ADVISORY OPINION 5.I.1: GENERAL PRACTITIONER ANNOUNCEMENT OF CREDENTIALS

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The Council on Ethics, By-Laws and Judicial Affairs of the American Dental Association (ADA) sent a ten-page document entitled ''Advisory Opinion 5.I.1.: General Practitioner Announcement of Credentials'' to a broad spectrum of groups who appeared to demonstrate interest in receiving it. The American Academy of Implant Dentistry (AAID) was among those groups. The ADA, in order to oversee and manage its multifaceted and complex areas of interest and obligation, is organized into councils and commissions, each of which is responsible for a specific domain. There are, for example, Councils on Education and Licensure, Dental, Federal and State Government Affairs, and Federal Dental Services, and a Commission on Dental Accreditation.

From time to time, as the result of a controversial or potentially divisive problem, these units will issue Advisory Opinions. The comments that follow are specifically written in response to an Advisory Opinion (5.I.1.), which is entitled ''General Practitioner Announcement (sic) of Credentials.'' The AAID, among others, was invited to make comments on the report. Although the report stated that the Advisory Opinion had taken effect in December of 1997, the Council claims that it will evaluate comments and suggestions received from members of the communities of interest to whom it was addressed, and the Council stated that its purpose was to provide discussion and to adopt final language following review.

Although interested parties were instructed that they were ''free to comment on the language of the advisory,'' the document continued with the note that ''the Council (did) not anticipate making changes . . . at this time.'' It would appear that the seemingly liberal invitation permitting the reception of opinions from all interested arenas was a pyrrhic gesture. If changes are not to be made, the only benefit to receiving suggestions would be that it provides the opportunity to blow off the steam of frustration.

There are three aspects of the document that invite comments:

(1) The language of the advisory opinion itself, for which no changes are anticipated,
(2) the draft report that follows, the language of which will not be finalized until the Council has had an opportunity to consider the comments received from the disparate factions to whom the report has been addressed, and
(3) the extant philosophies that governed the initial drafting of Advisory Opinion 5.I.1. and the explanatory report.

The entire document was created with bias. The body that issued the

Advisory Opinion represents the member organization (ADA) that created, supports, and sponsors the specialty recognition system presently in place—one that for so many years has been protected and preserved in a static posture. Efforts made by organizations possessing true legitimacy, to gain the precious status of recognized specialty, have traditionally and predictably been rejected by the ADA House of Delegates, despite the fact that on several occasions, the Council on Dental Education had recommended approval. It was the politically charged delegates who chose to reject the AAID application for specialty status, despite the fact that this organization had met all of the requirements. No entry through the front door. No opportunity to acquire legitimacy.

By admission of the framers of the ''General Practitioner Announcement'' (5.I.1.), past applicants have introduced practitioners who had acquired formal training and all of the associated companion requirements on a basis that was comparable with that of their colleagues in the recognized specialties. If one questions the motivation behind these numerous rejections, a not unreasonable conclusion would be that the rejections serve to protect the status quo, to limit the special areas of practice to the ''Sacred Eight,'' and to assure the ADA practitioner members that their sanctified and rarefied environment will not be invaded economically or professionally.

The Advisory Opinion document, in lines 12–16, emblazons its rationale with the standard of protecting the public. The intention is to inform with truth and to shield consumers from deception. These goals are positive and laudatory, but in these changing times, such goals can be considered misleading. Those members of the public who seek our services should be afforded the privilege of being apprised of the status of those practitioners who have formally acquired the skills of a specialty not included in the current stable of accepted disciplines. Announcements made by such practitioners would be ''truthful and nondeceptive'' so that patients could make intelligent, informed selections from a broader and more sophisticated domain.

The Advisory Opinion goes on to state (in line 28) that there are eight specialties ''currently'' recognized. To the initiated, the use of the adverb ''currently'' would seem to indicate that the process of recognition is an ongoing and dynamic process. Those who have attempted to convince the ADA that new specialties would bring improved health care options to the public know differently.

