1987 by Dr. Francis Sarro, Jr., secretary, Fourth Trustee District.

Background: Dental health policies are not available to a majority of families in the United States, and many parents of patients born with congenital deformities and associated craniofacial anomalies have limited funds to pay for the high costs of care that is necessary for the afflicted's rehabilitation. The multidisciplinary approach to treatment is necessary, and the extended time and effort to be devoted to these patients is extensive. Having dental benefits as part of health insurance policies would assist these families in this critical time of need.

40. Resolved, that the American Dental Association vigorously sponsor an effort to have health insurance policies provide dental benefits for persons with congenital deformities and associated craniofacial problems.

Fourth Trustee District

Development of Policy on AIDS

The following resolution was approved by the Fourth Trustee District and transmitted on September 21, 1987 by Dr. Francis Sarro, Jr., secretary, Fourth Trustee District.

Whereas, acquired immune deficiency syndrome (AIDS) and related diseases have reached epidemic proportions, therefore be it

41. Resolved, that the American Dental Association recognize the dental needs of patients with acquired immune deficiency syndrome (AIDS) and related diseases and establish an unequivocal policy that reaffirms dentistry as a caring profession concerned about the welfare of the sick; recognize that concerned health care professionals have an obligation and a responsibility to render compassionate care to all; educate the profession about the psychosocial realities of this disease both for patients and providers; maintain a scientific, rational basis for dental treatment of AIDS affected persons and be current with emerging data and information; provide liaison with other health care workers in the educational process of professionals; encourage the profession to continue to treat patients in available settings; and continue to educate the profession on all appropriate sterilization, barrier and infectious disease techniques necessary for appropriate patient care.

Fourth Trustee District

Alternative Methods for Payment of Dues

The following resolution was approved by the Fourth Trustee District and transmitted on September 21, 1987 by Dr. Francis Sarro, Jr., secretary, Fourth Trustee District.

Background: Most constituent and component societies in the country are finding it necessary to increase their dues to maintain the services and programs necessary for members. It has always been customary to pay dues in one, or at most, two payments. This can create a serious impediment to attracting more and new members.

42. Resolved, that the ADA Board of Trustees immediately undertake an investigation of the possibility of the payment of dues on a staged basis, such stages to be either quarterly or monthly.

Fourth Trustee District

Amendment of "Comprehensive Policy Statement on Dental Auxiliaries" (Involvement of Licensed Dentists)

The following resolution was adopted by the Fourth Trustee District and transmitted on September 21, 1987 by Dr. Francis C. Sarro, Jr., secretary, Fourth Trustee District.

Background: In a review of the proposed "Comprehensive Policy Statement on Dental Auxiliaries" it has come to our attention that the policy does not state that the dentist involved is to be licensed. This is in contrast to the many policies that are to be rescinded which definitely state that the functions performed by the dentist be a licensed dentist.

In many cases, it may be assumed that the functions performed in the new proposed policy statement are by licensed dentists. However, without specifically making this statement, it can also be assumed that the functions could be performed by an unlicensed dentist.

In light of the liberalization of treatment in the dental health care field which has reached the point where in some cases dentists do not treat the patient but only manage and supervise the care provided by the dental auxiliary, the new policy statement should make it crystal clear that a dentist functioning in a supervisory or managerial capacity is ultimately responsible for the care of the patient and should be a licensed dentist responsible to the jurisdiction's licensing board. Therefore, be it

58. Resolved, that the section titled "Glossary of Terminology Related to Dental Auxiliary Personnel Utilization and Supervision" of the "Comprehensive Policy Statement on Dental Auxiliaries" be amended by addition of the following language, to be inserted between the sections on "Community Dental Health" and "Dental Auxiliary Personnel":

> **Dentist:** An individual graduated from a dental school accredited by the Commission on Dental Accreditation of the American Dental Association and licensed in the geographic jurisdiction where he or she functions in the capacity of a dentist.

Fourth Trustee District

Specialty Organization Assistance Peer Review

The following resolution was adopted by the Fourth Trustee District and transmitted on September 21, 1987 by Dr. Francis C. Sarro, Jr., secretary, Fourth Trustee District.

Background: The New Jersey Dental Association has in its peer review mechanism a provision that specialists be reviewed by specialists. The California Dental Association has utilized the specialty organizations in this manner for the last seven years with a very satisfactory result. The definition of "peer" requires review by dentists of similar training and background to provide "peer review." This resolution would not affect the constituent dental association and component dental societies' authority of the peer review system. Constituents that do not have specialty organizations available for assistance in peer review could call on the national specialty organization for assistance or would not be affected by this resolution.

59. Resolved, that the American Dental Association affirms that constituent dental associations and component dental societies should utilize, whenever possible, the services of specialty organizations to provide, or assist with, peer review of dental specialists under supervision and authority of the constituent dental associations and component dental societies.

Fifth Trustee District

Amendment to Resolution 2

The following amendment to Resolution 2 was adopted by the Fifth Trustee District and transmitted on October 1, 1987 by Dr. H. Raymond Klein, secretary, Fifth Trustee District.

Background: In the "Guidelines on the Use of Radiographs in Dental Care Programs," paragraph 15, it is felt that simpler language would be better understood.

Also it is felt that if radiographs are lost, determination of claim's validity should rest with the carrier. The new resolving clause is as follows:

> **Resolved**, that the "Guidelines on the Use of Radiographs in Dental Care Programs," paragraph 15, be amended to read as follows:
>
> 15. If, for any reason, radiographs are lost or not returned to the dentist within 15 working days, the claim in question should be determined and settled immediately. Loss of the radiographs, in a question concerning a claims validity, places the burden of proof on the carrier and not the dentist.

2S-3. Resolved, that the "Guidelines on the Use of Radiographs in Dental Care Programs" (*Trans.*1976:867) be amended by addition of the following paragraphs thereto:

> 14. When, in accordance with guidelines 1-13, a dentist determines it is appropriate to submit radiographs to a third party, a duplicate set should be sent, so as not to place the dentist at risk.
>
> 15. If, for any reason, radiographs are lost or not returned to the dentist within 15 working days, the claim in question should be determined and settled immediately. Loss of the radiographs, in a question concerning a claim's validity, places the burden of proof on the carrier and not the dentist.

and be it further

Resolved, that the Council on Dental Care Programs disseminate the revised "Guidelines" to members, carriers, service corporations and other third-party payers.

Fifth Trustee District

Proposed Criteria and Procedures for Acknowledgment of Credentialing Committee in Nonspecialty Interest Areas

The following resolution was adopted by the Fifth Trustee District and transmitted on October 1, 1987 by Dr. H. Raymond Klein, secretary, Fifth Trustee District.

Background: At a June 8, 1987 meeting of the officers and executive directors of the eight dental specialties in Chicago, a June 5, 1987 letter from Dr. Joel Glover, chairman of the Council on Dental Education was distributed. The letter addressed a joint activity by the Council on Dental Education and the Council on Ethics, Bylaws and Judicial Affairs regarding proposed criteria and procedures for acknowledgment of credentialing committees in nonspecialty interest areas.

The letter requested input and a response from the eight dental specialties and other interested individuals, organizations and agencies.

The eight dental specialties commend the Academy of General Dentistry on its positive, promising, future-oriented and laudatory stance on continuing education for its members. The specialties are not criticizing the concept from an educational point of view, nor are they criticizing the Academy of General Dentistry or the generalists.

The concern of the specialists is "specialists being certified in other additional areas" with less than the vigorous two-year postdoctoral education process now in existence for recognition as specialists. It is a concern that the profession will have pediatric dentists claiming certification as orthodontists, periodontists claiming certification as endodontists, oral surgeons claiming certification as implantologists and generalists claiming certification in any number of areas, all under the auspices of ADA credentialing committees.

It is believed that the proposed criteria and procedures for acknowledgment of credentialing committees in nonspecialty interest areas will result in the following dilemmas:

1. It will increase consumer confusion and bewilderment.

2. It will increase fragmentation of the ADA.
3. It will result in a proliferation of special interest groups or increased emphasis on the existing nonspecialty interest groups.
4. It will result in an increase in advertising by the profession.
5. It will increase divisiveness among the generalists by creating a "super" generalist.
6. It will dilute the ADA position with regard to recognition of specialty areas in the profession.
7. It will weaken the eight specialties currently recognized by the ADA and by the public.
8. It will encumber the ADA's dialogue with the Federal Trade Commission and weaken the concept of limitation of practice in individual state dental practice acts.

81. Resolved, that further development of the proposed criteria and procedures for acknowledgment of credentialing committees in nonspecialty interest areas be discontinued, and be it further
Resolved, that recognition of specialists and criteria and procedures for acknowledgment of credentialing continue according to current Association policy.

Fifth Trustee District

Use of ADA's Seal of Acceptance on Dental Anesthetics

The following resolution was adopted by the Fifth Trustee District and transmitted on October 1, 1987 by Dr. H. Raymond Klein, secretary, Fifth Trustee District.

Background: In order to provide additional safeguards for the patient and the dentist, it is believed that every effort should be made to ensure medications may be properly identified as easily as possible.

82. Resolved, that the Council on Dental Therapeutics after January 1, 1989 shall not permit the use of the ADA's Seal of Acceptance to be applied to dental anesthetics that do not identify by color coding of the ampule that it contains an anesthetic with a vasoconstrictor.

Fifth Trustee District

Guidelines for the Practice of Dentistry in Infectious Disease Control

The following resolution was adopted by the Fifth Trustee District and transmitted on October 1, 1987 by Dr. H. Raymond Klein, secretary, Fifth Trustee District.

Background: The standard of care is the responsibility of each individual dentist and should be determined depending upon the circumstances, patient, procedure and other mitigating factors. It is believed that the standard of care should not be dictated by statute, rule or government regulation.

83. Resolved, that the Board of Trustees of the ADA request the participation of its Council on Dental Practice in the formulation of those guidelines which directly affect the practice of dentistry in infectious disease control. Particular attention should be directed to the necessity, efficacy and cost considerations to the public of those routine dental procedures which are not related to possible blood contamination or transmission when neither the patient nor the operator is at risk and therefore should not require stringent barrier techniques.

Fifth Trustee District

Commendation Regarding Fiscal Responsibility

The following resolution was adopted by the Fifth Trustee District and transmitted on October 1, 1987 by Dr. H. Raymond Klein, secretary, Fifth Trustee District.

Background: After several years of debate on financial philosophy of the Association and the powers of the Board and the House, it has been evident the last three years that the Board and staff have been sensitive to the concerns of the House and have reflected a fiscal responsibility in developing and implementing the budget. Therefore be it

84. Resolved, that the Board of Trustees of the ADA and the Executive Director be commended on their positive response to the concerns of the House of Delegates regarding fiscal responsibility.

Fifth Trustee District

Amendment of "Comprehensive Policy Statement on Dental Auxiliaries"

The following resolution was adopted by the Fifth Trustee District and transmitted on October 1, 1987 by Dr. H. Raymond Klein, secretary, Fifth Trustee District.

Background: The Fifth Trustee District concurs with the general concept of the "Comprehensive Policy Statement on Dental Auxiliaries" but believes that the statement could be strengthened in several sections and therefore offers the following substitute statement:

85. Resolved, that the "Comprehensive Policy Statement on Dental Auxiliaries" as amended by the Board of Trustees be further amended in the following manner:

Amend second paragraph on page 257 of *Supplement 1, 1987* by deleting the fourth and fifth sentences which read:

> A dental laboratory technician who is employed in the dental office is considered to be a dental auxiliary. A dental technician who performs a supportive function in an environment outside the dental office may be properly termed a supportive or allied member of the dental health team.

Amend fourth paragraph on page 258 of *Supplement 1, 1987* by deleting the last two sentences which read:

> Further, the functions or procedures delegated to the auxiliary personnel must be reversible so as not to create unalterable changes within the oral cavity and contiguous structures or tissues. To ensure patient protection, functions or procedures which, when performed, are irreversible and create unalterable changes within the oral cavity or the contiguous structures or tissues or place the patient at risk must not be delegated to dental auxiliaries.

and substituting therefor:

> Further, to ensure the protection of the patient, the functions or procedures delegated to the auxiliary personnel must be reversible to avoid creating unalterable changes within the oral cavity and contiguous structures or tissues. Those functions or procedures which, when performed, are irreversible and create unalterable changes within the oral cavity or the contiguous structures or tissues or place the patient at any actual or potential risks must be the responsibility of the dentist and must not be delegated to dental auxiliaries.

Amend fifth paragraph, item number 6 on page 258 of *Supplement 1, 1987* by deletion of the word "procedures" and substitution therefor of the word "therapy."

Amend fifth paragraph, item number 7 on page 258 of *Supplement 1, 1987* by deletion of the word "prosthodontic" and substitution therefor of the word "intraoral."

Amend sixth paragraph, first sentence on page 258 of *Supplement 1, 1987* by insertion of the words "and/or are reversible in nature" after the word "delivery" so that the amended sentence reads:

> Only functions that do not require the composite judgment, knowledge and skill attained through professional dental education, and that contribute to a meaningful role in dental care delivery and/or are reversible in nature should be delegated to dental auxiliaries.

Amend sixth paragraph, last sentence, on page 258 of *Supplement 1, 1987* by deletion of the words "or from one dental auxiliary to another" so that the amended sentence reads:

> The transfer of permissible functions from the dentist to the auxiliary must not result in a reduced quality of patient care.

Amend fourteenth paragraph on page 260 of *Supplement 1, 1987* by deletion of the last sentence and items 1, 2 and 3 as follows:

> In those instances where it is not possible to change the dental practice act, every effort should be made to include the following criteria for general supervision in the rules and regulations of these dental practice acts:
>
> 1. Any patient to be treated by a dental hygienist must first become a patient of record of a dentist. A patient of record is defined as one who:
>
>   a. has been examined by the dentist;
>   b. has had a medical and dental history completed and evaluated by the dentist;
>   c. has had his/her oral condition diagnosed and a treatment plan developed by the dentist.
>
> 2. The dentist must provide to the dental hygienist prior written authorization to perform clinical dental hygiene services for that patient of record. Such authorization shall be void after 45 days.
>
> 3. The dentist shall examine the patient following performance of clinical service by the dental hygienist. Such examination shall be performed within a reasonable time as determined by the nature of the services provided, the needs of the patient and the professional judgment of the dentist.

and placing this language as a footnote at the end of the glossary on page 264.

Sixth Trustee District

Study of Development of Fund Raising Activities for the ADA

The following resolution was adopted by the Sixth Trustee District and transmitted on September 28, 1987 by Dr. R. Malcolm Overbey, trustee, Sixth Trustee District.

Background: Recent changes in tax legislation, essentially the Economic Recovery Act of 1981, have brought about the opportunity for organizations such as the ADA to develop sizeable endowments for use by the ADA to fulfill our objectives and fund some of our programs.

There are many members that would like to develop just such an endowment, at little or no cost to the member, by utilizing instruments such as Charitable Remainder Interest Trust, the Charitable Lead Trust and other instruments. Other members might like to leave the ADA a gift of money, stock, etc. in their wills. All of this money could be used to develop and continue any program the member might like to benefit.

The Sixth District delegation is concerned about the future of the ADA, retention of members and fulfilling the

objectives and programs of this organization.

This opportunity may not exist forever, and we believe a timely study is in order.

65. Resolved, that the ADA Board of Trustees in consultation with other agencies study and develop a program that would allow ADA members to leave money to the ADA to fulfill the objectives and programs of that particular member's choice, and be it further
Resolved, that the Board of Trustees report its findings to the House of Delegates in 1988.

Sixth Trustee District

Study of Nonmember Benefits

The following resolution was adopted by the Sixth Trustee District and transmitted on September 25, 1987 by Dr. R. Malcolm Overbey, trustee, Sixth Trustee District.

Background: In the past, many direct membership benefits were available only to members of the ADA. Today this is still true for the most part. However, nonmembers benefit from our dues and nondues dollars that are spent in legislative, dental care, scientific, dental education, federal services and other areas just as our members.

At this time, the ADA's Recruitment and Retention Program is aimed at bringing more nonmembers and nonrenewal dentists into the active membership category.

The Sixth District delegation would like to encourage the appropriate agencies of the ADA, constituent and component societies to examine what nonmembers are allowed to do and participate in, and make the cost differential comparable to the cost of active membership.

66. Resolved, that the appropriate agencies of the ADA, constituent and component societies consider examining insurance programs, the sale of printed materials, attendance at meetings and all other areas of concern that nonmembers might participate in with the intention of making the payment differential close to the cost of active membership, and be it further
Resolved, that, where appropriate, nonmembers be denied participation in ADA, constituent and component activities.

Sixth Trustee District

Study of Temporomandibular Joint Disorders

The following resolution was adopted by the Sixth Trustee District and transmitted on September 28, 1987 by Dr. R. Malcolm Overbey, trustee, Sixth Trustee District.

Background: An ADA sponsored conference on the etiology, diagnosis and management of temporomandibular (TMJ) disorders was held in 1982. A committee was appointed and its deliberations and findings were published in the January 1983 issue of *The Journal of the American Dental Association.*

Although the subject (TMJ) is not new, it is a relatively new area of research and study. As a result, few organized or standardized approaches to the examination, diagnosis or treatment of TMJ exists.

The Sixth District delegation believes that all of dentistry would benefit from the continued study of this most important subject.

67. Resolved, that appropriate agencies of the Association resume the study of temporomandibular joint disorders with input from the leading practitioners, educators and researchers in the field of occlusion and TMJ, and be it further
Resolved, that a group of no more than six leading practitioners, educators and researchers be convened as early as feasibile to discuss their findings, and be it further
Resolved, that a report be prepared for the profession, as soon as possible, by publishing an interim report in *The Journal of the American Dental Association,* and be it further
Resolved, that this subject be brought back to the House of Delegates in 1988 for consideration as to whether the study should be continued.

Sixth Trustee District

Manpower Study

The following resolution was adopted by the Sixth Trustee District and transmitted on September 28, 1987 by Dr. R. Malcolm Overbey, trustee, Sixth Trustee District.

Background: The Future of Dentistry Report (*Supplement 1, 1985*:331) stated quite accurately that:

> Manpower planning must be based on demand rather than need. No dramatic changes are anticipated in the growth in overall demand for dental services. The overall increase in the numbers of dentists will continue throughout this century without a significant increase in demand. Competition among dentists will grow.

