The Council met in person on Friday and Saturday, July 30-31, 2021, during which it considered and discussed the following matters and took the following major actions:

1. Dr. Meredith A. Bailey, council vice chair and chair of the administrative and policy review subcommittee, indicated that three (3) of the Council’s statements were reviewed by the subcommittee prior to the July meeting. The subcommittee recommended that one of the statements – Reporting Abuse and Neglect be retained without amendment. The second statement reviewed – Unearned, Nonhealth Degrees – engendered discussion from the council respecting whether the word “unearned” in the statement was appropriate. Staff was requested to research whether the reasoning behind the use of “unearned” can be determined and provide a report to the council at its next meeting. The subcommittee recommended that amendments to the third statement (Marketing or Sale of Products and Procedures) be made and, as amended, the statement be retained. Upon review and discussion, the council adopted the subcommittee’s recommendations.

2. Dr. Bailey also reported that the administrative and policy review subcommittee had discovered that another statement entitled “Treatment of Patients with Infectious Diseases of Uncertain Transmission,” originally developed in conjunction with the Council on Scientific Affairs (CSA), had been archived by CSA. It was reported that CSA undertook that action upon finding that material available from the Centers for Disease Control adequately address the clinical treatment of patients infected with diseases having unknown transmission parameters. The subcommittee recommended that the council consider if it is necessary or advisable for the council to develop a statement concerning the ethical implications of treating patients with such infections. Following discussion, a consensus among council members was that the statement continues to have relevance in light of the COVID-19 pandemic, and the chair referred the matter to the administrative and policy review committee to revise the archived statement to focus on the ethical aspects of treating patients with diseases having unknown transmissibility parameters or, alternatively, develop a new statement. The chair requested that the subcommittee present a proposed replacement statement at the March 2021 council meeting.

3. The council was given a status report on its annual Student Ethics Video Contest and was told that marketing material for the 2021 contest has been distributed via, among other channels, the American Student Dental Association and the Student Professionalism &
Ethics Association as well as the ADA’s office of student affairs. Members were requested to encourage dental students in their districts to develop and submit entries for the contest and to publicize the contest to the constituent and component dental societies in their districts.

4. The Council received a report from the bylaws subcommittee concerning the subcommittee’s periodic review of sections of the *Bylaws* and *Governance Manual*. Reviewed this year were Chapter VI., Elective Officers of the Association and Chapter XI., Principles of Ethics and Code of Professional Conduct, Member Conduct Policy and Judicial Procedures. Dr. Jill M. Burns, bylaws subcommittee chair, summarized the editorial and conforming changes that the subcommittee recommended be made. Following discussion, the council unanimously approved the amendments presented by the subcommittee and directed the staff to report the amendments to the House of Delegates pursuant to Chapter VIII., Section K.6.b.iii. of the *Governance Manual*.

5. The bylaws subcommittee, through its chair Dr. Burns, reported on its consideration of the request that the duties of the Treasurer enumerated in the ADA *Bylaws* (Chapter VI., Section 90.F.) be reviewed and revised. Dr. Burns reported that the subcommittee thoroughly studied the issue and, for several interrelated reasons, recommended that the ADA assemble a special committee composed of individuals having budgeting and financial expertise to review the duties of the Treasurer, the Budget and Finance Committee of the Board of Trustees and the Chief Financial Officer to determine an appropriate division of authority in financial and budgeting matters for the ADA. The council concurred, noting that the council members lacked the experience needed. A communication of the council’s decision was forwarded to the ADA president, noting that the council could use its governance and bylaws language expertise, if needed, to assist in developing a resolution to amend the ADA *Bylaws* to embody a special committee’s intended restructuring of authority over financial and budgeting matters.

6. Dr. Burns, assisted by the chair, led the council through a review of amendments to the ADA’s teledentistry policy proposed by the bylaws and ethics subcommittees and a proposed background statement to accompany a resolution to approve those amendments. Following a lengthy discussion of the amendments, the council unanimously approved forwarding the background statement and amendments to the 2021 House of Delegates. A copy of the background statement and resolution amending the teledentistry policy is attached to this report as Appendix 1.

7. Dr. Guenter J. Jonke, chair of the ethics subcommittee, reported that the
subcommittee considered the issue of payer ratings of providers that was brought to the
council’s attention by an ADA trustee during its March 2021 meeting. Dr. Jonke stated that,
after review and discussion the subcommittee determined that, based on the ADA Principles
of Ethics and Code of Professional Conduct, no action by the council was warranted at this
time.

