### 2023 Updated Index

**Committee C (Dental Education, Science and Related Matters)**

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*Material Not Included in Early Posting
**Material Posted August 4
+++Newly Received (Received and Processed September 22; Posted September 29)
++Newly Received (Received and Processed September 21; Posted October 3)
++*Newly Received (Received and Processed September 21; Posted October 5)
Resolution No. 401

Report: N/A

Date Submitted: May 2023

Submitted By: Council on Dental Education and Licensure

Reference Committee: C (Dental Education, Science and Related Matters)

Total Net Financial Implication: None

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

AMENDMENT OF POLICY, COMPREHENSIVE POLICY ON DENTAL LICENSURE

Background: In accord with Resolution 170H-2012, Regular Comprehensive Policy Review (Trans.2012:370), the Council on Dental Education and Licensure has reviewed the policy, Comprehensive Policy on Dental Licensure (Trans.2018:341). This policy was first adopted by the 2018 House of Delegates as the result of the Council’s two-year comprehensive review of the Association’s numerous policies related to dental licensure. The House of Delegates agreed with the Council’s recommendation to eliminate redundancies and lengthy explanations found in 12 policy statements and adopted the new succinct yet comprehensive policy.

Monitoring the ever-changing dental licensure landscape, the Council believes that amendments to the current policy statement should be considered. Highlights include the addition of a statement urging dental boards to ensure all dental board members are free of real or perceived conflicts of interest and should not serve simultaneously as examiners with a clinical testing agency, affirmation that determination of clinical competence may include any of the listed assessment pathways, deletion of the Curriculum Integrated Format (CIF) category because non-patient examination options are now readily available, and the addition of a licensure compacts section to clearly reflect the ADA’s support of compacts. Non-substantive editorial changes related to sequencing of the content and alignment with three sections of the document (General Principles, Initial Licensure and Licensure by Credentials) also are proposed.

The Council on Dental Education and Licensure recommends adoption of the following resolution.

Resolution

401. Resolved, that the ADA Policy on Comprehensive Policy on Dental Licensure (Trans.2018:341) be amended as follows (additions are underlined; deletions are stricken):

Comprehensive Policy on Dental Licensure

General Principles

- One standard of competency for dental licensure must be in place in order to provide quality oral health care to the public.
- Provisions for freedom of movement across state lines for all dental professionals should exist to facilitate the provision of quality oral health care to the public.
• Federal licensure and federal intervention in the state dental licensure system are strongly opposed.

• Efforts of unlicensed and unqualified persons to gain a right to serve the public directly in the field of dental practice are strongly opposed.

• Elimination of patients in the clinical licensure examination process is strongly supported to address ethical and psychometric concerns, including those identified in the ADA Council on Ethics, Bylaws and Judicial Affairs statement entitled Ethical Considerations When Using Patients in the Examination Process (Reports 2008:103). State dental societies and dental boards are urged to work toward acceptance of valid and reliable clinical assessments that do not require single-encounter performance of procedures on patients.

• The state boards of dentistry in each state or licensure jurisdiction are the sole licensure and regulating authorities for all dentists and allied dental personnel.

• State dental boards are supposed to ensure that all dental board members are free of real and perceived conflicts of interest. The Association believes that dental board members should not serve simultaneously as examiners with a clinical testing agency.

• State dental boards are encouraged to require verification of completion of continuing dental education as a condition for re-registration of dental licenses.

• Dentists identified as deficient through properly constituted peer review mechanisms should undergo assessment and corrective competency-based education and such provisions should be included in laws, rules and regulations.

Initial Licensure

States are urged to accept the following common core of requirements for initial licensure:

1. Completion of a DDS or DMD degree from a university-based dental education program accredited by the Commission on Dental Accreditation.

2. Successful passage of the National Board Dental Examination, a valid and reliable written cognitive test.

3. A determination of clinical competency for the beginning practitioner, which may include any of the following assessment pathways:

• Acceptance of clinical examination results from any clinical testing agency that do not involve the use of single encounter procedure-based examinations involving patients; or

• Graduation from CODA-accredited PGY-1 program, that is, a residency program at least one year in length at a CODA-accredited clinically based postdoctoral general dentistry and/or successful completion of at least one year of a specialty residency program; or

• An Objective Structured Clinical Examination (OSCE), that is, a valid and reliable non-patient based examination that requires candidates to use critical thinking and their clinical knowledge and skills to successfully complete dental procedures; or

• Completion of a portfolio-type examination (such as employed by the California Dental Board) or similar assessment, that uses the evaluation mechanisms currently applied by the dental schools to assess and document student competence; or
An Objective Structured Clinical Examination (OSCE), that is, a valid and reliable non-patient-based examination consisting of multiple, standardized stations that require candidates to use their clinical and skills to successfully complete one or more dental problem-solving tasks.

For initial licensure in dentistry, international graduates of non-CODA accredited dental education programs should possess the following educational credentials: 1) completion of a university-based dental education program accredited by the Commission on Dental Accreditation (CODA) leading to a DDS or DMD degree or 2) graduation from an advanced dental education program in general dentistry accredited by the Commission on Dental Accreditation.

Curriculum Integrated Format Clinical Examination

A Curriculum Integrated Format (CIF) clinical examination addresses ethical concerns associated with single encounter patient-based examinations currently administered by dental clinical testing agencies. A CIF provides candidates opportunities to successfully complete independent "third-party" clinical assessments on patients of record prior to graduation from a dental education program accredited by the Commission on Dental Accreditation.

The curriculum integrated format, as defined below, should only be employed as a licensure examination until a non-patient based licensure examination is developed that protects the public and meets psychometric standards. The Association believes that the following CIF provisions must be required by state boards of dentistry and incorporated by testing agencies for protection of the patient:

- A CIF examination must be performed by candidates on patients of record within an appropriately sequenced treatment plan.
- The competencies assessed by the clinical examining agency must be selected components of current dental education program curricula and reflective of current dental practice.
- All portions of the CIF examination must be available at multiple times within each institution during dental school to ensure that patient care is accomplished within an appropriate treatment plan and to allow candidates to remediate and retake prior to graduation any portions of the examination which they have not successfully completed.

Graduates of Non-CODA Accredited Dental Education Programs

For initial licensure in dentistry, international graduates of non-CODA accredited dental education programs should possess the following educational credentials: 1) completion of a university-based dental education program accredited by the Commission on Dental Accreditation (CODA) leading to a DDS or DMD degree or 2) graduation from a postgraduate program in general dentistry accredited by the Commission on Dental Accreditation.

Licensure Compacts

State dental societies and dental boards should support licensure compacts to allow freedom of movement for practitioners across state lines. Licensure compacts increase licensees' mobility, facilitate quality oral health care for the public, and support relocating challenges for military members and their families. Licensure compacts benefit licensing boards by providing agreement on uniform
licensure requirements, a shared data system for access to primary source
documentation of applicant credentials and tracking of adverse actions. They
enhance cooperation and immediate availability of information between state
boards critical to protecting the public.

Licensure by Credentials

In addition to participating in licensure compacts, States also should have
provisions for licensure of dentists who do not participate in licensure compacts.
These individuals should demonstrate they are currently licensed in good standing
and also have not been the subject of final or pending disciplinary action in any
state or jurisdiction in which they have been licensed. This should also apply to
experienced, internationally trained dentists who have been licensed in a U.S.
jurisdiction, and who may or may not have graduated from a CODA-accredited
dental school.

Appropriate credentials may include:

• DDS or DMD degree from a dental education program accredited by the Commission
  on Dental Accreditation

• Specialty certificate/master’s degree from an accredited advanced dental education
  program

• Specialty Board certification

• GPR/AEGD certificate from an accredited advanced dental education program

• Current, unencumbered license in good standing

• Passing grade on Documentation of successful completion of an initial clinical
  competency assessment licensure exam, unless initial license was granted via
  completion of PGY-1, Portfolio examination, or other state-approved pathway for
  assessment of clinical competency.

• Documentation of completion of continuing education

For dentists who hold a current, unencumbered dental license in good standing in any
jurisdiction, state dental boards should:

• Not require completion of Accept pathways that allow for licensure without completing
  an additional clinical examination, e.g., by credentials, reciprocity, and/or
  endorsement.

• Consider participation in licensure compacts

• Implement specialty licensure by credentials and/or specialty licensure to facilitate
  licensure portability of dental specialists.

• Make provisions available for a limited or volunteer license for dentists who wish to
  provide services without compensation to critical needs populations within a state in
  which they are not already licensed.
• Make provisions available for limited teaching permits for faculty members at teaching facilities and dental programs accredited by the Commission on Dental Accreditation.

• Make provisions available for active-duty military dentists, military spouses and veterans of the armed services.

State dental boards are encouraged to grant the same benefits of licensure mobility to internationally trained dentists who are licensed by their respective jurisdictions.