Since that report was published, there has been an increasing uneasiness about the quality of dental school applicants who will be our future practitioners. The number of applicants has decreased to a level approaching only one applicant per opening. At the same time, there have been concerns expressed about our ability to maintain a high level of professionalism in the delivery of dental care services. New delivery and payment systems enter and leave with some regularity, while the actions of some government and corporate interests seem to ignore the values of professionalism and quality care. In this climate, some practitioners may be encouraged to overlook the ethical issues involved in certain treatment modalities and representations of care to their patients.

As manpower is a factor, it seems appropriate that the public will be best served by a profession which has agreed on how best to utilize the manpower available. Therefore, the following resolution is offered to address this issue.

76. Resolved, that the ADA Board of Trustees formulate a public statement on manpower, which tells a positive story of dentistry in meeting the public demand for oral health care and includes concerns the profession has about:

1. Future manpower
2. Quality of applicants
3. Numbers of dental schools

and be it further
Resolved, that the ADA Board of Trustees, the ADA Executive Director and appropriate agencies of the ADA hold a conference with dental educators in an atmosphere of free and productive discussions to resolve these concerns.

Sixth Trustee District

Personal Conduct of a Dentist as a Part of Ethical Professionalism

The following resolution was adopted by the Sixth District Trustee on October 11, 1987 and submitted by Dr. R. Malcolm Overbey, trustee.

Background: It is the opinion of the Sixth District delegation that the American Dental Association's *Principles of Ethics and Code of Professional Conduct* should be carefully reviewed for the purpose of strengthening the conduct of professionals that goes beyond public observation in paragraph 1-C "Community Service."

With the exception of paragraph 1-C "Community Service" in which it is stated that "...Dentists in such service shall conduct themselves in such a manner as to maintain or elevate the esteem of the profession," the existing *Code of Ethics* does not address personal conduct as a part of ethical professionalism. This statement does not address personal conduct beyond that directly associated with community service, hence it appears to leave a void in which there are no ethical standards identified for personal conduct external to this narrow band of observation.

Since the adoption of a code of ethics by the ADA in 1866, there have been considerable revisions. It has not been possible for most dentists to create patterns of professional ethics without relating them to their values about individuals and groups. As a result, in 1922, Section 1 of the ADA *Code of Ethics* read as follows: "The conduct of the dentist should be in accordance with the Golden Rule, both in its letter and in its spirit." Additionally, the *Code of Ethics* of 1934 states in Section 12: "Dentists should be good citizens and as such should bear their full part in sustaining institutions that advance the interests of humanity.... They should refrain from any act, comment, or insinuation which may reflect upon the dignity of the dental profession. Thus, it is imperative that the dentist in all his relations with his patients, his fellow practitioners, and the public, shall conduct himself as becomes a member of a profession whose prime purpose is service to humanity."

The *Code of Ethics* of 1950 reaffirmed the statement of the Golden Rule which stated that it is the obligation of the professional individual that "whatsoever you would that men should do to you, do ye even so to them." Section 3 of that same code stated, "The dentist's primary duty of serving the public is discharged by giving the highest type of service of which he is capable and by avoiding any conduct which leads to a lowering of esteem of the profession of which he is a member."

The Sixth District delegation would like to encourage that the current *Principles of Ethics and Code of Professional Conduct* be revised to emphasize the importance of total personal as well as professional ethical integrity.

91. Resolved, that the Council on Ethics, Bylaws and Judicial Affairs conduct a comprehensive review of Section 1, *ADA Principles of Ethics and Code of Professional Conduct* with the intent of appropriately strengthening this section in order to emphasize the importance of total personal integrity, as well as professional integrity, and be it further **Resolved,** that the Council report its recommendations to the House of Delegates in 1988.

Seventh Trustee District

Support for Individual Practice Associations

The following resolution was adopted by the Seventh Trustee District on September 13, 1987 and transmitted by Nancy C. Quinn, executive director, Ohio Dental Association on September 23, 1987.

Background: An individual practice association (IPA) is defined by the ADA as a legal entity organized and operated on behalf of individual practicing dentists for the primary purpose of collectively entering into contracts to provide dental services to enrolled populations. Participating dentists practice in their own offices and provide care to patients not covered by the contract as well as to IPA patients.

An IPA gives a group of dentists the ability to directly compete with other insurers in providing dental benefits to employee groups. IPAs afford dentists the strength to negotiate with employers as a group to provide dental benefits that balance the needs of the patient, employer and dentist.

Dentists and prospective purchasers of dental benefits should know that the IPA is an attractive alternative, best serving patients by preserving their freedom-of-choice of dentist and supporting dentists by providing strength to negotiate as a group as well as protecting the fee-for-service method of payment.

44. Resolved, that the ADA Council on Dental Care Programs which serves as a consultant to purchasers seeking to contain health care costs should inform members and purchasers that:

> A lawfully constituted, locally autonomous, properly administered IPA may, in addition to other types of dental payment systems, constitute a viable alternative to sustain the traditional quality standards of dental practice in the best interests of the patient, purchaser and dentist.

Seventh Trustee District

AIDS as a Communicable Disease

The following resolution was adopted by the Seventh Trustee District on October 11, 1987 and submitted by Dr. William Gilmore, trustee.

94. Resolved, that the American Dental Association take the position that Acquired Immune Deficiency Syndrome is a communicable disease rather than a handicap and inform state Civil Rights Commissions of this position.

Eighth Trustee District

Substitute for Resolution 2

The following substitute resolution was adopted by the Eighth Trustee District and transmitted on September 16, 1987 by Mr. Robert A. Rechner, executive director, Illinois State Dental Society.

Background: The Eighth District wishes to adopt a new second resolving clause and make the existing second resolving clause a third resolving clause. The new second resolving clause is as follows:

> **Resolved,** that the Council on Dental Care Programs develop a procedure code for the duplication of radiographs.

2S-1. Resolved, that the "Guidelines on the Use of Radiographs in Dental Care Programs" (*Trans.*1976:867) be amended by addition of the following paragraphs thereto:

> 14. When, in accordance with guidelines 1-13, a dentist determines it is appropriate to submit radiographs to a third party, a duplicate set should be sent, so as not to place the dentist at risk.
>
> 15. If, for any reason, radiographs are lost or not returned to the dentist within 15 working days, the claim in question should be adjudicated immediately,

and be it further
Resolved, that the Council on Dental Care Programs develop a procedure code for the duplication of radiographs, and be it further
Resolved, that the Council on Dental Care Programs disseminate the "Guidelines" to members, carriers, service corporations and other third-party payers.

Eight Trustee District

Issuance of Third-Party Payments

The following resolution was adopted by the Eighth Trustee District and submitted on September 16, 1987 by Mr. Robert Rechner, executive director, Illinois State Dental Society.

Background: Many dentists choose not to accept assignment of insurance payments for dental treatment. In such cases, insurance carriers send the reimbursement directly to the patient. Also, in many cases, the dentist's fee for such treatment remains unpaid even though the patient has been reimbursed by the insurance carrier.

Precedent for such a system already occurs in automobile financing where checks are issued to both a dealer and the owner.

48. Resolved, that the ADA urge all insurance carriers and dental service corporations to issue all unassignable benefit checks to both the treating dentist and the patient so that endorsements by both parties would be necessary to cash the check.

Eighth Trustee District

Promotion of Table of Allowances

The following resolution was adopted by the Eighth Trustee District and submitted on September 16, 1987 by Mr. Robert Rechner, executive director, Illinois State Dental Society.

Background: With the emergence of various third-party plans, it is becoming increasingly apparent to practicing dentists that the most equitable system of reimbursement is one in which the dentist and patient both know to what extent a particular procedure is covered by the carrier. When the patient and dentist know the amount that will be paid by the carrier, a more informed decision may be made by the patient to proceed with treatment as the patient will know exactly what percentage of the dentist's fee will be covered and what amount will be the patient's responsibility.

49. Resolved, that the ADA recommends that all third-party organizations compensate for dental services on a table of allowances (fees) known by all involved parties, and be it further
Resolved, that the Council on Dental Care Programs notify the dental industry of this ADA policy.

Eighth Trustee District

Protection of Retirement Assets

The following resolution was adopted by the Eighth Trustee District and submitted on September 16, 1987 by Mr. Robert Rechner, executive director, Illinois State Dental Society.

Background: The State of New York recently adopted a law to protect retirement plan assets from creditors. This law protects assets accumulated over a career. These assets cannot be taken by the holder of a judgment against the doctor arising from some event such as a malpractice claim, an auto accident, or a breach of contract. The new law does not protect individual retirement accounts (IRAs).

Most state legislatures do not have the resources to deal

with the complex commercial and legal issues. In many instances, states may follow New York's example by copying such a law. Respected legal authorities have predicted that many states will soon adopt similar laws in a cumulative fashion.

50. Resolved, that the ADA strongly support efforts at the state legislature level to enact laws which exempt IRS qualified Keogh, Corporate Pension or Profit Sharing Plans, and Individual Reitrement Accounts from attachment to satisfy any nondomestic judgment.

Eighth Trustee District

AIDS as a Handicapped Condition

The following resolution was adopted by the Eighth Trustee District and submitted on September 16, 1987 by Mr. Robert Rechner, executive director, Illinois State Dental Society.

Background: In 1985, the ADA adopted Resolution 104H-1985 (*Trans.*1985:608) which called upon dental schools to incorporate courses on infectious diseases, encouraged schools and public health agencies to set up care facilities for AIDS patients and urged dental societies to identify treatment sources for AIDS victims. Twenty-three states have officially recognized AIDS as a handicap protected under their human rights laws. The states of Tennessee and Georgia exempt infectious diseases from definition as a handicap. A recent Supreme Court ruling holds that contagious diseases are handicaps entitled to protection under the Federal Rehabilitation Act.

Where AIDS is protected as a "handicap," it appears that dentists may be barred from referring an AIDS patient, even though the patient may be new to the practice. It also seems that dentists may be barred from recovering any expenses related to extraordinary preparation of the operatory and equipment in order to treat AIDS patients and to reduce any hazard of challenging the AIDS patient with other infectious disease that may be found in the practice.

Many dental offices are incapable of proper preparation for the treatment of an AIDS patient without massive redesign and reconstruction. AIDS victims should receive dental treatment in a nonchallenging environment since they are unable to resist potential physiological challenges from airborne or ambient surface borne infections that may be found in a dental office.

51. Resolved, that the ADA actively endeavor through state and federal legislatures where applicable, to seek an exemption for AIDS and/or any disease or condition "which is infectious, contagious or similarly transmittable to persons" from legal definition as a handicap.

Eighth Trustee District

Birthday Rule for Coordination of Benefits

The following resolution was adopted by the Eighth Trustee District and submitted on September 16, 1987 by Mr. Robert Rechner, executive director, Illinois State Dental Society.

Background: Coordination of benefits in dental insurance plans has been a long-standing feature wherein two carriers who sustain liability for the same claim each determine its share of the liability. In some cases, the percentage share of liability becomes difficult to determine, especially where two different carriers do not follow the same processing policies, oftentimes leaving the patient with lack of coverage by either carrier. This confusion in coverage most often occurs in the determination of benefits for dependents of two spouses, both of whom have family coverage from their respective employers.

Generally, the employee's own carrier is the primary carrier for the employee's claims, and the spouse's carrier is the secondary carrier. However, when determining benefits for dependents in this situation, some carriers follow the so-called "Birthday Rule" while other carriers do not, thus creating the confusion. The "Birthday Rule" states that the primary carrier for dependents' coverage is determined by the earliest birthday of the two spouses, the secondary carrier being that of the other spouse.

In cases where the "Birthday Rule" is followed by both carriers, there is normally not a problem. However, where one carrier follows the "Birthday Rule," and the second carrier does not recognize this rule, an impasse sometimes occurs where neither carrier assumes liability.

52. Resolved, that the ADA Council on Dental Care Programs be urged to adopt the "Birthday Rule" as the preferred method for the processing of coordination of benefits for dependent claims, and be it further
Resolved, that the health insurance industry be urged to adopt the "Birthday Rule" as an industrywide standard for coordination of benefits, and be it further
Resolved, that the constituent dental societies be urged to pursue legislation requiring all dental prepayment carriers to adopt the "Birthday Rule" in their processing policies.

Eighth Trustee District

Clarification of Annual Budget

The following resolution was adopted by the Eighth Trustee District and submitted on September 16, 1987, by Mr. Robert Rechner, executive director, Illinois State Dental Society.

Background: The presentation of the annual budget to the House of Delegates has improved over the past few years. However, a further improvement would be realized with a more complete narrative explanation of variances from year to year, a further explanation of administrative budgets and a change in the format of Board Report 3. To accomplish these improvements, the Eighth District recommends the adoption of the following resolution:

53. Resolved, that the annual budget presentation to the House of Delegates include a narrative explanation on the opposing (facing) page of the actual budget figures, and be it further

Resolved, that the summary of division administrative budgets be presented with the budget figures for the following four categories:

1. Salaries and related personnel expenses
2. Travel expense
3. Program expense
4. Operating and general office expense

and be it further

Resolved, that the narrative report of the annual budget to the House of Delegates (Board Report 3) include an explanation of line item variances in excess of $10,000 from the previous year.

Eighth Trustee District

Conflicts of Interest

The following resolution was adopted by the Eighth Trustee District and submitted on September 16, 1987 by Mr. Robert A. Rechner, executive director, Illinois State Dental Society.

Background: In the past several years, the ADA has taken favorable positions and funded the direct reimbursement concept as the preferred reimbursement mechanism for third-party dental plans. Although the ADA is expending considerable funds to promote this concept, the Eighth Trustee District notes some concern about potential conflicts of interest that may arise between third-party carriers and persons contracted or employed by the Association to assist with its programs. In this regard, the Association needs to examine its employees and outside contractors or organizations receiving compensation from the ADA who may also be receiving compensation from any third-party carrier.

54. Resolved, that the appropriate agency of the ADA examine all employees and outside contractors to verify that they are working without conflict to any programs of the Association, and be it further

Resolved, that any person or persons having a conflict of interest should dissolve such relationships.

Eighth Trustee District

Bulk Benefit Payments

The following resolution was adopted by the Eighth Trustee District and transmitted on September 16, 1987 by Mr. Robert A. Rechner, executive director, Illinois State Dental Society.

Background: In 1983, the Association adopted Resolution 4H-1983 on Bulk Benefit Payments (*Trans.*1983:540) which addressed some of the practitioners' problems relating to patient record keeping. However, as yet few carriers who employ bulk payments properly notify the dentist causing exceptional time and work on the part of office staff to clarify and record benefits paid in patients' records. Accordingly, the Eighth Trustee District proposes the amendment of Resolution 4H-1983 by substituting a new third resolving clause.

56. Resolved, that Resolution 4H-1983 (*Trans.*1983:540), Bulk Benefit Payments, be amended by deleting the third resolving clause and substituting therefor the following:

> **Resolved**, that for all payments by third-party carriers, the attending dentist be furnished with an itemized explanation of benefits for each patient including dates of service, procedure codes, fees, coverages and percentage paid.

so that the amended policy shall read as follows:

Resolved, that in the interest of efficient dental office financial administration, bulk benefit payments should include a statement containing, at a minimum, the following information:

a. Subscriber (employee) name
b. Patient name
c. Dates of service
d. Total fee charged
e. Covered expense
f. Benefit paid

and be it further,

Resolved, that bulk payments should be issued no later than the last business day of the week in which the pertinent individual claims were processed, and be it further

Resolved, that for all payments by third-party carriers, the attending dentist be furnished with an itemized explanation of benefits for each patient including dates of service, procedure codes, fees, coverages and percentage paid, and be it further

Resolved, that the Council on Dental Care Programs advise insurance firms and service plans of these Association policies and urge their compliance.

Eleventh Trustee District

Substitute for Resolution 2

The following substitute resolution was submitted by the Eleventh Trustee District and transmitted on September 25, 1987 by Dr. Howard F. Curtis, Eleventh District caucus chairman.

2S-2. Resolved, that the "Guidelines on the Use of Radiographs in Dental Care Programs" (*Trans.*1976:867) be amended by addition of the following paragraphs thereto:

14. When, in accordance with guidelines 1-13, a dentist determines it is appropriate to submit radiographs to a third party, a duplicate set should be sent, so as not to place the dentist at risk.

15. If, for any reason, radiographs are lost, *mutilated*, or not returned to the dentist within 15 working days, the claim in question should be adjudicated immediately.

16. *A reasonable charge for duplicate X rays may be charged by the dentist.*

and be it further
Resolved, that the Council on Dental Care Programs disseminate the revised "Guidelines" to members, carriers, service corporations and other third-party payers.

Eleventh Trustee District

Inclusion of Oral Health Care Coverage in Medicare

The following resolution was adopted by the Eleventh Trustee District and transmitted on September 21, 1987 by the Washington State Dental Association.

Background: The increase in size of the oldest segment of the U.S. population, as recently projected, will be one of the most critical factors affecting health care delivery in the coming decades. The numbers of older adults, now approximately 28 million, will rise to 36 million by the year 2000, an increase of close to 30%. Because health needs escalate rapidly with old age, even the anticipated increase in demand arising from adults 65 to 74 years of age is overshadowed by the projected growth of the group of adults 75 years of age and older.

As older adults are already at a higher risk for oral disease, and because of the projected increase in the size of this population segment, their need for oral health services will grow exponentially in the future.

However, access to dental care will be problematic unless financing mechanisms and delivery system issues are addressed. Many of the individuals who need dental services might not be able to overcome these barriers. Therefore be it

57. Resolved, that the American Dental Association reaffirms its full support for inclusion of oral health care coverage in the Medicare Program.

Eleventh Trustee District

OSHA Regulation on Infectious Diseases

The following resolution was adopted by the Eleventh Trustee District October 11, 1987 and submitted by Ms. Martha Dearborn, executive director, Alaska Dental Society.

Background: The Occupational Safety and Health Administration (OSHA) has announced its intent to adopt regulations governing infection control practices in health care facilities, including dental offices. Early indications are that OSHA intends to adopt by reference those guidelines previously developed by the Centers for Disease Control (CDC). Once adopted, the OSHA regulation would supersede state regulations.

