

ADEA Policy Statements: Recommendations and Guidelines for Academic Dental Institutions

(With changes approved by the 2011 ADEA House of Delegates)

Introduction

These policy statements on Education, Research, Licensure and Certification, Access and Delivery of Care, Health Promotion and Disease Prevention, Partnerships, and Public Policy Advocacy are intended as recommendations and guidelines for allied, predoctoral, and postdoctoral dental education institutions, programs, and personnel.

When used in this document, “dental education” refers to all aspects of academic dental, allied dental, and advanced dental institutions, unless otherwise indicated. When used in this document, the term “institution” refers to the academic unit in which the educational program is housed.

The general topic of each policy statement appears in **boldface** at the beginning of the statement. All these policy statements are subject to a sunset review every five years.

I. Education

A. Admissions

All dental education institutions and programs should:

1. Diverse System of Higher Education. Support and help enhance the diverse system of higher education. Continued autonomy and growth in the private and public sectors depend on the preservation of this diversity. The nation’s private and public systems of higher education are complementary and interdependent. Their preservation depends on the continued attention of all institutional members and ADEA itself. Students must have the freedom to choose, from the broad spectrum of dental education institutions and programs, the institution or program best designed to meet the student’s specific needs.

2. Number and Types of Practitioners Educated. Use the public’s need and demand for dental services as the criteria for determining the number and types of practitioners educated at an

academic dental institution; and in partnership with appropriate federal, state, and local health agencies and state and local dental societies, constantly assess those needs and demands and the ability of the existing number and distribution of practitioners to meet them. Through ADEA, work with appropriate federal and state agencies to ensure consistent methods for collecting and assessing data to monitor demographic, epidemiological, and professional practice trends, so that dental education institutions and programs do not over- or underproduce practitioners in given areas. Collaborate with state and local dental societies and jointly advocate for federal and state funds and programs that will assist academic dental institutions in meeting projected workforce number and composition requirements, along with incentives and programs designed to achieve a more equitable distribution of practitioners to improve access to oral health care.

3. Preprofessional Recruitment Programs. Encourage their faculty and students to develop and sponsor preprofessional recruitment programs that help potential students assess career options, financial considerations, and various educational programs. Target high school and college students and education counselors at all levels about career options and appropriate academic preparatory requirements and interface with other professional organizations in these efforts.

4. Admissions Criteria. Base admissions policies on specific objectives, criteria, and procedures designed to identify students with high standards of integrity, motivation, and resourcefulness and the basic knowledge and attitudes required for completing the curriculum. Nondiscriminatory policies should be followed in selecting students.

5. Recruitment, Retention, Access: Best Practices. The American Dental Education Association strongly endorses the continuous use of recruitment, admission, and retention practices

that achieve excellence through diversity in American dental education. Dental education institutions and programs should identify, recruit, and retain underrepresented minority students and identify, recruit, and retain women students where inequities exist. Dental education institutions and programs should accept students from diverse backgrounds, who, on the basis of past and predicted performance, appear qualified to become competent dental professionals. Such efforts to achieve a diverse student body are predicated upon a highly qualified applicant pool and the support of private and public funding that benefits qualified disadvantaged individuals regardless of race, religion, ethnic background, gender, or sexual orientation. Dental education institutions should seek to identify and implement best practices in the recruitment and retention of underrepresented groups, including but not limited to:

- a. Commitment and proactive leadership to diversity initiatives from deans and program directors;
- b. Identification and implementation of admissions committee practices that promote diversity;
- c. Identification and use of noncognitive factors in admissions decisions;
- d. Regional collaboration among dental education programs to increase the numbers and qualifications of underrepresented individuals applying to dental education programs; and
- e. Collaboration with other organizations focused on increasing the numbers of under-represented minorities in the health professions.

6. Institutions and Programs That Are Closing.

If ceasing to accept new applicants, 1) adhere to the policy of the Commission on Dental Accreditation on termination of accredited education programs, 2) make a strong effort to complete the training of matriculated students, and 3) ensure that the school's or program's educational standards are maintained. Should the closing institution/program be unable to maintain a quality program, however, the institution/program should facilitate the transfer of students to other accredited institutions/programs.

7. Accepting Students from Institutions and Programs That Are Closing.

All academic dental institutions should accept students from academic dental institutions/programs that are closing and assist those students in continuing their education in a reasonable amount of time and at reasonable expense.

8. All predoctoral institutions should:

a. Preprofessional Education Requirements.

