

EXHIBITS

Exhibit 10: ADEA Policy Statements

All these statements of official ADEA policy were approved by the ADEA House of Delegates.

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ADEA Policy Statements: Recommendations and Guidelines for Academic Dental Institutions

(With changes approved by the 2018 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.

EDUCATION

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 practition-

ers 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 underrepresented 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 in which 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 ADEA AADSAS will report to ADEA AADSAS by March 1 the names of candidates who hold a position in their entering class. By March 5, ADEA AADSAS will report to each institution the names of candidates in their entering class who are holding acceptance(s) at additional institutions. Dental schools with candidates holding multiple positions on March 5 of the year of admission will give such candidates a minimum fifteen-day notice if they choose to withdraw the candidate from the entering class. Notification times may be shortened after April 15. Dental schools will have the option of rescinding an offer of admission to candidates who are holding positions at multiple institutions. 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 whether it provides applicants a reasonable time frame to complete their enrollment process.

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.*

* 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

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;
 - g. implementing a process to continually monitor all aspects of the policy; and
 - h. reviewing and updating the policy periodically.
8. **Nondiscrimination.** ADEA's Councils, Sections, Boards, the House of Delegates, committees, task forces, and similar entities do not discriminate on the basis of race, color, national or ethnic origin, ancestry, age, religion or religious creed, disability or handicap, sex or gender, gender identity and/or expression, sexual orientation, military or veteran status, genetic information, or any other characteristic as prohibited under applicable federal, state, or local law.
 9. **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

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.

- d. following recognized guidelines, laws, and standards of care for management of patient information.
10. **Confidentiality.** Educate staff, students, and faculty to respect and protect patient confidentiality as part of professional interactions.

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 professionals 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.
13. **Women's Health.** Recognize women's health and gender differences as an emerging science that is broader than reproductive health and includes the health of women and girls across the life span, as well as encompassing scientific concepts of gender differences from the molecular (cellular) to community levels with their clinical implications.

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.

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.

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 supporting 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 members 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 members 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.

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.

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 students 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.

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.

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.

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.

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 competence 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.

RESEARCH

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.

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.

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.

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.

Excellence in Teaching

Dental education institutions and programs should promote excellence in teaching through active programs of research on the teaching and 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.

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.

Forms of Research

Academic dental institutions should be encouraged to engage in innovative, collaborative, interdisciplinary, and interprofessional research including biomedical, social, and clinical research that contributes to the knowledge base and understanding of health issues that ultimately benefit both men and women, keeping in mind that women's health should be an integral part of the dental curriculum.

LICENSURE AND CERTIFICATION

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.

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.

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.

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 policy-making 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.

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.

ACCESS AND DELIVERY OF CARE

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.

Scope of Services

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

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.

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.

HEALTH PROMOTION AND DISEASE PREVENTION

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.

Dental Caries

1. **Prevention and Management.** 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.

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 weights, 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.

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 infectious 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.

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.

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.

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.

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.

ADEA Policy Statement on Health Care Reform

Oral Health Care: Essential to Health Care Reform (As approved by the 2009 ADEA House of Delegates)

As the voice of dental education, the American Dental Education Association (ADEA),¹ whose members serve as providers of care for thousands of uninsured, underserved low-income patients, believes that dental and allied dental educators have an ethical obligation to promote access to oral health care. To that end, ADEA believes that any comprehensive reform of the U.S. health care system should provide universal coverage to all Americans and access to high-quality, cost-effective oral health care services. Health care reform must also include investments in dental public health that improve our nation's capacity to meet the health care needs of patients, communities, and other stakeholders.

MILLIONS LACK DENTAL INSURANCE

Ensuring oral health is a shared responsibility of individuals and families, the private sector, and federal, state, and local governments. The United States spends over two trillion dollars annually on health care,² more than any other nation in the world.³ Nevertheless, access to health care is still beyond the reach of more than 47 million Americans.⁴

In 2003, the U.S. surgeon general reported that the number of Americans without dental insurance was more than 2.5 times the number lacking medical insurance.⁵ Approximately 130 million adults and children are without dental coverage.⁶ Many individuals, particularly those who are uninsured, often delay dental treatment until serious or acute dental emergencies occur. The cost of caring for Americans without health insurance in emergency rooms adds approximately \$922 to the average cost of annual premiums for employer-sponsored family coverage.⁷ And the cost of providing preventive dental treatment is estimated to be ten times less than the cost of managing symptoms of dental disease in a hospital emergency room.⁸

GRAVE ORAL HEALTH DISPARITIES EXIST

According to the U.S. surgeon general,⁹ dental disease is disproportionately found among individuals with special health care needs, with low incomes, from underrepresented minorities, and among those who live in underserved rural, urban, and frontier communities. Special care

patients have more dental disease, missing teeth, and difficulty in obtaining dental care than the rest of the population. These inequities challenge us to make adequate investments in a strong dental public health infrastructure that extends beyond the traditional, economically driven model of care. The current model may well serve a majority of U.S. citizens, but it is not achieving universal coverage and equitable access to oral health for everyone.