Although the CDC guidelines are in general agreement with American Dental Association recommendations, there are nonetheless a number of substantial differences. In these specific instances the CDC guidelines are at significant variance with the realities of everyday dental practice. Thus, if adopted, the OSHA regulation would have the practical effect of placing most practicing dentists in violation of the law and subject to substantial financial penalties. Those same dentists would also be at significant risk of inviting a malpractice suit. Morever, strict compliance with the proposed regulation would result in dramatically increased overhead costs which would likely be passed onto consumers, thus decreasing access to care and exacerbating the profession's noteworthy accomplishments in the area of cost containment.

Given the above, the American Dental Association should make every effort to insure that any infection control regulation adopted by OSHA reflects the least stringent practices necessary to accomplish the goal.

93. Resolved, that appropriate agencies of the American Dental Association make every reasonable effort to insure that the Occupational Safety and Health Administration adopt the guidelines and recommendations of the American Dental Association as the federal regulation governing infection control procedures in the dental office.

Eleventh Trustee District

Study of Federally Funded Dental Facilities

The following resolution was adopted by the Eleventh Trustee District and submitted on October 14, 1987 by Dr. Howard F. Curtis, delegate.

99. Resolved, that the appropriate agencies of the American Dental Association study the prevalence of rendering routine, nonemergency dental service to nonnative patients in any facility which has been federally funded for the care of Alaska Natives and American Indians where such action is in competition with the private practice of dentistry.

Twelfth Trustee District

Substitute for Resolution 10

The following substitute resolution was adopted by the Twelfth Trustee District and transmitted on September 28, 1987 by Dr. Skip D. Buford, secretary-treasurer, Twelfth Trustee District.

10S-1. Resolved, that the American Dental Association's *Principles of Ethics and Code of Professional Conduct* be amended by the addition of Section 1-K to the *Code of Professional Conduct,* to read as follows:

> Section 1-K. Informed Consent. The dentist should inform the patient of the proposed treatment and any reasonable alternatives.

Thirteenth Trustee District

Study of Implant Dentistry

The following resolution was adopted by the Thirteenth Trustee District and submitted on October 13, 1987 by Dr. J. Thomas Chess, delegate.

Background: In that the public at large and the dental profession are becoming aware of the emerging discipline of implant dentistry as a alternative mode of treatment, the time has come for the Association to investigate and study this rapidly expanding field. All information derived from this study should be disseminated to the profession as soon as possible and a report shall be given to the 1988 House of Delegates.

98. Resolved, that the Association direct the appropriate agency to study current practice of implant dentistry and the factors which may influence the future of implant dentistry, and report back to the 1988 House of Delegates.

Fifteenth Trustee District

Change in Dates for the House of Delegates

The following resolution was adopted by the Texas Dental Association on October 11, 1987 and submitted by Robert E. Caffrey, executive director.

Background: Better utilization of the delegates' time and increased reference committee attendance by the general membership would be more likely to occur if the House of Delegates convened on Saturday and closed on the Wednesday following. Therefore, be it

69. Resolved, that the first session of the House of Delegates be held on Saturday and the last session of the House be held on the following Wednesday.

Sixteenth Trustee District

Amendment to Resolution 15

The following substitute resolution was adopted by the Sixteenth Trustee District and submitted on October 5, 1987 by Ms. Patricia Watkins, caucus secretary, Sixteenth Trustee District.

Background: The Sixteenth Trustee District recommends the addition of a second resolving clause to make the amended resolution read as follows:

15S-1. Resolved, that when a dentist is employed and then leaves for new employment or to open his/her own practice, all insurance companies and/or dental service corporations shall allow said dentist to establish a new fee profile, and be it further

Resolved, that dentists beginning practice be advised of this ADA policy on the development of individual fee profiles and also be advised of the potential adverse effects of insurance industry practice in the development of fee profiles for individual practitioners.

Sixteenth Trustee District

Hotel Rates for Session Attendees

The following resolution was adopted by the Sixteenth Trustee District on October 14, 1987 and submitted by Dr. James H. Gaines, trustee.

Background: The Sixteenth Trustee District appreciates the efforts of the Council on Annual Session and International Relations in arranging successful annual meetings. However, there is increasing concern that the Council and staff could negotiate more favorable and equitable hotel rates for attendees in the convention city.

100. Resolved, that the appropriate agency of the Association study and take action to negotiate more favorable and equitable hotel room rates during the annual sessions of the ADA.

Delegate Ignatius J. Fiorenza, Massachusetts

Approval of "Rules of House of Delegates"

The following resolution was submitted on September 25, 1987 by Dr. Ignatius J. Fiorenza, delegate, Massachusetts.

Whereas, each House of Delegates of the American Dental Association is composed of many newly elected delegates with its own rules and manual; and

Whereas, each year the delegates have approved the rules under which they operate, be it

60. Resolved, that the rules of the House of Delegates which appear in the *Manual of the House of Delegates, 1987* be approved.

Delegate Ignatius J. Fiorenza, Massachusetts

State Society Officers Conference

The following resolution was submitted on September 25, 1987 by Dr. Ignatius J. Fiorenza, delegate, Massachusetts.

Background: The State Society Officers Conference has been and continues to be an extremely valuable and timely conference. It offers a unique opportunity for direct communication and interaction between the constituent societies and the American Dental Association concerning timely issues.

It should continue to function as a formalized body with elected officers, its own agenda, a line item in the budget and ADA staff support.

Insofar as the executive directors of constituent societies meet annually at the annual management conference, which is a continuation of the Secretaries Management Conference, the officers of the state societies conference should be only elected officers of constituent dental societies nominated through the currently existing nominating committee procedure.

61. Resolved, that the State Society Officers Conference continue to function as a formalized body with its own officers in conjunction with the annual meeting of the American Dental Association, and be it further

Resolved, that the elected officers of the State Society Officers Conferencce be selected through the traditional nominating committee method, and should be currently serving as elected officers of the constituent dental societies, and be it further

Resolved, that the Conference of State Society Officers be a separate line item in the annual budget presented to the House of Delegates.

Western States President's Conference

National Dental Health Month

The following resolution was adopted by the Western States President's Conference on August 1, 1987 and submitted by Dr. William L. Thomason, executive secretary, Nevada Dental Association.

Background: For many years, the celebration of National Children's Dental Health Week, later renamed National Children's Dental Health Month, has been successful in stimulating interest in and awareness of the importance of the dental health of children. The 1986 House of Delegates Resolution 69 (*Trans.* 1986:513) established a Senior Citizens' Dental Health Week during May 1987 to heighten awareness of the need and availability of geriatric dental care.

The Western States President's Conference is mindful of the need and importance of stimulating awareness of dental health at all ages of our population. However, we feel that the celebration of National Senior Smile Week has done nothing more than dilute the effectiveness of the annual celebration of National Children's Dental Health Month. Therefore, be it

35. Resolved, that the celebration of Children's Dental Health Month and Senior Citizens' Dental Health Week be consolidated into one celebration, National Dental Health Month, and, as such, be held each year during the month of February.

Reports of Board of Trustees to House of Delegates

Notes

Report 8

Health Policy Agenda for the American People

Background: The Health Policy Agenda for the American People (HPA) was initiated by the American Medical Association in 1982 to provide a comprehensive framework for the development of national health policy into the 21st century. The Final Report of the project, which includes policy proposals and 195 recommendations, was released in February 1987. The HPA has expressed its hope that each of the over 170 organizations that participated in the project will adopt principles and policies to use in its own health policy activities. It is recognized, however, that no organization is likely to embrace all aspects of the report.

Recognizing the significance and complexity of the Health Policy Agenda, President Devine appointed an eight-member special committee to study the HPA's Final Report and to present recommendations for the Board's consideration at its August 1987 session. Serving on the Committee were Dr. Kenneth M. Clemens, chairman, and Drs. John L. Bomba, Joel M. Boriskin, Joseph G. DiStasio, Albert H. Guay, Burton H. Press, Bernard S. Snyder and Henry M. Sorrels. The Special Committee met on July 29-30, 1987, in the Headquarters Building, Chicago.

The Board of Trustees considered the Special Committee's report at its August 1987 session and commended the members for their work. In reviewing the report, the Board noted that, although HPA implementation activities have been focused primarily at the national level, follow-up activities are currently taking place to raise awareness at the state and local levels. For example, press kits and HPA reports have been sent to all governors, major staff and heads of state health departments.

The Board believes that the Special Committee's report about the project and dentistry's involvement in the HPA should be brought to the profession's attention. The Board, therefore, is transmitting this informational report to the House of Delegates.

Overview of the HPA Project: The HPA was a broad-based effort of over 170 organizations representing business, government, consumer and health care groups. Its purpose was to examine immediate health care concerns as well as issues that will be confronting the health sector into the next decade and the next century. The HPA was guided by a 32-member steering committee representing various health, business and consumer organizations. Six work groups were responsible for developing the issues to be considered by the Steering Committee. Dr. Burton Press and subsequently Dr. John Bomba served on the Steering Committee. Several other Association members, members of dental specialty organizations and Association staff assisted in the development of principles and recommendations at work group and advisory committee meetings.

The complete HPA report includes three volumes: (1) a Summary Report of the 195 recommendations, (2) the Final Report that includes the 195 recommendations within the context of policy proposals and (3) the Reference Report that includes the reports of the six work groups. Order forms for the various reports are available from the Association's Office of Quality Assurance.

The HPA project included three phases, the first two of which were developmental. During the first phase, 159 principles were developed that described what should exist in health care. The Phase I Report was circulated in late 1984 to participating organizations for review and comment. In reviewing a report about these principles at its January 1985 session, the Board noted that, at that time, the material included in the Phase I Report presented no significant problems or conflicts with ADA policy. The Board, however, noted that several areas could potentially be of concern for the Association when specific policy and implementation procedures were established. One of the Board's concerns related to the fact that language in the report could be interpreted as suggesting that health care fringe benefits be taxed. The Board's concerns about the Phase I Report were submitted to the HPA project for consideration as the project progressed.

During the second phase, work groups developed policy proposals in seven areas: supplying the professionals, providing the technology and facilities, organizing the resources, communicating health information, ensuring quality, paying the bill and preparing for the future through research.

Upon completion of the final reports, HPA activities were transferred to the Implementation Committee, which will oversee the third phase—putting HPA recommendations into action. The HPA is committed to implementing key recommendations through a combination of information campaigns, coalition building, demonstration projects, legislative proposals and other activities. As with the two earlier phases of HPA, the Association is represented in this important activity. The other organizations included on the Implementation Committee are: Council on Employee Benefits, American Society of Allied Health Professions, Federation of American Health Systems, American Nurses Association, Inc., American Medical Association, Consumer Federation of America, American Association of Retired Persons, Health Insurance Association of America, National Medical Association, Service Employees International Union and Blue Cross and Blue Shield Association. There are also two at-large members on the committee.

The Association's Involvement in the Project: The American Dental Association has actively participated in all phases of the HPA project since its initiation in 1982. This participation has been vital since it would have been unthinkable that dentistry not have a voice in the discussion of health policy issues that affect the American public now and into the 21st century. All of those who represented the Association in these deliberations were knowledgeable about Association policy and presented dentistry's views effectively.

A consensus approach was used in the HPA deliberations. Even when consensus differed from Association policy,

dentistry's presence was advantageous—others learned of dentistry's interest and perspectives and the Association gained knowledge of those organizations with differing views.

The Uniqueness of the HPA Report: The HPA Final Report is a freestanding document. It does not belong to any one association although the American Medical Association initiated the project and committed at least $5 million to this effort. The AMA also provided a separate office in its Chicago Headquarters Building for the HPA staff, all of whom were employees of the project, not the AMA.

Once the HPA Final Report was distributed, the participating organizations were invited to submit minority reports. The American Dental Association, like most other organizations, chose not to respond formally as the objective of the project was to build consensus.

As noted earlier, the HPA does not expect any organization to endorse everything in the Final Report. Despite the AMA's strong commitment to the project, its own House of Delegates did not endorse all of the 195 recommendations.

Internal Review of the HPA Report: The appropriate Association agencies reviewed the 195 HPA recommendations and prepared comments for the Special Committee's consideration. Specifically, the agencies were asked to review the recommendations and (1) identify those that do not have implications for dentistry, (2) those that are consistent with current policy, (3) those that should be supported but will require new or revised policies and (4) those that are inconsistent with ADA policy and should not be supported. Because of the schedule of council meetings, in most instances council staff was called upon to prepare the requested information for the Special Committee's deliberations.

The Special Committee's Review of the HPA Report: The Special Committee members noted the scope and complexity of the issues addressed in the recommendations. Recognizing its inability to study all 195 recommendations and the need for more in-depth analysis of some issues, the Committee focused its attention on the five priority areas that have been identified by the HPA Implementation Committee. These are: Funding for Biomedical Research, Tort Reform, Consumer Health Information, Basic Benefits and Medicaid. The Committee also discussed the recommendations related to a Cost Effective Payment System, Financing Undergraduate Education and Financing Clinical Graduate Education as well as several other recommendations of special interest to individual members.

The Special Committee categorized these recommendations as follows: those that are consistent with Association policy, those that appear to be consistent with policy, those that are in opposition to policy and those that are not directly relevant to dentistry but are supportable from the standpoint of the health of the American people.

The Committee agreed in general with many of the recommendations that it reviewed. Some are consistent with Association policy; while for others, especially in the area of Funding for Biomedical Research, there is no policy, but the Association's support is probably warranted. As the major thrust of the document is medical care, not dental care, the Special Committee was unable to make direct comparison in some cases with Association policy or issues. But if implementation of a recommendation would be beneficial to the health of the public, even though there is no direct relationship to dentistry, the Special Committee believes that the Association's support should not be precluded.

It should also be noted that, at times, the members of the Special Committee disagreed about the intent of HPA recommendations. As explained by several Committee members and staff who served on various HPA groups, this ambiguity often resulted from the diversity of the groups involved in their development and the effort to arrive at consensus.

Conclusions of the Board: Although it is clear that the Association can support many of the HPA recommendations, others need in-depth analysis by the appropriate agencies of the Association. In its report to the Board, the Special Committee emphasized the following two observations about the Final Report of the Health Policy Agenda for the American People: (1) The HPA Final Report is not an ADA document and its 195 recommendations are not ADA recommendations, and (2) The American Dental Association should respond to actions relating to HPA recommendations as it would to those of any other external group. That is, the Association should support those HPA recommendations that are consistent with ADA policy and oppose those that are not.

Based on the Special Committee's recommendations, the Board voted to:

—Send an interim informational report to the 1987 House of Delegates that gives a historical review of the Health Policy Agenda project and the Association's involvement in the project's various phases.
—Refer the HPA recommendations to the appropriate agencies so they may assess the recommendations related to their activities (and to inform the various councils that they should not feel compelled to respond to the HPA recommendations by proposing policy where none now exists or proposing modification of existing policy unless they deem it critical to do so).
—Use the material prepared for and revised by the Special Committee as a working document that is updated continually to reflect current Association policy. The Office of Quality Assurance was assigned responsibility for maintenance of the document.
—Monitor carefully and continuously the activities of the HPA Implementation Committee, with the Board and the various councils to respond as appropriate.

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

Report 9

Update on Activities Regarding Resolution 51H-1986—Development of a Protocol to Study Capitation Programs

Subsequent to Board Report 6 (*Supplement 1*:294), the Association was informed that the W. K. Kellogg Foundation had rejected the request for funding. Kellogg's rejection was based on the fact that the study's emphasis is heavily research-oriented and Kellogg's guidelines restrict its funding to demonstration projects.

In addition, the Association was advised that Kellogg does not fund demonstration projects concerning financing of health care services. Kellogg praised the Association's protocol and suggested that it be sent to other foundations which are interested in the various aspects of health care financing.

The Association is considering The John A. Hartford Foundation, Inc., of New York, PEW Charitable Trusts and the Health Care Financing Administration (HCFA) as possible agencies for funding this protocol.

The Board is faced with three obligations:

1. to find a source of funding for the approximate amount of $4.88 million to conduct a comprehensive study of dental care provided to patients by U.S. dentists under all reimbursement mechanisms, as outlined in the protocol; and
2. to respond to the charge contained in Resolution 51H-1986 (*Trans.*1986:516) to develop a protocol to study capitation and provide financial implications for the study in a report to the 1987 House. An Executive Summary of the protocol together with a budget estimate for Project 4 are attached to this report as Appendix A and Appendix B. In addition, a report to the Board from the Council on Dental Care Programs is attached as Appendix C; and
3. to develop alternative mechanisms for funding should outside funding not be obtained. The Board notes that the $4.88 million could be obtained from Association reserves or through a dues increase of $51 per member over the term of the study.

Clearly, the Board is in favor of finding outside funding at this time for a comprehensive study. The data from such a study will provide an important source of available information for the public, plan purchasers, government and the profession, about the type and quality of care provided under all reimbursement mechanisms. So important does the Board believe this information to be, that the Association has solicited support for the study from U.S. Representatives Sander M. Levin, Michigan; Joseph D. Early, Massachusetts; Claude D. Pepper, Florida; and John D. Dingell, Michigan, as well as the Consumer Federation of America and the Center for Scientific Research in the Public Interest. The Board of Trustees is in agreement with the Council on Dental Care Programs that the proposed comprehensive study is of major importance to plan purchasers, the government and consumers and that it should be conducted as soon as possible, and that the credibility of the study would be enhanced if funding came from outside sources rather than the Association. Therefore, *the Board recommends adoption of the following resolution.*

Resolution

77. Resolved, that the American Dental Association continue to pursue funding in the amount of approximately $4.88 million from outside agencies for a comprehensive study of dental care provided by U.S. dentists under all reimbursement mechanisms.

Appendix A

Executive Summary of Research Protocol

I. BACKGROUND

A proposed research protocol has been developed by the American Dental Association that is committed to enhancing the measurement of the quality practice of dentistry, determining the several important factors associated with differing levels of quality, determining the role played by alternative methods of reimbursement for care on quality of care, and providing continued evidence to society on the growth in quality of dental services over time.

The objectives of the research protocol include responding to Resolution 51H passed by the 1986 ADA House of Delegates:

> **Resolved**, that the Board of Trustees through the appropriate agencies of the Association develop a protocol for study of capitation programs that shall include the parameters of a database and quality assessment indicators; and be it further
>
> **Resolved**, that the Board of Trustees report back to the 1987 House of Delegates with a study protocol and cost implications for conduct of the study.