Grant final acceptance only to students who have completed at least two academic years of preprofessional education (which must include all of the prerequisite courses for dental school), and who have completed the Dental Admission Test or the Canadian Dental Aptitude Test. Applicants should be encouraged to earn their baccalaureate degrees before entering dental school.

b. Early Selection Programs. Have the option of waiving for students accepted for an early selection program the requirement for at least two years of preprofessional education. An early selection program is one where a formal and published agreement exists between a dental school and an undergraduate institution(s) that a student, either upon the student's admission to the undergraduate institution or at some time before the completion of the student's first academic year at the undergraduate institution, is guaranteed admission to the dental school, provided that the student successfully completes the dental school's entrance requirements and normal application procedures.

c. Class to Which Applied. Consider students for acceptance to only the class to which they have applied.

d. Earliest Notification Date. Notify applicants, either orally or in writing, of provisional or final acceptance no earlier than December 1 of the academic year prior to the academic year of matriculation.

e. Applicant Response Periods. Allow an applicant who has been given a provisional or final acceptance between December 1 of the academic year prior to the academic year of matriculation and January 31 of the year of matriculation a response period of no fewer than thirty days. For applicants accepted on or after February 1, the minimum response period may be reduced to fifteen days. The response period may be lifted after May 15 of the year of matriculation.

f. Applicants Holding Positions at Multiple Institutions. Dental schools participating in AADSAS will report to AADSAS by April 1 the names and identification numbers of candidates who have paid a deposit and/or hold a position in their entering class.

After April 5, AADSAS will report to each institution the names of candidates in their entering class who are holding acceptance(s) at additional institutions. Dental schools will have the option of rescinding an offer of admission to candidates who have paid deposits and are holding positions at multiple institutions. Dental schools with candidates holding multiple positions on April 1 of the year of admission will give such candidates a minimum fifteen-day notice if they choose to withdraw them from the entering class until May 15, after which notification times may be shortened. This policy will be evaluated every two years by the ADEA Section on Dental School Admissions Officers to assess its impact on applicants and dental schools and provide applicants a reasonable time frame to complete their enrollment process.

B. Ethics and Professionalism

Dental education institutions and programs should:

1. **Ethical Behavior.** Through faculty development and other means, emphasize to faculty the importance of ethical behavior in the profession and emphasize this importance to their students. Further, dental education institutions and programs should implement criteria with appropriate due process procedures for dismissal or other actions when students violate ethical behavior.
2. **Formal Instruction in Ethical and Professional Behavior.** Provide students with formal instruction in ethics and professional behavior, and make the students aware of acceptable professional conduct in instructional and practice settings. Institutions and programs should ensure that student clinical experiences foster ethical patient care.
3. **The Profession's Societal Obligation.** Ensure that both faculty and students are aware of the profession's societal obligation. Provide formal instruction and faculty role models so that students clearly understand that society grants the privilege of professional education and self-regulation and that in return the oral health professional enters an implicit contract to serve the public good. Market forces, societal

pressures, and professional self-interest should not compromise the professional objective of equitable and adequate oral health care for all Americans.

4. Serving in Areas of Need. Offer programs that encourage students to serve in areas of oral health care need. These programs should be equally available to all students at a given educational institution and, when possible, implement an interdisciplinary care model.

5. Community Service. Encourage students to participate in outreach programs and, upon graduation, to participate in community service.

6. Professional Organizations. Encourage students to participate in professional organizations.

7. Sexual Harassment Policy. Work with their parent institutions to have up-to-date policies and well-defined procedures for preventing and responding to incidents involving sexual harassment. Dental education institutions and programs should strive to go beyond legal compliance and risk management considerations to create and sustain a positive learning and working environment. While there are numerous definitions of sexual harassment, institutions and programs are encouraged to develop their own definitions that could be applied in a broad context, including *quid pro quo* and hostile environments.*

Dental education institutions and programs should, in concert with their parent institution, demonstrate their commitment to preventing and dealing with sexual harassment by:

- a. educating faculty, staff, students, and residents about the issue;
- b. employing prompt and equitable grievance procedures;
- c. setting forth formal and informal procedures and sanctions for dealing with instances of sexual harassment;
- d. creating an environment that encourages persons to come forward with problems;
- e. ensuring that policies address sexual harassment by any individuals in an interactive or supervisory role, whether they be peers, patients, students, or a third party;
- f. including safeguards protecting confidentiality and prohibiting retaliation or reprisals;

*Examples of sexual harassment include the following: "Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when submission to such is made either explicitly or implicitly a term or condition of an individual's employment or academic advancement or when submission to or rejection of such conduct by an individual is used as the basis for employment or academic decisions affecting such individual" (ADEA Sexual Harassment Policy Statement, 1998). It also includes verbal or physical conduct that interferes with an individual's work, professional or academic or career opportunities, or services/benefits. Nonsexual conduct, such as intimidation, hostility, rudeness, and name-calling, and unwelcome behaviors influenced by gender, ethnicity, religion, disability, sexual orientation, or age are also included.

- g. implementing a process to continually monitor all aspects of the policy; and
- h. reviewing and updating the policy periodically.

8. Information Management. Dental education institutions and programs should demonstrate their commitment to the ethical and professional management of information by:

- a. educating faculty, staff, and students on the issues of copyright and fair use of information both professionally and personally;
- b. following copyright and fair use guidelines in the processes of information production and dissemination within the institution;
- c. providing faculty, staff, and students with formal instruction on “information privacy” including their rights and responsibilities in safeguarding information that is confidential, both to the institution and individuals; and
- d. following recognized guidelines, laws, and standards of care for management of patient information.

