HEALTH, WELFARE AND STATE INSTITUTIONS

Minutes of Meeting - March 14, 1975

The thirteenth meeting of the Health, Welfare and State Institutions Committee was held on March 14, 1975 at 12:15 p.m., Room 323.

COMMITTEE MEMBERS PRESENT: Chairman Lee E. Walker
Senator Neal
Senator Gojack
Senator Hilbrecht
Senator Schofield

See Exhibit A for others present.

S.B. 288 - Prohibits denial of hospital privileges to certain podiatrists solely because of their profession.

Dr. Blair V. Anderson, a Podiatrist from Reno, spoke in favor of the bill (see Exhibit B for copy of testimony).

Dr. L. Bruce Ford, D.P.M., also spoke in favor of the bill (see Exhibit C for copy of testimony). Dr. Ford further stated that the Joint Commission of Accreditation of Hospitals in 1973 issued a bulletin (which was later writtin into their manual), which states that podiatrists as well as dentists co-admits to the hospital. This means that the podiatrist initiates the admission procedure,and the general medical care of the patient is under the scrutiny of a physician who has done the history and physical work-up of the patient. The podiatrist is still responsible for the podiatry work-up and foot care, as well as the surgery.

Senator Hilbrecht indicated that he does not feel Section 1 of the bill is necessary; Senator Walker and Dr. Ford concurred with Senator Hilbrecht.

Senator Neal asked how many orthopedic surgeons there are in the State; Dr. Ford's reply was approximately 24 orthopedics and 12 podiatrists.

Dr. D.S. Droper, Nevada Podiatry Society, spoke in favor of the bill, and advised that he will speak on what podiatrists have done in the Las Vegas area. In October of 1974 Clark County Comprehensive Health Planning Council reviewed the qualifications of podiatrists and passed a resolution urging all hospitals to give staff privileges to podiatrists. They have met with the Chief of Staff at So. Nevada Memorial Hospital and have made some headway into that hospital. They are waiting now for a letter of acceptance or denial. For the past 6 years they tried unsuccessfully to gain entrance. They feel that if they were allowed hospital privileges, it would help the hospitals

with their occupancy problem -- they would help fill some of the beds. All insurance companies, Medicare, and N.I.C. honor the claims of podiatrists. Dr. Droper stated that they have no objection of going into a hospital and being monitored by a general surgeon or the chief surgeon.

Dr. Newton Thompson, Washoe Medical Center, stated that he is here to represent some of the opinions of the orthopedic surgeons. They feel that if this bill were passed, they would be getting additional medical and legal responsibilities if they were made responsible for the overseeing of the podiatrist. Dr. Thompson stated that he is the Chairman of the Orthopedic Department of Washoe Med., and they feel they are having enough difficulty in policing their own.

Senator Walker asked if this bill would subject them to additional malpractice; Dr. Thompson replied that it certainly would.

Sharon Greene, Nev. Hospital Assn., advised the committee that very few M.D.'s in Nevada are given full hospital privileges. If a person were given orthopedic surgical privileges by the privileges committee, then that individual, after having obtained those privileges, would be governed by Dr. Thompson's committee. Senator Hilbrecht asked why a podiatrist would be put under orthopedist; Ms. Greene replied that the rules and regulations state that every member of the medical staff has to be put under a department - the orthopedic department is probably the most closely related to podiatry. Senator Hilbrecht asked if a department of podiatry wouldn't be created; Ms. Greene responded in the affirmative. Dr. Ford referred to Exhibit D and stated that the last two pages indicate guidelines that would be adopted by the podiatrists.

Dr. Halvorson, Orthopedic Surgeon from Reno, spoke in opposition of the bill, and stated that in obtaining staff privileges, it is his understanding that the staff officer is responsible to the Board of Trustees for the standard of care that the patients get. This evolves down to the M.D.'s who are in charge of various staff committees and sections. Dr. Halvorson stated that he is unfamiliar with podiatry treatment; therefore, doctors would be hard-put to develope standards of care for podiatrists. For that reason, Dr. Halvorson feels this bill is not in order since they do not have enough information. Dr. Halvorson does feel that podiatrists could set up their own peer group; however, Sharon Greene feels that with only 14 podiatrists in Nevada, there would not be enough to establish a separate staff category.

Ms. Greene further stated, however, that possibly a podiatry department could be established under the general staff category. Dr. Halvorson stated that he would not be opposed to this set-up.

Dr. A. Curry, a licensed physician and representing the medical staff at Washoe Med., felt that clarification was needed between privileges and membership. Membership to a hospital is obtained by meeting the qualifications as submitted in the bylaws. Privileges are determined on an individual matter according to the person's training, experience and performance -- privileges can vary from day to day. When a physician applies for membership the following takes place: his application is received, credentials are checked, references are looked into, he is asked to supply information as necessary to qualify himself, an interview is had, membership is then so given and he is assigned to the appropriate department within the structure of the hospital. Following that, his privileges are then determined -- these privileges will then go to the appropriate peers who know this type of work; they then go into full detail of the ability of the person. They have received applications for podiatry; however, no action has been taken because there is no structure in their bylaws allowing for the practice of this medicine. They are currently working on the program of Allied Health Professions which includes dentists, podiatrists, psychologists, optomistrist, orthopedic assistants, and nurse practitioners; this will allow them to legally practice their health speciaity within the health care industry. They feel this legislation and the way it is written is totally unnecessary.

Mr. Wm. Hadley, Attorney for Washoe Med., stated that under the Allied Health Services, the person whose speciality is in question would be allowed to have a member of his profession on the committee. When a podiatrist's privileges are being discussed, there will be a podiatrist on the committee discussing his privileges. If he has a grievance, he can present it to the committee. If this bill were made law, Mr. Hadley stated that it would probably come in under the Allied Health Professions. Mr. Hadley feels there is no need for Section 1 of this bill; Mr. Hadley further stated that Section 2, line 12 should read: ...shall be made against practitioners of any regular school of medicine and surgery recognized by the laws of the State of Nevada, or any licensed hearing art also recognized...", or "any licensed Allied Health Profession". Line 14: "All such regular practitioners and licensees shall be afforded privileges in treating..." Senator Hilbrecht feels that line 13 should read: "...school of physicians and surgeons recognized by the laws...". Senator Hilbrecht also stated that we should either redefine "healing arts" or define Allied Health Services. Mr. Hadley feels that Allied Health is a more modern phrase. Senator Hilbrecht also feels that the practitioners should be itemized as to who will be allowed membership.

Mr. Hadley is to return in approximately two weeks with corrected language.

S.B. 304 - Creates dental hygiene examining committee; authorizes such committee to examine applicants for license to practice dental hygiene.

Cheryl Abbot, Nevada Dental Hygienists Assoc., spoke in favor of the bill and advised the committee that throughout the bill where "The committee" appears should read "The board and committee" (this was a bill drafting error). Ms. Abbot provided the members with a packet containing testimony and background information on the bill (packet may be found in back of minute books). It should also be noted that on page 2, line 45 the wording "and conduct" should be left in; also page 2, line 48 the wording "and dental hygiene" should also be left in. Page 2, Section 7 should also be amended to coincide with that which the board member receives.

Senator Gojack asked how many dental hygienists are in the state and how many are members of the Association; Ms. Abbot responded that there are 85 dental hygienists and 50 are members of the Association. The average yearly salary depends on the doctor and the area, but generally it would average $20,000 per year. Ms. Caryn Loftis commented that as a dental hygienist in Reno, she earns between $13,000 and $14,000 per year. (Exhibit E).

Dr. Peter D.Grazia, Nevada State Board of Dental Examiners, stated that this bill is bad legislation for the State of Nevada. They are opposed to the bill as written or as amended. The hygienst is an employee of the dentist, working in his office and using his equipment; therefore, the responsibility should lie with the dentist in examining applicants. The hygienist can monitor the Board at any time and they do receive written invitations to attend the examinations. Senator Gojack commented that she finds the written invitation rather bothersome, since it can be withdrawn at any time.

Ms. Cherrie Coulon, R.D.H., stated that she is appearing as an independent hygienist and spoke in favor of the bill. Ms. Coulon stated that it is their right to participate in the governing and control of their profession in the State.

Dr. Blaine Dunn, Dental Association, advised that at their meeting last month a motion to support this bill was defeated, and a motion to oppose the bill was also defeated; they are not that much opposed to the bill.

Senator Gojack moved "Do Pass" as amended, seconded by Senator Hilbrecht; unanimously carried.

Senate

Health, Welfare and State Institutions
Minutes of Meeting
March 14, 1975
Page Five

S.B. 309 - Permits bureau of alcohol and drug abuse to certify programs and personnel of facility dealing with alcohol and drug abusers apart from facility itself.

Mr. Paul Cohen, Rehab. Division, spoke in favor of the bill and stated that it clarifies S.B. 590 which was passed in the last session, in that it specifies "programs" and "personnel".

Senator Hilbrecht moved "Do Pass"; seconded by Senator Neal; unanimously carried.

Being no further business at this time, the meeting was adjourned at 3:10 p.m.

Respectfully submitted,

Sharon W. Maher

Sharon W. Maher, Secretary

APPROVED:

Lee E. Walker

Lee E. Walker, Chairman

Blair V. Anderson, D.P.M., FACFS
Podiatrist
1695 Lakeside Drive Reno, Nevada 89502
Phone 329-0631

14 March 1975

Mr. Chairman, Senators, Doctors, Ladies and Gentlemen,

We Podiatrists are here today to acquaint you with the most ill thought of, joked about, neglected portion of your anatomy namely the foot and to acquaint you with the Doctors who treat the foot.

We are few in numbers but are united to offer our support to legislation that will insure our admittance to the various hospital staffs in the State of Nevada.

This bill SB 288 as introduced by Senator Lee Walker is essentially the same as California bill AB 2138 which has become law in California as of January 1, 1975. We hope our remarks will strike a responsive chord in your minds in our behalf.

We are of the opinion that it is ridiculous to grant us surgical privileges in our State Law and not have legislation to guarantee our patients proper care.

The Nevada Law states : Podiatry: The diagnosis and the medical, surgical, mechanical, manipulative, and electrical treatment of all ailments of the human foot and leg not in connection with the practice of another licensed profession except amputation of the foot or leg or the administration of an anesthetic other than local. We believe that this law is explicit that the podiatrist is licensed and as far as the Legislature in the State of Nevada is concerned he is competent to treat the foot and leg.

In 1974 approximately two thousand patients were operated on in Nevada in our offices. A conservative number of four thousand individual procedures were done by the twelve licensed Podiatrists. As Podiatrists we operate on the hammered toe, the bunion, the soft corn, we remove bone spurs that occur on any boney surface, heel spurs are an example, ingrown nail, nerve tumors, over-lapping or under-lapping toes, lesions on the sole of the foot that need bone mobilization such as osteotomies where the bone is cut through and allowed to heal as a fracture heals with the lesion fading away as the result of reduced pressure, we remove warts, moles, and old scars, lengthen tendons, repair torn ligaments, we use plastic and metal implants to replace worn out or injured joints in the foot. In short we do what is necessary on the foot to make our patients comfortable. We believe that we do this as well or better than any one else.

Fifty percent of the patients that were operated on in the podiatrist 's office in the State of Nevada would have been better off in a hospital. We have thirty percent of our referrals come from primary care physicians who are interested in their patients having the very best care available. We believe that means hospital care for surgical patients. The great majority of our patients have hospital insurance some of the policies require hospitalization of the insured before they will pay for surgery. In these cases either the patient must pay for office procedures, not have the surgery done, or have someone who can hospitalize the patient do the surgery. We believe that this is an injustice and the injustice can only be remedied by our having hospital privileges.

EXHIBIT B

Blair V. Anderson, D.P.M., FACFS
Podiatrist
1695 Lakeside Drive Reno, Nevada 89502
Phone 329-0631

The marginal patient, the one with diabetes, heart or lung disease, circulatory problems should be hospitalized to make the foot surgery as safe as possible and to reduce any jeopardy to the patient. Up to this time we have not had an office emergency that has ended in a fatality. We are all trained and equipped in our office to treat emergencies but do not believe that we are the best qualified to treat emergencies.

I am a graduate of the University of Utah, Class of 1950, with a Degree of Bachelor of Science in Vertebrate Zoology. I am a graduate of the California College of Podiatric Medicine, Class of 1955, with a Degree of Doctor of Podiatric Medicine. I am a Fellow in the American College of Foot Surgeons and will be board certified in August of 1975. I am on the Staff of Barton Memorial General Hospital at Lake Tahoe, but have been prevented from doing surgery there because it states in their by-laws that a Podiatrist must be assisted by a doctor who does the same type of surgery, namely the orthopedic surgeon, and they refuse to assist. I have been a staff surgeon at the California College of Podiatric Medicine Hospital since it opened in 1960. I have been required to operate my hospital patients there at a considerable expense to my patients because of the transportation costs and the loss of time. You would be amazed at the loyalty that our podiatry patients show us as their doctors. I believe that if a patient chooses one of us to operate on them then they should have the opportunity to be hospitalized if their case so warrents.

