

JULY 1965

the Journal
of the
American College
of Dentists

THE IMAGE OF DENTISTRY

enhance (ĕn hăns', -hăns'), 1. to raise to a higher degree; intensify; magnify. 2. to raise the value of . . . —*Syn.* see ELEVATE.

the *Journal* of the American College of Dentists

A QUARTERLY PRESENTING IDEAS IN DENTISTRY

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Proceedings of a

*WORKSHOP ON ENHANCING
THE IMAGE OF DENTISTRY*

St. Louis • January 17-20, 1965

Presented by the

AMERICAN COLLEGE OF DENTISTS

JOURNAL OF THE AMERICAN COLLEGE OF DENTISTS

ST. LOUIS, MISSOURI

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Preface

In 1961, the Board of Regents of the American College of Dentists created and appointed a Committee on Social Characteristics. This Committee initiated a three-step program:

1. To determine and establish the extent of interest in the status of the dental profession;
2. To arrange a workshop to project the problems associated with enhancing the image of dentistry; and
3. To develop ways and means to further the objectives and recommendations that would result from such a workshop.

In accordance with these charges, the Committee planned a panel discussion on "The Image of Dentistry" at the Atlantic City meeting, October 12, 1963.

At that time, dentistry was examined critically on three fronts. John S. Millis, President of Western Reserve University, Cleveland, presented the views of an educator. Martin S. Hayden, Editor of *The Detroit News*, presented certain aspects of the public's view. Goldie Krantz, Washington, D. C., a noted representative of labor and health groups, looked at dentistry through the eyes of the consumer.

Considerable comment—vociferous, approbative, derogatory—followed the publication of the above discussions in the *JOURNAL* (December, 1963).

The Committee then moved on to the second step—arranging a workshop on "Enhancing the Image of Dentistry." This issue of the *JOURNAL* records the proceedings of that workshop.

Subsequent recommendations of the Committee, following through step three, are presented later in this issue, as well as the actions of the Board of Regents concerning these recommendations.



Introduction

Purpose of the Workshop. The objective was to bring together a group of about 125 dentists and persons sophisticated in dentistry to consider the problems associated with creating a better image of the profession in our society. This meant a study of what dentistry means to the public, the meaning of dentistry to the profession itself, and the ability of dentistry to serve the public. It was thought that by having a meeting of individuals with so many backgrounds and tremendous breadth of experience, that their interactions and definitions of the problems and mature consideration of some of the solutions, could and would act as a stimulus to the profession as a whole to accelerate its development and to increase its ability to assume its full responsibility.

The Workshop was called against the background of the present needs of the public for dental care. The size and nature of these needs provided an opportunity unparalleled in past history for leadership from the dental profession. The Workshop was called humbly, with no preconceived notion of what the solutions should be, nor the direction that the recommendations should take.

Role of the American College of Dentists. The College, in supplying the money to promote this meeting, did not do so with the idea that it was in any unique position to solve the problems. Instead, the College was carrying out its historical and traditional role of trying to assume the responsibility of presenting the most important problems that face the profession.

The position of the College in this conference was one of having recognized and studied the problems, invited the participants, and made some definition of the point of departure for discussions. The College invited, in a sense, panelists and participants of the broadest scope, and placed each of them in a position to discuss freely without restriction, according to their capacity to interact and to contribute from their experience and background, elements of insight and knowledge that would be helpful in stimulating processes that could result in desirable adjustments.

This explanation of the purposes and procedures of the Workshop was prepared by Dr. Nathan Kohn, Jr. for inclusion in his "Summary" that follows the Proceedings. It seemed more appropriate to present it here as an introduction. [Ed.]

The College, by publishing these proceedings, offers to our society and to the profession particularly, a stimulation, an opportunity, an invitation to every dentist and to any group, to assume one or all of the responsibilities that are here defined, in terms of their resources and abilities to effectuate solutions.

Procedures of the Workshop. Each participant, prior to coming to the meeting, was given a list of suggested issues in six basic areas, that might be discussed. This was so that the participants could be prepared to consider these issues, and think of others.

There was, first, an orientation discussion by the chairman of the Committee on Social Characteristics. Then, seven selected panelists in formal presentations, built the framework for study.

Participants were assigned to study-groups, with the aim that a representative group would discuss the issues in the light of special abilities, background, knowledge, and experience. Within each study-group there was a chairman, a recorder, and various resource people. The study-groups were not limited to the questions, issues, and suggestions given them in advance; in fact, all presented some changes at these points.

In general, the study-groups began with an examination of the problems, a discussion of the implications, a planning for achievement, and after group discussion, ended in preparing recommendations for presentation to the Workshop as a whole. The reports of the study-groups were concerned mainly with the nature of the problems, and the solutions or approaches that dentistry might take.

The reports were discussed and debated in a general session. This was similar to a plenary session of an organization. Finally, an effort was made to summarize the overall picture of the Workshop. (All study-group reports went back to the chairmen and recorders for editing and incorporation of changes brought forth in the general session; subsequently, each study-group participant was given the opportunity to review the edited report.)

This was the general technic of the Workshop. But in the publication of the proceedings, there is the further technic of making available to the dental profession, within and without an organization, to social scientists and to other groups, the attitudes, information, and insight that the participants had, in such a way as to help in drawing resources together for an approach to the solution of some of the problems of the dental profession.

PROGRAM OF THE WORKSHOP

Enhancing the Image of Dentistry

CHASE-PARK PLAZA HOTEL, ST. LOUIS
JANUARY 17-20, 1965

Sunday, January 17

Registration
Meeting of the Planning Committee
Meeting of Chairmen and Recorders

WELCOME

Harry Lyons
President, American College of Dentists

GREETINGS

LeRoy R. Boling
Dean, Washington University, School of Dentistry
Stephen P. Forrest
Dean, St. Louis University, School of Dentistry

ORIENTATION

Kenneth A. Easlick
Chairman, Committee on Social Characteristics

"Changing the Dentist's Image of His Own Profession."
Alvin L. Morris, Dean
University of Kentucky, College of Dentistry

"Enhancing the Image of Dentistry."
Harold Hillenbrand, Secretary
American Dental Association

Monday, January 18

"Changing the Interprofessional Image of Dentistry."
Russell S. Poor, Director
Division of Nuclear Education and Training
U. S. Atomic Energy Commission

"Environmental Reorganization of Dental Practice."
Carlton H. Williams
San Diego, Calif.

"The Lessons That Social Change Taught Canadians."

Donald W. Gullett, Retiring Secretary
Canadian Dental Association

"What They Are Saying About Dentistry."

Nathan Kohn, Jr., Director
NK and Associates, Inc.

"Measuring the Image of Dentistry."

Donald J. Galagan, Chief
Division of Dental Public Health and Resources
U. S. Public Health Service

Monday, January 18

ORGANIZATION OF STUDY-GROUPS

1. "Changing the Dentist's Image of His Own Profession."
2. "Enhancing the Public's Image of the Dental Profession."
3. "Methods for Improving the Interprofessional Image."
4. "Environmental Reorganization of Dental Practice."
5. "Removing Hysteria Over the Relationship of the Profession to Government in the Provision of Dental Services."
6. "Identifying and Planning Technics of Research to Gain Methods for Measuring the Various Images of Dentistry."

STUDY GROUP SESSIONS

Tuesday, January 19

Study Group Sessions—continued
Preparation of Reports

Wednesday, January 20

GENERAL SESSION

Receiving and discussing reports.

"Where Do We Go From Here?" (A summary.)
Nathan Kohn, Jr.

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Changing the Dentist's Image Of His Own Profession

ALVIN L. MORRIS, D.D.S., Ph.D.

One quickly gains enthusiasm for this Workshop and its objectives. We have gathered to do service to our profession by directing attention to a most timely problem. It requires courage and maturity for a profession to choose a subject so personal as its own image and give it the attention of a national meeting. It is entirely appropriate, and perhaps to be expected, that the American College of Dentists would provide the leadership for such an effort.

Since the first letter from Dr. Brandhorst, I have been intrigued and perplexed by the subject assigned to me. In the months since July, the matter has never been far from my mind. I have passed through periods of extreme frustration at my inability to conceive an approach to the subject which seemed appropriate.

As I continued to read and think, I began to develop some rather deep personal feelings about the subject, some of which have found their way into this paper. I acknowledge the risk which I am running. It is not fashionable today to feel deeply about things, and particularly to expose one's feelings to others. It will be difficult for you to remain totally neutral about my remarks. They include rather close scrutiny of matters we usually do not face squarely. Some discomfiture I fear is inevitable. My only objective, however, is to direct your attention to matters of importance and relevance to the image of dentistry today.

The title assigned to this presentation implies that a change is indicated in the image which the dentist has of his profession. It implies that the present image is negative, unfavorable, inappropriate, or inaccurate. The title does, in fact, imply that we know what the present image is, and further, that we know how it should be changed. For purposes of orientation to what follows, I must deny that such information exists. Indeed, this information is seriously needed, and I look forward to the direction which we will receive

from Dr. Galagan when he discusses methods of measuring images in dentistry.

It is fair to conclude as a point of departure for this presentation, however, that a recognizable dissatisfaction exists regarding the general image with which many dentists view the profession of dentistry at this point in our history.

If a dentist does not have a good image of his profession, one of two conclusions may be drawn. First, that the dentist is a sensitively-perceptive individual and that, in fact, the dental profession is undeserving of a good image. I soundly denounce this premise. But more important, I am confident that even the most unhappy, dissatisfied members of our profession would find this conclusion unacceptable. The second possible conclusion is that factors inherent in individual dentists, coupled with the peculiarities of dentistry's culture as it has developed in a complicated society, have resulted in an undesirable and undeserving image of the profession on the part of many dentists. It is to this second conclusion and the problems suggested by it that the remarks which follow will be addressed.

It is acknowledged that a significant increase in the prestige of dentistry in the eyes of the public and other professional groups would have a favorable impact on the dentist's image of his profession. These subjects, however, will receive the attention of other speakers and I shall attempt to avoid duplication by focusing upon matters identified more clearly with dentists as individuals.

SEEKING A PROFESSIONAL IMAGE

The story is going around our campus about the Kentuckians who were squatted before the court house of a small rural town. One turned to the other and drawled "How's your wife?" The other removed his pipe and after unhurried deliberation, responded, "Compared with what?"

If I asked almost any dentist, "How's your profession?" I think that he might appropriately respond, "Compared with what?" It is my impression that one of the difficulties facing the dentist of today is the lack of a clear concept of his professional identity. Dentistry is a relatively young profession, and its characteristics and its role have been undergoing constant change. These changes are of such magnitude and recent vintage that the image of dentistry held by laymen and dentists 60 years of age could not be expected to coincide

with the image held by individuals born 30 years later. This fact complicates the subject I am discussing as well as the general theme of the Workshop.

What is needed is a general understanding of what dentistry is in 1965. Unfortunately, the image of the profession carried by many dentists is an abbreviated, inadequate one. It is doubtful that the total scope of modern dentistry, including its responsibilities, capabilities and opportunities, has been adequately communicated to the profession at large. Communications are complicated by differences in age, characteristics of dental schools, the nature of specialties, and geography. I can think of nothing more complex than attempting to describe and define the "average" dentist today. If we found such a dentist, he might well ask, as did Saint Augustine, "What am I then, O my God? What nature am I!"

It is to be expected that the self-image of the dentist may have its roots in the self-image which he first acquires as a dental student. According to Quarantelli (1), the student dentist develops a negative self-image because he concludes that people in general take an unfavorable view of his services. This attitude on the part of the public, according to the student, is centered about the pain and high fees associated with dental care, plus the feeling that the dentist is more of a mechanic than a scientifically prepared practitioner of the healing arts. Quarantelli's study revealed that on few matters have students in dental school acquired stronger attitudes than the reaction against acceptance of an image of himself as a mechanic. It is my impression that strong reactions to this subject have been carried into practice by most dentists. In spite of the discomfort created by the admission that such a problem exists, concern over the emphasis placed on the technical aspects of dentistry appears to be an important element which influences the dentist's image of his profession.

While on the subject of the dental student, the role of dental educators in developing the self-image of the graduates of their school must be acknowledged. Great harm can be done by teachers and deans who refuse to take a realistic attitude about the practical and financial aspects of dental practice. Often there may be little similarity between the profession the student hears about, and the profession he finds himself a member of a few weeks after graduation. As More (2) points out, "No occupation is perfect in the way it meets the idealistic anticipations of those who enter it. However

heightened and sustained our initial excitement, part of becoming a professional man includes the recognition of the dirty, dull, unpleasant aspects of the job. . . . Mature adjustment to a profession, then, implies achieving a balance between daydream and disillusion, an appreciation of the correct limits of behavior while retaining and working toward the vision of an improved future."

The student who is ill-prepared for some of the everyday facts of life in practice may experience a great shock. The result may be disappointment and cynicism directed at dentistry which may always be a factor in his image of the profession.

In what may appear to be somewhat of a contradiction, I wish to state that in my opinion, one of the obligations of dental educators is to continually identify for the student the frontier of professional thought and activity. The dental schools represent a key source of leadership with a strong responsibility to influence the future course of the profession. This influence is exerted primarily through the contributions of students following graduation. It must be further acknowledged, however, that there is influence being mediated in a variety of ways, directly to the profession from the academic arena in dentistry. As Upshaw (3) pointed out, "As is true in any social system, everyone in any way connected with dental practice (patients, dental educators, dental hygienists, practitioners) develops expectations about how everyone else in the system should behave. . . . Perhaps some acts thought by educators to be an obligation of the dentist may be considered by him to be a matter of privilege, to be performed or not as he chooses. In this situation the practitioner may challenge the right of educators to pressure him into any particular practice habits, arguing the educators are no more valid definers of his role than are others in the system who may not agree with educators."

It certainly comes as no surprise that not everyone agrees with educators. But the resistance on the part of practitioners to the changes which inevitably must come to the profession and which are logically introduced through the dental schools must be acknowledged as significant. Attempts on the part of a recent graduate to establish an appropriate image of his profession may be complicated by the conflict between the influence of his teachers and the influence of his newly-acquired professional colleagues. The less cooperation and understanding which exists between a dental school and the practitioners

in the state or area, the greater will be the conflict. One step in improving the dentist's image of his profession is to improve the understanding and liaison between dental faculties and practitioners.

Another problem which confuses the dentist who is seeking a professional image is the contrast which may exist between the individual's image of himself and his image of the profession at large as he perceives it. Smith (4) has stated that every profession operates in terms of a basic set of fictions about itself; these provide the profession with a comforting self-image, some stereotype to help meet and adapt to the varied and often difficult aspects of every-day operation. What appears to happen is that sometimes the individual dentist selects a comfortable and perhaps quite true self-image, and then projects it to the profession at large. In this latter context, it may be unreal. The individual then becomes disenchanted with the profession at large because it does not measure up to the image which he has arbitrarily selected for it. It is important to emphasize that the dentist makes his most significant contribution to the image of his profession through the image which he projects as an individual. It is not appropriate, however, for him to establish a personal identity for himself as a dentist independent of the profession at large. The dentist's image of his profession can only be improved if he is willing and proud to be identified with it.

The matter of professional identity is a particularly challenging problem to the specialist. Modern professions are so complex that many different specialty groups within them may lose the sense of having a common culture or sharing a common fate. Some groups within our profession may feel closer to members of some other profession than they do certain members of their own (4). The behavior of some specialty organizations within dentistry suggests that they are encouraging an identity as specialists first and as dentists second. Such an attitude will surely work to the detriment of both the specialty and the profession in general. The specialist must recognize that he has unique opportunities to provide leadership, and the responsibility to exert that leadership for the common good of the profession which permits him to be called special. The image which the general practitioner has of himself and his profession can be improved if relationships with specialists which are damaging to his self-image are avoided. The responsibility for this matter rests squarely with the specialists.

I now wish to speak on a point which I feel has much significance to the image which the dentist has of his profession. Some will judge my comments to be inaccurate, others will regard them as indiscreet. Nonetheless, I feel the purposes of this Workshop will be best served if we face all issues squarely. It is my opinion that many dentists have a conscious or subconscious physician complex—and that this complex is detrimental to the image which they have of the dental profession. The physician complex is defined as the phenomenon by which some dentists exhibit irrational behavior in an attempt to suppress or disguise the inferiority which they feel in relation to the profession of medicine.

The behavior of such a dentist takes several patterns, depending upon the depth of his feeling and the nature of his practice. In some cases, an attempt is made to exaggerate all features of himself or his practice which are "physician-like." In other cases, a campaign is followed by which efforts are made to deprecate, when possible, the desirable features in the practice of medicine.

In seeking ways to improve the image which the dentist has of his profession, the problem of the physician complex must be faced and corrected. Hopefully, progress can be made by focusing attention upon it and discussing it in some detail.

Part of the problem can probably be traced to dental school admissions programs. Studies have shown that 11 to 25 per cent of entering dental students have applied or attempted to apply to medical schools (5, 6). It cannot be recommended that all such applicants be denied admission to dental school. All professions contain members who, at one time, considered other careers. Granted that many dentists at one time considered medicine, it does not follow that they all have a physician complex or that, if they do, the situation cannot be remedied.

Perhaps it will serve a useful purpose to acknowledge once and for all that dentistry is not equal to medicine. This statement should create no conflict in the mind of any dentist. The statement can also be made that dentistry is not equal to pharmacy or law or engineering. In fact there is no reason to expect a profession with so many unique characteristics to be equal to any other. The compelling necessity of some dentists to compare their profession with medicine is not rational. It is similar to comparing apples and pears. Both

grow in the same orchard and go well together in a salad. But regardless of the dressing, one still ends up with apples and pears.

Some dentists regard it as unjust that the medical profession is awarded an almost unequalled prestige by the public. This attitude is easily understood and is, in fact, logical when one acknowledges the drama associated with the physician's role as guardian of human life. It is true that some physicians react immaturely to their role and to the deference afforded them by society, with the result that a posture of superiority develops. The mature dentist should have no difficulty in recognizing this and reacting to such a physician with the same understanding that he exhibits to his other colleagues who have an imperfect adjustment to their social environment.

It is important to the image which the dentist has of his profession that he cease the useless grinding of an imaginary axe with regard to the medical profession. Let us all acknowledge and take pride in the accomplishments of our medical colleagues, while at the same time being humbly thankful for the privilege of being a dentist and all that it implies. And let us be thankful that a difference in the two professions does exist. For it is undoubtedly God's plan that there be apples and pears and physicians and dentists, each with their own flavor and their own place under the sun.

THE DENTIST'S IMAGE OF HIMSELF

In approaching the subject of this presentation, I have made the judgment that the dentist's image of his profession is dominated by his image of himself, as the representative of that profession about whom he is most intimately knowledgeable. Simply stated, it is my premise that the dentist who takes personal satisfaction in his work, and adds to his self-respect through his daily endeavor, has a good self-image which he extrapolates to a good image of his profession. Conversely, the dentist who is fundamentally unhappy in his work, and is dissatisfied with his own professional role, thereby denying at least a comfortable if not a stellar self-image, has lost the capacity to have a truly good image of his profession.

Therefore, in discussing the subject, *Improving the Dentist's Image of His Own Profession*, I find that I must discuss *Improving the Dentist's Image of Himself*. Those matters which contribute to the dentist's personal dissatisfactions must receive attention.

I recognize that I am embarking upon a difficult if not dangerous task. I must guide the reader of this material through a measure of self-analysis, always an unpleasant if not painful experience. Each reader will tend to reject or accept my comments based upon the extent to which, in his judgment, they have or do not have self-application. The more a remark applies only to someone else, the more acceptable it becomes. It serves no useful purpose, however, to pretend that things are different merely because we wish that it were so. The first step in solving our personal and professional problems is the recognition of these problems.

R. H. Snow (7) has written, "Competency in work performed is a major criterion by which we judge ourselves and others, and the normal craving for a favorable self-image will rarely be fully satisfied unless vocational achievement confirms and justifies the image."

In some fields, such as teaching, there may be difficulty in finding evidence of vocational proficiency; however, in the case of the dentist, the bare truths about the proficiency or relative lack of proficiency with which he has performed an act of patient care is so obvious that it cannot be ignored. Accordingly, the self-image of the dentist may be detrimental to a sense of happiness, pride, and well-being for a variety of reasons. He may be dissatisfied with his accomplishments because of unrealistic self-demands for excellence. On the other hand, he may recognize that his work does not reflect the level of accomplishment of which he is capable. He alone can make this judgment, and having made it, he can share it with no one. Only the most calloused practitioner can be successful in rationalizing this fact and its implications into a perspective which permits him satisfaction with his self-image. Even the fact that patients continue to seek his services, and he enjoys the deference accorded him as a member of an honored profession, does not heal the self-inflicted wound to his personal dignity.

It is inevitable for such a dentist to find that, to some extent, his practice has become a source of anxiety. With anxiety comes discontent, and he may well say of himself, as did Saint Augustine, "... I have become a problem to myself; and that is my infirmity."

In seeking relief from his anxiety and discontent, one approach is to diminish the importance of his practice in his own mind. As his personal commitment to the practice of dentistry as his key function

in society diminishes, so does his anxiety. Thus, he turns to other outlets, his practice assumes a more peripheral role, and his professional performance is less challenging to his personal status quo.

An example of this was recently described to a gathering of dental educators by a well-known president of one of the nation's prominent universities. Said the president, "During the past 15 years, I have been under the care of three dentists in three different states. Each had another business beside the practice of dentistry. One was a farmer, one dealt in real estate, and the third raised Hereford cattle. All the time I spent in their offices, they talked about their outside activities. I am convinced that dentistry was the sideline in the minds of these men."

It must be acknowledged that many excellent, dedicated, and contented dentists have hobbies or investments to which they direct some attention. But they do not use them as an escape from their profession or their personal professional inadequacies.

If a dentist is to have a good image of his profession, he must have a good image of himself as a dentist. If that image produces anxiety, he must not turn from the profession. Rather, as May (8) suggests in his book, *Man's Search for Himself*, he must strengthen his consciousness of himself to find centers of strength within himself which will enable him to carry out his professional role in such a way that it permits self-respect.

The first step in achieving respect for his professional role is a recommitment to dentistry and his practice. A fundamental challenge in life is for a man to choose the ground upon which he shall stand, the profession with which he shall assume identity, and the activity by which he shall be judged a success or failure. When men shun a true commitment to their life's work, the potential of their human resources is never realized. Our nation is in need of more committed men. The dental profession is in need of more committed dentists.

The second step which will assist the dentist as he seeks satisfaction in his practice is a dedication to excellence. Gardner (9) has written a thought-provoking book on the subject of excellence in which he states: "There is a way of measuring excellence that involves comparison between people—some are musical geniuses and some are not; and there is another that involves comparison between myself at my best and myself at my worst. It is this latter comparison which

enables me to assert that I am being true to the best that is in me—or forces me to confess that I am not. . . . Our society cannot achieve greatness unless individuals at many levels of ability accept the need for high standards of performance and strive to achieve those standards within the limits possible for them. . . . Many, many more can try to achieve it [excellence] than now do. And the society is bettered not only by those who achieve it but by those who are trying.”

No act of patient care can be considered adequate until it represents the best that one can do. Not only does the patient receive better care—the dentist is benefited also by the personal satisfaction which accompanies his best effort. The dentist's image of his profession is thereby improved as his image of himself as a committed man dedicated to excellence is reinforced.

Moreover, the dentist's commitment and dedication will have a compounding effect as he finds himself inexorably drawn into problems of dentistry beyond that of personal patient care. He will become interested and involved in organized dentistry and its efforts to meet its responsibilities to society in his community and beyond. His efforts on behalf of his community will, in fact, serve to improve the image of dentistry which in turn will justify a greater pride in his profession.

EDUCATION AND THE SELF-IMAGE OF THE DENTIST

Although one may accuse me of speaking from the biased view of an educator, nonetheless it is my opinion that the image which the dentist has of his profession can be improved through education. In this context, education is being used in its broadest sense.

Since the days of the Pilgrims, our country's development has been guided by a deep appreciation for and dedication to political freedom, religion, and education. Though Americans have been chastised for their materialism, they have never lost their fundamental respect for education and in this respect are becoming more profound with each generation. The more education per se the dental profession represents, the deeper will be the self-respect of its members. The most direct approach to improving the dentist's image of his profession is to improve the breadth and depth of his education. Let us consider the three phases of his education: preprofessional, professional, and continuing.

Our dental schools are entirely too possessive and casual about student recruitment, seldom exerting efforts beyond what is necessary to provide a reasonable number of reasonably prepared applicants. The student who is accepted to dental school, knowing himself to be little more than an average undergraduate with a limited education, can hardly be convinced that his chosen profession is a truly scholarly one. Imagine the disenchantment of the outstanding pre-dental student when it becomes common knowledge in his undergraduate college that you do not have to be outstanding to get into dental school. Because of the respect for education which is being ingrained in young people today, the best long-range approach to attracting larger numbers of better students to dentistry is to require a broader and better education to get into dental school. Although the dental schools would be forced initially to resort to more vigorous recruitment and more classes might not be filled for a few years, the Council on Dental Education of the American Dental Association should immediately increase the minimum pre-dental requirements to 90 hours. Within five to ten years a bachelor's degree should be the prerequisite for anyone entering the profession. The result of such action would have a marked impact upon the image which entering students have of their future profession. Part of that impact would reflect the knowledge by such students that dentistry is viewed with sincere respect by their fellow undergraduates and that this respect will exist in their future patients and friends who are college educated.