9. Confidentiality. Educate staff, students, and faculty to respect and protect patient confidentiality as part of professional interactions.

C. Curriculum

Curriculum Management

All dental education institutions and programs should:

1. Control and Management of Curriculum. Accept the right and responsibility for the curricula and academic programs under their purview, including the elimination of unplanned redundant material and management of the density of the curricula.

2. Flexibility and Experimentation. Support curriculum flexibility, evaluation, and experimentation in teaching methods, and oppose any attempt to change state practice acts that restrict such flexibility and experimentation.

3. Student Performance. Use stated criteria and demonstrated competencies as the primary basis for judging student performance.

4. Course Changes. Defer anticipated changes in the objectives or other aspects of an ongoing course until the course is completed.

5. Examination Policies. Develop institution- and program-wide examination policies. These policies should address such areas as:

- a. Examinations reflecting stated course objectives;

- b. Informing students of examination results in a timely manner; and
- c. Providing for faculty-student discussion of examination content and results.

6. Competencies. Provide all resources, including patient experiences, to allow students to reach competence and demonstrate continuing competence in all areas defined by the institution.

7. Dental Institution/Program Affiliations. Institute and periodically update formal affiliations among dental schools and dental hygiene, assisting, and laboratory technology education programs.

8. Curriculum Length

a. Predoctoral Dental Programs: should have four-academic-year curricula or the equivalent of four-year curricula provided in a flexible format.

b. Dental Hygiene Programs: should have curricula in a flexible format that consists of a minimum of two academic years or equivalent.

c. Dental Assisting Programs: should have curricula in a flexible format that consists of a minimum of one academic year or equivalent.

d. Dental Laboratory Technology Programs: should have curricula in a flexible format that consists of a minimum of two academic years or equivalent.

9. Clinical Guidelines. Provide predoctoral, advanced, and allied students with written clinical guidelines and expectations for graduation as soon as possible.

Curriculum Content

All dental education institutions and programs should:

1. Goals and Objectives. Base their curricula on sound, current educational philosophy and pedagogy in order to achieve defined goals and objectives that reflect contemporary methods of oral health care delivery.

2. New Ideas and Methods. Introduce new ideas and methods in their teaching in order to meet the changing needs of their students and the patients they will serve.

3. Physical, Biological, Technical, and Behavioral Sciences. Teach their students the physical, biological, technical, and behavioral sciences relevant to the practice of modern oral health care delivery.

4. Working Within an Integrated Health System. Develop and support new models of oral health care that involve other health profession-

als as team members in assessing the oral health status of patients and teach dental students to assume leadership roles in the detection, early recognition, and management of a broad range of complex oral and general diseases and conditions. When possible, interdisciplinary educational opportunities should be pursued.

5. Student-Patient Contact. Develop, review, and maintain appropriate clinical policies to ensure optimum clinical education and patient-centered care.

6. Dental Research

a. Predoctoral, advanced dental, baccalaureate, and graduate dental hygiene programs:

Teach the value, design, and methodology of dental research so that graduates may evaluate research findings and apply them to their practices.

b. Certificate or associate degree dental hygiene, dental assisting, and dental laboratory technician programs: Teach the value of and apply scientific concepts from research findings.

7. Basic Cardiac Life Support. Ensure appropriate training and certification in basic cardiac life support for all students before they begin clinical activity and throughout clinical training. The training should be basic cardiac life support for the health professional and should be provided in accordance with accepted standards and recommended guidelines.

8. Oral Health Care Team. Provide experiences working as a member of an interdisciplinary health care team.

9. Information Technology. Provide formal instruction, develop skills, and provide opportunities in the use of computer-based applications and information systems. Support the timely access to information by faculty, staff, and students to enhance their knowledge, critical thinking, and decision making processes and promote quality patient care.

10. Cultural and Linguistic Competence. Include cultural and linguistic concepts as an integral component of their curricula to facilitate the provision of oral health care services. Cultural and linguistic concepts should be included in the measurable dental curriculum objectives.

11. Care of Patients with Special Needs. Work with the American Dental Association Commission on Dental Accreditation to adopt or strengthen accreditation standards at all levels of dental education related to competence in

treatment of people with special needs. Include a requirement that graduates of dental education programs be able to manage or treat, consistent with their educational level, a variety of patients with complex medical and psychosocial conditions, including those with developmental and other disabilities, the very young, the elderly, and individuals with complex psychological and social conditions.

12. Preparation for Patients with Special Needs. Include both didactic instruction and clinical experiences involving special population groups such as the elderly, the very young, and patients with mental, medical, or physical disabilities in pre- and postdoctoral education as well as allied dental education.

Dental hygiene education programs should:

1. Transfer of Credit. Design curricula that facilitate transfer of credit from certificate and associate degree programs to baccalaureate degree programs in the same or a related discipline.