Licensure by Credentials for Dentists Who Are Not Graduates of CODA-Accredited Dental Education Programs

State dental societies and dental boards are strongly encouraged to grant the same benefits of licensure mobility to U.S. currently licensed dentists who were licensed by their respective jurisdictions prior to state implementation of the requirement for graduation from a CODA-accredited dental school with a DDS or DMD degree.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)
Resolution No. 401S-1 Amendment
Report: N/A Date Submitted: September 2023
Submitted By: Ninth District
Reference Committee: C (Dental Education, Science and Related Matters)
Total Net Financial Implication: None 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

AMENDMENT OF POLICY, COMPREHENSIVE POLICY ON DENTAL LICENSURE

The following amendment to Resolution 401 (Worksheet:4000) was submitted by Michelle Nichols-Cruz, governance manager, Michigan Dental Association, and transmitted on September 22, 2023.

Background: In review of the policy with current and retired members of the United States military services, the Ninth District recommends that the terms in the current policy reflect accurate terminology of who the policy affects. Therefore, the following amendment is proposed. Additions are double underlined; deletions are double stricken.

Resolution

401S-1. Resolved, that the ADA Policy on Comprehensive Policy on Dental Licensure (Trans:2018:341) be amended as follows (additions are underlined; deletions are stricken):

Comprehensive Policy on Dental Licensure

General Principles

- One standard of competency for dental licensure must be in place in order to provide quality oral health care to the public.
- Provisions for freedom of movement across state lines for all dental professionals should exist to facilitate the provision of quality oral health care to the public.
- Federal licensure and federal intervention in the state dental licensure system are strongly opposed.
- Efforts of unlicensed and unqualified persons to gain a right to serve the public directly in the field of dental practice are strongly opposed.
- Elimination of patients in the clinical licensure examination process is strongly supported to address ethical and psychometric concerns, including those identified in the ADA Council on Ethics, Bylaws and Judicial Affairs statement entitled Ethical Considerations When Using Patients in the Examination Process (Reports 2008:109). State dental societies and dental boards are urged to work toward acceptance of valid and reliable clinical assessments that do not require single-encounter performance of procedures on patients.
- The state boards of dentistry in each state or licensure jurisdiction are the sole licensure
and regulating authorities for all dentists and allied dental personnel.

- State dental boards are supposed to ensure that all dental board members are free of real and perceived conflicts of interest. The Association believes that dental board members should not serve simultaneously as examiners with a clinical testing agency.
- State dental boards are encouraged to require verification of completion of continuing dental education as a condition for re-registration of dental licenses.
- Dentists identified as deficient through properly constituted peer review mechanisms should undergo assessment and corrective competency-based education and such provisions should be included in laws, rules and regulations.

**Initial Licensure**

States are urged to accept the following common core of requirements for initial licensure:

1. Completion of a DDS or DMD degree from a university-based dental education program accredited by the Commission on Dental Accreditation.
2. Successful passage of the National Board Dental Examination, a valid and reliable written cognitive test.
3. A determination of clinical competency for the beginning practitioner, which may include any of the following assessment pathways:
   - Acceptance of clinical examination results from any clinical testing agency that do not involve the use of single encounter procedure-based examinations involving patients; or
   - Graduation from CODA-accredited PGY-1 program, that is, a residency program at least one year in length at a CODA-accredited clinically based postdoctoral general dentistry and/or successful completion of at least one year of a specialty residency program; or
   - An Objective Structured Clinical Examination (OSCE), that is, a valid and reliable non-patient based examination that requires candidates to use critical thinking and their clinical knowledge and skills to successfully complete dental procedures; or
   - Completion of a portfolio-type examination (such as employed by the California Dental Board) or similar assessment, that uses the evaluation mechanisms currently applied by the dental schools to assess and document student competence; or
   - An Objective Structured Clinical Examination (OSCE), that is, a valid and reliable non-patient based examination consisting of multiple, standardized stations that require candidates to use their clinical and skills to successfully complete one or more dental problem-solving tasks.

For initial licensure in dentistry, international graduates of non-CODA accredited dental education programs should possess the following educational credentials: 1) completion of a university-based dental education program accredited by the Commission on Dental Accreditation (CODA) leading to a DDS or DMD degree or 2) graduation from an advanced dental education program in general dentistry accredited by the Commission on Dental Accreditation.

**Curriculum Integrated Format Clinical Examination**
A Curriculum Integrated Format (CIF) clinical examination addresses ethical concerns associated with single encounter patient-based examinations currently administered by dental clinical testing agencies. A CIF provides candidates opportunities to successfully complete independent "third-party" clinical assessments on patients of record prior to graduation from a dental education program accredited by the Commission on Dental Accreditation.

The curriculum integrated format, as defined below, should only be employed as a licensure examination until a non-patient based licensure examination is developed that protects the public and meets psychometric standards. The Association believes that the following CIF provisions must be required by state boards of dentistry and incorporated by testing agencies for protection of the patient:

- A CIF examination must be performed by candidates on patients of record within an appropriately sequenced treatment plan.
- The competencies assessed by the clinical examining agency must be selected components of current dental education program curricula and reflective of current dental practice.
- All portions of the CIF examination must be available at multiple times within each institution during dental school to ensure that patient care is accomplished within an appropriate treatment plan and to allow candidates to remediate and retake prior to graduation any portions of the examination which they have not successfully completed.

**Graduates of Non-CODA Accredited Dental Education Programs**

For initial licensure in dentistry, international graduates of non-CODA accredited dental education programs should possess the following educational credentials: 1) completion of a university-based dental education program accredited by the Commission on Dental Accreditation (CODA) leading to a DDS or DMD degree or 2) graduation from a postgraduate program in general dentistry accredited by the Commission on Dental Accreditation.

**Licensure Compacts**

State dental societies and dental boards should support licensure compacts to allow freedom of movement for practitioners across state lines. Licensure compacts increase licensees' mobility, facilitate quality oral health care for the public, and support relocating challenges for military members and their families. Licensure compacts benefit licensing boards by providing agreement on uniform licensure requirements, a shared data system for access to primary source documentation of applicant credentials and tracking of adverse actions. They enhance cooperation and immediate availability of information between state boards critical to protecting the public.

**Licensure by Credentials**

In addition to participating in licensure compacts, states also should have provisions for licensure of dentists who do not participate in licensure compacts. These individuals should demonstrate they are currently licensed in good standing and also have not been the subject of final or pending disciplinary action in any state or jurisdiction in which they have been licensed. This should also apply to experienced, internationally trained dentists, who have been licensed in a U.S.
jurisdiction, and who may or may not have graduated from a CODA-accredited
dental school.

Appropriate credentials may include:

• DDS or DMD degree from a dental education program accredited by the Commission
  on Dental Accreditation

• Specialty certificate/master’s degree from an accredited advanced dental education
  program

• Specialty Board certification

• GPR/AEGD certificate from an accredited advanced dental education program

• Current, unencumbered license in good standing

• Passing grade on Documentation of successful completion of an initial clinical
  competency assessment, licensure exam, unless initial license was granted via
  completion of PGY-1, Portfolio examination, or other state-approved pathway for
  assessment of clinical competency.

• Documentation of completion of continuing education

For dentists who hold a current, unencumbered dental license in good standing in any
jurisdiction, state dental boards should:

• Not require completion of Accept pathways that allow for licensure without completing
  an additional clinical examination, e.g., by credentials, reciprocity, and/or
  endorsement.

• Consider participation in licensure compacts

• Implement specialty licensure by credentials and/or specialty licensure to facilitate
  licensure portability of dental specialists.

• Make provisions available for a limited or volunteer license for dentists who wish to
  provide services without compensation to critical needs populations within a state in
  which they are not already licensed.

• Make provisions available for limited teaching permits for faculty members at teaching
  facilities and dental programs accredited by the Commission on Dental Accreditation.

• Make provisions available for dentists who are active duty military active duty military
  dentists, military spouses and/or veterans of the armed services.

State dental boards are encouraged to grant the same benefits of licensure mobility to
internationally trained dentists who are licensed by their respective jurisdictions.

Licensure by Credentials for Dentists Who Are Not Graduates of CODA-Accredited
Dental Education Programs

State dental societies and dental boards are strongly encouraged to grant the same
benefits of licensure mobility to U.S. currently licensed dentists who were licensed
by their respective jurisdictions prior to state implementation of the requirement for
graduation from a CODA-accredited dental school with a DDS or DMD degree.

BOARD COMMENT: Received after the July-August 2023 Board of Trustees Meeting.
NOTES
Resolution No. 402  New

Report:  N/A  Date Submitted:  May 2023

Submitted By:  Council on Dental Education and Licensure

Reference Committee:  C (Dental Education, Science and Related Matters)

Total Net Financial Implication:  None  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

RESCISSION OF THE POLICY ON REQUIREMENTS FOR BOARD CERTIFICATION

Background: In accord with Resolution 170H-2012, Regular Comprehensive Policy Review (Trans.2012:370), the Council on Dental Education and Licensure has reviewed the policy, Requirements for Board Certification.

