Dentistry Is At A Crossroads
— I. Lawrence Kerr

Is There A Future For Tenure?
The Objectives of the American College of Dentists

The American College of Dentists in order to promote the highest ideals in health care, advance the standards and efficiency of dentistry, develop good human relations and understanding and extend the benefits of dental health to the greatest number, declares and adopts the following principles and ideals as ways and means for the attainment of these goals.

(a) To urge the extension and improvement of measures for the control and prevention of oral disorders;

(b) To encourage qualified persons to consider a career in dentistry so that dental health services will be available to all and to urge broad preparation for such a career at all educational levels;

(c) To encourage, stimulate and promote research;

(d) Through sound public health education, to improve the public understanding and appreciation of oral health service and its importance to the optimum health of the patient;

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

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

(g) To make visible to the professional man the extent of his responsibilities to the community as well as to the field of health service and to urge his acceptance of them;

(h) In order 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 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.

Revision adopted November 9, 1970.
CONTENTS

New Format For The Journal

The Journal of the American College of Dentists has a fresh new look for 1982 with this issue. It has enlarged to full-sized pages, adopts a more modern style and introduces several new departments to add interest for our readers.

The Journal will continue to be a publication which focuses on ideas and opinions in dentistry while maintaining an image of professionalism and leadership for the profession.

From The Editor's Desk .................................................. 3

Letters From Readers ................................................. 4

News of Fellows .......................................................... 6

Section Activities ....................................................... 8

Dentistry and the Public's Health
  Gordon K. Ting ....................................................... 11

Dentistry Is At A Crossroads
  I. Lawrence Kerr ................................................... 14

Scenes From Kansas City Meeting .................................. 22

A Treasury Of Dentistry
  Gardner P. H. Foley ............................................... 26

Is There A Future For Tenure In Dental Education
  Robert W. Mendel and James P. Scheetz ...................... 28

Opinions, Ideas & Views ............................................ 32

Directory Of Officers ................................................ 33
Who Deserves The Honor?
Why Are Some Not Accepted?
Why Aren't More Nominated?

Who deserves Fellowship in the American College of Dentists, one of the highest honors in the profession of dentistry? Should it be the expert practitioner, the educator, the researcher, the writer, the dental society leader or the dentist involved in public service?

Why are some dentists not accepted as members of the ACD? What determines (and who determines) that a dentist's accomplishments are either acceptable, or are insufficient, to be invited to Fellowship?

Why aren't more nominated? Surely, there are many dentists who seem to fit that description of "truly outstanding," whose accomplishments have never been recognized by the College.

These questions are asked frequently and deserve to be answered. In addition, there is sometimes confusion and misunderstanding regarding the qualifications required for a dentist to be invited to ACD membership.

The Committee on Credentials has the responsibility to judge the qualifications of the nominees and to determine whether they are deserving. The Committee is comprised of five highly qualified Active Fellows who are anonymous to all other Fellows of the College, including the Board of Regents.

The age of the nominee is not a factor, though most persons must have a number of years behind them in order to have attained the necessary accomplishments. Future potential may be recognized, however, and outstanding younger dentists with unusual abilities are strongly considered for F.A.C.D.

Who deserves Fellowship? The term "truly outstanding" must be interpreted by the Committee on Credentials as it evaluates the qualifications of every nominee, with each one being uniquely different. A dentist who is outstanding in any field may be deserving.

In recent years, the Committee on Credentials has followed a policy that, to be truly outstanding, a dentist should have preferably attained significant accomplishments in more than one field of endeavor within or outside of dentistry. The expert practitioner who is only involved in treating his own patients and the excellent professor who limits his work only to dental school teaching activities, may each be judged to have insufficient qualifications. A wider spectrum of involvement in the profession is considered to be a more substantial qualification and, therefore, more deserving of Fellowship.

Why are some not accepted? In some cases, the nominee simply lacks the qualifications. More frequently, however, the reason is that the nominator has failed to fully list all of the accomplishments and activities of his nominee as evidence of attainments.

Why aren't more nominated? Unfortunately, many qualified dentists are not ACD members because they have never been nominated. That essential first step requiring a Fellow of the College to fill out the Nomination Form is considered to be a difficult task by some and is probably the largest obstacle to inducting new members. Perhaps the newly revised and streamlined Nomination Form will make that function easier in the future.

Only an Active Fellow of the College can provide the opportunity for a dentist to be invited into ACD membership by submitting a nomination. Therefore, the present ACD Fellows hold the key to the future membership of the College.

It is unfair to a deserving dentist not to be nominated. It is unfair to the College not to have such a deserving dentist as a Fellow of the College.

The F.A.C.D. is a wonderful reward, a coveted prize to those dentists who deserve recognition because of their contributions to the profession. They may achieve that goal only if they are nominated.

Keith P. Blair
I have just read with more than passing interest your editorial in the Summer 1981 issue of the Journal. I commend your thoughts and your initiative in their publication.

When I was honored with election to the College in 1976, I was overwhelmed with the roster of elected Fellows who had preceded me. The membership of the College is a virtual “Who’s Who” of American Dentistry.

Just about this time also, the profession started to become eroded through commercialism, for lack of a better word. Our profession began to lose its professionalism. Public confidence began to wane. Advertising became legal and accepted again. The ADA began to issue opinions about the status of the Code of Ethics and about how not to enforce the Code too rigorously.

I wrote a rather lengthy letter to then Executive Director Bob Nelsen on the subject of professionalism and how important I felt about its continued life. I felt that what better body of men to carry this message than the Fellows of the College.

Here under one roof, so to speak, are the leaders of our schools, our communities and our local, state and national associations. We in the College would be best able to champion the cause of our profession to show the public what American dentistry has provided in the interest of the best dental health, ever.

Would that we could envision a network of capable leaders throughout the nation, section by section, sub-section by sub-section that would have as its goal the promulgation that dentistry is dedicated to the preservation of the professionalism that has made our profession rise to the degree that it has.

We would not have to look for leadership. We have them all within our ranks. We need a national project for every section to participate in—for every dedicated Fellow to show that the ideals that gained his membership into the College still mean something to him, a vehicle for us to show the younger members of our profession how very, very important it is to maintain the values of the doctor-patient relationship that is constantly being eroded. We need to point out that if these values and standards are not kept in good faith, our beloved profession might soon become the craft it was until men of vision and dedication lifted it above and beyond the horizon past.

What say we, Fellows of the College, pillars of our chosen profession. Shall we take the gauntlet and not leave it for others to do battle with public opinion. Shall we be the ones to lead our colleagues in maintaining our professional values, or Heaven forbid, shall we once more leave it for another day—for someone else.

Miles Lazerwitz
Ridgewood, New Jersey
Dental Advertising—Its Ramifications

The Major ramification of the advent and growth of dental advertising has been and continues to be the intrusion of promoter dentists and non-dentists into dental practice. Their interest is not an expression of their concern about the standards of quality and health, or the establishment of alternative systems for delivering health care to people who need it but to translate these concerns into money making ventures. While there is nothing wrong with making money, the problem is that these ventures are so structured as to deprive patients of freedom of choice of system as well as freedom of choice of practitioner. These advertising clinics dictate a patient-dentist relationship on a most elementary level and do not encourage or promote quality health care. Ever changing personnel does not encourage stable relationships.

This intrusion or involvement by advertisers has had a direct and profound effect on the established dental community, as well as on dental economics. No longer can we practice in self-imposed insularity, safe from the social and economic upheavals surrounding us. Our fee structure is being questioned, our patient-dentist relationship is being disturbed and, most of all, there appears to be a direct attack on the need for professionals to render care.

One must not close his eyes to the fact that change is occurring and inevitable. Dealing with change at any time is difficult and some of the feelings of inadequacy and frustration are by-products. We may all have to wait until the dust has settled before we can deal completely with the changes.

At the present time, there can be only one adequate response to advertisers and that is fourth tier involvement á la Avrom King. By fourth tier involvement, I am referring to your first and last line of defense, your voice—your Dental Society.

There is no doubt in my mind that we can, as a group, influence the course of events by acting together and offering reasonable alternatives. But you, the membership, must become involved. Together we must rekindle an acute awareness that we are vital participants in the social and economic affairs of the community at large and as such are concerned with its needs. We must participate as citizens and speak out to our friends and neighbors.

At the same time, we must not condone the destruction of that intimate relationship that exists between patient and dentist. Nor should we permit the destruction of our professional goals and standards to provide first-rate dental care to all people. The answer then lies in the unity of those of us who choose not to advertise and to learn how to communicate our overriding concerns and caring for our patients. This, too, is advertising and marketing but in an alternative manner.

If you don’t know what your Society is doing for you, perhaps becoming involved will enable you to get some answers. Failing this unity of effort, the patient-dentist relationship may be lost, freedom of choice will be lost and the advertiser may become the dominant factor. We could then paraphrase an old cliche, “We have met the enemy and they are us.”

Leo Taft
Garden City, New York
Domingo Donate-Torres has been named Professor Emeritus by the University of Puerto Rico. He was one of the first faculty members at the School of Dentistry at the University of Puerto Rico and served that institution for fifteen years as its Associate Dean. For the past ten years, he has been Chief of Dental Service for the Veterans Hospital at San Juan, Puerto Rico.

Ralph R. Lopez, Santa Fe, New Mexico, has been awarded the Tufts University Presidential Medal in recognition of his contributions to the health professions. President Jean Mayer of Tufts presented the award to Dr. Lopez at the University of New Mexico commencement exercises for the Medical School on May 15. Dr. Lopez is a former ADA Vice President.