2. Prepare Graduates for New and Emerging Responsibilities. Monitor and anticipate changes in supervision requirements within the state and modify the curriculum and extramural experiences of students so as to prepare them to provide more extended services in a variety of practice settings.

3. Collegiate-Level Dental Hygiene Curricula. Develop and maintain curricula that are collegiate-level and lead to an associate or higher degree.

4. Baccalaureate and Advanced Degree Hygiene Programs. Be encouraged to offer baccalaureate and advanced degree programs for dental hygienists.

D. Faculty Recruitment and Retention

All dental education institutions and programs should:

1. Faculty Qualifications. Recruit faculty who have backgrounds in and current knowledge of the subject areas they are teaching and, where appropriate, educational theory and methodology, curriculum development, and test construction, measurement, and evaluation. Full-time dental assisting and dental laboratory technology faculty should hold a minimum of a baccalaureate degree. Full-time dental hygiene faculty should hold a minimum of a master's degree or should be in the process of obtaining a master's degree. Full-time dental faculty should hold a degree that is consistent with their teaching and research responsibilities.

2. Promotion Criteria. Develop and utilize promotion criteria that include teaching, research (if appropriate to the type of academic setting), and service, and relate those criteria to the activity assignment profile of each faculty member.

3. Faculty and Administrative Evaluation. 1) Evaluate faculty members', including administrative personnel's, effectiveness in order to improve the quality of the educational program; 2) see that evaluation is formal and encompasses all areas of faculty and administrative members' activity assignment profiles; 3) conduct evaluation at scheduled intervals, with input from a broad cross-section of appropriate personnel at the institution; and 4) give evaluation results appropriate emphasis when reappointment, promotion, and tenure are being considered.

4. Gender and Minority Representation. Identify, recruit, and retain underrepresented minorities to faculty positions and promote, when qualified, underrepresented minorities to senior faculty and administrative positions, proportional to their distribution in the general population. Appropriate gender equity should be a goal of any faculty recruitment, retention, and promotion plan.

5. Debt Repayment. Develop funding sources for debt repayment for young faculty.

6. Alternative Compensation. Creatively evaluate and implement nonmonetary incentives valued by faculty.

7. Allied Dental Faculty. Employ, as faculty of dental students, allied dental personnel who are graduates of programs accredited by the Commission on Dental Accreditation or the Canadian Dental Association.

8. Mentoring Programs. Develop and support formal mentoring programs as a means of recruiting, preparing, and retaining new dental and allied dental faculty, as well as a vehicle for developing and retaining existing faculty.

E. Faculty Development

Introduction. Faculty development is a continuous process, providing opportunities for professional growth within the academic environment. The purpose of faculty development is to enhance the ability of faculty to perform their expected functions as dental educators. Faculty development programs should 1) cover teaching, research, and service; 2) assist faculty in selecting activities that fulfill their goals and those of the department and institution; and 3) prepare faculty to assume leadership positions in dental and higher education. The institution and faculty share the responsibility for seeking and sup-

porting faculty development. Faculty development programs should be broad-based and meet individual programmatic needs.

Dental education institutions and programs should:

1. Emphasize Faculty Development. Emphasize faculty development by providing or making available in-service training, instructional development support, teaching evaluation reports, scholarly activities, academic promotion guidance, and the technical and behavioral skills that facilitate the academic growth of the individual faculty member. Programs to encourage and train additional future dental and allied dental educators should also be available. Programs to train additional dental and allied dental educators should include advanced education in the discipline, as well as educational pedagogy.

2. Mentoring Programs. Mentoring programs for junior faculty should be developed and supported as a means of retaining faculty and ensuring their potential for future advancement. Such mentoring programs also have the potential to encourage senior faculty to maintain their currency and to create collaborative research and scholarship opportunities.

3. Financial Support. Provide financial support and other needed resources for faculty development programs, including incentives for faculty mentors.

4. Sabbaticals and Leaves. Grant faculty sabbaticals and other leaves with the same frequency and on the same basis as for other academicians in the educational institution.

5. Evaluating Faculty Development Programs. Periodically evaluate the availability, quality, and observable impact of faculty development initiatives in the departments, programs, sections, divisions, and other components of the institution or program.

F. Committees

Dental education institutions and programs should:

Student Members. Allow students to serve as members with full standing on appropriate committees, with the student members' privileges including, but not limited to, permission to 1) speak on any agenda items, 2) introduce and speak to any new business, and 3) vote on appropriate issues.

G. Counseling

Dental education institutions and programs should:

1. Financial Aid Obligations. Encourage close working relationships between their admissions and financial aid offices in order to counsel stu-

dents early and effectively on their financial aid obligations and debt management.

2. Psychological. Provide student psychological counseling services by formally trained individuals knowledgeable about the particular problems faced by faculty, staff, and students.

3. Alcohol, Tobacco, and Other Drug Abuse. Provide education on alcohol, tobacco, and other drugs of abuse.

4. Referrals for Substance Abuse. Provide faculty, staff, and students with confidential referral mechanisms on substance abuse evaluation and treatment.