It is obvious that the recommendation which I have made relative to preprofessional education could have a profound effect upon professional education of the future. Dental students with better preparation could be expected to successfully master a more challenging educational experience in dental school. And challenging it should be! No faculty should alter curricula merely for the purpose of submitting their students to more difficult academic exercise. It is, however, a disservice to all concerned when a faculty by choice or necessity offers a curriculum which is watered down in any of its aspects. Students who are merely prepared to practice dentistry as practice is defined at the time of their graduation are poorly prepared. The student must be prepared to accommodate to and provide leadership in the changing complexion of dental practice. Dr. Sam Martin (10)

has written, "The situation demands the production of more professional people who are more highly skilled, more integrated, and more versatile. The modern profession in the area of health and patient care is forced to deal with interactions of molecules, man and mankind in a rapidly changing universe. . . . The educator must disavow his interest in education for practice but avow his interest in education for growth in practice. The student is given the opportunity to learn how to learn in the field of practice." Such education can only be achieved by a professional school program which demands that the students utilize their intellect, background, and energies to maximum capacity.

It is my thesis that the young graduate who has the benefit of a good, well-rounded undergraduate education followed by a modern, challenging professional school experience, will begin his practice with a good image of his profession. He will have fewer concerns about his image as a mechanic referred to earlier. But now, if he is to retain a good self-image, he must recognize that he is beginning a lifetime of learning. We are experiencing an explosion of knowledge. More information has been published in the last ten years than has been published in the written history of mankind (10). Monteith has been quoted as describing the consequence of the rapid growth of knowledge by saying that a graduate engineer now has a half life of ten years. Half of what he has learned will be obsolete in a decade (11). The dental graduate must be convinced of the inadequacy of his present education to sustain him in the future. He might well be told what Sir William Osler said to a graduating class: "Gentlemen, I have a confession to make—half of what we have taught you is in error, and furthermore we cannot tell you which half it is."

More graduates should be encouraged to intern in an attempt to add to their preparation. Indeed, it can be expected that greater numbers will enter graduate and specialty training. The key factor of the future of the graduate, however, is a program of continuing education. The dentist who continues to learn and attempts to keep up with the changes of dentistry, will not only render better service but will be reinforcing his image of himself as an educated man. The dentist who tries to get along on what he learned in dental school knows that he is falling farther and farther behind, and has great difficulty in respecting his own image as a dentist. Continuing educa-

tion is the key to the dentist's image of himself and his profession. I am a firm believer in the quotation from Proverbs, "Happy is the man who finds wisdom and the man who gets understanding, for the gain from it is better than gain from silver and its profits better than gold."

THE MINISTRY OF DENTISTRY

For several years I have been harboring the urge to write a paper entitled "The Ministry of Dentistry." After much thought it was decided to introduce the subject as part of this presentation. The point I wish to make is that dentistry should not—must not—be simply looked upon as a job. The dentist who regards his practice primarily as a means to making a living has lost the true meaning of his work and perhaps the true meaning of his life.

Like so many other things which we know to be true but which cannot be defined, it is difficult to convey in words what it means to be a dentist—or at least what it can mean. We may stand beneath the Matterhorn and be in total agreement as to its beauty, but there is no way that we can prove it to one another. How would you set out to prove that it is beautiful—measure its height, or the whiteness of the snow? It is beautiful because something within you tells you it is so.

I think that becoming a dentist makes you different—something within you tells you so and sets you apart in society. The dentist who does not sense his apartness—his special relationship with and responsibility to society should search his soul deeply. Volkart (12) has said that if people define a situation as real, it is real insofar as it has consequences for their behavior. If a dentist accepts his profession as being something different and special, it will have an effect upon how he conducts his practice. It will likewise have an effect upon his image of himself and his profession.

Dr. Henry Clark (13), Administrator of the Division of Health Affairs at the University of North Carolina, has written: "As one grows older and hopefully wiser, it is found that the lasting satisfactions are those associated with what one *gives* to others—family, friends, and community-at-large—rather than what one *gets* for oneself. The truly happy persons are those who, by and large, spend their time, thought, and energy in being helpful to others. The den-

tist is among the most fortunate of men in that his daily practice, if undertaken in proper spirit, can bring him routinely a good measure of life's satisfactions."

Dentistry is a calling and if undertaken in proper spirit will transcend any attitude of practicing for oneself. While the dentist will undoubtedly prosper, his professional life will have its greatest meaning as he regards it as the opportunity and the privilege of serving others—as his "Ministry of Dentistry."

What should be done to change the image which the dentist has of his own profession? Several suggestions have been offered. The dentist must be assisted as he seeks a true professional identity. He should be encouraged to become committed to his profession and dedicated to excellence. He should be supported as he seeks to enrich his life and practice through education. He should be helped to view his practice as his "Ministry of Dentistry."

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Enhancing the Image of Dentistry

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I was not exactly elated when Dr. Brandhorst assigned to me the topic of "Enhancing the Image of Dentistry" and this for a variety of what I consider to be reasons of some excellence.

First, in very erudite and sophisticated circles—to which I admit I do not have ready access—the very mention of the word "image" stimulates shuddering and the retching reflex. The word "image" is strictly unfashionable in these esoteric circles and one must learn to substitute the word "profile." If you belong to this cult, you can amuse yourself by substituting "profile" every time I use the word "image." This will have the added advantage of making you concentrate on what I am saying and this always flatters the ego of a speaker.

Second, as I discuss my topic I will be giving some of my very own opinions of the image of dentistry and thus, I am sure, disclose to every Freudian and amateur psychoanalyst in the audience some of my own image. I am sure the result could be a very unflattering image and I will end up as a personality blending the major assets of Walter Jenkins, Zsa Zsa Gabor, and Barry Goldwater. I have never had a session on the couch so I might as well be a beneficiary of this involuntary catharsis.

Third, I am sure some members of the audience expect me to do a little image-breaking so that the clatter will keep them awake. Henry Mencken, who was no mean iconoclast in his own Germanic, beer-drinking way, showed his fine scorn for image-breakers by publishing his famous "Schimpflexikon" which, literally translated, means the lexicon of scolding. In this book Mencken published every derisive and scurrilous remark which had been hurled at him by his more vitriolic critics. This made very interesting and libelous reading while demonstrating—inescapably I think—that Mencken didn't give a damn about his own image because this would inevitably arise out of his writings and not out of the collective venom of his critics. I have no intention, therefore, of rehearsing the dissonant notes of the critics of our image and thus will disappoint some segment of my audience.

Fourth, by making some hopefully profound remarks about the image of dentistry, I could find myself in the position of the president of a brand new college who, on the opening day, addressed a memorandum to the student body directing that a long list of items would be considered as traditions of the college from that day onward. I doubt that traditions can be made in this way by fiat as much as I doubt that the image will instantly be improved by any strictures of mine.

Finally, in talking about the image of dentistry I could ruin my own image by boring all of you stiff with a long speech in which I rehearsed every known cliché about the dental profession and a few that I invented along the way. If I have no control over all of these hazards which are implicit in Dr. Brandhorst's assignment, I do have control over the length of my speeches and I shall try to exercise this well below the tolerance of your patience and your affection.

Before beginning my disquisition I must share, as our friends in the behavioral sciences are always saying, with you, Jerry Timmons' tale of the beautiful girl who refused to take a hot shower because it fogged the mirror and blurred her image.

In talking as a participant of an international symposium (1) on the image of dentistry I said:

It is difficult to talk about the "image" of any profession in any country without an awareness that it is but a part of the total image of a complex national society. In the United States, as in other countries, the dental profession obtains some of the shadings and contours of its own image directly from the nation of which it is an important part. Dentistry in the United States has been influenced and formed by the ideals and goals of the nation which it serves. These ideals and goals change as the nation and the world change to meet the challenges of peace or war, want or plenty and the rising standards of living for all citizens. . . . The dental profession in the United States participates actively in attempting to satisfy these "new expectations" (of its citizens) by devoting its resources to raising the standard of total health for all citizens through programs for better dental health. The profession has a permanent commitment to the principle that "dental care should be available to all regardless of income or geographic location" (2).

I think now, as I did when the remarks just quoted were originally written, that the image of American dentistry is good, particularly when it reflects the socially aware, sustained effort of the profession to raise the levels of dental and total health. The President of the

United States has recently recognized this part of the profession's image when he said (3):

You have provided leadership not only in treating dental ills but also in preventing them, and your programs in research and education have helped to raise the standards of American and world dentistry to a position of eminence in the health sciences. Your wholehearted support of public health has done much to promote a better and healthier life for citizens in all parts of the world. I wish you . . . many more years of effective service.

Late last year Representative John Fogarty, a true statesman in the field of health, said in the Congress of the United States (4):

During my years in Congress, I have become intimately acquainted with many of the programs of the American Dental Association and have developed great respect for this group. The association has done much over the years to further the cause of better health in this country and fully deserves commendation. . . . Dental disease is not dramatic and there was a time when its importance and its relation to total health were overlooked. This is not so anymore. Today most people recognize that oral disease is serious, is often crippling and, in the tragic instance of oral cancer, can be fatal. This new awareness has in great part been the result of the educational effort of the American Dental Association. It is a creditable achievement. Together with the association's activities in the fields of dental public health and dental research, it displays a pattern of progressive and positive interest in the health of the Nation.

I have been trained too long in the discipline of the Council on Dental Therapeutics not to be wary of giving much credence to testimonials but I submit that a testimonial from the President of the United States and from one of the leading Congressional spokesmen in the field of health are not easily come by, and contribute legitimately to the image of the dental profession in the United States. Whatever their worth, I would think the absence of such testimonials would make the dental profession pause, and adverse testimonials would make it listen. Consider the following report from a recent article in the *New York Times* (5):

There are few people who take the middle ground when asked to judge the American Medical Association. To its enemies, it resembles a medieval guild, embracing a cold philosophy and suppressing dissent within its ranks. To its friends, it is a superbly professional organization, insuring excellence within the fraternity and protecting its members against those who would intrude upon their liberties. It is never far from the center of controversy, and it is usually worried about something. Today it is deeply involved in controversy and more worried than ever. . . . The AMA's penchant for political conflict has tended to obscure its scientific accomplishments.

This testimonial in reverse was illustrated with a cartoon in which two physicians diagnosing the American Medical Association said: "It looks like rigor mentis." I think this Workshop would need to stay in session for a month if this article and cartoon had been directed at the American Dental Association and the dental profession.

While I think that, by and large, the image of the dentist and of the dental profession is good, I also believe that, like most things, it could be better. The responsibility for the improvement of the present image rests with the individual dentist as well as with the many organizations of the dental profession. For the next three days you will participate in workshop discussions in which many problems relating to the image of dentistry will be considered and analyzed. I have neither the competency nor the temptation to do this work for you, so I will content myself with a description of some of the graces and blemishes of our professional image without special regard for their rank order of importance.

Provincialism: I am in agreement with Dr. Timmons who, in his 1963 presidential message to the House of Delegates of the American Dental Association, called attention to the dangers of provincialism in the following words (6):

The dentist does not do full service to himself or his profession when he limits his knowledge to the present and ignores the visions of the future; when he is unaware of the counsel and experience which are available to him in history and literature; when he is unwilling to accumulate facts and separate them from conjecture and opinion; when his sense of personal responsibility does not extend beyond his personal and provincial interests. Such is the provincial dentist; for that matter, such is any provincial man.

It is, perhaps, a sign of our times that there is an apparent trend to provincialism not only in dentistry but in many phases of our national life. This trend must be resisted if we are not to characterize dentists and the profession as those who will not look to the horizon to see the warm glow of national ideals, objectives, and achievements.

Legislation: In the past two decades, dentistry has been quite successful in avoiding the stigma of provincialism which carries with it the strong implication of self-interest and self-service. This is particularly true in the field of national legislation where the image of the profession is bright. The profession has limited its pronouncements in the field of legislation to those issues which involved the

responsibilities of the dental profession or were health-related. The profession has not attempted to use its influence by speaking out on issues in which it had neither authority nor competence. As long ago as 1938, the profession opposed the first of the national health program bills with a constructive counter proposal; in 1949, the dental profession saw the need for federal aid to dental education and has vigorously supported legislation to achieve this objective since that time. Last year this effort was successful. The profession has supported scholarship and loan funds in federal legislation while these proposals were drawing sharp attacks from some of the other health professions; the profession fought, successfully, for earmarked funds for the dental divisions of state health departments while others were drawing pictures of the enlarging tentacles of the federal octopus. The profession has taken a firm position on the dangers of cigarette smoking unlike the major spokesmen in the field of medicine and I will not appreciate your comments about my own inability to date to conform to the mandate of my profession. For many years the profession has supported dental research by testifying before the Congress but never has our sister profession of medicine recognized the necessity of playing this important role.

The dental profession has, on occasion, found itself in the loyal opposition to federal proposals and it has expressed this opposition by relevant, forceful, and dignified arguments and methods.

This bright image is in danger of being marred by the hysterical, unreasoning, and contemptible tactics of a few who wish to use the profession to serve their own political ends.

The Rightists: This group, largely of the ultra-conservative right, can do much to blemish the image of the profession. Their flight from the realities of the nineteenth century—to say nothing of the twentieth—their pathologic fear of any change in the status quo, their use of the evil tactics of subversion, distortion and untruth to gain their private ends, and their sneering contempt for the democratic process make these groups a clear and present danger. The democratic process upholds their right to exist but they should be identified and isolated before their virus impairs the health and the image of the profession.

Survey of Dentistry: These groups of the ultra-right have an unswerving devotion to the fetishes they have created for their peculiar rites. Two of these involve an almost fanatical opposition to *The*

Survey of Dentistry in the United States and to the destruction of the dental service corporation. In their attacks on *The Survey*, they demonstrate their contempt of the freedom of speech, except for themselves, and the repudiation of the scientific method of study and report. In attacking dental service corporations, they demonstrate their childish fears of a new mechanism which cannot help but serve the public interest.

If these attacks are permitted to be successful, the image of the profession will be stained and disfigured for a long time to come.

Fluoridation: The profession's fight for the fluoridation of public water supplies has enhanced its public image by convincing many of the profession's objective to advance dental health, even at possible economic risk to itself. The failure of some dentists to identify themselves publicly with this program has caused the dimming of the image in some areas because of the implied disinterest when there was a clear call for effort and courage in a public and professional issue.

Auxiliaries: In the image of the profession, we find an area that portrays the state of the relations between the profession and its auxiliaries. In some local and national areas, this part of the image needs repair.

The auxiliaries should be recognized and treated as valued members of the dental health team, even as the dentist receives such recognition and treatment from his medical and hospital colleagues. The auxiliaries should have an economic status consistent with the economic status of the dentist; they should have better programs for education and training so that they can expand their skills in serving as members of the dental health team; they should be invited to participate in appropriate activities of the profession to develop closer rapport and understanding; they should have the respect of the dentist for, and not his grudging acceptance of, the services that are rendered.

There are more than one hundred thousand auxiliaries in the dental profession and too little sustained effort has been made to win their interest to the improvement of the dental image. Unless this situation is repaired, we confront the possibility of hostility and non-cooperation from the auxiliary groups and the development of the same chasm of separation that exists between the medical and the nursing professions.

The strong opposition that exists in the profession to the careful reevaluation of the duties of the dental hygienist and dental assistant does no credit to the image of the profession. We all should be willing to review these experiments and the evidence they produce in order to accept those changes which will enable the dentist to serve his patient more efficiently without impairing his professional prerogatives.

Relations with Other Professions: The dentist should continue routinely to protest the use of the term "doctors and dentists" but he should not develop either an obsession or an inferiority complex from the use of a phrase which is solidly, if improperly, rooted in the American idiom. The dentist should develop a greater knowledge of the problems, objectives, and frustrations of the other health professions and manifest his understanding of these through cooperation and friendship.

Many dentists are affronted by the characterization of dentistry as a "paramedical" profession. Personally, I prefer not to be affronted but to educate my colleagues in the other professions to the use of the term "paradental" when they are describing themselves. It is a successful and amusing contribution to the eventual eradication of an inaccurate term.

All of the health professions must work together as members of the team which carries the total responsibility for the health of the patient and the nation. Dentists are too frequently remiss in leadership in the development of interprofessional relations and, more frequently still, are unwilling to carry the burden of effort and time which the maintenance of these wholesome and rewarding relations requires.

Other Elements of the Image: There are many other problems and situations which add or detract from the image of dentistry and which deserve the extended consideration which is not possible here.

The silly fussing about the propriety and superiority of one dental degree—D.D.S. or D.M.D.—over the other should cease and the issue—if there is one—resolved on its merits—if there are any.

The indifference or hostility to dental service corporations or commercial insurance companies as third parties in programs for making dental health care more widely available should be diminished; their value in prepaying the costs of dental care is recognized as an undeniable public service.

The fallacy that the publications of the profession must be wholly supported by revenue from commercial sources and not through the payment of dues should be discarded as quickly as possible.

The failure of more dentists to serve their communities and their nation by making themselves available for elective public office should be corrected in all parts of the country.

The social consciousness, the community awareness, the administrative leadership, the interprofessional contacts, the grammar and writing ability of the profession as a whole, and many other things could be improved with subsequent benefit to the image of the profession.

I doubt that I have given you much of a prescription for enhancing the image of dentistry but I hope I have suggested some areas in which consideration is needed. I am certain that these areas will be more clearly defined and that new ones will emerge from the deliberations of this workshop.

I would hope that your deliberations would not be narrowly restricted to professional problems which relate to the image of dentistry but that there would be the wider view which envisions the dentist as an educated participant in all phases of the cultural and intellectual life of the nation and of the world. At his wish, the dentist can open many doors which lead beyond his preoccupation with his profession and thus enhance the image of dentistry as a profession.

There are many opportunities for participation in the world's concern by dentists who have been trained in the disciplines of our great universities (7).

In political life, there is need for the political scientist and the statesman to show through the democratic process how it is the best compromise between meeting and reconciling the conflicting needs of the individual and the community.

In industrial life, there is need to order the use of the machines, the methods of production and of automation, without infringing or destroying human rights and dignity. There is need to use the results of industrial production in providing better schools, better homes, and better roads. There is a need to make collective bargaining work, and to insure that the results of our national productivity lead to more leisure and a higher culture for our people.

In our own field of health, there is need to close the gap between our knowledge of the health sciences and their application to more of the people; to reconcile the universal need for health aids with rising costs and increasing technification so that health care may be available to all; to preserve, in spite of social and technical developments, the relation of practitioner and patient so that there may be a full understanding of the personalities involved in human disease and in human suffering.

In the field of international relations, there is need for all of our education and all of our skills to advance and raise to a higher level of civilization and human dignity, the peoples and nations of whole continents, and thus set up a new organic unity among all the peoples and nations of the world.

In the field of psychology, there is need to know more about the forces involved in aggressiveness, hostility, and destruction; of the forces involved in the collective hatreds and tensions which govern groups, races, and nations.

In the field of the arts, there is need to adapt our art forms to the aspirations and ideals of our modern life; to overpaint the stains and scrawls which so frequently vandalize our dignity and our culture.

In every area of human activity, there is the need for those with professional education and imagination to take a personal part in the world's crises. When this is done by an ever increasing number of dentists, then, indeed, the image of dentistry will be newly bright, not only in the nation but in the world as well.

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Changing the Interprofessional Image of Dentistry

RUSSELL S. POOR, Ph.D., D.Sc.

The title given me implies that the image of dentistry should be changed. In part this may be true, but I doubt that anyone can indicate many areas where dentists themselves are not already aware of such needs. The whole profession is constantly reexamining all facets of its posture—its educational program, its service activities, and its practice. But this is as it should be with any vital, progressive, and alert profession. Change is constant and inevitable and, hopefully, toward improvement. I think there is ample evidence that the dental profession, as a whole, is ready and willing to examine its position and, if need be, inaugurate steps to bring about the desired changes. So my remarks are aimed at a profession already hard at work correcting its deficiencies.

Dentistry is an important segment of the totality of health professions, and it is destined to grow in stature at an accelerated pace in the next decade. There are parts of dentistry in need of change to be sure, but the younger dentist especially is not afraid of change and many studies are in progress or recently completed delineating the guidelines for further professional progress. That the dental profession is dynamic and accustomed to progressive changes is attested by reflection on the several survey studies made of it. There have been comprehensive studies (1) by Gies in 1926, Blauch in 1934-1935, O'Rourke and Miner in 1941, by Horner in 1947, and, recently, *The Survey of Dentistry* directed by Hollingshead and published in 1961 by the American Council on Education. Each of these studies has brought about changes in one or more aspects of dentistry. Many of the far reaching recommendations proposed by *The Survey* are currently under study. One probably could do no better than to list the recommendations printed in *The Survey* in pinpointing some of the areas of dentistry which need changing. I am assuming that

each dentist in this audience has at least read these recommendations. My purpose today, therefore, is to examine briefly each of several views of dentistry as these have been expressed by other professions and certain other segments of society.

THE MEDICAL PROFESSION'S VIEW

As the practicing physician looks at dentistry what does he believe should be changed? A library search has revealed no printed statement of a medical practitioner's view of the practicing dentist. A few personal interviews, however, reveal that some physicians actually envy the dentists they know. They say, "Look at that lucky character! He has no house calls to make. He rarely has to deal with an emergency." Or, "The dentists I know live a good life. They work hard from nine to five, with an hour for lunch if they wish. When they leave their offices they rarely are worried by telephone calls, and they have a comfortable income." Some physicians are even a bit cynical. They comment, "Observe the relatively shorter period of training for the average general practicing dentist as compared with most general practitioners in medicine." They then add the perhaps comforting thought, "But, believe me, I wouldn't want to stand on my feet all day every day!" These cynics are not up-to-date on either count. Some dentists in general practice may have set up their practice after a four year educational program but most of the younger generation at least have had some kind of internship beyond the four-year basic training—in the military service, if no other. Most of the services, as well as the United States Public Health Service, have well planned experience programs for their young dentists. The breadth of their two year military experience is often very good. The USPHS Career Development Program is outstanding. Also, these quoted observers apparently do not know that most modern dental schools require students to learn to do their work while in a sitting position. No longer are flat feet a deterrent to dental practice.

THE DENTAL PATIENT'S VIEW

Dental patients as a group certainly have a major role in establishing the image of the dental profession. While this group is not in itself a profession, it does contain representatives of many professions. Opinion surveys have been multiplied in an attempt to docu-

ment such opinions quantitatively but, speaking generally, these surveys have not been completely satisfactory. Recently, I scanned some of the papers prepared for the 1962 World Health Organization Expert Committee on Dental Health meeting in Geneva. (Drs. W. R. Mann and M. M. Chaves were the representatives from the United States.) In my opinion, a significant summary of the dental patient's view was made by Israel's representative, Dr. I. Sciaky, Director, Hadassah School of Dentistry, Hebrew University, Jerusalem. I believe Dr. Sciaky's statement (2) worthy of full quotation:

Let us look at a dentist from the patient's point of view. Physical illness is always associated with an emotional component. The patient is very directly interested in the scientific achievements of his dentist. He is interested in a man in whom he finds sympathy, understanding, and one who makes him reasonably comfortable. He hates to be considered an interesting case. He has a name, a family, and moods. He wants to be the centre of interest as a human being and not as a syndrome. As a rule, a research investigator is interested in problems. A good dentist is interested in patients, in people. The former wants to solve a problem and this challenge brings its rewards through the solution of the problem. The latter wants to solve a problem because it helps solve his patient's problem. Both are necessary, but the motivation is different.

It seems self-evident that a statement such as that just quoted may be applicable to any health profession. Since dental patients come largely from the better educated component of society it is reasonable that they should demand competence, sympathy, understanding, and obvious personal interest on the part of their personal dentist.

THE GENERAL PUBLIC'S VIEW

While a consideration of the viewpoint of the general public is a slight departure from the assigned topic, it may be useful at this point in covering all the multitude of other professions too numerous to mention in this brief paper. First, a few well known facts by way of background. Leatherman (3) has said: "In the United States it is estimated that there are in the neighborhood of 700 million untreated cavities, an average of nearly four per head of the population. By the age of 50, nearly 50 per cent of the population has developed periodontal disease and at the age of 60 nearly 100 per cent. A little over 40 per cent of the population visit a dentist every year, an additional 30 per cent receive some care, and the rest, about one-third of the nation, no care at all, except a possible extraction to relieve pain."

In view of these facts, the term "general public" is somewhat a misnomer. Possibly 40 per cent, maybe 60 per cent, of the people have had enough experience with dentists to warrant an opinion. The image of dentistry in the eyes of the public is generally good, and this is no accident. Dentists work at it. Through their national, state, and local organizations, over 100,000 members strong (4), dentists are constantly engaged in the development and encouragement of a variety of programs for professional improvement. The public's image of dentistry is greatly influenced by these efforts of the organized profession. "In the United States, the dentist has unquestioned status as a university-educated, scientifically oriented, technologically competent, professional person" (5).

Thus we may conclude that any change in dentistry's image now demanded by the public is negligible, and that organized dentistry is constantly at work to improve the status quo.