Vincent V. LaBruna, an orthodontist in New York City, has been selected to be the recipient of the Eastern Dental Society's Man of the Year Award. The presentation was made at a dinner attended by local civic and political dignitaries along with dental society members.

Left to right: Dean Richard D. Mumma, Jr., of New York University School of Dentistry; Dr. David Kratenstein, President of Eastern Dental Society; Dr. Vincent LaBruna, Recipient of the Man of the Year Award and Sister Joseph Tsuei, MSC, President of Cabrini Medical Center
**John M. Coady**, Executive Director of the American Dental Association has been named Alumnus of the Year by the Loyola University School of Dentistry at Chicago. The award was presented at the 99th Annual Homecoming Banquet in April.

**John F. Helfrick** of Detroit, Michigan, was recently elected as chief of staff at Sinai Hospital of Detroit. Dr. Helfrick also chairs the Hospital's Department of Dental and Oral Surgery and is chief of Oral and Maxillofacial Surgery. In addition, he is co-director of the Head and Neck Tumor Clinic, director of the Cleft Palate Clinic and director of the Oral and Maxillofacial residency program.

**Richard J. Reynolds** of Memphis, Tennessee and the current President of the American College of Dentists, was named Alumnus of the Year by the University of Tennessee School of Dentistry.

**Matthias J. Hourigan** has been appointed Associate Professor and Head of the Oral and Maxillofacial Surgery Section at Southern Illinois University School of Dental Medicine. He recently retired from the U. S. Army Dental Corps with the rank of Colonel.

**Harold L. Martin** of Flora, Illinois, has been elected President of the Illinois Dental Service (Delta).


**Saul B. Arbit** of Milwaukee, Wisconsin was installed as President of the American Association of Dental Examiners after serving four years on its executive council. Formerly he was Chairman of the Wisconsin State Board of Dental Examiners.

**Marvin C. Goldstein** of Atlanta, Georgia was named 1981 Man in Dentistry of the Northern District Dental Society. He is Chief of Staff at the Ben Massell Dental Clinic and Clinical Professor of Orthodontics at the Medical College of Georgia School of Dentistry and is well known as an innovator in orthodontic treatment. Dr. Goldstein has achieved a remarkable reputation as a business man, civic leader, humanitarian and fund raiser.
**New England**

The annual meeting was held at the Sheraton Hotel in Boston. Guests of note were ACD Regent Gerard McGuirk, Massachusetts Dental Association President Herbert Schilder, and ADA Trustees Donald Bentley and Joseph Hagan.

Regent McGuirk brought greetings from the ACD Central Office and reported on progress to date in microfilming College files and in computerizing procedures. The guest speaker was Assistant Dean Jay Stinson of Tufts University who spoke on "The Changing Dental Applicant". He stated that only a few years ago there were close to 25 applicants for every dental school seat and now we have only 1.3 applicants for every opening. Dean Stinson cited the main reasons for this change as the cost of dental education, the overcrowding in numbers of dentists, and the cost of opening a practice. He also commented that other fields, such as engineering and business, are gaining in popularity over dentistry.

Newly elected Section officers are John R. Mann, Jr., Chairman; Ehrling Johansen, Vice Chairman and Sumner Willens, Secretary-Treasurer.

**Alabama**

The Alabama Section sponsored a continuing education program on April 3 in cooperation with the University of Alabama School of Dentistry at Birmingham. This was the third program in a series supported by local Fellows of the American College of Dentists. Tuition was free for all dentists practicing in Alabama.

The clinician was Dr. Wallace V. Mann, Jr., Dean of the University of Mississippi School of Dentistry in Jackson who reviewed new concepts and techniques in periodontics.

Gray Carter

Sumner H. Willens
**Southern California**

The midwinter meeting of the Southern California Section was held at the Atlantis Restaurant, overlooking Mission Bay in San Diego.

National ACD Editor, Keith P. Blair, reported on College activities around the country, current changes in the ACD Central Office and recent actions of the Board of Regents.

Guest speaker was Dr. Carlton H. Williams, ADA Past President from San Diego, who addressed the group on, "The Fragmentation of our Profession vs. A Strong Unified Profession in the '80's."

Lennart E. Karlson

---

**Northern California**

The Section met at the Fairmont Hotel. Guest speaker was ADA President-Elect Burton H. Press who is also Assistant Dean at the University of the Pacific School of Dentistry in San Francisco.

Dr. Press challenged the group with his dynamic presentation covering such subjects as communication, manpower control, marketing of dentistry and new methods for funding the dental education system.

He asked, "Does the College have a plan for the younger practitioner?" He urged that dentists, who are practicing less than full-time, utilize younger dentists in their offices the remainder of the week to assist them into traditional practice. The only alternative for many recent graduates is to be employed in large clinics.

William A. Elsasser

---

**New York**

The New York Section met at the New York Hilton. Dr. Gerard E. McGuirk, ACD Regent for Regency 1, presented a eulogy for our recently departed member and ACD National Treasurer, Dr. George Mullen.

ACD Executive Director, Dr. Gordon Rovelstad brought greetings from the Board of Regents and enlightened the group about current activities of the College and the ACD Central Office.

Assistant Dean Howard L. Ward, representing Dean Richard D. Mumma of New York University College of Dentistry, presented Mr. Michael Sinkin with the Section's Certificate of Merit.

Associate Dean Irving Naidorf, representing Dean Ralph Formicola of Columbia University School of Dentistry also presented a Certificate of Merit to Mr. Allan Kucine.

New officers elected were George L. O'Grady, Chairman; Arthur Resnick, Vice Chairman; Howard L. Ward, Secretary-Treasurer; Robert L. Fisher, Historian; Henry I. Nahoum, Immediate Past Chairman and Joseph Fiasconaro and Louis Marino, Members of the Board.

Howard L. Ward
Oregon

The Section is planning a survey to collect data on the feelings and reactions of dentists in Oregon, Washington and British Columbia regarding expanded duties for auxiliaries. The data will later be used for a possible conference on that subject.

Hopefully, the information gathered by the survey would be useful in determining auxiliary goals and objectives, offer guidance to the educational institutions, reduce present antagonisms and maximize professional and personal potentials.

This data may also help to better interact and communicate between groups in the dental family.

Recently elected officers of the Oregon Section are Martin G. Kolstoe, Chairman; Gerald R. Wolfsehr, Vice Chairman and Robert Sheridan, Secretary-Treasurer.

Robert Sheridan

Hawaii

During 1981, five boxes of ADA Journals (243 copies) were collected and sent to dental schools in Indonesia. Transportation was arranged by Dr. Victor Niiranen and Captain Noel Wilkie.

New officers elected for 1982 were Allen M. Ito, Chairman; Kanemi Kanazawa, Vice Chairman and John M. Fujioka, Secretary-Treasurer.

Allen M. Ito

Maryland

The annual Section business meeting was held at the Woodholme Country Club in Baltimore, with the largest attendance in the history of our Section.

Guest speakers were Mr. Roy S. Bredder, JD, Secretary to the ADA Council on Legislation at the Washington, DC ADA office, and Dr. Gordon H. Rovelstad who is Executive Director for the American College of Dentists.

New Section officers are Bernard Gordon, Chairman; Frank A. Dolle, Vice Chairman; William R. Paterson, Secretary and Arnold S. Feldman, Treasurer.

Dr. Gordon H. Rovelstad, left, ACD Executive Director and Maryland Section Chairman, Gerson A. Freedman are pictured at the University of Maryland Dental School on American College of Dentists Day.

Joseph Pollack

New Jersey

The New Jersey Section met at the Ramada Inn in Clark, N.J. Dr. H. Curtis Hester, ACD Regent for Regency 2 addressed the Section on recent activities of the College and on the meeting of the Board of Regents held in Kansas City.

Guest speaker was Dr. Alden Haffner who is Associate Dean for Health Sciences at the State University of New York at Albany. Dr. Haffner stressed that professionalism is not changing—only the delivery of dental care is changing.

Dr. Haffner urged that a new survey on the status of professionalism in dentistry should be conducted by the dental profession.

New officers elected were Thomas M. DeStefano, Chairman; Joseph Pollack, Vice Chairman and Clifford W. Doeringer, Secretary-Treasurer.

Joseph Pollack

Upper Midwest

The Section is considering a proposed project dealing with a professional responsibility curriculum in dental education. Chairman Daniel E. Waite explained how the Fellows in our Section might become involved in such a project at the University of Minnesota School of Dentistry.

The School has recently surveyed 700 Minnesota dentists to determine the most frequently occurring problems confronting dentists in this area.

Eric E. Stafne
University students today are very pragmatic, and a larger number of them are career oriented. While not all of them actually plan to enter a professional school such as law, medicine, dentistry, or nursing, they are curious about the "real world" around them and are not content to deal only in abstractions in their education.

In this climate, professional schools on university campuses can offer a unique educational opportunity to these students by providing tangible links between the theoretical world of general academics and the applied world of professional activity. Dr. David Saxon, President of the University of California system, recognized this when he stated that professional schools can provide a college-level student with an opportunity to test academic theory against a "real world" setting. In these comments Dr. Saxon called upon the medical campuses of the university to provide courses "... aimed specifically at general campus students, those not even specifically interested in becoming health professionals..."4

The School of Dentistry at the University of California, Los Angeles (UCLA) has taken the initiative by sponsoring a course especially designed for general campus students. Developed by the author and entitled "Dentistry and the Public's Health", the course is an in-depth look at the dental profession's mission in health care. Its major goals are to introduce university students to the concept of oral health and disease, prevention, dental care issues and research as part of their general education, and to allow any interested predental students to really examine all aspects of dentistry and challenge their own perceptions of its nature.