While the objectives of the research protocol include response to the resolution, the protocol in total contains broader implications regarding the practice of dentistry, alternative methods of reimbursing for dental care and, measuring and monitoring the quality of dental care over time. These broader implications are also in partial response to opportunities to seek outside funding of this research protocol.

The purpose of this overview of the research protocol is to (1) identify the research objectives, (2) summarize three of the four proposed research projects contained in the protocol that are directly related to Resolution 51H, and (3) summarize the implications of the three projects as a means for responding to the Resolution.

II. RESEARCH PROTOCOL OBJECTIVES

The overall objective is to assess and examine the quality of dental care and treatment rendered to the public through the practice of dentistry in the US. Specifically, the protocol contains the following objectives:

1. To assess the influence of alternative methods of reimbursing for dental care on the practice of dentistry and the quality of dental care rendered to the public.

2. To assess the quality of dental treatment rendered to patients through further development of the means to evaluate treatment, including intra-oral evaluation.

3. To enhance the quality of decision making by dentists as a further means of improving the quality of dental care rendered to the public.

4. To examine the implications for the quality of care and practice of dentistry from decisions to treat a mix of patients whose care is reimbursed through alternative dental benefit programs, and including direct patient payment.

III. PROPOSED RESEARCH PROJECTS

This section contains a summary of three proposed research studies having implications for response to resolution 51H passed by the 1986 House of Delegates. The remainder of this section briefly summarizes each of the proposals and each concludes with a summary of the means for responding to the resolution.

PROJECT 1: MEASUREMENT AND EVALUATION OF QUALITY OF CARE

Purpose: To build on the work completed by others as it relates to the assessment and measurement of quality of care including structure (i.e., practice facilities, equipment, organization, administration and personnel), process of providing care (i.e., completeness of history and oral examination, appropriateness of the diagnosis and treatment plan, and the technical skill in providing treatement), and technical evaluation through intra-oral examinations.

Methods: This research project consists of three research phases that include:

1. Conduct a comprehensive review and compilation of existing information and means of conducting measurement and assessment of quality of care which will be directed through the Association's Office of Quality Assurance.

2. The review and development of indicators of quality among selected categories of dental services to serve as the focus for intra-oral evaluation. This phase will consist of identifying and organizing experts to assist with project direction and requiring in-house and field testing of measurement instruments.

3. To conduct a full national field test of the components for measuring quality of care through use of a national sample of practitioners, and including the following activities: (a) conduct mail survey of dentists about opinions and attitudes regarding measurement and evaluation of quality of care; (b) organize and train a cadre of evaluators to contact a national sample of dentists and conduct on-site measurements of care rendered to patients; and (c) conduct, after completion of the field test, focus group sessions held independently with two groups from the national sample including dentist participants and those not participating.

Issues: What categories of service should be included in the measurement process ? Can evaluators be calibrated to within acceptable limits of difference ? Will a national sample of dentists participate in a field test of the measurement instrument and do attitudes and opinions explain participation versus nonparticipation ? What dentist, practice, or attitudinal characteristics tend to explain the likelihood of participation ? Do scores from measurement of quality correlate with practice, dentist and attitudinal characteristics ? What are the major practice and dentist characteristics that must be overcome to achieve greater willingness to participate in a quality assessment program ?

Implications for Resolution 51H: The resolution requires quality assessment indicators as part of the database developed from a study of capitation programs. This project draws on and builds on the work of others to develop a more comprehensive and acceptable means of measuring various facets of quality of care, including intra-oral evaluations. Since the means for measurement of quality is not well developed at this time, this research effort is required prior to the inclusion of quality assessment indicators as part of a database on the effects of alternative methods of reimbursing for dental care, including capitation, on the practice of dentistry.

PROJECT 2. ORAL HEALTH CONDITIONS, QUALITY OF CARE AND PRACTICE OF DENTISTRY

Purpose: To assess the oral health conditions of the population and examine differences in health status and need for treatment as they relate to the quality of practice, style of practice, and alternative methods of reimbursement

Methods: 1. Determine oral health status, treatment needs and utilization of dental service using a national sample of the population.

2. Determine the experience of patients with treating dentists, including utilization, length of time a patient, and time since last visit.

3. Determine the patient experience with alternative methods of reimbursement for care, including time covered, use, and last time using benefits.

4. Requires the selection of a population sample that includes pre-screening and/or oversampling for patients covered by a program where a fixed dollar amount per period is paid to a contracting dentist for the care of patients.

5. Determine character of practice of dentists treating patients from the population sample over a recent period of time.

6. Assess the quality of care associated with treating dentists as related to the structure of practice and process of rendering dental services.

7. Conduct follow-up data collection with the purchaser of the dental benefit program identified by the sample patient to provide record information about plan benefits and to survey purchaser about various conditions of the plan.

Issues: What are the differences in oral health conditions and treatment needs of patients with various lengths of experience in alternative reimbursement programs ? Do oral health conditions and treatment needs differ according to experience of dentists treating patients covered by alternative methods of reimbursement ? How do patient oral health conditions and treatment needs vary according to measurement scores determined from an assessment of the quality of care related to structure and process ? What are the important characteristics of quality of care that seem to explain differences in oral health conditions and treatment needs ? To what extent are oral health and treatment need differences related to patient, dental practice and dental benefit plan characteristics ?

Implications for Resolution 51H: This project will contribute information to a database based on data collected from a population sample covered under alternative methods of reimbursing for dental care, including capitation programs. Population pre-screening and/or oversampling of population covered by capitation can be included to intensify analysis of capitation effects and comparisons. Analysis will include data from population covered by capitation programs, dentists treating different mixes of patients including sampled patients covered by capitation, assessment of quality of care according to structure and process of treating patients, and comparisons of oral health conditions and need for treatment of patients covered by capitation and other methods of reimbursing for dental care.

PROJECT 4: ALTERNATIVE METHODS OF REIMBURSEMENT FOR DENTAL CARE AND THE PRACTICE OF DENTISTRY IN THE US

Purpose: To examine the practice characteristics and the quality of care among dentists with varying mixes of patients covered by alternative methods of reimbursement within the same practice.

Methods: 1. Select a sample of practicing dentists that is representative of private practicing dentists and/or reflects pre-screening or oversampling of dentists with patients covered by capitation to facilitate comparisons with dentists having no patients covered by capitation.

2. Conduct a survey of the sampled dentists to determine characteristics of practice and patients treated including the mix of patients covered by alternative reimbursement plans.

3. Abstract a sample of patient records to determine the historical mix of services rendered over a period of time.

4. Conduct a prospective survey of dental services rendered by each practice selected in the dentist sample.

5. Conduct assessment of the quality of care related to the structure of practice and process of providing treatment.

Issues: What are the effects of mixing patients covered under different reimbursement programs within the same practice ? What are the major reasons dentists allow or desire different mixes of patients ? What are the differences in structure and process measures of quality of care according to different mix of patients covered under alternative reimbursement plans ? What are the important components of process and structure measurements of quality associated with different patient mix ? How does the distribution of dental services vary according to different mixes of patients covered under alternative reimbursement programs ? How does the distribution of dentist and practice staff (assistant and hygienist) time vary according to different mixes of patients ? How do the financial conditions of practice, including pricing of services, vary according to different patient distributions among reimbursement methods ? How does the mix of patients covered by different reimbursement programs vary according to influences external to the practice such as the density of dentists; population per capita income and growth; population composition, size and growth; population age distribution; industrial characteristics; employment conditions and economic growth; and other economic/demographic characteristics.

Implications for Resolution 51H: This project will provide information for the database based on data collected from a sample of dentists treating varying mixes of patients covered by alternative reimbursement plans, including capitation reimbursement. Sample pre-screening or oversampling of dentists treating patients covered by capitation can be applied to facilitate better comparisons to dentists not treating similarly covered patients. Analysis will focus on differences among dentists treating different distributions of patients according to methods of reimbursement including capitation, assessment of measured quality of care according to structure and process of providing treatment, and analysis of service mix differences with regard to varying mixes of patient reimbursement plans.

Appendix B

Alternative Methods of Reimbursement for Dental Care and the Practice of Dentistry in the United States

BUDGET ESTIMATE FOR PROJECT 4

I. BACKGROUND

The purpose of this research project is to examine the practice characteristics and the quality of care among dentists with varying mixes of patients covered by alternative methods of reimbursement for dental care capitation payment. The study will focus on the influence of alternative mixes of prepayment on practice of dentistry and quality of care.

The project will involve obtaining the cooperation of a national probability sample of 3,000 US dentists in private practice. Dentists will be asked to complete an interview in which demographic, professional, and attitudinal/perceptual data will be obtained. Additional information will be obtained about the dentists practice and the mix of patients treated that are covered by different dental benefit programs. The dentist will also be asked to allow a trained professional to abstract the dental records for a sample of about 120 patients treated during the previous 12 month period. Data will include patient age, gender, coverage status, procedures received, charge, and other payment data. Finally a trained dental profession will request that the dentist allow the collection of practice data as part of a practice evaluation. The evaluation instrument used will be based on the results of the project entitled DEVELOPMENT OF EVALUATION METHODS AND COMPUTER APPLICATIONS IN DENTISTRY.

II. BUDGET ESTIMATES, PROJECT 4

Project 4, as budgeted in the following tables, is proposed as a three year project consisting of three phases, each covering one year. Phase One consists of development activities while Phase 2 consists primarily of data collection work. Phase 3 consists of data collection finalization, data analysis, and report preparation. The following table contains a summary of the estimated budget for completion of Project 4 over a three year period followed by a description of project tasks:

SUMMARY OF ESTIMATED PROJECT COSTS - PROJECT 4

YEAR	TASK DESCRIPTION	$ AMOUNT	PERCENT
1	Project Management/Labor	116,237	24.0
	Sample Design	77,870	16.0
	Survey Development/Design	63,803	13.0
	Analysis Plan/Reports	37,327	8.0
	Pilot Study/Pretest	190,352	39.0
	YEAR 1 TOTAL	485,589	100.0

SUMMARY OF ESTIMATED PROJECT COSTS - PROJECT 4

YEAR	TASK DESCRIPTION	$ AMOUNT	PERCENT
2	Project Management/Labor	153,720	4.0
	Analysis of Pilot Study	77,894	2.0
	Sampling	16,281	0.4
	Data Collection	2,636,322	67.0
	Data Processing	1,029,951	26.0
	Preliminary Data Analysis	17,044	0.6
	YEAR 2 TOTAL	3,931,192	100.0
3	Project Management/Labor	91,414	20.0
	Data Processing	73,973	16.0
	Analysis/Weights	214,959	46.0
	Final Report/Data Files	84,696	18.0
	YEAR 3 TOTAL	465,042	100.0

SUMMARY

YEAR 1	$ 485,589	10.0 %
YEAR 2	3,931,192	80.5
YEAR 3	465,042	9.5
PROJECT TOTAL	$ 4,881,823	100.0 %

PHASE ONE: DEVELOPMENT AND DESIGN

Task 1: Project Management

The project management activities are performed in this task to include meetings by task leaders, review of deliverables, preparation of monthly progress reports, liaison with the ADA project leader, quarterly meetings with the ADA project staff (two at ADA and two off-site), review of key forms and documents by outside staff and leader, budget monitoring and review, monitoring of task activities, and establishing and maintaining a project schedule. Work will have to take place closely with ADA to prepare materials, articles, support and endorsements, and other announcements.

Task 2: Sample Design

This task is premised on the availability of the ADA to provide a sampling frame based on the 1987/88 Distribution of Dentists Survey currently underway. Primary sampling units (PSUs) consisting of geographic clustering of dentists will be created using ZIP codes, county codes or other geographic designations. The number and size of these clusters will be determined based on consideration of statistical and operational efficiency. A small sample of PSUs (10) will be selected for a pilot study and within each PSU an average of 15 dentists will be chosen at random. The sampling design for the full study will be developed in this task as well. The budget estimates are based on a sample of 150 PSUs with a response rate of 70% yielding 3,000 participating dentists, i.e., completed dentist interview, practice evaluation, and record abstraction. To allow for a lower response rate and still be able to complete the targeted 3,000 dentists, an

adaptive procedure will be used in which an "over" sample is selected and can be fielded in subsequent waves in PSUs where response to the original sample was unacceptably low. A procedure for sampling patient records will be developed based on the appointment book, payment ledger or other appropriate listing of patients seen in the previous 12 month period.

Task 3: Instrumentation/Survey Development

All data collection instruments, training materials, and administrative forms will be developed in this task. This will involve review of existing instruments and materials; adaptation of them for this study; creation of new items, sections; and formatting them in a readable, usable and clear manner. A pretest of instruments and surveys with dentists will be conducted throughout this task (and phase).

Task 4: Analysis Plan

The research questions and study hypotheses to be tested will be specified during this task. An initial effort will be made to specify the analytical approach and statistical techniques used. A preliminary specification of variables to be created for use in the analysis will also be made.

Task 5: Pilot Study/Pretest

A small pilot study will be performed in this task. The pilot study will provide information on a number of operational issues that need to be settled before embarking on the main study (Phase 2). Methods of approaching the dentists to request cooperation, the effect of incentives and the expected level of cooperation will be estimated. Methods of collecting interview data, abstracting records and collecting prospective dental procedure data will be tested and analyzed.

PHASE TWO: DATA COLLECTION

Task 1: Project Management

The activities in this task are a continuation of those in Phase One. In addition, an automated project activity monitoring system will be designed to monitor the flow of work assignments from the first contact to final disposition and transferring of data to computer tapes.

Task 2: Analysis of Pilot Study

Examination and estimation of response rates, debriefing of abstracters and evaluators, and the examination of data completion will be conducted in this task. All results will be used to assess for implications in the main study concerning sample size, revision of contacting dentists, revision of all data collection forms and instruments, and other project activities.

Task 3: Sampling

The sample for the main study will be selected in this task. Success of the abstracters in obtaining dentist cooperation will be closely monitored for implications in the main study. For

estimated budget purposes, 150 PSUs and 4,511 dentists will constitute the sample. This is expected to yield about 3,000 dentist respondents assuming a 75% response rate.

Task 4: Data Collection

Data collection is the largest project task and can be partitioned into several subtasks including printing and distribution of forms: letters and instruments; recruiting abstracters/interviewers/evaluators; training of field staff; and final collection of all data.

Task 5: Data Processing

Included in this task and to data collection are data receipt control, editing, coding, fail-edit resolution, data entry programming, transferring of data to computer tape, and data quality control.

Task 6: Preliminary Analysis

A preliminary analysis of data will be conducted during this task to provide the first examination of a data collected to date. Using an unedited data file, this analysis will assist in evaluating the analysis plan, and providing input to the process of editing data.

PHASE THREE: ANALYSIS AND REPORTING OF DATA

Task 1: Project Management

These tasks are the same as in Phases One and Two.

Task 2: Data Processing

The processing of all data and data files based on all data collected throughout the main study. Activities include the machine editing of data, imputation of key data items, derivation of all analysis variables, completion of study weights and creation of analysis files.

Task 3: Sampling Weights/Data Reduction/Analysis

The analyses proposed consist of a combination of tabular and multivariate modeling approaches. In addition, the computation of final sampling weights will be performed reflecting the effects of non-response, ineligibility, disproportionate sampling rates, and any necessary post-stratification adjustments.

Task 4: Final Report

Final results of all project activities will be finalized and delivered to the ADA. A final report of all data collected and analysis performed will be prepared, in consultation with ADA staff and delivered to the ADA. Both a draft and final report have been included in the budget.

Appendix C

Report of Council on Dental Care Programs: Update on Resolution 51H-1986—Development of a Protocol to Study Capitation Programs

Following the Board of Trustees' August meeting, Council staff was called by Mr. Robert DeVries of the W.K. Kellogg Foundation regarding the Association's protocol for a comprehensive study of dental care provided under all reimbursement mechanisms.

Mr. DeVries expressed the concern that the research would primarily benefit dentists and was not disciplinary. The Council selected projects 2 and 4 from the protocol and wrote to Mr. DeVries about the need for this study as it would benefit the public, plan purchasers and the government. In addition, the Association solicited support from consumer advocates in Representatives Claude Pepper, John Dingell, Sander Levin, and Joseph Early, as well as the Consumer Federation of America and the Center for Scientific Research in the Public Interest. A letter soliciting support from the United Auto Workers was sent to Dr. William Hoffman who had expressed a willingness to review the protocol.

The Kellogg Foundation was unable to fund the Association's proposal because of its heavy research orientation. Kellogg's funding guidelines focus on demonstration projects. Mr. DeVries was complimentary about the Association's research protocol and suggested that it be directed to other foundations, such as The John A. Hartford Foundation and The Pew Charitable Trusts, which are interested in health care financing projects.

The Association is pursuing outside funding for this study and will keep the Board of Trustees informed of its progress. In the meantime, the Board is faced with the charge contained in Resolution 51H-1986(Trans.1986:516), which asks that the Board report back to the 1987 House of Delegates with a protocol to study capitation programs together with financial implications.

In order for the Board to make its report to the House, the Council has developed a protocol for Resolution 51H-1986, and a budget for the study has been prepared with the assistance of the Association's Bureau of Economic and Behavioral Research.

In order to assist the Board in its discussion on this rather complicated subject, the Council would like to review the year's activities which have brought the Council and Board to the current state:

1. At the Council's December 1986 meeting, a subcommittee was appointed by the Council chairman, Dr. Albert H. Guay, to develop a protocol to study capitation. The subcommittee consisted of Dr. Myron Bromberg, chairman, Dr. Richard D'Eustachio and Dr. Nick Varallo. In addition to Council staff, staff members from the Bureau of Economic and Behavioral Research and Office of Quality Assurance were included.

2. At this meeting, the Council was advised by the Association's outside counsel that in order for the study to have credibility, it would need to be independently-based scientific research.

3. At its first meeting, the subcommittee met with Dr. Tryfon Beazoglou of the University of Connecticut; Dr. Tom Gotowka of St. Francis Hospital, Connecticut; Dr. Max Davis, president of U.S. HMO Dental Consultants, Inc.; and Dr. Douglas Franklin. Dr. Beazoglou had just completed a study of an auto workers' capitation program in Racine, Wisconsin and

   Dr. Gotowka was about to embark on a study of capitation at St. Francis Hospital.

4. At the Council's March 1987 meeting, Dr. Ginley informed the Council of a possible funding opportunity through the W. K. Kellogg Foundation. The Council was informed also that any proposal submitted to Kellogg would have to clearly demonstrate its value to the public at-large.