Because of the expense not all podiatry offices are equipped with the latest and the best equipment for surgery, it is our contention that our patients should have available to them the best of care and equipment, that means hospital care. In a hospital atmosphere we would have contact with other doctors that may give an objective critique to our methods. We would be in a controlled atmosphere conducive to the best care for our patients. We would welcome this as a further strengthening to Podiatry.

It might be well to mention here that dentists enjoy hospital privileges and are able to do their surgeries according to their ability and training.

Many hospital beds in Nevada are empty, thirty percent plus, we would help fill these beds cutting costs of subsidy by the Federal and State Governments.

We believe that we would be a great credit and asset if we are admitted to the staffs of the various hospitals of Nevada.

Dr. L. Bruce Ford will give you an analysis of our education requirements and some statistical data concerning this complex appendage we specialize in.

Thank you for your consideration of this bill.

SENATE Health, Welfare COMMITTEE

ROOM # 223
DAY Friday DATE 3-14-75

NAME	ORGANIZATION	ADDRESS
Dr John Sande	WMC	Reno
Dr Sarah Curry	WMC	"
Dr Stephen Dow	WMC	"
Wm Hadley attorney	WMC	"
Dr Newton Thompson	WMC	"
Mr. Richard Freeman	Nev. Podiatry Soc	Sparks
Dr Daniel J McNeil	Nev. Podiatry Soc	Reno
Dr L. Bruce Ford	Nv. Podiatry Soc.	Reno
Dr Stephens	Nev Podiatry Soc	Las Vegas
Dr. H Tim Bean	Nev. Podiatry Soc.	Carson City
Blair V. Anderson DDS	Sec. Nev. Podiatry Soc	RENO NV
Cheryl Abbott, RDH.	Nevada Dental Hygienists Assoc	Las Vegas
Sharon M. Barber, RDH.	Nev. Dental Hyg Assoc	Las Vegas
Carolyn Loftus	Nev. Dental Hygiene Assoc	Reno
Victoria G. Stein RDH	Nev. Dental Hygiene Assoc.	Las Vegas.
Peter D Guzzo	Nevada State Board of Dental Exam.	Reno.
Sherrie M Conlon RDH	non-affiliated dental hygienist	Las Vegas
Paul Cohen	Reeds Division	Carson City
Del Frost	" "	" "
Dr Halverson	WMC	Reno

EXHIBIT A

L. BRUCE FORD D.P.M

PRACTICE LIMITED
TO
DISEASES AND SURGERY OF THE FOOT

309 KIRMAN AVENUE
RENO, NEVADA 89502
786-2878

"Mr. Chairman & Distinguished Senators"

Because the practice of Podiatric Medicine is one of the most recent of the Medical specialties to emerge, it is my purpose today to better acquaint you with the scope and training of a Podiatrist and thereby give you a better foundation on which to make your judgements.

By definition, Podiatric Medicine is that specialty of medicine and surgery which is concerned with the prevention, diagnosis, and treatment of diseases and disorders which affect the human foot and contiguous structures. As is true of most definitions, the one just given - while accurate - is too limited to adequately define the scope of the profession. It would be impossible to treat conditions affecting the foot without at the same time being concerned with the patient as a whole. Hence, while the training of a Podiatrist focuses itself principally on the lower extremeties the student is given a solid background in general medicine.

More importantly than a discrete definition, the Podiatrist shares with the medical doctor, the most important characteristic of a member of a health profession: the legal right to make, and act upon, his own independent medical judgment.

I will not dwell on the actual curriculum to which the Podiatry student is exposed as it is printed for you in your material. I'm certain that you will note that the curriculum outline compares very closely with that of the leading medical schools in the nation. It might also be of interest to you to know that approximately 30% of the faculty in the Colleges of Podiatric Medicine is composed of Medical Doctors.

In addition to the didactic training, Doctors of Podiatric Medicine participate in a very concentrated clinical training program. In California, this program includes rotation at Stanford University Medical School, University of California School of Medicine, Fort Miley V.A. Hospital, and the Kaiser Hospitals.

It might be interesting to note at this time there are Podiatrists serving on the Faculties of many of the medical schools including Stanford University, University of California, Georgetown Medical School and Dartmouth, to name but a few.

Why Is Podiatry Necessary In The Total Health Care Picture?

It has been estimated that over 70% of the U.S. population is afflicted with ailments of the feet, and that millions of man hours are lost yearly due to foot problems. Because general physicians were not well enough qualified to treat these specialized problems, Podiatry came into being. If the foot were being adequately cared for by primary care physicians, there would be no need for Podiatry and it

would wither and die. This is quite the opposite, as Podiatric Medicine is one of the fastest growing specialties in Health Care today. To illustrate my point, in the December 25th,1972 issue of American Medical News there was an article entitled "Transition To Practice Challenging to Young M.D." In this article, the author recalls "being thrown for a loop" after one of his early patients reported with an infected, ingrown toenail. "I never did many things like that in medical school", he said.

Following the mandate that health care is a right, rather than a privilege, consumers are demanding quality care provided within a comprehensive medical setting.

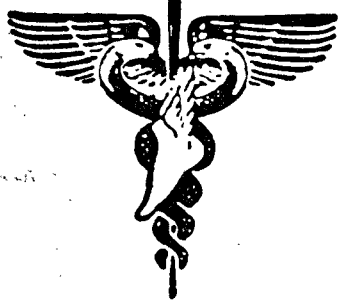
If the hospital is to serve as the focal point for delivery of comprehensive health care it must, on the one hand, provide a complete range of services for its patients by fully utilizing all members of the health care team to their maximum potential, and on the other hand, assure through continued education, supervision and supportive services, that quality care is maintained.

Offering hospital privileges to the podiatrist satisfies both these requirements. First, it provides patients with a valuable and necessary service, in addition to making time available to practitioners with unlimited medical licenses to treat patients whose ailments are beyond the scope of Podiatry. Second, as for all practitioners, it assists and monitors the performance of the individual Podiatrist who, in many instances, has remained outside the hospitals formal and structured control.

L.Bruce Ford, D.P.M.

LBF:jw

Podiatry In Today's Hospital



Prepared for:
The American Podiatry Association
Washington, D.C.

By:
Block, McGibony + Associates, Inc.
Health and Hospital Consultants
Silver Spring, Maryland

October 1973

INTRODUCTION

Following the mandate that health care is a right, rather than a privilege, consumers are demanding quality care provided within a comprehensive medical setting. In this regard, they are supported by government, planning agencies, third-party payors and the medical community itself. Nowhere are the effects of these demands being felt more clearly than in the nation's hospitals.

With increasing regularity, consumers are turning to their hospitals as both a point of entry into the medical labyrinth and as an initiator of change within the health care community. By and large, these institutions are responding to the public's overall health needs and are organizationally and operationally structuring themselves to provide comprehensive health care. The key to this restructing rests in obtaining maximum utilization of all available health professionals, particularly since the demand for manpower resources far exceeds the supply.

Within this evolving hospital environment, podiatrists are fulfilling an expanding role and adding to the effectiveness of the health manpower pool by performing a service for which they are professionally trained and uniquely qualified—the care of the foot.

During 1969, approximately one and a half million patients were treated in hospitals by podiatrists—equally divided between inpatients and outpatients—and an additional one-half million patients were treated in clinics.[1] There is every indication that this is an upward trend. Increasingly, podiatrists are requesting—and receiving—hospital privileges and hospitals are seeking information on podiatry in general and, in particular, the inclusion of hospital podiatric services.

The Need for Podiatric Services

It has been estimated that ailments of the feet afflict well over half of the U.S. population; and some sources place the figure as high as 70 percent.[2] Although common, the effects of poor foot health cannot be minimized. Any disease or disorder of the foot which results in pain, and therefore disability, will create serious problems for the individual as well as the family and the community.

For the child, a disabling foot condition can mean loss of time from school and decreased participation in sports and other activities so important to normal development. For the working adult, painful foot conditions can lead to decreased efficiency, loss of income and inability to be employed in most occupations. For older people, disabled feet can prevent them from taking care of their personal needs and from participating in other aspects of daily life. In all age groups people with foot disabilities lack independence and often become social and economic burdens.

Foot problems may also be manifestations of diseases and disorders occurring elsewhere in the body. Among these are diabetes mellitus, osteoarthritis, rheumatoid arthritis, collagen diseases, peripheral vascular disease, neoplasms, and neurovascular diseases.

For these reasons, it is essential that professional foot care be made available to all people. The podiatrist is uniquely qualified to administer this care. Moreover, he is totally concerned about foot problems—problems which might be ignored by other medical practitioners.[3]

PODIATRY IN GENERAL

"Podiatry is that profession of the health sciences which deals with the examination, diagnosis, treatment, prevention and care of conditions and functions of the human foot by medical, surgical and other scientific knowledge and methods."[4]

The profession of podiatry, like all other healing arts professions, has come a long way since the first recorded references to foot problems were made by the Greeks in the 4th Century, B.C. Gradually there has evolved, until our present day, a profession forming a separate, distinct, and complementary division of the healing arts, and possibly the most recent such division. It was not until 1846 that the first podiatry office was founded in Boston, followed in 1895 in the State of New York by the nation's first licensing act for the profession.

Status of the Profession

The podiatrist shares with the medical doctor, the osteopathic physician, and the dentist the most important characteristic of a member of a health profession: the legal right to make, and act upon, his own independent medical judgment.[5] With this right developed the concurrent requirement for regulation to insure the public an appropriate level of competence for these as for all other health practitioners.

Today in all states, the Commonwealth of Puerto Rico and in the District of Columbia the practice of podiatric medicine is regulated by law. Licensing

agencies may be organized as State Boards of Podiatry Examiners or State Boards of Medical Examiners; the latter may include one or more podiatrists on their examining boards. There is also a National Board of Podiatry Examiners for administering examinations whch are accepted, either in whole or part, by over 40 states[6] and branches of the armed forces.

Although each state has its own individual law regulating the profession, each generally complements the definition of podiatry as "that health service specifically concerned with the examination, diagnosis, treatment, prevention and care of conditions and functions of the human foot by medical and surgical means." These laws, by and large, license the podiatrist to diagnose, to treat, to operate and to prescribe medications for such diseases, injuries, deformities or other conditions of the foot. This includes surgery for the correction of deformity and disability.

In addition, a few states require a period of internship (for example, Michigan, New Jersey and Rhode Island each require a one-year internship) prior to licensure, and a growing number of states also require a stipulated number of hours of participaion in approved post-graduate training programs as a condition for license renewal. These provisions are welcomed, indeed fostered, by the profession to assure an ever-increasing quality of foot care.

Education and Training

Podiatrists receive their professional education at one of five Colleges of Podiatric Medicine accredited by the Council on Podiatry Education of the American Podiatry Association. The Council is recognized for this purpose by the U.S. Office of Education and the National Commission on Accrediting. The colleges located in Chicago, Cleveland, New York City, Philadelphia and San Francisco, award the degree of Doctor of Podiatric Medicine (D.P.M.) to candidates who have successfully completed the formal four-year program.