5. Advanced Education and Professional Opportunities. Counsel students on postdoctoral education and professional opportunities, and counsel undergraduate allied dental students on baccalaureate and graduate education opportunities.

6. Medical. Provide education and counseling on chronic diseases.

7. Academic Counseling. Provide academic counseling, including time and stress management, and study and test-taking skills.

8. Advanced Education and Career Choices. Encourage students to consider careers in research, education, administration, dental public health service, and the military.

H. Accreditation

Dental education institutions and programs should:

1. Recognized Agencies. Participate in an accreditation program conducted by a nongovernmental agency recognized by the secretary of the U.S. Department of Education or its equivalent.

2. Commission on Dental Accreditation. Recognize the Commission on Dental Accreditation and the Canadian Dental Association, through its Council on Education, as the official accrediting agencies for those dental and allied dental education programs within the purview of the commission and the Canadian Dental Association.

3. Non-Recognized Specialties. Ensure that dental education programs in special areas not recognized by the Commission on Dental Accreditation undergo institutional and external review at intervals comparable to those for recognized programs.

4. Opposition to Preceptorship Training. Oppose preceptorship training or other nonaccredited alternative programs for dentists, dental hygienists, dental assistants, and dental laboratory technicians.

I. Finance

Federal and state governments should:

1. Public Funds for Dental Education. Support public and private dental education institutions and programs, including providing funds to the fullest extent possible for student assistance, faculty salaries, maintenance, modernization, and construction of teaching facilities.

Federal, state, and private entities should:

2. Funds for Advanced Education. Provide support for advanced education programs preparing dentists and dental hygienists for careers in education, research, and public service.

Dental education institutions and programs should:

3. Supplemental Funds. Seek and use supplemental public and private funds if the conditions for accepting those funds do not jeopardize the quality of education or result in loss of control of the educational process. Institutions are encouraged to use such funds only for targeted projects and not for ongoing support.

4. Clinic Fee Schedules. Adopt clinic fee schedules that adequately reflect the value of given services. Such reimbursement should be the same as that given to other providers in other settings for the same service. Further, dental education institutions and programs should ensure a fee schedule that promotes educational services to the student and provides care to the underserved.

5. Policies on Patient Debt Management and Fee Collections. Provide students, before their clinical experience, with a written statement of the school's policy on patient debt management and fee collection.

6. Support for Careers in Education, Research, and Public Service. Provide fellowships, assistantships, loans, and loan forgiveness to support dental and allied dental personnel preparing for careers in education, research, and patient care services.

J. Advanced Education

Dental education institutions and programs offering advanced education should:

1. Classic Education Patterns. Conform their graduate dental education programs to classic educational patterns applicable to other academic disciplines, terminating in a graduate degree under the auspices of the university's graduate school or a comparable agency of the university.

2. Requirements for Master's and Doctoral Degrees. Award master's and doctoral degrees in programs that include research and require a thesis or dissertation.

3. Specialty Program Requirements. Not require applicants to complete a general practice residency as a prerequisite for possible admission to a specialty education program.

4. Advanced Education Program Affiliations. Affiliate these advanced education programs with teaching hospitals and/or academic health centers, preferably those with dental schools or dental departments.

5. Promoting the Goal of Advanced Education. Coordinate the educational goals, objectives, and competencies of predoctoral and advanced dental education to allow for a designed continuum of the educational phases of a dental practitioner and ensure readiness as one moves from phase to phase. Encourage dental graduates to pursue postdoctoral dental education. Facilitate and advocate for the development of high-quality, accredited postgraduate education opportunities that build upon an effective predoctoral curriculum.

6. Advanced Education and Residency Positions in Primary Care Dentistry. Work to help ensure that the number of positions in advanced general dentistry and other advanced education programs in primary care dentistry is adequate to provide all dental graduates an opportunity to pursue postdoctoral dental education.

7. Funding. Advocate for increased funding and loan forgiveness for General Practice Residency and Advanced Education in General Dentistry Programs and accredited advanced dental education programs, particularly primary care programs, so that the number of positions and funding are sufficient to provide opportunities for all dental graduates to pursue a year of service and learning in an accredited PGY-1 program.

8. Graduate Medical Education (GME). Work with hospitals and organized dentistry groups to increase the number of and funding for dental residency training positions through GME.

9. Stipends. Whenever possible, provide stipends to dental residents and allied dental students in advanced education and clinical specialty programs.

Dental schools should:

1. Disclosure of Class Rankings. Disclose (with student consent) the class rankings, or equivalent measures of performance, of students applying to advanced education programs.

2. Integration of New Knowledge and Skills. Allow for dynamic incorporation of new knowledge and skills and/or standards of care.

3. Interdisciplinary Communication. Develop mechanisms for effective communication between organizations establishing credentialing and accreditation of advanced dental education training programs/residencies and those administering programs, as well as between the specialties themselves. Develop constructive relations between ADEA sections representing advanced education and specialty boards or organizations bestowing status on practicing members.