8. Dr. Jonke also led the council through a review of the statement on the ethics of
teledentistry that the ethics subcommittee was requested to develop in response to
Resolution 106-2021. Following the council’s review the statement developed by the ethics
subcommittee was approved and the council requested that the statement be forwarded to
the 2021 House of Delegates.

9. Because the council had not met in person for two years, a detailed summary of the
council’s responsibilities with respect to developing Ethical Moment articles for publication in
The Journal of the American Dental Association (JADA) was provided. Council members
also participated in a workshop that provided guidance and suggestions for authoring Ethical
Moment articles.

10. The Council adopted a resolution calling for each council members to author or co-
author one Ethical Moment per year during their tenure on the council to ensure sufficient
production for an Ethical Moment article to appear in each issue of JADA.

11. Dr. Alma J. Clark, chair of the continuing education subcommittee, reported on the
activities of the subcommittee, including its involvement in the development of a council
sponsored on-demand continuing education webinar for SmileCon™ 2021 on the ethical
considerations of conscious and unconscious bias on the dental practice. A discussion
ensued regarding the potential of using a non-council expert in diversity and inclusion in the
webinar, including facilitating a discussion among council members on the ethical
implications of conscious and unconscious bias. After discussing the concept, the council
approved the participation of a non-council individual with expertise in diversity and inclusion
matters in the council's webinar under development.

12. Dr. Clark also provided a report to the council concerning the initial work that has
been undertaken to develop a continuing education offering for SmileCon™ 2022.

13. Ms. Nanette Elster, Manager of Ethics Outreach and Programs informed the council
that an overture has been received from the American College of Dentists and the American
Society for Dental Ethics for the council to collaborate in the development of ethics
programming. It was explained that the initial suggested effort would be to develop
facilitator guides to accompany selected Ethical Moment articles; it was explained that the facilitator guides would allow the Ethical Moment articles to be easily used as ethics teaching tools and that such uses would have clear and consistent learning objectives. Following the presentation and ensuing discussion, the council approved the exploration of establishing a collaborative relationship with the American College of Dentists and the American Society for Dental Ethics with the development of facilitator guides for Ethical Moment articles as the initial project to be undertaken. The ethics subcommittee was requested to report back to the council in March 2022 on the status of the collaboration.

14. The council received a presentation from the Executive Director, Dr. Kathleen T. O’Loughlin, concerning the ADA’s membership and economic recovery from the pandemic, the emphasis that the ADA is placing on segments of the dental profession (e.g., women, young, ethnically diverse and employed dentists) and the progress that has been made toward fulfilling the goals of the ADA’s current strategic plan.

15. The Council received short presentations from several council chairs and a council vice chair and the chair of the Committee on Annual Meetings (CAM) concerning important initiatives and projects that have engaged the councils and CAM in 2021.

16. Dr. Gary Oyster, Board of Trustees Liaison to the council, presented plaques to Dr. Jill M. Burns, Dr. Guenter J. Jonke, Dr. Onika R. Patel and Dr. Robert J, Wilson, Jr. to commemorate their four years of service to the council, the American Dental Association and the profession of dentistry.

17. Dr. Meredith A. Bailey (1st District, Massachusetts), current council vice chair, was selected as the council chair for the 2021-2022 term.

18. Dr. Bruce A. Burton (11th District, Oregon) was elected as vice chair of the council for the 2021-2022 term.
Resolution No. 0  New
Report: [Report] Date Submitted: August 2021
Submitted By: Council on Ethics, Bylaws and Judicial Affairs
Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: N/A
Net Dues Impact: 
Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

PROPOSED AMENDMENTS TO THE COMPREHENSIVE ADA POLICY STATEMENT ON TELEDENTISTRY

Background: In 2020, the House of Delegates adopted Resolution 16-2020, amending the Comprehensive ADA Policy Statement on Teledentistry (Trans.2015:244; 2020:107). Unfortunately, the policy as it was amended, in some circumstances conflicts with the ADA Principles of Ethics and Code of Professional Conduct (“the Code of Ethics”). The resolution proposed for adoption seeks to amend the ADA’s comprehensive teledentistry policy to solve that conflict issue and also adds additional patient safeguards and otherwise modifies the teledentistry policy pursuant to the ethical principles of Patient Autonomy, Nonmaleficence and Veracity.