Prerequisites for admission include a minimum two years of pre-medical study (although now more than 75 percent of the entering students have baccalaureate or higher degrees)[7] and a sarisfactory level of achievement on the Colleges of Podiatry Admission Test (CPAT) developed in cooperation with the Educational Testing Service, Princeton, New Jersey. Students receive their podiatric education and training within the framework of a modern medical curriculum that "compare(s) quite favorably with those of the various other institutions involved in teaching the health sciences."[8] Increasing emphasis is placed on the health of the body as a whole—not the feet alone—with many of the requirements and electives the same as those offered by the country's leading medical schools. Additionally, attention is being given to such subjects as biostatistics, epidemiology, and social and economic relations of podiatry.[9]

The curriculum of the California College of Podiatric Medicine is typical of the four-year course of study followed by podiatric students:

CALIFORNIA COLLEGE OF PODIATRIC MEDICINE: CURRICULUM[10]

First Year	*Hours*
Gross Anatomy	224
Microscopic Anatomy	120
Neuroanatomy	80
Biochemistry	162
Physiology	162
Introduction to Podiatric Biomechanics	48
Introduction to Podiatric Surgery	16
Introduction to the Profession of Podiatric Medicine	24
Orientation	16
Total	852

Second Year	*Hours*
Microbiology	162
Pathology	132
Pharmacology	162
Physical Diagnosis	68
Podiatric Medicine	128
Podiatric Biomechanics	128
Epidemiology and Biostatistics	12
Podiatric and General Radiology	56
Clinic Observation	32
Total	880

Third Year	*Hours*
Podiatric Surgery	64
Podiatric Biomechanics	64
Dermatology	64
Orthopedic Surgery and Traumatology	32
General and Peripheral Vascular Surgery	32
Neurology	48
Internal Medicine	48
Clinical Therapeutics and Pharmacology	16
Podiatric Radiology Conference	16
Plastic and Reconstructive Surgery	16
Clinical Assignments (Medicine, Radiology and Podiatric Medicine, Surgery and Biomechanics)	800
Total	1,200

Elective Courses	*Hours*
Local Anesthesia and Therapeutic Injections	16
Plethysmography	16
Special Studies	8 to 32

Fourth Year	*Hours*
Anesthesiology	16
Regional Surgical Anatomy	16
Practice Administration	16
Private Office Clerkship	60
Clinical Therapeutics	16
Clinical Assignments (at the C.C.P.M., University of California Medical Center, and other facilities—in Medicine, Radiology and Podiatric Medicine, Surgery, and Biomechanics	1,160
Total	1,284

Elective Courses and Assignments	
Private Office Clerkship	2- 4 weeks
Home Care Service, U.C. Medical Center	6 weeks
U.S. Marine Corps Recruit Depot, San Diego	1- 2 weeks
V.A. Hospital, Leavenworth, Kansas	6-12 weeks

As shown, the first- and second-year curricula stresses the basic sciences which form the foundation for the practice of all medical professions. However, to assure that students recognize the importance of these fundamental courses to clinical practice, a gradual shift is being made to integrate clinical courses with the basic sciences early in the curriculum. Future plans are to provide first-year students with more exposure to direct patient care.

During the third and fourth years, traditionally known as the "clinical years," students acquire the direct skills and experience necessary to practice podiatric medicine. Under the direction and guidance of faculty members, they gradually assume more and more responsibility for patient care and are exposed to as many facets of podiatric medicine as possible; spending the largest portion of their time gaining clinical experience.

At the California College of Podiatric Medicine, for example, students receive their clinical training through assignments to the inpatient and outpatient services of the California Podiatry Hospital as well as through assignments to other cooperating or affiliated institutions in the San Francisco area and elsewhere in the nation. This exposure to a variety of institutions provides the student with a broad range of clinical experience and teaches him to perform as part of the "patient-care team." In addition, elective assignments to a practicing podiatrist's office enables the fourth-year student to experience, firsthand, the realities of practice.

Residency Programs

For the majority of graduating podiatrists, formal training does not end with their degree.[11] Many enter postgraduate residency programs carried out in teaching hospitals accredited by the Joint Commission on Accreditation of Hospitals or the Committee on Hospitals of the American Osteopathic Association.

The resident receives advance training in podiatric medicine and surgery, and serves rotation in emergency room service, anesthesiology, radiology, general medicine, pathology and general surgery. Some programs also include experience in other services, such as pediatrics, dermatology, neurology and orthopedics.

Continuing Education

Continuing education for the practicing podiatrist, as in medicine, dentistry, and other health professions, is essential in maintaining and increasing the professional knowledge and skills of the practitioner. Such programs are offered by the colleges of podiatric medicine, other institutions of higher education, professional societies and local, state, and national podiatry associations.

The podiatric colleges are a major influence in promoting increasingly higher professional standards. Indeed, they are probably the greatest single factor in the continuing development of the profession's role, functions and standards. In addition to providing this leadership and the basic education for the graduate and continuing education for the practitioner, the colleges increase the knowledge of the profession and contribute to its growth through research and other forms of study.

Through appointment of members of other professions to their respective staffs, and podiatrists serving on medical school staffs, the colleges promote cooperative relationships between podiatric medicine and other professions. This serves to foster a cooperative academic interrelationship between institutions. Today podiatrists are found on the faculties of such schools as the Medical College of Virginia, Georgetown Medical School, Dartmouth Medical School, and the University of California Medical School.

This trend in expanding education represents an awareness of the vital need for both the educational and practicing branches of the profession to coordinate educational activities. The delivery of podiatric and medical care, changing concepts of public health, and the ever-increasing role of the podiatrist in the total health care planning of the nation mandate this approach.

PODIATRY IN THE HOSPITAL

If the hospital is to serve as the focal point for delivery of comprehensive health care it must, on the one hand, provide a complete range of services for its patients by fully utilizing all members of the health care team to their maximum potential, and on the other hand, assure through continued education, supervision and supportive services, that quality care is maintained.

Offering hospital privileges to the podiatrist satisfies both these requirements. First, it provides patients with a valuable and necessary service, in addition to making time available to practitioners with unlimited medical licenses to treat patients whose ailments are beyond the scope of podiatry. Second, as for all practitioners, it assists and monitors the performance of the individual podiatrist who, in many instances, has remained outside the hospital's formal and structured control.

The inherent advantages of hospital privileges are recognized by most podiatrists. They realize it offers them the opportunity of functioning to the full extent of their ability and license—particularly where surgery is concerned. They need the availability of well-trained support personnel and the range of sophisticated equipment and facilities (such as laboratory and X-Ray), more extensive than they can individually provide within their own offices. They also desire to receive consultation from, and give consultation to, other medical practitioners, within an environment offering continual exposure to the entire field of medicine.

The podiatrist, in turn, offers the hospital specific knowledge and skills which can improve the quality of patient care. As far as the foot is concerned, the podiatrist is qualified to apply the skills of his area of concentration more effectively and efficiently than the practitioner who does not devote full time to ailments of the lower extremities.[12]

The podiatrist can serve in an educational capacity within the hospital, providing consultation and information to other physicians and allied health professionals at all levels, so that they too can aid in the prevention of foot conditions which may result from other diseases or deformities.

In addition, the podiatrist possesses the skill and judgment to detect evidence of diseases that present symptoms in the feet, and in such cases consults with an appropriate specialist for continuing treatment.

Although there are innumerable ways for either an individual podiatrist, or an entire podiatric service or department, to be structurally and functionally integrated into a hospital, the following case history of Abington Memorial Hospital, Pennsylvania, provides one example of a current program.

A Hospital Podiatry Service[13]

The Podiatry Service at Abington Memorial Hospital consists of five practicing podiatrists. In accordance with the bylaws of the staff, all podiatrists must be legally licensed to practice within the state in which the hospital is located and must be members of, or eligible for membership in, a duly recognized podiatry society.

Structurally, the Podiatry Service is a division of the Department of Surgery. The Chief of the Podiatry Service is "responsible to the Governing Board of the Hospital through the Director of the Department of Surgery, and the Chief-of-Staff for the functioning of his division . . ." Initial application for membership to the staff is made to the Chief of the Podiatry Service. Subsequently, the applicant's credentials are presented sequentially to the Director of the Department of Surgery, the Executive Committee of the Staff, the Chief-of-Staff, and finally to the Board of Trustees. Formal appointment for all medical staff members is made by the Board.

The function of the Podiatry Service is to provide comprehensive foot care to the hospital's inpatient and outpatient community. This is accomplished through the following mechanisms:

- ☐ Members of the Podiatry Service are required to serve as consultants on cases where inpatients require foot evaluations and/or foot care. Such consultations are requested by members of the medical or surgical staff and are available to all patients. A written consultation report for the patient under consideration is the responsibility of the consulting podiatrist, and such reports are incorporated in the patient's hospital chart.
- ☐ The Podiatry Service has the responsibility of maintaining an outpatient podiatry clinic. This can function on a one- or multiple-morning-per-week basis. Its purpose is to offer efficient, active and preventive foot care to those individuals economically unable to afford private care. Attendance in the clinic is mandatory for all podiatry staff members.
- ☐ Foot care by the Podiatry Service is preventive as well as active. All new diabetic patients in the metabolic

clinic are required to receive a complete foot evaluation by a member of the podiatry staff. In addition, all outpatients seen in the clinic who are suffering from diabetes mellitus or vascular insufficiency are given printed instructions on the proper home care of the foot in such disorders.

- ☐ The podiatry clinic offers students from the school of nursing direct exposure to the management of foot problems. The nursing students receive periodic observational assignments in the clinic and attend supplementary lectures in nursing care for foot problems.
- ☐ Members of the podiatry staff have the privilege of admitting patients to the hospital for inpatient medical or surgical care. Such admissions are on a combined podiatric-medical-surgical service. Once admitted, the patient's general medical care is the responsibility of the physician, while his foot care is the responsibility of the podiatrist.

In summing up his experience with this podiatric service, the Chief-of-Staff and Director of the Surgical Division of Abington Memorial Hospital states:

"The development of an inpatient podiatric service has made the podiatrist an effective member of the health care team. By his availability for consultation, physician interest in disorders of the foot has been stimulated. The initiation of podiatric surgical procedures in the operating suite has made another service available to our community without imposing a burden on our facilities—since the majority of such procedures are either carried out in the short procedures unit as outpatient situations or performed on inpatients and require only a brief hospital stay. Furthermore, development of inpatient podiatry stimulates the podiatrist to higher levels of performance, since the creation of such a section carries with it certain standards of care which must be followed and obligations to the hospital and its staff which must be met. In our hospital this has resulted in the generation of a sense of pride of membership on the part of the podiatrist which has, I believe, even up-graded the outpatient podiatry clinic.

"In short, our experience with a structured podiatric service with inpatient and outpatient privileges represents an advance in health care—and where today's well-trained podiatrist is available, a community hospital should find little, if any, problems in developing such a section. A service of this type should prove advantageous to both."

Guidelines for Hospital Bylaws

Providing clinical privileges for podiatrists in medical staff bylaws is a relatively uncomplicated procedure. The Joint Commission on Accreditation of Hospitals Manual states in Medical Staff Standard 1:[14]

The governing body of the hospital, after considering the recommendations of the medical staff, may grant clinical privileges to qualified, licensed podiatrists in accordance with their training, experience and demonstrated competence and judgment. When this is done, podiatrists must comply with all applicable medical staff bylaws, rules and regulations, which must contain specific references governing podiatric services.

A podiatrist with clinical privileges may, with the concurrence of an appropriate member of the medical staff, initiate the procedure for admitting a patient. This concurring medical staff member shall assume responsibility for the overall aspects of the patient's care throughout the hospital stay, including the medical history and physical examination. Patients admitted to the hospital for podiatric care must be given the same basic medical appraisal as patients admitted for other services.

The scope and extent of surgical procedures that each podiatrist may perform must be specifically defined and recommended in the same manner as all other surgical privileges. Surgical procedures performed by podiatrists must be under the overall supervision of the chief of surgery. The nature and degree of supervision is a matter of determination, in each instance, within the medical staff policy that governs the relationship and dual responsibility existing between the medical staff and the podiatrist. A physician member of the medical staff must be responsible for the care of any medical problem that may be present or that may arise during the hospitalization of podiatric patients. The podiatrist is responsible for the podiatric care of the patient, including the podiatric history and physical examination and all appropriate elements of the patient's record. The podiatrist may write orders within the scope of his license, as limited by the applicable statutes and as consistent with the medical staff regulations.

On April 14, 1973, the Joint Commission also clarified some questions regarding podiatry in hospitals when it approved a number of changes in the Accreditation Manual for Hospitals. These changes included:

- ☐ A revision in the section on "Survey Eligibility Criteria" to the effect that hospital admissions must be made by a member of the medical staff "either individually or in cooperation with a podiatrist with clinical privileges." That only "licensed practitioners" (M.D.'s, D.O.'s, D.D.S.'s and D.P.M.'s) shall be directly responsible for diagnosis and treatment of patients. That other direct medical care to patients may be provided only by members of the "house staff" and by "other specified professional personnel."
- ☐ The glossary definition of "house staff" has been expanded and now covers "licensed practitioners and graduates of medical, dental, or podiatric schools who participate in a hospital graduate training program that is formally approved by an agency recognized by the National Commission on Accrediting and the United States Office of Education, or who are eligible under state law for such participation, and who participate in patient care under the direction of licensed practitioners of the pertinent profession who have clinical privileges in the hospital."
- ☐ A new glossary definition for "specified professional personnel" has been added to the Accreditation Manual. This category includes licensed practitioners, house staff, and "other personnel qualified to render direct medical care under supervision of a practitioner with clinical privileges." Such "other personnel" expressly refers to, among others, "medical, dental or podiatric students of North American or foreign schools who are participating in an intrahospital educational clinical experience leading to graduation and/or qualification to take state license examinations."