K. Continuing Education

Dental education institutions and programs should:

1. Encouragement. Strongly encourage their students to become lifelong learners and to participate meaningfully in continuing education throughout their professional careers.

2. Student Attendance. Give their students an opportunity to attend continuing education courses and professional development opportunities.

3. Faculty Participation. Create incentives for their faculty to conduct, attend, or participate in continuing education courses, and recognize attendance at ADEA annual sessions as a continuing education activity.

4. Content. Offer continuing education programs in the clinical, technical, behavioral, and biomedical sciences to improve the competencies of practitioners in general and specialty practice areas.

5. Cooperation with Dental, Allied Dental, and Other Professional Organizations. Cooperate with appropriate dental organizations in providing continuing education.

6. Evaluation. Frequently evaluate their continuing education courses for quality and content, soliciting impressions from appropriate groups about their continuing education needs.

7. Community Service. Develop mechanisms for academic dental institutions to encourage learning and to provide ongoing services in the form of information and training to former students and area professionals.

II. Research

A. Fundamental and Applied Research. Dental education institutions and programs have the right and responsibility to conduct fundamental and applied research in the natural and social sciences and in the area of health services, in particular as it relates to oral health disparities. Dental education institutions and programs should actively foster and support basic

and applied clinical research. Incentives should be provided to encourage both faculty and students to actively participate in research as appropriate to the type of academic setting.

B. Research Findings in Courses. Dental educators should be expected to include new information and research findings in their courses of instruction and to encourage students to engage in critical thinking and research. Students should be encouraged to contribute to the development of new knowledge for the profession.

C. Commercial Sponsors. ADEA encourages dental education institutions and programs and dental educators to interact with commercial and other extramural sponsors of research, clinical trials, and demonstration projects, under conditions in which the academic rights of faculty are protected. These conditions include rights of publication, ownership of intellectual property, and rights of patent and copyright within institutional policy, subject to appropriate contractual protection of the sponsor's legitimate interests.

D. Publication of Commercially Sponsored Research. ADEA encourages publication by faculty of the results of research, clinical trials, and demonstration projects supported by commercial and other extramural sponsors. Peer review by scientist/educators with expertise in the relevant field(s) of the research or project is the best means of ensuring the quality of the publication. ADEA discourages submission of manuscripts to any publisher that allows sponsors of the work to influence editorial policy or judgment after the completion of the peer review process.

E. Excellence in Teaching. Dental education institutions and programs should promote excellence in teaching through active programs of research on the teaching/learning process. Faculty members should be encouraged to conduct both quantitative and qualitative studies of educational programming including case studies that examine the impact of these various educational programs on student attainment of outcomes.

F. Scholarship. Dental education institutions and programs should encourage a broad range of scholarship from their faculty. Faculty members should be encouraged and rewarded, if appropriate to the academic setting, through the tenure and/or promotion and review process for systematically developing and validating new educational programs; for evaluating, analyzing, and interpreting the impact of educational programs on students and patients; and for publishing reports of these endeavors.

III. Licensure and Certification

A. Goals. ADEA supports achievement of the following goals for dentists and dental hygienists who are students or graduates of accredited programs and have successfully completed the National Board Dental Examination or the National Board Dental Hygiene Examination: freedom in geographic mobility; elimination of those licensure and regulatory barriers that restrict access to care; elimination of the use of patients in clinical examinations; and high reliability of any licensure examination process and content as well as predictive validity of information used by licensing authorities to make licensing decisions.

B. Live Patient Examination. By the year 2015, the live patient exam for dental licensure should be eliminated, and all states should offer methods of licensure in dentistry that include advanced education of at least one year, portfolio assessment, and/or other non-live patient-based methods and include independent third-party assessment.

C. Achieving Goals. In order to achieve these goals, the Association should work diligently, both independently and cooperatively, with appropriate organizations and agencies, to support appropriate demonstration projects, pilot programs, and other ways to explore development of alternative testing methods and to develop uniform, valid, and reliable methods that can be used nationally to measure the competencies necessary for safe entry into independent practice as licensed dentists and legally authorized practice as licensed dental hygienists. In the interest of ensuring high quality oral health care, ADEA has always supported periodic third-party evaluation of dental and dental hygiene students and graduates through mechanisms like the National Board Dental and Dental Hygiene Examinations. In considering the clinical competence of dental and dental hygiene students and graduates, ADEA also supports the development and administration of a national clinical examination. ADEA also supports with the American Dental Association the principle that a clinical examination requirement may also be met by successful completion of a postgraduate program in a general dentistry or dental specialty training program, at least one year in length, which is accredited by the Commission on Dental Accreditation.

ADEA also strongly supports development of means for licensing authorities to assess continuing competence. With valid, reliable, and fair methods for continuing competence determinations, initial licensure examinations may become unnecessary.