ENHANCING PRODUCTIVITY AND PRESERVING EMPLOYER-SPONSORED COVERAGE

Dental disease significantly impacts the nation's domestic productivity and global competitiveness. More than 51 million school hours and 164 million hours of work are lost each year due to dental-related absences.⁵ More generally, uncompensated care adversely affects American businesses as costs are shifted to private payers. Health care costs added \$1,525 to the price of every car produced by the Big Three auto makers in 2007.¹⁰ Most workers and families receive health insurance through employer-sponsored coverage. Changes to the health care system should bolster rather than erode businesses' capacity to purchase health and dental coverage for their employees. Any proposal to reform the U.S. health care system should ensure that the economic viability of American businesses is maintained and that they are able to compete in the global marketplace.

PRINCIPLES FOR HEALTH CARE REFORM

Academic dental institutions are vital public trusts and national resources. They educate the future dental workforce, conduct dental research, inform communities of the importance and value of good oral health, and provide oral health care services and serve as dental homes to thousands of patients. It is within the broad range of oral health expertise and the interests represented by our membership that the American Dental Education Association offers the following principles for providing access to and coverage of affordable oral health care services in health care reform:

- 1. The availability of health care, including oral health care, fulfills a fundamental human need and is necessary for the attainment of general health.** Every American should have access to affordable diagnostic, preventive, restorative, and primary oral health care services so as to eliminate pain, suffering, and infection. Coverage must ensure that individuals are able to obtain needed oral health care and must provide them with protection during a catastrophic health crisis. Oral health care services are proven to be effective in preventing and controlling tooth decay,¹¹ gum infections, and pain, and can ameliorate the outcomes of trauma. Oral health services should have parity with other medical services within a reformed U.S. health care system. The equitable provision of oral health care services demands a commitment to the promotion of dental public health, prevention, public advocacy, and the exploration and implementation of new models of oral health care that provide care within an integrated health care system.
 - 2. The needs of vulnerable populations have a unique priority.** Health professionals, including those providing oral health care services, must individually and collectively work to improve access to care by reducing barriers that low-income families, minorities, remote rural populations, medically compromised individuals, and persons with special health care needs experience when trying to obtain needed services. New integrated models of care that expand roles for allied dental professionals as well as other health professionals (including family physicians, pediatricians, geriatricians, and other primary care providers) as team members¹² may be needed to address the complex needs of some patients. Statutory language may be needed to clarify and expand coverage of “medically necessary” dental care provided under Medicare to beneficiaries with serious medical conditions in order to prevent complications and death associated with their health condition and treatment.
 - 3. Prevention is the foundation for ensuring general and oral health.** Prevention and wellness hold the promise of stemming escalating costs and treating diseases at early stages before expensive emergencies occur. Most dental diseases are preventable, and early dental treatment is cost-effective. Preventing and controlling dental diseases include adequate financing of organized activities to promote and ensure dental public health through education, applied dental research, and the administration of programs such as water fluoridation and dental sealants. Improving oral health by multiple preventive approaches (including periodontal disease management) has saved more than \$4 billion per year in treatment costs.¹³ Prevention of dental dis-
- eases ranks above HIV screening and influenza immunization in cost savings.¹⁴ Children who receive preventive dental care early in life have lifetime dental costs that are 40 percent lower than children who do not receive care.¹⁵ Oral cancer treatment costs in the earliest stages of the disease are estimated to be 60 percent lower than those at an advanced stage of disease.¹⁶ Every dollar invested in community water fluoridation yields approximately \$38 in savings on dental treatment costs.¹⁷
- 4. The financial burden of ensuring coverage for health care, including oral health care coverage, should be equitably shared by all stakeholders.** Access to affordable health care services requires a strong financial commitment that is a responsibility shared by all major stakeholders, including individuals and families, as well as providers, employers, private insurers, and federal, state, and local governments. To ensure health, oral health care services must be an integral component of financing and delivery systems regardless of whether the care is provided by a public or private insurance program or in a community or an individual setting. The burden of uncompensated care and the cost shifting that occurs adversely impact U.S. businesses, limit governments’ capacity to address other pressing economic and social concerns, and strain the health care safety net to the breaking point.
 - 5. A diverse and culturally competent workforce is necessary to meet the general and oral health needs of our demographically changing nation.** Racial and ethnic diversity of health professionals contributes to improved access to care, greater patient choice and satisfaction, and enriched educational experiences for students.¹⁸ Proposals to reform the U.S. health care system should include adequate funding for programs that are designed to increase the number of underrepresented minorities in the health professions. This would ensure a workforce that is prepared to meet the needs of a diverse population that continues to expand. Academic dental institutions, which educate and train oral health care professionals, have a distinct responsibility to educate dental and allied dental health professionals who are competent to care for the changing needs of society. This responsibility includes preparing oral health care providers to care for a racially and ethnically diverse population, an aging population, and individuals with special needs.
 - 6. Reducing administrative costs and realigning spending can increase quality, improve health, and create savings for additional reforms.** Approximately \$700 billion (about a third) of U.S. health care spending is used for administrative and operating costs or to benefit third-party payers and does not directly

impact health outcomes.¹⁹ Reducing these administrative burdens in the delivery of health care and creating new payment incentives that reward providers for delivering quality care will improve health care. It also has the potential to enhance provider participation and lower health care costs over time. More dollars would then be available for reforms such as strengthening primary care and chronic care management, increasing the supply and availability of primary care practitioners, and reinvesting in the training of a twenty-first-century health care workforce. Targeted tax changes might also be used to improve efficiencies, ensure the even distribution of health care, and promote efficient use of consumers' health care dollars.