The Joint Commission also revised its survey questionnaire which the hospital administration completes when the hospital is evaluated. The hospital must now certify that medical practice "is limited to appropriately licensed practitioners who have been granted clinical privileges within the limits of their qualifications" and that "clinical duties and responsibilities for segments of patient care are assigned to specified professional personnel."

These changes recognize the role of podiatric residents and externs in approved training programs to be on an equivalent basis to comparable medical and dental personnel.

The recent actions of the Joint Commission on Accreditation of Hospitals

have significantly clarified the status of the podiatrist to whom clinical privileges have been granted in a hospital. In addition, they further simplify considerations in the adoption of additions to the bylaws to provide for clinical privileges for podiatrists.

Although the clinical privileges for podiatrists are defined in various ways within hospital bylaws (they are provided for in some cases specifically as podiatric staff bylaws, and in other cases under the department of surgery), all provisions, in general, closely parallel medical staff bylaws in format and requirements.

While each hospital may write specific, individual statements in rules and regulations to reflect local conditions, standard statements in medical staff bylaws and rules and regulations regarding podiatrists generally include:

- ☐ Appropriate reference statements to the effect that doctors of podiatric medicine may be granted specific clinical privileges in accordance with their training, experience, judgment and demonstrated competence.
- ☐ A statement that all appointments to the podiatry staff shall be made by the governing board on recommendations of the Credentials Committee of the medical staff. The scope and extent of the surgical procedures that each podiatrist may perform shall be specifically delineated and granted in the same manner as is set forth in these bylaws relating to attaining and maintaining membership on the medical staff, and the granting of all other surgical privileges.
- ☐ A statement that the podiatry staff shall conform in general to these bylaws, the rules and regulations of the medical staff, and shall be subject to other standards governing the medical staff.
- ☐ A statement that surgical procedures performed by podiatrists shall be under the overall supervision of the Chairman of the Department of Surgery. All podiatric patients shall receive the same medical appraisal as patients admitted to other surgical services.

Rules and Regulations for the Podiatry Staff

The rules and regulations of the medical staff of a hospital with a Podiatry Service typically include sections stating that:

- ☐ Members of the Podiatry Staff shall be assigned to the Department of Surgery. The Podiatry Staff shall be directed by a Chairman who shall be a podiatrist. He shall be appointed in the same manner as all other chairmen. Members of the Podiatry Staff are encouraged to attend regular and special Medical Staff meetings, clinical pathological conferences, and other meetings that will enhance their understanding of the particular subjects that bear upon the practice of podiatry.
- ☐ The Chairman of the Podiatry Staff shall annually appoint members of the Podiatry Committee, subject to confirmation by the Chairman of the Department of Surgery and by the Medical Staff Executive Committee. The Podiatry Committee shall meet at least quarterly and shall keep minutes. This Committee shall formulate and recommend to the Chairman of the Department of Surgery all proposed rules, regulations and policies for the Podiatry Staff, Podiatry Staff appointments, and Podiatry Staff privileges. The Podiatry Committee shall work with other committees of the Department of Surgery and Medical Staff to promote high-quality care, to discuss mutual problems, and to promote educational and ethical standards.
- ☐ Patients admitted for podiatric care may be admitted by the podiatrist to the Department of Surgery with the written concurrence of the Chairman of the Department of Surgery or his physician designee. Patients may be discharged by the podiatrist on the written concurrence of the Chairman of the Department of Surgery or his physician designee. With each such admission, the Chairman of the Department of Surgery shall also assign the patient to an attending physician on the Medical Staff who shall assume responsibility for the care of any medical problem that may be present or may arise during hospitalization. The physician shall be responsible for the written medical history and physical examination prior to anesthesia and surgery.
- ☐ The podiatrist shall be responsible for the maintenance and proper quality of podiatric care and treatment of the patient, including the written podiatric history and physical findings. A podiatrist may write orders within the scope of his license, as may be limited by his privileges or by the Staff Bylaws, these Rules and Regulations, or by the Rules and Regulations of the Department of Surgery.
- ☐ Complete records, containing both podiatric and medical elements, shall be maintained for each patient admitted to the Podiatry Service. Progress notes and the clinical resume and summary statement shall be written by either the podiatrist or the physician, or both, as may be applicable. The record shall include a reasonably detailed and complete description of any podiatric surgery performed, including the findings and technique. All tissues removed shall be sent to the hospital pathologist for examination.
- ☐ All podiatrists granted privileges shall serve a provisional staff appointment of the same duration as the provisional staff appointments for the Medical Staff. During this time the Chairman of the Department of Surgery, or his designee, shall review and approve all elective surgeries, follow the patient postoperatively to the degree the physician deems necessary, and file summary reports with the Credentials Committee. These "credentials-audit" responsibilities are in addition to the medical management responsibility set forth above, but the Chairman of the Department of Surgery may designate the same physician or physicians to perform both functions.

The overriding consideration when developing bylaws and rules and regulations for any organization is simplicity and flexibility. Although specific questions of organization must be addressed by each institution to suit its own needs and requirements, the previous guidelines should serve to delineate the areas that should be covered.

CONCLUSIONS

The recent actions of the Joint Commission on Accreditation of Hospitals, recognizing podiatrists as "licensed practitioner(s)"—similar to medical doctors, doctors of osteopathy and dentists—to whom hospitals "may grant clinical privileges," has been a significant step towards paving the way for podiatrists to fully serve on the hospital team. However, recognition itself will not result in a fait accompli. Rather, widespread implementation of hospital podiatric services will require a progressive, enlightened attitude and concentrated effort by all members of the hospital health care team.

In this regard, the hospital administrator can be of immeasurable assistance by stimulating interest and initiating steps to provide podiatric services within his hospital. He can provide relevant, factual and timely information on podiatry to other hospital officials. He can arrange initial introductions for podiatrists, assist in the development and implementation

of appropriate administrative procedures, and he can acquaint the podiatrist with hospital protocol.

The medical staff, by maintaining a receptive attitude towards, and fair appraisal of, the qualifications of the individual podiatrist seeking clinical privileges, can assure not only the quality of care provided by their institution, but add to the scope of services it can offer.

The ultimate responsibility rests with the hospital's governing board. It must be kept aware of changing patterns and concepts in the delivery of health care and how it relates to its institutions. Its members must be knowledgeable of, and responsive to, the health needs of their community. Since the needs for podiatric services are great and podiatry is a valuable component of comprehensive health care, it is the governing board's responsibility to assure that the policy it sets reflects a proper and realistic understanding of the role podiatrists can fulfill within the hospital.

REFERENCES

1 Gleason, Jacqueline, National Center for Health Statistics, "Preliminary Results of the Podiatry Manpower Survey of 1970," *Journal of the American Podiatry Association*, Vol. 61, No. 3, March 1971.

2 American Podiatry Association, *Podiatry and the Nation's Health*, Washington, D.C., 1962.

3 Pugh, H. Lamont, "Podiatry—A Boon, Not a Boondoggle," *Virginia Medical Monthly*, Vol. 95, October 1968.

4 Council on Public Health, "Podiatry in Public Health," *Journal of the American Podiatry Association*, Vol. 57, July 1967.

5 Podell, Richard N., "Issues in the Organization of Medical Care: Podiatry In the United States," *The New England Journal of Medicine*, Vol. 284, No. 11, May 1971.

6 Blauch, L. E., *The Podiatry Curriculum*, American Association of Colleges of Podiatric Medicine, Washington, D.C., 1970.

7 "Podiatric Medicine: Function and Education," *Journal of Podiatric Education*, Vol. 4, No. 1, March 1973.

8 Sharp, J. T., "Podiatry Service in a Suburban Hospital," *Pennsylvania Medicine*, October 1972.

9 Pennell, Maryland Y., "Podiatry Education and Manpower," *Journal of Podiatric Education*, Vol. 1, June 1967.

10 California College of Podiatric Medicine, *Bulletin*, 1971-1974.

11 "Podiatric Medicine: Function and Evaluation," *Journal of Podiatric Education*, Vol. 4, No. 1, March 1973.

12 Podell, Richard N., "Issues in the Organization of Medical Care: Podiatry in the United States," *The New England Journal of Medicine*, Vol. 284, No. 11, May 1971.

13 Sharp, J. T., "Podiatry Service in a Suburban Hospital," *Pennsylvania Medicine*, Vol. 75, October 1972.

14 Joint Commission on Accreditation of Hospitals, *Accreditation Manual for Hospitals 1970*, Chicago, Illinois, 1971.

Northern Nevada Dental Hygienists' Association

March 14, 1975
S.B. 304

I, being a licensed dental hygienist engaged in practice in Nevada, and having a deep pride in my profession, wish to see that quality dental services to the consumer continues. Therefore I urge the Nevada State Legislature and this committee to approve the amended version of the proposed amendment to NRS631.

My reasoning behind this statement is as follows;
I. In keeping with national level policy position statements the 1970 American Association of Dental Examiners adopted the position "that boards of dental examiners give consideration to the use of qualified, licensed dental hygienists as consultants in the formulation of policies relating to the practice of dental hygiene." This statement was endorsed by the A.D.H.A. in 1971 in their house resolution #R-6, 1971. And furthered in the form of house resolution #R-6 1971 which states "that A.D.H.A. support the sue of qualified and licensed dental hygienists by boards fo dentla examiners for examining dental hygiene candidates for licensure."

II. In 1973 an A.D.H.A. survey showed 32 states had some form of hygiene representation to their board of examiners. In 14 states the hygienists were used as clinical examiners, however 4 of the 14 allowed the hygienists full authority over who recieved a license, the remaining 10 were permitted to assist the board or make recommendations to the board as to who should recieve a license. Note in 1973 Nevada had no representation while over ½ of the states did.

III. In 1974 a hygienist was invited to "observe" the state board examination. She was allowed to examine each dental hygiene applicant but was not premitted to participate in the decision or discussion making proceedures following the exam.

IV. At the same 1974 examination she was not reimbursed for her expenses.

V. As it stands as of 1974 with the invitation by the board being optional there is no assurance of a continual representation. Therefore with no voice there is no incentive to attend especially at our own expense.

VI. Other professions such as nursing, have some form of self-government as well as control on quzlity for the protection fo the consumer by means of a peer review or an examining committee of board.

VII.

EXHIBIT E

Northern Nevada Dental Hygienists' Association

VII. With an ever increasing number of dentists and hygienists taking the board of examination each year the assistance that the hygiene subcommittee could give would help to free the dentists on the board to spend more of their qualified and valuable time examining the dental applicants so that good quality dentistry can continue to our Nevada dental consumers.

Presented by,

for more information, Contact:

Cheryl Abbott, RDH
1408 Carson
Las Vegas 382-1316

TABLE OF CONTENTS

SENATE BILL NO. 304—SENATOR WALKER (by request)

(Amended)

167

MARCH 5, 1975

Referred to Committee on Health, Welfare and State Institutions

SUMMARY—Creates dental hygiene examining committee; authorizes such committee to examine applicants for license to practice dental hygiene. Fiscal Note: No. (BDR 54-1136)

EXPLANATION—Matter in *italics* is new; matter in brackets [ ] is material to be omitted.

AN ACT relating to dental hygiene; creating the dental hygiene examining committee; authorizing such committee to examine applicants for a license to practice dental hygiene; and providing other matters properly relating thereto.

The People of the State of Nevada, represented in Senate and Assembly, do enact as follows:

SECTION 1. Chapter 631 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 8, inclusive, of this act.

SEC. 2. *As used in this chapter, "committee" means the dental hygiene examining committee.*

SEC. 3. *1. The dental hygiene examining committee consisting of three members appointed by the board is hereby created.*

2. The board shall appoint the committee members from a list of nominees submitted by the Nevada Dental Hygienist Association, if such a list is submitted.

3. The members of the committee shall serve for terms of 2 years and shall hold office until the appointment and qualification of their successors.

SEC. 4. *1. Members of the committee must possess the following qualifications:*

(a) Hold a valid license to practice dental hygiene in this state; and

(b) Have been legally and ethically engaged in the practice of dental hygiene for 5 years or more, of which the 3 years of practice next preceding their appointment have been in this state.

2. No member of the committee may be an officer or faculty member of any college, school or institution engaged in dental hygiene instruction.

SEC. 5. *The board shall remove from office at any time any member of the committee for:*

1. Continued neglect of duty.

2. Incompetency.

3. Dishonorable or unprofessional conduct.

SEC. 6. *The committee shall meet at least twice a year and conduct examinations of applicants for licenses to practice dental hygiene. The committee may conduct such examinations outside of the State of Nevada, and for this purpose may use the facilities of dental colleges, but all examinations shall be conducted by committee members.*

the board & committee

the board & committee

by board & committee

SEC. 7. *1. Each member of the committee shall receive:*

(a) A salary of not more than $25 per day, as fixed by the board, while engaged in the business of the committee.