D. Allied Dental Personnel. In addition, the Association supports the following principles concerning the licensure and certification of allied dental personnel. Qualified dental hygienists should be appointed to all agencies legally authorized to grant licenses to practice dental hygiene. Dental hygienists should participate in the examination of candidates for dental hygiene licensure and be full voting and policymaking members of licensing authorities in all matters relating to the practice of dental hygiene. Successful completion of an accredited program should be a prerequisite for eligibility for the certification examination of the National Board for Certification of dental laboratory technicians and the Dental Assisting National Board for dental assistants.

E. Preparing Students for Licensure in Any Jurisdiction. Institutions that conduct dental and allied dental education programs have the right and responsibility to prepare students for licensure examinations in any jurisdiction in the United States, Puerto Rico, and Canada.

Individuals or students applying for dental hygiene licensure in any jurisdiction must successfully complete the didactic, laboratory, and clinical instruction and meet the competencies for providing patient care as required by the dental education Accreditation Standards of the Commission on Dental Accreditation.

IV. Access and Delivery of Care

A. Health Care Delivery and Quality Review. Dental education institutions and programs and ADEA should be leaders in developing effective health care delivery systems and quality review mechanisms and in preparing their students to participate in them.

B. Scope of Services. Dental education institutions and programs should provide treatment consistent with contemporary standards of care.

C. Dental Health Personnel. Dental educators and ADEA should inform policymakers and the public that:

1. Dental education institutions and programs are important national, regional, state, and community resources.
2. Dental education institutions and programs have a vital role in providing access to oral health care to all, with special consideration for the underserved.
3. Dental education institutions and programs are a vital component of the health sciences segment of universities.

4. Dental education institutions and programs, through their graduates, contribute significantly to meeting the oral health needs of the public.

5. Dental education institutions and programs collaborate and create linkages with community-based agencies to increase access to care.

6. Dental education institutions and programs prepare their graduates to provide services in a variety of settings to reduce barriers to care and provide more accessible care to various population groups.

D. Dental Insurance, Federal, and State Programs.

ADEA should be a strong advocate on both the federal and state levels for:

1. Strengthening reimbursement and inclusion of meaningful dental and oral health care services provided under Medicaid and the State Children's Health Insurance Program.

2. Strengthening Medicare by seeking inclusion of medically necessary oral health care services for populations covered under the program.

3. Encouraging states to appoint a chief dental officer for every state.

4. Educating federal and state policymakers about the lack of dental insurance and its relationship to access to oral health care for underserved and unserved populations.

V. Health Promotion and Disease Prevention

A. Standards. Dental education institutions and programs have the obligation to maintain standards of health care and professionalism that are consistent with the public's expectations of the health professions.

B. Dental Caries

1. ADEA supports and encourages the education of students, professionals, and the public on behaviors that will promote health by preventing and managing dental caries based on proper disease diagnosis, caries risk assessment, and prognosis, including preventive oral health care measures, proper nutrition, and the management of dental caries utilizing risk-based, minimally invasive nonsurgical and surgical modalities, as dictated by the best evidence available.

2. **Fluoride.** ADEA supports and encourages fluoridation of community water supplies and the use of topical fluoride. Community water fluoridation is safe, practical, and the most cost-effective measure for the prevention of dental caries.

3. Dental Sealants and Fluoride. ADEA supports and encourages widespread use of dental sealants and fluoride varnishes as a significant cost-effective primary preventive method for the prevention of dental caries.

C. Periodontal Disease

1. Research. ADEA supports and encourages research into the correlation between oral and general health, including the possible link between periodontal disease and heart and lung diseases, stroke, diabetes, low birth rates, and premature births.

2. Education. ADEA supports and encourages the education of students, professionals, and the public on behaviors that will prevent disease and promote health, including preventive oral health care measures, proper nutrition, and tobacco cessation.

D. Infectious Diseases

1. Human Dignity. All dental personnel are ethically obligated to provide patient care with compassion and respect for human dignity.

2. Refusal to Treat Patients. No dental personnel may ethically refuse to treat a patient solely because the patient is at risk of contracting, or has, an infectious disease, such as human immunodeficiency virus (HIV) infection, acquired immunodeficiency virus (AIDS), or hepatitis B or C infections. These patients must not be subjected to discrimination.

3. Confidentiality of Patients. Dental personnel are ethically obligated to respect the rights of privacy and confidentiality of patients with infectious diseases.

4. Confidentiality of Faculty, Students, and Staff. Dental education institutions and programs are ethically obligated to protect the privacy and confidentiality of any faculty member, student, or staff member who has tested positive for an infectious disease. Dental personnel who pose a risk of transmitting an infectious agent must consult with appropriate health care professionals to determine whether continuing to provide professional services represents a material risk to the patient. If a dental faculty member, student, or staff member learns that continuing to provide professional services represents a material risk to patients, that person should so inform the chief administrative officer of the institution. If so informed, the chief administrative officer should take steps consistent with the advice of appropriate health care professionals and with current federal, state, and/or local guidelines to ensure that such individuals not engage in any

professional activity that would create a risk of transmission of the infection to others.