   On that basis, a protocol for a comprehensive study of dental care provided by U.S. dentists under all reimbursement mechanisms was developed and submitted to Kellogg.

5. The Board of Trustees reviewed a complete outline of the protocol at its August 1987 meeting and copies of the entire protocol were available for those trustees interested in the specific detail of each of the four projects.

6. During the past year, the spectre of capitation, while very real to those members who are faced with patients whose employers have adopted a capitation program, has not materialized in a national way nor has it swept the country as promised by its promoters. In fact, capitation, in spite of the enormous amount of funding for promotion of the concept, has only a 2.6% (down from 3% last year) market share, according to the latest figures compiled by the Council.

   This lack of success is understandable. Very few dentists actually sign into capitation programs. The Council has been told by the Aetna representative that its own capitation program, PREVENT, is at a stand-still and its future is uncertain. Furthermore, the pool of dentists is so small, that each program (CIGNA, Aetna, Prudential, etc.) is competing for the same available dentists.

   In addition, most specialists refuse to sign into these programs, which is making it very difficult for the carriers to promote high quality, full service, dental benefit plans.

   Dr. Beazoglou has stated that capitation is not going anywhere. The figures about market share optimistically projected by insurance carriers a few years ago are simply not being realized.

The Executive Summary attached to Report 9 contains specific discussion of how each of the three projects addresses Resolution 51H. Of these three projects, the Council believes that Projects 2 and 4 are most important, with the highest priority on Project 4. The estimated cost for all three projects is $12 million. The attached estimated budget for Project 4 only indicates a cost of $4.88 million. If Project 4 is changed from a comprehensive study to a study focusing solely on capitation, the budget would change little, if at all, because the sample size required would remain the same. The project design would also remain unchanged, but the method of sampling would be different.

The Council strongly believes that the comprehensive study (Project 4) is of major importance to plan purchasers, the government and consumers and that it should be conducted as soon as possible. However, the Council is convinced that the credibility of the study would be greatly enhanced if funding came from an outside agency, rather than the Association.

Mr. Peter Sfikas, outside counsel to the Association, advised the Council that if the research is conducted by an independent, well respected research institution, and yet funded by the Association, its results could not be considered biased or tainted and would stand any legal challenge. The Council fully accepts Mr. Sfikas' opinion. The Council's concern about an Association funded study is that the insurance industry will try to discredit the study to prospective purchasers by identifying it as an ADA study so that unless the Association is willing to institute legal proceedings each time the study is incorrectly identified, it will be very difficult for the Association to protect the study's integrity. In other words, the problem is one of perception and in such circumstances, the Council believes that perception will be reality.

Since the Association has only just begun its search for funding of the study from outside agencies, the Council would prefer to wait and see whether this process can be successful. However, the Council fully recognizes that responsibility for Resolution 51H-1986 belongs to the Board and will, of course, defer to the Board's judgment if it believes that the study should be funded by the Association without delay.

Because of the length and complexity of the comprehensive protocol document, the Board may wish to transmit only the Executive Summary to the House of Delegates, with an indication that the complete protocol is available on request. It may also decide to submit neither the protocol nor the Executive Summary, since each of the projects and their applicability to Resolution 51H-1986 were described in Board Report 6 to the House of Delegates (Worksheet: 518).

Resolutions

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

Report 10

Professional Liability Insurance

Designation of Brokerage Firm for Proposed Association-Sponsored Professional Liability Insurance Program: In response to the withdrawal of Association endorsement of the Professional Protector Plan in November 1986, the House of Delegates adopted Resolution 94H (*Trans.* 1986:524), which called for the Council on Insurance to investigate all alternatives for reestablishing Association influence and involvement in the professional liability insurance marketplace.

In response to this mandate, at its March 24-25, 1987 meeting, the Council considered three courses of action for the future. The first of these was to discontinue direct involvement in the marketplace and to serve as a resource for membership inquiries, while advancing the interests of the profession through risk management and tort reform initiatives. Although the Council concluded that this approach had merit, it was perceived as a contingency measure in the event that a sponsored program could not be developed.

The second option was to enter the market with a profession-owned insurance company. However, given emerging competition and pricing that appeared actuarially supportable, the Council concluded that the substantial financial risks of activating the Association's Bermuda captive could not be justified.

The third alternative was to develop and endorse a new commercially underwritten program. Towards that end, the Council approved specifications that set forth the philosophies and criteria that should serve as the foundation for any insured arrangement. These guidelines were intended to reflect the collective needs and expectations of the profession. They further commented on the expertise, resources and purchasing power that organized dentistry can bring to such a relationship.

Although it was recognized that program specifications may not be completely attainable in the marketplace, they would provide guidance in future negotiations with carriers. Foremost among the objectives was that any future program must offer advantages over competing products. In addition, the Council supported the concept of forming a purchasing group, as provided by the Risk Retention Act of 1986, which would minimize regulatory requirements relating to the approval of policy forms and rates. A key component was the introduction of a new approach to classifying risks that would promote a more equitable distribution of costs and reduce the prospects of adverse selection. Finally, the profession would play an integral role in decisions affecting all facets of the program.

In addition to developing these specifications, the Council further determined that a brokerage firm should be appointed to assist in conducting a search for an underwriter. This would allow the Association to go to the marketplace with one voice, while assuring a measure of control over plan administration. In evaluating candidates, preference was to be given to those brokerage firms which were experienced in dental professional liability, and had the financial resources necessary to invest in staff and administrative systems and the willingness to assume the economic risks inherent in such a program. It was also desirable for the broker to have a national presence, access to worldwide reinsurance markets and captive management capabilities.

Among the many firms that were considered, Johnson & Higgins (J&H) and Marsh & McLennan Group Associates (MMGA) were deemed the most qualified. Both companies were asked to submit a conceptual proposal outlining three approaches to structuring a broker/administrator relationship. The first would be for the Association to self-administer the program under the guidance and tutelage of the brokerage firm. In its advisory capacity, the broker would provide the expertise necessary to develop billing and policy issuance capabilities, administrative procedures, transaction processing, management information and claims analysis systems, marketing, licensing, staff training, etc. The Association would make the entire investment in the agency and assume all of the financial risks.

The second called for a joint venture between the Association and the brokerage firm, where all administrative and marketing tasks, as well as the investment, risk and profit would be shared. The role of the Association would focus on providing services where it has existing capabilities.

The third would be a conventional arrangement whereby the broker and/or insurer provides all administrative support. However, under this scenario, it was specified that the Association could elect to sell certain services to the program including marketing, loss prevention and professional expertise.

Initial proposals submitted by both firms were carefully analyzed with the assistance of the actuarial consulting firm of Tillinghast, Nelson & Warren. Based upon this evaluation, it became apparent that the self-administered approach would present the greatest difficulties. The Association-owned company would have to be licensed and qualified in each state if it were to market other than liability coverages under a purchasing group. Marsh & McLennan indicated that the legal costs alone of establishing such an agency could approach $800,000 with annual licensing fees of $30,000.

As most legal and regulatory requirements are contingent upon the responses of government bodies, it could take up to one year before the company would be fully operational. In addition, the agency would need to commit an estimated $1 million to develop administrative support systems, as well as finance personnel and operating costs in the first year. In short, a self-administered program may require an investment on the part of the Association of millions of dollars, which could be lost if it were to fail. It was determined that the risks of such a venture far outweighed the potential rewards.

Both Johnson & Higgins and Marsh & McLennan were willing to work with the Association under a brokerage

agreement. Although this option remains available, there is concern over the lack of control inherent in such traditional arrangements.

The proposition of a joint venture had appeal, as it offered shared ownership, a role in program management and for-profit opportunities. However, this could require the Association to contribute to the capitalization of the enterprise and participate in any financial losses.

After discussions with both firms, it was the judgment of the Council that the optimal approach might be one under which the program was initially brokered, and then converted to a joint venture after attaining some threshold of profitability. This would buffer the Association from the financial risks in the formative years of the program and allow it time to assess whether a joint venture is in its long-term interests.

With these concepts in mind, Marsh & McLennan Group Association and Johnson & Higgins were instructed to prepare a detailed business plan for the operation, coupled with expense and revenue projections under various assumptions of enrollment and premium levels. These proposals also set forth the respective duties and responsibilities of the parties, as well as other understandings and agreements.

After carefully analyzing the reports and seeking additional clarification from representatives of both firms attending the September 14-15 Council meeting, it was determined that the proposal submitted by Johnson & Higgins offered the most advantageous method for achieving Association goals with the minimum level of investment and risk.

Johnson & Higgins is seeking an active partner in plan administration and proposed a creative approach to financing Association participation in the joint venture. The firm has demonstrated expertise in managing a dental professional liability insurance program, and previously developed a data processing system that bills and collects premiums, issues policies and tracks liability claims. Its scope of operations gives Johnson & Higgins considerable leverage with insurance companies, and most importantly, it appears philosophically disposed to the concept of entering into a joint venture with the Association.

Upon receipt of a broker of record letter, the company will assemble a cadre of experienced individuals who will be dedicated to the development of the ADA Program. They will work closely with the Council to identify a prominent insurance company experienced in professional liability coverage to serve as underwriter and to negotiate the terms and conditions of the policy. The proposal envisions that initial enrollments in the program could be possible within six months of the date J&H is appointed broker of record.

A conventional brokerage arrangement, where J&H provides administrative and marketing services in exchange for a commission, is envisioned until annual written premium income reaches a predetermined level. Upon attaining this threshold, the relationship may convert to a joint venture. If this option is exercised, J&H would relinquish a controlling interest in the administrative/brokerage operation to the Association over a five-year period.

However, the agreement would provide that in any one year, the Association may choose to acquire all or none of its rightful share, depending upon the economics of the venture or any other considerations. Once the joint venture is activated, the Association would share in the revenues and expenses of the operation to the extent of its ownership interest.

Funding for the joint venture would be obtained from commission income, which would be substantially lower than the compensation paid by CNA to its administrative and marketing network. These savings will be accomplished through centralized administration and the use of direct-mail marketing as opposed to state agents.

To assure that Johnson & Higgins, and ultimately the joint venture, does not receive windfall profits at the expense of participating dentists, the proposal set forth several methods by which commissions would be capped in the event that unusual circumstances would inflate revenues during any one year or on a cumulative basis. Moreover, initial commission levels would be scaled downward if excess profits were generated and monies would be returned to policyholders in the form of dividends or premium credits.

Although J&H is seeking a long-term relationship with the Association, its proposal sets forth various buy-out arrangements through which the Association could purchase the entire interest in the administrative/brokerage operation. There are also provisions that allow both parties some degree of flexibility to terminate the contract.

From the onset of the Program, Council members and staff would have an active role in negotiations, marketing and other communications with the dental community. The Association would also make its professional expertise available to the carrier on claims, underwriting matters and loss prevention activities. To offset the expenses arising from these services, the Association would receive administrative allowances along with income from conducting loss prevention seminars.

Ownership of participant records would at all times be vested with the Association, which would receive duplicate copies of all billing, underwriting and claim transactions on a quarterly basis. J&H would be permitted to use these records for purposes of soliciting member dentists and administering the Program while the agreement is in effect.

Johnson & Higgins believes that it can provide administrative data processing services at competitive costs by utilizing the systems of an affiliated company, J&H/KVI. This is a joint venture between J&H and Kirk Van Orsdel, Inc. (KVI), located in Des Moines, Iowa. KVI ranks among the largest administrators of association insurance programs and is reputed to have costs per transaction which are among the lowest in the industry. J&H/KVI would prepare and mail premium bills, issue policies, prepare endorsements, process changes, reconcile cash balances and operate the loss analysis system. The Chicago office of J&H would serve as the headquarters for the program and have access to these records through computer terminals and dedicated data lines. Consideration will be given to transferring the administrative operation to the Association Headquarters Building once the joint venture is activated.

J&H's proposal commits the firm to providing the Association with a complete accounting of all revenues and expenditures involved with the Program. This full financial disclosure will apply both under the conventional brokerage arrangement and during the joint venture.

Johnson & Higgins has agreed to cooperate with Tillinghast, Nelson & Warren, or any other independent actuarial consultant retained by the Association, to analyze the rate-making process or other financial matters. Compensation for such services would be paid for by the Association from its administrative allowance during the conventional brokerage arrangement. During the joint venture, such consulting fees would become regular operating expenses of the enterprise.

The proposal envisions a relationship with a quality, primary carrier which will assume and retain the majority of the underwriting risk. J&H believes that its ability to attract such a company will be enhanced by relatively low commissions and the prestige of Association endorsement, both of which will provide the Program with a competitive advantage. The selection process would be undertaken with the active participation of Council representatives.

Johnson & Higgins did express concern about its ability and that of prospective insurers to write policies in certain territories. Although the Council is cognizant of this potential problem, it unanimously adopted a resolution recommending that the program should be marketed in all states. It further expressed the opinion that availability of an Association program should not be restricted by the presence of alternative plans sponsored by other dental societies.

Given its evaluation of the advantages of Johnson & Higgins' proposal, the Council was of the opinion that it offered a means of controlling program administration with minimal financial risk to the Association. It further concluded that the proposed commission levels could provide premium savings for participants. Finally, the Council believes that Johnson & Higgins is knowledgeable in professional liability matters and will prove to be competent managers of an Association-endorsed plan. This should lessen the cost and time needed to introduce a program of national scope.

Based on these judgments, the Council recommended that the Board approve the appointment of Johnson & Higgins as broker/administrator. The Council further suggested that a non-binding letter of intent be drafted with the assistance of legal counsel. Although from a legal perspective this is merely an expression of good faith, it underscores certain understandings between the parties that can serve as the basis for a formal contractual relationship. After the letter of intent is executed, the parties will prepare separate brokerage and joint venture agreements.

The Board considered the recommendations of the Council and concurred that these were in keeping with the directive of the House. It further agreed that the proposal submitted by Johnson & Higgins offers an attractive approach to the development of a sponsored professional liability insurance program as well as the potential for an Association-owned company to administer such a program. The Board adopted a resolution authorizing the Executive Director to continue negotiations with respect to this proposal and to execute documents as appropriate.

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

Report 11

Policy Statement on AIDS, HIV Infection and the Practice of Dentistry

Background: In August 1987 the Board of Trustees transmitted to the House of Delegates Report 5 on Association Activities Regarding Acquired Immune Deficiency Syndrome (*Supplement 1*:291). That report indicated that an ad hoc committee of the Board had been established to develop a recommended policy statement for transmittal to the House. The Board believes there is a clear need for an Association policy statement on AIDS that will serve as a guide for the profession in dealing with the ethical, legal and treatment issues associated with the care of AIDS patients and HIV-infected individuals. Such a policy statement also would demonstrate to government agencies and to the public that the dental profession is responding to the AIDS problem in a compassionate, responsible manner. The Board believes that the following policy statement appropriately articulates the profession's position on important AIDS-related issues. The statement, in the Board's opinion, provides a fair balance between the interests of member dentists and concern for HIV-infected patients and the public. Accordingly, the Board recommends adoption of the following proposed policy statement.

Policy Statement on AIDS, HIV Infection and the Practice of Dentistry

The dental profession in the United States has a long tradition of providing appropriate and compassionate care to the public, including special groups with special needs. The American Dental Association believes that it has the responsibility to articulate a clear position on issues related to acquired immune deficiency syndrome (AIDS) and human immunodeficiency virus (HIV) infection and to formulate policy based on current scientific knowledge and accepted legal, moral and ethical imperatives. This policy statement will be reviewed on a regular basis and may be modified as new information and developments become available.

National Policy—The Association is supportive of initiatives to develop a national policy on HIV infection that can become the basis for coordinated efforts by the public and private sectors. The oral health aspects of HIV infection and issues related to the practice of dentistry should be included in national policies as they are developed.

Legal Issues—Antidiscrimination laws and regulations should be clarified or amended, either legislatively or through the courts, in consideration of the rights of the patient to be free from acts of prejudice and the rights of others to be protected against an unreasonable risk of disease.

Public Information—The health care and communications communities should work together, in consultation with government agencies, to develop public service announcements and other educational messages regarding AIDS. Public education to increase awareness of how AIDS is transmitted should include information that will diminish irrational fears about transmission of the disease through dental treatment.

Professional Considerations—The Association believes that HIV-infected individuals should be treated with compassion and dignity. Current scientific and epidemiological evidence indicates that there is little risk of transmission of infectious diseases through dental treatment if recommended infection control procedures are routinely followed. Patients with HIV infection may be safely treated in private dental offices when appropriate infection control procedures are employed. Such infection control procedures provide protection both for patients and for dental personnel.

A sound approach to the treatment of infectious patients requires an assessment of the patient's condition based on reasonable and informed medical judgments, given the state of medical knowledge at the time. The Association believes that special accommodations may be required for some patients with HIV infection. Informed and sensitive referrals to environments equipped to serve medically compromised patients may be advisable in some instances.

Dentists should be alert to signs and symptoms of HIV infection that may be identified during the provision of dental care. Patients with histories or conditions possibly indicative of HIV infection should be referred to their physicians for diagnostic procedures, counseling and medical follow-up. The referring dentists should be notified of test results and should protect the confidentiality of such information.

The Association believes that individuals with HIV infection should have access to dental treatment, and that treatment considerations should provide for a judicious balance between the well-being of these patients and the protection of the health of the public as well as the dental care providers.

Resolution

86. Resolved, that the "Policy Statement on AIDS, HIV Infection and the Practice of Dentistry" be adopted.

Board Report 12

Further Recommendations on Reports and Resolutions

The following are comments of the Board of Trustees on reports and resolutions which were compiled (for historical purposes only) from worksheets utilized by the House of Delegates in its deliberations on these issues.

Divisions of Dental Practice and Health Affairs

Dental Care Programs, Council on, Supplemental Report 1, Response to Resolution 60-1985 Regarding Customary Fee (*Supplement* 2:327/Resolution 75): *The Board recommends the adoption of Resolution 75* (Vote: Unanimous*).

Dental Care Programs, Council on, Supplemental Report 1, Update on Recent Council Activities (*Supplement* 2:330/ Resolutions 78, 79, 80): *The Board recommends the adoption of Resolution 78* (Vote: 18 Yes—Morrow, Gaines, Springer, Earle, Schoessler, Dugoni, Hayashi, Opinsky, McKechnie, Larson, Faget, Overbey, Harris, Truono, Friend, Gilmore, Booth, Saddoris; 1 No—Benson). *The Board also recommends the adoption of Resolution 79* (Vote: Unanimous*) *and Resolution 80* (Vote: Unanimous*).