(b) Actual expenses for subsistence and lodging, not to exceed $25 per day, and actual expenses for transportation while traveling on business of the committee.

2. All expenses of the committee shall be paid from the fees received by the board, and no part shall be paid from the state general fund.

SEC. 8. *The committee shall:*

1. As directed by the board, investigate each applicant applying for a license to practice dental hygiene and recommend to the board whether an applicant is qualified to be examined or licensed pursuant to the requirements of this chapter.

2. As directed by the board, receive and investigate complaints and obtain information and evidence relating to any matter involving the conduct of dental hygienists, or any violation of any of the provisions of this chapter by dental hygienists.

3. Serve as consultants to the board in the adoption of rules or regulations pertaining to dental hygienists.

SEC. 9. NRS 631.170 is hereby amended to read as follows:

631.170 1. Examination meetings. The board shall meet at least twice a year for the purpose of examining applicants [.] *for licenses to practice dentistry.* The dates of the examinations shall be fixed by the board. The board may conduct examinations outside of the State of Nevada, and for this purpose may use the facilities of dental colleges, but all examinations shall be conducted by board members.

2. Other meetings. The board shall also meet at such other times and places and for such other purposes as it may deem proper.

3. Quorum. Three members of the board shall constitute a quorum.

SEC. 10. NRS 631.190 is hereby amended to read as follows:

631.190 In addition to the powers and duties provided in this chapter, the board shall:

1. Adopt rules and regulations necessary to carry out the provisions of this chapter.

2. Appoint such committees, examiners, officers, employees, agents, attorneys, investigators and other professional consultants and define their duties and incur such expense as it may deem proper or necessary to carry out the provisions of this chapter, the expense to be paid as provided in this chapter.

3. Fix the time and place for [and conduct] examinations for the granting of licenses to practice dentistry and dental hygiene.

leave as it was

4. [Examine applicants for] *Conduct examinations for the granting of* licenses to practice dentistry. [and dental hygiene.]

leave as it was

5. Collect and apply fees as provided in this chapter.

6. Keep a register of all dentists and dental hygienists licensed in this state, together with their addresses, license numbers and renewal certificate numbers.

7. Have and use a common seal.

8. Keep such records as may be necessary to report the acts and proceedings of the board, which records shall be open to public inspection.

9. Maintain offices in as many localities in the state as it finds necessary to carry out the provisions of this chapter.

10. Have discretion to examine work authorizations in dental offices or dental laboratories.

SEC. 11. NRS 631.300 is hereby amended to read as follows:

631.300 1. Any person desiring to obtain a license to practice dental hygiene, after having complied with the rules and regulations of the board under its authority to determine eligibility, shall be entitled to an examination by the [board] *committee* upon such subjects as the [board] *committee* may deem necessary, and a practical examination in dental hygiene, including but not limited to the removal of deposits from, and the polishing of, the exposed surface of the teeth.

2. The examination shall be:

(a) Written, oral or a combination of both; and

(b) Practical, as in the opinion of the [board] *committee* will be necessary to test the qualifications of the applicant.

3. In lieu of the written examination or oral examination or combination of both required by subsection 2, the [board] *committee* shall recognize a certificate from the National Board of Dental Examiners.

The Nevada Dental Hygienist Association has requested Senate Bill 304, creating a dental hygiene examining committee to examine applicants for a license to practice dental hygiene.

I would like you to be aware that of the multitude of professions and vocations licensed by the state of Nevada, dental hygiene is the only one to be regulated--examined and judged--by a Board whose members represent another profession, Dentistry.

Dental hygienists are educated to perform intraoral procedures which include the removal of hard and soft deposits from the teeth, both above and below the gumline, with sharp instruments. To accomplish this with a minimum of trauma to the oral tissues not only dexterity is required, but a knowledge of the anatomical, histological, and physiological characteristics of the tissues and of the nature and distribution of the deposits. The pruposes of scaling go beyond removal of deposits to smoothing the tooth surfaces to minimize the tendency for reaccumulation. The ultimate objective is to maintain the gingival (or gum) tissue in a healthy state.

Dental hygienists are licensed to protect patients from having these procedures performed by incompetent practitioners.

We agree that dental hygienists should work under the supervision of dentists, and liken our situation to that of Registered Nurses, who are required to work under the supervision of physicians, but are examined by the State Board of Nursing, which is composed of 7 nurses and one consumer.

Quoting from the Principles of Ethics of the American Dental Hygienists' Association, "Every profession receives from society the right to regulate itself, to determine and judge its own members."

A study was conducted by the American Dental Hygienists' Association in 1973; it revealed that thirty-two states had some form of dental hygiene representation to state boards. In 14 states, the hygienists were used as clinical examiners; ten of the 14 permitted the hygienists to assist the board in deciding or to make recommendation to the board whether a candidate should pass or fail. The other four, California, Maine, Michigan, and Oklahoma, gave the dental hygiene examining committee full authority to pass or fail a candidate. New York allows the committee to pass, but failure must be confirmed by the New England Regional Board.
Most of these representatives are appointed by the board or constituent society, but in 1974 the Maryland Legislature passed the first act providing a governor-appointed hygienist a full voice on the board.

The ADHA is now conducting a clinical evaluation project to develop clinical examination guidelines, evaluation criteria, and a rating index for dental hygiene board exams.

The Nevada Dental Practice Act presently grants the Board of Dental Examiners authority to "appoint such committees, examiners, officers, employees, agents, attorneys, investigators, and other professional consultants and define their duties and incur such expense as it may deem proper or necessary to carry out the provisions of this chapter".

In Sept. 1974 a dental hygienist was invited for the first time to "observe" the board exam. But with invitation by the board optional at each exam time, we have no assurance of continuous representation. Without a voice, there is no incentive to attend, especially at our own expense.

Southern Nevada Dental Hygienist Society

February, 1975

The Nevada Dental Hygienist Association has prepared the enclosed proposal (~~a bill~~) requesting the state legislature to amend the Dental Practice Act, to include representation from the dental hygiene profession to the State Board of Dental Examiners. This representation would be as a three member subcommittee to the Board.

A study was conducted by the American Dental Hygienists' Association in 1973; it revealed that thirty-two states had some form of dental hygiene representation to state boards. In fourteen states the hygienists were used as clinical examiners; ten of the 14 permitted the hygienists to assist the board in deciding or to make recommendation to the board whether a candidate should pass or fail. The other four, California, Maine, Michigan, and Oklahoma, gave the dental hygiene examining committee full authority to pass or fail a candidate. New York allows the committee to pass, but failure must be confirmed by the New England Regional Board.

Most of these representatives are appointed by the board or constituent society, but in 1974 the Maryland Legislature passed the first act providing a governor-appointed hygienist a full voice on the board.

The ADHA is now conducting a clinical evaluation project to develop clinical examination guidelines, evaluation criteria, and a rating index for dental hygiene board exams.

Nurses, like dental hygienists, are required to work under supervision (by physicians). Nurses are judged by their own examining board, which, in Nevada, consists of five registered nurses, two practical nurses, and one consumer, all appointed by the governor.

The Nevada Dental Practice Act presently grants the Board of Dental Examiners authority to "appoint such committees, examiners, officers, employees, agents, attorneys, investigators, and other professional consultants and define their duties and incur such expense as it may deem proper or necessary to carry out the provisions of this chapter".

In September 1974, a dental hygienist was invited for the first time to "observe" the board exam. She was permitted to examine all twenty-four dental hygiene candidates but was not allowed to participate in the discussion or decision-making following the exam. She was not remunerated for her expense.

With invitation by the board optional at each exam time, we have no assurance of continuous representation, Without a voice, there is no incentive to attend, especially at our own expense.

We are asking you to support our position and to be willing to say that yes, dental hygienists should be allowed a measure of self-government, and should be part of the board which examines dental hygienists, and to urge the Nevada legislature to pass this amendment.

Nevada Dental Hygienist Association

January 1975

The Nevada Dental Hygienist Association, in the interest of providing for future applicants for licenses to practice dental hygiene in Nevada to be examined by a group of persons trained in the same profession, proposes the following amendments to NRS 631:

631.190 Powers and Duties of the Board

add: A dental hygiene examining committee shall be appointed by the board.

631.191 (new section) Dental Hygiene Examining Committee

1. The dental hygiene examining committee shall consist of 3 members to be appointed from the list submitted by the Nevada Dental Hygienist Association, if such a list is submitted.
2. Members of the dental hygiene examining committee shall possess all of the following qualifications:
   a. Shall have a valid license to practice dental hygiene in this state and shall have been legally and ethically engaged in the practice of dental hygiene for at least 5 years, the three most recent in Nevada.
   b. Shall not be an officer or faculty member of any college, school, or institution engaged in dental hygiene instruction.
3. Members of the committee shall hold office for two years.
4. Duties
   a. The committee shall assist the board in the examination of applicants for a dental hygiene license at least twice a year, pursuant to 631.170.
   b. As directed by the board, the committee may investigate each applicant applying for a license to practice dental hygiene and recommend to the board whether an applicant shall be admitted to the examination and whether a license shall be issued, pursuant to the requirements of this chapter.
   c. As directed by the board, the committee may receive and investigate complaints and obtain information and evidence relating to any matter involving the conduct of dental hygienists, or any violation of any of the previsions of this chapter by dental hygienists.
5. Members of the dental hygiene examining committee shall serve as consultants to the board in the adoption of rules and regulations pertaining to dental hygienists.
6. The board has the power to remove from office at any time any member of the dental hygiene examining committee for continued neglect of duty required by this chapter or for incompetency or unprofessional or dishonorable conduct.
7. Each member of the committee shall receive a per diem and expenses, pursuant to section 631.180.

Change 631.180 and 631.300 to include the words "and dental hygiene examining committee" wherever "the board" appears.

References to dental hygiene as a self-governing profession and its capabilities as such

In a report by Dr. W.G. McIntosh, Executive Director of the Canadian Dental Association, delivered at the Federation Dentaire Internationale Congress in London, quotations are given from a newspaper article written by M.J. Trebilcock, professor of law at the University of Toronto, to substantiate Dr. McIntosh's position on the rights of selfgoverning professions:

> "Mr. Trebilcock believes that a master-policy in relation to the self-governing professions should be established. He identifies six 'touch-stones' such a master policy should meet.
> (1) No profession should be conceded any self-governing rights whatever unless there pre-exists a comprehensive, cohesive, professional association which commands the adherence of most members of the relevant profession."

The American Dental Hygienist's Association has been in existence since 1923. The Nevada Dental Hygienist Association, a constituent of ADHA, was formed in 1961. The majority of licensed dental hygienists in Nevada are members of these organizations.

The next four of the six points do not pertain to our request; we proceed to quote #6:

> "(6) No self-governing profession should have statutory control over others who are not members of that profession, for example, dentists over dental hygienists--dentists over denturists, except for matters of work supervision. There seems to be a growing attitude that this form of paternalism inhibits the development of paraprofessionals and auxiliaries, who because of lower educational backgrounds may be capable of providing certain routine professional services for the public at reduced prices."

Similar testimony, reinforcing our position, is included in a report by Justice McRuer, chairman of the Royal Commission of Ontario's Inquiry into Civil Rights, which was published by the Queen's Printer, Ottowa, Ontario, in 1968, in three volumes. The McRuer report is in Report #1, Volume 3. Excerpts from it are on p.4, this testimony.

American Dental Hygienist's Association policy statements regarding the use of dental hygienists on state boards of dental examiners

House resolution # R-6, 1971

RESOLVED, that the ADHA endorse the following position as adopted by the American Association of Dental Examiners at their annual session in 1970:

> "that boards of dental examiners give consideration to the use of qualified and licensed dental hygienists as consultants in the formulation of policies relating to the practice of dental hygiene."

House resolution # R-7, 1971

RESOLVED, that the ADHA support the use of qualified and licensed dental hygienists by boards of dental examiners for examining dental hygiene candidates for licensure.

The Maryland Dental Hygiene Association has, in an unprecedented move, in 1974, prevailed upon the legislature in Maryland to back them for a voice on the Maryland State Board of Dental Examiners. The term of office for the dental hygiene member on the Maryland State Board of Dental Examiners will be four years--dentists serve for six years.

(from the Bulletin of the American Association of Dental Examiners August-Sept. 1974)

DENTAL HYGIENISTS AND REGISTERED NURSING ASSISTANTS

By section 12(a) of the Dentistry Act[5] power is given to the Board of Directors of the Royal College of Dental Surgeons of Ontario to provide for "the establishment, development, regulation and control of an ancillary body known as dental hygienists".