REFERENCES

1. The American Dental Education Association (ADEA) represents all fifty-seven dental schools in the United States in addition to 714 dental residency training programs and 577 allied dental programs, as well as more than 12,000 faculty members who educate and train the nearly 50,000 students and residents attending these institutions. It is at these academic dental institutions that future practitioners and researchers gain their knowledge, where the majority of dental research is conducted, and where significant dental care is provided.
2. Poisal JA, Truffer C, Smith S, Sisko A, Cowan C, Keehan S, Dickensheets B. Health spending projections through 2016: modest changes obscure part D's impact. *Health Affairs*, February 21, 2007;W242-53.
3. Organization for Economic Cooperation and Development. Health data updates: data, sources and methods, and software updates. At: www.oecd.org. Accessed: December 8, 2008.
4. DeNavas-Walt C, Procter BD, Lee CH. Income, poverty, and health insurance coverage in the United States: 2005. Washington, DC: U.S. Census Bureau, 2005:18.
5. U.S. Department of Health and Human Services. National call to action to promote oral health. NIH Publication No. 03-5303. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Institute of Dental and Craniofacial Research, 2003.
6. National Association of Dental Plans/Delta Dental Plans Association. 2007 dental benefits joint report: enrollment. Oakbrook, IL: National Association of Dental Plans/Delta Dental Plans Association, August 2007.
7. Stoll K, Thorpe K, Pollack R, Jones K, Schwartz S, Babaeva L. Paying a premium: the added cost of care for the uninsured. Washington, DC: Families U.S.A., 2005.
8. Pettinato E, Webb M, Seale NS. A comparison of Medicaid reimbursement for non-definitive pediatric dental treatment in the emergency room versus periodic preventive care. *Pediatr Dent* 2000;22(6):463-8.
9. Oral health in America: a report of the surgeon general. Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Dental and Craniofacial Research, 2000:74-8.
10. Dalmia S. Health care costs imperil big three: the UAW's health care dreams. *Wall Street Journal*, July 27, 2007.
11. Diagnosis and management of dental caries throughout life. NIH Consensus Development Program, Conference Statement. Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, 2001.
12. Haden NK, Catalanotto FA, Alexander CJ, Bailit H, Battrell A, Broussard J, et al. Improving the oral health status of all Americans: roles and responsibilities of academic dental institutions—the report of the ADEA President's Commission. *J Dent Educ* 2003;67(5):563-83.
13. Dolatowski T. Confronting the burden of dental disease: employers hold key to lessening the effects. In: Delta Dental Plans Association. Delta in-depth: an article series for producers. At: www.deltadental.com. Accessed: December 2008.
14. Silverstein S, Garrison HH, Heinig SJ. A few basic economic facts about research in the medical and related life sciences. Bethesda, MD: Federation of American Societies for Experimental Biology, 1995, vol. 9:833-40.
15. Sinclair SA, Edelstein B. Cost-effectiveness of preventive dental services. Washington, DC: Children's Dental Health Project, 2005.
16. Zavras A, Andreopoulos N, Katsikeris N, Zavras D, Cartos V, Vamvakidis A. Oral cancer treatment costs in Greece and the effect of advanced disease. *BMC Public Health* 2002;2:12.
17. U.S. Department of Health and Human Services. Cost savings of community water fluoridation. Atlanta: Centers for Disease Control and Prevention, Division of Oral Health, August 2007. At: www.cdc.gov/Fluoridation/fact_sheets/cost.htm. Accessed: June 19, 2008.
18. Smedley BD, Butler AS, Bristow LR. In the nation's compelling interest: ensuring diversity in the health care workforce. An Institute of Medicine Report. Washington, DC: National Academies Press, 2004.
19. Orszag PR. Increasing the value of federal spending on health care. Testimony before the U.S. House of Representatives, Committee on Budget, July 16, 2008.

ADEA Statement on Professionalism in Dental Education

(As approved by the 2009 ADEA House of Delegates)

The American Dental Education Association (ADEA) is committed to developing and sustaining institutional environments within the allied, predoctoral, and postdoctoral dental education community that foster academic integrity and professionalism. The ADEA Task Force on Professionalism in Dental Education was charged by the ADEA Board of Directors with the development of an ADEA Statement on Professionalism in Dental Education for the dental education community. All seven ADEA Councils endorsed this effort and were represented on the Task Force. Through its work, the Task Force sought to identify and clarify those personal and institutional values and behaviors that support academic integrity and professionalism in dental education and that are aligned with the existing values and codes of the dental, allied dental, and higher education professions.

The Task Force acknowledges and respects that each academic dental institution has its own unique culture, institutional values, principles, processes, and, in some cases, codes of conduct for institutional members. The ADEA Statement on Professionalism in Dental Education is not intended to replace or supersede these codes.

The Task Force hopes that this statement stimulates broad discussions about professional behavior in dental education, provides guidance for individual and institutional behavior within dental education, and, in so doing, supports professionalism across the continuum of dental education and practice.

VALUES DEFINING PROFESSIONALISM IN DENTAL EDUCATION

The Task Force identified and developed the following six values-based statements defining professionalism in dental education:

Competence: Acquiring and maintaining the high level of special knowledge, technical ability, and professional behavior necessary for the provision of clinical care to patients and for effective functioning in the dental education environment.