The Council reviewed the ADA Requirements for Recognition of Dental Specialties and Certifying Boards for Dental Specialists adopted by the 2022 House of Delegates and noted that the Certification Requirements section of the Requirements for Recognition of National Certifying Boards for Dental Specialists include a specific provision on waivers addressing board eligibility and permits certification boards to have exceptions (such as graduation from a program prior to 1967) which states:

A certifying board may establish an exception (alternative pathway) to the qualification requirement of completion of an advanced education program that is two (2) or more academic years in length accredited by the Commission on Dental Accreditation for the unique candidate who can demonstrate comparable educational and/or training requirements to the satisfaction of the certifying board. A certifying board must submit a separate petition to the National Commission for permission to establish and/or revise policy on alternative pathways.

The Council has concluded that this policy is redundant with the Requirements for Recognition and recommends recission.

Resolution

402. Resolved, that the policy, Requirements for Board Certification (Trans.1975:690; 2018:325) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)
WORKSHEET ADDENDUM
COUNCIL ON DENTAL EDUCATION AND LICENSURE
ADA POLICY TO BE RESCINDED

Requirements for Board Certification (Trans.1975:690; 2018:325)

Resolved, that candidates for board certification who completed the prescribed length of education for board certification in a program of an institution then listed by the Council on Dental Education and Licensure prior to 1967 and who have announced ethically limitation of practice in one of the recognized dental specialties are considered educationally eligible.
**RESCISSION OF THE POLICY ON SPECIALTY AREAS OF DENTAL PRACTICE**

**Background:** In accord with Resolution 170H-2012, Regular Comprehensive Policy Review (Trans.2012:370), the Council on Dental Education and Licensure has reviewed the policy, Specialty Areas of Dental Practice, and believes that this policy is redundant with the ADA Requirements for Recognition of Dental Specialties and Certifying Boards for Dental Specialists (Trans.2001:470; 2004:313; 2009:442; 2013:328; 2018:326; 2022:XXX). Specifically, the Introduction to the Requirements for Recognition states, “Dental specialties are recognized to protect the public, nurture the art and science of dentistry, and improve the quality of care in disciplines of dentistry in which advanced knowledge, skills and training are essential to maintain or restore oral health.” In addition, Requirement (2) states, “A proposed or recognized specialty must be a distinct and well-defined field that requires unique advanced knowledge, skills and training beyond those commonly possessed by dental school graduates as defined by the Commission on Dental Accreditation’s Accreditation Standards for Dental Education Programs.”

Further, Requirement (6), states, “A proposed or recognized specialty must have formal advanced education programs accredited by the Commission on Dental Accreditation that are a minimum of two (2) academic years in length.” The intent of the policy Special Areas of Dental Practice is clearly reflected in the Requirements for Recognition and is duplicative. The Council on Ethics, Bylaws and Judicial Affairs agrees that the policy is duplicative of the Requirements for Recognition and should be rescinded.

Accordingly, the Council recommends that the House rescind the policy statement on specialty areas of dental practice.

**Resolution**


**BOARD RECOMMENDATION:** Vote Yes.

**BOARD VOTE:** UNANIMOUS (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)
Resolved, that the specialty areas of dental practice meet the ADA’s “Requirements for Recognition of Dental Specialties” to assure the public of the competence of the dentist who holds himself/herself out to the public as a specialist who performs services which require formal advanced education, training and skills beyond those commonly possessed by the general practitioner.
RESOLUTION OF THE POLICY ON EXAMINATIONS FOR ALLIED DENTAL (NON-DENTIST) PERSONNEL

Background: In accord with Resolution 170H-2012, Regular Comprehensive Policy Review (Trans.2012:370), the Council on Dental Education and Licensure has reviewed the policy, Examinations for Allied Dental (Non-Dentist) Personnel, and believes that this statement is irrelevant and not necessary. The Council questioned which personnel categories the policy is addressing. It was noted that dental therapist licensure candidates are currently examined together with dental licensure candidates to ensure there is no bias in scoring of the clinical examinations and ensure one standard of care. Further, it was noted that the examination process for dental hygiene licensure candidates is separate from the process for dentists and dental therapists. Because of the ambiguity of the term "allied dental (non-dentist) personnel" and the current practice of examining candidates for dental and dental therapy licensure together and dental hygiene candidates separately, the Council recommends that the House rescind this policy statement.

Resolution


BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)
Examinations for Allied Dental (Non-Dentist) Personnel (Trans.2010:595; 2018:322)

Resolved, that the ADA strongly urges state dental boards to require examination of candidates for dental licensure separately from candidates for allied dental (non-dentist) licensure.
RECISSION OF ADA POLICY ON TOOTH WHITENING ADMINISTERED BY NON-DENTISTS

Background: In accordance with House Resolution 170H-2012, the Council on Scientific Affairs (CSA) reviews Association policies on a broad range of scientific issues every five years. The ADA Policy on Tooth Whitening Administered by Non-Dentists (Trans.2008:477) was first developed in 2008. The Council reviewed this policy as part of its regular review process and recommends rescission. The policy language is provided in the Worksheet Addendum. The following highlights the Council’s reasons for rescission:

- The first resolved clause is redundant. The language reflects the general need for patient education and treatment planning, both of which are topics covered in other ADA policies.

- The second resolved clause is a completed directive. Under House Resolution 73H-2008, the Council developed a report in 2009 that outlined a range of information on whitening/bleaching that can be considered by dentists and their patients (Appendix 1). This report, entitled “Tooth Whitening/Bleaching: Treatment Considerations for Dentists and Their Patients,” was submitted alongside a formal petition to the FDA in 2009.

- The third resolved clause is a completed directive. In 2008, the House passed Resolution 73H-2008, which directed the Council on Government Affairs (CGA) to prepare a formal petition to the U.S. Food and Drug Administration (FDA) classifying extra coronal whitening/bleaching products. A CSA report was submitted in support of the petition in 2009. The FDA denied the petition in 2014 citing lack of sufficient data to support its underlying claims.

- The fourth resolved clause is redundant and not supported by currently available science. Furthermore, the language in the policy reflects the need for advocacy to support a position that is not supported by the FDA nor by currently available data.

Upon review, the Council determined that the policy as written is outdated, redundant, and contains multiple completed directives. As such, the Council recommends rescission of the policy. In reviewing this policy, the Council sought feedback from the Councils on Dental Practice (CDP), Government Affairs (CGA), and Ethics, Bylaws, and Judicial Affairs (CEBJA), all of whom expressed alignment and support of this recommendation.
405. Resolved, that the policy titled Tooth Whitening Administered by Non-Dentists (Trans.2008:477) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS
Tooth Whitening Administered by Non-Dentists (*Trans.*2008:477)

**Resolved**, that the American Dental Association supports educating the public on the need to consult with a licensed dentist to determine if whitening/bleaching is an appropriate course of treatment, and be it further

**Resolved**, that the Council on Scientific Affairs compile scientific research to describe treatment considerations for dentists prior to the tooth whitening/bleaching procedure in order to reduce the incidence of adverse outcomes and report these findings to all state dental associations, and be it further

**Resolved**, that the American Dental Association petition the Food and Drug Administration to properly classify tooth whitening/bleaching agents in light of the report from the Council on Scientific Affairs, and be it further

**Resolved**, that the American Dental Association urges constituent societies, through legislative or regulatory efforts, to support the proposition that the administering or application of any intra-oral chemical for the sole purpose of whitening/bleaching of the teeth by whatever technique, save for the lawfully permitted self application and application by a parent and/or guardian, constitutes the practice of dentistry and any non-dentist engaging in such activity is committing the unlicensed practice of dentistry.
Appendix 1

Tooth Whitening/Bleaching: Treatment Considerations for Dentists and Their Patients

ADA Council on Scientific Affairs

Introduction

Over the past two decades, tooth whitening or bleaching has become one of the most popular esthetic dental treatments. Since the 1800s, the initial focus of dentists in this area was on in-office bleaching of non-vital teeth that had discolored as a result of trauma to the tooth or from endodontic treatment. By the late 1980s, the field of tooth whitening dramatically changed with the development of dentist-prescribed, home-applied bleaching (tray bleaching) and other products and techniques for vital tooth bleaching that could be applied both in the dental office and at home.

The tooth whitening market has developed into four categories: professionally applied (in the dental office); dentist-prescribed/dispensed (patient home-use); consumer-purchased/over-the-counter (OTC) (applied by patients); and other non-dental options (e.g., mall kiosks, spa settings, cruise ships). Additionally, dentist-dispensed bleaching materials are sometimes used at home after dental office bleaching to maintain or improve whitening results.