THE MEDICAL EDUCATOR'S VIEW

Undoubtedly there is a growing awareness of the importance of dentistry in any program of education which is predicated on "total patient care." Many universities have developed, or are in various stages of planning, medical centers or health centers that will be staffed and equipped to provide total patient care and educational programs which can produce the trained personnel to meet the teaching, research, and service demands of such centers. More and more, dentistry is becoming an integral part of these programs; sometimes by the integration of an existing school of dentistry as at the University of Alabama and the State University of New York at Buffalo, or by the addition of a new dental school as at the University of California at Los Angeles, the University of Florida, and the University of Connecticut.

As the medical educator views dentistry he is apt to be more critical than are members of other professions. Dentistry, to many in internal medicine, surgery, psychiatry, and even pediatrics, is an easier way out for the medical student who "couldn't quite make it." Happily, this conception is rapidly disappearing. Medicine has advanced beyond dentistry in its everyday use of the basic medical sciences but this gap also is being narrowed more and more each year. Dental schools are slowly coming to the realization that if they are to be genuinely productive members of the university family of col-

leges, they must meet the competition for the better student on common ground. If dental students are to be educated in the basic sciences with medical students; if, with medical students, they are to share clinical experiences with patients in the hospital as competent members of the health team, and if they are to partake of the fruits of the new dental knowledge resulting from comparable research, they must obtain an approximately comparable background of education from their high school and college experience. In the face of these demands of modern training in a common setting in the health professions, dental schools can no longer tolerate substandard admission requirements and hope to entice their fair share of better students into dentistry. The educational pace is too severe for the poorly prepared. Any school which tolerates mediocrity at the time of admission will not be able to avoid mediocrity at the time of graduation. The university is the binding force which should and eventually will demand these standards. If a dental school is to have its share of the better students and its share of financial support—for its own sake and for the sake of competition with other health professions—it must convince the university of its ability to recognize quality.

The dental teaching and research staff must be of a quality comparable to that of medicine in order to reach and maintain a competitive position in the university. This means comparable salaries, equipment, space, and fringe benefits. Given these things it follows as night the day that a fair share of the better students will be attracted to dentistry.

Medical educators tend to be critical of dental education when it must play the role of a second class citizen because of the lack of these basic essentials. Dental educators, as a whole, are not content with these conditions where they exist, and hopefully it is only a matter of time when these unhappy situations will be greatly improved.

There is no set formula for a better than average dental school. It must be developed with imagination and individuality. Minimum requirements must be met, to be sure, but the modern dental school is a member college of the university. It will take a great deal from the university and it should give a great deal in return. No dental graduate should ever have to apologize for the quality of his education because his school failed to meet the university's expectations. Some dental schools have failed in this respect and as a consequence

have had their doors closed and their programs canceled and withdrawn.

Medical educators differ in their view of dental education but none will deny the need, the potential, and the satisfaction of working with men of similar training in a university setting. There is no need for dentistry to lose its well developed independence but the only way to avoid this loss is to develop real cooperation. The team is no stronger than its weakest member. The health team of today contains more than 150 different and distinct health-related professions (6). Serious deficiencies in any one weaken all others.

A well known medical educator and surgeon, Dr. I. S. Ravdin (7), Vice President for Medical Affairs of the University of Pennsylvania, speaking of dentistry recently emphasized the need for dentists to be aware that "new knowledge in medical genetics will undoubtedly influence the practice of dentistry"; and that "the dentist of the future must play an important role in the problems associated with preventive medicine." I am sure you will agree with the good doctor, but I am also sure you will want to remind him that the dental profession has led the way in preventive medicine in this country. Also, you may want to point out that human genetics include dental genetics as well as "medical" genetics. There are no compartments in health or disease if we really believe in the concept of total patient care.

In order that change, wherever needed in dentistry's image, may move along the lines of improved basic college education as a basis for dental student admissions, better education in fundamentals and essential techniques in dental schools, and the ability of dentists to function as members of the health team in the hospital and the community, there must be established, however slowly, a stronger, more thoroughly prepared dental teacher. Teachers with the M.D. degree and the Ph.D. degree must be present in greater numbers, because the problems in dental disease today require those who can function effectively at the very frontiers of knowledge. The Ph.D. alone is not enough. Postdoctoral work is mandatory in many fields today. The Doctor of Philosophy degree is, in one sense, a symbol. It symbolizes or stands for a type of education which emphasizes research-oriented thoroughness and depth-oriented knowledge—and probably not much more. Many of you have heard me urge this requirement so often you may have reached the conclusion I am oversold.

I trust I am not. I believe I can agree with President Grayson Kirk, of Columbia University, who said of this degree:

Let me illustrate what I mean by the Ph.D. which is both a professional and a nonprofessional degree. Here, the great barrier, as far as the student is concerned, is the dissertation. It is defined everywhere as an original contribution to human knowledge and many young men put in years of dreary drudgery upon a subject that is of little or no significance to anyone. Few dissertations do contribute anything of value to the sum total of human knowledge. The young man is not ready to make a major contribution and he may not be ready until he is a mature scholar some years hence. Would it not be better if we were to regard the dissertation merely as a trial run in scholarship, giving satisfactory evidence that the student can do competent research on an assigned topic and that he can write his conclusions in clear, effective English. If we agree upon this we could shorten the doctorate time and we would have lost nothing of importance.

What dentistry needs—what most professions need—is not teachers who know more and more about less and less, but those who have learned from education and experience how to analyze a problem, gather correct data accurately, recognize error, measure results, and render a diagnosis. In other words, teachers need to know the research process and how to present results in clearly understandable English. Discovery of new knowledge is important but not essential for this process.

Almost all people tend to resist change, but change is inevitable. Change is usually rapid, but acceptance of change is slow. Change is necessary but it is threatening. The status quo is so comfortable! Don't believe that I am holding up any institution, especially the dental school, as being alone in resistance to change. Higher education is a notably poor example of rapid adaptation to change. In a recent publication, "The College and World Affairs," we read:

The change that has swept the world in our century, has altered the lives of nearly every person in it or will soon do so. Unfortunately, it has not yet produced anywhere in corresponding magnitude the necessary adaptations in education. There has come into being a fateful lag between the circumstances of life in which men and women must live and their inner preparation to do so wisely and effectively.

Dentistry is now a working partner in university education. It knows full well that changes have taken place and that others are inevitable. Some of the newer schools hopefully will adopt the best of these new ideas but, I repeat, established education is notoriously

slow to accept change—significant change. The easier way is to follow the same old path. A friend of mine once mused on how many extra, unnecessary miles he had walked as a boy because he followed twice a day a crooked trail through pasture and woodland just because it was there. He said in his later years a visit to his old home reminded him of his boyhood habit and he wondered why so many of us, as individuals and as institutions, still follow the same old trail. It's easy, but it may lead to lasting harm, as Sam Walter Foss (1858-1911), author of "The Calf-Path" says so effectively:

THE CALF-PATH

One day, thru the primeval wood,
A calf walked home, as good calves should;
But made a trail all bent askew,
A crooked trail as all calves do.

Since then two hundred years have fled,
And, I infer, the calf is dead.
But still he left behind his trail.
And thereby hangs my moral tale.

The trail was taken up next day
By a lone dog that passed that way;
And then a wise bellwether sheep
Pursued the trail o'er vale and steep,
And drew the flock behind him, too,
As good bellwethers always do.

And from that day, o'er hill and glade,
Thru those old woods a path was made;
And many men wound in and out,
And dodged, and turned, and bent about
And uttered words of righteous wrath
Because 'twas such a crooked path.

But still they followed—do not laugh—
The first migrations of that calf,
And thru this winding wood-away stalked,
Because he wobbled when he walked.

This forest path became a lane,
That bent, and turned, and turned again;
This crooked lane became a road,
Where many a poor horse with his load
Toiled on beneath the burning sun
And traveled some three miles in one.
And thus a century and a half
They trod the footsteps of that calf.

The years passed on in swift fleet,
 The road became a village street;
 And this, before men were aware,
 A city's crowded thoroughfare;
 And soon the central street was this
 Of a renowned metropolis;
 And men two centuries and a half
 Trod in the footsteps of that calf.

Each day a hundred thousand rout
 Followed the zigzag calf about;
 And o'er his crooked journey went
 The traffic of a continent.
 A hundred thousand men were led
 By one calf near three centuries dead.
 They followed still his crooked way,
 And lost one hundred years a day;
 For thus such reverence is lent
 To well-established precedent.

A moral lesson this might teach,
 Were I ordained and called to preach,
 For men are prone to go it blind,
 Along the calf paths of the mind,
 And work away from sun to sun,
 To do what other men have done.

They follow in the beaten track,
 And out and in, and forth and back,
 And still their devious course pursue,
 To keep the path that others do.

But how the wise old woods could laugh,
 Who saw the first primeval calf!
 Ah! many things this tale might teach—
 But I am not ordained to preach.

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Environmental Reorganization of Dental Practice

CARLTON H. WILLIAMS, D.D.S.

The tremendous acceleration of mechanical changes in dental armamentarium and the burgeoning revelations in the fields of the biologic sciences are making it imperative that dentists take a realistic reevaluation of some of the fundamentals that constitute the success of every day dental practice. The problems of office placement, office atmosphere, operating room efficiency, auxiliary personnel, and patient education, information, and cooperation in the light of these technological and biologic advances must be re-examined.

The environmental reorganization of dental practice is not a single step achievement. It has developed slowly, but today has reached a point whereby we can concisely delineate some necessary steps to bring modern operating procedures in focus and relate them to the more complete picture of more and better dental treatment for greater numbers of patients at fees most patients can afford.

The discreet location of the dental office should be a foregone conclusion, and yet many qualified practitioners have failed because of injudicious selection of office locations. The office should be carefully selected in relation to the people the office is to serve. Public transportation, adequate parking arrangements, and ease of access in relation to modern highways, should be carefully considered.

It is poor business as well as extremely poor public and professional relations to place the office in an area that is inaccessible or lacking in public transportation facilities. Many of our younger married, school age children, as well as our growing senior citizen population must depend on public transportation facilities to keep their appointments.

Modest income communities as well as the more opulent districts should and do expect their health facilities to be placed for their convenience. The astute practitioner will see that he has made every effort to be available so far as his location is concerned.

The exterior of the office where possible, as well as the interior, should be given careful consideration in regard to decor, as this consideration will set the entire atmosphere of the office. It should be in good taste, not too expensive. A modest well selected color scheme in wall surfaces, floor coverings, and furnishings can be the best public relations outlet, next to a warm and friendly receptionist, that there is. The reception room should carry the impact of thoughtful efficiency. It should be restful, relaxing, as spacious as possible, and confusion should be eliminated both here and in the operating areas. Patient comfort, as well as that of office personnel should be considered, and air conditioning is rapidly becoming a paramount consideration in this respect in all parts of the country.

The reading material available should cover a broad spectrum of interests, and should be both instructional and entertaining. There is no place, in an office that expects to progress, for old, outdated, and outmoded literature. Dental educational material should certainly be a part of the available information in a reception room, and it should be changed periodically.

The business office should be integrated into the total operation of the practice by judicious correlation of operating room procedures and the necessary financial arrangements to accomplish the care needed. The business office itself should be removed from the mainstream of patient traffic, and should be efficiently appointed. It should carry the impression that here, indeed, was the business side of the practice and business concepts prevail.

The question of fees has been receiving much attention in dental periodicals, and there are many different concepts of how the fee problem should be presented as well as the basic establishment of the fee requirement itself.

There is little room and no justification for the concept of yesteryear which was to "charge what the traffic will bear." I believe that a fee should be based upon reality of cost of production plus a reasonable profit. I am also confident that special training and post-graduate study are proper bases for an increase over the usual. The fee, however, should be relatively standard for the individual office, and barring exceptional or extenuating circumstances, an assistant, bookkeeper, or receptionist should be able to record the fees after a diagnosis has been outlined.

The diagnosis, of course, must be made by the doctor, the fees set down by either the doctor, or more preferably an assistant, then the total fee should be quoted by the doctor. If there are any questions regarding method of treatment, extent of restorations, or types of materials, which could affect the total fee, the doctor alone is capable and qualified to answer them. It is my firm belief that this is a critical point in the professional relationship with the patient and should not be delegated.

After the fee quotation and its acceptance, the financial secretary can then be introduced to make the necessary arrangements for payment. This is a business arrangement, not a professional responsibility, and can better be handled by an auxiliary.

Lest one give the impression that the business end of the practice is the only one to be considered, let us consider the operating areas and the use of the auxiliaries in achieving the benefits which should be accomplished from a well integrated team effort.

The modern operating room should be much less cluttered than that of but a few years ago. It is not necessary nor desirable to impress the patient with a great show of gadgetry and Rube Goldberg contraptions. These tend to intimidate rather than sedate the patients. The operating room should be airy, well ventilated, and organized in such a manner as to take full advantage of the effective utilization of a carefully trained chairside assistant.

The operating and instrument cabinet should be placed behind the patient in such a position as to be easily reached by both doctor and assistant, but with primary emphasis on the assistant, as she is the one who has the primary responsibility of armamentarium preparation and placement for utilization, having instruments out of the view of the patient helps to allay apprehension. If preoperative tray setups are utilized these should be placed so as to be conveniently available to the operating team, preferably on the cabinet area or operating stand developed for this purpose.

Time and motion studies have effectively emphasized that the dental assistant must be fully conversant with every phase of any given operating procedure in order to be prepared, one step in advance of the operator, to place in his grasp each instrument as it is required. The operator should be able to complete most procedures without removing his eyes from the operating field. If this is accom-

plished it is not unusual for a two surface alloy or gold inlay preparation to be accomplished in less than five minutes actual operating time. With this type of efficiency it is easy to see that multiple restorations become an economic necessity because much more time is taken to seat, prepare, and dismiss a patient than is taken in the actual preparation.

Quadrant dentistry, or preparation of half a mouth is becoming common practice, and with this advent, economy of time, both that of the patient and the dentist, makes higher levels of earnings to the dentist as well as less cost to the patient a reality.

The dental assistant should be at chairside continuously during an operation and should be capable of doing everything for the patient except the actual intra-oral procedures for which the doctor alone is trained and licensed.

The dental assistant should also be able to do modest laboratory procedures of model preparation, inlay investments, and casting, and where the assistant leaves off the dental laboratory technician should be able to take over. He should be able to do all the laboratory fabrication, setups, castings, finishing, etc., but always and only under the guidance and counsel of the dentist. I do not believe the laboratory technician and the patient should ever meet.

The dental hygienist is a most necessary, important, and effective member of the oral health team. She is a specialist in a restricted field and is quite capable of doing the necessary prophylactic procedures to keep the mouth in a healthy condition barring unusual biologic or pathologic *conditions*.

I believe the dentist should not only see every hygiene patient, but also should actually check the subgingival areas to assure the completeness of the case. This can be quickly done and assures both the patient and the hygienist of the continued interest of the dentist in the patient's welfare.

The changes in operating routine mean the effective delegation of non-professional personnel to do everything possible except that for which the dentist alone is trained and licensed to do. This use of auxiliaries plus a tightly integrated team effort will result in a higher rate of production in an easier and less fatiguing manner than has heretofore been possible.

The use of ultra-speed handpieces has not really hastened operat-

ing time, but has made the operations much easier on the operating team of doctor and assistants, and more noticeably on the patient. However, because of this greater ease and less tiring program of operating, a reorganization of the approach to appointment schedules is imperative.

Longer working appointments should be considered to do multiple restorations. Thought must be given to doing not only quadrant dentistry but also half of the mouth at a given time. Many times a number of rather small cavities can be completed in a single sitting provided the doctor knows his time requirements, and this amount of time is reserved to accomplish the necessary treatment. This recognition of time requirement, and its routine judicious use can reduce the cost of dental treatment by savings in time off work, less expense in transportation costs, baby sitting costs, and other allied non-dental expenses, as well as increasing the dentist's gross income by eliminating lost time and expensive repetition of in and out costs which raise overhead needlessly. This area of reorganization needs much additional attention and in this evaluation the use of the newer pharmaceutical preparations for patient comfort must not be overlooked.

Preoperative medication, tranquilization, and sedation can all be used effectively to make longer and more comprehensive dental treatment easier and more palatable for the apprehensive patient. In the extreme cases some dentists are doing an increasing amount of comprehensive care under general anesthesia; however, because of inherent problems and limitations of this type of practice, a greater emphasis and understanding of the effective use of the aforementioned preparatory drugs is certainly to be recommended.

As we view these many factors that constitute today's sophisticated dental practice it becomes quite apparent that the busy practitioner will prudently appraise the possibility of gaining some relief by developing some type of cooperative arrangement with other dentists to cover periods when he cannot meet the demands on his time.

The group practice has developed to answer this need. It gives the practice greater flexibility to handle emergencies, cover for vacations, meetings, and postgraduate study, as well as to reduce the costs by spreading the expense of some items of equipment, and the increasing of benefits of bulk purchasing of supplies. The group practice

also allows the hiring of personnel in specialized areas to do a more comprehensive coverage of certain auxiliary areas, as well as offering to the practitioners involved a continued postgraduate seminar in discussing and following complicated restorative problems.

The practice of dentistry by men associated in groups presents many advantages of which the aforementioned are but a few; however, there are a number of deterrent factors to be considered. In the group, an individual must give up some part of his own individuality by subjugating it to the group as a whole. This necessity, and the additional necessity of working with other dentists as a team effort has a tendency to limit those who can succeed in practicing in groups. It is difficult for some men to realize that even though they are a member of a group they must continue to do all of the things to promote their practice that they would have to do as individuals. There is a tendency in groups to believe the group can do for them what they cannot do for themselves, and this can be a fatal error.

Prepayment for dental services is another factor which is rapidly forcing a change in the environmental reorganization of dental practice. It has come about by the expansion, primarily, of the fringe benefits of labor contracts. It is definitely here to stay, and at the present time nearly one and one-half million people are covered under some sort of prepaid dental program, and twice this number will be seeking coverage within the next eighteen months.

These demands are seeing the rise in some acceptable and some unacceptable methods of dental practice. One of the most dangerous growing concepts is the development of closed panels.

A closed panel practice is established when patients are obtained through the provisions of an agreement with a given group and when such agreement does not provide for the purchase of dental care by the patients from any other source.

Because of the essential limitation which this method of practice imposes on the patient and the profession, it should be discouraged. Closed panel practices should be established only in special circumstances to meet needs which cannot be met in any other way. When established, closed panel practices should be under the direct supervision of a dentist legally licensed in the state, should conform to the *Principles of Ethics* of the American Dental Association and the local codes of ethics and should maintain close liaison with the constituent and component dental societies of the area. (*Transactions of the American Dental Association*, p. 254, 1961.)

It has been stated to be a method to be discouraged because it

deprives the patient and the doctor of the freedom to choose their doctor and their patient respectively, and further denies to the patient the benefits he is supposed to receive as a fringe benefit of employment if he does not like the treatment or atmosphere of the closed panel, and as a result his dental costs for treatment are doubled. The closed panel violates nearly all the principles of prepaid dental care as set forth by the American Dental Association. There is an insidious movement afoot to make the term group practice and closed panel synonymous. They are not. They are two separate and distinct entities and must not be confused.

Another form of prepaid program that is presenting much cause for concern is the union operated self-insured programs. These are run exclusively by the union and are in many instances resulting in the steering of patients to particular offices, the dictation of fees, and a domination of the professional aspects of the program by non-professional, union officials. These programs vary with the union official involved and tend to change character as the political fortunes of the union officials ebb and flow. It has been stated by all factions concerned with these problems that control of the statistics and the purse strings of prepaid programs will lead eventually to control of the profession.

The profession, therefore, has felt the need to provide a mechanism of its own. This has resulted in the formation of the dental service corporation.

The Council on Dental Health states the problem quite clearly in *Reports of Officers and Councils—American Dental Association 1964, p. 26*:

The Council believes that the not-for-profit type of operation is in the best interest of the public and the profession, a good and healthy competitor to other prepayment mechanisms, and cites the following reasons: (1) the not-for-profit, professionally sponsored dental service corporation is the *only* mechanism available in which the dental profession will have a significant voice in the development of standards and policies, (2) the not-for-profit, professionally sponsored dental service corporation will serve in the market place as the profession's own example of what dental prepayment should be and, thereby, provide a competitive incentive for all forms of dental prepayment plans as well as a yardstick against which purchasers can measure other plans and (3) the not-for-profit type of operation can offer the greatest return in benefits for premium investment.

The dental service corporation acts in concert with the dental pro-

fession to establish programs acceptable to the profession on an open panel basis, and one that will maintain the integrity of private dental practice within the framework of policies set forth by the professional association it serves. The dental service corporations will not write all of the programs, but they will act as the profession's answer in the prepaid field and will cause commercial insurance companies to write programs that are equally as good or better in order to get contracts in what is rapidly becoming a highly competitive field. I personally am a supporter of private enterprise and the profit system, but where my profession is involved I believe that the profits of efforts of dentists should be returned to the dentist through his fees for service. If there are monies available above the costs of the programs these should be spent with the profession in the form of expanded program benefits for the patient rather than being returned to non-professional stockholders as profit. The profits from professional services belong to the dentists doing those services, and the benefits to the patient for whom the monies are spent.

It is my firm belief, after ten years of experience in the prepaid field, that the profession of dentistry must institute some controls on their membership to prevent a small minority of unscrupulous practitioners from creating monumental ill will against the profession by their willingness to prostitute these prepaid programs for their own immediate financial gain. If the profession itself does not provide this protective mechanism it will only be a matter of time, and short time at that, before an aroused public will demand legislative protection. This can be avoided by the judicious development of professional review committees and must be a prime objective in the planning for our immediate future.

In considering the changes that are being wrought by the prepayment of dental costs, and the effect these programs will have upon the profession, we must assuredly consider the concepts of payment for services rendered. An item already on the agenda for the coming 1965 session of the House of Delegates of the American Dental Association is the consideration of these fee concepts.

It would seem most imprudent and dangerously short sighted if the entire dental profession were to go on record as favoring a mixed unflexible schedule of fees for various services. Such a recognition would ignore the many economic variables throughout our country,

the differing levels of educational preparation, and differing individual efforts at self-improvement. Such a recognition would go a long way toward destroying the incentive to do a better job in our everyday practice and would relegate the sale of professional services to the same market place level as the sale of groceries or hardware. If, on the other hand, an informed profession can sponsor a flexible approach to fees and inaugurate the mechanisms necessary to see that these flexible fees are kept within prudent limits, the incentives of private practice, incentives for self-improvement, and willingness to extend one's efforts for the benefit of the profession as a whole will not be destroyed.

In California the flexible fee concepts have been used, and at the present time there are more than forty programs using this approach effectively and economically. I urge the members of the American College of Dentists to consider this important aspect of our changing environment with meticulous care. In my opinion nothing will affect future dental progress as adversely as an improper policy in this important area.

No matter what mechanism we support as we proceed in these areas, and particularly in view of the present acceptance of the service corporation concept, it becomes crystal clear that an acceptable set of policies be adopted by the organized profession to guide the officials charged with responsibility in these new and challenging endeavors. Unfortunately, many state societies still do not have a definite framework of policies to be used as guidelines and to be promulgated as a basis for the construction of programs.

All of these many facets of modern sophisticated dental practice could be the subject for an entire paper in themselves, but at least the subjects have been presented for discussion and dissection during the workshop periods. Because of the tremendous scope of the subject matter and the limitation of time I feel certain that much time can be saved by selective discussions covering the particular points of greatest interest as this meeting progresses.

I have felt that some of the points outlined are quite basic and universally accepted, and therefore, in a sense shallow. However, because they are so very fundamental I believe they simply had to be placed before you to be sure that we all agreed on these points as we proceed to more profound analyses.

The Lessons That Social Change Taught Canadians

DONALD W. GULLETT, D.D.S.

As this presentation is read, the title may easily be considered a misnomer. It would be most difficult to list lessons learned by Canadians respecting social change. I know of no means by which such data can be compiled or any effort that has been made to do so. The transition from one phase to the next is so rapid that the man who stops to reason through to the full implications in a scientific manner is left far behind. This rapid transition in society places the scientifically trained individual at a disadvantage, unfortunately not well-recognized. We live in an age where so often what was considered socialism yesterday is liberalism today, and even becomes conservatism tomorrow. Of one thing I am certain—if you were to refer to the average Canadian as a socialist or infer that he lives in a socialistic country I am sure he would warmly deny it.

GENERAL OBSERVATION

From the political standpoint an interesting study can be made of the timing of the security movement throughout the various countries. In Canada, it took nearly 40 years from the time the first serious political promise was made to launch a national health insurance program until the first phase—hospital insurance—was finally set in motion. Timing varies considerably from country to country but if my time schedule is correct it is now 20 years since the issue was first seriously injected into the political arena in the United States. The reason for introducing this point here is to illustrate the pertinacious nature of the subject. History is replete with examples that what the public persist in demanding, they finally obtain. While opposition can and does succeed in delaying action, the evidence on a world-wide basis is heavily weighted on the side of ultimate action in introducing compulsory health insurance in some form or other. In my opinion most leaders of the health professions

in Canada have been convinced for some time that this action in some form was inevitable. Only the method has been in doubt. Furthermore, many have been convinced that the actual decision as to timing would depend far more upon the economy and financial structure of the country than any opposition promulgated by the health professions.