Fairness: Demonstrating consistency and evenhandedness in dealings with others.

Integrity: Being honest and demonstrating congruence among one's values, words, and actions.

Responsibility: Being accountable for one's actions and recognizing and acting upon the special obligations to others that one assumes in joining a profession.

Respect: Honoring the worth of others.

Service-Mindedness: Acting for the benefit of the patients and the public we serve and approaching those served with compassion.

A discussion of each of these values follows and includes a fuller definition of each value and a description of the behaviors that enactment of the value requires and to which all members of the dental education community can aspire.

In developing the ADEA Statement on Professionalism in Dental Education, the Task Force sought to align the statement with existing codes of ethics and conduct within the allied, predoctoral, and postdoctoral dental communities. To illustrate the continuity of these values between the dental education community and the practicing community, the discussion of each value includes a reference to the ethical principles espoused by the American Dental Association (ADA Principles of Ethics and Code of Professional Conduct) and the American Student Dental Association (ASDA Student Code of Ethics) and the values expressed in the American Dental Hygienists' Association (ADHA) Code of Ethics for Dental Hygienists.

Finally, examples of how the value applies to different constituencies within the dental education community are provided.

DETAILED DEFINITIONS OF THE SIX VALUES

Competence

Acquiring and maintaining the high level of special knowledge, technical ability, and professional behavior necessary for the provision of clinical care to patients and for effective functioning in the dental education environment.

Expanded definition: Encompasses knowledge of oral health care (having acquired the unique knowledge, skills, and abilities required for effective provision of clinical care to patients); knowledge about how people learn and skills for effective pedagogy (including developing curriculum and assessments); knowledge of ethical principles and professional values¹; lifelong commitment to maintain skills and knowledge; modeling appropriate values as both an educator and a dental professional; developing ability to communicate effectively with patients, peers, colleagues, and other professionals; recognizing the limits of

one's own knowledge and skills (knowing when to refer); and recognizing and acting upon the need for collaboration with peers, colleagues, allied professionals, and other health professionals. Includes recognizing the need for new knowledge (supporting biomedical, behavioral, clinical, and educational research) and engaging in evidence-based practice.

Alignment with:

ADA Principles of Ethics: beneficence, nonmaleficence

ADHA Code of Ethics: beneficence, non-maleficence

ASDA Student Code of Ethics: nonmaleficence and beneficence

Examples:

1. *For students:* Learning oral health care is a top priority. Develop the habits and practices of lifelong learning, including self-assessment skills. Accept and respond to fair negative feedback about your performance (recognize when you need to learn). Learn and practice effective communication skills. Know the limits of your knowledge and skills, and practice within them; learn when and how to refer.
2. *For faculty:* Engage in lifelong learning, and evaluate and enhance your abilities in this area; model continuous professional development in oral health care and pedagogy. Ensure curricular materials are current and relevant. Model effective interactions with patients, colleagues, and students; accept and respond to constructive criticism about your performance (recognize when you need to learn). Know the limits of your skills and practice within them; model how and when to refer; acknowledge and act on the need for collaboration.
3. *For researchers:* Generate new knowledge. Engage in lifelong learning and evaluate and enhance your abilities in this area; model continuous professional development. Model effective interactions with patients, colleagues, and students; accept and respond to fair negative feedback about your performance (recognize when you need to learn).
4. *For administrators and institutions:* Set high standards. Learn and practice effective self-assessment skills; accept and respond to fair negative feedback (recognize the need for institutional learning and address it); acknowledge and act on the need for collaboration. Support the learning needs of all members of the institution and encourage them to pursue lifelong learning.

Fairness

Demonstrating consistency and even-handedness in dealings with others.

Expanded definition: Encompasses consideration of how to best distribute benefits and burdens (to each an equal share, to each according to need, to each according to effort, to each according to contribution, to each according to merit² are some of the possible considerations); encompasses even-handedness and consistency; includes setting process standards, striving for just consideration for all parties, ensuring consistency in application of process (following the rules) while recognizing that different outcomes are possible, transparency of process, and calibration; consistent, reliable, and unbiased evaluation systems; commitment to work for access to oral health care services for underserved populations.

Alignment with:

ADA Principles of Ethics: justice, beneficence, non-maleficence

ADHA Code of Ethics: justice and fairness, beneficence, nonmaleficence

ASDA Student Code of Ethics: justice, non-maleficence and beneficence

Examples:

1. *For students:* Follow institutional rules and regulations. Promote equal access to learning materials for all students and equal access to care for the public.
2. *For faculty:* Use appropriate assessment and evaluation methods for students; view situations from multiple perspectives, especially those that require evaluation; provide balanced feedback to students, colleagues, and the institution. Use evidence-based practices. Promote equal access to oral health care.
3. *For researchers:* Set high standards for the conduct of research, and use unbiased processes to assess research outcomes. Generate data to support evidence-based practice and education.
4. *For administrators and institutions:* Set high standards, and ensure fair, unbiased assessment and evaluation processes for all members of the institution, including applicants to educational programs. Ensure that institutional policies and procedures are unbiased and applied consistently; ensure transparency of process. Provide leadership in promoting equal access to care for the public.