Consumer whitening products available today for home use include gels, rinses, chewing gums, toothpastes, paint-on films and strips. The latest tooth whitening trend is the availability of whitening treatments or kits in non-dental retail settings, such as mall kiosks, salons, spas and, more recently, aboard passenger cruise ships. Non-dental whitening venues have come under scrutiny in several states and jurisdictions, resulting in actions to reserve the delivery of this service to dentists or appropriately supervised allied dental personnel.

Current tooth bleaching materials are based primarily on either hydrogen peroxide (H₂O₂) or carbamide peroxide. Both may change the inherent color of the teeth, but have different considerations for safety and efficacy. In general, most in-office and dentist-prescribed, at-home bleaching techniques have been shown to be effective, although results may vary depending on such factors as type of stain, age of patient, concentration of the active agent, and treatment time and frequency. However, concerns have remained about the long-term safety of unsupervised bleaching procedures.

Although published studies tend to suggest that bleaching is a relatively safe procedure, investigators continue to report adverse effects on hard tissue, soft tissue, and restorative materials. The rate of adverse events from use or abuse of home-use OTC products is also unclear because consumers rarely report problems through the FDA Medwatch system. Based on these factors, the ADA has advised patients to consult with their dentists to determine the most appropriate whitening treatment, particularly for those with tooth sensitivity, dental restorations, extremely dark stains, and single dark teeth. Additionally, a patient’s tooth discoloration may be caused by a specific problem that either will not be affected by whitening agents and/or may be a sign of disease or pathology that requires dental therapy.

The purpose of this report is to outline treatment considerations for dentists and their patients prior to tooth whitening/bleaching procedures so that the potential for adverse effects can be minimized. This report does not address agents used for non-vital intracoronal bleaching procedures.
Safety Concerns with Tooth Bleaching Materials

Concerns regarding the safety of all bleaching treatments and products have long existed, but were heightened since the introduction of at-home bleaching. Discussions in this section focus on peroxides and their use as active ingredients in tooth bleaching materials. Important concerns related to patient examination and diagnoses are addressed elsewhere in this report.

A variety of peroxide compounds, including carbamide peroxide, H$_2$O$_2$, sodium perborate and calcium peroxide, have been used as active ingredients for bleaching materials; however, essentially all extracoronal bleaching materials currently available for whitening of vital teeth in the United States contain carbamide peroxide and/or H$_2$O$_2$. Recently, products containing chlorine dioxide were introduced in the United Kingdom, but there is no evidence that tooth bleaching products using chlorine dioxide as the active ingredient are safer than peroxide-based materials. In fact, safety concerns have been documented with chlorine dioxide and its use for tooth bleaching treatment due to the low pH of the material and resultant tooth etching.

Most OTC bleaching products are H$_2$O$_2$-based, although some contain carbamide peroxide. Carbamide peroxide decomposes to release H$_2$O$_2$ in an aqueous medium: 10% carbamide peroxide yields roughly 3.5% H$_2$O$_2$. In-office bleaching materials contain high H$_2$O$_2$ concentrations (typically 25-38%), while the H$_2$O$_2$ content in at-home bleaching products usually ranges from 3% to 7.5%; however, there have been home-use products containing up to 15% H$_2$O$_2$.

Safety issues have been raised regarding the effects of bleaching on the tooth structure, pulp tissues, and the mucosal tissues of the mouth, as well as systemic ingestion. Regarding mucosal tissues, safety concerns relate to the potential toxicological effects of free radicals produced by the peroxides used in bleaching products. Free radicals are known to be capable of reacting with proteins, lipids and nucleic acids, causing cellular damage. Because of the potential of H$_2$O$_2$ to interact with DNA, concerns with carcinogenicity and cocarcinogenicity of H$_2$O$_2$ have been raised, although these concerns so far have not been substantiated through research. However, studies have shown that H$_2$O$_2$ is an irritant and also cytotoxic. It is known that at concentrations of 10% H$_2$O$_2$ or higher, the chemical is potentially corrosive to mucous membranes or skin, causing a burning sensation and tissue damage. During office bleaching treatment, which routinely uses materials of ≥25% H$_2$O$_2$, severe mucosal damage can occur if gingival protection is inadequate. Clinical studies have also observed a higher prevalence of gingival irritation in patients using bleaching materials with higher peroxide concentrations.

Data accumulated over the last 20 years indicate no significant, long-term oral or systemic health risks associated with professional at-home tooth bleaching materials containing 10% carbamide peroxide (3.5% H$_2$O$_2$). However, these data were collected from studies conducted by dental professionals, and there is no safety evidence on bleaching materials that do not involve dental professionals, regardless of H$_2$O$_2$ concentration or application venue. Additionally, consumers are not generally aware of how to report adverse events through FDA’s Medwatch system. If a licensed dental professional is not consulted when patients use OTC bleaching products, many adverse effects may go unreported.

Regarding hard tissues, transient mild to moderate tooth sensitivity can occur in up to two-thirds of users during early stages of bleaching treatment. Sensitivity is generally related to the peroxide concentration of the material and the contact time; it is most likely the result of the easy passage of the peroxide through intact enamel and dentin to the pulp during a five- to 15-minute exposure interval. However, there have been no reported long-term adverse pulpal sequellae when proper techniques are employed. The incidence and severity of tooth sensitivity may depend on the quality of the bleaching material, the techniques used, and an individual’s response to the bleaching treatment methods and materials. To date, there is little published evidence documenting adverse effects of dentist-monitored, at-home whiteners on enamel, but two clinical cases of significant enamel damage have been reported, apparently associated with the use of OTC whitening products. This damage may be related to the low pH of the products and/or overuse.
In vitro studies suggest that dental restorative materials may be affected by tooth bleaching agents.\(^1,17\) These findings relate to possible physical and/or chemical changes in the materials, such as increased surface roughness, crack development, marginal breakdown, release of metallic ions, and decreases in tooth-to-restoration bond strength. Such findings have not appeared in clinical reports or studies.

To address the safety of bleaching materials, the American Dental Association (ADA) convened a panel of experts in 1993. The ADA subsequently published its first set of guidelines for evaluating peroxide-containing tooth whiteners.\(^18\) These guidelines have been revised periodically.

In March 2005, the European Scientific Committee on Consumer Products (SCCP) concluded the following: “The proper use of tooth whitening products containing >0.1 to 6.0% hydrogen peroxide (or equivalent for hydrogen peroxide-releasing substances) is considered safe after consultation with and approval of the consumer’s dentist.”\(^11\) The SCCP, in January 2008, again recommended that up to 6% H\(_2\)O\(_2\) is a safe limit to use for at-home tooth bleaching; however, it did not recommend use of such products without dental consultation.\(^19\)

In summary, available data indicate that extracoronal bleaching treatment in the dental office or at home may cause short-term tooth sensitivity and/or gingival irritation. More severe mucosal damage is possible with high H\(_2\)O\(_2\) concentrations. While available evidence supports the safety of using bleaching materials of 10% carbamide peroxide (3.5% H\(_2\)O\(_2\)) by dental professionals, there are concerns with the use of at-home bleaching materials with high H\(_2\)O\(_2\) concentrations. Studies designed specifically to assess the long-term safety of high H\(_2\)O\(_2\) concentration in at-home bleaching materials are needed, especially for repeated use of these products. There appears to be insufficient evidence to support unsupervised use of peroxide-based bleaching materials.

Similar to other dental and medical interventions, questions have been raised about the safety of tooth whitening treatments during pregnancy. In the absence of such evidence, clinicians may consider recommending that tooth whitening be deferred during pregnancy.

The safety of tooth bleaching for children and adolescents is also a consideration. More research is needed to establish appropriate use and limitations for these patients. However, bleaching is a conservative approach compared with restorative options when tooth discoloration causes significant concern. If possible, delaying treatment until after permanent teeth have erupted is recommended, as is use of a custom-fabricated bleaching tray to limit the amount of bleaching gel.\(^20\) Close professional and parental/guardian supervision are needed to maximize benefits and minimize adverse effects and overuse.

**Bleaching Treatment Considerations**

**General Considerations**

A typical dental examination begins with a health and dental history. Intra-oral and extra-oral examinations of the hard and soft tissues of the mouth and head are also conducted to exclude or diagnose cancer, abscesses, periodontal disease, and other pathology. Seminal to decisions regarding tooth bleaching, the patient history would include the patient’s opinions regarding the cause of tooth discoloration, a history of allergies (which may include ingredients in bleaching materials), and information regarding any past problems with tooth sensitivity. Some tooth discolorations may be the result of pathology or conditions that require endodontic therapy, restorations or dental surgery. Such diagnoses can only be made by a dentist or another licensed health care professional, depending on local licensing regulations. In light of these and additional factors noted below, a dental examination with appropriate radiographs or other screening or diagnostic tests is recommended prior to considering tooth bleaching.