Dental Practice, Council on, Supplemental Report 2, Cooperative Continuing Education Efforts Between Dentists and Dental Laboratory Organizations (*Supplement* 2:335/Resolution 55): *The Board recommends the adoption of Resolution 55* (Vote: Unanimous*).

Relief and Disaster Fund Activities, Commission on, Supplemental Report 1, Amendments to the Relief and Disaster Funds "Indentures of Trust" (*Supplement* 2:340/ Resolution 39): The Board recommends adoption of the resolution proposed by the Commission on Relief and Disaster Fund Activities to amend its *Indentures of Trust* to be consistent with the Association's *Bylaws* and the Commission's historical practices. The Board is mindful that any such amendment to the *Indenture of Trust* of the Relief Fund (Article IX) and Disaster Fund (Article X) require advance notice to the House of Delegates, in the same way as notice is given to a proposal to amend the *Constitution* of the Association. In the absence of unanimous approval, these resolutions must lay over for consideration by the 1988 House of Delegates. However, the Board believes that there is no substantive reason for layover of these resolutions and *recommends immediate unanimous adoption this year* (Vote: Unanimous*).

Resolutions from Constituent Societies, Component Societies, Trustee Districts, Delegates and Related Organizations

Louisiana Resolution on Development of Protocol for Treatment of AIDS Patients (*Supplement* 2:343/Resolution 36): The Board of Trustees strongly disagrees with the statement that significant cross-contamination occurs in dental offices and laboratories. If this were the case, dentists, dental health care workers and patients would continually suffer the effects of infectious diseases. Infection control guidelines are available that when properly followed will minimize cross-contamination in the dental office. Furthermore, the Board notes that the Division of Scientific Affairs has long accepted responsibility for guiding the dentist in the use of safe infection control procedures and is currently updating a number of publications that specifically address this subject. The Division is also collaborating with other agencies, including the Centers for Disease Control, the Veterans Administration, the National Institute of Dental Research, and the Health Resources and Services Administration, in developing guidelines and protocols for infection control. This loose coalition of groups believes that it is worthwhile to formulate guidelines that are uniform and that can be universally endorsed by all the agenices and adopted by all dental professionals. The Board therefore suggests that it would not be in the best interests of the American Dental Association independently to formulate strict protocols for different dental settings but rather to work as rapidly as is scientifically feasible towards the formulation of guidelines and protocols that, having been developed in concert with other concerned groups, are acceptable to them. In addition, the Council on Community Health, Hospitals, Institutional and Medical Affairs is, as described in Board Report 5 (*Supplement1*:291), developing Guidelines for Dental Management of Patients with AIDS and HIV Infections which will serve as a resource tool for dentists and physicians on the cooperative management of AIDS patients. These guidelines will incorporate (1) infection control procedures to be used in treating all dental patients, including those with HIV infection; (2) special precautions and procedures needed for dental treatment of patients known to be immunocompromised by HIV infection; and (3) treatment of the oral mucosal diseases which may be found in the HIV-infected patient. Finally, scientific evidence suggests that it is not possible to recognize all HIV-infected patients, and therefore the Division of Scientific Affairs strongly urges that dental professionals follow CDC/ADA infection control guidelines for all patients. Therefore, *the Board of Trustees recommends that this resolution be postponed indefinitely* (Vote: Unanimous*).

Ohio Resolution on Hepatitis B and AIDS Testing for Dental Health Care Workers (*Supplement* 2:343/Resolution 43): The Board of Trustees views the issue of testing of dental health care workers as sensitive and complex. It believes that Resolution 43 does not make adequate distinction between anonymous and confidential testing and calls attention to the facts that anonymous means that the

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results of testing are not revealed to the patient but merely become part of prevalence data, while in confidential testing the individual is informed of the results of the test which are not necessarily revealed to any outside parties.

Accordingly, *the Board of Trustees recommends the adoption of the following substitute resolution* (Vote: Unanimous*).

43B. Resolved, that the appropriate agencies of the American Dental Association be directed to investigate fully the practicality of instituting voluntary anonymous or confidential hepatitis B and antibody testing programs for dental care workers.

Texas Resolution on Tax Deductibility of Dues Paid to Professional Dental Organizations (*Supplement 2*:343/Resolution 37): The Board shares the concerns of the Texas Dental Association about the impact of this discriminatory change in the tax codes. As this particular tax change affects employed professionals in all disciplines, the Board recommends that this resolution be broadened to seek support and cooperation from other professional organizations. Additionally, there are professional expenses other than direct dues which are subject to the 2% threshold and which relate to professional growth. These also should be addressed.

Accordingly, *the Board recommends adoption of the following substitute resolution* (Vote: Unanimous*).

37B. Resolved, that the American Dental Association, as a priority item, seek, in cooperation with other appropriate professional organizations, changes in the federal tax law to permit employed professionals to deduct the full amount of dues paid to their professional organizations as well as related professional expenses.

Texas Resolution on Opposition to Separate Fee Schedules (*Supplement 2*:343/Resolution 38): The issue raised in Resolution 38 is one part of a comprehensive study of "usual, customary and reasonable," as these terms are defined by the Association, insurance industry and service corporations, currently being conducted by the Council on Dental Care Programs and reported in its Supplemental Report 1 to the House of Delegates (*Supplement 2*:324).

Based on Phase Two of the study, as outlined in the Council's Supplemental Report, which will be conducted in 1988, the Board believes that no action should be taken on this part of the study, independent of the Council's final recommendations, which will be made to the 1988 House of Delegates. As the intent of Resolution 38 is already an integral part of the study, *the Board recommends that Resolution 38 be referred to the Council on Dental Care Programs for its review* (Vote: Unanimous*).

First Trustee District Substitute Resolution for Resolution 11 (*Supplement 2*:344/Resolution 11S-2): The Board believes it was the intention of the Council on Governmental Affairs and Federal Dental Services in Resolution 11S-1 (*Supplement 1*:229) to include all health benefits, dental benefits prominent among them. However, the Board believes an editorial refinement would enhance this resolution. Accordingly, the Board suggests that the word "dentistry" be changed to "dental benefits" and *recommends adoption of the following substitute resolution* (Vote: Unanimous*).

11B. Resolved, that the American Dental Association believes that employer-sponsored health benefits, including dental benefits, should be encouraged through the use of positive incentives, and be it further

Resolved, that the American Dental Association does not support employer-mandated health benefits.

First Trustee District Resolution on Keynote Speaker Honorarium (*Supplement 2*:344/Resolution 62): Each of the delegates receives Board Report 3 (*Supplement 1*:265) which includes narrative and financial information relating to the proposed budget. The decision as to the format of the opening session, entertainment or a featured speaker, is made in consultation between the president and the Council on ADA Sessions and International Relations. A cost estimate is made based on actual prior years expense for either a featured speaker or entertainment. As such, the total expense budgeted for the keynote session appears in the budget and covers all aspects of the opening ceremony. Therefore, *the Board of Trustees recommends that Resolution 62 be postponed indefinitely* (Vote: Unanimous*).

First Trustee District Resolution on Commemorative Stamp Honoring Dr. Horace Wells (*Supplement 2*:344/Resolution 63): *The Board recommends the adoption of Resolution 63* (Vote: Unanimous*).

First Trustee District Resolution on Treatment Costs of Barrier Techniques (*Supplement 2*:344/Resolution 64): The Board has carefully considered the issues raised in Resolution 64 and agrees that action must be taken to help resolve the problem of increased costs due to compliance with the latest recommended infection control procedures.

The Board does not believe that the study recommended by the First Trustee District, which would include a financial impact of $18,000, will serve any practical purpose and, in fact, may delay implementation of solutions to the problem as well as place an unnecessary financial burden on dentists. *Therefore, the Board recommends adoption of the following substitute resolution* (Vote: Unanimous*).

64B. Resolved, that the Board of Trustees, through the appropriate agencies of the Association, advise insurance companies and service corporations that compliance with barrier techniques and new infection control procedures have resulted in increased operating costs for dentists which, in turn, have resulted in increased fees, and be it further

Resolved, that insurance companies and service corporations be asked to revise their current methodologies for calculating reimbursement levels to reflect these increased costs, and be it further

Resolved, that dentists be encouraged to inform their patients that dental fees will be increased due to compliance with new infection control procedures.

First Trustee District Resolution on Deans' Statement Opposing Unsupervised Practice by Dental Auxiliaries (*Supplement 2*:344/Resolution 68): Although the Board appreciates the intent of this resolution and recognizes the

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importance of the issue of unsupervised practice, the Board wishes to point out that during the past year it has met with the leadership and staff of the American Association of Dental Schools (AADS) to discuss this topic. Specifically, a meeting was held in June 1987 and involved representatives from the ADA Board of Trustees and staff and staff and representatives of the AADS Executive Committee.

It was pointed out by AADS in correspondence to the Board that its policy on delegation states:

> Dental schools should educate dental auxiliary personnel so they will be qualified to perform competently duties delegated by the dentist and qualified to work effectively with dentists, thus increasing the dentists' capacity to provide efficient and competent oral health care.

Relative to supervision, the AADS has indicated that it has no policy on the issue and indicates its plan to remain silent on the matter. The AADS' position on the levels of supervision is vested in governmental jurisdictions.

The Board will continue to maintain dialogue with the deans of U.S. dental schools through the AADS on issues of importance to both organizations. It is the Board's belief that when issues arise at the state level, it is more appropriate for constitutent societies to work directly with dental educators and state boards of dentistry within their jurisdictions when dealing with the state legislature. For this reason, *the Board recommends adoption of the following substitute resolution* (Vote: Unanimous*).

68B. Resolved, that constitutent dental societies, dental educators and dental examiners work closely and cooperatively on issues of dental auxiliary education, credentialing and practice and be it further **Resolved,** that these parties be encouraged to oppose legislative efforts supporting unsupervised practice or the fragmentation of the "dental team" concept of practice.

First Trustee District Resolution on Equitable Dental Benefits for all Military Dependents (*Supplement* 2:345/ Resolution 70): The Board of Trustees carefully reviewed Resolution 70, submitted by the First Trustee District. The Board is well aware of the provisions of the Uniformed Services Active Duty Dependents Dental Plan which do not conform to Association policy. It notes that the Council on Dental Care Programs has sought changes in these provisions in correspondence with the Policy Division, Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS), the government agency that is responsible for the program. Prominent among the changes being sought is one to provide the same level of reimbursement for participating and nonparticipating dentists, which is in accordance with Association policy (*Trans.* 1977:912).

At the same time, it must be recognized that implementation of this program represents a major achievement for the Association in its longstanding support for "the provision of dental care benefits in the offices of civilian dentists under the free choice delivery system for all uniformed service dependents" (*Trans.* 1976:875). Acknowledging the program's conflicts with Association policy, it nevertheless provides basic dental benefits to 1.7 million dependents, many of whom sorely need financial assistance with their dental care expenses. These dependents are not restricted to certain contracting dentists, as would be the case in capitation or certain contract dentist organization (preferred provider organization) arrangements. Similarly, no licensed dentist is excluded from treating dependents under the plan, as would be the case in these other arrangements. Further, the Board notes that these other arrangements remain options for OCHAMPUS.

The Board is convinced that the appropriate course of action to correct the plan's deficiencies is the one in which the Council on Dental Care Programs is currently engaged, namely, seeking administrative changes. *Therefore, the Board recommends adoption of the following substitute resolution* (Vote: Unanimous*).

70B. Resolved, that the Council on Dental Care Programs continue to seek administrative corrections to the Uniformed Services Active Duty Dependents Dental Plan to bring it into full accord with Association policy, reporting the results of its efforts to the 1988 House of Delegates.

First Trustee District Resolution on Publication on Management of Hazardous Waste (*Supplement* 2:346/ Resolution 71): The background statement and resolutions submitted by the First Trustee District address a number of related issues concerning hazardous substances, infection control procedures and the disposal of toxic waste. In its consideration of these matters, the Board notes that certain of the actions called for in Resolution 71 will be accomplished through regulations currently being implemented by the Occupational Safety and Health Administration (OSHA). A recent federal rule issued by that government agency establishes a single, national hazard communication standard in lieu of the individual and conflicting state and local "Right-to-Know" laws. Additionally, and of particular importance, is the requirement in the OSHA regulation that manufacturers, importers and distributors of hazardous substances must provide, with each shipment after September 23, 1987, material safety data sheets which detail the substances' properties and the nature of the hazard. In the opinion of the Board, this requirement will be of significant value to dentists and other employers in the nonmanufacturing sector in the conduct of hazard communication programs, (for example, informing and training staff on the presence of and precautions for products with hazardous substances). The Board does, however, concur in the directive contained in the resolution that the Association develop and provide to the membership an OSHA-approved hazard communication program. Although the Board notes that this effort is currently underway, it nonetheless believes that the adoption of a resolution on this matter would underscore the importance of timely Association action to assist dentists in complying with the OSHA regulation.

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With regard to federal rules on infection control, the Occupational Safety and Health Administration, with the assistance of the Association, will conduct a nationwide campaign to inform the dental community of the guidelines and compliance procedures required by that government agency. An October mailing to all practicing dentists, national dental organizations, constituent societies and dental schools is planned as an initial step in this effort.

A number of the concerns expressed by the First Trustee District have or are being addressed by the Association. Further, the Board has recommended adoption of Resolution 47 (*Supplement* 2:349) which calls for Association development of a hazard communication program. Therefore, *the Board recommends that Resolution 71 be postponed indefinitely* (Vote: Unanimous*).

First Trustee District Resolution on Exclusion of Dentistry from OSHA Regulations (*Supplement* 2:346/Resolution 72): The Board concurs with the objective of this resolution regarding Association oversight and monitoring of federal laws and regulations governing hazardous substances, infection control and toxic waste to ensure that they do not impose an unreasonable burden on the dental profession. Activities in this area already are underway with regard to the OSHA rules and standards both for hazardous substances and infection control guidelines. *The Board thus proposes the following substitute resolution, with the recommendation that it be adopted* (Vote: Unanimous*).

72B. Resolved, that the Association continue its efforts to ensure that federal laws and regulations governing hazardous substances, infection control and toxic waste are reasonable, appropriate and scientifically justified.

First Trustee District Resolution on Financial Assistance for Defense and Litigation Related to Management of Hazardous Waste (*Supplement* 2:346/Resolution 73): Although the Board is sympathetic to the concerns which have prompted this resolution, it believes that the existing procedures for constituent societies to request financial assistance in special circumstances are adequate for the situations contemplated by this resolution. The Board also notes that the financial implication of this resolution could be potentially infinite. Accordingly, *the Board recommends that Resolution 73 be postponed indefinitely* (Vote: Unanimous*).

First Trustee District Resolution on Identification of Potential Hazardous Waste Materials (*Supplement* 2:346/Resolution 74): *The Board recommends the adoption of Resolution 74* (Vote: Unanimous*).

Second Trustee District Resolution on Study of Continuation of Associate Membership Category (*Supplement* 2:347/Resolution 45): *The Board recommends the adoption of Resolution 45* (Vote: Unanimous*).

Second Trustee District Resolution on Malpractice Litigation Videocassette (*Supplement* 2:348/Resolution 46): The Board agrees that a professional liability allegation can produce anxiety and stress for the dentist and that some practitioners may benefit from an understanding of the judicial process. However, it has been estimated that if all of the topics mentioned in Resolution 46 were addressed in a tape, there could be no more than five to seven minutes of actual mock trial footage. This observation is based on the fact that videotapes are generally no longer than 20 minutes, a length which research has shown to be most effective in holding an audience's interest. In addition, the cost of filming a mock trial is believed to approach $150,000 in view of the number of actors, filming time and set costs that would be involved.

For these reasons, the Board recommends an alternative approach that would call for the production of a videotape in the form of a documentary. This would examine the summons, the insurance company's role in the defense of the claim and the fact gathering process. It could also include the procedures necessary to prepare dentists to testify effectively on their own behalf and explain the circumstances under which a settlement might be offered.

The Board believes that such a tape and accompanying manual could be produced and distributed at a cost of $75,000, which represents a savings of $75,000 from the money that would be needed to film a mock trial.

Monies for a tape have already been allocated in the 1988 budget for the production of one of the remaining videocassettes in the loss prevention series as outlined in Board Report 6 to the 1985 House of Delegates (*Supplement 1*, 1985:339). For these reasons, the Board believes that the tape envisioned by the Second Trustee District can be produced in the amended version described above, using resources budgeted in 1988 for risk management activities. *Therefore, the Board recommends adoption of the following substitute resolution* (Vote: Unanimous*).

46B. Resolved, that a videocassette be produced that will demonstrate the process by which a defense is formulated against a malpractice allegation, including the serving of the summons, the discovery process and the preparation of the dentist's testimony at the trial, and be it further **Resolved,** that funding for this project would come from the Council on Insurance's proposed 1988 budget.

Second Trustee District Resolution on Prototype Hazard Communication Program (*Supplement* 2:348/Resolution 47): *The Board recommends the adoption of Resolution 47* (Vote: Unanimous*).

Fourth Trustee District Resolution on Dental Benefits for Patients with Congenital Deformities (*Supplement* 2:348/Resolution 40): The Council on Dental Care Programs advises that benefits for treatment of the health conditions referred to in Resolution 40 are typically excluded from dental benefit contracts according to the following language: "Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons." The examples usually cited are cleft palate, maxillary and mandibular malformations, enamel hypoplasia, fluorosis

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and anodontia. The Board agrees that, within the context of dental and medical benefit policies, treatment for these and other medical conditions should be available to beneficiaries of these policies. As indicated, the necessary treatment for many of these conditions must be multidisciplinary in approach, and benefits for certain aspects of this rehabilitation may be appropriate for medical, rather than dental, benefit coverage. Further, treatment through necessary restorative, oral surgery, prosthodontic and orthodontic procedures suggest a complicated relationship between coverage provided by dental and medical insurance plans.