Discussion and Analysis:
A. Resolving the Conflict between the Teledentistry Policy and the Ethical Prohibition against Patient Abandonment. To provide safeguards for patients engaged in treatments provided through teledentistry techniques, the teledentistry policy as amended by Resolution 16-2020 requires that dentists engaging in teledentistry encounters be licensed in “the state where the patient receives services.” While that licensure requirement may adequately protect and safeguard patients who are receiving their initial treatment from a dentist through a teledentistry encounter, it is believed to be too restrictive where a pre-existing doctor-patient relationship exists at the time of the teledentistry treatment. As currently written, should an existing patient of record who is midway through a multi-visit treatment develop treatment-related issues during a business trip to another jurisdiction, the teledentistry policy adopted in 2020 prohibits the treating dentist from treating the patient through teledentistry by prescribing an antibiotic or pain medication unless the dentist is licensed in that remote jurisdiction. The dilemma the treating dentist faces in that situation is clear. On the one hand, the teledentistry policy prohibits treatment if the dentist is not licensed in the remote jurisdiction. On the other hand, the guidance of the Code of Ethics under the ethical principle of Nonmaleficence prohibits abandoning a patient once a course of treatment has begun. That conflict between ADA policies puts the dentist in an untenable situation – either the dentist ignores the teledentistry policy in favor of proceeding in accordance with the guidance of the Code of Ethics, or ignores the ethical guidance of the Code of Ethics and adheres to the licensure restrictions set forth in the teledentistry policy.

An existing doctor-patient relationship signifies that there is a relationship of trust and mutual respect that has developed between the patient and the practitioner. Many dentists have numerous patients that they have treated for long periods of time. Many, if not most, dentists have experienced patients who relocate substantial distances upon retiring only to return to their former places of residence for periodic dental
examinations and treatments with their long-time dentists. Other dentists practicing in areas bordering
another jurisdiction have patients who travel across jurisdictional lines for dental treatment, prioritizing the
trust and respect signified by the doctor-patient relationship over the protection of the dental practice act
protections afforded them by their own jurisdiction’s laws and regulations. It is believed that the mutual
trust and respect developed by existing doctor-patient relationships, which are continually validated and
strengthened each time the patient returns to their dentist’s office for an examination or treatment can
safely be relied upon as the principal patient safeguard in a teledentistry encounter between a dentist and
a patient of record. Indeed, in such instances, allowing the patient to be treated through teledentistry by
their chosen treating dentist allows the practitioner with the most knowledge of the patient’s dental history
and any ongoing treatment to apply that experience and knowledge to carry out the duty of putting the
patient’s welfare first, as the ethical principle of Beneficence requires.

The proposed amendments to Paragraph No. 1 in the policy’s Patients’ Rights section allows for there to
be different requirements for teledentistry treatment between patients of record and new patients.
Modifying the patient safeguards provided in the current teledentistry policy based upon whether a pre-
eexisting doctor-patient relationship exists between the patient and the dentist performing the teledentistry
treatment will alleviate the abandonment dilemma faced by practitioners using teledentistry techniques to
remotely treat patients-of-record.

B. Providing Additional Safeguards Where Teledentistry is used with New Patients Further
Supports the Tenets of the Code of Ethics. Maintaining the existing licensure requirements of the
teledentistry policy for situations where services are delivered to new patients provides some protection of
the patient’s welfare, and those safeguards should remain in place. Proposed new Paragraph No. 2 in
the Patients’ Rights section of the teledentistry policy provides the licensure requirements found in the
current policy continues when new patients are treated via teledentistry. It is believed, however, that
additional safeguards should be added to the teledentistry policy to bolster the patient protections
afforded by the policy. The proposed amendments to the teledentistry policy prohibit the provision of
comprehensive or elective care solely by teledentistry. Instead, where a doctor-patient relationship is first
established by the provision of services through a teledentistry encounter, to protect the welfare of and
safeguard the patient, the treating dentist must perform an in-person oral examination as soon as
possible after the teledentistry encounter and before any comprehensive care or elective treatment is
undertaken. The requirement for an in-person examination will allow the dentist to detect any issues or
conditions that would potentially affect the outcome of any procedure or treatment that went undetected
during the teledentistry encounter. The addition of a requirement of an in-person examination for new
patients before comprehensive or elective treatment is added to the Patients’ Rights section of the policy
by the addition of proposed Paragraph No. 3.

It would also provide additional patient protections and bolster the patient’s right to self-determination
under the ethical principle of Patient Autonomy for the ADA’s teledentistry policy to require additional
basic information concerning the practitioner providing the teledentistry services and to require a
disclosure of the limitations of teledentistry encounters. These additional measures are added by the
amendments to Paragraph Nos. 4 and 8 of the Patients’ Rights section of the policy. Also supporting the
ethical principles of Patient Autonomy and Nonmaleficence is the addition of Paragraph No. 9 to the
Patients’ Rights section of the teledentistry policy. Only by allowing patients the right to discuss their
treatment with any third party is it possible for patients to exercise their right to seek a second opinions or
pursue separate consultations regarding the treatment rendered by teledentistry.