Development of the Course

A survey of existing university curriculum in 1977 revealed that very few universities had formally addressed these challenges. A small number of vocational approaches had been reported to be successful in introducing predental students to the technical aspects of dentistry.1,2,3 The UCLA Prehealth Counseling Office had been encouraging these students to carefully consider all aspects of dentistry before rushing ahead with a career decision, and the dental school had a volunteer program for predents to actually experience some of the laboratory procedures used in dentistry. The University had also recently begun a "Professional Schools Seminar Program" where faculty from various professional schools on campus could offer courses to general campus students. This seemed to be the ideal setting for an innovative dental seminar which would benefit university students. In keeping with the academic goals of UCLA, it was decided that the course would be much more meaningful as an opportunity for all university students to gain insight into the issues of health care that would affect them, rather than as a prep course for dental school.

The course as developed concentrates on five major areas of dental care:

1. Determinants of oral health, epidemiology, prevention, and control of disease;
2. Real problems of applying scientific research and development to human settings;
3. Current dental care issues as seen from the perspectives of the profession and the public;
4. The influence of technology and social change on the approaches to disease control;
5. Implications of current events
leads to a detailed consideration of issues, focusing on how society and further changes. Included here are services, and how these have growth and development of the health care system, such as expenditure in health care, utilization of dentists, discovery of oral-facial region is presented, with discussion centering on problems which will have a direct impact on the individual's future health status and which in turn will affect the types of demands made upon the health care system, such as cleft palate, malocclusion, the effects of poor nutrition, and the lack of early primary prevention, and other systemic diseases.

The class then concentrates on the etiology and treatment of dental caries and periodontal disease. Current research findings that have led to the concept of the multifactorial nature of these diseases is discussed, as are efforts at controlling these diseases. This leads to a detailed consideration of the pragmatic side of theoretical and clinical concepts. The fluoridation issue serves as an example here of the social and political problems encountered in trying to apply a scientifically well-researched and documented method on a large public scale. Basic epidemiology principles such as age adjustment are included to illustrate how misuse of data and research design can easily cause confusion in public decision-making.

The second half of the course starts with an exploration of historical health concepts and issues, focusing on how society and health professions each react to changes in the other, and how these reactions in turn cause further changes. Included here are the effects of the Amalgam War on the advancement of a major dental procedure and the public's perception of dentists, discovery of Vulcanite from Goodyear's process, the many efforts at upgrading dental education, and current spinoffs from the space program. Connections between various diverse fields are drawn to illustrate their involvement on technological advances. The rise of professionalism is contrasted with the realities of the business world in which professionals function.

Next, the course deals with current dental care issues. Topics in this section change with current events, but have in the past included denturism, advertising, malpractice, national health insurance, foreign dental systems, and expanded function auxiliaries. Various viewpoints are presented to give the students a balanced presentation of the social, economic, and political factors that affect these issues and the delivery of dental care.

It was decided at the outset that the class size should be kept under 30 students to promote effective class participation and that the course should be graded on a PASS/NOT PASS basis. Presently, grading is based on 2 exams and a written assignment. The written assignment has produced some imaginative efforts by the students, since the topics have varied with each class. In doing these, the following format was used:

The students are placed into groups of 4-5, and are encouraged to study together, plan their projects, and exchange information. Thus there is very little "competition" between individuals in the class, and a slower student is able to receive help from the group. Each group then works on a specific topic and presents its findings in a general discussion before the class at the end of the course.

Projects in the Real World

A popular topic has been investigating the feasibility of opening a dental office in a neighborhood of the students' choosing. Those who have done this project have been involved in analyzing census data visiting the area and physically surveying the daily goings-on, identifying crucial demographic details such as ethnicity of the area, age, major businesses, etc. In addition, this project required them to visit dental suppliers, landlords, and banks in order to discover the logistical problems faced by a new dentist starting a practice. In short, this project was a basic "location analysis" exercise, which is regularly performed by consultants to large organizations.

The results from this project have been interesting to say the least. Students rapidly discovered which financial institutions were experienced in dealing with dentists and how dental suppliers conducted business. They also discovered how a neighborhood can change character between census counts, and noticed details about local activities they had taken for granted before. One group discovered a region that had no population in 1970 but is now filled with residential and commercial development. Another group initially selected a location near a university, based on the premise that they could attract the nearly 30,000 students at the university. They then learned that most of the students commuted from other areas, that the college community already had a number of dentists, and that the college had an insurance plan for the students. They concluded that their location was not feasible—a very acceptable result. It was also interesting to note that while these students were quite willing to go to great lengths to do all this and felt that their experiences were valuable, many senior dental students who are required to perform a similar but much less time-consuming project complain severely that this is a waste of time. Since it is important both in collegiate and professional education to acquire knowledge and experience beyond technical skill, the dedication of the students in seminar is to be highly commended.

Another project involved con-
structing a theoretical dental delivery system for hypothetical populations, based upon the different demographics of each population. Students who did this project had to first identify the characteristics of their population, such as young families vs. old adults, income, dietary patterns, and education. They then had to decide which of the various dental delivery alternatives could be used for each of these populations, i.e., totally private dentists or dentists supplemented by expanded function auxiliaries? Massive treatment programs or health maintenance organizations? Out of pocket payments or private dental insurances? Students did not always agree on the conclusions, and were able to appreciate that health care really did involve much more than pure science.

The current class has been divided into four groups of four, and each group is conducting a survey on public attitudes towards certain aspects of dentistry and dentists, such as professional image, male vs. female dentists, advertising, and cost of dental care. Each group has total freedom to select their population, what questions to ask, and how to conduct the survey. While not a rigorous scientific study, this will give these students an opportunity to experience basic survey-taking and discover qualitatively what certain segments of the public think about the profession.

Class Composition and Feedback

A survey made of the students who have completed the course has revealed the following: 55% were males and 45% were females, ranging from 18 to over 23 years of age. Most were between the ages of 18-22. They were very evenly distributed among the Freshman, Sophomore, Junior, and Senior classes, with 1 graduate student. About one-third were majoring in biological sciences, one-fourth in social sciences, one-fourth were undecided, and the rest were scattered among the physical sciences, public health, nursing, English, and kinesiology. Sixty percent of the students stated that they wanted to be dentists; 28% were undecided, and the rest were interested in other fields including aerospace and acting.

Evaluations for “Dentistry and the Public’s Health” were initially conducted by the dental school, and currently are conducted by the Seminar Program on the main campus. The dental school evaluations used a five-point scale from 1 = low to 5 = high, with 3 = average. Students were asked to anonymously rate a series of items concerning the course and instructor, including instructor concern, interaction, learning, and content. No aspect of the course scored lower than 3, and several were rated 5.

The mean overall rating for the course was 4.80 and the mean overall rating for the instructor was 4.73. The Seminar Program used a nine-point scale to evaluate these aspects of the course, with 1 = low, and 9 = high. Again the returns were consistently high, with the overall rating of the course at 7.67 and overall rating of the instructor at 7.90. These results are very gratifying, and are significant because few courses are consistently rated this high.

Discussion

Since its inception, “Dentistry and the Public’s Health” has consistently drawn praise from the students. Based on the class composition, it has been able to attract a variety of students and not just predents—a very satisfying result. The students’ personal comments to the instructor and the Director of the Seminar Program have reinforced the written evaluation, and these students have also felt that their education has been enhanced by the material presented and their own written projects. Some of the projects demonstrated a superior ability to organize, well-thought-out methodology, and logical analysis of results. These students were quite willing to put in more effort than required of them. The classes as a whole felt that the course enabled them to really think about the way health care is provided, and many of the predental students also expressed surprise and even mild shock at how little they really knew of the dental care system. At this time, the course is so popular that there is invariably a waiting list of students each time it is offered, and the course has also drawn acclaim from the university administration.

Summary

A university level course in dental care, presented in seminar format, can be a valuable learning experience for today’s students, whether they are predents or not. The small size of the class enables students to actively participate in critically examining key dental care topics of general public concern, and since these topics do change with time, the course always has new material to be discussed. Whether or not some of these students actually become dentists, all of them will have gained an understanding of the diverse factors that affect the functioning of a major segment of health care.

References

4. Saxon, D., Is the Medical School a Proper Part of the University? Address before the American Association of Medical Colleges, San Francisco Meeting, November 14, 1976.

Reprint requests to Gordon K. Ting, DDS School of Dentistry University of California at Los Angeles Los Angeles, CA 90024.
DENTISTRY IS AT A CROSSROADS

A Presentation to the American College of Dentists October 24, 1981

by I. Lawrence Kerr

Dentistry as a profession is at a crossroads. Some have described our current state of mind as a moral schizophrenia. We have just gone through a period of unequalled scientific and economic advantages. The scope and capability for service is at an all time high. The most recent figures from the ADA and independent organizations show an increase of dentists in the higher income brackets, with the average net income of general practitioners reaching $60,000 for 1980—and yet—the most talked about subject coming into this annual session is "the lack of busyness". This seeming paradox is indeed an actuality since those enjoying this new affluence are in the 40 year old or older group, while the younger segment of our profession is indeed in difficult times. They do have a just concern about their future and it is pertinent that we meet here to discuss the pressures of the day on all of us.

A trend that runs through all of our lives regardless of age is the adjustment we must make to increasing crescendo of changes. There are changes in our life style, changes in our mores, changes in technology, changes in our attitudes and, the constant concern of the elders in the group, the changes we see in our young people. The increasing emphasis on individuality, and the disdain of the institution is both apparent and understandable in the light of the 70's. Evidence exists that the pressures of the economic picture are mounting. We see a confused picture of a return to conservatism, while at the same time new forms of dental practice are abounding.

