

# The Who, What, Why, and When of the American Board of Dental Specialties (ABDS)

“In the beginning...” was the phrase which first appeared in the book of Genesis. However, that phrase has become both legendary and used for millennia ever since. It is an appropriate introduction to the history of American Dental Association (ADA) specialties, the ADA specialty process, case law relating to the First Amendment’s protections for commercial free speech (Advertising), and the “genesis” of the American Board of Dental Specialties (ABDS).

It all began in 1947, when the ADA pronounced, with little fanfare, the creation of five ADA specialties. These were Periodontics, Oral Surgery, Prosthodontics, Orthodontics, and Pediatric Dentistry. While handy for general practitioners to know, it was of little consequence to the dental profession as a whole. Then in 1950, the ADA declared another area of specialty, Public Health Dentistry. Again, these specialty declarations were met with little concern by the dental profession. The next ADA pronouncement of another specialty occurred in 1963, when Endodontics was bestowed “specialty” status by the ADA, again with little comment or concern in the dental world.

It is important to keep in mind that until the late 1970s, professional advertising was almost universally prohibited. So although these areas of specialty were useful to the dental profession for referral purposes, a specialist could not declare himself/herself as a “specialist” to the public, or otherwise capitalize on their specialty status in the marketplace. However, as the laws relating to commercial free speech evolved, so did dental advertising and marketplace competition.

Note that during the 80s and 90s, multiple applications to the ADA for specialty recognition were submitted, and resubmitted, by various areas of dentistry and all such applications were deemed to not fulfill the (ever changing) criteria of the ADA.

Let’s move ahead to 1999, when the ADA House of Delegates (HOD) was confronted by four applications for specialty recognition. As is commonly known, by 1999 professional advertising had continued to escalate, and marketplace “turf wars” were a reality. Ultimately, at the ADA HOD in Hawaii in 1999 it was decided that Radiology was deemed worthy of ADA recognition as a specialty. However, why would *only* radiology meet the alleged criteria of the ADA for specialty recognition, despite meritorious applications from the American Academy of Orofacial Pain, American Dental Society for Anesthesiology (ADSA), and the American Academy of Implant Dentistry (AAID)?

Now it becomes interesting. About 4 months prior to the 1999 ADA meeting, the Supreme Court of the United States had

concluded (*California Dental Association v Federal Trade Commission*) that the Federal Trade Commission (FTC) had jurisdiction over the California Dental Association relating to their enforcement of their ethical provisions relating to California members’ advertising. Clearly, by virtue of the tripartite structure of the ADA, this decision sent a clear message to the ADA that the FTC had the authority and would view its practices and ethical constraints carefully, as potentially having a negative impact on marketplace competition, and therefore higher costs to dental consumers.

Fast forward several months to the 1999 HOD in Hawaii, when legal counsel for the ADA was advising that the acceptance of at least one new specialty might diminish FTC scrutiny, as opposed to denying all pending applications for specialty recognition. (This author was present, on the HOD floor, as legal counsel for all specialty applicants.) Then, in discussions in the HOD, radiology was deemed to be the least threat to the economic and marketplace competition among dentists. So, after a 36-year lapse in declaring a new specialty, Radiology was crowned.

Again, let’s fast forward to the 2012 HOD consideration of the ADSA application for recognizing Dental Anesthesiology as a specialty. Despite having the recommendations for approval by every council, committee, and the Board of Trustees, the American Association of Oral and Maxillofacial Surgeons (AAOMS) felt economically threatened by the creation of a dental specialty in anesthesia, and the anticompetitive forces effectively lobbied, crusaded, and spread misinformation about the lack of any need for dental anesthesiologists, and how it might hamper the delivery of dental care. They openly expressed concerns about the negative economic impact to the OMS population should a new specialty in anesthesia be created. These statements have all been substantiated by multiple depositions emanating from the legal challenge against the Texas Board of Dentistry’s sole deferral to the ADA for specialty recognition. That regulation was deemed unconstitutional by a federal court in Austin (January 2016) and the appeal filed by the Texas Board is still pending in the United States 5th Circuit Court of Appeals. (This author represented all four plaintiff organizations in that litigation.)

Objectively viewing the ADA’s HOD, all consisting of economic competitors, the nature of the specialty game had been revealed in 2012 as a political process among economic competitors, and the self-evident nature of professional advertising and marketplace competition had overwhelmed any objectivity of the ADA specialty recognition process. There and then, it beheaded itself. An inevitable result of this reality was the creation of the ABDS, an objective, apolitical entity not controlled by any dental organization, comprised of bona fide certifying boards of multiple areas of dentistry. To date, the

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member certifying boards of the ABDS are Oral Medicine, Oral Facial Pain, Implant Dentistry, and Dental Anesthesiology. ADA recognized certifying boards are expected to seek recognition by, and be accepted, the ABDS in the near future.

After the formation of the ABDS, the ADA began to study its own specialty recognition process. At present, it is anticipated that the ADA HOD will be presented with a resolution, at the 2017 meeting in Atlanta, by which the HOD would transfer its authority to declare specialties to the ADA's own newly created Commission on Dental Specialty recognition. This move is clearly intended to avoid the obvious self-interest complications of the HOD and to create the appearance of nonpolitical determinations of new specialties by the ADA (or rather the new Commission!). Similarly, it was of little surprise that the ADA HOD approved "Resolution 65" in Denver in 2016, which acknowledged that some "licensure jurisdictions" were expected to adopt and recognize specialties *not* recognized by the ADA (ie, ABDS). Moreover, in Resolution 65 it removed the ethical prohibition against a dentist advertising as a specialist if his/her specialty is recognized by their jurisdiction. So why would the ADA, at this point in history, amend 5H of its ethical provisions, and remove any objection to a member dentist advertising as a specialist in a

non-ADA recognized specialty area of practice? I will defer to the FTC for that answer.

We, as members of the dental profession, have simply brought these realities upon ourselves. When one views the history of the ADA specialty process, and the evolving Commercial Free Speech rights under the First Amendment, we should not be surprised. No dentist on the floor of the ADA HOD wants to return to his practice after having created a new specialty, which will promptly raise its head in the dental marketplace (advertising), creating new economic and marketplace hurdles.

We were once a patient oriented (not economically oriented) and respected profession whose focus was on patient care at a reasonable cost (also effected by marketplace competition). I personally would suggest that the ADA step out of the way on the specialty issue, and welcome the presence of the ABDS. That would constitute a new day for the profession and a new "In the beginning...".

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