Integrity

Being honest and demonstrating congruence among one's values, words, and actions.

Expanded definition: Encompasses concept of wholeness and unity³; congruence between word and deed; representing one's knowledge, skills, abilities, and accomplishments honestly and truthfully; devotion to honesty

and truthfulness, keeping one's word, meeting commitments; dedication to finding truth, including honesty with oneself; willingness to lead an examined life; willingness to engage in self-assessment and self-reflection; willingness to acknowledge mistakes; commitment to developing moral insight³ and moral reasoning skills; recognizing when words, actions, or intentions are in conflict with one's values and conscience⁴ and the willingness to take corrective action; dedication and commitment to excellence (requires more than just meeting minimum standards), making a continual conscientious effort to exceed ordinary expectations.¹ Encompasses fortitude, the willingness to suffer personal discomfort, inconvenience, or harm for the sake of a moral good.³

Alignment with:

ADA Principles of Ethics: beneficence, nonmaleficence, veracity

ADHA Code of Ethics: beneficence, non-maleficence, veracity

ASDA Student Code of Ethics: nonmaleficence and beneficence, dental student conduct

Examples:

1. *For students:* Strive for personal and professional excellence. Take examinations honestly; make entries in patients' records honestly.
2. *For faculty:* Strive for personal and professional excellence in teaching, practice, research, or all of these. Represent your knowledge honestly.
3. *For researchers:* Strive for personal and professional excellence. Report research outcomes honestly.
4. For administrators and institutions: Strive for personal, professional, and institutional excellence. Use appropriate outcomes measures, and acknowledge openly when improvements need to be made. Ensure institutional systems and structures are honest, open, and respectful and do not create undue conflicts.

Responsibility

Being accountable for one's actions and recognizing and acting upon the special obligations to others that one assumes in joining a profession.

Expanded definition: Encompasses the concepts of obligation, duty, and accountability; requires an appreciation of the fiduciary relationship (a special relationship of trust) between oral health professionals and patients and between the profession and society. Accountability requires fulfilling the implied contract governing the patient-provider relationship as well as the profession's relationship to society¹; includes standard setting and management of conflicts of interest or commitment,¹ as

well as meeting one's commitments and being dependable. It requires striking a morally defensible balance between self-interest³ and the interest of those who place their trust in us, our patients and society; keeping one's skills and knowledge current and a commitment to lifelong learning; and embracing and engaging in self-regulation of the profession, including peer review and protecting from harm those who place their trust in us.

Alignment with:

ADA Principles of Ethics: beneficence, nonmaleficence

ADHA Code of Ethics: beneficence, non-maleficence

ASDA Student Code of Ethics: nonmaleficence and beneficence

Examples:

1. *For students:* Meet commitments; complete assignments on time; make your learning a top priority. Acknowledge and correct errors; report misconduct and participate in peer review.
2. *For faculty:* Continuously improve as a teacher; stay current; set high standards. Respect time commitments to others; be available to students when assigned to teach; meet commitments. Acknowledge and correct errors; report and manage conflicts of interest or commitment. Ensure that all patient care provided is in the best interest of the patient; ensure that patient care provided is appropriate and complete; protect students, patients, and society from harm. Report misconduct and participate in peer review.
3. *For researchers:* Know and practice the rules and regulations for the responsible conduct of research; stay current. Meet commitments; report and manage conflicts of interest or commitment; report scientific misconduct and participate in peer review.
4. For administrators and institutions: Continuously improve as administrators. Use appropriate institutional outcomes assessments, and continuously improve institutional systems and processes; acknowledge and correct errors. Report misconduct and support institutional peer review systems.

Respect

Honoring the worth of others.

Expanded definition: Encompasses acknowledgment of the autonomy and worth of the individual human being and his or her belief and value system¹; sensitivity and responsiveness to diversity in patients' culture, age, gender, race, religion, disabilities, and sexual orientation⁵; personal commitment to honor the rights and choices of patients regarding themselves and their oral health care, including obtaining informed consent for care and

maintaining patient confidentiality and privacy¹ (derives from our fiduciary relationship with patients); and according the same to colleagues in oral health care and other health professions, students and other learners, institutions, systems, and processes.¹ Includes valuing the contributions of others, interprofessional respect (other health care providers), and intraprofessional respect (allied health care providers); acknowledging the different ways students learn and appreciating developmental levels and differences among learners; includes temperance (maintaining vigilance about protecting persons from inappropriate over- or undertreatment, abandonment, or both³) and tolerance.

Alignment with:

ADA Principles of Ethics: autonomy, beneficence, non-maleficence

ADHA Code of Ethics: individual autonomy and respect for human beings, beneficence, nonmaleficence

ASDA Student Code of Ethics: patient autonomy, non-maleficence and beneficence

Examples:

1. *For students:* Develop a nuanced understanding of the rights and values of patients; protect patients from harm; support patient autonomy; be mindful of patients' time and ensure timeliness in the continuity of patient care. Keep confidences; accept and embrace cultural diversity; learn cross-cultural communication skills; accept and embrace differences. Acknowledge and support the contributions of peers and faculty.
2. *For faculty:* Model valuing others and their rights, particularly those of patients; protect patients from harm; support patient autonomy. Accept and embrace diversity and difference; model effective cross-cultural communication skills. Acknowledge and support the work and contribution of colleagues; accept, understand, and address the developmental needs of learners. Maintain confidentiality of student records; maintain confidentiality of feedback to students, especially in the presence of patients and peers.
3. *For researchers:* Protect human research subjects from harm; protect patient autonomy. Accept, understand, and address the developmental needs of learners. Acknowledge and support the work and contributions of colleagues.
4. *For administrators and institutions:* Recognize and support the rights and values of all members of the institution; acknowledge the value of all members of the institution; accept and embrace cultural diversity and individual difference; model effective cross-cultural communication skills. Support patient autonomy, protect patients from harm, and safeguard privacy; protect vul-

nerable populations. Create and sustain healthy learning environments; ensure fair institutional processes.