The major concern for all of us should be the awareness that what these changes portend is the pitting of "real" professionalism against the reality of materialism as we review the so called new trends in practice. Perhaps the profession may be suffering from the most discussed "disease" of the day—Burn Out. Students of psychology indicate that, in spite of our national (professional) successes, we are restless, unsatisfied and deeply concerned about our future. In his book "Burn Out", Dr. Freudenberger describes all this unrest and relates to the impact of change.

"We are living in times of change so rapid, they've left us without moorings."

He compares our feelings to those displayed during a roller coaster ride.

"You've plunged along with it, but your system hasn't. Your head snaps, your body lurches, you're giddy and breathless." "These have been remarkable times, moving forward at breakneck speed. We have seen greater change in the past few decades, than in all of history. Like the roller coaster, it's been exciting. But for many of us a bit too fast."

None the less, we must indeed return to our moorings for the
DENTISTRY IS AT A CROSSROADS

We find that less than 50% of our 228 million population find their way into a dental office in a year’s time. The publications are full of stories about lack of busyness while half of the nation goes without dental care.

moment. For those of us here today, one of the major ties has to be the objectives of the college. The lead paragraph you will recall: “The American College of Dentists in order to promote the highest ideals in health care, advance the standards and efficiency of dentistry, develop good human relations and understanding and extend the benefits of dental health to the greatest number, declares and adopts the following principles and ideals as ways and means for the attainment of these goals.”

Then follows the nine goals which we believe forms the essence and thrust of this great organization.

We live as part of a total economic system. The familiar word today to describe the elements of that system is the study of macroeconomics. The totality of the dental activity is measured in some basic statistics. The system consists of dentists, patients, manufacturers and dealers, auxiliaries of all kinds and the livelihood that comes from the educational segment. While there is a total of 150,000-plus dentists, only about 110,000 are in private practice.

90% of these private practice dentists are in general practice, the remainder in the specialties, education, and the military. The dental “industry”, the term for all activities, will generate about 18 billion dollars this year. Inflation and increased utilization have skyrocketed the dollar figures, with the greatest boost coming from prepayment plans. The private sector provides 96% of all the funds for dentistry, far different figures than those for the practice of medicine. The increase in the cost of our services is approximately the same as the rise in the cost of living. The number of dentists is being increased in increments of 6000 per year from a dental school population of nearly 23,000 students. The key figure, however, is the number of persons who visit a dentist. Here we find that less than 50% of our 228 million population find their way into a dental office in a year’s time.

The publications are full of stories about lack of busyness, while half of the nation goes without dental care. The anachronism is too often, too simply defined. One symposium on the program of this ADA Annual Session is concerned with the “failure of organized dentistry to meet the dental needs of the American people”. Other discussions are always influenced by the phrase “there are too many dentists”. Very few ever discuss the programs necessary to fulfill the phrase, “there are not enough patients”.

The answers to all these statements is not simple, the issue is complex and the familiar cries to cut the student bodies only touch on part of the total answer.

Certain factors describe the

I. Lawrence Kerr

Dr. I. Lawrence (Larry) Kerr was President of the American Dental Association in 1979-1980. For many years he has been involved with national dental issues and dental delivery systems.

A former general practitioner, he is now an oral surgeon who is the founder and president of a multi-discipline group practice.

Among his many appointments, he is a consultant to the Robert Wood Johnson Foundation, a member of the Executive Committee for the New York-Pennsylvania Health Systems Agency, a member of the Advisory Committee on Dental Delivery Systems for the National Academy of Sciences.

He is member of the Board of Overseers at the University of Pennsylvania, a visiting lecturer at Columbia University, and an advisor at the University of Connecticut and the University of Washington.
dental market. In spite of the fact that dental disease is endemic and is the most prevalent disease of all, the American people have not sought the care they need. As we proudly hail the high quality of our American dentistry and the high capability of the dentists, we must also admit that all people are not receiving that care.

The free choice of people to seek or receive care is a vital part of our system, just as other freedoms are a part of our way of life. Our professionalism to this point simply responded to those that sought our care. Yes, our friends in dental hygiene products and commercial TV did more to stimulate the population to seek care, than any other effort. The ADA has always expended, and still does, many millions of dollars for dental health education, but this must compete with the countless number of desires and products also being projected to the people.

Even the government, during times of the New Deal, The Great Society and the rest placed a low priority on dental care. Medicaid has been a farce, and Medicare shunned us entirely. It was through dentistry's efforts that dental prepayment plans now reach 70 million people, and in spite of our "in fighting", has been the greatest stimulant to maximize our efforts. The ADA has always expended, and still does, many millions of dollars for dental health education, but this must compete with the countless number of desires and products also being projected to the people.

Even the government, during times of the New Deal, The Great Society and the rest placed a low priority on dental care. Medicaid has been a farce, and Medicare shunned us entirely. It was through dentistry's efforts that dental prepayment plans now reach 70 million people, and in spite of our "in fighting", has been the greatest stimulant to maximize our efforts.

But, I think that most of our frustrations lie in the figures revealed by an ADA survey on public opinion which showed that: 63% do not perceive the need for care
23% feel dental care is too expensive
10% fear the possibility of pain
These statements affect all of the segments of the American people and represent our greatest challenge for the future.

It was through dentistry's efforts that dental prepayment plans now reach 70 million people.

Professionalism
All this has been an introduction to discussing the issue of the day. The alternative delivery systems, the major concern about the loss of professionalism as the "new but old" entities return to the American dental scene.

There is nothing new about retail dentistry, franchise dentistry, HMO's, advertising, or the independent practice of auxiliaries. Anyone who has studied dental history, knows that thru the 1800's and the first decades of the 20th Century, we had to fight our way up from the barber chair, through the proprietary schools, and the "Painless Parkers" to the early twenties. Then, in 1926, William Gies delivered his report on dental education to the Carnegie Foundation and the major cornerstones of the profession were laid.

We now see a return to some of the practices of the past, particularly advertising, and we worry and we wonder. Is all this we are witnessing, a better way of reaching the 100+ million who do not seek our services? Are we truly the elite serving the elite? Before we can go any further, we must once more define what we mean by professionalism as we knew it, before the Supreme Court, the FTC and the economic binds created the atmosphere in which this meeting is held.

Let me assure you that we are still a private fee for service activity. The numbers game is changing, but not yet overwhelming. When we graduated from dental school, we knew we had to make a living, but believed we could do so in the area of "professionalism". G. V. Black provides a base for the definition:

"If we can admit that there are differences in the degree of moral obligation among men, the moral obligation of the professional man must be greater than that which rests with any other. For those whom he serves are dependent on his moral integrity and his skill to a degree that is greater than the obligation of any other."

In an earlier paper I considered professionalism synonymous with integrity. The accepted connotations of the word are honesty, sincerity, soundness and wholeness.

Dr. Black finalizes this definition with these words:
"The persons who enter upon a profession as their life's work are supposed to devote themselves to the welfare of man and to the communities in which they live. The professional man sells no goods. In general terms his equipment is his mental endowment supplemented by his training, which has become an integral part of himself. The professional man does not advertise or sell, he serves; he uses his mental endowment and special training to relieve the difficulties and distresses of men, and for the benefit of society or of the state."

In 1927, under many of the same circumstances we are in today, Dr. Leon Harris said:
"The great curse of dentistry is the fact that its greatest deprecation has come from the dental profession itself. We have brought it down to a level where it has been reduced to a sale of merchandise and the profit thereof interpreted as a fee for service."

Competition
Having defined one side of the equation of concern—professionalism let me now discuss the other side; the realism of the competitive world in which we live.
All of us have exalted the free enterprise system, but too many forget that the essence of that system is—competition. The major emphasis today is on competition, and I am afraid we are speechless. Were we really talking about a system of monopoly and protectionism in the good old days of solo, or group private practice fee for service? And why do we want to leave a system we have fought to develop?

The shibboleth for the coming year will be competition for better or worse.

Is advertising, the hammer that struck the blow to the “Good old days” really in the best interest of the consumer-patient? I think that the FTC is jumping up and down with glee having accentuating the concept of competition. In a recent bulletin they said “Public alarm over rising medical costs and dissatisfaction with government regulation have led in recent years to increased interest in permitting competitive forces to help provide a more efficient and less expensive health care system.”

Wotman and Goldman, after noting that the number of dental students in the first year has almost doubled since 1965 said this: “This large outflow of young dental graduates appears to be the major factor in the resurgence of competition in dentistry. The changing dental market along with the national inflation has made it difficult to begin a traditional private practice in a middle class neighborhood. Recent figures suggest that 85% of the middle class already visit the dentist.”

Rovin and Nash, in an excellent paper, evaluating the impact of new and emerging forms of dental care delivery suggest—“However, what is happening in dentistry cannot be looked at as an isolated phenomenon. The emergence of alternative delivery systems is a manifestation of a profoundly changing society in which the public is demanding better economic performance from all its systems, not just health. As a result, the shibboleth for the coming years will be competition for better or worse.”

What direction will this competition take? Who are going to be the competitors? How many non-dentists are going to be in the game? And what will be the ultimate impact on the profession? Will the private practitioners go the way of small business during the last 30 years, when big corporations nearly wiped out small business because they had greater business sense and capital? Who are the “entrepreneurs”, what do they desire and why?

What does the organized profession perceive as the factors influencing busyness, etc.