The powers provided by these acts have been exercised[5] and in neither case are the regulations satisfactory.

In any event, the situations created with respect to dental hygienists and nursing assistants are quite anomalous and entirely unjustifiable. These are not cases of delegation of power to self-governing bodies to control their own affairs but rather of delegation of legislative and judicial powers to regulate and control the affairs of others who have no part in making the rules by which they are governed.

We recommend that these powers be abrogated. One would have thought that the normal, commercial powers of hiring and dismissing which dentists and hospitals have would provide sufficient "quality control". If, however, some form of regulation is required, then we think that these are clearly cases for provincial licensing boards. We can see no justification for the present situations which are thoroughly undemocratic.

Recommendation 27. No self-governing body should have statutory control over others who are not members of the body. If employees of members of a self-governing body are required in the public interest to be controlled, this should be done by some form of licensing and not by the conferring of legislative and judicial powers exercisable over them.

from McRuer Report, Inquiry into Civil Rights by the Royal Commission of Ontario

THE NATIONAL BOARD COMMITTEE ON DENTAL HYGIENE

The 1973 ADHA House of Delegates passed a resolution creating a new committee, Committee on Dental Hygiene, of the Council of National Board of Dental Examiners. This action recognized the efforts of numerous hygienists who have served as consultants to the National Board since 1961. It was also a welcome move toward demonstrating to the general membership the active participation ADHA has had in the National Board Dental Hygiene Examination. The contributions of ADHA date back further than the beginning of the National Board program for dental hygienists, however, the first involvement of hygienists was in the three year achievement testing project which started in the late 1950's. By means of this project, the Association showed that uniformity among dental hygiene programs did exist, a factor which was essential in order to make a national testing program possible.

When it became apparent that a National Board was going to become a reality for dental hygiene, ADHA conducted its fourth Workshop on Dental Hygiene Education in the fall of 1961. This was structured to allow three full days for development of a recommended blueprint for the National Board Dental Hygiene Examination. These recommendations for areas of examination and weighted outlines were submitted to the Council for approval. The Council Committee on Dental Hygiene prepared rules and regulations for the conduct of the proposed examination. These were also submitted to the Council and approved. Test construction was then begun using existing dental test construction committees in subject areas which paralleled those of the dental examination. Additional consultants or subject matter specialists who were often dental hygienists were utilized in several areas such as dental hygiene education, public health and first aid.

The initial structure of the Council's Committee on Dental Hygiene consisted of three members of the National Board of Dental Examiners and four dental hygienists appointed by the ADHA president. Of the three members of the National Board there is one each from the American Association of Dental Examiners, the American Association of Dental Schools and the American Dental Association. Of the four dental hygienists, two represent ADHA membership as private practice hygienists and two are dental hygiene educators. This committee was responsible for making recommendations to the Council concerning rules and regulations for the conduct of examination and certification of successful candidates. Requirements for participation, regulations governing re-examinations, administration, irregularities, and examination areas were included. The Committee reported to the Council and all actions were subject to the Council's approval. This structure remains essentially the same.

The first Dental Hygiene National Board examination was administered on April 2, 1962 at 49 testing centers throughout the country. Over 1,560 dental hygienists and dental hygiene students took the examination. Included in that count were 576 graduates of previous years dating back as far as 1927. The initial support and recognition of the National Board Dental Hygiene Certificate by 30 states far exceeded expectations and was greater than that initially given to any national board program in the health professions. It markedly exceeded the initial support given the Dental National Board when, almost thirty years previously, only six states were involved. At present, 51 of the 53 licensing jurisdictions accept the National Board results for the fulfillment of the state written examinations, with 23 jurisdictions requiring candidates for dental hygiene licensure to have earned National Board credentials. In 1973, 4,427 candidates were examined, bringing the total of National Board Dental Hygiene Certificates issued to 27,089.

Construction of the first comprehensive, function-oriented dental hygiene examination began more than two years ago. Appropriate existing dental test construction committees were asked to select test items conforming to their section of the original examination. The test items were then recatagorized to fit the new format before being submitted. At the same time, case problems were also being developed. These were reviewed and refined by several test construction committees in 1972. All of this data was brought to a Master Dental Hygiene Test Construction Committee for final selection of items, with the exception of those dealing with community dental health. Currently, the Master Committees have five members each: a basic scientist–dentist; a periodontist; a dentist or dental hygienist with expertise in radiography; a clinical dental hygienist; and a dental hygienist with strong curriculum background. The response to the new examination format has been essentially positive.

When the national Board Dental Hygiene program began, the American Dental Association agreed to finance the examination program until it became self-supporting. From that point on, all excess income was to be turned over to ADHA for the proposed Post Certificate Scholarship Fund. The first payment to the scholarship fund was made in 1965. During the initial years of the program, the payments from the National Board exceeded the amounts distributed. Unfortunately, this trend has reversed and in the last five years, scholarship awards have exceeded the National Board Payments. This situation was hastened by the conversion to the function-oriented examination which was more costly to produce.

In 1962, the following resolution was adopted unanimously by the Council of the National Board of Dental Examiners and transmitted to the American Dental Hygienists' Association,

> "RESOLVED. . .that the Council of National Board of Dental Examiners, in recognition of the outstanding contributions made by the American Dental Hygienists' Association in the development of the National Board Dental Hygiene Examinations expresses its sincere appreciation and its pledge to conduct a quality examination service which will be a credit to the dental and dental hygiene professions."

The Council has lived up to that pledge and ADHA has continued its valuable input into the program. With the creation of the new National Board Committee on Dental Hygiene, ADHA has reaffirmed its shared responsibility in the National Board Dental Hygiene Examination

Creation of a dental hygiene examining committee by California legislature
Page 8, California Dental Practice Act

Article 1.5. Examining Committee
(Added by Stats. 1971, Ch. 1011)

1621. There is within the jurisdiction of the Board of Dental Examiners of the State of California an examining committee.

1621.1. The examining committee shall consist of 10 members appointed by the board. The board shall appoint the examining committee members from lists submitted by the dental and dental hygienists associations, if such lists are submitted.

1621.2. Members of the examining committee shall posses all of the following qualifications:

(a) Six shall have a valid license to practice dentistry in this state and shall have engaged in the practice of dentistry in this state for at least five years next preceding his appointment.

(b) Four shall have a valid license to practice dental hygiene in this state and shall have practiced dental hygiene in this state for at least five years next preceding his appointment.

(c) Shall not be an officer or faculty member of any college, school or institution engaged in dental instruction.

1621.3. The members of the examining committee shall hold office for two years.

1621.4. (a) The examining committee shall assist the board in the examination of applicants for a dental license and a dental hygiene license at least once a year, at the time and place designated by the board.

(b) As directed by the board, the examining committee may investigate each applicant applying for a license to practice dentistry and a license to practice dental hygiene and recommend to the board whether an applicant shall be admitted to the examination, and whether a license or certificate shall be issued, pursuant to the requirements of this chapter.

(c) As directed by the board, the examining committee, or subcommittees thereof appointed by the board, may receive and investigate complaints and obtain information and evidence relating to any matter involving the conduct of dentists or dental hygienists or any violation or alleged violation of any of the provisions of this chapter by dentists or dental hygienists.

(d) The examining committee shall advise the board regarding the establishment, implementation, and operation of the continuing education requirements authorized by Sections 1647 and 1749 of this chapter.

1621.5. The board has the power to remove from office at any time any member of the examining committee for continued neglect of duty required by this chapter or for incompetency or unprofessional or dishonorable conduct.

1621.6. Each member of the committee shall receive a per diem and expenses as provided in Section 103.

Article 2. Admission and Practice

Practice of Dentistry Defined

1625. Dentistry is the diagnosis or treatment, by surgery or other method, of diseases and lesions and the correction of malposed posi-

AMERICAN DENTAL HYGIENISTS' ASSOCIATION

211 E. Chicago Avenue
Chicago, Illinois 60611
Phone: (312) 944-7097

Testing Division:
(312) 642-3954

January 28, 1975

Ms. Cheryl Abbott
1408 Carson Avenue
Las Vegas, Nevada 89101

Dear Ms. Abbott:

In response to your letter inquiring about requirements for clinical instructors in dental hygiene schools, I quote from the Requirements and Guidelines for Dental Hygiene Education Programs regarding faculty qualifications.

"Dental hygiene faculty members should have background in, and current knowledge of, dental hygiene and the specific subjects they are teaching. Faculty members' experience should include teaching, or completion of courses in education theory and practice. Individuals who do not have this background should be continuing their education in this area.

Faculty who provide clinical instruction should have recognized competence in dental hygiene procedures and clinical practice experience.

It is expected that the dental hygiene faculty will advance professionally through continuing education courses, conferences, institutes, meetings and workshops."

In 1973, the ADHA conducted a survey of dental hygienists who serve on state boards of dental examiners and I suggest that perhaps this might be more helpful to you in achieving your goal of having an examining committee of and for hygienists as part of the Nevada State Board. If you would like more information in regard to this study, I will be happy to send it to you.

You might also be interested in the fact that as an outgrowth of the survey, there is a Clinical Evaluation Project now being carried on by ADHA to develop clinical examination guidelines, evaluation criteria, and a rating index for dental hygienist board examinations.

I am interested in developing a "clearing house" of information in central office to enable me to provide constituents with pertinent information about legislative activity in other states. Such a file would give an indication of what procedures have been successful in pursing new dental hygiene legislation. Please keep me informed of what progress you are making.

Sincerely,

Marlene Benzuly

Marlene Benzuly
Legislative Assistant

178

ITEMS (WITH EXPLANATION OF CODING) ON SUMMARY OF SURVEY OF DENTAL HYGIENISTS' REPRESENTATION TO STATE BOARDS

1. Name of state reporting

2. Has your state established some form of representation to the Board of Dentistry (Board of Dental Examiners)?

3. Is action pending to provide representation to your State Board?

4. What type of representation do you have (or propose)? (Check all applicable areas)
   A = member(s) of the Board B = voting C = ex officio D = consultant(s) to the Board
   E = sub-committee of the Board (Advisory Board) F = clinical examiner G = liaison
   H = other

5. If your representation is in the form of a Sub-Committee or Advisory Board, please explain the structure. (See page 6 for summary of responses.)

6. How many Dental Hygienists serve as representatives to your State Board?

7. How are your representatives appointed to the Board?
   A = appointed by state governor B = appointed by State Board C = other

   Are your representatives recommended to the appointing agency by your Constituent Dental Hygienists' Association?

   Are there specific qualifications for representation? If yes, please include a copy of the qualifications.

8. What is the term of office of your representative(s)?

   If you have more than one representative to the Board, do the terms rotate?

9. Is your state a member of a Regional Examining Board?

   Is utilization of a Regional Examining Board proposed in your state?

   Name:

10. Is your representative(s) involved in administering examinations for Dental Hygiene licensure?
A = written B = clinical C = both

Are Dental Hygienists other than official representatives utilized in administering examinations?

How many Dental Hygienists are utilized in administering examinations?

Does the representative:
A = have full authority in the examination (pass or fail) B = assist in the examination with Board member C = recommend to the Board (pass or fail)

11. Briefly explain the role of your representative(s) to the State Board (other than examination) e.g. consults on request, involved in all Board matters. (See page 7 for summary of responses.)