Service-Mindedness

Acting for the Benefit of the Patients and the Public We Serve and Approaching Those Served with compassion.

Expanded definition: Encompasses beneficence (the obligation to benefit others or to seek their good⁴ as well as the primacy of the needs of the patient or the public, those who place their trust in us); the patient's welfare, not self-interest, should guide the actions of oral health care providers. Also includes compassion and empathy; providing compassionate care requires a sincere concern for and interest in humanity and a strong desire to relieve the suffering of others³; empathic care requires the ability to understand and appreciate another person's perspectives without losing sight of one's professional role and responsibilities³; extends to one's peers and coworkers. The expectation that oral health care providers serve patients and society is based on the autonomy granted to the profession by society. The orientation to service also extends to one's peers and to the profession. Commitment of oral health care providers to serve the profession is required in order for the profession to maintain its autonomy. The orientation to service also extends to encouraging and helping others learn, including patients, peers, and students. Dental education institutions are also expected to serve the oral health needs of society not only by educating oral health care providers, but also by being collaborators in solutions to problems of access to care.

Alignment with:

ADA Principles of Ethics: beneficence, justice

ADHA Code of Ethics: beneficence, justice and fairness

ASDA Student Code of Ethics: nonmaleficence and beneficence, justice

Examples:

1. *For students:* Contribute to and support the learning needs of peers and the dental profession. Recognize and act on the primacy of the well-being and the oral health needs of patients and society in all actions; provide compassionate care; support the values of the profession. Volunteer to work for the benefit of patients, society, colleagues, and the profession to improve the oral health of the public.
2. *For faculty:* Model a sincere concern for students, patients, peers, and humanity in your interactions with all; volunteer to work for the benefit of patients, society, colleagues, and the profession to improve the oral health of the public. Model recognition of the primacy

of the needs of the patients and society in the oral health care setting and, at the same time, support the learning needs of students. Contribute to and support the knowledge base of the profession to improve the oral health of the public.

3. *For researchers:* Generate new knowledge to improve the oral health of the public; contribute to and support the learning needs of students, colleagues, and the dental profession. Model the values of and service to the dental profession and to relevant scientific and research associations; volunteer to serve the public and the profession; engage in peer review.
4. *For administrators and institutions:* Recognize and act on opportunities to provide oral health care for underserved populations. Encourage and support all members of the institution in their service activities; provide leadership in modeling service to the profession and the public.

REFERENCES

1. Stern DT. Measuring medical professionalism. New York: Oxford University Press, 2006:15-32.
2. Beauchamp TL, Childress JF. Principles of biomedical ethics, 3rd ed. New York: Oxford University Press, 1989.
3. Rule JT, Bebeau MJ. Dentists who care: inspiring stories of professional commitment. Chicago: Quintessence Publishing Co., Inc., 2005:171-2.
4. American College of Dentists. Ethics: core values & aspirational code of ethics. At: www.acd.org/acdethics1.htm. Accessed: December 8, 2008.
5. Accreditation Council for Graduate Medical Education. Common program requirements: general competencies. At: www.acgme.org/outcome/comp/GeneralCompetenciesStandards21307.pdf. Accessed: December 8, 2008.

ADEA Task Force on Professionalism in Dental Education

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ADEA Guiding Principles for the Education of Oral Health Professionals in Emerging Workforce Models

(As approved by the 2011 ADEA House of Delegates)

INTRODUCTION

In September 2009, the Board of Directors of the American Dental Education Association (ADEA) approved the creation of the ADEA Task Force on the Education of Oral Health Professionals in Emerging Workforce Models. Its charge was to “enunciate a set of principles to guide the educational preparation of oral health professionals in emerging workforce models.”

ADEA believes that its role, in collaboration with its member institutions, is to anticipate and prepare for changes to the curriculum and the academic environment that emerging workforce models will require as states consider modifying their practice acts to include emerging workforce models. The Association’s role is not to develop new workforce models, but to ensure the quality of the educational preparation of oral health professionals in these models.

These guiding principles are based, in part, on the following assumptions:

- Demographic shifts in society have major implications for the future composition of the oral health workforce. Professionals in the workforce of the future should possess values, attitudes, knowledge, and skills that enable them to competently meet changing societal needs.
- A single standard of quality should apply when the same service is provided by different members of the oral health team.
- The creation of new workforce models will require modification to the educational preparation of existing oral health team members to support the successful integration of emerging models.
- The guiding principles articulated for emerging workforce models have application to and implications for the education of all oral health professionals.