I. Factors directly affecting dental busyness
   - Inflation and the current economy
   - Slackening demand for dental care
   - Effects of preventive dentistry
   - Practice productivity
   - Manpower supply and distribution
   - Motivation of practitioners

II. Population factors
   - Higher educational levels of the public
   - New social values
   - New economic realities
   - New demographics
   - Unsettled and changing political conditions

III. Perceptual factors from the profession
   - Too many dentists
   - Not enough patients
   - Decreasing disease
   - Low population growth
   - New kinds of providers

Dental school applications are now down about 43%.

Manpower

In the area of manpower supply the dental schools are currently educating about 22,890 students. Applications are now down about 43%. In fact, Powell tells us the ratio of applications is now the same as 1961—1:1.4 applicants per freshman place. The American Association of Dental Schools indicated there would be, “1500 fewer students who will embark on dental careers” by 1985. One private school this year could not fill all the designated places in its freshman class. The reasons are—the perception that there are too many dentists, the high cost of education, the lack of low interest loans, the high cost of starting practice compared with projected income, the fact that the dental schools are no longer required by the federal government to maintain enrollments and the perception that people can start in other occupations at a higher income with a lower cost for education. In assessing manpower, dentist per population ratios are archaic. The productivity of a dentist with auxiliaries has increased so much that each dentist is a multiple producer compared to his predecessor. We can conclude the manpower discussion by the strong assumption that we have a greater manpower base to treat the people.

Qualified Practitioners

Several major impacts are now felt in the traditional system as a result of the factors previously illustrated. As patient loads decrease, there is movement toward expanding the scope of treatment into such modalities as biomagnetic therapy, mega vitamin therapy, extensive TMJ therapy, dental kinesiology, holistic den-
tistry, nutritional and genetic counseling. In paradox, we only treat about 1–2% of the periodontal problems present in the mass population. The point to be brought to this audience is the question—is all of this in the best interest of the patient, not just the provider, and is there a recognition of the competence to provide all this care?

One very noticeable change due to the lack of busyness is the referral patterns to specialists. As we do more and try more of the specialists procedures, there will be less referral. Again, we must exercise our ethical responsibility to be fully capable of rendering that particular care.

The use of auxiliaries, after all the years of argumentation on the validity of expanded function, is increasing because of the training programs in the schools. The use of EFDA's, other type auxiliaries will be directly proportional to the demand for care.

**Retail dentistry, department store dentistry, dental centers**

The location of these entities (about 63) is usually in a large department store or shopping mall. Inevitably it is a small group practice, financed by the owner-entrepreneur or by outside financing. In fact, the phenomenon of retail dentistry is of great interest to numerous corporations, many of them not in the health care business. The actual clinic is developed where traffic is very high. The claimed characteristics of this type of activity are:

- Lower fees (ranging 15%–60% lower)
- Expanded hours—7 days a week, day and evening
- Walk in service—no appointment for first visit
- High patient volume
- Visibility to many people in the mall
- Extensive use of advertising to bring patients
- Expanded use of auxiliaries
- Young dentists, at moderate salaries
- Absolute appeal to low income and infrequent visit dental patients
- Own laboratory on premises
- Use of department store credit facilities

The success of these entities will be based on how many of the “price conscious” 23% of the people can be brought in. Dr. Robert King, a pioneer said, “I don’t believe that private practitioners will lose patients to retail centers even if they are located across the street from one. Most of these doctors are not interested in the type of patient, we see.” Some surveys disagree.

Also, how long will they keep their young dentists? We all know continuity and service are highly developed characteristics of the traditional system. While there are those that have had problems, anecdotal stories tell us, there is a first surge of patients due to advertising. The clinics constantly seek more patients desirous of “low cost.” There are some studies now going on, but no hard information is yet available. Nash, reminds us that in dentistry, “the battle is won at the chair.” That is the way the patient feels about the dentist at anytime during treatment. It is the repeated returns of a patient with trust, that makes a practice grow. It is too early to tell if there are advantages to the “one trip” person who shops and who brings her children or herself to the dentist at the same time. In addition to newspapers and to other advertising, the centers take advantage of storewide promotions and mailers. It is anticipated that well over 100 million dollars a year will come from this kind of promotion.

What about quality? It is a mistake to proclaim that low fees mean low quality or that the form of practice breeds low quality. These assertions must be proven, and it must be remembered that there is no check for quality even in the most modest, solo practice. When quality assurance programs develop they will have to be applied to all practices.

Having said that, the challenge to the retail centers is for them to maintain quality and financial strength at the same time. Research into all these subjects is being carried on by the ADA and the Urban Systems Group for HHS.

We must conclude, that if the benefits of retail store dentistry match the desires of the people, these centers will be most successful. My concern is that they might fall into the hands of non-dentist owners who will be in it for the “buck”, and work the “bottom line”. Regretfully, there is evidence that some of the advertising is misleading. There is no doubt that some of these centers are flourishing, while others fail. I can assure this audience, however, that there is a lot of interest in the development of hundreds more of these centers. The use of advertising places the center at a distinct advantage, for at least the short term, over the traditional practice. How they fare...
over the long term cannot be predicted at this time. A major concern to me is that the young dentist opening a traditional practice must compete at some disadvantage, since he is seeking to serve the same patient. Of course, if these centers out-do the traditional private practitioners in fee and quality, then they will inherit the dental profession.

The referral system is one distinctly obnoxious alternative system. In this case the union, organization, or an agile salesman sells “bodies” to the dentist after he promises to abide by a specific fee schedule. This, in reality, eliminates freedom of choice by pointing the employee or union member toward a participating dentist. At the same time, the opportunity arises for kickbacks. Here again, the dentist signing up for such a plan most probably is concerned about competition and loss of patients to other participants. To me it is an example of the insecurity some of us develop in days like this. The Blue Shield system is similar, in that participants agree to accept the fees of the plan, while Blue Shield advertises their availability.

Thousands of physicians have done this since 1934, but many drop out. There is no way organized dentistry, especially this college can publicly condemn such practice, but we must wonder why it happens, and how to compete against this patient solicitation by fee acceptance.

The “discount house” is closely related but, in my opinion, bordering on the unethical and illegal. Here the dentist advertises that he will accept the insurance allowance as full payment. The variation of allowances certainly places the dentist in a risky financial position. Regretfully, some of the dentists accept a reduced fee, and illegally bill the patient or the insurance company for the rest. My experience of observation also shows that the technique of “baiting and switching” occurs in a set-up like this. However, I can assure you that many of these offices are flourishing because so many people do not want to pay out their own cash. It would seem to be a financially precarious activity in times of inflation, when the percentage cost to run a practice rises at a faster rate then insurance companies increase their benefits.

When the Reagan administration withdraws the financial subsidies and special treatment (from the HMO’s), then we will see how the competition stands up.

The HMO Capitation. There is no doubt that this model of medical delivery has become the darling of politicians and big business. The savings on cost and cost containment is based on the efforts of the HMO to keep the patient out of the hospital. Well they should, when the hospital costs in the consumer price index is 453.8, while the over-all CPI is 260.5 (100=1967). It is most interesting to note that dental services are indexed at 251.4.

Capitation in dentistry is a relatively small activity. When the Reagan administration withdraws the financial subsidies and special treatment, then we will see how the competition stands up. HMO’s are not new, there are many forms, but capitation in dentistry is new and we must have hard facts to make judgements. That the profession has concern is best illustrated by a resolution passed by the Pennsylvania Dental Association just a few months ago. After expressing concern about the loss of freedom of choice—the resolution reads “The PDA expresses its serious concern with respect to capitation dental plans in so far as these plans place restrictions on the free choice of dentist. Due to the fixed per capita compensation mechanism, capitation by definition may encourage the delivery of minimal rather than optimal dental services. Accordingly, the PDA cannot endorse or support the capitation compensation concept.”

Franchising in my opinion is not necessarily a delivery system, but in reality a first cousin to Kentucky Fried Chicken. It is a very successful management methodology possibly attractive to the young graduate who doesn’t understand the business end of practice. He is willing to purchase (along with bodies) services of management, training auxiliaries, advertising, purchasing and other services. The owner-dentist must be willing to pay the price for these services and it isn’t cheap. While there is no violation of ethics or policy, there is financial stress.

Denturism or one service dentistry, is a phenomenon of the economics of delivering prosthetic care. The delivery of a professional service by a craftsman, nontrained dentally, is strongly opposed by the profession. The story of Oregon is familiar to us all, when the lay voter selected price over training, and said he had the freedom of choice as to whom he selected to provide his services. It was a terrible blow to our ego and of course, an economic threat. Worse still, with the blessing of the FTC and others, it is an attempt to fractionate all professions, by the denial of an educational system that prepares us for total care. It was the dollar that motivated this action and, interestingly enough, it is the dollar that has slowed it down. When advertising dentists joined with dental societies in providing low cost dentures, it took the impetus out of the denturist movement. Each year a number of states consider legislation but, after Oregon, Arizona and Maine, no legislation has been passed. Now the people are saying—why not go to a real dentist?

Independent practice of hygiene—After spending the first decades of the 20th Century creating and assisting in the development of a valuable auxiliary, the dental
profession today faces a small but firm movement for the creation of an independently licensed practitioner. The hygienist would, according to a few leaders, provide a segmented service to the dental population. This movement again was influenced by economics, the FTC, changes in the health care system, federal initiatives to expand the roles of auxiliaries, the threat of the expanded function dental assistant and, in my opinion, the self interest of too many dentist-employers, who came up with too many schemes of compensation, pension denial, and failure to understand the need for career mobility and security. The American Dental Hygienists Association and the American Dental Hygienists Association for years created co-operative effort. The passage of resolutions intimating the development of independent hygiene practices occurred over the past 3 years. For the practicing dentist, the issue is basically fragmentation of his care of the patient, loss of the ability to supervise a noteworthy auxiliary and plain economics.