If the inevitability of political action is recognized, then the most controversial question of all arises for a health profession in that decision must be made as to attitude. In the majority of countries the professions opposed action up to the very last hour. While in a few, the professions realizing the position, concentrated their efforts on the best methods to be employed, and to this extent cooperated with government. The lasting effect of the attitude taken by the professions is noticeable to the observer in all those countries where compulsory health insurance measures have been adopted. Too often the statements made by the representatives of the professions have taken the form of "Parthian shots" without the retreat being a simulated one. Every country has its way of doing things, commonly referred to as "way of life," and it is to be expected that each country will solve its problems in its own way. Yet, in many countries the actions and attitudes of the health professions have had remarkable similarity with much the same result. It would appear that the health professions have learned little from the experience of their counterparts in other countries. In every case the old cry of "It can't happen here" or "They can't do it to us" has occurred. The fact is it did happen and they did do it to them. In the light of political environment, in the light of the reason for the very existence of professions, and in the light of the professions' position in general society, the professions must make their own assessment and decision as to attitude and action.

RELATIONSHIP OF SOCIAL SCIENCE

The development of social science has been exceedingly rapid and the strength and importance of the social scientist in our society is little realized within the professions. One reason for this situation is that social science is not the type of science recognized by the health professions. As a science, it does not depend upon formulae nor does it seek rationalization by experiment. It is said that social science depends upon historical evidence, but history is not a science,

does not have scientific data, and does not have a formula. The social sciences differ greatly from the basic sciences of the health professions and consequently are not understood by the professions. The whole training of a dentist is factual in nature. With us, facts are facts, and not approximately so. Elton Mayo, in "The Social Problems of an Industrial Civilization" (Harvard University), has said, "Science did not begin with elaborate and overwhelming systems, and thence proceed to study of facts."

Nothing I am saying here is intended to be disparaging of the social scientist, for he has been eminently successful in his efforts, particularly on the political level. His efforts in establishing a society of equal opportunity for all citizens is an altruistic one. So strong is the force created by him that some observers have said in view of the merging of health and welfare services that members of the health professions may easily become social scientists. My point here is that need exists within the professions for better understanding of social science.

The current idea of creating a department of social dentistry in dental schools is a step in the right direction. The content of the course is really the important thing. Unless such a course is presented by those whose training is in the proper disciplines it can be crudely biased and worse than no course at all. To cover the subject properly is a tremendous task, particularly among students without background training to underlie such training.

Virgil said two millennia ago "Happy is he who has been able to learn the causes of things." Perhaps too much time has been spent looking at results and too little at causes. One lesson we in Canada have learned by hard experience is that the social scientist acts long before the whole subject reaches the political level. If I have criticism to offer of the social scientist it is that he plans for others to carry out his ideas. Perhaps this critical remark is more applicable to health services than some others. His often grandiose plans are greedily accepted by the politician and at this point of development the professions become cognizant of what is happening. I submit that the professions are one step too late in their action and have already either lost ground or been placed in an awkward position to support acceptable health principles.

In the Canadian experience we have found severe contrasting

views in health matters to exist between the social planner and the health professions. The following are examples:

1. *Need versus demand*—The dental profession knows full well what the demand for dental services, is, and that increase of demand depends upon increasing the appreciation of the services. The social scientist takes an adamant stand that dental services must be supplied to all just as education is furnished. He even goes farther and states that health services are more essential on a free basis than education because education is of little use without health.

2. *Quality versus quantity*—All health professions have labored consistently to elevate the quality of their services. It is abhorrent to dentists or the organizations representing the dental profession to think in terms of status quo or lowering the standard of service. It is sincerely believed that only the best quality of service is worthwhile. On the other hand the social scientist states in his writing that it is much better to spread the service to all the people which is now only received by the few, even if it lowers the quality somewhat.

3. *Prevention versus treatment*—The social scientist appears to recognize the important place of prevention in general health services but reverses his position respecting the relationship of preventive services in dentistry. He places almost the entire requirement on treatment services, with emphasis on the number of treatments rather than reduction. His reasoning seems to be that the needs of the people for dental treatment are so great that any plan must be based upon meeting these needs by some sort of crash program. The dental profession in Canada has for many years given emphasis to the preventive approach as a means of dealing with the dental health problem.

Very gradually the health professions have built up a mountain of knowledge, with an ever increasing peak, based upon scientific research. Within recent decades social scientists have very rapidly built a mountain of knowledge, initially based solely on welfare but have gradually come to include health services. A deep valley of misunderstanding exists and by some means a bridge of understanding needs to be built between the two mountains. Otherwise the health professions will continue to fight for adoption of sound health principles after those on the political level are convinced of, or committed to, proposals of the social scientist.

HEALTH LEGISLATION (SEE APPENDIX A)

The integration of welfare and health services is well illustrated by the social security enactments which have taken place in Canada. The first legislation of a social security nature was the Old Age Pension Act in 1927. Initially, this Act granted \$20.00 per month with a means test to citizens beginning at the seventieth birthday. Various amendments have been made during the intervening years, including doing away with the means test and gradually increasing the amount of the pension until today every citizen on his seventieth birthday receives \$75.00 per month until his death.

Several other acts strictly of security nature have been enacted, including the Unemployment Insurance Act and the Family Allowance Act or "Baby Bonus" as it is popularly called. The first legislation in the social security category dealing with health came in 1948, at which time legislation was adopted to prepare the way for a health insurance program. The legislation consisted of a number of federal health grants such as a grant for health surveys, a grant for hospital construction, a grant for professional training, and several others. The original grant structure has been amended several times. This background is given concisely to form some basis of understanding for succeeding government actions.

In 1957 the Hospital Insurance and Diagnostic Act was adopted which provided financial assistance to provinces in operating hospital care programs. By January 1, 1959, six provinces (out of ten) were participating in this plan, and by 1961 all the provinces were participating. Shortly, reference will be made to the hearings of the recent Royal Commission on Health Services. In fairness it should be said that at every hearing all across the country, the Commissioners themselves asked pointed questions respecting the operation of the hospital plan. On all occasions both lay and professional representatives appearing before the Commission praised the hospital plan.

Outside of Canada a great deal of misunderstanding exists respecting the hospital plan, which is noticeable in the literature. While the hospital plan forms a part of the national health program or plan, it actually cannot be called a "national hospital program." It really is a cost-sharing agreement between the federal and provincial governments. The actual operation of the plan is provincial and there are four or five types of plans across the country.

In one province, the hospital people and the medical profession have tried to cooperate with the government. The result has been that this province does not have a centralized administration of hospitals, but leaves the actual control of operations to the individual hospitals. Hospital boards have been encouraged to remain autonomous. The boards now act in a responsible way:

- (a) they do not expect the government to do everything for them;
- (b) they realize that efficiency and economy in the operation of their hospital will benefit all taxpayers.

At the other extreme we have a province which has stringent over-centralization. Here hospitals are not dealt with individually but on the basis of inflexible rules and regulations.

Hospitals in the province of Ontario are today better equipped, staffed, and operated than before the plan went into operation. This is the opinion of men in the hospital field regardless of their political convictions.

Costs of health care have increased rapidly in all developed countries. From the Canadian experience it would appear that a critical point for the professions is reached when public expenditures for health exceed private expenditures (See Appendix B). This happened in Canada with the introduction of the hospital plan being supported by public financing. During the year 1963, 9 per cent of the consumer dollar was spent on health care.

How far has Canada progressed in the social security area? According to the United Nations Statistical Year Book for 1963, Canada is a little more than midway among the chief nations of the world in the percentage of income allotted to welfare (See Appendix C). In Canada, 11.6 per cent of the income is devoted to welfare. From this same source of data, the United States spends 6.9 per cent and Britain 8.1 per cent. The classification of countries as to which are welfare states and which are not is a thing of the past. The only distinguishing characteristic is a matter of degree.

ROYAL COMMISSION ON HEALTH SERVICES

In 1961 the Federal Government set up a royal commission to investigate health services. In general terms the commission was instructed to inquire into and report upon the existing facilities and methods for providing personal health services, methods of improving such health services, and all matters related thereto. The terms

of reference were broad and the commission was not restricted in any way. The commission held hearings all across the country and in every province. Some 400 briefs were presented, of which approximately 65 were from health professional organizations. The other briefs were presented by voluntary health organizations, voluntary medical service plans, governments, farm and labor organizations, universities, and many additional organizations and individuals.

Volume I of the Commission Report was issued in June 1964, containing some 200 recommendations. Of these, 57 recommendations directly dealt with dental services, which is considered a high proportion in a report on health services in general. Volume II of the report will follow with the tentative date set for early 1965 and we are informed will contain the reasons and explanations behind the recommendations.

A high proportion of the recommendations respecting dental services are acceptable to the profession. While often worded differently, many have similar intent to those contained in the brief submitted by the Canadian Dental Association. For many years the profession has sought assistance for dental education and the report makes generous recommendations, in some respects more generous than requested. We welcome the indicated support for dental research but undoubtedly will question the suggested method of administration. With several other recommendations the profession will raise little, if any, objection.

However, some recommendations will be objected to strenuously by the profession. The main point being a recommended dental care program for children to include all children up to the age of 18 by 1980. According to the report this is to be accomplished by the development of specially trained auxiliaries to perform the necessary services under the supervision of one dentist to four auxiliaries. It is proposed that the services be performed in clinics to be established across the country for the purpose. Financial provision is made for necessary capital expenditures for buildings and training of the indicated personnel. All this is calculated in the report on a mathematical basis to include all the children in Canada.

Canadian dentistry has concentrated efforts on prevention and control for many years. In order to accomplish effectively such objective, we believe that the best qualified personnel must diagnose

and be in direct control of treatment for the young age groups. If improvement of the dental health of the population is to be the objective of a program, then the most vital part of the population must not be entrusted to partially trained personnel.

All the recommendations contained in the report are under serious study by the dental profession, under the direction of steering committees on both national and provincial levels. Even some humor enters into the study. One recommendation calls for a dental service program for expectant mothers. It has been suggested that such a program calls for an added item to the fee schedule—test for pregnancy. Objection to this part of the program has been received to the effect that it is discriminatory against the male sex.*

Even to summarize the recommendations contained in a volume of over 900 pages is not possible in this presentation. Some of the recommendations are very acceptable and others will be strenuously objected to by the dental profession. Just as in the case of hospitals, any program established will be a federal-provincial cost-sharing plan and not a central administration. Some variation in carrying out any adopted health program can be anticipated among the provinces. In the case of hospitals the government was dealing with institutions, but with health services it is individuals who are involved. At this stage no predictions as to outcome can be made.

The overall health services program recommended by the Commission includes: medical services, dental services (for children, expectant mothers, and public assistance recipients), prescription drug services, optical services (for children and public assistance recipients), prosthetic services, and home care services. The proposed administration at the provincial level is to be a commission representative of the public, the health professions, and government.

Perhaps one of the great debates of the age is what should be financed by the public sector and what should be financed by the private sector. The Commission argues this point at considerable

**Ed. Note [T.McB]*—A squib appeared in the *Journal of the Canadian Dental Association* (April, 1965, p. 280) as an anonymous comment on this proposed maternal dental health program: ". . . I don't consider it necessary to establish dental care as a reward for getting pregnant. . . . It discriminates against the male population, as there is no way in which they can directly benefit from such a program. There may be secondary benefits, however, as their services are required in order to make the female population eligible for such a program."

length, arriving at two main conclusions. First, that a comprehensive, universal, health care program cannot be established by continuing on a private sector basis. Second, that by 1971, a health care program providing for the *whole* population will only cost \$466 million additional to the amount which will be spent during the same year if the present system is continued. This figure has been questioned by many authorities.

The Commission recommends that the program be tax supported in such fashion so that the recipient will know what he is paying for but does not specify the exact method. The Canadian Tax Foundation has estimated that implementation of the scheme could mean a 50 per cent increase in personal income tax if implemented immediately. If the plan were to be implemented it is probable that the provinces would raise their part of the cost-sharing arrangement by various means. At the present time the federal government is very much involved in another social security measure entitled the Canada Pension Plan. This is a compulsory contributory pension plan similar in many respects to the social security plan for employees in the United States and would be additional to the present old age security payment of \$75.00 per month now in existence. With both this proposal and health insurance under discussion, it is said by many eminent economists and business organizations that the general economy cannot support both without disastrous consequences. In addition, many authorities are stating that the time has arrived when priorities must be established with the need for tremendous financial support for education at all levels taking precedence. In summary, this is the position at the present time.

In passing it should be noted that one province, namely Saskatchewan, has a government sponsored insurance plan for medical services in operation. This plan was born amidst great travail in 1961, gaining considerable publicity in the process. No dental services are included. Since adoption, a change of government has occurred in this province, but the new government has not indicated any intention of discarding any feature of the plan. An important point is illustrated in that no government in any country has ever discarded compulsory health insurance. The trend has always been to increase the scope.

CONCLUSION

Any attempt to set down a list of lessons that social change has taught Canadians is an impossible task because of the difficulty in assessing what has been learned both within and without the health professions. One haunting question exists—Can a social demand for comprehensive, universal health care be met by the health professions without direct government participation? The answer to this question involves not only the services themselves but administration and financing as well.

We all know that government operated health plans in various countries are dominated by administration and finance. Apparently this important point is understood by very few men in the professions. Stagnation of the type of services rendered is too often the result. The standard of dental services in Canada has reached a high level with a gradual increased appreciation of the services by the public. The profession will oppose strenuously any program, the introduction of which will lower the quality of services. In doing so it is necessary to produce counter proposals on a realistic basis. We have found no hard and fast rules for dealing with the problem—only hard ones.

It should be pointed out that the proposals before us are recommendations only but made by a commission appointed by the federal government. When or what recommendations may or may not be implemented is unknown. Serious study of the report is now being made by both government and the health professions. All realize that change is inevitable. The health professions are engaged in strenuous efforts to oppose those recommendations which are not in the best interests of the public.

Speaking more generally, you may call it what you will—new deal, fair deal, new society, great society—the issue is much the same. A rose is a rose by any name, but I would remind you that the thorn on the rose is a thorn is a thorn is a thorn.

In some 50 countries around the world the same question has arisen, and regretfully the health professions in those countries have not been able to solve it by themselves. Too often the result has been domination of health services by government. Perhaps we are different on this continent and perhaps we only like to think we are differ-

ent. We may have great friends on the political level but we can be sure of one thing—when the chips are down, when the mass of voters make adamant demand for some form of compulsory health insurance, we will get compulsory health insurance in some form. Primarily I speak from Canadian experience, but also from personal studies made in numerous countries. The pattern is essentially the same. The timing and methods adopted differ considerably.

One last question—The social aim is to do away with poverty—How can poverty be abolished for all without provision of dental services? Society has presented a problem, initially and forcibly, to the health professions. If the health professions fail to meet or face the issue, strong evidence shows that it will be solved without our acquiescence.

APPENDIX A

FEDERAL SOCIAL SECURITY ENACTMENTS IN CANADA

- 1927—Old Age Pensions Act—\$20 per month with means test.
- 1937—Old Age Pension Act amended to include pensions for blind persons 40 years and over (reduced to 21 years in 1947 and is now 18 years).
- 1943—Old Age Pension increased to \$25 per month with means test.
- 1947—Old Age Pension increased to \$30 per month with means test.
- 1949—Old Age Pension increased to \$40 per month with means test (means test changed from time to time as cost of living increased).
- 1951—See below.
- 1940—The Unemployment Insurance Act—compulsory contributory unemployment insurance scheme.
- 1944—Family Allowances Act—allowances for every child under 16—does not involve a means test.
- 1948—National Health Program
Federal Health Grants for
Health Surveys
Hospital Construction
General Public Health
Tuberculosis Control
Mental Health

Venereal Disease Control
Crippled Children
Professional Training
Cancer Control
Public Health Research.

1951—Alteration of Old Age Pensions Act (1927) to:

Old Age Security Act (universal pension to all persons aged 70 and over)

Old Age Assistance Act (to persons aged 65 or over who are in need)

Blind Persons Act (blind persons aged 18 or over who are in need)

The means test was eliminated with pensions for all persons over 70 years of age and granting assistance payments on basis of means test to persons over age 64.

1953—National Health Program (Health Surveys Grant discontinued)—broadened to provide three additional grants:

Laboratory and Radiological Service

Medical Rehabilitation

Child and Maternal Health.

1954—Disabled Persons Act—allowances to persons permanently and totally disabled, to include persons aged 18 or over who are in need.

1955—New Unemployment Insurance Act replaced 1940 act—to include several additional groups.

1956—Unemployment Assistance—Federal government reimburses provinces for 50 per cent of the unemployment assistance payments made by the province and their municipalities to unemployed employables and unemployables who are in need.

1957—Hospital Insurance and Diagnostic Services Act—assistance to provinces operating hospital care insurance programs.

1957—Old Age Security Act amended twice raising pension to \$46 and four months later to \$55 a month.

1958—Provincial participation requirements relaxed for National Hospital Insurance (5 provinces signed for effective date July 1, 1958—Newfoundland, Manitoba, Saskatchewan, Alberta and British Columbia, and Ontario for January 1, 1959).

1960-61—Venereal Disease Control and Laboratory and Radiological Service Grants absorbed into General Public Health Grant.

Medical Rehabilitation and Crippled Children Grants merged.

1961—All ten provinces included under National Hospital Insurance and Diagnostic Services Act.

1962—Old Age Security Act pension raised to \$65 a month.

1963—Old Age Security Act pension raised to \$75 a month.

Old Age Assistance Act pension raised to \$75 a month.

Blind Persons Act pension raised to \$75 a month.

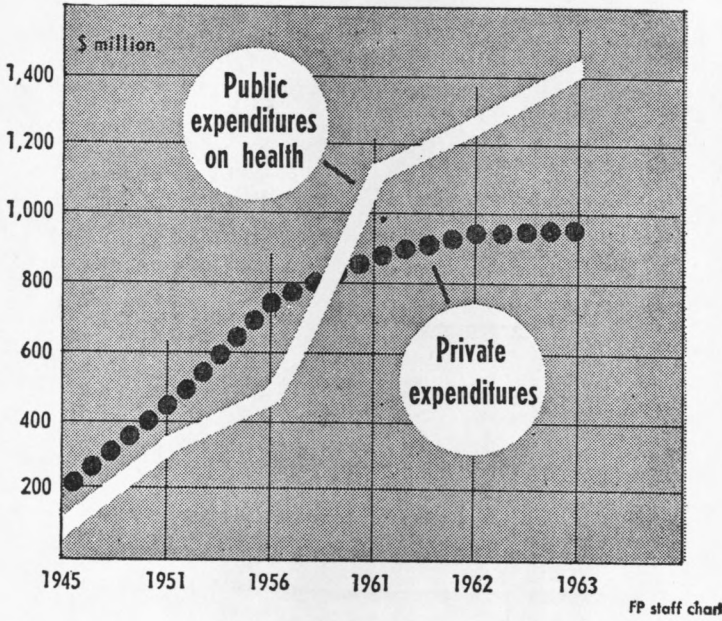
(In 1962, there were 927,590 recipients of Old Age Security.)

Total and per capita government expenditures on health and social welfare.

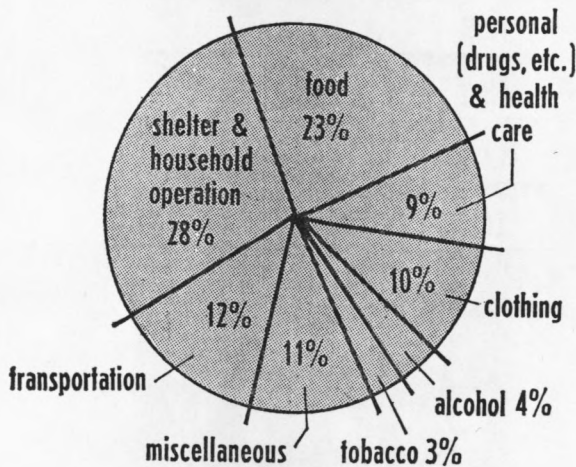
	<i>Federal government</i>	<i>All governments (Federal & Provincial)</i>
Total expenditures		
1957	\$1,402,500,000	\$2,003,500,000
1962	\$2,575,800,000	3,678,800,000
Per capita		
1957	\$ 87.21	\$124.59
1962	141.23	201.71

NOTE: For approximation and comparison purposes only, between Canada and United States, it is customary to multiply the above figures by ten (10).

As costs of health go up ... governments' share increases

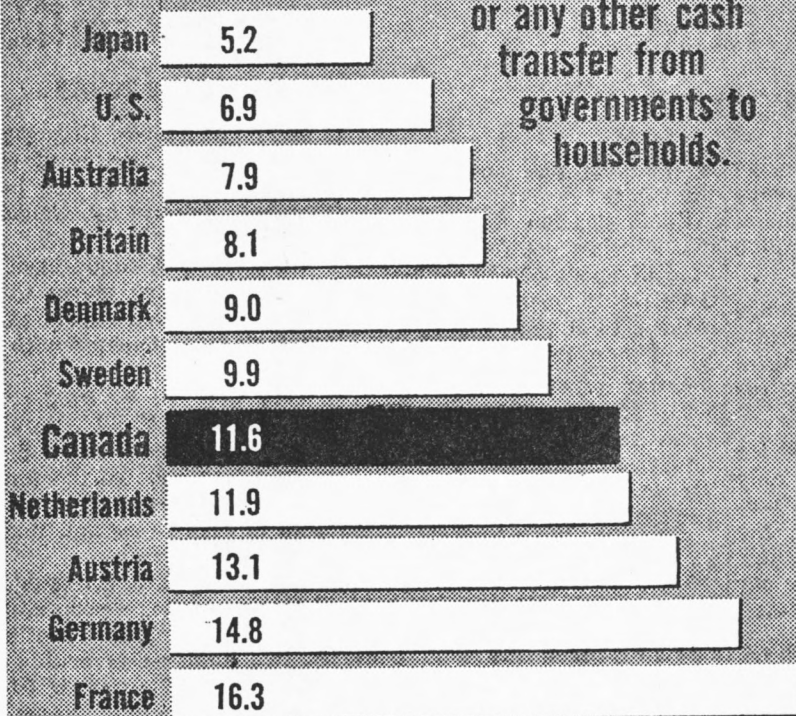


How consumer \$ is spent (1963)



How much welfare?

This is the percentage of income allocated to welfare by the leading nations of the West — pensions, family allowances, unemployment insurance or any other cash transfer from governments to households.



Data: IAH

THE FINANCIAL POST

Measuring the Image of Dentistry

DONALD J. GALAGAN, D.D.S., M.P.H.

As I reviewed the program of this Workshop, a recently read short story came to mind as an appropriate introduction to this session of the proceedings.

In the story, four people waited at an airfield for a plane that was returning with the survivors of a crash. Though word had come that only one person had lost his life, his identity was not yet known and none of the four could be sure whether the person he was there to meet was living or dead.

Among the four waiting were two women, one, hopefully to greet her husband, the other, her lover; a lawyer impatient to get his client's signature on a legal document if he were still alive; and a man to see his business partner.

In the tense moments before the plane landed, each one recalled his experiences with the person for whom he waited. But those who paced anxiously at the airport were waiting to learn the fate of just one individual. The four vignettes making up the story described one man, differently, of course, as viewed through the eyes of four beholders—each with a different image of the same man.

This story is told to emphasize something that all of us know. Though we may speak of *the* image of dentistry, there is no such thing as a "single" image. Rather, there is a composite of attitudes, differently accented according to the particular aspect of the dentist's role being visualized, and varying according to the viewer.

There are, then, many images of dentistry. There is, for example, the image which the college graduate may have—and the image in the minds of the uneducated person. There is the image that a wealthy group might have—and the image which the low income families hold. Members of the other health professions will have still a different image of the dentist—and dental students yet another.

In fact, not even within a fairly well defined group is there a single image of the dental profession. Take the image of dentistry held by college presidents, for example. Probably every segment of that

group, when considering the prospect of dental treatment, conjures up an image of dentistry that is quite different from one evoked in other circumstances. At the same time, there is no single image even for those for whom treatment is imminent. Teenagers from a controlled fluoride area are unlikely to picture dentistry in precisely the same way as their parents, whose history of need and treatment antedates both fluoridation and the high speed engine. Although for parents and children alike, the image represents bringing into focus a montage of remembered experiences, the experiences of each differ, not only in their actual content, but also in their emotional intensity and in their relationship to experiences in other areas of life.

The result is a kaleidoscope of attitudes: about pain, for example, and professional competence, about the reasonableness of fees and the dentist's personality—attitudes which are both different in themselves, and differently weighted in the pictures which finally take shape in the minds of the image-holders.

Yet the fact that dentistry has many faces does not mean that the measurement of dentistry's image is impossible or impractical. But it does suggest that when we speak of measuring *the* image we are talking not of a single study, but rather of a series of studies, each measuring one of the many images of dentistry. And further, that since the number of images available for study is almost limitless, that there is need not only to be selective in what we choose to study but also to set priorities so that we may assure an ordered sequence of studies in which we study first those images which most clearly affect the attainment of our professional goals.

Although the technicalities of image-measuring can best be left to the professional responsible for the conduct of studies of this type, my assignment calls for an examination of the various methods of study available from the standpoint of their potential usefulness.

There are really very few ways in which we might study our image. There is the attitude survey, conducted either by interview or by self-administered questionnaire, and its cousin, the opinion poll. There is also the media study, an analysis of references to dentists or dentistry appearing in newspapers and magazines and in radio and television shows. While there are others, these are the two general types most often employed.