12. Please provide the names of your representatives to your State Board.

SURVEY OF DENTAL HYGIENISTS' REPRESENTATION TO STATE BOARDS

1	2		3		4	6	7	7		7		8	8		9		9		10	10		10
Constituent	Yes	No	Yes	No	A to H	No.	A to C	Yes	No	Yes	No	Years	Yes	No	Yes	No	Yes	No	A to C	Yes	No	No.
Alabama		X		X												X		X				
Alaska																						
Arizona		X	X		DEFG											X		X				
Arkansas																						
California	X		X		DEFG	4	B	X		X		2		X		X	X		C		X	4
Colorado	X				CD	1	B	X			X			X	X							
Connecticut		X																				
Delaware																						
D.C.		X		X											X							
Florida	X			X	G	3	B	X			X	3	X			X		X			X	0
Georgia	X				D	3	C	X				1	X			X		X	C		X	3
Hawaii	X				F	1	C	X			X					X		X	B		X	1
Idaho																						
Illinois	X		X		F														B	X		3
Indiana		X		X																		
Iowa	X		X		G	1	C	X		X					X						X	0
Kansas		X		X											X							
Kentucky	X				DF	3	C	X		X		2	X			X		X	B		X	3
Louisiana	X			X	G	1	C		X		X	2-3				X		X			X	0
Maine	X				F	1	B	X			X	3			X				B		X	1

SUMMARY SHEET

SURVEY OF DENTAL HYGIENISTS' REPRESENTATION TO STATE BOARDS

181

1 Constituent	2 Yes	2 No	3 Yes	3 No	4 A to H	6 No.	7 A to C	7 Yes	7 No	7 Yes	7 No	8 Years	8 Yes	8 No	9 Yes	9 No	9 Yes	9 No	10 A to C	10 Yes	10 No	10 No.
Maryland	N			X	CD	1	C	X		X				X	X						X	
Mass.		X	X		AD										X							
Michigan	N			X	CDEFG	4	C	X		X					X				C		X	4
Minnesota	X			X	DG	1	C	X		X		3			X				A		X	
Miss.		X	X		G											X	X					
Missouri		X		X											X							
Montana	X		X		DF	1	C	X		X		2				X		X	C		X	1
Nebraska		X	X		ACDF										X							
Nevada		X		X												X		X				
New Hamp.	X				D	1	B	X			X	1-3			X						X	
New Jersey		X	X		ABEF											X	X					
New Mexico	X				CDG	2	B	X		X		5	X			X		X	C		X	2
New York	X				DEFG	2		X		X		5	X		X				C		X	
N. Car.	X				D	1	C	X			X	1				X					X	C
N. Dakota	X		X		D	1	B	X			X				X		X				X	
Ohio	X		X		EG	5	C		X		X	3	X		X					X		C
Oklahoma	X				DF	1	B	X			X	2			X				C		X	1
Oregon	X			X	CDE	7	B	X		X		3	X			X	X		B		X	1
Penn.		X	X		ABDF										X		X					
Puc[redacted] R.		X		X												X		X				
[redacted]															X							

SURVEY OF DENTAL HYGIENISTS' REPRESENTATION TO STATE BOARDS

1 Constituent	2 Yes	2 No	3 Yes	3 No	4 A to H	6 No.	7 A to C	7 Yes	7 No	7 Yes	7 No	8 Years	8 Yes	8 No	9 Yes	9 No	9 Yes	9 No	10 A to C	10 Yes	10 No
S. Carolina	X			X	GH	1	B		X	X		1				X	X				X
S. Dakota	X				DF	1	B	X		X		3			X				C		X
Tennessee	X			X	DEG	3	C	X		X				X		X	X				X
Texas	X			X	EG	3	C	X			X	3	X			X		X			X
Utah	X				D	1	C		X		X	1				X		X			X
Vermont	X			X	CDG	2	C		X	X		2	X		X						X
Virginia	X		X		EG	3	C				X					X	X				X
Washington	X				G	1	B	X			X			X		X	X				X
W. Virginia		X		X											X						
Wisconsin	X		X		D	1	C	X			X				X		X				X
Wyoming	X		X		D	1	C		X	X		4				X		X	C		X

SUMMARY OF RESPONSES TO ITEMS 5 AND 11 ON

SURVEY OF DENTAL HYGIENISTS' REPRESENTATION TO STATE BOARDS

Item 5: Sub-Committee/Advisory Board Structure

A. Examining Committees

1. CALIFORNIA reports a 10-person examining committee, 6 licensed dentists and 4 licensed hygienists with minimum 5 years' practice--no academicians. Additional duties include the development of requirements for continuing education.

2. OREGON reports 7 clinical examiners who are beginning to function as a committee in that they are working with the Board of Dental Examiners on dental hygiene problems.

3. KENTUCKY is actively seeking circumstances similar to California's.

B. General Liaison and Advisory Sub-Committees

1. MICHIGAN reports a sub-committee comprised of 4 dental hygienists (2 MDHA committee members, the state clinical examiner and the 4th chosen from MDHA membership at large) and 1 dentist from the State Board. Duties include liaison between the Board and MDHA and a consultant function. Note that Michigan also has clinical examiners, only one of whom serves on this sub-committee.

2. NEW YORK reports a "State Committee on Dental Hygiene" appointed by the Board of Regents, which consists of 2 licensed dental hygienists. Duties include general assistance and consultation to the "Board for Dentistry" in dental hygiene matters and examination (with authority to pass but failures must be confirmed by NERB members).

3. OHIO reports Advisory Board consisting of 5 dental hygienists appointed by ODHA, all ODHA delegates (term "delegates" not explained). Duties include general assistance and consultation to Board and the development of requirements for continuing education.

4. TENNESSEE, TEXAS and VIRGINIA report liaison committees, each consisting of 3 licensed dental hygienists appointed by the state dental hygiene association. Duties include general assistance and consultation to the Board.

5. WISCONSIN reports imminent appointment of "Periodontal Advisory Committee" consisting of 2 dental hygienists, 2 dental assistants, 2 lab technicians and 2 dental students. The dental hygienists are to be appointed by WDHA. Duties not defined.

Item 11: Role of Representative(s) to State Boards (other than examination)

A. Pre-Examination

1. CALIFORNIA and NEW MEXICO: Investigation of applicants

2. MINNESOTA: Interviewing of candidates

3. UTAH and WYOMING: General assistance

B. Ethics and Conduct

1. CALIFORNIA: Investigation of complaints and obtaining information

2. MICHIGAN, MINNESOTA, NEW MEXICO, NEW YORK and OHIO: Advisory capacity

C. Continuing Education

1. CALIFORNIA and MICHIGAN: Consultation on establishment and implementation of continuing education requirements

2. MINNESOTA: Service on Board continuing education committee

3. OHIO: Formation of continuing education courses

D. General Consultation on Board Request

CALIFORNIA	OREGON
COLORADO	TENNESSEE
FLORIDA	TEXAS
MICHIGAN	UTAH
NEW MEXICO	VERMONT
NEW YORK	VIRGINIA
NORTH CAROLINA	WASHINGTON
OHIO	WISCONSIN
OKLAHOMA	WYOMING

AMERICAN DENTAL HYGIENISTS' ASSOCIATION

211 E. Chicago Avenue
Chicago, Illinois 60611
Phone: (312) 944-7097

January 5, 1975

413 South Front Street
Rio Vista, Ca. 94571

Ms. Cheryl Abbott
1408 Carson St.
Las Vegas, Nev. 89101

Dear Cheryl:

Enclosed is the page from the California Dental Practice Act which I mentioned in our conversation. The markings have no special significance -- just my doodling.

These are the ADHA policy statements which you may find useful:
House resolution # R-6 -- 1971
RESOLVED, that the ADHA endorse the following position as adopted by the American Association of Dental Examiners at their annual session in 1970:

> "that boards of dental examiners give consideration to the use of qualified and licensed dental hygienists as consultants in the formulation of policies relating to the practice of dental hygiene."

House resolution R-7 -- 1971
RESOLVED, that the ADHA support the use of qualified and licensed dental hygienists by boards of dental examiners for examining dental hygiene candidates for licensure.

I hope you will find these items helpful. Please don't hesitate to call on me or on Carl Hauber for further information or support.

I look forward to seeing you in Tucson and hearing a report of your progress with the proposed legislation.

Sincerely,

Grace Anderson, Legislative Consultant
Western Region ADHA

enc.

11224 Orleans Way
Kensington, Maryland 20795

March 2, 1975

Ms. Cheryl Abbott
1408 Carson
Las Vegas, Nevada 89101

Dear Cheryl:

Kathy Silko sent your letter for me to answer since I am the Dental Hygiene Member of the State Board of Dental Examiners in Maryland. We are the first state to have a full-fledged voting dental hygiene member and I think it is working well. There is some controversy over the position, but not from within the Board.

I am enclosing a copy of our law and will briefly describe the progression of this change. Before our law was changed, we had a dental hygiene consultant on our Board and felt the position was ineffective. With the help of a lawyer, we constructed a bill identical in wording and content to that of the law regarding the appointment of dental members of the board, substituting the words "dental hygiene" for dental and making the term 4 years, instead of 6 years. Enclosed is the copy - check the sections 2 and 2 A.

The law was well-written and we approached the legislature with as much dental support as possible. The legislature loved it and both houses passed it with a first try. They felt that it was long overdue and that no group should be denied representation on its own licensing and regulating board. Even today, some of the legislators feel that dental hygienists should be involved in all decisions affecting dentistry, not just dental hygiene. The intent of the law, was that the hygienist would be present at all meetings and hygiene exams, and vote on hygiene matters only.

Our MDHA held elections open to all hygienists in the state and selected three nominees to the governor for the appointment of one. One of the nominees was not a member and this is important because the Board regulates all dental hygienists in the state not just association members.

The acceptance has been excellent. The Board seems appreciative of dental hygienist's involvement. There is still some controversy and there have been attempts at legislation to change it, but so far they have only angered the legislators. The controversy is not within the Board, but is among some members in dentistry. I have participated in examinations, answered hygiene inquiries, and been involved in investigations of auxilliary misuse for the Board.

I was recently accepted into the American Association of Dental Examiners as their first Dental Hygiene Member. I find that communications improve when different factions start talking and empathizing.

The most important items to remember are: Make sure your law is concise (not rambling or lengthy) and well written. Don't try to change too much at once. Work first with your dental association and if all efforts fail, then go alone. Be prepared to compromise and remember that compromise is important. In presenting your changes, never become emotional, be prepared with facts, be rational, be polite. Anger, emotion, and argument never impress the legislators. If you are right, and reasonable, you will succeed.

I hope this letter is prompt enough. The added responsibilities of this new position have become very demanding since I am already working three days a week, help my husband in his business, and care for my two preschoolers. Good luck.

Sincerely,

Dana B Godbout

Mrs. Dana Beers Godbout RDH

appointment. On the expiration of the term or terms for which any one or more of the members of the present Board have been appointed, in accordance with this article, the Governor, with the advice of the Secretary of Health and Mental Hygiene, shall appoint a successor or successors from a list of duly qualified dentists of double the number of vacancies to be filled. This list shall be jointly proposed and submitted to the Governor by the Maryland State Dental Association and the Maryland Dental Society. The list shall be chosen and approved by a majority of the members of both associations present at a joint meeting of both associations, called for that purpose. At least two weeks' notice of a meeting, stating the time, place and purpose, shall be mailed by the secretary of each association to the members at their respective addresses appearing in the records of each association.

The term for which the members of the Board shall be appointed shall be six years, until their successors have been appointed and qualified. No member who has served two full consecutive terms is eligible to succeed himself In case of a vacancy occurring in the Board by reason of the death of any member, or of his incapacity, neglect or refusal to act, or in any other way, the Governor, with the advice of the Secretary of Health and Mental Hygiene, shall, from a list of duly qualified dentists of double the number of vacancies to be filled, chosen, submitted and proposed to him as above, appoint a successor or successors of the member or members, who shall hold office for the remainder of the unexpired term or terms of the member or members. Any member of the Board, who, without adequate reason is absent from two successive meetings of the Board, shall cease to be a member. The Governor, upon the recommendation of the Secretary of Health and Mental Hygiene may remove from office at any time, any member of the Board for continued neglect of duty required by this article, or for incompetency, unprofessional or dishonorable conduct. The three additional memberships created on the State Board of Dental Examiners shall be added by separate and individual appointments in the respective years 1971, 1973 and 1975; and until the full membership of the Board is reached in the year 1975, the Board shall have successively 6, 7 and 8 members until the full membership is reached.

Section 2A. Dental Hygienist member of the Board.

In addition to the dentist members of the Board, there shall be a dental hygienist member who may vote only on matters directly affecting dental hygienists. In those matters his vote shall count as fully as the vote of dentist members. The dental hygienist member shall be a registered and practicing hygienist, a resident of the State of Maryland, and shall have been in an active practice in the State for at least three years immediately preceding his appointment. No member of the faculty or teaching staff of any university or college in the State of Maryland which offers undergraduate courses in dental hygiene shall be eligible for appointment. The Governor, with the advice of the Secretary of Health and Mental Hygiene, shall appoint the dental hygienist member from a list of three duly qualified hygienists proposed and submitted to him by the Maryland Dental Hygienists' Association, and chosen by a majority vote of the members of the Association present at a meeting of the Association called for that purpose, of which meeting at least two weeks' notice, stating the time, place and purpose, shall be mailed by the Secretary to the members of the Association at their respective addresses appearing in the records. The term for which the dental hygienist member of the Board is appointed shall be four years, and until his successor shall have been appointed and qualified. No member who has served two full consecutive terms may be eligible to succeed himself. In case of a vacancy

occurring in the dental hygienist position by reason of death, or incapacity, neglect or refusal to act, expiration of term, or in any other way, the Governor, with the advice of the Secretary of Health and Mental Hygiene, shall, from a list of three duly qualified hygienists, chosen, submitted and proposed to him as provided, appoint a successor to the vacating member who shall hold office for the remainder of the unexpired term of the member or for a new term in the case of expiration of term. If the dental hygienist member, without adequate reason, is absent from two successive meetings, he shall cease to be a member, and the Governor, upon the recommendation of the Secretary of Health and Mental Hygiene, has the power to remove from office, at any time, the dental hygienist member of the Board for continued neglect of duty required by this article, whose duty is the same where appropriate as the duty of dentist members, or for incompetency, unprofessional or dishonorable conduct.