Fortunately, within the past few weeks, an easing of the tension has occurred after meetings between officials of the ADA and ADHA. None the less, the situation is there and the essential target has to be the welfare of the patient. There is no economic sense in splitting the profession, the consumer will just not find costs contained. There is no history to prove that splitting off of the nurse and related auxiliaries has resulted in lower fees for the patient. The ADA Board of Trustees has developed a seven point program to meet the situation, but has withheld implementation because of the current tenor of communications. We have been a very efficient team with our technicians, hygienists and assistants. It can be shown that this was in the best economic and professional interest of the patient. But, we must allow all our people to grow, become financially stable, and to be supported by the strength of professionalism.

The element of integrity is at the basis of the doctor-patient relationship... a fee should be fair to both the patient and the doctor... merchandising will destroy the profession.

Corporate dentistry. This term applies to self administered dental clinics in corporate buildings. This is a very small activity, with one notable example being in Winston-Salem. This R. J. Reynolds service is totally supported by the corporation, and the patient is offered the choice of the plan or his own practitioner. He does pay a penalty of 20% of the fee if he chooses his own. The facility is exciting and beautiful, however, and well managed with an effective quality control system. It is obviously expensive to the company. Here too, hard data on utilization and cost is difficult to come by.

Advertising

You will recall that at the beginning of this presentation, I said we may be suffering from a moral schizophrenia. This is most noticeable in our considerations of advertising. Bently defines advertising, "as any message that is broadcast or published and designed to increase the demand for services provided by a particular dentist or group of dentists. In this regard, advertising is only one method which a dentist might use to market services. Promotional messages that are directed toward patients active in the practice are not considered advertisements. Even an announcement in a neighborhood paper is directed toward a limited population and is not considered an advertisement. These methods of promotion which stress personal contact and/or recommendation are consistent with the traditional norms of promoting a dentist."

Our concern is with the advertisements that are intended to reach mass audiences. In my opinion, it is the availability to use advertisements that has led to all the new concepts and delivery systems. These, of course, focus on price and availability. Our split personalities are created by a desire to assist the population by educating and motivating them for dental health, while concerned about our young people who have the need to attract many patients as soon as possible. We weigh the value of mass exposure of our profession against the commercialism of the "pure convenience" advertiser. There are others who say that the public deserves to know what the scope of services are and their costs. Obviously, many do not know.

There are many questions that have not been answered such as: Why have previous efforts failed to bring in the mass of patients required to balance the "oversupply" of dentists? Who really is affected by advertising? What is their education and income status? What item at what price, will pay the bill? Will they return to the office, and how long will the advertising impact last? Since you need a high volume of new patients to pay for all this—where is there a breakpoint for the dentist and the patient?

The ADA House of Delegates continues to wrestle with the problem of institutional advertising and/or other marketing forms to increase the supply of patients. We want to help the young dentist, we are afraid of the misleading advertiser, we want to increase the market of patients, and we don't want a return to "Painless Parker". Therein, lies our problem.
I too am schizoid. I see and worry about the evils of merchandising and yet we need more patients. I have long argued for the local dental society to announce the opening of the practice of a new colleague. I detest the diminishing of the service aspect of the profession by many who list procedure and price. There is no room for individuality of service or ability. I still believe the element of integrity is at the basis of the doctor-patient relationship. I also believe a fee should be fair to both the patient and doctor. I believe in restraint as much as I believe that our services have a higher value than we get credit for. I also believe that merchandising will destroy the profession because anyone participating in “price wars” must ultimately decrease the cost of labor. To do that you get rid of the dentist and replace that person with piece workers at less cost.

To create the $99 denture you have to have $99 techniques and lesser cost people. Is this in the best interest of the patient? If our fees are expensive, then the market place will determine what fee the patient will pay for what quality.

Segmented markets are a way of life in the commercial world. Do we need 8 years of training to care for patients in the high-volume, low-fee, restricted-service practice? I know corporate planners and unless they are dealing with the production of high cost and high quality items, then they are not interested in high cost people. If we teach ourselves to deal mainly with the segment of highly educated—high income people, the number of successful practices will be small indeed. Who is going to take care of other patients if they wish to have care?

I do not advocate the premise that low fees mean low quality, but certainly the cost of education and setting up an office creates great strain. 67% of the graduating classes that I addressed felt they had to work for someone else because of anticipated financial strain.

Preservation of our Profession

We must preserve our profession and professionalism. Our objectives challenge us to “develop good human relations and extend the benefits of dental health to the greatest number”, I believe that the objectives are sound, that “real” professionalism can survive another round of these activities just as we can serve all the segments of American life with the proven principles of service, integrity and quality. I believe that the golden rule will stand up in the face of “what did you do for me today”. I believe that the public wants quality at a fair fee and has been our greatest ally against the forces of socialism. It will not be easy in the face of the changes that come to all about us. I believe that social responsibility is equally important to high technology and we must continue to convince the people, our patients and others, that we serve their best interests. Each patient creates two, and when we convince each one that we are interested in them as a person and not a procedure number with a fixed fee, then the future is secure. Our greatest challenge is to convince ourselves and our young people that these principles upon which this profession grew, served and prospered have withstood the test of time and with our skills we can compete in anybodys market place.

To do anything else is to deny the tenets of this College and our profession.

References

Reprint Requests to I. Lawrence Kerr, D.D.S.
Dental Wing
Medical Arts Building
Endicott, NY 13760
1981 Annual Meeting and Convocation

Left to right: Dean Richard C. Oliver, Arthur E. Comolli, ADA President John J. Houlihan and Leo E. Young, Incoming Regent.

ACD President Elect Odin M. Langsjoen, left and President Richard J. Reynolds

Photos by Edward F. Leone, DDS
In Kansas City

New officers of the College, left to right, Gordon H. Rovelstad, Executive Director; Richard J. Reynolds, Incoming President; William C. Draffin, Outgoing President; Odin M. Langsjoen, President Elect and Lynden M. Kennedy, Vice President. Editor Keith P. Blair and Treasurer George E. Mullen were not pictured.

Convocation Procession Climbing The Stairs

Photos by Edward F. Leone, DDS
Left to right, Regent Gerard E. McGuirk; Regent Paul S. Butcher; Recipient of the Gies Award, Edward V. Zegarelli, Dean Emeritus of Columbia University School of Dentistry; and Regent H. Curtis Hester.

Convocation flag bearers John R. McFarland, left and A. Edward Hall, right, line up behind Keith P. Blair, center, the Assistant Marshall for the procession.

Photos by Edward F. Leone, DDS
President Richard J. Reynolds introduces guests at Dinner-Dance.

Installation of officers at the Dinner-Dance: Standing, left to right, are President Elect Odin M. Langsjoen, Vice President Lynden M. Kennedy, Regent Leo E. Young, Regent Robert C. Coker and Executive Director Gordon H. Rovelstad. Seated are outgoing President William C. Draffin and Mrs. Richard J. Reynolds.

Seated at the noon luncheon are Dr. and Mrs. George C. Paffenbarger, left and Dr. and Mrs. Robert J. Nelsen, right. The lady in the middle is not identified.

Regent Robert Cupples carries the torch in the Convocation Procession.

Roy W. Menninger, M.D., left, the Convocation speaker is pictured with President Richard J. Reynolds.

Dr. and Mrs. I. Lawrence Kerr at Head Table

ADA President and Mrs. John J. Houlihan at the Head Table for the Dinner
Focal Infection

Although since the birth of periodical literature, with the founding of the American Journal of Dental Science in 1839, American writers had discussed the possibilities of focal infection from diseased teeth, it was the warning expressed by Sir William Hunter in 1910 that started the dramatic agitation that caused dentistry to widely acknowledge the importance of the theory.

In 1910 Hunter addressed the Faculty of Medicine of McGill University on "The Role of Sepsis and Antisepsis in Medicine." In his address he warned of the sepsis that came from accumulation around crowns, bridges, and artificial dentures, calling them, "gold traps of sepsis." However, the oral sepsis of which he complained had nothing to do with the concept that during the next decade caused the greatest concern among the profession—focal infection from the apical ends of pulpless teeth.

Directly and indirectly Hunter's propaganda had a notable effect in calling attention to the evils resulting from oral sepsis. It aided the cause of university dental schools that were demanding that more medical knowledge be incorporated in the dental curriculum and prompted many dental educators to consider the requirement of medical education as a prerequisite for admission to dental schools.

The widespread publicity given to Hunter's alarming counsels by the newspapers and magazines and by novelists and cartoonists led to the creation of several millions of medical and dental patients who were susceptible victims of the popular diagnosis then rampant: "these teeth must come out." After sacrifice of millions of good teeth, the tide of reckless postulation turned; patients, physicians, and dentists realized that they had been misled by the deceptive propaganda that had been developed from Hunter's McGill Address.

About the Author

Though not a dentist, the author is a Professor Emeritus of Dental Literature and Dental History who taught over 40 years at the Baltimore College of Dental Surgery.

He is a Fellow of the American College of Dentists and was a founder of the American Academy of Dental History. He is an honorary member of many dental organizations.