Both are capable of providing valuable insights into what people think about dentists or dentistry. A study of the mass media, however,

would provide information from which an image of the dentist or dentistry might be inferred. But whose image this was, or what potential meaning it had for advancing the aims of the dental profession, would be something else again. One of our local disc jockeys shudders audibly every time he mentions anything related to dentistry—most recently when he referred to the scheduled meeting of the local association of dental assistants—and, from his remarks, I would assume that though he hastens to add “some of my very best friends are dentists,” he has what we would have to describe as an essentially negative image of the dentist. It is possible that his viewpoint results from some personal experience.

However, it is possible also that he reacts in this way because he believes this is the prevailing public image of dentistry, or at least the image held by that segment of the public making up his early morning audience. Or, equally plausible, he reacts in this way because his writers hold such an image or believe that others do.

In short, apart from the technical difficulties of conducting a media study, and they are many—the mass of material to be covered, the range of subject matter, the problem of formulating meaningful categories for organizing and analyzing its contents—there is reason for questioning the value of this approach from the standpoint of the knowledge it could impart.

In this particular instance, we could probably direct an inquiry to the disc jockey himself and find out whether his remarks reflected his personal image of dentistry, or someone else's. But in most cases involving mass media, such a follow-up would be difficult or impossible. The most we could count upon from a study of the mass media would be to arrive at a description of the image to which the public, or more often, some undefined segment of the public, was being exposed. Unanswered would be the more pertinent questions: what influence, if any, has that image upon the behavior and attitudes of those to whom it is purveyed, and what specific elements of the image are most responsible for whatever influence it has.

In other words, the mass media study has some very great limitations. Fascinating in itself, it would be unlikely to provide us with any specific leads for improving the attitudes which affect progress toward the realization of our professional goals.

To develop such leads—and I would suggest that any statement of study objectives will necessarily encompass the intent of action—

we must turn to a more systematic study of our image and its components. In this context, I am using systematic to mean a study which not only meets certain technical requirements, allowing us control over the order and form of the questions and the representativeness of the sample, but one which also permits an analysis in depth: a study which identifies the specific attitudes germane to an image, and relates these attitudes to the characteristics of respondents and to those aspects of their behavior which are of particular concern to the dental profession.

I stress the need for depth because one of the hazards we must guard against in undertaking studies of this type is the danger that the findings will prove interesting, perhaps even enlightening, but like those of the media study, essentially unusable as a basis for action.

All too often, when we speak of measuring an image, we seem to imply a willingness to accept a single summary judgment or evaluation—a placing of the image on a scale which ranges from negative to positive, a ranking of dentistry as compared with another profession, or a ranking of certain attributes of the dentist by different image-holders. There is little that is helpful about such limited values.

For example, there is a recently published report on trends in occupational prestige which shows the dentist to have advanced to 14th place on a list of some 90 different occupations from 18th place on the same list in 1947. Based upon interviews in which a cross-section of the population was asked to evaluate the "general standing" of each occupation, this study is an example of a carefully designed, well-conducted study of a type which we have grown to expect these days. Yet, any thoughtful reading of this first report from the study raises many more questions than the study can possibly answer.

There is, first, the simple matter of being unclear as to how the respondents defined the term "general standing," whether they shared any common understanding of its meaning. Did rankings for those thinking that an occupation's standing arose largely from monetary success differ from those who believed it stemmed from some other kind of achievement? If there had been separate ratings on these different elements, would the overall ranking of the occupations have differed?

What was there about the image of lawyers or diplomats in the United States Foreign Service that was responsible for their preceding dentists on the list? Did the fact that physicians had yielded first place to the nuclear physicists reflect some actual tarnishing of the physician's image or only the emergence of a new and more glamorous competitor?

While some of these questions will undoubtedly be answered in later reports from this study, there are others of more immediate concern which just as surely will not. What did dentistry's improving position mean, for instance? Did the improvement affect all age groups in the population, or did it simply result from the fact that the older people dropping out of the population thought less of us than the young people who replaced them? Is there any relationship between the amount of care people get and how they rate our standing in the community? If so, had this relationship changed?

If we were to have a simple prestige ranking of dentistry from several different groups of image holders—say the teenager, the student who had already opted for dentistry and the one selecting a rival profession, the dental school faculty member, the medical school faculty member, the regular patient, and the non-patient—there is no question that we would add depth to our understanding of the dentist's reputation in today's society.

By adding other attributes besides prestige to the ranking, we would learn even more. But still we would be left in essentially the same position as we were by the more generalized report just cited. Instead of one summary measure, for one group, we would have a series of such measures for several groups, all of interest to us because, like our fellows, we care what others think of us. But before a summary evaluation or judgment can be useful, we must have some knowledge about the attitudes upon which this judgment rests, the relationship of these attitudes to reality and to each other, the circumstances which contribute to them, the personal characteristics which influence them, and, always, their relevance to behavior which affects dentistry in the pursuit of its goals.

Although the study of images in their own right is fashionable today, this Workshop offers ample evidence that dentists at least are both knowledgeable enough and practical enough to attach little virtue and less value to the conduct of a study which aims only at finding out how well the profession is thought of. In fact, the charges to the

various study groups are replete with common sense suggestions for altering some specific element of an image which is considered likely to be affecting the dental profession's potential for service. And, as often as not, the suggestion implies a need and a willingness on the part of dentists to modify their own behavior.

Yet, both the identification of the elements of an image which need altering and the means for producing the changes needed are themselves questions for research. Even a final definition of what it is we want to measure, what specific attitudes are important to an image, may have to wait upon preliminary research efforts.

Therefore, though we start our series of studies with the premise that attitudes can be improved and images altered, and that these changes will be reflected in significant changes in behavior, we must be prepared to test this premise as an independent step. Whether we succeed or fail in effecting changes—or barring failure, just how successful our efforts prove to be—is something which only later research can tell us. For this reason, it is extremely important that any study we initiate be carefully designed to provide baselines against which future progress may be measured.

Given the complexities of measuring an image and the fact that—though I myself have long since lapsed into the singular “image”—we are concerned not with one image but with many, there is good reason for limiting the scope of our initial venture.

We might, with wisdom, select some particular image as the subject of a pilot study, preferably an image which we have reason to believe is involved in the solution of some problem confronting dentistry today. The pilot project might involve not only the measurement of the image but also an effort to apply the knowledge gained from the study to the solution of the problem concerning us.

Any number of possibilities for study exist. One possibility might be a study of the labor union leader's image of the dentist and dentistry with particular reference to the elements in the image bearing upon the leader's actual or planned behavior relating to prepaid dental care as a fringe benefit.

Or perhaps, since the dental profession is likely to expand its services in hospitals, the image of the dentist by the hospital staff, and the relevance of this image to the dentist's position in a hospital setting might be selected for pilot study. For discussion purposes, let

us assume that the latter choice is made and review briefly some of the steps necessary to the completion of this pilot study.

The initial step in such a study would be to conduct exploratory interviews with staff personnel in a hospital in which dental services are already offered. And since the dentist's self-image could prove highly relevant, there would be considerable value also in interviewing dentists affiliated with the hospital. Undertaken only to clarify or add to our store of ideas, these interviews would be few in number. They might be supplemented by short periods of observation in the hospital proper and in its dental department. In this initial stage of the study, we might also give some thought to the inclusion of staff from hospitals which did not offer dental services, so that their attitudes toward dentists and toward having an active dental department might also be explored.

Based upon the information and insight gained in these exploratory interviews and observation, a second step to be taken would be a systematic study of the group selected for study. In addition to the identification of factors relating to the image of dentistry, and specifically to its attitudinal components, the inquiry would include a variety of questions about particular kinds of work relations in the hospital or about the potential acceptability of such relations. For example, the physician's referral of patients to his dental colleagues and the participation of the dentist in policy decisions or in the day-to-day administration of the hospital.

If when the tabulation and analysis of data are completed, the staff image or the dentist's self-image or certain aspects of either prove to be relevant to the work relations in the hospital, and particularly if their effect is to diminish the effective use of the dentist's professional skills, then the next step might be to determine what could be done to correct the situation. If the problem seemed a matter of misunderstanding or misinformation, this knowledge would provide a basis for efforts at correction. And, if the study has been carefully planned, the findings will help pinpoint where in the hospital organization, and to what particular kinds of persons in what positions, the efforts toward correction might be directed.

This, or some other, pilot study might be the first of a series of related studies each of which focuses upon some specific image involving problems or attitudes which are of concern to the dental

profession. There have already been studies relating to attitudes held by the general public and by certain segments of the public, such as high school students and dental students, and the detailed findings from these could perhaps be brought together and collated as a first step toward developing what, for want of a better term, we might call general profiles of dentistry, describing the dentist as healer, as citizen, as colleague in terms of the diverse attitudes which these studies reveal. As additional studies are completed, findings from these too could be integrated into the appropriate profile or profiles steadily filling in these outlines until each is complete.

By the time that sufficient evidence accumulates to suggest that some specific attitude or set of attitudes effectively limits the dentist in the performance of his role—or conversely that the dentist more fully realizes the potential of that role where certain attitudes are present—we will also have accumulated sufficient information to guide us in a course of action.

By the same token, if evidence accumulates that certain attitudes bear no relationship to behavior, that some are so linked to the age of the image holder that time itself will erode them or that still others are rooted in a reality we can not change, we will then know that we should leave them unchanged. In short, we will know in what directions we might most profitably move and which routes might prove the most direct.

In summary, then, I have tried to make six simple points:

1. The dental profession does not have a single image, but many. It may be possible to compile, from the elements making up these images, one or more profiles;
2. It will be necessary to develop a systematic and sequential approach to studying our images;
3. We will need to have the purposes or objectives of these studies worked out in advance and to set priorities for their accomplishment;
4. We will need to select methods of study suitable to these purposes;
5. It would be desirable to select a specific area—hospital dentistry was suggested—in which to begin to gather data, and
6. Every study should be so designed that it could lead to constructive action when necessary and indicated.

What They Are Saying About Dentistry

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There are as many images of dentistry as there are people who are aware of dentistry. I can think of three major groups: first, the dentists themselves; second, the group of patients that have good dental relationships; and third, those individuals who have no on-going dental relationships and a paucity of experience with dentists. Many of the reactions of these groups are derived indirectly rather than directly.

Dentists exist in the social vortex of our times which has many forces with impact. The entire health field has certain schizoid-like tendencies. On the one hand the science of dentistry has, from the standpoint of an understanding of the basic sciences, techniques of treatment, available materials, instruments, and procedures, advanced unbelievably. On the other hand the nature of the relationship of the patient, the improvement of dental education of patients, has failed to progress accordingly. It is easier for the dentist to identify and change in terms of specifics related to the evolving science of dentistry as opposed to the art of human relations, education, and so on. These are less specific and harder to evaluate. Dentistry is more than a natural science. Every dental procedure includes a personal relationship.

The role of public health has expanded tremendously. This is frightening to many dentists. There are those who feel that dentists cannot accept money, guidance, and other assistance from public health sources without changing the image of dentistry, not only to the dentist but to the patient. Recent years have seen the growing role of public health in prevention, research, education, research in dentistry as a profession, and studies of the realistic situation within the profession (as for example the pressure for more dental schools and more dentists.)

From a political standpoint there has been a growing pressure for more and cheaper or free dental services. This trend is a reflection of the development of a changing image of dentistry by a large segment of the population.

The public image of dentistry results from the sum of many individuals' interaction with dentistry, as well as their being influenced by other people's attitudes toward dentistry. Part of the image of dentistry is contaminated by the frequent use of dentistry as the butt of jokes, and the profession is viewed derisively. Another aspect is the fear that many people have of dentists—their fear of pain. The dentist's reaction to this suspicion and hostility from the patient tends to condition him and to change his attitude toward the profession and toward patients. Psychological appraisal of many dentists indicates that a fair proportion are influenced by their feelings as to how others feel, and leaves many with hostile and defensive feelings that influence their attitudes toward the profession and their desire to be of service to people.

Dentists live in a world that is not only exploding scientifically but socially. There is little indication that the health professions have understood what is happening to the concept of the dentist, of his profession, and much less to his perception of the future implications.

Studies indicate that the dental students' concept of dentistry is quite centered on the economic return. Careful analysis of the curriculum of dental schools show them to be struggling increasingly to stay abreast of the scientific, procedural, and material knowledge of the profession. But there seems to be no major trend toward what could be described as the study of the profession: the analysis and understanding of the practice of dentistry, better understanding of people—their motivation and adjustment, and the sociology of dentistry.

In 1962, a small group of dentists with whom I was associated, wrote letters substantially as follows to a half-dozen dental schools:

We have been increasingly concerned with a plan to merge the social sciences within the dental curriculum. Too many of us receive excellent training in dental school as oral technicians, and fail to possess the training to enable us to establish an effective communication with our patients. As a result there is a large proportion of trained, competent dentists who cannot understand their patients' needs and desires, and thereby fail at

least in part to develop mature dental-patient relations, adequate programs of dental education, and adequate services for the patient.

Should this not receive study, and is it not imperative that in the interest of the profession and in the interest of training dentists that research in such a curriculum be immediately conducted? Could a foundation grant be secured for such a study?

Does this seem to be as important to your school and your faculty as it does to us?

None of the deans thought that this was unimportant. But none of them followed up or accepted the offers of help. It would seem as if there were lacks of ability to deal with training the whole dentist, and that these lacks not only hurt the image of dentists, of their profession, but indirectly are quite detrimental to the image of the public. What is it in the mind of the dental educator as to how the dental student acquires knowledge and values of his profession or understanding the people it serves?

It would seem as if a basic prerequisite for the maturing and adjustment of the image of dentistry must include a much more inclusive attitude toward training the whole dentist—the man as well as his technical capacity. To explain this: what if as little as two clock hours a week were to be devoted to establishing a frame of reference for the dental student, of his profession, and of his potential patients? It is possible that this would make a contribution because it is related to values and meanings; and it would actually contribute to the students' meaningful understanding of the rest of the curriculum.

The curriculum of such an addition to the dental program as is anticipated would require two clock hours a week throughout the four years. The studies of NK & Associates in studying dental students, and the medical studies as presented in books such as *Students in White* and others, indicate that such a program can start best with a careful, clinical appraisal of each dental student during the freshman year. As a basis for the interpretation of these appraisals, the first 24 clock hours would be spent on the sociology of dentistry, the place of the dentist in his practice, and the physiological and psychological strains of a young dentist. This would be done, correlated with both theory and practice, on a comprehensive basis, which would serve from a philosophical, abstract, and theoretical standpoint to aid in the orientation of the freshman student.

In spite of the fact that the word "comprehensive" was used, in

this context it was intended as a deeper orientational presentation, including the philosophy and ethics of dentistry, than is normally given. (The dental school is the only professional school known to the writer that does not have an introduction to the philosophy of the profession during the freshman year.)

Freshman year—During the period from November to March, each student would have a competent, clinical interpretation of his appraisal. On the basis of this appraisal, given by a competent professional person, certain questions and issues would be set up for him to investigate further, to read about, and to consult members of the faculty who practice, in order to fill in his own background, insight, and understanding. This would be done by appointment on his own time. (This follows the highly successful Harvard, Washington University, and Oregon system that the medical schools have been developing in the last five years.)

The second 13 weeks of the freshman year would be a course on the physiological and psychological growth and development of the child, up through puberty, with emphasis on not only the evolutionary development, but the various psychological stages, with some effort to have these seen as something to which people revert under certain kinds of emotional strain. Efforts would be made in this study to help the dentist not only understand these people, but to understand at least the elements of how the dentist may have to relate himself to such individuals. (Obviously, the first parts of this course would be concerned with children before the time that they would go to the dentist.)

The third quarter of the course would be the physical, psychological, and sociological tension systems of the adolescent to the young adulthood group in terms of individual differences, growth, and development, on the same basis as the previous course.

Sophomore year—The first quarter would consider the study of the psychology of young adults from a physical, psychological, and social standpoint, up through the early years of marriage when they have children. The emphasis of this entire program would be, after careful study and cooperative planning, to utilize appropriate resources within and without the profession, to use interdisciplinary resources, to establish relationships within the community where things can be observed, or people talked to who have had the experience to recognize the importance of adequate theoretical train-

ing, and to recognize the importance of being able to identify the problem by relating it to the clinical and practical experience of a person in practice, or in the community. Every effort would be made to try to orient the outside resource people in such a way that they could relate to the curriculum.

The second quarter of the sophomore year would be, for the time being, the study of the mature person and geriatrics from the same standpoint as the preceding developmental courses.

The third quarter would be a detailed and intensive study of the sociology of dentistry. This study would include, in preparation for the junior and senior year, the role of the dentist, the role of the patient, the differing roles that patients play, the climate of the community in terms of the social pressures which it creates, the dentist's concept of dentistry, the patient's concept of dentistry, the socio-educational philosophy of dentistry, and a beginning definition from a sociological standpoint of the attitudes of people toward dental service.

Junior year—The first two quarters would be spent, based on the preparatory material, on the personality theory, including understanding what people mean rather than what they say, semantics—the basis of communication, why people differ, some of the processes of human adjustment, definition of some of the processes of human interaction, and definition and elementary processes of human motivation, and related topics.

The third quarter would consist of techniques in listening, in communication, in public speaking to small groups, and the theory and principles of small group dynamics—all relating back to personality development, and the sociology of dentistry.

During the third year, the school that has this program would set up a lecture series for the school as a whole, but particularly for the juniors. There would be six lectures by outstanding dentists on the ethics, philosophy, service, future, research, relationships, etc. of the profession. Each lecturer would be asked not to entertain, but to deliver a serious paper acceptable for publication.

Senior year—Practice management, whether we call it by this or another title, will be dealt with intensively, including the study of office layout, purchase of equipment, other dental purchasing, flow of patients, utilization of resources and equipment, setting up of the business part of the office, presentation of the problem of patient ed-

ucation, interprofessional relationships, establishment of relationships within the community, the avoidance of stress and strain, scheduling, the selection and training of auxiliary personnel, and the like.

In addition, during the middle quarter of the senior year, each man will have another interview, or series of interviews, with a clinically adequate person concerning his growth and development as compared to the appraisal when he came into school. In conjunction with this, his own personal problems such as choice of location, selection of type of practice, whether to go on for additional training and if so on what basis, the nature of the kind of practice he may want to establish, and other problems he is fearful of, will be discussed and outlined. A specific series of experiences to help him to overcome these problems will be designed, including visits to dental offices, biblio-therapy that deals with his particular problems, and the opportunity to consult with people who have faced these problems and worked through them. If necessary, and in a surprising number of cases it probably will be necessary, the opportunity will be provided for some clinical counseling to obviate in part some of the fears, trepidations, and anxieties which make young dentists ineffective during that period when they should be the most effective.

The last ten lectures would be on a series of topics about the future of dentistry, the projection of the profession, the dentist in the dental society, the place of the dental profession in the group of professions, the contribution of the dentist, the dentist in the future, and similar subjects.

It is not important that *this* curriculum be the one adopted. But it is important for this type of overall frame of reference to be established, studied through and worked through by dentists, if the image of dentistry for dental students, dentistry as a whole, and for patients, is to mature adequately.

In the same vein, since it seems important to the image of dentistry for there to be this type of training and insight for students, it seems as if the expansion of the dentist's concept of dentistry must begin by an effort on the part of the dentist to come to a more mature concept of himself. It is only as this is done that recommendations in terms of the specific objectives for this workshop and the assignments of the study groups can have meaning. These objectives are:

1. To review and define the image of dentistry currently held by the dental profession itself, and as related to the images held by other groups, including the public;

2. To identify methods of measuring the image of dentistry, now held by groups within and outside the profession, as a means of establishing baselines for evaluating future progress in improving the image of dentistry; and

3. To suggest methods of approach to the improvement of the various images of dentistry, beginning with the profession's image of itself as the basic determinant of the images held by other groups.

In order for dentists to study themselves, there are many things which they can do. It is important for the dentist to review his goals and purposes in being a dentist, to do a job analysis of how he spends his time, to appraise what he thinks the patient feels about his office, to determine what he is doing with auxiliaries—the training of them, to appraise the number of days per month or number of hours per week he devotes to professional relations—how much they have contributed, to discover what he has done in terms of on-going education, and of what value these things have been. He must try to understand his patients in terms of their actual feelings and not by just what they say, to evaluate them objectively as the people they are or are not in reference to the practice, to determine and appraise the effectiveness of the patient education that is going on through dental education, and many other things that are pertinent.

What are the greatest weaknesses that you have as a dentist: a) from the standpoint of an oral technician, and b) from the standpoint of being a professional? What are your greatest strengths; what is your program to improve these? How do you project the image of dentistry into the community through your patients, or in other ways? These are only a few of the questions which have to be asked. In asking them, you are in effect appraising yourself and thus educating yourself. It may be that you will want the help of a clinical psychologist or some other such person to help to determine your attitudes and feelings, your hopes and aspirations, the things you do not talk about as well as the things you do talk about, and to see these things in a perspective that has power and meaning for you and for the profession.

It is against this background, not only of a student frame of reference in terms of the practice of dentistry and not only of the pub-

lic's interest but of the practicing dentist's interests, that we will be able to appraise and to consider the particulars in the outline which has been presented.

It is my hope that out of the research that I have done, and out of interaction with you during these three days, to be able to be of assistance to each of your groups as you plan how to answer the specific questions of the outline with which you have been provided.

What are people saying about dentistry? Many dentists have panicked because they see an invasion of a socialized trend in the health services. Too many dentists have far too many materialistic goals. Yet on the other hand there are thousands of dentists who, because of their sincere interest in their patients and the nature of the service they render, daily expand and increase the image of dentistry in the hearts of their patients and in the community.

So much of the image of dentistry depends on whom you talk to. In this there is real discouragement, for there is a borderline group who is buying services and recreation when they need help with their dental health. There are 60 per cent of the people who have never had that level of education to enable them to appreciate the services of dentistry, and these are the people who appreciate or think that they appreciate, the criticisms and ridicules of the dentist. These are the people who perpetuate the problem of the cost of dentistry. These are the people who, because they do not understand, do not appreciate the significance of good dental care. They are a major group; they are our challenge and our threat—they are our opportunity and our danger.

Basically, however, as we go into the entire picture, the most frightening thing to me about what is being said, are those things that are being said by dentists themselves. For they are the ones who, through lack of confidence in their profession, through a sense of inadequacy or a defensive position, so act and so behave and so believe, that they fail in their own contacts with the public and with their patients, as well as with members of the dental and other professions, to so develop the image of dentistry that it can be projected in terms of the adjustment of the total growth of the profession.

Improving the Dentist's Image of His Own Profession

REPORT OF STUDY-GROUP I

As a frame for their activity, the members of this group decided that the title of the Workshop implied that the image of dentistry needed improvement and the assumption was made that the image could be improved by specific, practical means. Study-Group I, therefore, charged with the responsibility for examining the dentist's image of his own profession, focused attention on areas affecting the dentist as a professional man.

The members of the group, representing individuals from many different dental interests, expressed opinions at the onset that they were proud of their profession and their individual parts in it. They concluded, nevertheless, that there were specific recommendations that could be made for improving the image of dentistry in the dentist's own mind.

Five areas of impact then were listed as important in affecting the image of the profession held by a member of that profession:

- A. Education
- B. Professional Societies
- C. Professional Practice
- D. Qualification
- E. Scientific Publications

The 16 assignments, submitted to the Study-Group, were considered in relation to these five areas. Specific recommendations then were made for enhancing the dentist's own image of dentistry. The recommendations that follow represent the consensus of the entire group.

A. Education. The ever widening gap between scientific knowledge and clinical practice makes it imperative that improved methods of graduate, postgraduate, and other types of continuing education be developed. Dentistry can enjoy much satisfaction from its advancement in continuing education, but, because of the rapid progress of

scientific knowledge during the 20th century, the need for such education becomes more and more urgent. The present system of dental education was designed when methods and technics of treatment were relatively static when compared to the revolutionary advances which have occurred recently in the basic biological and technological sciences.

1. *Postgraduate Study*—To extend opportunity for, and utilization of postgraduate study; it is recommended:

a. That dental schools be encouraged to develop opportunities for the continuing education of the practicing dentist in addition to the preparation of the undergraduate student of dentistry;

b. That dental societies, organized at all levels, accept, as a recognized service to their members, the responsibility for a dynamic program of continuing education;

c. That programs of continuing education in dentistry be provided for the allied health professions in hospitals and other health agencies;

d. That continuing education be made self-supporting and that each participating dentist be urged to accept his financial responsibility; and

e. That dental societies and licensing boards study the feasibility of requiring evidence of continuing education as a requirement for membership or licensure.

2. *Teaching Staffs*—To improve the quality of the teaching of undergraduate students, it was concluded that all segments of the dental profession felt that dental schools should be staffed with more full-time, dedicated, research-minded, technically-prepared teachers, but since the attainment of such an objective depended on the availability of suitable financial support; it is recommended:

a. That private financial support and governmental support to professional education be endorsed and encouraged; and

b. That continued efforts be made to interest private foundations in the support of experiments in undergraduate dental education;

3. *Gaining Highly Qualified Students*—To enhance the dentist's own opinion of his profession, it seems to be imperative to attract more highly qualified and motivated students to enroll in dental schools; it is recommended:

a. That dental societies, on all levels of organization, initiate a

well-organized effort to project to counselors and faculties of high schools and preparatory colleges, the opportunities and challenges afforded by dental science, not only in dental practice, but in dental education, research, and public health;

b. That the American Dental Association be encouraged to continue vigorously its program of urging and motivating state and local societies to participate in science fairs, and to aid students with projects as a method of stimulating interest in dental science;

c. That a study be instituted to determine the validity or falsity of data collected by the testing groups which purportedly connotes that a career in dentistry requires lesser educational standards and skills than do the other learned professions;

d. That better publicity of the scientific accomplishments of dentistry in improving oral health be developed; and

e. That a study be made to ascertain the optimum age or time at which to motivate and test prospective dental students.