C. The Question of Equivalency of Care. In reviewing the comprehensive teledentistry policy, there
was concern expressed regarding the blanket statement of equivalency between in-person (face-to-face)
care and care provided by teledentistry techniques that is found in the policy. Given that providing
treatment via teledentistry is a relatively new development and that new technologies are continuing to
emerge that have application to telehealth and teledentistry encounters, it may be premature to declare
without qualification that all care provided by the provision of teledentistry techniques is equivalent to in-
person care. It appears that the import of the statement is to urge that insurance reimbursement rates be
the same for equivalent in-person and teledentistry care. Changing the first word of sentence from "As" to "When" allows that same point to be made without the questionable accuracy of a statement of equivalency between all delivered in-person and via teledentistry.

D. Remaining Proposed Amendments in the Policy. The current policy uses the term "state" when referring to, for example, licensure. Technically, licensure in the area served by the American Dental Association is the province of not only states, but also territories and the District of Columbia. For that reason, the amendments to the policy include amending the word "state" to the phrase "state or other territory or jurisdiction." These amendments have the added benefit of aligning the statement with other policy and governance documents of the Association, including the ADA Bylaws.

The remaining amendments proposed in the following resolution are conforming in nature, providing amending language needed to make the policy internally consistent with the principal amendments discussed above.

The Council on Ethics, Bylaws and Judicial Affairs requests adoption of the following resolution:

Resolution

0. Resolved, that the Comprehensive ADA Policy Statement on Teledentistry (Trans.2015:244; 2020:107) be amended as follows (additions underscored, deletions stricken through):

Comprehensive ADA Policy Statement on Teledentistry

Teledentistry refers to the use of telehealth systems and methodologies in dentistry. Telehealth refers to a broad variety of technologies and tactics to deliver virtual medical, health, and education services. Telehealth is not a specific service, but a collection of means to enhance care and education delivery.

Teledentistry can include patient care and education delivery using, but not limited to, the following modalities:

Synchronous (live video): Live, two-way interaction between a person (patient, caregiver, or provider) and a provider using audiovisual telecommunications technology.

Asynchronous (store and forward): Transmission of recorded health information (for example, radiographs, photographs, video, digital impressions and photomicrographs of patients) through a secure electronic communications system to a practitioner, who uses the information to evaluate a patient’s condition or render a service outside of a real-time or live interaction.

Remote patient monitoring (RPM): Personal health and medical data collection from an individual in one location via electronic communication technologies, which is transmitted to a provider (sometimes via a data processing service) in a different location for use in care and related support of care.

Mobile health (mHealth): Health care and public health practice and education supported by mobile communication devices such as cell phones, tablet computers, and personal digital assistants (PDA).

General Considerations: While in-person (face to face) direct examination has been historically the most direct way to provide care, advances in technology have expanded the options for dentists to communicate with patients and with remotely located licensed dental
team members. The ADA believes that examinations performed using teledentistry can be an effective way to extend the reach of dental professionals, increasing access to care by reducing the effect of distance barriers to care.

Teledentistry has the capability to expand the reach of a dental home to provide needed dental care to a population within reasonable geographic distances and varied locations where the services are rendered.

In order to achieve this goal, services delivered via teledentistry must be consistent with how they would be delivered in-person. Examinations and subsequent interventions performed using teledentistry must be based on the same level of information that would be available in an in-person environment, and it is the legal responsibility of the dentist to ensure that all records collected are sufficient for the dentist to make a diagnosis and treatment plan. The treatment of patients who receive services via teledentistry must be properly documented and should include providing the patient with a summary of services. A dentist who uses teledentistry shall have adequate knowledge of the nature and availability of local dental resources to provide appropriate follow-up care to a patient following a teledentistry encounter. A dentist shall refer a patient to an acute care facility or an emergency department when referral is necessary for the safety of the patient or in case of emergency.

As When the care provided is equivalent to in-person care, insurer reimbursement of services provided must be made at the same rate that it would be made for the services when provided in-person, including reimbursement for the teledentistry codes as appropriate.

**Patients’ Rights:** Dental patients whose care is rendered or coordinated using teledentistry modalities have the right to expect:

1. That any dentist delivering, directing or supervising services to a patient of record using teledentistry technologies will be licensed in the state or other territory or jurisdiction of the United States where the patient receives services, or be providing these services as otherwise authorized by the that state’s dental board of that state, territory or jurisdiction.