Section 3. Same — Election and duties of officers; adoption of rules and regulations; meetings.

Said Board shall choose one of its members, president, and one secretary thereof, whose duties shall be those usually appertaining to their respective offices, and shall adopt such rules, regulations, or bylaws as may be necessary or expedient to assist it in its organization under this article. The secretary shall also be the legal custodian of all the property, money, minutes, records, proceedings and the seal of said Board. Said Board shall hold two regular meetings as determined by the Board of Dental Examiners, and special meetings as it may deem necessary, upon call of the president or secretary thereof and upon due notice. Meetings may be held at any time and place and without notice, by the unanimous consent evidenced either by writing or by the presence of any member whose consent is necessary.

(a) The State Board of Dental Examiners in any duty, function or power under this Article shall not discriminate against any person because of his race, creed, color or national origin.

Section 4. Same — Duty as to examinations.

The Board shall give an examination twice each year at a suitable place in Maryland to be decided by the Board, to all persons who may desire to qualify to practice dentistry in this State. This examination shall be at such time, place, under such conditions and of such kind or character as the Board is its sole discretion may determine.

Section 5. Examination and registration.

(a) *Who may apply, examinations to be in writing; certificates of registration.*—Any person of good moral character, twenty-one or more years of age, who has been graduated and admitted to the degree of doctor of dental surgery, doctor of dental medicine, or other equivalent degree by any university or college duly incorporated and authorized to grant said degree by the laws of the United States or any of its territories, districts or possessions, or by the laws of any state of the United States, or the laws of any province of the Dominion of Canada and recognized by the Board as requiring adequate preprofessional collegiate training and as maintaining an acceptable course of dental instruction, may make application in writing to said Board to be examined by it with reference to his or her qualifications to practice dentistry, and upon his or her passing an examination satisfactory to said Board, which examination shall be in writing so far as said Board shall deem practicable, the Board shall cause the name and residence of such person to be registered in a book kept by it for that purpose, and shall issue to such a person a certificate of registration, as evidence of his or her eligibility to practice dentistry, signed by the officers of the Board and

Report from Dental Hygiene Observer of the State Board Exam, 1974

In June, 1974, a member of the State Board of Dental Examiners suggested verbally to the president of the Nevada Dental Hygienists Association that a hygienist be chosen to observe the next examination of applicants for a dental hygiene license.

I, Mary Moran, am the dental hygienist selected by that association to observe the examination conducted by the State Board in Sept. 1974.

Two days prior to the examination, the secretary of the Board called me and stated that a meeting would be held on the day before the examination, at which time I could present the hygienists problems and complaints to them. I told him that we did not have complaints, but would like the opportunity to communicate with the Board and be included in the examination and rule making for the practice of dental hygiene. He stated then that there would be no need for me to attend the meeting but that I could observe the examination. This is as close to a formal invitation as we received.

On the day of the dental hygiene examination, the President of the State Board informed me that this "was to be a trial situation and that from this experience the Board would decide whether to invite an observer in the furure." I was not permitted to check "in" the first group of patients, but was asked to check them "out" at the completion of the oral prophylaxis, and to check the second group of patients "in" and "out". The grading sheet used by board members has no points relevant to dental hygiene, such as patient education, scaling, stain removal, and x-ray exposure, so I made my own sheet for each candidate. I was given an examiner-number, and asked to mail my grading sheets to the Board, which I did immediately upon my return to Las Vegas. I was told I'd receive a list of those candidates who passed and their numbers, so I could compare the groups results with my own. I have not received such a list, or any other communication from the Board.

I wrote, after the exam, to the Board, in care of its secretary, thanking them for the opportunity, and stating that being an observer at the examination was one of the most rewarding and educational experiences of my professional career. At this time I felt that the Board had good feelings about my presence and would discuss the advantages of having a hygienist included in the examination of dental hygiene applicants.

It would have been more rewarding to me and to the group I represented if communication between our two groups could have continued. The hygienists' association has had no communication from the board, and we do not know if an observer is to be invited to the examination which will be held in March, 1975, just one week away.

During the September examination I noticed and discussed with Board members some inequities, including:

Each candidate was instructed to bring one "stain patient" and one "calculus patient" to the examination.

Dental hygienists are taught in school to remove all deposits from each patients' teeth, to treat each patient to the extent or our ability--not to remove one type of deposit only. Some of the earliest candidates to finish left visible stain and calculus; one even argued with me when I asked her to check an area again.

The candidates were required to bring a recent set of radiographs to the examination. The Board assumes that the candidates took these x-rays themselves as proof of their ability. Several of the candidates told me they had not exposed the films themselves, and that the instructions they received did not require that.

One who did take the x-rays herself freely admitted to me that the friend who posed as her patient was in her first trimester of pregnancy. Taking x-rays on a woman in the first 3 months of pregnancy is strictly unethical, and potentially hazardous to the fetus. This is certainly not in the best interest of the patient, who expects to be able to trust a licensed professional person.

Twenty four hygiene applicants were examined and all passed. Of 29 dentists who took their Board, only 7 passed. I feel that not all of the hygiene applicants were that qualified, and that the Board was obviously more critical of the dental applicants than of the hygienists. I wonder how the public can be protected from treatment by unqualified practitioners of dental hygiene if licenses are indiscriminately given to any hygienists who take the test.

When I expressed to the Board just prior to the examination that the Dental Hygienists' Association would like to be helpful to the candidates, I was told that this is not a purpose of the Board.

One example of the need for assistance is that some candidates have been forced at examination time to rent handpieces at a cost of $25. They are instructed to bring a handpiece to the test bot not told what size or type. A local dental supply company has volunteered the use of handpieces at no cost, but if our association can't determine the names of applicants, and the candidates can't find out from the board what type of handpiece is required, they cannot avail themselves of the service. I asked a Board member why the applicants aren't informed as to the type of handpiece needed; he said they should take the initiative to find out on their own. One hygienist called the secretary of the Board to inquire about it, and he could not answer her question.

In at least one state, a dental supply company also assists the applicants in finding suitable patients for the exam. This would be especially helpful in Nevada since the applicants are required the additional effort and expense of traveling to California for the test.

Our association has been unable to get the Board to send us a list of hygienists who have passed the exam, much less those who intend to take it, so we cannot assist them in preparation.

For these reasons I urge you to pass legislation creating a place for dental hygienists in the governing of dental hygiene practice in Nevada.

Respectfully submitted,

Mary Moran RDH.

Mary Moran, RDH

632.000 Renewal of license: Fee schedule (Cont.)

	Not less than	Not more than
Examination fee for registered nurse's license	*$10.00*	*$15.00*
Examination fee for practical nurse's license	*7.50*	*10.00*
Rewriting examination for registered nurse's license	*10.00*	*15.00*
Rewriting examination for practical nurse's license	*7.50*	*10.00*
Duplicate license	*5.00*	*5.00*
Proctoring examination for candidate from another state	*10.00*	*15.00*

8. The board may collect the fees and charges established pursuant to this section, and such fees or charges shall not be refunded.

(11:256:1947; A 1949, 536; 1955, 608) — NRS A 1963, 613 — (6:154:1949; A 1955, 547) — NRS A 1959, 188; 1963, 615) — (NRS A 1973) — (12:256:1947; A 1955, 608) — (NRS A 1963, 613) — (Added to NRS by 1959, 189; A 1963, 616) — NRS A 1973)

632.010 Definitions of words and terms as used in this chapter.

1. "Accredited school of nursing" means a school of nursing which has been accredited by the board or other body or agency authorized by law to accredit or approve schools of nursing in the state in which the school is located.

2. "Board" means the state board of nursing.

3. *"Certified registered nurse anesthetist" means a person who has completed a nationally accredited program in the science of anesthesia, who, when licensed as a registered nurse under the provisions of this chapter, administers anesthetic agents to individuals under the care of those persons licensed by the State of Nevada to practice dentistry, surgery or obstetrics.*

4. *"Emergency" means an unforseen combination of circumstances calling for immediate action.*

5. "Licensed practical nurse" means a person who is licensed to practice practical nursing as defined in subsection 6 of this section and as provided in this chapter.

6. "Practice of practical nursing" means the performance for compensation of selected acts in the care of the ill, injured or infirm under the direction of a registered professional nurse, a licensed physician, a licensed dentist or a licensed chiropodist, not requiring the substantial specialized skill, judgment and knowledge required in professional nursing.

7. "Practice of professional nursing" means the performance for compensation of any act in the observation, care and counsel of the ill, injured or infirm, in the maintenance of health or prevention of illness of others, in the supervision

632.010 Definitions of words and terms as used in this chapter.

and teaching of other personnel, or in the administration of medications and treatments as prescribed by a licensed physician, a licensed dentist or licensed chiropodist, requiring substantial specialized judgment and skill based on knowledge and application of the principles of biological, physical and social science, but does not include acts of medical diagnosis or prescription of therapeutic or corrective measures. *A professional nurse may also perform such additional acts, under such emergency or other special conditions as may be prescribed by rules and regulations adopted by the board, which shall include special training, as are recognized by the medical and nursing professions as proper to be performed by a professional nurse under such conditions, even though such acts might otherwise be considered diagnosis and prescription, but nothing in this chapter authorizes professional nurses to perform those functions and duties specifically delegated by law to those persons licensed as dentists, podiatrists, optometrists or chiropractors.*

8. "Registered nurse" means a person who is licensed to practice professional nursing.

9. Unless the context otherwise requires, the masculine gender shall include the feminine gender, and the singular number shall include the plural number.

(2:256:1947; A 1949, 536; 1943 NCL § 4756.02) + (2:154:1949; 1943 NCL § 4759.02) — (NRS A 1963, 608) — (NRS A 1973)

632.020 State Board of Nursing: Creation; members

1. The state board of nursing consisting of five registered nurses, two practical nurses and one consumer is hereby created.

2. The members of the board shall be appointed by the governor.

3. The consumer shall be a bona fide public representative whose occupation is neither the administration of health activities nor the performance of health services, who has no fiduciary obligation to a hospital or other health agency, and who has no material financial interest in the rendering of health services.

(Part 3:256:1947; 1943 NCL § 4756.03) — (NRS A 1963, 609) — (NRS A 1973)

632.030 Members of Board: Qualifications: Consecutive Terms

1. Each registered nurse member of the board shall:

(a) Be a citizen of the United States.

(b) Be a resident of the State of Nevada.

(c) Have been graduated from an accredited school of nursing.

(d) Be licensed as a professional nurse in the State of Nevada.

(e) Have been actively engaged in nursing at least 5 years immediately preceding appointment or reappointment.

2. Each licensed practical nurse member of the board shall:

Clark County Dental Society

STATE OF NEVADA

Minutes of the February 10, 1975 meeting

The meeting was called to order by president L. J. Hendrickson. Guests this evening are Dr. Gordon Christensen, Vickie Stien and Cheryl Abbott.

Dr. Jim Jones reported that the Delta Dental Plan has been accepted by the State Insurance Commissioner. On February 27 there will be a luncheon and a dinner and on February 28 there will be a dinner to explain the Delta Dental Plan. All dentists are encouraged to attend. Information will be sent out to each dentists informin them which meeting they are to attend.

Dr. Hendrickson introduced Cheryl Abbott who is representing the Southern Nevada Dental Hygienists on the subject of representation of Hygienists on a committee to help examine incoming hygiene applicated. (The actual proposal follows on the next page.) Dr. M. C. Hack moved that the CCDS support the hygienists in their effort to be represented on the committee to help examine the future applicants for licenses to practice dental hygiene in the State of Nevada. The motion was seconded by Dr. Kelly and carried. A letter to the State Board of Dental Examiners with the proposal will be sent showing the support of the society.

Dr. Thomason via Dr. Hendrickson reminded everyone that it is the House of Delegates duty to select nominees for NDA Vice President and Scretary. There will be a meeting at Dr. Hendrickson's home on February 17 to do this.

New Business:

There will a ski seminar at Mt. Holly, Beaver, Utah on March 7-9. All doctors are encouraged to come and bring their families.

Dr. Christensen spoke on Semi-precious metals and non semi-prescious metals. Thank you Dr.

With no further business, the meeting was adjourned.

Respectfully submitted

Kathleen F. Clark

Kathleen F. Clark
Executive Secretary