The ADEA Guiding Principles for the Education of Oral Health Professionals in Emerging Workforce Models aim to maintain high standards for the education, preparation, and competence of oral health professionals in emerging workforce models. These principles can inform and influence the education of oral health professionals in emerging workforce models to ensure they possess the values, attitudes, knowledge, and skills needed to provide quality oral health care.

The American Dental Education Association encourages institutions, organizations, and policymakers that are designing oral health workforce models and those that are developing educational programs to prepare these professionals to incorporate these guiding principles into their planning and decision making.

PRINCIPLE 1

Educational programs for oral health professionals in emerging workforce models should be based on clearly defined goals and desired educational outcomes. These programs should be competency-based, providing learning experiences to ensure that students attain the values, attitudes, knowledge, skills, and experiences needed to provide quality care in a collaborative, interprofessional environment.

- Competency domains should be consistent across educational programs and should align with the ADEA Competencies for Entry into the Allied Dental Professions. Where the scope of practice for emerging workforce models extends beyond the allied dental competencies, competency domains should align with the ADEA Competencies for the New General Dentist. Competency domains for oral health professionals in emerging workforce models should include communication, culture and diversity, evidence-based patient care, health policy and advocacy, health promotion and disease prevention, professionalism and ethics, and systems thinking and financial management. Specific competencies within each domain should reflect the scope of practice of each professional position.
- The academic dental community should be involved in decisions regarding the length and rigor of educational programs. The academic dental community possesses the expertise and experience to ensure that graduates have sufficient time to achieve competencies and demonstrate the values, attitudes, knowledge, experience, and skills (including critical thinking, ethical decision making, teamwork, communication, and cultural competence) needed to provide care at the level defined by their scope of practice.
- Curricula should include instruction in biomedical, clinical, behavioral, social, and economic sciences. Educational programs should expose students to experi-

ences working with dental, allied dental, and other health professionals in integrated clinical settings to ensure that all members of the oral health team understand the roles and responsibilities of each member of the team.

PRINCIPLE 2

Educational programs for oral health professionals in emerging workforce models should have appropriate processes to ensure program quality and assessment of graduates' competencies.

- National accreditation standards should be developed and implemented by the Commission on Dental Accreditation to ensure ongoing quality and continuity across educational programs.
- The education, knowledge, skills, and experience needed to safely provide oral health services, as defined by scope of practice, should inform decisions about the appropriate level of supervision. These decisions should be made with input from the academic dental community.

PRINCIPLE 3

Educational programs for oral health professionals in emerging workforce models should ensure that students attain the skills necessary to engage individuals from diverse populations in decisions about their oral health.

- Educational programs should emphasize the principles of population-based public health science as a means of engaging diverse populations and communities in the prevention and control of oral diseases and in reducing oral health disparities.

- Educational programs should ensure that graduates attain the values, attitudes, knowledge, and skills needed to provide care that is respectful of a patient's culture, class, race, ethnicity, and socioeconomic background.
- Educational programs should implement strategies to recruit, retain, and promote individuals from diverse backgrounds.

PRINCIPLE 4

Educational programs for oral health professionals in emerging workforce models should be evaluated continuously to determine their success in meeting their defined goals and educational outcomes.

- Educational programs should ensure that graduates are educated in a timely, efficient, and equitable manner, and possess the values, attitudes, knowledge, and skills needed to provide safe, appropriate, patient-centered care.
- Educational programs should prepare graduates to meet a single standard of quality for the same service provided by different members of the oral health team.

CONCLUSION

The ADEA Guiding Principles for the Education of Oral Health Professionals in Emerging Workforce Models aim to maintain high standards for the education, preparation, and competence of oral health professionals in emerging workforce models. ADEA encourages institutions, organizations, and policymakers that are designing oral health workforce models and those that are developing educational programs to prepare these professionals to incorporate these guiding principles into their planning and decision making.

Statement of ADEA Policy on Diversity and Inclusion

(As approved by the 2016 ADEA House of Delegates)

A Statement of ADEA Policy on Diversity and Inclusion was needed for the following reasons:

1. To facilitate communication of the ADEA Principles of Diversity and Inclusion through a common language.
2. To lend support to ADEA's mission, policies, and programs that promote diversity and inclusion throughout dental, allied dental, and advanced dental education.
3. To meet the current and expanded role of ADEA in promoting diversity and inclusion now and in the future.

Diversity and inclusion are critical components of success in a global context and in an ever-changing world. ADEA, in its leadership role, will constantly strive to be a model of diversity and inclusion.

ADEA's ability to promote effective inclusion practices is necessary to fulfill our mission and to uphold the quality of the dental education system. ADEA's Board of Directors, faculty, staff, students, and members therefore must resemble the diversity that is so proudly reflected in the citizenry of our nation.

ADEA's value of diversity is embedded in respect and appreciation of race, color, national or ethnic origin, ancestry, age, religion or religious creed, disability or handicap, sex or gender, gender identity and/or expression, sexual orientation, military or veteran status, genetic information, and perspectives of each individual. To be inclusive is to collectively utilize the unique talents and perspectives of the diverse array of individuals who constitute the dental education community and its partners.

Thus, ADEA believes that the number of graduates of dental and allied dental programs should reflect their representation in the population and the communities in which they will serve. Recruitment, retention, and graduation of practitioners from diverse groups are goals that are important for the public's health. ADEA is committed to developing and sustaining institutional environments within the dental education community that are inclusive and supportive of all diverse groups of students, faculty, employees, and patients.