In the matter of assessing the credentials of general practitioners, the document stated (lines 33–38) that ''Announcement of credentials by general dentists raises ethical concerns because there is no standardized, nationally accepted program for recognizing achievement in non-specialty interest areas.'' The ethical concerns, it appears, were introduced by the very organization that refuses to recognize the validity and benefits offered by the educational programs and certification approved and sponsored by the AAID. ADA acknowledgment and approval would be a far safer and better way to protect the public and to oversee the announcement of credentials than their present, totally exclusionary edicts.

It is intended by the American Board of Oral Implantology (ID) that patients seeking dental implant care will acquire an understanding that credentialed dentists are better qualified than general dentists without training or certification. Just as there are different levels of skills among specialists, the same situation applies to generalists. It is demeaning to know that the ADA lumps all general practitioners into one amorphous group. Has the ADA lost sight of the anesthesiologists, stomotologists, radiologists, and implantologists, who have long and conscientiously studied in informal programs and who have applied their capabilities so assiduously to patients in need? Essentially the present rulings amount to subjecting the public to a state of information deprivation.

Today implantology is one of the most significant dental disciplines practiced in the United States. Its labrynthine complexities are best transmitted by full-time programs dedicated to this singular area of practice. Graduates of such programs and their colleagues, who have acquired skills by means of long experience, bring the highest levels of care to the public. Specialists in prosthodontics, oral and maxillofacial surgery, and periodontology have many disparate professional responsibilities. Few practitioners among these specialties limit their practices to implantology. Many of them have acquired their information from the despised ''non-existent to basic weekend continuing education course'' (as noted in line 36 of the Advisory Opinion document).

I can think of no better substantiation of qualifications in implant dentistry than Board certification. The Board is open to all qualified applicants. Criteria for admission, quality of the examination, and associated key factors are available for scrutiny by the Commission or by any other duly-appointed, neutral group. Diplomates (Board-certified implantologists) have labored futilely to enter the hallowed realm of ADA recognition by admission through the front door.

Efforts in the state of Florida to permit such specialty achievements to be recognized publicly have been sponsored by the AAID, and these efforts appear to have been greeted with success. In Florida, AAID-credentialed implantologists may now announce these distinctions. But these privileges have been acquired (via a back-door entry) despite the opposition of the Florida State Dental Association, which was supported in its opposition by the ADA. It is regrettable that the ADA is instructing constituent dental societies to defy state law. Overprotection of the public can amount to despotism.

If the ADA is unwilling to offer equitable opportunities to its members

who have legitimate special training, experience, and qualifications, and if it threatens disciplinary action through its component societies despite state law, resignation possibly, offers a viable alternative.

Additional discriminatory problems with Advisory Opinion 5.I.1. abound. Specialists who announce additional, nonspecialty qualifications have, for the time being, escaped the harsh pen of the Council (lines 135–139). Recommending that specialty status be based on completion of a formal, full-time program of only one year is a demeaning concession to those striving for recognition (lines 141–147). If the minimum training and experience requirement for those with accepted specialty status is two years, the same time should be demanded of orphan groups.

The ADA's refusal to evaluate the quality or content of nonrecognized programs is further indication of its attitude of denial (lines 161–166) and neglect of significant segments of its membership. These practitioners should be accorded all privileges, rights, and responsibilities available to the organization's favored sons.

Individuals qualified in oral implantology (as manifested by Board certification) deserve the same benefits afforded to other specialists. Practitioners who limit themselves to this single discipline should not have to dilute the significance of their skills and training by being directed to place disclaimers in advertisements and on announcements and stationery (lines 192–196).

It is unfortunate that the CEBJA does not consider the status of the examinations being given to qualified candidates of sufficient importance to evaluate them. Their discouraging approach is that of benign neglect. Only upon the receipt of a complaint of an ''alleged'' violation will the matter of credential and examination validity be reviewed (lines 174–175). This represents an attitude of flagrant negativity.

Overcontrol of practitioners may lead to their unlawful behavior. If cool heads prevail and if impartial arbiters are consulted, this dilemma might be solved in time to greet the new millennium with optimism. ■