5. Counseling and Follow-Up Care. The chief administrative officer must facilitate appropriate counseling and follow-up care, and should consider establishing retraining and/or counseling programs for those faculty, staff, and students who do not continue to perform patient care procedures. Such counseling should also be available to students who find they cannot practice because of 1) permanent injury that occurs during dental training, 2) illnesses such as severe arthritis, 3) allergies to dental chemicals, or 4) other debilitating conditions. Dental education institutions and programs should make available institutional guidelines and policies in this area to current and prospective students, staff, and faculty.

6. Protocols. Chief administrative officers of dental education institutions and programs must establish and enforce written preclinical, clinical, and laboratory protocols to ensure adequate asepsis, infection and hazard control, and hazardous waste disposal. These protocols should be consistent with current federal, state, and/or local guidelines and must be provided to all faculty, students, and appropriate support staff. To protect faculty, students, staff, and patients from the possibility of cross-contaminations and other infection, asepsis protocols must include a policy in adequate barrier techniques, policies, and procedures.

7. Testing for Infectious Diseases and Immunization. Chief administrative officers must facilitate the availability of testing of faculty, staff, and students for those infectious diseases presenting a documented risk to dental personnel and patients. Further, the administrative officers must make available the hepatitis B vaccine and appropriate vaccine follow-up to employees such as faculty and staff, in accordance with Occupational Safety and Health Administration (OSHA) regulations. Also, in accordance with Centers for Disease Control and Prevention (CDC) guidelines, all students should 1) demonstrate proof of immunity, 2) be immunized against the hepatitis B virus as part of their preparation for clinical training, or 3) formally decline vaccination. Students who decline to be vaccinated should be required to sign a formal declination waiver form, consistent with procedures promulgated by OSHA for employees. Chief administrative officers should also strongly encourage appropriate faculty, staff, and students to be immunized against not only hepatitis B, but also other in-

fectious diseases such as mumps, measles, and rubella, using standard medical practices. In addition, all dental education institutions and programs should require prematriculation and annual testing for tuberculosis.

E. Alcohol, Tobacco, and Other Drug Hazards

1. Discouraging Alcohol, Tobacco, and Other Drug Abuse. Institutional and individual members are urged to:

- a. discourage use of excessive amounts of alcohol,
- b. discourage the use of illegal and/or harmful drugs,
- c. establish tobacco-free environments and tobacco use policies,
- d. incorporate information about the adverse health effects of all types of tobacco in course offerings and its application to clinical practice, and
- e. provide training on general, culturally competent, and gender-specific tobacco prevention and cessation techniques for application in clinical practice.

2. Tobacco-Free Environments. Institutional and individual members should have tobacco-free environments on their campuses and in their health science centers and patient-care facilities. Institutions should also encourage and support continued research related to the health effects of tobacco use.

3. Community Education Programs. Institutional and individual members are encouraged to participate in the development of community education programs dealing with the health hazards of alcohol, tobacco, and other drug use.

F. Child Abuse/Neglect and Domestic Violence

1. Familiarity with Signs and Symptoms. Dental and allied dental education institution officials and educators should become familiar with all signs and symptoms of child abuse/neglect and family violence that are observable in the normal course of a dental visit and should report suspected cases to the proper authorities, consistent with state laws.

2. Instruction in Recognizing Signs. Dental and allied dental education institution officials and educators should instruct all of their students, faculty, and clinical staff on how to recognize all signs and symptoms of child abuse/neglect and domestic violence observable in a dental visit

and how to report suspected cases to the proper authorities, consistent with state laws.

3. Monitoring Regulations. Dental and allied dental education institution officials should monitor state and federal legislative and regulatory activity on child abuse/neglect and family violence and make information on these subjects available to all students, faculty, and clinical staff.

VI. Partnerships

A. Dental education institutions and programs and ADEA should develop partnerships among health care organizations, corporate entities, and state and federal government to collectively educate the public on the importance of oral health and the significant role it has in total health.

B. Dental education institutions and programs should prepare graduates to work with community-based programs to expand disease prevention and health promotion techniques to meet the needs of various populations including the indigent, minorities, the elderly, and other underserved groups.

C. Dental education institutions and programs and ADEA should create, expand, and enhance awareness and a strong knowledge base among lawmakers and the public about the role of oral disease on total health.

VII. Public Policy Advocacy

A. ADEA and its membership should work together to identify and promote emerging issues in public policy and take action to secure federal and state policies and programs that support the mission of ADEA.

B. ADEA should work to form and maintain strategic alliances that will promote the public policy objectives of the Association.

C. Dental educators should participate actively in promoting and securing public policy objectives with federal, state, and local executive branch and legislative bodies that promote and secure the public policy issues of ADEA.

D. Dental educators and students should work to ensure that policy decisions that may critically affect dental education be formulated in conjunction with representatives of appropriate educational institutions and organizations.