Bleaching discolored teeth in which the color change is the only visible indication of underlying pathology may change tooth color, but will not remove any underlying pathology. This masking effect, which can occur in abscessed teeth and teeth with external or internal resorption, can result in tooth loss or other complications.
Dental caries or leaking restorations may also cause teeth to appear dark. Patients should be advised that bleaching treatments will not remove tooth decay that may subsequently progress and result in the need for more extensive and expensive treatments. Examination of tooth function and para-function may reveal conditions that could affect bleaching procedures. For example, bruxism, temporomandibular dysfunction, or other conditions may be aggravated by use of bleaching trays. Radiographs may be necessary to aid in screening and diagnosis of pathologies that may manifest as tooth discoloration, such as periapical abscess, anomalous pulp chamber size and anatomy, calcific metamorphosis, root resorption or other pathoses. A history of tooth sensitivity should be investigated carefully to determine the cause(s) and whether treatment before tooth bleaching will benefit the patient.

A dental examination will identify and record the presence and locations of existing tooth restorations. This step may be quite important to an acceptable tooth bleaching outcome, since restorations do not change color. Dental restorations can also be a cause of tooth discoloration: metallic and other restorative materials may influence tooth color significantly depending on the translucency and thickness of the remaining tooth structure.

Patient expectations may be unrealistic unless cosmetic issues with existing restorations are addressed initially. Additional examination considerations include: tooth/enamel cracks and related sensitivity; exposed root surfaces (that resist bleaching); and other smile considerations such as translucency or defects in tooth form or anatomy.

Patient habits and lifestyle, as well as the presence of removable or fixed appliances or prostheses, should also be considered during an examination. Pre-treatment photographs are often helpful to record a baseline to better assess treatment success.

Upon completion of the dental examination and diagnosis, treatment may be recommended and prioritized. Although the patient’s primary concern may be tooth discoloration, bleaching procedures may not be recommended (or effective) until other problems are addressed. If dental restorations are present, often the expense and/or the risks related to the replacement fillings or crowns to match post-bleaching tooth color may contraindicate bleaching.

When bleaching is pursued, the dental team will consider and recommend the appropriate materials, techniques, and delivery systems to best serve the patient’s needs and desires (see next section for further discussion of method-specific considerations). These factors affect the costs and may influence treatment decisions.

The length of treatment and expected outcome will depend on the discoloration etiology and diagnosis, as well as the chosen product and technique. Dentists can discuss these concerns with their patients in the treatment plan development process. Success will vary when tooth discoloration is related to inherited/developmental aspects, age-related tooth changes, extrinsic staining (e.g., from diet or smoking), or intrinsic staining such as tetracycline-associated stain or color change secondary to tooth trauma.

If a patient has a history of sensitive teeth, or experiences sensitivity during tooth bleaching, appropriate measures can be initiated to minimize and manage further discomfort before, during and after tooth bleaching. Pre-treatment options may include use of non-steroidal anti-inflammatory drugs (NSAIDs), fluoride, amorphous calcium phosphate, or potassium nitrate. During treatment, it may be necessary to select an alternate bleaching product, or change the delivery system, treatment duration or treatment interval. Depending on the patient’s response, side effects or other issues, it may be in the patient’s best interest to discontinue treatment.

**Method-Specific Considerations**

Dentist-managed bleaching treatments may include in-office bleaching, at-home use of bleaching trays at night or during the day, or a combination of these treatment methods. Additionally, the need for and
effectiveness of maintenance or periodic re-treatment can be addressed depending on the patient’s individual response to tooth whitening. A dental examination, including any necessary radiographs, should precede re-treatment.

Other considerations consistent with those covered previously, such as the presence or history of sensitivity, presence of dental restorations, and occlusal/temporomandibular dysfunction may raise method-specific concerns that merit attention as well. Allergies to bleaching tray materials, isolation barriers, or bleaching materials may also limit treatment options.

With the tray bleach method, if tooth sensitivity is problematic, the tray may be used in advance for the application of potassium nitrate for ten to 30 minutes. Use of potassium nitrate-containing toothpaste before bleaching and throughout the bleaching therapy can also help minimize side effects. Higher peroxide concentrations result in more sensitivity without significantly shortening the treatment time, since the tooth can only change color at a certain rate, regardless of the peroxide concentration of the materials.

Although brown discolorations respond well to bleaching, white discolorations remain unchanged, though the background may be lightened to make the white areas less noticeable. Occasionally, bleaching may need to be combined with abrasion techniques or bonded restorations to address non-esthetic white areas. With tray bleaching, teeth normally lighten in three days to six weeks. However, nicotine-stained teeth may take one to three months, and tetracycline-stained teeth may require two to six months (or more) of nightly treatment.

Bleaching products should ideally be formulated at neutral pH. Carbamide peroxide seems to be more effective overnight as a result of its urea content elevating the pH to desirable levels. Hydrogen peroxide formulations are short-acting and have a lower pH. Bleaching with H₂O₂ takes more days but less time per day, while carbamide peroxide takes fewer days but more contact time. The choice between the two types of products relate to the patient’s lifestyle, caries history, tooth sensitivity, and discoloration type. The need for re-treatment also varies widely, from as soon as one to three years after initial treatment to more than ten years.

With in-office bleaching, both proper isolation and protection of mucosal tissues are essential. Dentists may also wish to consider prescribing non-steroidal anti-inflammatory medications prior to treatment, since post-treatment sensitivity is unpredictable. The treatment schedule may also be a useful method to help minimize tooth sensitivity. Multiple appointments are typically scheduled one week apart to allow sensitivity to abate. A “bleaching light” is sometimes used with in-office bleaching procedures as well. Some reports suggest that pulpal temperature can increase with bleaching light use, depending on the light source and exposure time. Pulpal irritation and tooth sensitivity may be higher with use of bleaching lights or heat application, and caution has been advised with their use.

There is conflicting evidence on the effects of bleaching lights on tooth color change. Most studies comparing effectiveness of in-office bleaching with or without light application were conducted in vitro. The effects on tooth color change were variable, and some differences detected electronically were not detectable visually. This observation was reported in a recent clinical study report as well. Of studies conducted in vivo, most found no added benefit for light-activated systems. Heat and light application may initially increase whitening due to greater dehydration, which reverses with time. Actual color change will not be evident until two to six weeks after bleaching treatment.

The average number of in-office visits for maximum whitening is three, with a range of one to six visits, so the patient should be prepared for additional in-office treatments or for a combination of office visits and tray delivery to complete the process.

As noted previously, the unsupervised use of OTC whitening products raises concerns about possible masking of undiagnosed pathology (whether related to tooth discoloration or not), cosmetic or functional aspects of existing dental restorations, and unknown allergies or other untoward responses. In addition to these safety concerns, absent a dental examination and consultation, user expectations may not be realistic.
Finally, bleaching offered in a mall kiosk or other non-dental venue may present the image of a dental practice and professional supervision without providing the benefits of care from fully trained and licensed oral health care providers.

**Regulatory and Scope of Practice Aspects of Bleaching Treatment**

Presently, all extracoronal tooth bleaching products remain unclassified by the U.S. Food and Drug Administration (FDA). This includes all peroxide-based products used in the in-office, dentist-dispensed products for at-home use, OTC (patient-purchased) products, as well as products used in non-dental settings.

In the early 1990s, the FDA proposed regulating the peroxide-based bleaching materials as drugs and sent warning letters to manufacturers. The FDA’s position was challenged legally, and in alignment with court decisions, the FDA suspended attempts to classify the bleaching materials. To date, the FDA has taken no further action to classify tooth bleaching products.

Products from reputable manufacturers are developed and marketed according to U.S. “cosmetic” regulations. This may lead to the perception that the products are innocuous, though they have the potential to cause harm and may result in undesirable effects to the teeth or oral mucosa. Such adverse effects are generally related to low pH and poor product quality.

The recent appearance of tooth-bleaching businesses in non-dental settings has led to state dental board decisions, attorney general opinions, and legislation in some states. Some jurisdictions have taken recent action to better limit patient risks associated with tooth bleaching. These include: Florida, Iowa, Massachusetts, Nevada, New Jersey, Tennessee and the District of Columbia.

Concerns regarding tooth bleaching in non-dental settings have been raised. Non-dental personnel lack the knowledge, resources (such as radiographs), education and license needed to provide dental examinations. The facilities generally lack effective infection control capabilities and protocols, personnel are not trained in standard infection control precautions and may not be prepared to provide emergency care for allergic reactions.

Tooth bleaching in the United Kingdom (U.K.) emerged in conflict with existing regulations that applied to hairdressers and the use of hydrogen peroxide. Steps toward resolution of this conflict are underway, including an extensive review of tooth bleaching safety data. As noted previously, the Scientific Committee for Consumer Products (SCCP) in Europe supported the safety of tooth bleaching materials containing up to 6.0% H₂O₂ for use by dental professionals. It is expected that this SCCP recommendation will eventually be ratified by the European Council and by the U.K. government. The timeline for these actions is unclear at present.