The Board agrees with and supports the intent of Resolution 40. At the same time, the Board feels that in order to be successful in encouraging benefit coverage for these conditions, the Association must provide detailed guidance to benefit plan administrators on the appropriate categorization of benefit determinations in these complex treatment situations. *Therefore, the Board recommends that Resolution 40 be referred to the Council on Dental Care Programs for further study and report back to the 1988 House of Delegates* (Vote: Unanimous*).

Fourth Trustee District Resolution on Development of Policy on AIDS (*Supplement 2*:349/Resolution 41): The Board of Trustees notes the compassion and professionalism expressed in the resolution from the Fourth Trustee District regarding dental treatment for patients with AIDS and related diseases and agrees with the sense of the resolution. However, Board Report 5 makes it clear that the Association is engaged in many activities that confirm the profession's commitment to these principles. Furthermore, the Board is forwarding a policy statement on AIDS that will be presented to the House of Delegates for approval. In the interests of having a single statement express the policies of the American Dental Association on the treatment of patients with AIDS and HIV infection, *the Board recommends that Resolution 41 be postponed indefinitely* (Vote: Unanimous*).

Fourth Trustee District Resolution on Alternative Methods for Payment of Dues (*Supplement 2*:349/Resolution 42): The Board of Trustees on previous occasions has investigated methods by which the payment of annual dues by the membership could be eased. Several reports to the House of Delegates in recent years have dealt with this subject (*Supplement 1*, 1982:275; *Trans.* 1982:508; *Supplement 2*, 1984:393; *Trans.* 1984:512; *Supplement 1*, 1985:290; *Trans.* 1985:568; and *Supplement 1*, 1986:253). The Board of Trustees agrees with the New Jersey Dental Association that some method be devised to ease the burden on the membership. Many constituent societies have instituted changes to ease the burden of payment of dues by members, such as prepaid monthly and/or quarterly payments and the use of credit cards. The Association has a program in place with the Maryland Bank that allows the constituent and/or component society to receive payment of dues by the member using the Maryland Bank Mastercard. There is no discount fee charged to the constituent or component society and the member then has a choice of paying the Bank at his/her convenience. *Therefore, the Board of Trustees recommends the adoption of the substitute resolution 42B* (Vote: Unanimous*).

42B. Resolved, that members, constituent and component societies be informed of the availability of the Maryland Bank Mastercard for incremental dues payment in 1988, and be it further

Resolved, that the Board of Trustees continue to investigate the feasibility of payment of dues on a staged basis and report back to the 1988 House of Delegates.

Fourth Trustee District Resolution on Amendment of "Comprehensive Policy Statement on Dental Auxiliaries" (Involvement of Licensed Dentists) (*Supplement 2*:349/Resolution 58): The Board understands the objective of this resolution that only a person who is licensed or legally authorized to practice dentistry should be permitted to supervise the functions of dental auxiliaries. However, the Board believes that the policy statement deals with the issue of supervision of dental auxiliaries and therefore it seems inappropriate that it include a definition of dentist. Further, the Board believes that implicit in the use of the title "dentist" is the legal authority to practice, and for this reason it is not necessary to include a definition.

If the House of Delegates disagrees and feels that a definition is necessary, the Board must point out that the proposed definition has a number of practical problems which must be addressed. First, the dentist must be graduated from a dental school accredited by the Commission on Dental Accreditation (CDA). Currently, there are 20 states that license foreign-trained dentists. Among the 20 states having this provision:

—Twelve states require documentation of graduation from a dental school recognized by the World Health Organization.
—Ten states require information regarding the curriculum of the nonaccredited dental school for evaluation by the state.
—Ten states require that foreign-trained candidates obtain supplementary education from an accredited dental school.
—Twenty states require passing the National Board Dental Examinations.
—Fourteen states require passing a preclinical technique test.
—Six states require that foreign-trained candidates undergo evaluation by faculty of an accredited dental school.
—Twenty states require passage of the state or regional clinical examination.
—One state allows foreign-trained dentists to perform probationary practice under supervision.

There are several dental schools that have special programs for foreign-trained dentists; but these programs do not culminate with the granting of a dental degree. Further, these special programs are not accredited by the Commission on Dental Accreditation. Therefore, individuals who complete such programs cannot be considered graduates of an accredited dental school as defined in this resolution.

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It would be difficult, if not impossible, for the Association to apply the definition to military and other federally employed dentists, because federal law supersedes state law regarding federal health professional personnel. A further complicating factor is that, although the Defense Department has adopted formal policy requiring all military dental personnel to have a license from a U.S. jurisdiction, military dentists are reassigned periodically. It would be extremely difficult for these dentists to be licensed in each jurisdiction upon reassignment, if for no other reason than the time lag between assignment and dates of licensure examinations and notification of results.

A number of dental practice acts have provisions for dentists in academia to apply for teaching licenses without completing a program accredited by the Commission. Dentists in this category may have supervisory responsibility for students in dental auxiliary programs.

Finally, the definition appears to overlook the reciprocal accreditation agreement between the Association and the Canadian Dental Association. Graduates of Canadian dental schools are not considered foreign-trained; and yet the dental schools in Canada are not accredited by the Commission on Dental Accreditation, but are accredited by the Canadian Dental Association's Council on Education and Accreditation.

For these reasons, *the Board recommends that Resolution 58 be postponed indefinitely* (Vote: Unanimous*).

Fourth Trustee District Resolution on Specialty Organization Assistance in Peer Review (*Supplement 2*:350/Resolution 59): The Board has carefully considered the resolution submitted by the Fourth District and concurs with the intent as expressed in the background statement and the resolution. The use of specialists in the review of specialty treatment under consideration by peer review affords the best opportunity for a clinically objective review. The Board has been advised by the Council on Dental Care Programs, the agency responsible for assisting, guiding and supporting dental societies in the development and management of peer review systems, that the *Peer Review Procedure Manual* includes a provision that if a dentist who limits his practice is being reviewed, he may require the peer review committee chairman to obtain a panel of at least three similar practitioners from the appropriate specialty organization. That panel, along with the chairman or vice-chairman or designated member, would comprise the review committee in the particular instance.

The Council will be recommending revisions to existing peer review policies and is including a provision that speaks to this issue. Specifically, the guidelines on the structure and function of peer review committees indicate that the peer review committee should also have as resources specialists who can be appointed on an ad hoc basis, if the dentist being reviewed is a specialist and requires the chairman to appoint a committee of like specialists, or if the committee feels the need for additional expertise. Any additional members appointed on an ad hoc basis should have the same status, for that particular case, as do permanent members of the committee.

The Board is aware that, as stated in the background to the resolution, not all constituents have specialty organizations and so would need to seek the assistance of the appropriate national specialty organization or would not be affected by the resolution. The Board is of the opinion that the Council's existing guideline regarding review of specialty care, as found in the *Procedure Manual*, and as similarly recommended in the guidelines on peer review being transmitted to the House, acknowledges the necessity of appropriate specialist review of specialty care.

Also, the existing and proposed guidelines encourage greater consistency among peer review systems while allowing enough latitude for individual dental society peer review mechanisms to make the most appropriate determination for a particular case within the available resources in that dental society. Most important, however, these guidelines ensure the prerogative of the individual dentist.

The Board appreciates that the makers of Resolution 59 did not have access to the Council's proposed guidelines on the peer review structure and functions. *The Board recommends that Resolution 59 be postponed indefinitely* (Vote: Unanimous*).

Fifth Trustee District Amendment to Resolution 2 (*Supplement 2*:350/Resolution 2S-3): The Board is sensitive to the issues expressed in Resolution 2S-2 (*Supplement 2*:358) and supports the addition to guideline 15. However, the Board is of the opinion that the word "mutilated" is too narrow in scope. Damage to a radiograph may not cause it to be mutilated, yet it may be enough to make the radiograph unusable.

Regarding the proposed guideline 16, the Board has been advised by the Council on Dental Care Programs that guideline 13 speaks to the issue of charging for duplication of radiographs (*Trans.*1986:533). It states, "A dentist should be entitled to remuneration from the patient and/or third party for copies of radiographs and clinical records requested for the purpose of benefit determination." In addition, the Board agrees with the intent of Resolution 2S-3 and supports the change and addition to section 15 of the guidelines. *The Board recommends adoption of the following substitute resolution* (Vote: Unanimous*).

2B. Resolved, that the "Guidelines on the Use of Radiographs in Dental Care Programs" (*Trans.*1976:867; 1984:524; 1986:533) be amended by addition of the following paragraphs thereto:

> 14. When, in accordance with guidelines 1-13, a dentist determines it is appropriate to submit radiographs to a third party, a duplicate set should be sent, so as not to place the dentist at risk.
>
> 15. If, for any reason, radiographs are lost, damaged, or not returned to the dentist within 15 working days, the claim in question should be determined and settled immediately. Loss of the radiographs, in a question concerning a claim's validity, places the burden of proof on the carrier and not the dentist.

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and be it further
Resolved, that the Council on Dental Care Programs disseminate the revised "Guidelines" to members, carriers, service corporations and other third-party payers.

Fifth Trustee District Resolution on Proposed Criteria and Procedures for Acknowledgment of Credentialing Committees in Nonspecialty Interest Areas (*Supplement* 2:350/Resolution 81). The Board believes that the joint study on the proposed development of criteria and procedures for acknowledgment of a credentialing mechanism in nonspecialty interest areas is in the phase of obtaining input and comment from a broad community of interest. The Board is of the opinion that it would be inappropriate that the study be discontinued before the Council on Dental Education and Council on Ethics, Bylaws and Judicial Affairs have had an opportunity to conclude the study. After soliciting comment it would seem that a logical closure to the study would be precluded if the Councils did not have an opportunity to consider and analyze critically the comments received. Further, the issue would not come to a conclusion and a final report of the results of the study would not be available to the House from a historical perspective. The Board further believes that the Councils will consider carefully all information including testimony presented at the Reference Committee before making any recommendation to the House. Further, the Board wishes to point out that the second resolving clause reaffirms existing Association policy and, therefore, believes that existing policy should not be reaffirmed. For these reasons, *the Board recommends that Resolution 81 be postponed indefinitely* (Vote: 18 Yes—Morrow, Gaines, Springer, Schoessler, Dugoni, Hayashi, Opinsky, Benson, McKechnie, Larson, Faget, Overbey, Harris, Truono, Friend, Gilmore, Booth, Saddoris; 1 No—Earle).

Fifth Trustee District Resolution on Use of ADA's Seal of Acceptance on Dental Anesthetics (*Supplement* 2:351/Resolution 82): The Council on Dental Therapeutics, in accordance with Resolution 103H (*Trans.*1986:538) thoroughly reviewed the question of color coding of local anesthetics, both for specific anesthetic agent and for vasoconstrictor. After seeking information from the FDA and local anesthetic manufacturers, staff presented the information to the Council at its June 1987 meeting and arrived at conclusions that are published in the Council's Supplemental Report 1 (*Supplement 1*:227). The sense of these conclusions was that color coding is neither financially feasible nor professionally desirable. The Board emphasizes that adoption of this resolution, rather than ensuring that "medications would be properly identified as easily as possible" would, in the opinion of the American Society of Testing and Materials, "deviate careful reading of the product label." The Board therefore rejects the notion that local anesthetics manufacturers be penalized by loss of the ADA Seal for failing to use a color code and *recommends that Resolution 82 be postponed indefinitely* (Vote: Unanimous*).

Fifth Trustee District Resolution on Guidelines for the Practice of Dentistry in Infectious Disease Control (*Supplement* 2:351/Resolution 83): The Board notes that the current scientific wisdom indicates that all dental procedures carry the potential for transmission of infection and that there are, therefore, no procedures that can scientifically be exempted from infection control procedures. The Board also notes that a report from the Council on Dental Research contains a strong recommendation that the Association's agencies work towards meeting the needs of the membership for information including cost-of-care implications of implementing infection control guidelines, need for modification of equipment and offices and optimal flow patterns for delivering dental care in different clinical settings.

The Board therefore recommends that Resolution 83 be postponed indefinitely (Vote: Unanimous*).

Fifth Trustee District Resolution on Commendation Regarding Fiscal Responsibility (*Supplement* 2:351/Resolution 84): The Board of Trustees appreciates the commendation on fiscal responsibility. The Board has and will continue to inform the House of Delegates on a timely basis and in a manner consistent with full reporting of financial matters. The Board has been notified by the Speaker of the House of Delegates that as the 1987 *Manual of the House of Delegates* (page 14) specifically prohibits commendations to an organization, this resolution will be ruled out of order (Vote: Unanimous*).

Fifth Trustee District Resolution on Amendment of "Comprehensive Policy Statement on Dental Auxiliaries" (*Supplement* 2:351/Resolution 85): The Board considered the further amendments offered in Resolution 85 to the "Comprehensive Policy Statement on Dental Auxiliaries" as amended by the Board of Trustees.

The Board concurs with the amendments, excepting two—one which recommends the deletion of the definitions of the dental laboratory technician, and the second which recommends deleting the reference to general supervision from the text of the document and inserting the language as a footnote at the end of the glossary. The Board believes that all other amendments either clarify or strengthen the statement or provide editorial and reformatting changes.

The Board believes that it is important to retain the clear distinction between the dental laboratory technician who is an auxiliary employed to work in a dental office and those who work in a commercial dental laboratory. For this reason, the Board does not support the amendment to delete the definition of the dental laboratory technician. Further, the Board is concerned that moving the section on general supervision as an explanatory footnote will decrease the importance and significance of the statement. For this reason, the Board does not believe that it should be placed as a footnote to the document.

The Board, therefore, recommends that the Reference Committee incorporate the amendments enumerated in Resolution 85 into the proposed statement as amended by the Board of Trustees, but that the Reference Committee retain the definitions of the dental laboratory technician (Supplement 1:263) and that the introductory sentence which reads, in part: "In those instances which it is not possible to change the dental practice act,..." and the following three (3) enumerated paragraphs on page 260 of Supplement 1, not be inserted as a footnote at the end of the glossary (Supplement 1:264) (Vote: Unanimous*).

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Sixth Trustee District Resolution on Study of the Development of Fund Raising Activities for the ADA (*Supplement 2*:352/Resolution 65): *The Board recommends the adoption of Resolution 65* (Vote: Unanimous*).

Sixth Trustee District Resolution on Study of Nonmember Benefits (*Supplement 2*:353/Resolution 66): It is true that nonmembers of the American Dental Association do benefit from many of organized dentistry's activities due to the fact that the ADA is not constituted solely for the benefit of its membership.

Some benefits accrue to the nonmember because legal considerations suggest the Association should provide some services to all dentists. It is equally true, however, that the ADA's Recruitment and Retention Program is compromised by the nonmembers' attitude that they can reap benefits without paying dues.

Therefore, a comprehensive study of membership benefits is deemed advisable. The study should seek to determine which ADA benefits could withstand a member/nonmember differential increase from the current 25%, with all due concern for any pertinent legal and/or policy considerations.

Rather than direct the study to particular areas of investigation and predetermine denial to nonmembers, the Board believes the resolution language directing the study should be as nonrestrictive as possible. Therefore, the *Board recommends the adoption of the following substitute resolution* (Vote: Unanimous*).

66B. Resolved, that the appropriate agencies of the American Dental Association undertake a comprehensive study to determine whether the member/nonmember differential for benefits and services can be increased without compromising legal/policy considerations, and be it further

Resolved, that the Board of Trustees report back to the 1988 House of Delegates the results of this study.

Sixth Trustee District Resolution on Study of Temporomandibular Joint Disorders (*Supplement 2*:353/Resolution 67): *The Board concurs that continued research into the etiology, diagnosis and treatment of TMJ disorders is needed and recommends that Resolution 67 be adopted* (Vote: Unanimous*).

Sixth Trustee District Resolution on Manpower Study (*Supplement 2*:353/Resolution 76): The Board is sensitive to all of the issues raised by this resolution and the Association has worked tirelessly in these areas. The Association also maintains liaison with the educational community. In addition, representatives of the American Association of Dental Schools (AADS) and the American Association of Dental Examiners (AADE) are members of the Council on Dental Education.

Agencies of this Association compile and analyze information on manpower and that information is available to interested parties. Since 1978, first-year enrollments in dental schools have decreased from 6,301 to 4,554, a decline of 28%. The ADA and AADS have instituted the SELECT program which is specifically designed to attract highly qualified students to pursue careers in dentistry. At the same time, the ADA has studied and reported on the matter of professionalism and placed great emphasis on maintaining the highest ethical standards for benefit of the public. As all that this resolution asks for is already being done, *the Board recommends that Resolution 76 be postponed indefinitely* (Vote: 18 Yes—Morrow, Gaines, Springer, Earle, Schoessler, Dugoni, Hayashi, Opinsky, Benson, McKechnie, Larson, Faget, Harris, Truono, Friend, Gilmore, Booth, Saddoris; 1 No—Overbey).

Seventh Trustee District Resolution on Support for Individual Practice Associations (*Supplement 2*:354/Resolution 44): The Board agrees that the individual practice association (IPA) form of providing dental benefits presents a number of advantages to purchasers of dental benefits, patients and dentists. Recent initiatives in the formation and marketing of dental IPAs across the country have demonstrated the cost advantages to purchasers, as well as the concept's attractiveness to patients and practicing dentists in terms of maintaining the patient's freedom-of-choice, protecting the dentist's professional judgment in treatment planning and generally maintaining the close dentist-patient relationship.

For these reasons, the Board agrees with the intent of Resolution 44, but recommends that the House of Delegates adopt a more specific and direct resolution. *Therefore, the Board recommends adoption of the following substitute resolution* (Vote: Unanimous*).

44B. Resolved, that the American Dental Association, through its Council on Dental Care Programs, educate members and plan purchasers that independent practice associations (IPAs) can be a viable alternative to closed panel capitation plans, because IPAs may offer benefit plans compatible with private practice, fee-for-service dentistry and freedom-of-choice.

Eighth Trustee District Substitute for Resolution 2 (*Supplement 2*:355/Resolution 2S-1): The Board recognizes that dental offices do incur some costs related to the duplication of radiographs, primarily the initial one-time fixed cost of the equipment.

The purpose of the *Code on Dental Procedures and Nomenclature*, as stated in its preface, is to facilitate reporting of dental treatment. However, in the Board's opinion, the duplication of radiographs is not a dental treatment, and the cost of duplicating radiographs should be incorporated into the operating costs of a dental office, which are then reflected in the dentist's fees. Therefore, the Board believes that it is inappropriate to assign a procedure code to this process.