Dental education can show leadership in the following ways:

- Continue efforts to gain visibility for dentistry/dental education where the mission of diversity and inclusion

can be advanced in an interprofessional health care environment.

- Sponsor faculty training and best practices in the creation of an inclusive supportive environment.
- Support faculty and staff recruitment that visibly announces the institution's nondiscrimination policy.
- Provide benefit plans that allow same-sex partners to participate in all benefits available to spouses and dependents.
- Become recognized as visible partners in the community to foster visibility, engagement, and support.
- Enact student support systems to fully support LGBTQ students during their education.
- Create an accessible structure for counseling and mental health support for students in all aspects of their gender and sexuality.
- Support ongoing conversations for students who may request help in deciding whether or not to make their diverse characteristic/s visible in their postgraduate applications and other academic milestones.
- Support transgender students who may have medical needs because of transitioning and who may wish to change their gender identification in their records.
- Include curriculum time devoted to diversity education, including time to teach about the needs of the LGBTQ communities, their unique cultural characteristics, and challenges they face in the community. This may include programs like Safe Zone training to facilitate sensitivity, understanding, acceptance, and cultural competence.
- Provide a clinical environment that supports LGBTQ patients by being open, accepting, and culturally competent to manage unique needs.
- Engage members of the community to evaluate success in meeting the needs of all patients.

Diversity within dental education plays a critical role in the professional development of a culturally competent dental workforce for the future. Additionally, ADEA's ability to advocate for effective inclusion practices throughout dental education positions our members to be of value to the increasingly diverse system of higher education in the United States and to the oral health imperative of the nation.

ADEA strongly endorses the continuous use of practices that achieve excellence through diversity and inclusion.

ADEA Policy Statement on the Prevention and Elimination of Racism, Harassment, Discrimination, and Bias in Dental Education

(As approved by the 2021 ADEA House of Delegates)

All health care professionals are committed to the basis of the Hippocratic Oath, which is to “do no harm.” Dental professionals are bound by the American Dental Association Code of Ethics Principles of nonmaleficence, beneficence, justice and veracity. In accordance with the ADEA Diversity and Inclusion Strategic Framework, ADEA partners with its membership, strategic partners, and the health care community to advance access, diversity, equity, inclusion and the wellbeing of all constituencies as priorities in dental education.

Black Lives Matter and the Anti-Racism movements, the continued erosion of LGBTQIA+ rights, and the COVID-19 pandemic have further magnified the effects of social determinants of health and other related disparities on the health and wellbeing of vulnerable and historically underrepresented and marginalized populations. The #MeToo Movement has also highlighted the gender-based harassment and discrimination that continues to impact our communities. It is evident that the history of these ongoing social justice challenges has energized the movements and exposed the glaring inequities among marginalized populations.

As The Voice of Dental Education, ADEA recognizes the necessity for and benefits of a diverse, equitable and inclusive environment for all members of the dental, allied dental and advanced dental education communities, as reaffirmed in the Statement of ADEA Policy on Diversity and Inclusion (revised 2016). As a leader in health professions education, ADEA must acknowledge that our country’s painful history of racial and gender discrimination and bias—both conscious and unconscious—has played a role in the health and workplace inequities that plague our country today and that these destructive entities will not be tolerated in dental, allied dental, or advanced dental education.

This resolution supplements the Statement of ADEA’s Policy on Diversity and Inclusion and will enable ADEA to:

1. Facilitate communication of ADEA’s commitment to combat hate, bias, harassment and racism in dental, allied dental and advanced dental education.
2. Lend support to ADEA’s mission and strategic plan to develop and sustain institutional environments within the dental education community that are inclusive and

supportive of all diverse groups of students, faculty, residents, fellows, employees and patients.

3. Meet the current and expanded role of ADEA as an access, diversity, equity and inclusion leader in health care and health care education globally.

ADEA has recognized the need for a renewed effort to prevent and eliminate racism, harassment, discrimination and bias in dental education, meeting the current and expanded role of ADEA in promoting access, diversity, equity and inclusion now and in the future.

ADEA and dental education can show leadership in the following ways:

- Increasing the number of pathways and pre-professional programs to improve the diversity of the dental and allied dental student bodies;
- Expanding recruitment, retention and mentorship programs for new faculty and researchers from historically underrepresented and marginalized groups;
- Advancing and creating novel research initiatives focused on unconscious bias and racism in dental education and the profession at all levels; and
- Implementing effective inclusion practices necessary to fulfill the mission and enhance a humanistic environment and the quality of dental education.

ADEA stands firmly and unequivocally against all aspects and forms of hate, bias, harassment and racism and affirms its commitment to the reduction and elimination of these destructive entities in all aspects of dental education. Dental education recognizes racism as an urgent public health crisis that significantly impacts oral health and oral health education.

Together, with our counterparts in health professions education, ADEA is committed to collaborating on the development of policy to combat racism, harassment, discrimination and bias in health care and health care education globally. Additionally, ADEA recognizes that access, diversity, equity and inclusion are critical to the success of dental education and public health, such that faculty, staff, students, residents, fellows, patients, and ADEA Members must resemble the diversity so proudly reflected in the citizenry of our nation.