**Rationale for Dental Professional Involvement in Extracoronal Bleaching Treatment**

Dental professionals are responsible for managing patient care, and are a key resource on oral health to the public at large. Consumers may pursue tooth bleaching without understanding the risks of treatment or the factors that may affect treatment success or failure. For optimal safety and to ensure proper diagnosis and treatment, examination by a dentist is necessary. To aid in patient communication on whitening/bleaching, a helpful summary of considerations is available that can also be used as a resource for the public at large.

As discussed previously, tooth discoloration, particularly intrinsic discolorations, may not be amenable to bleaching. Bleaching materials can affect filling materials, and may also result in color mismatch of teeth with existing fillings or crowns. Therefore, pre-treatment examination and routine monitoring of bleaching by dentists allow for professional assessment of each patient’s situation, recommendations for methods and/or materials to help minimize problems, as well as earlier detection and better management of any adverse effects. Professionally performed or supervised bleaching reduces the risk of patients selecting and using inferior products, inappropriate application procedures and/or product abuse.
Summary

Tooth bleaching is one of the most conservative and cost-effective dental treatments to improve or enhance a person’s smile. However, tooth bleaching is not risk-free and only limited long-term clinical data are available on the side effects of tooth bleaching. Accordingly, tooth bleaching is best performed under professional supervision and following a pre-treatment dental examination and diagnosis.

In consultation with the patient, the most appropriate bleaching treatment option(s) may be selected and recommended based on the patient’s lifestyle, financial considerations, and oral health. Patients considering OTC products should have a dental examination, and should be reminded that they may unknowingly purchase products that may have little or no beneficial effect on the color of their teeth and may also have the potential to cause harm.

References

5. Li Y. Biological properties of peroxide-containing tooth whiteners. Food and Chem Toxicology 1996; 34:887-904.


REPORT 6 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: ADA LIBRARY AND ARCHIVES ADVISORY BOARD ANNUAL REPORT

Background: In November 2013, the ADA House of Delegates approved the ADA Library and Archives Transition Plan, including the establishment of a volunteer board to oversee operations of the ADA Library and Archives. An engaged and functioning advisory board is considered a best practice for library management. The ADA Library and Archives Advisory Board serves in an advisory capacity to the Board of Trustees.

At its July/August 2023 meeting, the Board of Trustees approved the appended Annual Report of the ADA Library Archives Advisory Board for transmittal to the 2023 House of Delegates.

Resolutions

This report is informational, no resolutions are presented.

BOARD RECOMMENDATION: Vote Yes to Transmit.

BOARD VOTE: UNANIMOUS* (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)

*Dr. Irani was not in attendance.
Appendix 1

ADA Library & Archives Advisory Board

Graham, Frank J., 2022, Board of Trustees, 4th District (chair)
Liddell, Rudolph T., 2022, Board of Trustees, 17th District
Kademani, Deepak, 2023, Minnesota, Council on Scientific Affairs
Lefebvre, Carol A., 2022, Georgia, Council on Scientific Affairs
Keith Coble, Shandra, 2023, Alabama, Council on Dental Education and Licensure
Mousel, Barbara L., 2023, Illinois, Council on Dental Education and Licensure
Marcos, Carliza A., 2023, California, at-large member
Segelnick, Stuart, 2023, New York, at-large member
De Groote, Sandy, 2023, public member, special/dental librarian
Nickisch Duggan, Heidi, director, ADA Library & Archives
Fleming, Anna, electronic resources & research services librarian, ADA Library & Archives
Matlak, Andrea, archivist & metadata librarian, ADA Library & Archives
O’Brien, Kelly, informationist, ADA Library & Archives
Pontillo, Laura, coordinator, ADA Library & Archives
Strayhorn, Nicole, data informationist, ADA Library & Archives

Areas of Responsibility

The areas of responsibility for the ADA Library & Archives Advisory Board (LAAB) are as follows:

- Creating and developing the mission and strategic plan of the ADA Library & Archives.
- Ensuring that the ADA Library & Archives remain relevant to the ADA strategic plan.
- Providing input during the annual ADA budgeting process on library funding, priorities and needs.
- Adopting policies and rules regarding library governance, assets and use; developing, approving, and codifying all policies, based on input from the library staff; also delegating procedural work to the library staff.
- Regularly planning and evaluating the service program.
- Evaluating the library facility to ensure that it continues to meet ADA member and ADA staff needs.
- Launching a marketing plan for the promotion of the ADA Library & Archives to ADA members; ADA component and constituent societies; the local dental and medical communities; and affiliated dental organizations.
- Conducting the business of the library in an open and ethical manner in compliance with all applicable laws and regulations and with respect for the association, staff and public.

Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures

Objective 1: Grow Active, Full Dues Paying Membership

Initiative/Program: Scientific Support/Utilization of Library Content

Success Measure: Achieve a 5% variance in the number of user searches via electronic resources from prior year, by December 2022.

Target: 133,606 (Regular and automated searches)

Range: 126,926 – 140,287
Outcome: 130,286

Usage statistics show continued and increased use of the library’s electronic resources (journals, databases, e-books, clinical resources). ADA members and staff conducted approximately 2% more regular and automated searches in 2022 over 2021’s 127,244 regular* and automated** searches. This outcome is not inclusive of all the databases members can access.

*Regular Searches refers to the number of times a user searches a database, where they have actively chosen that database from a list of options or there is only one database available to search.

**Automated Searches refers to the number of times a user searches a database, where they have not actively chosen that database from a list of options. That is, Searches Automated is recorded when the platform offers a search across multiple databases by default, and the user has not elected to limit their search to a subset of those databases.

Table 1: Top 5 Most Heavily Searched Subscribed Databases, 2022

<table>
<thead>
<tr>
<th>Rank</th>
<th>Database Name</th>
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<tbody>
<tr>
<td>1</td>
<td>Dentistry &amp; Oral Sciences Source</td>
</tr>
<tr>
<td>2</td>
<td>MEDLINE Complete</td>
</tr>
<tr>
<td>3</td>
<td>Cochrane Database of Systematic Reviews</td>
</tr>
<tr>
<td>4</td>
<td>CINAHL Complete</td>
</tr>
<tr>
<td>5</td>
<td>DynaMed</td>
</tr>
</tbody>
</table>

Dentistry & Oral Sciences Source (DOSS) is a full-text database covering all facets of dentistry including dental public health, endodontics, facial pain and surgery, odontology, oral and maxillofacial pathology/surgery/radiology, pediatric dentistry, and periodontology. MEDLINE Complete and CINAHL Complete provide access to over 7,000 journals covering various health disciplines including medicine, nursing, consumer health, and dentistry. Health Business Elite provides access to more than 600 journals on healthcare administration and management.

Objective 2: Grow Active, Full Dues Paying Membership

Initiative/Program: Scientific Support/Utilization of Library Content

Success Measure: Achieve a 5% variance in the number of unique item investigations and full-text downloads via electronic resources from prior year by December 2022.

Target: 37,786

Range: 35,897 – 39,676

Outcome: Exceeded, 42,876

Downloads and unique item investigations (the number of unique content items (e.g., chapters) investigated by a user) are more difficult to predict because ADA staff and members tend to search for known items and ask for staff assistance when conducting more open research, for instance, to answer a clinical question. As a result, ADA Library & Archives staff search more broadly, thus increasing the total search numbers but selecting fewer and more focused full-text downloads than the typical user might. ADA Library & Archives service goals influence sending only the most relevant full-text downloads combined with abstracts and citations to prompt user evaluation.
### Table 2: Downloads & Unique Item Investigations, 2022

<table>
<thead>
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<th>Target</th>
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<tr>
<td>37,786</td>
<td>42,876</td>
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### Table 3: Top 10 Journals by Article Downloads, 2022

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<th>Journal</th>
<th>Downloads</th>
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<tbody>
<tr>
<td>The Journal of the American Dental Association</td>
<td>6,678</td>
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<tr>
<td>The Journal of Prosthetic Dentistry</td>
<td>1,473</td>
</tr>
<tr>
<td>American Journal of Orthodontics and Dentofacial</td>
<td>1,226</td>
</tr>
<tr>
<td>British Dental Journal</td>
<td>1,176</td>
</tr>
<tr>
<td>Dental Clinics of North America</td>
<td>966</td>
</tr>
<tr>
<td>Journal of Dentistry</td>
<td>824</td>
</tr>
<tr>
<td>Journal of Endodontics</td>
<td>593</td>
</tr>
<tr>
<td>Clinical Oral Implants Research</td>
<td>555</td>
</tr>
<tr>
<td>Journal of Esthetic and Restorative Dentistry</td>
<td>511</td>
</tr>
<tr>
<td>Clinical Oral Investigations</td>
<td>480</td>
</tr>
</tbody>
</table>