B. *Professional Societies.* Professional societies, study clubs, and organizational activities afford the dentist opportunities for exchanging ideas, for becoming better acquainted, for activating projects and programs, for advancing and maturing professionally, and for solving problems. It is expected, therefore, that the dentist's image of dentistry will be affected markedly by the relative excellence with which these organizations function.

1. *Better Utilization of Programs*—To obtain a better utilization of the programs of dental societies, study club, conferences or workshops; it is recommended:

a. That dental organizations, at all levels, provide ample opportunity for continuing education and motivate other members to participate;

b. That dental organizations recognize the need for adequate financial support of their educational programs;

c. That the parent or larger organizations support the educational programs of the small or rural components;

d. Since the *Survey of Dentistry* devotes but two pages to scientific sessions, and the American College of Dentists has explored continuing education in its publication, *An Outline for a Continuing Educational Program for the Dental Profession*, that an assessment of the problems and methods associated in the development of programs

of continuing education of dental organizations should be carried out by the American College of Dentists;

e. That dental organizations, particularly dental societies, improve their methods of organizing and administering their programs of continuing education; and

f. That dental organizations continuously emphasize the value of fellowship with colleagues as it is attained by attendance at dental meetings.

2. *Gaining Dignified Publicity*—Since publicity implies a relationship with the public, it was concluded that the primary consideration of publicity belonged with Study-Group II. The dentist's pride in his own profession, however, will be enhanced by appropriate recognition of dental achievements in both professional journals and the public newspapers.

It is recommended, therefore, that means be developed to obtain dignified publicity of dental achievements in public media and that dental organizations be encouraged to include news of their accomplishments and the achievements of individual members.

3. *Securing Unified Appreciation of the Goals of Organized Dentistry*—Lack of unity of support of the goals of organized dentistry stems from two sources: (1) from dissident minorities whose activities lead to fragmentation of effort and, (2) from members who are apathetic and disinterested in dental affairs; it is recommended:

a. That every dental society remain constantly aware of the danger of fragmentation and utilize all available mechanisms to keep its membership adequately informed in order that a consensus may be attained through the democratic process;

b. That each dental society expend every effort to stimulate the participation of apathetic members in the affairs of the society; and

c. That every component society encourage its members to participate actively in the development of the policies of the constituent and national associations.

C. *Professional Practice*. The practice of dentistry expresses the highest order of a dentist's respect for his own profession. The concept of total care of the patient and the performance of technical procedures, that are high in quality when rendering such care, demonstrates the image of dentistry to other dentists in a manner

impossible by any other means. To enhance the image of dentistry through its professional practice the following activities are recommended:

1. *Accreditation for Hospital Practice*—Four recommendations are submitted:

- a. That dental schools include instruction or experience in hospital practice to encourage a desire for internships and residencies;
- b. That a study be made of the feasibility of requiring internship or a similar experience as a requisite for licensure;
- c. That continuation courses in hospital practice for prospective members of the dental staff be established; and
- d. That hospitals be encouraged to study the feasibility of establishing part-time internships and residencies.

2. *Emphasis on Preventive Technics*—To emphasize the value of preventive measures to both practitioners and the public; it is recommended:

a. That appropriate dental organizations sponsor national symposiums to cover all aspects of prevention of oral disease, in order to create a desire to learn the application of preventive technics. (Dental schools and dental societies should be encouraged to offer at least one course of excellence and quality, initially, in preventive measures and practices as part of their programs of continuing education.);

b. That dentists be made aware that the economic reward of a preventive practice should be placed on the same level as all other professional services;

c. That the liaison between the dentist and agencies for the public health be improved so that each can understand the problems and contributions of the other;

d. That schools of dentistry develop curriculums which are oriented toward prevention both didactically and clinically; and

e. That dental societies and dentists utilize all means of communication as technics of education in dental health to acquaint the public with the value of preventive measures.

3. *Application of Research to Diagnosis and Treatment*—The attitude of any practitioner can be improved by applying the findings of research to diagnosis, prevention, treatment, and education of the patient. To accomplish this end, it is recommended:

- a. That a study be completed to determine the reason for the

reluctance to change methods of practice which demand keeping abreast of the findings of research; and

b. That dentists be encouraged and motivated to participate in group functions such as study clubs, hospital dental services, and group practices.

D. *Qualification.* Qualification for the practice of dentistry provides a baseline for recognition of competence in the dental profession about which the education and experience of the undergraduate dental student, graduate student, and dental practitioner are evaluated. Licensure and certification provide the means for such qualifications. The image of dentistry is directly affected through the standards set by licensing and certifying boards.

1. *Coordinating Scientific Information and Technics of Testing With State Board Examinations*—It is recommended that an effective coordination of current scientific information and technics become a constant goal of examinations conducted by licensing boards in dentistry as a step toward the freer movement of dentists among all states.

2. *Keeping Abreast of Current Developments*—It is recommended:

a. That the American Dental Association experiment with a more comprehensive service which will include abstracts of articles published in the *Journal of the American Dental Association* as well as pertinent articles from every recognized publication;

b. That the American Dental Association explore the need for additional publications in other areas of interest than *Accepted Dental Remedies* and *Guide to Dental Materials*; and

c. That specified numbers of hours of continuing education or its equivalent in each five-year period as decided by examining boards eventually be prescribed for recertification.

3. *Qualification for Practice of a Specialty*—It is recommended:

a. That sufficient education in the basic sciences pertinent to the specialty become a requisite for specialization; and

b. That the courses in education for a specialty be given in an accredited program of training.

E. *Scientific Publications.* The most permanent record of a profession is that which is recorded in the literature. Since the stature of a profession in the scientific world has a direct relation to its

image, and since publications in the scientific literature by dentists mirror the scientific and cultural image of the dental profession, it is recognized that the dentist's image of his own profession is significantly affected by this area of professional activity.

1. *Mastering an Acceptable Style of Scientific Writing*—It is recommended:

a. That dental publications adopt and adhere to an acceptable style in presenting investigative reports, the findings of epidemiological surveys, the accounts of observations and new technics, and reviews of literature. Contributors should prepare their material in the style prescribed by the publication to which the material is submitted. Ordinarily this format should include a standard formula for presenting scientific material as follows:

- (1) Title
- (2) Introduction
- (3) Materials and Methods
- (4) Presentation of Data
- (5) Discussion
- (6) Summary
- (7) Conclusions
- (8) Bibliography

b. That a formal course in scientific writing be included in the undergraduate dental curriculum;

c. That the style of an article on technical procedures should be a sequence of steps and stages which can be grasped readily by the reader;

d. That methods for reducing the lag between publication of scientific data by nondental publications and its application to dentistry should be studied.

2. *Standards for Dental Literature*—It is recommended:

a. That the standards for the publications of dental societies approved by the Board of Trustees and the House of Delegates of the American Dental Association, be accepted and endorsed by the members of this Workshop; and

b. That dental publications which include advertising should have, in writing, an acceptable advertising code.

3. *Critical Appraisal of Published Information*—It is recommended:

a. That dental publications utilize a Board of Review for the evaluation of technical and scientific manuscripts;

b. That dentists be discouraged from contributing to proprietary or the so-called "throw away" publications;

c. That in the interest of the public welfare, lay publications be encouraged to submit articles on dental health education to the appropriate agencies of the American Dental Association, the National Dental Association, the Canadian Dental Association, and their component societies, for review of the authenticity of their content.

F. *Final Statement and Recommendations.* As a result of the deliberations of this group it has become obvious that achieving pride in one's profession becomes an overall objective for enhancing the dentist's image of his own profession. Recognizing that dentists are the guardians of the oral health of the people whom they serve, believing that pride in one's own profession will be better achieved when everyday practice and teaching are conducted at the highest level of biological orientation, and realizing further that dentists are the primary source for projecting the character of dentistry as a profession which serves the public, it is recommended:

1. That dentists individually and collectively become missionaries for dentistry in their relations with their fellow practitioners, members of allied health sciences, and the public; and

2. That every dentist adopt for himself a code of conduct, in addition to the Code of Ethics of the American Dental Association, that will guide him continually so that his actions and activities, professional and non-professional, in the interests of individuals, groups, or organizations, will meet the following Four-Way Test made famous by a well-known service organization:

- a. Is it the truth?
- b. Is it fair to all concerned?
- c. Will it build good will and friendships?
- d. Will it be beneficial to all concerned?

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Enhancing the Public's Image of the Dental Profession

REPORT OF STUDY-GROUP II

In North America, professional men and women help in large measure to set the pattern of national life. The character of that pattern depends neither upon their technical ability alone, nor upon whatever ability they may possess in dealing with human or social situations. It depends, and depends critically, upon their attitudes and the way that they look at issues.

There are few professions that are so constantly in contact and so closely associated with so many people for so long a period of time as the profession of dentistry. The profession, hence, has an enviable opportunity to influence the attitudes of people toward their own health. These concepts have guided Study-Group II in its efforts to recommend methods by which the public's image of dentistry could be enhanced.

A. *Removing the Impression That Dentist's Fees Are Exorbitant.* Except in exceptional instances, dental fees are not too high. It seems reasonable to point out that fees for dental services *have* increased along with the cost of living. Criteria for establishing fees already have been developed, but there is a need for more reliable criteria that may be based on a study of relative values. The establishment of sound criteria will enable each dentist to justify better his fees to his patients. Studies of relative values are costly and efforts already have been made to develop such studies, but without success. These efforts should be renewed and pursued vigorously to stimulate national agencies (U. S. Public Health Service, American Dental Association, foundations, etc.) to undertake such a project. The observation that some patients express the feeling that fees are too high probably is based on their limited incomes and their attitudes toward and appreciation of dental services. The interpretation of the fairness of a given fee will vary from one individual to another. Unlike medicine, dentistry has not made much use of pre- and postpayment

plans. When a fee for dental services is not budgeted by a family, regardless of its fairness, it may be interpreted as too much. Dentists have improved in their efforts to present their programs of treatment and, hence, the reasons for the amount of their fees. Much remains, however, in educating patients in order to reduce many concerns. Concern may be reduced significantly by the wider use of prepayment. Other procedures are:

1. *Adjusting Fees to Reflect Reductions in Operating Time*—High-speed rotating instruments probably reduce operating time somewhat. The time that is saved likely is balanced by higher costs of operating (cost of additional training, repeated modifications in equipment, and greater need for auxiliaries). More important than saving time, the new operative methods result in greater comfort and convenience to the patient, and better attitudes toward dentistry. These advantages should be pointed out to the public at every opportunity, through personal patient-dentist relations and through utilization of mass-media.

2. *Adjusting Fees to Reflect Savings in Cost Achieved by the Use of Technicians Who Process Prosthetic Restorations and Complete Other Laboratory Procedures*—The cost of the laboratory's services have risen markedly in recent years, and the greater use of technicians probably has not resulted in any reduction in the cost of dental restorations. This increased reliance on technicians, however, does create more chair-time for the dentist and allows him to serve more patients and spend more time in diagnosis and planning treatment. These advantages should be conveyed to the public.

3. *Reducing Fees by the Effective Utilization of Assistants, Dental Hygienists, New Equipment, and by a Reorganization of the Operating Room and Its Technics*—Greater efficiency in the dental office is accompanied by expenditures for continuing education, periodic changes in the design of the office and its equipment, and in the use of more auxiliary personnel. The reduction in operative time is balanced at least in part by an increase in the dentist's overhead expense. The patient benefits in many ways from this increased efficiency, however, and these advantages should be pointed out. The advantages of greater comfort and convenience and the ability to serve more people cannot help but improve the image of the profession.

4. *Emphasizing Preventive Procedures That Improve Oral Health and Achieving a Reduction of Costs to the Patient*—Preventive practices, although they are used by dentists more than ever before, have not kept pace with research. Dentists seem reluctant to assess adequate fees for preventive services and, hence, fail to practice them. The concept of preventive dentistry should permeate the teaching in every department of dental schools, and not be limited to one or more special departments. Patients should be taught that prevention will reduce dental disease, and thus reduce the cost.

Dentists may delegate the implementation of preventive measures to auxiliaries (especially to dental hygienists), and the scheduling of patients should provide the hygienist with sufficient time to carry out this function. Dentists should support their auxiliaries in this activity, and each office should repeat instructions to patients periodically. If the environment of the office revolves around a concept of prevention, the image of the profession surely will improve.

5. *Developing the Feeling on the Part of the Patient That He Is Receiving a Thorough, Comprehensive, and Essential Diagnosis*, and

6. *Educating Each Patient About His Oral Condition and the Appropriateness of Treatment*—Many patients come to the dental office for the treatment of a single or a specific emergent problem and they may wish no other service or be unaware that they have other needs. Of course the emergency requires the initial treatment, but even those seeking care for an emergency only, should receive as complete an examination as is possible—one that makes use of all appropriate diagnostic aids. The dentist should endeavor to develop rapport promptly so that such procedures will be accepted willingly. Educational aids should be employed to explain the need for a thorough diagnosis. The diagnosis and treatment may vary from one dentist to another, confuse the patient, and dim the image of dentistry. Dental schools should reduce the time that students spend by repeating technical procedures in the laboratory by delegating these tasks to technicians. This time then could be used for learning more about diagnosis and could result in more uniformity of practice.

7. *Developing Methods for Patients to Finance Dental Treatment*—The concepts of pre- and postpayment are important to the dental services. Organized dentistry is proceeding correctly in developing

dental service corporations, and encouraging the participation of the private insurance carriers. The dental profession must assume the lead in developing methods of payment. No other group has the technical knowledge. Such programs of budgeting will reduce the public's concern over fees and will result in a greater demand for dental services.

8. *Presenting Concrete Facts About the Dentist's Costs, His Inability to Delegate Many Procedures, and the Extent of His Time Required for Operative Procedures as Compared to the Actual Time Spent by the Physician When a Patient Visits His Office*—Dentists cannot and should not be compared to any other profession. Dentistry encompasses a unique combination of technical skills and intellectual ability, and is composed of responsibilities many of which cannot be delegated to those of lesser qualifications. One must recognize that patients often compare the services of the dentist and the physician, and hence, the dentist should point out to patients why many of his services cannot be delegated to others. Experimental studies regarding the expansion of the duties of auxiliaries should be encouraged. The danger of jeopardizing service to the patient and the dentist-patient relationship, it must be pointed out, is inherent to over-delegation.

9. *Reducing the Notion That the Well-To-Do Are Charged High Fees to Provide Services for the Poor*—While dentists often reduce fees for those who have limited ability to pay for dental services, the concept of "soaking the rich," if it ever existed, certainly is no longer present. It is doubtful that this concept is held by more than a very few practitioners, and no recommendation has been made.

B. *Achieving an Impression That the Dentist Has a Personal Interest in Each Patient and Patient's Total Health*. With the current emphasis being placed on an efficient dental office there is a danger of losing the personal touch with one's patients. Departments of community (social) dentistry in the dental schools should be designed, in part, to help students learn how to deal with people and how to develop sound dentist-patient relations. A sound, sympathetic chairside manner is essential. Pre-entrance tests for dental schools should be developed to assess the integrity and human interest of applicants, and the results should be studied in evaluating each student's fitness for dentistry.

Patients should be taught the relationship of oral health to total health, and they should be taught that dentistry is concerned with the entire oral facial complex. Health histories should become a part of every diagnosis; such information is essential for the dentist to point out to the patient the relationship that exists between oral health and total health.

C. *Serving on Local Committees and Implementing Recommendations to Gain More or Improved Dental Treatment for Families Which Have Low Incomes.* Component dental societies in cooperation with public health agencies, should take the lead in developing programs to provide for the dental needs of families experiencing low incomes. Several approaches appear feasible: (1) Local dental societies in cooperation with responsible organizations should be encouraged to develop facilities for low income families. Success will depend upon the enthusiasm of the administration of such facilities. Women's Auxiliaries have organized and implemented such projects in some areas with considerable success. The attendant publicity can do much to enhance the public's image; (2) Local dental societies should encourage service clubs to participate actively in financing dental care for families having low incomes; (3) In communities with dental schools, local dental societies should cooperate with these institutions in working out programs of dental care for the needy.

D. *Organizing the Local Dental Society for the Treatment of Emergencies.* All dental societies should develop programs to treat emergencies. Guidelines should be established by constituent societies and communicated to the components. The constituent society should assume responsibility for encouraging each component to develop a suitable program. Such programs will convey the concern of the dental society for the welfare of the public.

E. *Developing Suitable Dental Treatment for Recipients of Public Welfare and for Handicapped Individuals.* Local dental societies should work with county departments of welfare to program dental care for recipients of welfare. State dental societies should work through legislative channels to get more funds (Kerr-Mills legislation, for example) for these activities and cooperate with state departments of welfare to develop suitable programs. Dental societies should make it quite clear that the quality of care for these patients is in no way less than that provided for any other individual.

Dental schools should provide more instruction on the care of the handicapped patient. When treatment becomes available in communities, this information should be disseminated widely to the public.

F. *Assuming a Full Share of Civic Responsibility as a Citizen of the Community in Which the Dentist Lives.* By virtue of his education, each dentist is a potential civic leader. Predental requirements should be reviewed. Requirement of courses in sociology, psychology, philosophy, and other subjects that help prepare the student for his civic responsibilities should be studied seriously. Departments of community (social) dentistry should promote the concept of leadership.

Dental standards of ethics often tend to stifle the dentist's participation in community, state, and national affairs. Such concepts and attitudes are not compatible with the role of the professional man in society. A dentist should be encouraged to work for his community, be it for his church, the United Fund, schools, youth activities, or government. Any legitimate public recognition which results should be regarded favorably by his fellow dentists.

G. *Promoting Community Measures for the Prevention of Oral Disease.* The prevention of all dental diseases is the ultimate goal of the profession; therefore, all dentists should support actively community measures for the prevention of dental disease. The wholehearted, active support by dentists of programs to provide mouthguards for young athletes, publicizing the dangers of smoking, teaching early detection of cancer, and promoting fluoridation of drinking water are important and will result in a favorable public opinion. Time spent in such activities without compensation is part of a dentist's responsibility as a citizen. Any attendant publicity will help the image of dentistry and help motivate people to seek dental care.

H. *Promoting Better Understanding of Dental Services by Patients Through Better Communication.* One basic theme weaves its way through all of the efforts to develop a better public image of dentistry—better communication. The best method to develop a greater appreciation of dentistry by the public is through the "face-to-face" contact of dentist and patient in the office, and dentist and public outside of the office. Perhaps through departments of community (social) dentistry, dentists should be taught different methods of effective communication and their effects on attitudes of patients.

Dentists should be warned about falling prey to the commercially oriented teacher of practice administration or those persons engaged in commerce related to the practice of dentistry, who place the dollar sign above service to people.

The dentist should be regarded as one of the outstanding members of his community, not as an impression but as a reality. If the dentist wishes to improve his image he must do it himself, either in the office or out of it. His communication with his patients and his public comes about in many ways: his voice and selection of words; his personal appearance (dress, hair, teeth, nails); and even the look on his face.

The "face-to-face" contact is the most effective means of communication. Other avenues will help: (1) local societies should work continually with all of the channels of mass communication—radio, television, and newspapers, since good personal relations between dentists and persons responsible for the various mass media are important; (2) local societies should develop active speakers' bureaus and help train dentists in public speaking and other methods to enhance good interpersonal relations; (3) local societies should plan and conduct conferences for school teachers, school administrators, and guidance counselors. These activities should be preceded by workshops at the state level to develop formats for component societies to follow. Teachers should be encouraged to present dental health educational materials effectively to the young. No person can help more than the well informed school teacher; (4) local societies and dental schools should educate counselor trainees about dentistry; (5) bringing dental health educational exhibits to local meetings is difficult, hence state dental societies should be encouraged to develop such exhibits and make them available to all interested groups such as teachers, nurses, and physicians; and (6) The American Dental Association is working effectively with mass media at a national level and is supplementing the work of local societies.

If the public's image of dentistry is to be improved, the means to accomplish this result must be conveyed to every dentist at the "grass-roots" level. Two methods to accomplish this mission should be studied: (1) exploration of the possibilities of compulsory attendance at meetings of the dental society; and (2) exploration of the possibility of demanding evidence of continuing education for maintaining membership in dental associations.

As a concluding statement, Study-Group II agreed that many factors enter into the development of the public's image of dentistry. The image will vary from one person to another and from one group to another. The dentist's image should have no upper limits. He should be known as one who is skilled technically and well educated in his profession. Equally important, he should be known as a leader in society. He should play an active role in all of the aspects of life which are concerned with the health of the people, and not limit his interests to his own professional activity. The public's image of dentistry seems to be basically good, but there is room for improvement. To realize the full potential of his image the dentist must place service to people above all else, and learn to use every available method of communication. A facade may come easily, but a true image will be developed only through time and hard work. A good public image of dentistry is the task of the individual dentist, and a good image has to be earned. There is no other way.

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Methods for Improving the Interprofessional Image of Dentistry

REPORT OF STUDY-GROUP III

Study-Group III considered the development of methods for improving the interprofessional image of dentistry. At the outset, some thought was spent on the professions which were to be included for consideration and it was agreed that the definition of professions should be limited to those associated with health services.

The Terminology: "Doctor and Dentist." Changing this terminology demands a long-range, subtle, educational program. Dentists should refer to a physician as a physician, and not by the title "doctor" alone. It is recommended that statements about the suitability of proper terminology be presented to state and federal health agencies for implementing a change.

The Impression That a Dentist's Knowledge of Basic Biological Science Is Less Than the Physician. While this impression by physicians may have existed in the past, the emphasis on basic science today makes teaching comparable. The knowledge of this comparability rapidly is becoming apparent to members of the allied health professions.

The Treatment of Oral Conditions by Physicians. The members of Study-Group III agreed that medical and dental relationships are favorable in practically all areas of the United States and they recommended that continued emphasis on this relationship be fostered. For those infrequent instances in which physicians do prescribe for or treat the oral cavity it was suggested that committees on dental-medical liaison be organized at state and local levels to study such a situation and work out a solution.

Informing Physicians About Dental Research. Members of the dental profession should accept every opportunity to acquaint the medical profession with the latest findings of dental research that are immediately applicable to the improved health and well-being of the public. Methods by which such education may be accomplished are listed:

1. By providing dental educators in the undergraduate internship and residency programs of young physicians
2. By participation in interprofessional meetings
3. By increased contribution to the medical literature
4. By the activity of the American College of Dentists in subsidizing qualified speakers to appear before medical societies to report on the findings of dental research.

The Inclusion of Dentistry as a Paramedical Profession. It appears that the administrator of a health installation should have the responsibility of directing all of the health services in his installation. The term "paramedical" in this sense is not an objectionable term, since dentists are supportive to the total health of the patient. Whenever this terminology is applied improperly, the instance should be referred to the appropriate agency of the American Dental Association.

Status of the Dentist in the Hospital. It is recognized that hospitals are being encouraged to include dentistry as one of the disciplines, and that there are problems incidental to such inclusion. It is urged that support be given to the existing recommendations of the American Hospital Association and other appropriate approving and accrediting agencies, and that a department of dentistry be included as rapidly as possible in all hospitals. The dental department should possess the status, rights, and privileges of other departments of the hospital. The department should be organized according to the recommendations of the Council on Hospital Dental Services of the American Dental Association.

Comparability of Salaries in Public Health. There is no disparity in salary of dentists and physicians having similar administrative positions at the national level, and in most of the larger states when there are comparable backgrounds of education, experience, and responsibility for programs. In those states or communities where a disparity does exist, it is recommended that the state and local dental society take appropriate action to correct this situation.

Acceptance of Specialization in Dental Practice. Where there is no general acceptance of specialization in dental practice by professional groups, education by various means seems to be indicated. The change can be brought about by the dental profession itself by:

1. Greater emphasis on the chairside education of the patient

2. More publicity from pamphlets, radio, and television
3. Interprofessional undergraduate and postgraduate education
4. Gaining mutual respect through social and professional contacts.

Acceptance of the Dentist as a Health Scientist. In order to identify the dentist with his appropriate contribution to the total care of the patient, as a health scientist, knowledge must be disseminated widely that he not only is a skilled technician but additionally is concerned with all aspects of a patient's health. He is knowledgeable in phases of a number of fields, such as basic biological science, medicine, teaching, engineering, psychology, and sociology. It is recommended that other professions be made aware of these facets by utilizing a variety of means, such as:

1. Chairside education
2. Media for publicity
3. Lectures to interprofessional groups.

Attitudes That Dental Fees Are Exorbitant. The opinion expressed by the group was that other professions did not feel that dentists' fees were exorbitant.

Acceptance of the Dentist as a Cultured Individual. The opinion expressed by the group was that there was no foundation for the statement that the dentist is not accepted as a cultured individual by other professions.

Impression of Extent of Civic Mindedness. This group thought that dentists are contributing to civic affairs in as great a proportion as other allied professional groups. The group recommends, however, that the dentist, to the limit of his time and ability, participate in important civic enterprises.