2. That any dentist delivering, directing or supervising services to a new patient using teledentistry technologies will be licensed in the state or other territory or jurisdiction of the United States where the patient receives the services.

3. That if a dentist-patient relationship is established via a teledentistry encounter, an in-person (face-to-face) oral examination should be performed by the dentist as soon as practical and prior to initiating any comprehensive care or elective care.

24. Access to the name, practice address, telephone number, email address, licensure and board certification qualifications and emergency contact information of the all oral health care practitioners who is providing the care via teledentistry techniques in advance of the visit will be made available to the patient prior to such encounter.

35. That the delivery of services through teledentistry technologies will follow evidence-based practice guidelines, to the degree they are available, as a means of ensuring patient safety, quality of care and positive health outcomes.

46. That patients will be informed about the identity of the providers collecting or evaluating their information or providing treatment, and of any costs they will be responsible for in advance of the delivery of services.
57. That relevant patient information will be collected prior to performing services using teledentistry technologies and methods including medical, dental, and social history, and other relevant demographic and personal information.

68. That the provision of services using teledentistry technologies will be properly documented, that and the records and documentation collected will be provided to the patient upon request and that the limitations of teledentistry encounters should be disclosed to a patient prior to the initiation of any teledentistry encounter.

9. That any patient has the right to discuss their treatment with any third party. A patient should not be required to agree to any provision that restricts the patient's freedom to bring any concerns about their dental treatment to the attention of an entity of the patient’s choosing.

710. That services provided using teledentistry technologies and methods include care coordination as a part of a dental home and that the patient’s records be made available to any entity that is serving as the patient’s dental home.

811. That the patient will be actively involved in treatment decisions, will be able to choose how they receive a covered service, including considerations for urgency, convenience and satisfaction and without such penalties as higher deductibles, co-payments or coinsurance relative to that of in-person services.

912. That the dentist shall determine the delivery of services using teledentistry technologies and all services are performed in accordance with applicable laws and regulations addressing the privacy and security of patients’ private health information.

Quality of Care: The dentist is responsible for, and retains the authority for ensuring, the safety and quality of services provided to patients using teledentistry technologies and methods. Services delivered via teledentistry should be consistent with in-person services, and the delivery of services utilizing these modalities must abide by laws addressing privacy and security of a patient’s dental/medical information.

Supervision of Allied Dental Personnel: The extent of the supervision of allied dental personnel should conform to the applicable dental practice act in the state, territory or jurisdiction of the United States where the patient receives services and where the dentist is licensed. The dentist should be knowledgeable regarding the competence and qualifications of the allied personnel utilized, and should have the capability of immediately contacting both the allied dental personnel providing service and the patient receiving services. All services delivered by allied dental personnel should be consistent with the ADA Comprehensive Statement on Allied Dental Personnel.

Licensure: Dentists and allied dental personnel who deliver services through teledentistry modalities must be licensed or credentialed in accordance with the laws of the state, territory or jurisdiction in which the dentist practices. Allied dental personnel who deliver services through teledentistry modalities must be licensed or credentialed in accordance with the laws of the state, territory or other jurisdiction in which the patient receives service. The delivery of services via teledentistry must comply with the state’s scope of practice laws, regulations or rules applicable to the encounter. Teledentistry cannot be used to expand the scope of practice or change permissible duties of dental auxiliaries allied dental personnel. The American Dental Association opposes a single national federalized system of dental licensure for the purposes of teledentistry.

Reimbursement: Dental benefit plans and all other third-party payers, in both public (e.g. Medicaid) and private programs, shall provide coverage for services using teledentistry
technologies and methods (synchronous or asynchronous) delivered to a covered person to the same extent that the services would be covered if they were provided through in-person encounters. Coverage for services delivered via teledentistry modalities will be at the same levels as those provided for services provided through in-person encounters and not be limited or restricted based on the technology used or the location of either the patient or the provider as long as the health care provider is licensed in the state where the patient receives service as indicated above.

Technical Considerations: Dentists are encouraged to consider conformance with applicable data exchange standards to facilitate delivery of services via teledentistry modalities. These include, but are not limited to, Digital Imaging and Communications in Medicine (DICOM) standards when selecting and using imaging systems, X12/HL7 for the exchange of information and ICD-9/10-CM/SNOMED/SNODENT for documentation consistency.

DRAFT BOARD RECOMMENDATION: Vote Yes.

PLEASE NOTE YOUR COMMENTS/CHANGES TO THIS DRAFT BOARD RECOMMENDATION BELOW.