### Table 4. Top 10 eBook Title Usage, 2022

<table>
<thead>
<tr>
<th>Title</th>
<th>Usage</th>
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</thead>
<tbody>
<tr>
<td>Fairness in Educational and Psychological Testing:...</td>
<td>99</td>
</tr>
<tr>
<td>Newman and Carranza’s Clinical Periodontology</td>
<td>52</td>
</tr>
<tr>
<td>Ingle’s Endodontics</td>
<td>45</td>
</tr>
<tr>
<td>Anesthesia Complications in the Dental Office</td>
<td>21</td>
</tr>
<tr>
<td>Manual of Minor Oral Surgery for the General...</td>
<td>18</td>
</tr>
<tr>
<td>Oral Health and Aging</td>
<td>18</td>
</tr>
<tr>
<td>Endodontics - E-Book: Principles and Practice</td>
<td>17</td>
</tr>
<tr>
<td>Contemporary Fixed Prosthodontics</td>
<td>17</td>
</tr>
<tr>
<td>Esthetic Soft Tissue Management of Teeth and...</td>
<td>13</td>
</tr>
<tr>
<td>Craig’s Restorative Dental Materials</td>
<td>11</td>
</tr>
</tbody>
</table>
Emerging Issues and Trends

Libraries continue to maximize resources through the expanded use of digital and electronic means to convey information to their patrons. The ADA Library & Archives continually reviews these rapid changes in order to remain relevant to ADA Members and the profession.

The ADA Library & Archives Advisory Board is committed to:

1. Expanding access to state and local society-published dental literature through Resolution 411H-2022

In dental and oral health research, there is a growing need for storing, moving, finding, sharing, and accessing digital publications and their associated data files. The 2022 House of Delegates passed Resolution 411 directing the ADA to establish a searchable digital archive of state and component publications. The supporting funds approved in 2022 enable the ADA to curate and maintain dental and oral health scholarly works using advanced technologies and make it possible to hire specialized personnel to collaborate with the state and local societies in this important endeavor.

Purpose: This open digital archive of scientific research, literature, and Tripartite publications, events, digital collections and more, ensures global discoverability and findability to dental professionals and other researchers all over the world. The enhanced visibility of individual publications also serves to increase author submissions. This online archive is intended to include curated collections tailored for dental and oral health research needs: state and local journals, newsletters, photograph collections, webinars and conference videos, other events, data sets, etc. The site is geared toward dental and oral health professionals, educators, researchers, and the public.

Progress: Digital Commons has been selected as the platform that meets the expressed needs of our members and society editors. The ADA's Digital Commons instance is called ADACommons.

The library team has been working closely with Digital Commons consultants to design the digital archive, establish the internal structures and administration of the repository and engage in training to fully realize and implement the architectural design and journal publishing features of the platform. This process is a several months-long process, but the careful planning in the early developmental stages of the project will help ensure an increasingly valuable dental archive for the future, a stable and fully functional journal publishing platform, and repository for other Tripartite digital assets. Additionally, the library team is developing a workflow for accepting and ingesting publications and identifying policy issues and needs around the digital archives including copyright and reprints. Staff have given multiple presentations, including for publications teams and the ADA Power of Three and the American Association of Dental Editors and Journalists (AADEJ) webinars to engage with and gather participation interest from states and components for inclusion in the digital archive. Now that the repository is underway, recruiting for a Digital Publishing and Archives Librarian and Digital Archives Assistant has begun.

Future Plan: ADACommons will go live in July 2023, under the URL commons.ada.org. At that point the ingest of content from state and local components for global utilization can begin. Several states have already begun the planning and design phases of their journals and other publications and will go live on a continuing basis. ADACommons team will continue to provide training for editors and staff to ensure knowledge transfer for all aspects of the content and editorial management systems. ADACommons will be on display at the ADA Library & Archives booth in Dental Central at SmileCon in October 2023. The team can be reached at commons@ada.org.
2. **World-wide Remote Access**

Providing efficient searching using current eResources and making the ADA Library & Archives a 24/7 knowledge center.

a. This was partially accomplished by the implementation of DISCOVERY and OpenAthens, an identity access management tool that allows members to access subscribed electronic content 24/7.

![ADA Commons](image)

<table>
<thead>
<tr>
<th>Year</th>
<th>Accesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>5,234</td>
</tr>
<tr>
<td>2019</td>
<td>5,040</td>
</tr>
<tr>
<td>2020</td>
<td>5,591</td>
</tr>
<tr>
<td>2021</td>
<td>9,923</td>
</tr>
<tr>
<td>2022</td>
<td>10,015</td>
</tr>
</tbody>
</table>

**Table 5. OpenAthens Usage***
*On-site (ADA building at 211 E. Chicago) usage is not reflected in these statistics; complete resource use is much higher and includes staff use, in-house and clinical guidelines research, etc.

### Table 6: OpenAthens Users by Country in 2022

![Map of OpenAthens Users by Country in 2022]

b. Improvements to the website and access management have made services and resources increasingly accessible, and library staff continue to see a rise in members’ remote and independent use of electronic resources to perform searches and article retrieval. In many cases, the member does not have to enter a resource from the ADA Library’s webpage but can authenticate from within a journal website or other resource on the internet. Even so, the library saw nearly 9000 new users engage with library webpages in 2022.

<table>
<thead>
<tr>
<th>Table 7: Top 5 States using the library website in 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Illinois</td>
</tr>
<tr>
<td>2. California</td>
</tr>
<tr>
<td>3. Louisiana</td>
</tr>
<tr>
<td>4. Indiana</td>
</tr>
<tr>
<td>5. Florida</td>
</tr>
</tbody>
</table>

c. Continued interlibrary loan (ILL) services to provide ADA Staff and members with scholarly articles not held in the collections of the ADA Library & Archives (borrowing) and providing those same services to outside researchers via other libraries (lending). In 2022, outside libraries fulfilled 74% of ILL requests made by ADA members and staff. ADA Library staff fulfilled 63% of ILL requests from outside libraries. From late April through May 2022, staff were not able to provide any interlibrary loan services to either ADA staff and members or outside libraries due to the cybersecurity event. This event contributed to the decrease in interlibrary loan requests in 2022 over previous years.
d. New Electronic Resources

i. eBooks:
1. Oral Health & Aging (2022)
3. Wilkins' Clinical Practice of the Dental Hygienist (2021)

ii. Databases:
InCites: This important resource is a research analytics and evaluation tool designed to help showcase research program's strengths, identify influential researchers, analyze institutional productivity, and visualize collaborators around the world. InCites enables deep analysis of research publication trends and citation patterns. Research performance benchmarking can be accomplished at various levels – individual researchers, groups, organizations, countries, journals, and research areas.
3. Information Services

Reference and information services and access to a robust collection of evidence-based resources remain one of the most visible values the ADA Library & Archives offers to members.

a. In 2022, library staff conducted research for over 200 in-depth clinical queries for ADA members and staff, each requiring 2 hours or more of research. This was in addition to countless daily ready reference questions.

b. In addition to member support, the ADA Library & Archives staff continue to provide robust reference services to various ADA divisions and departments including, ADA Science and Research Institute (ADASRI), the Practice Institute, and the Health Policy Institute. The ADA Library & Archives Informationist Kelly O’Brien actively engages in expert searching for clinical practice guideline development, systematic reviews, and other evidence synthesis, provides education and access to evidence-based clinical tools and drug information, and provides expert support for ADA initiatives and publications including:

1. Direct materials for restoring caries lesions clinical practice guideline and systematic review (published in 2023)
2. FDA-ADA joint statement on dental radiographs update (did updates for panel meeting and IADR submissions)
3. A report on the connection between diabetes and home oral care (to be published 2023)
4. An update of the pediatric topical fluoride measure for the National Quality Health Forum via the ADA Dental Quality Alliance
5. A report in response to the NCCIH Whole Person Health request for information suggesting “number of teeth” be added to their measures of whole person health

4. ADA Archives and Dental History

The ADA Archives is the official repository of the Association’s historical publications and records. The Archives collections are maintained by Ms. Andrea Matlak, Archivist & Metadata Librarian, who also provides expert reference and research assistance to ADA staff, members, and other dental organizations and institutions searching for information on ADA history, history of dentistry, and biographical information on individuals involved in the profession.

- Compiled timeline to document diversity, equity, and inclusion milestones at the American Dental Association throughout its history at the request of the Diversity, Equity & Inclusion Joint Action Team (made up of leaders from four Councils/Committees). The timeline summarily documents the history of diversity, equity, and inclusion at the ADA and includes milestones such as racial and gender precedents, officer appointments, and elimination of race-based impediments to ADA membership.

- Answered queries from ADA staff, ADA members, and members of the public on a variety of topics on the history of dentistry and people involved in its history.