Discussion. As a general statement, Study-Group III concludes, in order to improve the interprofessional image of dentistry, that the American College of Dentists should encourage its members at the local level to initiate and carry through plans to hold combined meetings of the dental, medical, and allied groups. Such meetings should not be planned for less than 100 participants. The American College of Dentists should maintain a list of qualified speakers, pay the honorarium and expenses of the speaker, and strive to stimulate interest in the presentation of a message pertaining to the science of dentistry.

The group is aware that the interprofessional image of dentistry cannot be improved if unscrupulous methods of practice exist. It recognizes the excellent work of organized dentistry and the state agencies in prosecuting illegal and unethical violators of dental practice. It thinks, however, that a more strenuous program should be initiated immediately to eliminate the "denture-mill" type of operation and other undesirable types of practice, and it recommends that a copy of this report be sent to appropriate agencies.

The American College of Dentists, in the past, has made speakers available to appear before graduating classes of dental schools, a program that has been discontinued. The group concludes that this type of effort can accomplish much to improve the interprofessional image of dentistry and recommends that the program be reinstated, but *only* if outstanding speakers are obtained for such assignments. It recommends further, if this program is again adopted, that it be extended to include the graduating classes of medical schools.

As a final recommendation, the group urges that every effort be made to advance the image of dentistry by presenting the names of qualified dentists and dentally oriented scientists to serve on national committees which serve as consultants on science and on research. By this means the profession can contribute to, as well as gain from, the tremendous accumulation of knowledge currently available.

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Instituting an Environmental Reorganization of Dental Practice

REPORT OF STUDY-GROUP IV

There are many factors that exert an impact on the image of dentistry, and the foremost is the dentist himself. The image of dentistry is based on the esteem and respect for the profession and the individual dentist as both relate to the public, to allied professions, to associates, to colleagues, and to the community in which the dentist lives. The approach to the subject by this group was directed toward the effect that certain of the factors studied had on the image of the dental profession, and not toward practice administration. It was agreed that the environment in which the dentist operates plays a very important part in the respect with which he is held. The efficiency of practice management, with personnel trained to recognize the importance of good human relations, can do much to raise the social characteristics of the dental profession.

The first directive to Study-Group IV charged the group to observe the background of an improved public image and public appreciation and to state concretely the extent to which gains might be achieved through attention to (1) location of the office; (2) the decor of the reception room and business office; (3) economy in the patient's education; (4) spirit and behavior of the office's personnel; and (5) details for the comfort of the patient, such as furnishings, music, reading material, promptness in keeping appointments, and maintenance of cleanliness.

The second directive requested that the group state concretely and objectively the gains that accrue from the judicious utilization of (1) changes in equipment; (2) rearrangement of equipment; and (3) reorganization of the pattern of operating.

Statements follow in regard to the physical facilities of the office and the general demeanor of the dentist and his auxiliary personnel. It should be understood that these statements are only adjunctive to,

and not substitutes for the character, motivation, and competence of the dentist—which are factors of primary importance. The conduct, personal appearance, and hygiene of the dentist and auxiliaries are related factors.

Location. The office should be situated in the optimal location consistent with the needs of those persons whom the dentist serves.

Decor of Office. Careful consideration should be given to the decor of the reception room. It should be furnished in good taste with patients' comfort a paramount consideration. The finances of the office are secondary to the care and treatment of the patient. The business office should supply privacy, be suitable for the purpose for which it is intended, and yet not create a feeling of commercialism.

Pattern for Education of the Patient. It is the responsibility of the dentist to educate his patients with regard to dental health. Case presentation should be made in a manner that is based upon the highest professional standards rather than upon those practices usually associated with the market-place.

Behavior of Personnel. The office's personnel should act in a manner conveying to the patient an awareness that his problem and its treatment are their primary concern. The personnel should be cheerful and friendly, and project an air of efficiency, competence, and sympathetic understanding.

Comfort of the Patient. Serious attention to the importance of the details for the comfort of the patient will tend to enhance the dental image. Some examples of such details are furnishings, music, reading material, promptness in keeping appointments, proper ventilation, and maintenance of cleanliness.

Equipment. Equipment used should be relatively new, immaculately clean, and efficiently arranged. Equipment should be revaluated periodically, keeping in mind possible changes and rearrangement to facilitate more effective dental service.

Reorganization of Operating. Whenever the reorganization of the pattern of operating contributes to the added comfort and welfare of the patient, the dental image is enhanced.

With the background of an improved public image and public appreciation in mind, the group was directed to state concretely the

extent to which gains may be achieved through attention to (1) presentation of fees; (2) methods of payment; (3) auxiliary personnel; and (4) to list the advantages and disadvantages of group practice. It was suggested that the group prepare a statement of guiding principles for group practice. The statements follow:

Presentation of Fees. In case presentation to the patient, the dentist's image should reflect concern for the patient's oral health and well-being. It should emphasize a desire to help and should educate the patient to want to better his oral health. Fees should be of secondary emphasis, based upon a careful diagnosis of the patient's dental condition and requirements for treatment. Fees should be based upon the services rendered and the realities of cost of production, plus a reasonable profit, and should be presented to the patient by the doctor.

Methods of Payment. The practitioner should be flexible in presenting various methods of payment in order to make the needed treatment possible. To ensure a harmonious relationship, the dentist and the patient must have a clear and complete understanding of their responsibilities to each other at all times.

Dental Auxiliaries. Properly trained dental auxiliaries are necessary, important, and effective members of the oral health team. The dentist's professional image is enhanced greatly when he concentrates his efforts on those procedures, which only he should perform, and delegates all other functions to his auxiliary personnel. Their proper utilization will provide an image that reflects efficiency of operation, allays the tensions and apprehension of patients, develops improved public relations that induce confidence in the service, and provides a fertile opportunity for education of the patient.

Group Practice. The Judicial Council of the American Dental Association has defined group practice as "that type of dental practice in which ethical, licensed dentists, sometimes in association with members of other health professions, agree formally between themselves on certain central arrangements designed to advance the economical and efficient conduct of a dental practice in order to render an improved health service to the public." Group practice can make a worthwhile contribution to the image of dentistry by conveying the impression that a more complete dental health service is available with such an organization. The advantages that such practice present in relation to the dental image can be listed:

(1) Organization for the improvement of service that reflects high professional standards

(2) Development of a sense of security for the patient in the knowledge that, when his dentist is absent, treatment will be continued by other equally competent associates

(3) Delineation of the duties of auxiliaries to facilitate improved care for the patient

(4) Provision of a broad, flexible, professional base for the care of the entire family.

It should be recognized, however, that certain hazards to the dental image may exist in a group practice. Patients must not be allowed to become "cases," to lose their individual identity, or to be subjected to impersonal attention.

The final two charges to the group were: (1) with the pattern in mind of the extensive delegation of tasks by the physician to his auxiliary personnel, proceed to develop a sensible, guiding, philosophical statement for the immediate future of dental practice—one which delimits the extent of activities beyond which delegation should not proceed in the ethical dental office; and (2) develop concrete suggestions for dealing with (a) the self-advertising dentist, and (b) the introduction of legislation by dental laboratories to permit the practice of prosthodontics. Statements from the group follow:

Delegation of Activities to Auxiliaries. The question concerning the limits of delegation of activities for duties by dentists to auxiliary personnel has been studied by other workshops on related subjects. As an initial premise, it should be assumed that dentistry could not permit the extensive delegation of tasks that are included in accepted definitions of the practice of dentistry without a certain loss of respect by the public for the value of dental education.

The action of the American Dental Association's House of Delegates in 1963 delineates five areas of duties that must be performed by the dentist:

1. Diagnosis, treatment-planning, and prescription
2. Surgical procedures on hard and soft tissues
3. Those prosthetic, orthodontic, and other procedures which require the knowledge and skill of the dentist

4. Prescriptions of drugs, medicaments, and authorization of work
5. The direction and supervision of those services rendered by auxiliary personnel.

This policy is not considered unduly restrictive since it provides a guide which may be used by the dentist as he supervises the activities of his auxiliaries. Within the framework of these guidelines, and those established by each state's legal requirements, programs of education and training for auxiliary personnel should continue to be improved. The dental student and the practicing dentist who use auxiliary personnel should be educated to the optimum employment of the abundance of auxiliary services which are ethically, morally, and legally available. Such optimum employment would so benefit the services of the dentist, and so fill the working hours of the auxiliary, as to obviate the need for expanding into those areas which should be restricted to the dentist's personal performance.

Self Advertising. Self advertising on the part of a dentist, whether in the form of soliciting for professional patronage, publicly proclaiming professional superiority, advertising fees directly to the public, or any of various similar acts, is contrary to the code of ethics which organized dentistry maintains. The individual dentist, however, who willfully and knowingly indulges in self-advertising, will not be deterred by the censure of, or expulsion from, a dental society. To elevate the stature of dentistry, the promotion of legislative action by all states to gain carefully worded provisions for the apprehension and prosecution of violators is recommended as the only effective means of controlling self-advertising.

Licensing of Dental Laboratories. In the initial stages, licensing of dental laboratories may not lead to the provision of prosthetic dental services by the personnel of laboratories directly to the public. There is danger, however, that such might be the eventual result. Maintenance of a good relationship between the dental profession and the laboratories, and cooperative efforts to solve mutual problems are deterring factors to the introduction of legislation to licensing laboratories for prosthetic services. At the same time vigilance and proper preparation to combat such legislation which might be introduced must be constantly maintained.

The public image of dentistry would be enhanced by education of both dental students and practitioners to improve knowledge of

diagnosis, planning of prosthetic treatment, designing appliances, and proper delegation to the laboratory by prescription. It should be the aim of the profession to correct any impression that the dental laboratory is the authority in this segment of dental service.

Study-Group IV recommends:

1. That the Report of this Workshop be offered to the dental profession to be used as a foundation by its individual members, academies, organizations, societies, and schools in developing detailed programs for improving their particular fields of interest, and to achieve efficiency and progress with the overall objectives of the workshop in mind. To accomplish this end, the report should be published, and reprints should be sent to the various organizations which should be interested in its implementation. The American College of Dentists also is urged to make the proceedings of this Workshop available to the participating members and other interested members of the health professions.

2. It is recommended further that the pertinent sections of the report of Study-Group IV, and those of the other Study-Groups, be compiled and included as a part of the booklet *Dentistry, A Health Service* which is distributed to senior dental students by the American College of Dentists.

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Removing Some Misunderstandings Over the Relationship of the Profession to Government

REPORT OF STUDY-GROUP V

First, Study-Group V presents a group of statements which it hopes will delimit with some precision the meaning of terms often misconstrued because of lack of specificity. Second, other aspects of the assigned topic then follow.

Governmental dentistry encompasses dental programs that supply services to specific beneficiaries. The services are paid from tax funds, and administered by a branch of local, state, or federal government.

State dentistry is the provision of dental care for an entire population, or a portion thereof, by a state or national government. Services are rendered by government employed personnel paid from tax funds.

Federal dentistry is any form of governmental dentistry that is specifically administered by the personnel of any branch of the federal government, including the Armed Forces, Veteran's Administration, Public Health Service, and other federal agencies.

Socialized dentistry is an ambiguous term that has a variety of meanings subject to individual interpretation. It connotes national compulsory health insurance to many. The use of the term "socialized dentistry" should be discontinued.

Preventive dentistry includes educational and motivational procedures and the application of practices or measures that prevent the occurrence or the progression of dental disease or disorder.

Public-minded dentistry is an ambiguous term and its use should be discontinued.

Welfare dentistry is an organized program for providing treatment to improve the dental health of a group of individuals who qualify as recipients of public welfare under the requirements of an administrative agency.

Closed panel dentistry is that type of practice in which a group of dentists share operating facilities to provide stipulated services for an eligible group; or that type of practice by a group of dentists selected by the administrators of a group care plan to render care to beneficiaries of the plan.

Dental prepayment is a system for paying the cost of dental services in advance of their receipt, through dues or premiums paid into a fund or to an organization to cover the cost of the services as they are received.

Dental postpayment is a system designed to assist individual patients to finance the cost of their dental care through the issuance of notes for later payment, usually by installment through the facilities of a bank.

Group practice is that type of dental practice in which licensed dentists, sometimes in association with members of other health professions, agree formally among themselves on certain arrangements designed to advance the economic and efficient conduct of a dental practice in order to render an improved health service to patients.

Medicare dentistry is a vague term that at this time has no precise meaning. Formerly the term applied to the provision of dental care for the dependents of military personnel, but such programs properly come under the heading of federal dentistry. "Medicare dentistry" cannot be defined until the provisions for dental care that may be included in the enactment of legislation providing for the governmental sponsored health program, popularly called "Medicare," become known.

A. *Unacceptable Types of Practice*—The types of practice most undesirable for the good of the public and the profession are those that assume control over the dentist-patient relationship and interfere with professional decisions relating to diagnosis and treatment.

B. *Types of Practice to Promote*—The profession should promote the type of practice that is in the best interest of the public, that preserves the traditional dentist-patient relationship, preserves professional autonomy, and permits freedom of diagnosis and treatment.

C. *Prepayment Through the Dental Service Corporation*—A dental service corporation may be defined as a legally constituted organization which contracts with groups of consumers to administer plans of dental care on a prepaid basis. These corporations are sponsored by state dental societies and operate on a nonprofit basis.

1. *Characteristics of prepayment* under the administration of a dental service corporation will vary with the articles of incorporation within the state in which it is incorporated. The usual characteristics are:

a. It consists of a not-for-profit corporation administering programs of dental prepayment in which the patient usually has free choice of dentist and the dentist has free choice of patient;

b. Premiums are paid to the corporation on a contractual basis;

c. The insured is eligible for dental care according to the provisions of a contract which may vary from basic minimal care to total comprehensive care;

d. The dentist is reimbursed by the corporation for his services by any one, or combination, of the following methods:

Usual and customary fee of the dentist

Indemnification or "table of allowances"

Maximum fee

Fee for service under a fixed schedule of fees

Co-payment

Deductibles

Maximal annual coverage

e. Usually a service corporation may contract for service in any manner that a dentist operates.

2. *Philosophy of Operation.* The philosophy of operation under which the dental service corporation should be organized can be stated as follows:

a. The basic concept of a dental service corporation is to make prepaid dental care available through programs administered under the direction of members of a dental profession in the state in which it is incorporated;

b. The members of the profession of that state must assume the responsibility of financing and maintaining the fiscal integrity of the corporation;

c. Pre-authorization is an essential factor to ensure the eligibility of the patient and the coverage of the contract for the service to be performed;

d. Since one of the desirable features of a contract with a dental service corporation is a good program for control of quality, mechanism for such control should be established at the component level;

- e. In the negotiation of contracts the corporation should encourage the maintenance of high standards of dental treatment;
- f. The corporation should conform to the policies for prepayment approved by the American Dental Association;
- g. All plans should be encouraged to include a sound program of dental-health education for its beneficiaries;
- h. The maximum benefit per dollar can be achieved through the not-for-profit dental service corporation;
- i. The availability of plans of dental service corporations should be made known to prospective purchasers.

The American College of Dentists should recommend that the dental service corporation be approved as an acceptable method for financing and increasing dental services and should recommend that each state exert its efforts to develop a dental service corporation. The dental service corporation is a desirable mechanism for providing dental care under governmental financed programs.

For a service corporation to be successful, the participating dentists and those about to enter the profession must be well informed about the opportunities offered by such a plan for prepayment.

D. Maintaining Minimum Standards for Dental Services in the Future—A practical method for the profession to promote in the maintenance of these standards will be found in the strengthening of existing agencies, local and national (including education), and in suggesting new methods and means of maintaining and improving the image of dentistry through expanded control of quality. In this objective, it becomes necessary to review many dental procedures and practices. It is paramount, therefore, that national, state, and local societies and state boards of licensure cooperate with the American Dental Association and with the federal government in programs approved to expand dental health care.

A prime responsibility of the profession is to stimulate and promote the highest ideals of conduct and practice among dentists everywhere. This group recommends that the profession foster and promote procedures designed to maintain and improve standards of quality under current or any new expansion of services. In dental education, this group thinks that it is the role of the profession to aid

in the recruitment of more highly qualified candidates for the study of dentistry. The following observations are presented:

1. *State Board of Dental Examiners.* In addition to the administration of all dental laws, a new duty of the state board may be suggested as that of designing standards to improve the quality of service through continued education. In this context, the group concludes (a) that some form of required program should be devised for keeping dentists abreast of the rapidly expanding biological and technological knowledge; (b) that dental schools and dental societies should make refresher and short postgraduate courses more widely available to all dentists, even in remote areas.

2. *Continued Education and Membership.* This group concluded that continuing education should become a prerequisite for continued membership in the American Dental Association, and that the proper agency of the American Dental Association should study, evaluate, and make positive recommendations concerning continuing education.

3. *Recertification.* This group was opposed to any periodic certification. It concluded that tenure of license should be continuous and for life, except in instances of due and fully proven cause. Refusal to adapt to the accepted, ethical, physical or mental standards for practice may present reasons for the withdrawal of licensure. It was the consensus of the group, however, that stringent efforts toward public protection must be exercised at all times. The earned rights of the individual practitioner also must be zealously guarded, and must in no way be subjected to arbitrary action.

4. *Local Committees on Grievances.* These committees which bear a variety of names, such as committees on professional relations, mediation, arbitration, and grievances, are more accurately designated by the title "Committees on Professional Relations." This designation would relate more closely to the usual manner of their operation. It is the consensus of the group that all matters of grievance or concern generally can best be handled at the most proximal source—the local level. All matters in this area of conflict should first be presented to, and considered by the local committees on professional relations. The right of appeal, however, all the way to the House of Delegates, always must remain inviolate. Nowhere in hearings should there be a place for civilian agencies, such as the Cham-

ber of Commerce or the Better Business Bureau, except for mutually desired consultation.

5. *Licensure and Ethics*. While licensure has its base in moral and ethical judgments, its legal statutes are drawn on the basis of minimal standards of knowledge, skill, conduct, and moral values acceptable to society and woven into law by the state legislatures. It extends legal consent to the individual to practice his profession. Professional ethics, on the other hand, include and extend beyond the law. The "Principles of Ethics" of the American Dental Association through the component level, evolve from the inherent privilege of a profession to govern itself and is based on the provisions of the Golden Rule. As a general statement, it may be said that professional ethics represent a self-imposed discipline and dental law reflects a mandate of the people as expressed by their legislative bodies.

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Identifying and Planning Technics of Research to Gain Methods for Measuring the Various Images of Dentistry

REPORT OF STUDY-GROUP VI

This group began study with a series of pointed statements and questions in reference to the purpose of its assignment, and whether the group was capable of completing the assignments during its meetings. It was decided quickly that the group should not subject itself to an academic exercise, and that the total assignment was an impossible task to perform within the prevailing time limitations. Time was spent in discussing the objectives of the group, and to establish a springboard for the recommendation of a series of active programs designed to assess the image of dentistry among selected groups of the population. A prompt consensus was to emphasize before any specified study was begun, that a complete review be made of all related work which has been completed or initiated by others.

Three questions were listed to bring the objectives of the group into focus:

What does the group want to identify?

What methods does it use?

What will they cost?

All subsequent discussion and recommendations were directed toward the desire of the dental profession to provide more and better dental care for the public. Improvement of the profession's image should contribute toward the satisfaction of this objective.

A. Studies to Assess the Opinions of Dentistry Now Held by Population Groups—A partial order of priority was determined:

1. Study those people in segments of the public who are experiencing low and high incomes and those experiencing low and high educational attainment, to determine their image of the dentist and the relationship of those images to:

Age
 Economic status
 Educational status
 Availability of service
 Competition with other needs
 Previous experience
 How they see the dentist (if contacted)
 Urban living
 Rural living
 Relevance of importance of treatment
 Emotional consideration
 Self-assessed needs versus actual needs
 Number of visits to the dentist
 Idea of the profession's responsibilities to the public
 Attitudes toward dental care sponsored by government and by prepaid programs.

2. Set up categories of dentists to study their image of themselves and the implication of this image in relation to:

Age
 Income
 Type of practice
 Geographical location
 Educational attainment
 Use of auxiliary personnel
 Their idea of what the public thinks
 What they say about the public
 Attitudes toward dental organizations
 Attitudes toward colleagues and specialists
 Attitudes toward dental schools
 How they see themselves as citizens
 Attitudes toward career-guidance
 Impact of professional journals
 Attitudes toward governmental sponsored programs of health care and prepaid health care.

3. Study the image of dentistry in terms of the attitudes of auxiliary personnel and the effect of their attitudes on the efficiency of the office:

What they think of dentistry
 What they think the public thinks of it
 What they think of their relationship with the dental profession
 What caused them to choose their vocation
 When was choice first made
 What are their complaints
 What keeps them in their vocation
 The impact of professional journals (publications)
 Attitudes toward governmental sponsored health care and prepaid programs for health care.

(Special attention should be given to studies which will determine why auxiliary personnel leave the field either temporarily or permanently and whether their reasons are related to the image of dentistry.)

4. Study of teachers in elementary schools who relate to dentistry:

Attitudes toward dentistry

Whether dental health education is taught in the system

Whether they teach dental health education

Whether they think they should teach it

How they think it should be taught

Whether they think it should be taught

The timing in teaching it

Parental reactions to the teaching of it

Personal data of teachers

Personal data of parents

(Any study of teachers should be carried out in depth after which additional steps should be taken to determine the teacher's influence on children in reference to knowledge of dental health gained and the changes observed in behavior regarding practice for dental health. Additional studies should be made of the same relationship in other appropriate school environments.)

5. Study of students (high school, college, dental [including freshmen, seniors], and graduate dental students). No list of specific areas for questioning was developed.

6. A study of the image of dentistry held by the medical profession should be determined regarding:

Hospital relationships

Group practice

Referrals

Specific views about the dentist himself and the dental profession as a whole.

(In the studies of these groups of the population, the data gathered should include an assessment of the emotional dynamics associated with the information of attitudes as well as the influence of the opinions of "significant other" people associated with the individual being questioned. Because some persons' opinions count more than others, their influence on the information of attitudes in another person must be considered.)

B. *Analysis of the Media of Communication.* The consensus of the group was to assign the analysis of the media of communication

a low priority because such a task is vast, complex, expensive, and will not yield as much useful information as the analysis of the image of dentistry in the various groups of the population previously indicated. It was decided as desirable, however, to remove professional publications from this category, and to study their impact on the image of dentistry through questioning in the appropriate populations to be studied.

C. *Procedural Recommendations for Gaining Useful Data.* The group concluded that its members could not make appropriate *technical* recommendations for surveys in the time allotted, and that the *validity* of data acquired would have to result from technical negotiations between the College and the agency selected to perform the research. The validity of the data will reflect the technical competence of the investigators. The members of the group concluded that data should be acquired which could lead to action to improve the image of dentistry, and this consideration, too, influenced the decision to substitute *useful* for *valid*.

In the development of plans for the acquisition of useful data on the images of dentistry, the group felt that there were certain actions which the College must take independently and initially, and certain requirements which the College should demand of any agency that undertakes research for the College. The group recommends that the College take steps to determine: (a) the present state of knowledge about the several images of dentistry in the groups of the population listed; and (b) define what it wants to know additionally about these groups.

Accomplishment of these steps may require committee action or they might be accomplished by contract with another agency.

In light of the recommendations of this group, once the College has assessed the state of knowledge and reached decisions about specific groups for further investigation, it then would be in a position to determine how it proposes to accomplish its objectives. It may wish to sponsor projects of research itself, but its primary function will be to stimulate the efforts of other agencies and institutions to engage in useful research in its field of interest. Consideration should be given to the establishment of a full-time position in the College for this purpose.

In the implementation of the proposal to sponsor research, directly or indirectly, the following critical questions become important

requirements for the College to consider for each project which it promotes or in which it engages:

Will there be a pilot study in order to sharpen the focus of the research?

Will the researching agency develop a preliminary draft of the questionnaire or interview-schedule for pre-testing?

Will the questionnaire be available to the College for final review before it is used?

Does the selection of the sample provide for adequate numbers and distribution of respondents and for adequate levels of confidence?

Does the proposed analysis of data meet modern statistical requirements?

Have provisions been made for adequate publication of the findings?

This group wishes to emphasize that many other dental and related organizations are interested in, and also engage in, research related to the image of dentistry. It is recommended that the College keep other agencies informed of its plans and, to the extent possible, coordinate its efforts with other dental and auxiliary organizations.

D. *Costs.* In considering this assignment, the consensus of the group was that its ability to place a dollar-value on research which was not yet defined would be problematical. The cost of studies made on each group of the population listed should be classified:

Costs of Preparation	20-30 per cent
Costs of Gathering Data	} 68-78 per cent
Analysis of Costs	
Costs of Publication	2 per cent

Specifically, the costs of gathering data would amount to approximately \$6.00 for an interview of not more than three questions, \$10.00 for an interview of 10 to 15 questions that would last 30-40 minutes, and \$20.00-\$100.00 for an "in-depth" interview, depending upon its extent. Every dollar which is spent for interviewing would require \$2.00 for processing the data. The total cost of research on a given group of the population would depend upon the size of the sample chosen.