An experienced dental editor of many years, he is more recently recognized for his "Foley's Footnotes" in the ADA Journal.
Visions with Nitrous Oxide

One of the most interesting facets of the dental practice experience has received little attention by dental writers; the thoughts of patients while under general anesthesia. Dentist often hear words uttered by the anesthetized patients and also hear postoperative reports from the recovered patients. A resourceful examination of the dental periodical literature of the 19th century will show many citations of vexatious court cases involving dentists who were sometimes ruinously victimized by aggressively accusatory women who, while under anesthesia, had hallucinations of erotic attacks by their dentist. The eventual, but stupidly delayed, solution to that recurring problem was the protective presence of a female attendant for all operations on women necessitating general anesthesia.

To illustrate the fascinating interest of this aspect of the dentist's operative experience, I present the significant report given by J. B. Priestley in his autobiographical Rain Upon Godshill (1939). Priestley is the English author of several good novels and plays.

I remember once having nitrous oxide gas at the dentist's office, and as I gulped and began to suffocate I was thinking about consciousness and self-consciousness, which were topical enough as subjects at that moment. Then I suddenly saw, felt, apperceived that the problem of self-consciousness was solved for me and with if the whole problem of the universe. My vision penetrated to the very heart of all things, and I cried out in ecstasy Eureka! And it was no use, my dentist pointing out that all was over, the bad teeth were gone, and all was well, for now all was not well, for I had awakened to a muddled little world, my triumphant ecstasy had vanished with my bad teeth, and it was as if for a moment I had heard the harmony of the spheres and had then lost it for ever. I muttered something of this to the dentist, who grinned and said that his last patient had come out of the gas babbling about horse-racing . . . The vision does not come from the gas, but the gas, by blocking all access to ordinary reality, releases some part of the mind, which now looks further and fares better. There is no metaphysical ecstasy in nitrous oxide gas, the ecstasy is somewhere in me, buried deep, buried so damnable deep that I had to lose seven teeth finding it.

Dr. Evans
Natural Dentures

Dental writers and lay writers have given a great deal of attention to the multifarious interests and accomplishments of Dr. Thomas W. Evans, who was born in Philadelphia in 1823 and died in Paris, France in 1897. In 1848 Dr. Evans began his practice in Paris and soon established a reputation that brought to his office a large representation from the reigning and noble families of Europe. He occupies a prominent place in dental history not only because of the prominent patients who sought his services but also because of his contributions to the art and science of his profession. Particularly is Dr. Evans remembered for his friendship with Louis Napoleon, Emperor of France, and his dramatic action in aiding Empress Eugenie in her flight from France after the downfall of her husband's government following the crushing victories of the German armies and the rising of the Parisian populace.

In an 1887 issue the Medical and Surgical Reporter of Philadelphia published a sharply implicative account of an episode in the professional life of Dr. Evans, a native of the publication's city. The news item is titled “An Executive Set of False Teeth.”

Dr. Evans, the American dentist in Paris, made a set of teeth for an English lady, the ivories being carefully chosen from the mouths of twenty Breton girls, who submitted to the extraction for a pecuniary compensation. Shortly after the set was delivered, the lady traveled to Mentone [a winter resort on the Mediterranean coast of France], and was aroused from her bed by the recent earthquake. She is now back in Paris with sunken-in lips, having forgotten her teeth in the escape from the shaking hotel. A fresh lot of peasant girls with sound teeth are now wanted.
There appears to be support for the continued existence of tenure

It has been suggested that the tenure system in higher education is dying. While this prediction referred specifically to Arts and Sciences Colleges, some of the reasons mentioned also could be a threat to tenure systems as they currently exist in dental schools.

The purposes of this paper are to:
1. present a brief summary of tenure in U.S. and Canadian dental schools as it exists today.
2. identify some current educational and economic changes and their possible affects on current tenure systems in dental education.
3. suggest some modifications by which tenure systems in dental schools may be preserved during a period of financial crisis.

Tenure Today
A tenure system is in existence today in every dental school in the United States and Canada. To the dental school dean, a tenure system may be a means by which the school recruits and retains an effective group of faculty. In return for long term financial commitments to tenure recipients, the school usually hopes to maintain a congenial, stimulating environment in which faculty freed from concern for job security may pursue excellence in teaching, research and service. Professional activity of untenured faculty is encouraged by the prospect of

by Robert W. Mendel* and James P. Scheetz**
obtaining tenure if certain standards of productivity are met. To the dental faculty member, receipt of tenure means advancement to a position of continued employment by the institution and endorsement of one's abilities by colleagues. Appointments of tenured faculty usually may be terminated only for immoral conduct, professional incompetence, failure to perform one's duty, medical reasons or attainment of a specified age. Termination also may occur in cases where a program or a department is eliminated or in a financial exigency which threatens survival of the institution, but dismissal for these reasons has been rare in the past. A tenure endorsement by one's colleagues usually results in increased prestige because it may represent the accomplishment of many demanding tenure criteria over the period of more than five years since beginning a career in dental education. According to a recent survey of dental school deans, the tenure criteria most highly rated by the deans are effectiveness of instruction and quality of research and publications. The relative emphasis placed on instruction as opposed to scholarship varies widely among the schools and is affected by the educational philosophy of the university. Dental schools with large numbers of advanced training programs and high levels of grant support tend to require higher quality and greater numbers of publications from tenure candidates than do schools with fewer programs and grants. Tenure criteria in most schools are determined by school-wide or university-wide faculty committees according to the deans.

Since 75 percent or more of a school's budget usually is allocated for faculty personnel costs, there is a very limited opportunity for a school to reduce its budget without affecting funds targeted for faculty salaries.

The tenure process involves a successive series of reviews of the candidate's credentials beginning with a departmental committee or department chairperson. The next steps in the sequence are reviews by a school-wide faculty committee, the dental school dean, the chief executive of the health sciences unit, the university president, and finally by the university governing body. The initial decision to deny tenure is most likely to be made by the departmental chairperson or the school-wide faculty committee. Higher officials tend to support these decisions.

The tenure award is very important for both the school and the tenure candidate since the long term financial obligation by the school may be over one million dollars over a faculty member's career. At present, few dental deans view this as a financial burden to the institution. Less than one-third of U.S. and Canadian dental schools require that funds for salaries of tenure track faculty come from recurring sources and only two schools impose a limit on the percentage of faculty who may hold tenure.

Denial of tenure may mean that the faculty member must leave the school when his/her contract expires, continue employment on a temporary or part-time basis, or be reconsidered for tenure. Few schools at present report grievances filed by faculty who have been denied tenure and even fewer have become involved in litigation as a result of a negative tenure decision. This suggests that relatively few dental faculty may be denied tenure. The relative tranquility reflects the availability of dental school funding for new positions during the 1960's and 1970's and is also due to the fact that for many years there was a shortage of qualified dental faculty, particularly in the clinical disciplines. The source of many dental educators in the clinical specialties are recent graduates of advanced training programs who have the option of entering clinical practice or pursuing a career in dental education. In the past, the greater financial rewards probably have played a large part in decisions of advanced dental education graduates to enter clinical practice rather than academics and have contributed to the dental educator shortage.

Changes Affecting Dental Education and Tenure

There are indications, however, that several changes are occurring which are having far reaching effects on dental education. Dental research discoveries and recent economic trends are eliminating the shortage of dental educators and may eventually create a surplus if their influences on dental education increases. The increased demand for dental care predicted two decades ago, which contributed to the establishment of new dental schools, has been obviated by the wide spread use of fluoridation and its consequent...
reduction in the need for dental treatment for a generation of patients. Increased unemployment and a depressed economy has further reduced the public's demand for dental treatment, thereby reducing the need for increased numbers of practitioners. As a result, dental schools are accepting fewer students than previously, and therefore require fewer faculty. Presently, 28 U.S. schools plan to reduce enrollments which will result in an approximate annual reduction of 430 entering dental students by 1985. This trend may continue for a few years.

The demand for dental educators is further diminished by lack of funds for new faculty positions because school budgets today are much tighter than in previous years. Federal capitation funds provided to the schools for each dental student are being phased out and private and government research funds are becoming much more difficult to acquire. State and federal legislators are demanding more justification for appropriated dollars. Since 75 percent or more of a school's budget usually is allocated for faculty personnel costs, there is a very limited opportunity for a school to reduce its budget without affecting funds targeted for faculty salaries. If this financial crunch continues, it is possible that some existing dental schools may close and, in any case, the number of faculty in those remaining is more apt to decrease or remain constant than to expand. This possibility plus the federally mandated extension of the retirement age of higher education faculty to 70 years effective in 1982 also may result in a need for fewer new dental educators.

Unfortunately, during this time of reduced demand for professors, the pool of applicants for existing faculty appointments may tend to increase. Greater numbers of advanced education graduates faced with soaring interest rates on funds borrowed to begin practice, plus greater competition for the dental care dollars of patients, may seek the relative financial security of a faculty appointment. Long lasting reduction of the demand for, and an increase in the supply of dental faculty, aggravated by the depressed economy could produce severe and long lasting changes in tenure and other personnel policies. With a greater ratio of applicants to openings, administrators and search committees would be in a position to be more selective in appointments of new faculty. Tenure decisions might be influenced more by administrators than previously because of their knowledge and responsibility for the financial status of the school. Tenure criteria may become more stringent and tenure itself may become more difficult to obtain since those making tenure decisions might be less reluctant to terminate marginal faculty who could be replaced by highly qualified applicants.