The Board is mindful of the ethical implications of reporting a procedure to a third-party payer without intent to collect the patient's portion of the cost. If duplication of radiographs is submitted to a third-party payer, but the process is not covered by a patient's dental benefit contract, the dentist is obligated to collect the amount in full from the

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patient. *The Board, therefore, recommends that Resolution 2S-1 be postponed indefinitely* (Vote: 18 Yes—Morrow, Gaines, Springer, Earle, Schoessler, Dugoni, Hayashi, Opinsky, Benson, McKechnie, Larson, Faget, Overbey, Harris, Truono, Gilmore, Booth, Saddoris; 1 No—Friend).

Eighth Trustee District Resolution on Issuance of Third-Party Payments (*Supplement* 2:355/Resolution 48): The Association's Legal Department, subject to further research, believes that, under state insurance regulations, it is not permissible to issue benefit checks to both the treating dentist and the patient. In addition, it is the policy of the American Dental Association that each dentist has the right to determine whether to accept or reject payment from a prepaid program (*Trans.* 1977:909).

It is the Board's opinion that, unless bound by a contractual agreement with a third-party payer, it is the dentist's responsibility to reach an agreement with each patient regarding the method of patient-payment for treatment. If, in the dentist's opinion, a patient's bill for treatment remains unpaid for an inappropriate length of time, it may become necessary to submit that patient's account to a collection agency. However, this is a matter to be resolved between the dentist and the patient; it is not the responsibility of the third party. *Therefore, the Board recommends that Resolution 48 be postponed indefinitely* (Vote: 18 Yes—Morrow, Gaines, Springer, Earle, Schoessler, Dugoni, Hayashi, Opinsky, Benson, McKechnie, Larson, Faget, Overbey, Harris, Truono, Gilmore, Booth, Saddoris; 1 No—Friend).

Eighth Trustee District Resolution on Promotion of Table of Allowances (*Supplement* 2:355/Resolution 49): The Board recognizes the difficulties for both dentists and patients posed by the administration of usual, customary and reasonable (UCR) dental benefit programs. Many of these difficulties will be addressed and resolved in Phase 2 of the Council on Dental Care Programs' action plan on customary fee (*Supplement* 2:327). The strengths and weaknesses of each benefit model, including table of allowances, are relative in nature and are a function of many factors in addition to ease of understanding. Among these competing factors are important patient economic issues such as level of benefits and ability of the benefit program to respond to fluctuations in the cost of dental care. Recognizing this diversity of factors, a 1975 *Survey of Dentists* identified advantages and disadvantages with each model, while demonstrating a substantial preference among the profession for the UCR model over the table of allowances model. Further, current Association policy on the education of prospective purchasers of dental benefit programs (*Trans.* 1986:515) states that "...in this effort, promotion of the direct reimbursement concept is preferable, but other models may be acceptable." To adopt Resolution 49 would, therefore, require an extensive review of this, and other, current Association policies to assess its impact on Association positions in several areas. *Therefore, the Board recommends that Resolution 49 be postponed indefinitely* (Vote: 18 Yes—Morrow, Gaines, Springer, Earle, Schoessler, Dugoni, Hayashi, Opinsky, Benson, McKechnie, Larson, Faget, Overbey, Harris, Truono, Gilmore, Booth, Saddoris; 1 No—Friend).

Eighth Trustee District Resolution on Protection of Retirement Assets (*Supplement* 2:355/Resolution 50): *The Board recommends the adoption of Resolution 50* (Vote: Unanimous*).

Eighth Trustee District Resolution on AIDS as a Handicapped Condition (*Supplement* 2:356/Resolution 51): The Board understands and is sympathetic to the concerns in Resolution 51. The Board has taken into account this policy issue in its development of the proposed "Policy Statement on AIDS, HIV Infection and the Practice of Dentistry" (*Supplement* 2:383). The Board noted in this statement that antidiscrimination laws and regulations should be clarified either legislatively or through the courts. In addition, the Board noted in the proposed policy statement that HIV-infected individuals may be treated in a private dental office as long as infection control procedures are followed.

The Association believes that infectious diseases should not be considered a handicap, because of the broad ramifications that follow from this classification. Therefore, *the Board recommends adoption of the following substitute resolution* (Vote: Unanimous*).

51B. Resolved, that the Association work towards persuading state legislatures, Congress, and federal and state agencies that infectious diseases are not a "handicap" within the meaning of the applicable handicap discrimination laws.

Eighth Trustee District Resolution on "Birthday Rule" for Coordination of Benefits (*Supplement* 2:356/Resolution 52): The Board supports the concept of the "Birthday Rule" being the primary method of determining coordination of benefits for dependents. However, the Board also recognizes that, although in 1985, the National Association of Insurance Commissioners recommended use of the "Birthday Rule" for determination of coordination of benefits, incorporation of the "Rule" into state insurance statutes is up to each individual state insurance department. *Therefore, the Board recommends adoption of the following substitute resolution* (Vote: Unanimous*).

52B. Resolved, that the American Dental Association recognizes the "Birthday Rule" as the preferred method for the processing of coordination of benefits for dependent claims, and be it further

Resolved, that third-party payers be urged to adopt the "Birthday Rule" as an industry-wide standard for coordination of benefits, and be it further

Resolved, that the constituent societies be encouraged to seek enactment of legislation that would require all policies and contracts that provide benefits for dental care to use the "Birthday Rule" to determine coordination of benefits.

Eighth Trustee District Resolution on Clarification of Annual Budget (*Supplement* 2:356/Resolution 53): As stated in Board Report 3 (*Supplement 1*, 1987:265), budget variance comparisons are difficult in light of the reorganization of the

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Association authorized by the 1986 House of Delegates. The reassignment of divisions, agencies, personnel and functions has skewed comparisons that had been made in the past. The format of Board Report 3 is determined annually by the Board of Trustees so that as complete a picture as is possible of the proposed budget is presented to the House of Delegates.

The refinement of budget reporting to the House of Delegates is an ongoing procedure of the Board of Trustees. It is the intention of the Board to continue that process. Material is now presented in the budget to provide figures that are related to the various divisions' administrative budgets.

Detailed budget information is available by budget package from the Finance Office of the Association. The staff is working on computer programs which will be able to more accurately report items requested in the second resolving clause. Detail clarification will be available at both the budget information meeting and the Finance Office.

Over the last several years, the House has requested, and rightfully so, an explanation on how the budgeted dollars are going to be spent by program and activity rather than by line item. The reports to the House have been much more detailed than in the past and the Board recognizes the need for full explanation of major items. As the Board of Trustees is aware of the needs of the House and will implement narrative changes as deemed necessary, *the Board recommends that Resolution 53 be postponed indefinitely* (Vote: 17 Yes—Morrow, Gaines, Springer, Earle, Schoessler, Dugoni, Hayashi, Opinsky, Benson, McKechnie, Larson, Faget, Overbey, Truono, Gilmore, Booth, Saddoris; 2 No—Harris, Friend).

Eighth Trustee District Resolution on Conflicts of Interest (*Supplement 2*:357/Resolution 54): The Association has always been most cautious in dealing with potential conflicts of interest between its officers, trustees, council or commission members, staff and consultants and outside organizations and businesses. Examples of this effort include the policies on conflict of interest in the *Organization and Rules of the Board of Trustees*, the *Standing Rules for Councils and Commissions* and the ADA Employee Personnel Manual, as well as the procedures for appointment of consultants to these agencies. In addition, many of the professional consultants and advisors are governed by the codes of ethics of their respective professions on the issue of conflict of interest. The Board believes that the existing mechanisms appropriately handle this management area and reiterates that the Office of the Executive Director is the appropriate agency to achieve the intent of Resolution 54. *Therefore, the Board recommends that Resolution 54 be referred to the Executive Director* (Vote: Unanimous*).

Eighth Trustee District Resolution on Bulk Benefit Payments (*Supplement 2*:357/Resolution 56): It has come to the Board's attention that many Association members believe that, for the sake of clarity, specific reference to the treatment provided for each patient should be included in the explanation of benefits statement provided by the third-party payer to the dentist and the patient. However, the Board believes that amending the first resolving clause of Resolution 4H-1983, rather than the third, will make the intent of the resolution clearer. *Therefore, the Board recommends adoption of the following substitute resolution* (Vote: Unanimous*).

56B. Resolved, that the first resolving clause of Resolution 4H-1983 (*Trans.* 1983:540) be amended as follows:

> **Resolved,** that in the interest of efficient dental office financial administration, bulk benefit payments should include a statement containing, at a minimum, the following information:
> a. Subscriber (employee) name
> b. Patient name
> c. Dates of service
> d. Specific treatment (code number(s))
> e. Total fee charged
> f. Covered expense
> g. Benefit paid

so that the revised resolution will read:

Resolved, that in the interest of efficient dental office financial administration, bulk benefit payments should include a statement containing, at a minimum, the following information:

a. Subscriber (employee) name
b. Patient name
c. Dates of service
d. Specific treatment (code number(s))
e. Total fee charged
f. Covered expense
g. Benefit paid

and be it further
Resolved, that bulk benefit payments should be issued no later than the last business day of the week in which the pertinent individual claims were processed, and be it further
Resolved, that, in all instances in which benefits are reduced, the attending dentist should be furnished a copy of the patient explanation of benefits statement, and be it further
Resolved, that the Council on Dental Care Programs advise insurance firms and service plans of these Association policies and urge their compliance.

Eleventh Trustee District Substitute Resolution for Resolution 2 (*Supplement 2*:358/Resolution 2S-2): The Board is sensitive to the issues expressed in Resolution 2S-2 and supports the addition to guideline 15. However, the Board is of the opinion that the word "mutilated" is too narrow in scope. Damage to a radiograph may not cause it to be mutilated, yet it may be enough to make the radiograph unusable.

Regarding the proposed guideline 16, the Board has been advised by the Council on Dental Care Programs that guideline 13 speaks to the issue of charging for duplication of radiographs (*Trans.* 1986:533). It states, "A dentist should be entitled to remuneration from the patient and/or third party for copies of radiographs and clinical records

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requested for the purpose of benefit determination." In addition, the Board agrees with the intent of Resolution 2S-3 and supports the change and addition to section 15 of the guidelines. *The Board recommends adoption of the following substitute resolution* (Vote: Unanimous*).

2B. Resolved, that the "Guidelines on the Use of Radiographs in Dental Care Programs" (*Trans.*1976:867; 1984:524; 1986:533) be amended by addition of the following paragraphs thereto:

> 14. When, in accordance with guidelines 1-13, a dentist determines it is appropriate to submit radiographs to a third party, a duplicate set should be sent, so as not to place the dentist at risk.
>
> 15. If, for any reason, radiographs are lost, damaged, or not returned to the dentist within 15 working days, the claim in question should be determined and settled immediately. Loss of the radiographs, in a question concerning a claim's validity, places the burden of proof on the carrier and not the dentist.

and be it further
Resolved, that the Council on Dental Care Programs disseminate the revised "Guidelines" to members, carriers, service corporations and other third-party payers.

Eleventh Trustee District Resolution on Inclusion of Oral Health Care Coverage in Medicare (*Supplement 2*:358/ Resolution 57): Although the Board agrees with this resolution, it is a reaffirmation of existing policy (*Trans.*1977:901; 1986:529). Pursuant to the Rules of the House, resolutions which merely reaffirm policy shall not be introduced in the House of Delegates. *Accordingly, the Board must recommend that the Speaker rule Resolution 57 out of order* (Vote: Unanimous*).

Twelfth Trustee District Substitute Resolution for Resolution 10 (*Supplement 2*:359/Resolution 10S-1): The Board is informed that the Council on Ethics, Bylaws and Judicial Affairs determined to include the concept of patient involvement in its recommendation on informed consent because every ethicist in the last decade who has addressed this issue has stressed its importance. Thus, to eliminate reference to this concept would frustrate the very reason the Council on Ethics, Bylaws and Judicial Affairs is suggesting the *Principles of Ethics and Code of Professional Conduct* be amended, i.e. to bring the *Code* into compliance with an ethical doctrine that society has now accepted.

The *Code* also has the function of educating the profession as to what is expected of them. Patient involvement is a basic element of the legal requirement of informed consent. Although it is not the intention of the Council to mirror all legal requirements in the *Code*, to eliminate such a basic point could lead a member into error.

The Board recommends that this substitute resolution be postponed indefinitely (Vote: Unanimous*).

Sixteenth Trustee District Amendment for Resolution 15 (*Supplement 2*:359/Resolution 15S-1): The Board agrees with the intent of the proposed second resolving clause to Resolution 15, submitted by the Sixteenth Trustee District. However, the phrase "adverse effects" inaccurately implies that the insurance industry and service corporations are engaged in a harmful business practice. The problem results from the methodologies used by insurance carriers and service corporations to calculate reimbursement levels which are too inflexible to accommodate the changing status of dentists who leave employment situations to open new practices. *Therefore, the Board recommends adoption of the following substitute resolution* (Vote: Unanimous*).

15B. Resolved, that when a dentist is employed and then leaves for new employment or to open his/her own practice, all insurance companies and/or dental service corporations shall allow said dentist to establish a new fee profile, and be it further
Resolved, that dentists beginning practice be advised of this policy on the development of individual fee profiles and also be advised of the potential limitations due to methodologies used by the insurance industry and service corporations to develop fee profiles for individual practitioners, and be it further
Resolved, that the Council on Dental Care Programs work with the insurance industry, service corporations and other appropriate agencies to solve this problem for dentists beginning practice.

Delegate Ignatius Fiorenza, Massachusetts, Resolution on Approval of Rules of House of Delegates (*Supplement 2*:359/ Resolution 60): The Board wishes to inform the House of Delegates that this resolution raises two issues that were addressed and resolved only last year. The Speaker advised the House that he was returning to the original practice of not asking the House to approve its standing rules each year. The Speaker explained that the standing rules are based upon the ADA *Bylaws* and the Association's parliamentary authority, *Sturgis Standard Code of Parliamentary Procedure.* They also include certain additions and variances from *Sturgis* that have been adopted by the House to facilitate its business. The Speaker explained further that as the standing rules are intended to stand until revoked, they are policy of the House on how it conducts its business. As the House does not reaffirm existing policy, the Speaker took the position that there was no need to approve the standing rules at each annual session, and the House sustained that position.

It was agreed that the *Manual of the House of Delegates* would be distributed as early as possible so the delegates could study the procedures of the House and offer any amendments they felt were important. This was accomplished.

The House also agreed last year that if an amendment were offered, it should be treated like all other resolutions. That resolution could be submitted by a delegate 15 days before the opening of the House or by a trustee district at any time. The resolution would be referred to a reference committee where it could be debated and considered fully before the House was asked to take any action. The

*"Unanimous" constitutes a vote of all 19 voting members of the Board of Trustees.

resolution would be reported to the House as a priority item at the beginning of the second meeting on Wednesday morning. If the House adopted the resolution, the amendment would govern the balance of that session as well as future sessions.

By considering Resolution 60, the House would be reversing the position it took last year and voting to reaffirm its existing policy. Also, this resolution could be used as a vehicle to try to amend the standing rules from the House floor without the benefit of reference committee study and recommendation. Agreeing with the principle of fairness which underlies the current procedure, *the Board recommends that the Speaker rule this resolution out of order* (Vote: Unanimous*).

Delegate Ignatius Fiorenza, Massachusetts, Resolution on State Society Officers Conference (*Supplement 2*:360/Resolution 61): The Board of Trustees concurs that the State Society Officers Conference provides a valuable and timely issues forum and strongly supports the continuation of the Conference annually in conjunction with the annual session. The annual nomination and election of Conference officers in the past was for the sole purpose of providing input into the program for the Conference. Earlier this year, the Board discussed the purpose, format and agenda for the State Society Officers Conference and directed that the Conference program annually provide a state and federal legislative forum for dental society leadership. Based on this new focus for the Conference, it was determined that election of a slate of officers was unnecessary and should be discontinued. Although the Board fully intends to include the State Society Officers Conference in future proposed budgets, its does not believe there is a demonstrated need for the continued election of officers, nor does it believe that such election should be mandated by Association policy. *The Board therefore recommends that Resolution 61 be postponed indefinitely* (Vote: Unanimous*).

Western States President's Conference Resolution on National Dental Health Month (*Supplement 2*:360/Resolution 35): The Board is sympathetic with the intent of this resolution and agrees that most national promotional programs should not be restricted to specific target audiences but should, instead, promote improved dental health awareness among the public at large. The Board recognizes that constituent and component societies may face different local constraints in conducting program activities for various age groups of the population.

However, the Board is aware that the ADA's annual program planning kits allow flexibility in the design and implementation of programs at the local level. In addition, a survey of constituent and component societies was conducted to assess the level of participation in and the effectiveness of the 1987 Senior Smile Week program. The majority of respondents felt the two observances should be kept separate.

If the two observances were combined into one, print and audiovisual materials, along with planning kits, would have to be completely redesigned. Additional materials, suitable to age groups not currently accommodated in either of the two existing campaigns, would need to be developed. Estimated costs for all print and broadcast materials are $380,000. Of this amount, approximately $240,000 is already in the 1988 budget. A sum of approximately $140,000 would need to be appropriated to accommodate this resolution.

The Board is also aware that the pros and cons of this proposal have been debated at length by the House of Delegates on several separate occasions. Each year, the proposal has been postponed indefinitely—primarily because of the persuasive argument that dropping the word "Children's" from the title would adversely affect the publicity potential of the national promotion. For these reasons, *the Board recommends that Resolution 35 be postponed indefinitely* (Vote: Unanimous*).

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Notes

Appendix

Notes

Index to Resolutions

Res. 98	*Suppl.2*:359	**Thirteenth Trustee District** Study of Implant Dentistry
Res. 99	*Suppl.2*:358	**Eleventh Trustee District** Study of Federally Funded Dental Facilities
Res. 100	*Suppl.2*:359	**Sixteenth Trustee District** Hotel Rates for Session Attendees
1986 Resolution		
Res. 93-1986	*Suppl.2*:234	**Thirteenth Trustee District** Proposed ADA "Bylaws" Amendment Regarding Proration of Dues for Former Members
Res. 93-1986B	*Suppl.2*:256	Board of Trustees Recomendation (Reference Committee on Communications Membership and Marketing Services)

Resolutions 95 and 96 will be published and indexed in *Transactions, 1987*.

Map of Trustee Districts