In addition to the cost of the studies, the College would have to plan for increase in its budget to support the position suggested for

consideration under assignment C. Since this position would require expenditures for salary, secretarial service, travel, and miscellaneous support, the proposed annual budget for this position was estimated by the group to approach \$30,000.00.

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Where Do We Go From Here?

A Summary of the Workshop

NATHAN KOHN, JR., M.A., LL.B., Ed.D.

The image, or profile, of dentistry is not a constant thing. Part of our problem is not only the definition of the image, but the recognition that the social changes of our society are so quick and so catastrophic that even as we study them, there will continue to be major changes. Therefore, one of my first premises is that however we study or implement the findings of the Workshop, it must be done through a process which is self-perpetuating. It cannot be done by a single study, at a single time, or by a single investment. It has to be a process which is on-going, because the first design of a process cannot fit the problem at that moment, much less future problems; it has to have built-in means of self-correcting, self-adapting, and self-adjusting.

From a historical perspective of dentistry, its growth and stature in the mind of the public, in the minds of other professions, as well as in the minds of dentists, has been tremendous. But we must look to our present and future opportunities and problems. We must face a projected growth of need and responsibility. Even though dentistry has matured in a remarkable fashion, and is continuing to mature at a rapid rate, the probabilities are that it is not changing as fast as the climate of dentistry is changing in our society. There are things that dentists have done that few other professions can talk about to the same degree. There has been the unselfish work of thousands of dentists in preventive dentistry through campaigns to establish fluoridation and other related preventive measures. This is only an illustration of the ways in which so many dentists have responded to the importance of the service they can render, rather than only to the economic or status return of their profession.

What we face today is the problem of a generation where change is essential. The changes that have affected the profession and took ten years to be accomplished, will now be happening in a single year.

This is a difficult adjustment for professional groups who meet infrequently, and who do not always have adequately trained professional staffs. This is an important problem, one which may in part define our survival and the definition of our role in the future. It will depend on our capacity to adjust to this rate of change that surrounds us, and the change will continue to accelerate.

SOME OF THE PROBLEMS POSED BY THE STUDY GROUP REPORTS

This list is not complete. It was not possible for it to be organized so that the problems could be presented in parallel to have equal value. But the order of presentation of the problems is not necessarily of importance. Some are merely listed, others are discussed briefly. This should in no way be taken as an indication of a lack of appreciation for some over others.

1. Many dentists think that socialization is a threat to the profession, and that this threat may mar their feeling toward the profession as they have known it, and may serve to inhibit some young people from coming into the profession. This problem is almost a hysterical one with some dentists, and with others something of a crusade. This problem is closely related to definition of what the practice of dentistry may include, and what the nature of dentist-patient relationships may be in the future.

2. We can project that fast as dental practice has been changing in the last decade, it will change even more quickly in the next. There will be a great deal more preventive dentistry. This may become so prominent as to change the nature of dental practice, and the definition of the needs of the public.

3. The future of any profession is defined and determined by the nature of the students that come into it. The growing population, and the increased proportion of people who desire dental services, make the procurement and selection of dental students in the competitive world today, when there are so many occupations from which to choose and so much opportunity for people who are bright and capable, a difficult one that must be faced by each dentist in his practice, and on an organizational basis by the profession.

4. In the discussions, it was obvious that the image of dentistry held by dentists varied widely. An important problem is to so im-

prove communications and to so study the nature of obligations to the public, that the image of dentistry will emerge on a positive and constructive basis.

5. The range of concept and the image of dentistry held by other health professions is large. Because of the need for inter-referral, and of the influence that some of the health professions have on the public, the importance of making more accurate and adequate the insight into dentistry by other health professions looms large.

6. Limited studies of the public indicate that there is not a real consensus and attitude toward dentistry. It is, however, clear that those people who have contact with dentistry have a more adequate image. This defines the major problem: education of the public in terms of their dental services and how they can best procure them.

7. Another related problem is the increasing importance of an on-going appropriate relationship between public health services—both national and state—and the profession in the interest of the best use of the total resources of the community for providing dental care.

8. A definition is needed of an appropriate relationship with the public that will enable the public to procure prepaid dental services if it so desires, either through plans within industry or on an individual basis.

9. There should be recognition of the extent and nature of the responsibility of the individual dentist for the dental health, not only of his own practice, but of his neighborhood and of the community in which he serves.

10. In terms of training the whole dentist, and recognizing the explosive addition of new material to the technology and science of dentistry, the adequacy of the resources for undergraduate and graduate education should be extended.

11. The nature of the person coming into the dental school and the preparation of the dentist to be graduated, requires a review of the degree of appropriateness of the undergraduate dental curriculum. The mechanism of continuing modification and giving adequate emphasis to the importance of training the whole man as a dentist and having him prepared to deal with the whole patient, must be up-dated.

12. There is the problem of defining a flexible, suitable program of continuing education within and without the specialties.

13. There is a need to define and synthesize the organizations and activities of the dental profession more meaningfully with increased communication with special reference to the speed with which adjustments and adaptations of organizations and programs can be effectuated.

14. Points of reference for scientific, technical, and social research which will help in the process of solving the problems of dentistry should be established.

15. A better definition of referral and playback, not only within dentistry but also interprofessionally, is indicated.

16. More consideration must be given to the dentist's responsibility to the community in motivating appropriate concern of the individual for his own dental health.

17. Attention should be directed to the selection, training, and development of more adequate teachers of dentistry. On-going training is necessary for the continued adjustment of dentistry.

18. There should be continuing definition of the relationships of the roles and functions of the dentist and his auxiliary aids—hygienists, technicians, and assistants, and his relations with those who supply him various necessities of practice.

19. That some persons are unable to complete their dental program as students because of the lack of financial resources should be recognized. Financial resources should be made available to enable students to adequately complete their education.

20. The degree to which dentists should assume the financial responsibility for the growth and development of dentistry as a service to society should be studied.

21. A continuing study of programs of prepaid insurance, or other devices for paying for dental services, should be maintained and enlarged.

22. The dentist needs help in establishing the degree to which he has hostility, or other attitudes or rigidities which may in any way limit his capacity to work with auxiliary aids, to cooperate with the profession, and to serve the public.

As indicated in the beginning of this section, these problems were abstracted from the discussions of the Workshop. There is no intention to say they are the only ones, or to put them in order of priority. But, in general, these are among the basic problems that dentistry needs to solve.

SOME BASIC PREMISES RELATED TO THE PROBLEMS

At the expense of duplication, some of the concepts and problems should be redefined in terms of premises. The reason for this is that, in general, there was a relatively high degree of unanimity on these premises in the groups, and therefore these can serve as points of departure for future action.

1. The present economy of our society coupled with the needs of the public for dental care, provide an unparalleled opportunity for dental leadership.

2. To meet the challenge of satisfying the need for more dental services will require constructive cooperation of the profession, public, public health services, and other groups such as behavioral scientists.

3. Significant changes in the image of dentistry, and the capacity of the profession to assume in full the opportunities presented rest with the continuing development, training, and awareness of the dentist and the dental student.

4. The role of the American College of Dentists is that of support, encouragement, stimulation, and innovation—not of program (except when no one else participates) and never of control.

5. It is the responsibility of the profession to develop programs that will adequately motivate the public to recognize their dental needs, and to enable the patient to be willing to seek and demand the best dental care that can be made available. Further, the advances in science, longer life expectancy, and greater understanding of people, mean that this represents a continuing, growing opportunity rather than a limitation.

6. The image of the health professions in the eyes of the public, is an important part of the public's image of itself and the public's life and values.

7. Dental health already holds an important place in the scheme of values of our society.

8. The perception of the public in terms of how good the dental services it receives are implicit in the individual's concept of himself, and his place in his group, as well as his place in society. This is coupled with the extent and nature of his past experience with dentistry, and is dependent on whether or not he has ever had an appropriate dentist-patient relationship.

9. The values of our culture in the health areas, especially dentistry, stress the importance of personal values, intimacy, and personal decisions. All of which are closely related to the intrinsic meaning of private practice and the intrinsic values of a democratic society. We dare not throw away the person we are trying to help by the services, by the form or nature of the services that we are creating or rendering.

A FEW OF THE PRIORITIES AND THEIR IMPORTANCE

In studying the discussions of the Workshop groups, the problems they defined, and the recommendations they made, there are certain priorities that need consideration. As a matter of fact, in any program, for any profession, it is important to study the problems, their implications and importance, and then to organize and establish priorities. Those listed are an attempt to establish a hypothesis, which others through their greater experience and wisdom can better define and organize. Those listed are an attempt to begin to establish a series of points of reference for both research and implementation. The list is tremendously inadequate; but even such a limited approach begins the process—and that is important.

In a sense, this statement of priority deals with the criteria by which we will be able to judge whether we are approaching the problem or not.

1. Absolutely basic to changing the image of the dental profession is the behavior and the nature of the practice of the individual dentist. An insight can be gotten into the momentum and direction of the changes of dentistry through the pattern of adjustment, dedication, flexibility, and openness to change of the individual dentist in his several locations across the country.

2. Any solution to problems which is a set solution to solve a problem, at this time could, in effect, be thought of as a step backward. The priorities would indicate that we must develop, even if it takes longer and is more difficult to do. The processes of solution, which in turn can be self-adjusting and self-adapting to the continuing changes of dentistry, will have to deal with such problems as:

- a. The relationship between public health and the dental profession
- b. The relationship between public health and the public so far as dentistry is concerned
- c. The nature of recruitment and selection methods of students of dentistry

d. The method of defining the membership of the several professional specialties within the profession

e. The capacity, without overstressing from an economic standpoint, to develop patient education as a primary tool in the development of the image of dentistry and dental values with the individual

f. The acceptance of the responsibility of selection, training and continuous development of the entire auxiliary: hygienists, laboratory technicians, assistants, supply houses, and others

g. The development of the process of intra- and inter-professional referrals as appropriate and on an increasing and continuing basis

h. The better definition and development of on-going training for dentists in terms of their particular needs and opportunities, as opposed to the random offerings that now exist

3. Perhaps this can be said another way by stating: To make it possible for the dentist to enlarge and improve his own image of dentistry in such a way that he faces the future without fear; develops that flexibility to expand as a professional person; and always has available an adequate foundation for a professional and personal future, regardless of the technical, scientific or other changes, or the nature of dental treatment.

These priorities place a tremendous emphasis on the importance of, the self-study of, the various organizations of dentistry. They present the dental schools with an almost unbelievable problem of trying to accept all of the new technical and scientific material a student should know, while confining the curriculum to its present length. And at the same time, to educate the student as a person, and to teach him to deal with his patient as a person with understanding and insight.

It is important not to ignore the size and complexity, as well as the urgency, of these responsibilities. Solutions to these problems cannot be achieved through more dental schools, nor can they be achieved through the addition of a particular course or curriculum. There must be instead, a recognition of the fact that this will require, over a period of time a re-study of the curriculum and experience of the dental student as a whole. This re-definition will, in turn, perhaps indicate the nature of the continuing training that will be necessary for the dentist if he is to remain adequate in his profession.

ANALYSIS OF THE RECOMMENDATIONS AND THE PROBLEMS DISCUSSED

The recommendations of the six study-groups revealed a number of thoughtful and important concepts and ideas that require further

study. In this summary, however, we must work with the process of how this can be accomplished, rather than trying to deal with important individual subjects. The intent and the meaning of the Workshop might include the following:

1. Dental organizations at all levels need to reappraise their values and purposes, and to re-study their organizational structure and technic of membership and activities, to be sure that they are capable of responding adequately to the opportunities of the present. This major responsibility will have to be done in part by people who are professional in the field of organization, as well as those who are intimately aware and professional in the field of dentistry.

2. A process of insight and understanding into the nature of the practice of dentistry, in depth and over a period of years, must be studied continually with occasional groups of students studied when they enter dentistry and then followed by studies throughout their life cycle. This is in order to understand the adequacy of their selection, the competence of their training, the nature of their adjustment, the pattern of their continued growth, and the definition of their service to the profession and to the public.

3. The role of the individual dentist in private practice and the importance of the dentist-patient relationship must be defined continuously in such a way that in order to give services we do not lose the basis or the reason for giving the services. This means that dentistry, public, and government, must look cooperatively at not the minimums that can be achieved, but rather the maximums that any person at a given time is prepared to use in terms of dental service.

4. The organizations of dentistry must survey themselves continuously and study their effectiveness and adequacy in terms of the needs of the profession and the public. So must the dental schools set up a similar, but even more intensive, procedure of reviewing in detail the impact of the experience of dental education on the dental student, and the meaning of this in terms of the service of dentistry to the public.

5. An intrinsic part of this is to make each dentist aware of the importance of his doing an appraisal of himself, his achievements, success, contributions, his weakness and his strengths, and the degree to which he has trained or failed to train his associates. Every dentist should find means not only to continue his training, but also to im-

prove the practice of dentistry as he experiences it through the establishment of goals, the reviewing of achievement, the facing of mistakes, and the interaction with other professional people.

6. The grist for the mill of understanding the image of dentistry is the continuing study of the patient. This must be explored in terms of the climate in which the patient lives, the nature of his past experiences with dentistry, and his level of awareness as to what his real needs are for dental services. This study must include his fears and prejudices. We cannot be led astray by those who would please us; nor can we allow ourselves to be thrown off by those who would only criticize.

We need, even if the first investigations are not completely adequate, to learn of the experience of dentistry and its various specializations in the life of different people in our society, at different times and under different circumstances. The changes in the last decade, in terms of prosthodontics alone, are indescribable; changes in the future will be even greater. Therefore, this is not a study that can be done and dropped, but is a continuing work which must be planned and maintained on a perpetual basis.

In final summary of the analysis of the recommendations, I believe four things stand out:

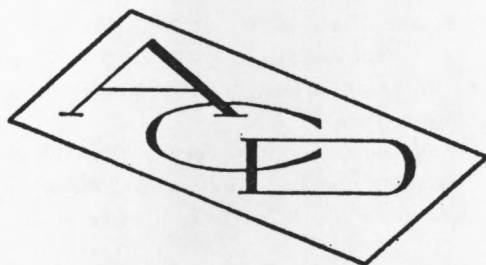
1. The need for the process of research and development, as opposed to the result or the solution type of research;
2. The need to mobilize finances in a way never before defined within the dental profession;
3. The need to mobilize dental organizations, and to coordinate and communicate in ways never before envisaged; and
4. The need to reach and communicate to the individual dentist his role, his opportunity, and his obligation on a continuing basis so that he can be a part of this program.

The implications for dentistry are revolutionary—revolutionary in the role of dental organizations; revolutionary in the dental schools; revolutionary in dental practice. This is a challenge! Can we accept that fact that we are living in a revolution? That this change affects each of us in dentistry? If so, then we can define the way in which we should be able to adjust to them.

If dentistry recognizes that this is an exploding time, and will react to change in the interest of the service that can be rendered, and will assume that broader responsibility to get ahead of change and in-

fluence the way in which new resources can best be used, then dentistry will be accelerating to meet its opportunities in a way that can hardly be described.

The role of the American College of Dentists is to continue to keep these problems, which are of such intrinsic and basic importance, before the profession and the public in the hope that by so doing persons and organizations with power and resources, will be motivated to accept part or all of the responsibility of providing the best dental care to the public that can be offered.



RECOMMENDATIONS:

Committee on Social Characteristics

ACTIONS:

Board of Regents

All of the Workshop material—key papers, study group reports, general assembly modifications, and summaries were given to the Committee on Social Characteristics for study and evaluation.

The Committee met in the Central Office, St. Louis, April 2-3, 1965, for final consideration, and preparation of its report and recommendations. The Board of Regents met April 9-10, 1965.

Interests and actions of the six study-groups overlapped considerably. It was decided to consider the various recommendations under several headings, extracting from the group discussions and recommendations pertinent material without referring to each group as such.

Members of the Committee were: Kenneth A. Easlick, Chairman, James M. Dunning, Walter J. Pelton, Vincent A. Tagliarino, Robert Thoburn, and O. W. Brandhorst, Secretary.

RECOMMENDATION I

The Committee, recognizing the increasing interest of the federal government in health care programs at this time and the responsibility of the profession in providing dental care for those seeking such services, and believing that time rapidly was running out for influencing such programs at the national level, recommends:

That the American College of Dentists urge and if necessary, plan a workshop to develop a program, or programs, for providing dental health care for the people of the United States.

ACTION: The Board of Regents approved the recommendation in principle, with the details to be developed.

RECOMMENDATION 2

The Committee, recognizing the desirability of definite steps to assure the public of the continuing competence of the practitioner to render efficient and up-to-date services and noting the trend to apply this as a requirement for membership in dental organizations and possibly re-certification, recommends:

That a study or workshop be encouraged by the American College of Dentists to explore the application of continuing education as a requirement for membership in representative organizations of the profession and certification of licensure.

ACTION: The Board of Regents agreed, and referred the matter to the Committee on Education for further study and development.

RECOMMENDATION 3

The Committee's reaction to the study-group reports dealing with the research necessary to measure the various images of dentistry, emphasizes the desirability of the Board of Regents to establish a long range program of social research, and thus assure a continuing responsibility for studies related to the providing of dental care. The possible social studies enumerated by Study-Group VI are regarded by the Committee as a reasonable appraisal of the areas of investigation which may be used profitably as a guide to develop the program. The Committee recommends:

That the Board of Regents consider the desirability of conducting a series of social research studies to determine the attitude of certain groups of the population toward the dentist and the profession.

ACTION: The Board of Regents approved the recommendation.

RECOMMENDATION 4

The Committee believes that a study of relative values would go far toward a better understanding of fee charges in dentistry, and recommends:

That the American Dental Association be urged to undertake a study of relative values as an approach to the problem of fees for dental services.

ACTION: The Board of Regents approved the recommendation.

RECOMMENDATION 5

It was recognized that the communication methods of the profession, as in other professions, are often quite ineffective. A thorough study should point out where the faults may be. The disciplines of social science should be used to full efficiency in this study. The Committee recommends:

That a broad study be made of communication methods within the profession, and between the profession and other professional groups, as well as the public.

ACTION: The Board of Regents approved, and referred the matter to the Committee on Communications.

RECOMMENDATION 6

The Committee records its interest in dental society programs to treat emergencies and urges that the American College of Dentists bring this matter forward in order to encourage local societies to develop such programs. Guidelines should be established by constituent societies and communicated to the component societies. The matter should be brought to the attention of the State Officers Conference. The Committee recommends:

That a plan for emergency dental services be developed at local levels so that suffering may be kept to a minimum.

ACTION: The Board of Regents approved the recommendation, and assigned the task to a special Committee on Emergency Dental Care.

RECOMMENDATION 7

The ever-widening gap between scientific knowledge and clinical practice makes it imperative that improved methods of graduate, postgraduate, and other types of continuing education be developed.

The need for better cooperation between dental societies and teaching institutions is apparent. Improvement in content and quality of many courses seems desirable. The Committee suggests that the American Association of Dental Schools, the Council on Dental Education, and the American Association of Dental Ex-

aminers cooperate to establish standards and requirements in the interest of the public and the profession.

This area received considerable attention and comment by the study-groups. It is urged that continued attention be devoted to action programs in this specific area. The Committee recommends:

That an effort be made to bring about a closer cooperation between dental societies and teaching institutions in providing continuing educational opportunities.

ACTION: The Board of Regents approved the recommendation, and referred it to the Committee on Education and Recruitment.

RECOMMENDATION 8

That the dentist owes something to his community in participating in its affairs, need not be argued and should be encouraged. The Committee recommends:

That dentists recognize their responsibilities as citizens in the community and participate in the affairs of the community; and *That* the Judicial Council of the American Dental Association be urged to develop a code of conduct that would guide the dentist in avoiding infractions of the Principles of Ethics.

ACTION: The Board of Regents approved the recommendation.

RECOMMENDATION 9

The Committee thinks that a new look should be taken at the entire matter of student selection, counseling, recruitment, and methods of interesting young people to enter dentistry. Such things as science fairs, and employment as helpers in dental research, should be explored as methods of attracting highly motivated and top quality persons to enter the profession and need to be reviewed. The Committee recommends:

That there be a reevaluation of present methods of career guidance.

ACTION: The Board of Regents approved the recommendation, and referred it to the Committee on Education and Recruitment.

RECOMMENDATION 10

With the rapid turnover in methodology in every field of endeavor

today, a continuing review of teaching methods is logical. Associated with this is the teacher problem. The Committee recommends:

That a study be made of teaching methods including opportunities for teacher training and continuing study and incentives.

ACTION: The Board of Regents approved the recommendation, and instructed the Secretary to communicate with the American Association of Dental Schools for information and further possible action.

RECOMMENDATION 11

The Committee recognizes the importance of payment plans that will enable persons to meet the cost of dental services. Postpayment plans have been in effect for years. Prepayment plans, on the other hand, are of more recent development. Associated with this has been the development of the dental service corporation.

Previously, the American College of Dentists has expressed its belief that service corporations, if properly organized and conducted, are an acceptable mechanism to handle the problems associated with prepayment plans in the interests of the public and the profession.

The formation of a national organization to coordinate service corporation activities, as suggested by the American Dental Association, is a logical and favorable development. The Committee recommends:

That the Board of Regents reiterate its support of the dental service corporation as an acceptable mechanism for dealing with prepayment problems; that the Sections of the American College of Dentists be urged to become active and involved in promoting and fostering dental prepayment plans; and that the Board of Regents consider using this topic as the theme of an annual meeting or a workshop in order to support the efforts of the American Dental Association.

ACTION: The Board of Regents approved the recommendation.

RECOMMENDATION 12

The ability to prepare scientific manuscripts reflects favorably on the writer and the profession he represents. Dental students should be taught how to do this. A lack of such ability reflects unfavorably. The Committee recommends:

That the American Association of Dental Schools be urged to give special attention in its curriculum studies to a course of study in scientific writing for dental students.

ACTION: The Board of Regents approved the recommendation.

RECOMMENDATION 13

A logical and well planned approach to the grievance problems of patients has much to commend it. Yet there are many societies that have no planned approach to such procedures. The American College of Dentists, after a review of the methods now used here and there, should develop a brochure on this subject and distribute it widely. This could have a great influence on improving the image of dentistry. The Committee recommends:

That the American College of Dentists prepare a guide book on grievance problems.

ACTION: The Board of Regents approved the recommendation, and referred the matter to the Committee on Professional Relations.

RECOMMENDATION 14

The prevention of oral disease is one of the greatest responsibilities of the profession. The public expects it, and looks to the profession for advice and guidance. Yet many practitioners, for one reason or another, pass up the opportunity of expanding this service. It is in order to stress the various methods in an extended program of known methods. No program could influence the image of dentistry more favorably. The Committee recommends:

That consideration be given by the American College of Dentists to sponsoring a symposium or a program at an annual meeting covering all aspects of the prevention of oral disease.

ACTION: The Board of Regents approved the recommendation.

AUXILIARY DENTAL SERVICES

A statement concerning these services and their impact on the image of dentistry.

The Committee believes that this area of interest is well in hand and needs little attention by the Board of Regents at this time.

The federally sponsored Dental Auxiliary Utilization program, designed to train dental students to use dental assistants efficiently, rapidly is becoming a potent force in stretching the services supplied to the public by present and future dental graduates. The program needs further support and a larger budget to become fully effective.

Training facilities for post-high school courses of dental assisting seem to be expanding quietly through the use of federal funds from several sources. These programs need to be vastly expanded if the profession wants better trained and more mature girls for assisting duties. The expansion seems to be taking place in those geographic areas where the profession has been active in promoting them.

Research on the expansion of the duties of auxiliaries is underway in several places in the United States and Canada. All research programs in the United States have met the American Dental Association criteria, and are being conducted within the limits established by the House of Delegates.

Training facilities for dental hygienists appear to be experiencing a healthy growth; this auxiliary group seems to warrant no further attention by the Board of Regents at this time.

ACTION: Statement accepted by the Board of Regents.

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In support of the suggestion of Dr. Harry Lyons, President of the American College of Dentists, for contributions to The Fund for Dental Education, Inc., please find enclosed my check in the amount of \$.....

Sincerely yours,

.....
.....



The Objectives of the American College of Dentists

The American College of Dentists, in order to promote the highest ideals of the dental profession, advance the standards and efficiency, develop good human relations and understanding with our patients, and extend the benefits of dental health services to the greatest numbers, declares and adopts the following principles and ideals as ways and means for the attainment of these goals:

(a) To encourage qualified persons to consider a career in dentistry so that the public may be assured of the availability of dental health services now and in the future;

(b) To urge broad preparation for such a career at all educational levels;

(c) To encourage graduate studies and continuing educational efforts by dentists;

(d) To encourage, stimulate, and promote research;

(e) To urge the development and use of measures for the control and prevention of oral disorders;

(f) To improve the public understanding and appreciation of oral health service and its importance to the optimum health of the patient through sound public dental health education;

(g) To encourage the free exchange of ideas and experiences in the interest of better service to the patient;

(h) To cooperate with other groups for the advancement of interprofessional relationships in the interest of the public; and

(i) To urge upon the professional man the recognition of his responsibilities in the community as a citizen as well as a contributor in the field of health service.

To give encouragement to individuals to further these objectives, and to recognize meritorious achievements and potentials for contributions in dental science, art, education, literature, human relations and all the other areas that contribute to the human welfare and the promotion of these objectives—by conferring Fellowship in the College on such persons properly selected to receive such honor.

This is the Preamble in the Constitution and Bylaws of the American College of Dentists.