- Assisted ADA staff answering requests for information including: for Membership Division staff provided information on African Americans who served as officers of the ADA for an ADA officer participating in a panel for Black History month; for ADA Business Group staff provided information on the origins of Dudley the Dragon as ADA mascot; for Council on Dental Education & Licensure and Legal staff located information on the final report of the Oral Preventive Assistant (OPA) curriculum & licensing agreement; for Communications staff found information on the history of toothpaste in preparation for a media interview;
for Product Development & Sales staff found and provided a copy of the ADA’s first patient brochure on periodontal disease for a presentation.

5. Data Visualization Services

Providing expertise in data visualization to drive policy, planning, and other decision making in support of ADA initiatives, publications, and strategic goals. The ADA Library & Archives Data Informationist Nicole Strayhorn actively collaborates with multiple divisions across the ADA to consult and provide data visualization services, including:

- Enhancing the National Membership Dashboard and State Membership Dashboard in collaboration with the Membership Data Analytics and Reporting team (MDAR) by creating charts and figures that communicate the progress and results of growing segments, member retention, identify opportunity states, and improve data-driven decision making for membership growth.

- Developed a fourth companion map for the Dental Licensure dashboard originally implemented in 2019, which now incorporates specialty licensure information to help established dentists and new dentists working across state lines navigate continuously changing information and upcoming deadlines on licensure requirements from all states, [https://www.ada.org/resources/licensure/dental-licensure-by-state-map](https://www.ada.org/resources/licensure/dental-licensure-by-state-map).
6. **COVID-19 Response**

Leverage expertise and organizational knowledge to support the ADA’s leadership during the COVID-19 pandemic.

- Ms. Matlak oversaw the transfer of the official COVID-19 Archive to the custody of the ADA Library & Archives to preserve for historical reference. The COVID-19 Archive comprises Association-wide documentation and records of the ADA’s response to the pandemic compiled by the Emerging Issues Team. Items transferred to the custody of the ADA Library & Archives include information handouts, reports, and presentations previously shared on ADA.org/VIRUS and other media outlets. The COVID-19 Archive will serve as the record going forward of what the organization experienced and how it responded to the crisis. This is the first time in the history of the ADA Archives that such an intact group of office records has been transferred to its custody.

- Library and archives staff continued to maintain the searchable COVID-19 FAQ repository by evaluating and adding meaningful questions from ADA members and corresponding answers from key ADA staff and other health professionals. The site was accessible to ADA staff, volunteers, state societies, and the Board of Trustees. It was archived in March 2022.

- Ms. Laura Pontillo continued to manage content updates for ADA.org/VIRUS in collaboration with ADASRI, Dental Practice Institute, Government Affairs, and other divisions.

- Ms. O’Brien has continued to support ADASRI, with automated searches of published materials and pre-prints on COVID-19, COVID-19 variants, COVID-19 long-term vaccination response, and Long COVID.
7. Professional Contributions

Library staff continue to contribute to professional activities and continue to be active in the library and archive community-at-large by participating in professional organization committees and building partnerships in 2022.

- Ms. O’Brien served as a peer reviewer for the *Journal of the Medical Library Association* and for *BMJ Open*.
- Ms. Strayhorn served a second term as the co-chair of ADA 4 ALL to help strengthen the ADA employee community and further the Association’s commitment to diversity, equity and inclusion. She also served on the Journal of the Medical Library Association Editor-in-Chief search committee to ensure a more inclusive and equitable search was conducted to identify potential candidates.
- Ms. Pontillo served as chair of the Resource Sharing Caucus of the Medical Library Association. She remains the group lead contact for the Greater Midwest Region Reciprocal Group (GMRRG) for the Network of the National Library of Medicine. Ms. Pontillo served on the planning committee for the first-ever Collection Development and Resource Sharing Symposium for the 2022 MLA annual conference and co-organized the popular session, “Think Like a Lawyer: A Socratic Seminar on Copyright Law” held during the conference.
- Ms. Fleming served as chair of the Dental Caucus in the Medical Library Association beginning in June 2022. In that capacity, she completed a Caucus history report, led Executive Committee and Caucus meetings, managed a special election for Caucus leadership, and mentored incoming Caucus leadership.
- Ms. Matlak, a Certified Archivist, started coursework (and completed six courses) for the Society of American Archivists Digital Archives Specialist (DAS) Certificate which will facilitate her work with the increasing volume of digital publications and records being collected and preserved in the ADA Archives.
- Ms. Nickisch Duggan delivered a talent and strengths development workshop for the National Library of Medicine Associate Fellows Program. She continues to lead the redevelopment of the ADA Institutional Review Board (IRB). She also served as a non-affiliated member of the IRBs of the Ann & Robert H. Lurie Children’s Hospital of Chicago and Northwestern University.
The following resolution was submitted by the Seventeenth Trustee District and transmitted by Ms. Lianne Bell, leadership affairs manager, Florida Dental Association, on September 21, 2023.

Background: As CODA did not have a clear rationale for setting faculty to student ratios in all allied education programs and received correspondence from 17 states questioning their standards for validity and reliability, CODA formed an ad hoc committee to survey, study, and evaluate problems and concerns that plague the Allied education programs in the United States. The results of this ad hoc committee report, including the survey given, can be found here. The survey was sent to the 582 allied dental education programs, and upon analysis of the survey responses it was found that 74% (or 431 programs) reported their top three factors negatively affecting the matriculation of Allied personnel in the workforce to be the following:

1. Almost half of all responding programs indicated they would like to expand enrollment but also voiced impediments to their mission to increase enrollment to satisfy local employment demands.
2. Approximately 30% of programs indicated inability to hire and retain sufficient CODA standard three to nine qualified faculty.
3. Dental Hygiene programs listed capacity of facilities, ability to hire and retain sufficient number of qualified faculty to maintain ratios required by CODA standards and cost of education to students. Dental assisting programs listed lack of student interest, student attrition once in programs and inability to hire CODA standard qualified faculty. Dental Laboratory programs listed program funding, hiring of qualified faculty to meet ratios required by CODA standards and lack of student interest.

Allied Dental Programs are struggling to attract and graduate Allied personnel. The ADA Health Policy Institute’s (HPI’s) surveys show that 35.8% of dental offices are looking for dental assistants, 28.8% are looking for dental hygienists and 26.5% are looking to hire administrative staff. As stated by the ADA HPI there is an Allied personnel workforce shortage that is estimated to get much worse.

Resolution

408. Resolved, that the appropriate agency use the CODA ad hoc committee findings to suggest programs to attract students into allied educational programs and careers, and be it further

INCREASING ALLIED PERSONNEL IN THE WORKFORCE
Resolved, that the appropriate agency recommend programs and policies to urge CODA to improve the ability of Allied Programs to expand enrollment, such as, faculty ratios and the associated costs of tuition for these programs.

BOARD COMMENT: Received after the July-August 2023 Board of Trustees meeting.
Resolution No. 409  

Report: N/A  

Date Submitted: September 2023  

Submitted By: Seventeenth Trustee District  

Reference Committee: C (Dental Education, Science and Related Matters)  

Total Net Financial Implication: None  

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  

METHODOLOGY OF CODA ACCREDITATION STANDARDS  

The following resolution was submitted by the Seventeenth Trustee District and transmitted by Ms. Lianne Bell, leadership affairs manager, Florida Dental Association, on September 21, 2023.  

Background: The accredited standard of teacher to student ratios in Dental Hygiene Programs was reduced from (6 to 1) to (5 to 1) around 2004 for preclinical, clinical, radiography, and laboratory sessions. This decreased ratio standard has increased the schools' costs and, in some cases, reduced graduates in dental hygiene programs because schools had been designed with ratios of six operatories. While it is not CODA's purview to be concerned with work force issues, their decisions do affect the matriculation of ancillary personal into the workforce and the costs associated with that for the schools and ultimately the Dentists hiring and cost of services to patients. Presently programs that teach more invasive and irreversible procedures for dental auxiliaries have a larger faculty to student ratio so it appears that patient safety may not be one of the concerns for this change. At the same time, since 2004 technology has enhanced the teaching environment. Another impediment for Dental Hygiene Programs has been the required education of instructors. Standard 3-6 states that full-time and part-time faculty of a Dental Hygiene Program must possess a baccalaureate or higher degree which restricts those dedicated professionals who have worked in the profession for many years and would like to give back to it by helping with their experience as part-time or adjunct educational staff. In both of these cases CODA has not had to show and does not claim to have specific methodology or rationale for these standards.  

Resolution  

409. Resolved, that the ADA urge CODA to demonstrate transparent methodology for teacher to student ratios and educational requirements for part time teachers and adjunct instructors in all allied educational programs, and be it further  

Resolved, that the ADA urge CODA to allow Registered Allied personnel with ten or more years of experience to act as part time and/or adjunct faculty for Allied Dental educational programs who have other faculty who meet current requirements actively teaching in the same program.  

BOARD COMMENT: Received after the July-August 2023 Board of Trustees meeting.