**Effects of Retaining Current Tenure Policies**

One effect of maintaining current tenure policies during a period of financial retrenchment could be lack of faculty mobility. With a greater ratio of applicants to unfilled positions than previously, more faculty would be likely to remain in their current positions until a tenure decision was made because of reduced job opportunities elsewhere. Unless tenure standards were raised, greater numbers of faculty might receive tenure. As the percentage of tenured faculty becomes very high, the opportunity for recruitment of new faculty would tend to become very low. Lack of faculty mobility could result in fewer ideas introduced by incoming faculty with consequent stagnation and limitation of innovation and creativity within the school. It might be difficult to balance such a faculty with minority groups and women. A high percentage of tenured faculty could cause another problem for the school. In the event of a financial crisis, there would be insufficient funds available to pay the salaries of all faculty and some would have to be dismissed. Presumably, the tenured faculty would be the last group in which terminations would take place. However, the priorities of dismissals in accordance with tenure policies might not be those which would best serve the school's mission.

**Effects of Eliminating Tenure for New Faculty**

To avoid the stagnation or imbalance of faculty mentioned above, administrators might recommend appointment of all new faculty on a nontenure track. Since those temporary faculty would be unable to earn the job security associated with tenure, faculty commitment to the school might be reduced. If the policy of appointing faculty on non-tenure tracks continued for a long period and became widespread in dental education, the collegial environment resulting from the tenure system may be replaced with one of self interest. Eventually a generation of faculty members might emerge with a primary goal of increasing their marketability or enhancing their academic reputations rather than becoming involved in institutional activities.

Elimination of the opportunity to earn job security through tenure, combined, with erosion of faculty salaries by inflation, and reduced job opportunities may open the door to large scale unionization of faculty in dental education. At present the faculty of only four dental schools are represented by unions. If widespread unionization occurs, some decisions such as those on appointments, promotion, vacation policies, and insurance benefits which now fall under the purview of the administration or faculty groups, may be determined by collective bargaining which would override pre-existing poli-
cies. If tenure survives under unionism, tenure criteria and tenure decisions also may be made under the influence of union officials. Collective bargaining teams and faculty grievance committees might include professional union officials without backgrounds in dental education. An adversary relationship between dental school administrators and dental school faculty could become more common in schools, replacing the collegial fellowship prevalent in many institutions.

If the reduced job opportunities, long term competition for personnel positions and stifling of creativity previously mentioned were to continue for a long period of time, many prospective dental educators might turn to clinical practice or not enter the dental profession at all. As older professors die or retire, the lack of new individuals entering dental education could cause a more serious shortage of dental faculty than has existed in the past.

Suggested Modifications During a Financial Crisis

The effects of fluoridation on dental education manpower needs are unlikely to be reversed. However, the effects of increased unemployment and a sagging economy which tend to diminish the need for dental faculty should be reduced or eliminated once the economy returns to a healthy state. To maintain its corps of effective dental educators and yet maintain its present form. These alterations could take several forms. To speed up the turnover of tenured faculty, Spellman and Meiklejohn suggest lowering the retirement age or shortening the annual appointment of older tenured professors from a 12 month to a 10 month academic year. To stimulate the recruitment of new faculty and provide an opportunity for untenured professors to gain job security, some of the following changes could be implemented. Temporary tenure quotas could be established; the length of time necessary to achieve tenure could be increased; or tenure could be restricted to full professors. To decrease the schools' financial obligation to faculty, new appointees might be given appointments in which only a part of the faculty member's salary would be provided by the school and they would receive time to devote to clinical practice to supplement this income. Faculty whose primary duty is research might be appointed for indefinite terms depending on continued funding of research projects rather than offering them tenure track appointments. Reduction or elimination of cost of living increases during some years or across the board salary reductions also are a possibility.

The alternatives mentioned above are not pleasant either for administrators or faculty, but they may be preferable to termination of individuals on a priority basis with the first to go being clerical and clinical support personnel followed by temporary and part-time faculty, non-tenured faculty, and finally, tenured faculty. This is bound to create a situation in which the combination of individuals with the proper skills to adequately staff the complex of departments in a dental school would not be available, resulting in serious compromise of key educational programs and research projects. Any decisions made during a financial crisis should take into consideration the obligation of the institution to the staff and faculty concerned as well as the effect on the school. Brown recommends that a contingency plan be developed to deal with a financial crisis before it is expected to occur and that faculty participate in determination and implementation of the order of faculty terminations or income reductions.

Summary and Conclusions

For many years the tenure system in dental schools has been instrumental in stimulating faculty productivity of teaching, research and service, and has contributed to recruitment of new faculty. To perpetuate the collegial environment of the past and assure the continuance of a corps of dental educators for the future, dental schools may have to temporarily modify their tenure systems to meet a financial crisis which currently exists or may be rapidly approaching. There appears to be support for the continued existence of tenure among dental school deans and support probably also exists among faculty. If the flexibility of tenure can be increased, the tenure system may survive this and future financial crises and continue to play a significant role in advancement of dental education in the United States and Canada.

References

6. Letter from Harry Bruce, Executive Director of the American Association of Dental Schools, to Dental Deans, July 24, 1981.

Reprint requests to:
Robert W. Mendel, DDS
University of Louisville School of Dentistry
P. O. Box 35260
Louisville, Kentucky 40292
Four years ago I was asked if I would accept the office of Secretary-Treasurer of the New England Section. I was told the job consisted of collecting dues, keeping track of addresses and deaths, arranging two meetings a year and notices thereof, and representing the Section at the Annual Convocation. Little did I know that it also consisted of instructing new officers, publishing a newsletter to induce members to attend the meetings, and writing letters of congratulations to the new members. After beginning my term of office, an award was set up for a member of the graduating classes of each of the four dental schools in New England. (which I had to do). With new officers being elected every year, a great deal of work and responsibility falls upon the Secretary-Treasurer and he is more or less the executive officer of the Section.

The newsletter proved to be the most interesting part of my job. It was needed in order to publicize our two meetings a year. By mentioning many names and keeping it short and to the point, readability was increased. A questionnaire was developed and sent to all members. All the personal information gathered proved to be eye-catching and interesting to our members. By publishing in our newsletter the activities of new Fellows, it gives a guide as to what constitutes an eligible nominee.

It is most irritating to a member not to have his nominee accepted and by measuring up his credentials against one who is accepted, it is very helpful indeed. The names of new Fellows should be published in our State Dental Journals and even the ADA Journal. It would help publicize the ACD and what it stands for.

When presenting an award to a Senior student, as many of the Sections do, we have designed a plaque which states the meaning of the award and the purposes of the ACD. In these troubled times for our profession, honesty, truthfulness, and indeed professionalism, mean more than ever. We should give as much publicity to our College and what it stands for as we can.

Another need is for a small brochure describing the meaning of the College which can be given out at Section-sponsored affairs held for dental students and at booths run by organizations such as ours and the FICD. Many times since being identified as the representative of the ACD in New England, I have been asked how one can become a member. There has been some confusion in the profession with how dentists are nominated to Fellowship in the College.

One thing that has helped our Section is the holding of meetings in different areas. We have two meetings a year, one during the Yankee Dental Conference, the other later in the year, during a state dental meeting if possible. Last year it was in Hartford, CT and this Fall, at Stratton Mountain Inn in Vermont.

The past four years have been most enjoyable, especially in the opportunity it has given me to become familiar with Dental School Deans, College Professors, Dental Examiners, and busy practitioners who are all active in dentistry and are doing much more than just a job.

We need more nominees, especially younger ones, to keep our American College of Dentists growing.

We need more communication between the Sections to know what their programs are and how we can utilize them. Better information is needed regarding what the College stands for in these troubled times for the professions. The discerning public still respects quality in its professional cadre and that is what the American College of Dentists is all about.
### OFFICERS

**President**  
**RICHARD J. REYNOLDS**  
5350 Poplar Street  
Memphis, Tennessee 38119

**President-Elect**  
**ODIN M. LANGSJOEN**  
301 Morley Parkway  
Duluth, Minnesota 55803

**Vice President**  
**LYNDEN M. KENNEDY**  
1918-A Skillman Avenue  
Dallas, Texas 75206

**Treasurer**  
**ROBERT W. ELLIOTT**  
8732 Falls Chapel Way  
Potomac, Maryland 20854

**Editor**  
**KEITH P. BLAIR**  
4403 Marlborough Avenue  
San Diego, California 92116

**Executive Director**  
**GORDON H. ROVELSTAD**  
7315 Wisconsin Avenue  
Bethesda, Maryland 20814

### REGENTS

<table>
<thead>
<tr>
<th>Regency 1</th>
<th>GERARD E. McGUIRK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Connecticut, Maine, Massachusetts, New Hampshire, New York, Quebec, Rhode Island, Vermont</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regency 2</th>
<th>H. CURTIS HESTER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Delaware, District of Columbia, Maryland, New Jersey, Pennsylvania</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regency 3</th>
<th>CHARLES W. FAIN, JR.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Alabama, Florida, Georgia, North Carolina, South Carolina, Puerto Rico, Virginia</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regency 4</th>
<th>NORMAN H. OLSEN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Illinois, Indiana, Kentucky, Ohio, West Virginia</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regency 5</th>
<th>PAUL S. BUTCHER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Iowa, Kansas, Manitoba, Michigan, Minnesota, New England, North Dakota, South Dakota, Oklahoma, Ontario, Wisconsin</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regency 6</th>
<th>ROBERT C. COKER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Arkansas, Louisiana, Mississippi, Missouri, Tennessee, Texas</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regency 7</th>
<th>LEO E. YOUNG</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Arizona, Southern California, Colorado, Nevada, New Mexico, Utah, Wyoming</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regency 8</th>
<th>ROBERT A. CUPPLES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Alaska, Alberta, British Columbia, Northern California, Hawaii, Idaho, Montana, Oregon, Washington, Saskatchewan</td>
</tr>
</tbody>
</table>