

SUMMER • 1984

JOURNAL

AMERICAN COLLEGE OF DENTISTS



INFORMED CONSENT

DENTISTRY'S ROLE IN THE OLYMPICS

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.

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**A Quarterly
Publication
Presenting
Ideas & Opinions
In Dentistry**

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FROM THE EDITOR'S DESK

CPR

Your 52-year old patient has suddenly collapsed in the operatory chair. He isn't breathing and he has no pulse. A minute has gone by and you are convinced that this man has suffered a cardiac arrest. You now have only 2-3 more minutes to act before your patient may have irreversible brain damage. It is your responsibility to immediately initiate cardiopulmonary resuscitation (CPR) to keep this emergency from becoming a fatality.

Are you, the dental doctor, currently trained in CPR? Is your office staff also trained in CPR? Have both you and your staff been re-certified in CPR once each year? Do you have established procedures in your office for handling this kind of emergency? Does your secretary have the telephone number ready to request immediate emergency medical aid? Will your assistant know where to instantly find your office emergency kit? Do you have an adequate oxygen supply? Have you and your staff rehearsed your emergency procedures in the last 6 months?

You had **BETTER** be prepared



Keith P. Blair

to administer CPR because dentists are expected to have CPR training. In some states it is mandatory for relicensure. If a death ever occurred in your office, it would be very difficult to explain in a court of law why you neglected to acquire CPR training.

This year it is estimated that as many as 1,500,000 Americans may have a heart attack and that about 550,000 of them will die. 4,400,000 people alive today have had a history of heart attack or have

chest pains. Nearly one-fourth of all people who die from cardiovascular disease are under the age of 65. An estimated 35,520,000 people are also afflicted with high blood pressure in this country.

Many of these heart attack victims could be kept alive, resuscitated with CPR, including this man in your chair, if you are prepared to act immediately. His wife and family would be eternally grateful for your quick, positive, professional action.

Millions of Americans are now certified in CPR training. The American Heart Association, the Red Cross, other health organizations and educational institutions provide the necessary training courses. It is hoped that, with perseverance, we can train many more millions in the next few years.

Perhaps an even more important reason to learn CPR is that the life you might save could be one in your own family.

Your four minutes are up doctor. Have you begun the necessary CPR treatment to save this man?

Keith P. Blair

NEWS OF FELLOWS

Richard D. Mumma, Jr. has been selected to be the new Executive Director of the American Association of Dental Schools. Dr. Mumma is resigning from his present position as Dean of the New York University College of Dentistry.

Ralph R. Lopez of Santa Fe, New Mexico continues to add awards and recognitions to his distinguished career in dentistry. This year he has received the Regents Recognition Medal from the University of New Mexico for outstanding service to the University and the University of Colorado Distinguished Service Award in recognition of distinguished contributions to the University. In addition, he will receive later this year the prestigious Pierre Fauchard Medal for 1984.



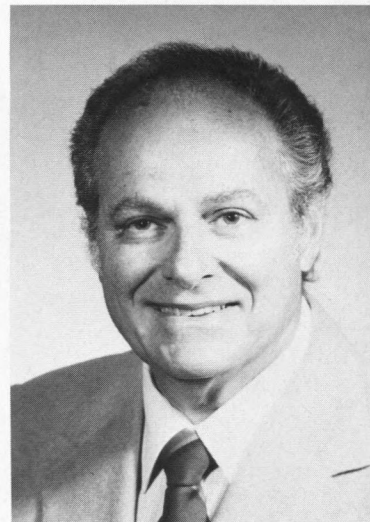
Ralph R. Lopez

Albert Wasserman, ACD Regent for Regency 8, has received the "Medal of Honor" from the University of California School of Dentistry Dental Alumni Association in recognition of service to the School of Dentistry and for accomplishments in advancing the quality and standards of the dental profession. Dr. Wasserman was recently appointed to a four-year term as a member of the California State Board of Dental Examiners.

Juliann Bluitt, associate dean for admissions and student affairs at Northwestern University Dental School, has received the Colgate-Palmolive/ADA Award for Outstanding Service to the Public and the Profession. She was recognized for her overwhelming interest in recruiting women and minorities into dental education and for being instrumental in establishing a People's Clinic at Northwestern to treat dentally indigent children.

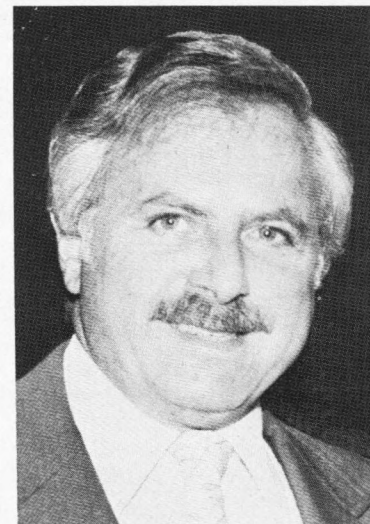
Saul Kamen of New Hyde Park, New York, was recently elected a Fellow in the Clinical Medicine Section of the Gerontological Society of America and is only the second dentist to be appointed to this prestigious section. Dr. Kamen is Chief of Dental Services at the Jewish Institute for Geriatric Care, a 527 bed geriatric/rehabilitation facility. He established the only general practice residency training program in geriatric dentistry accredited by the American Dental Association.

R. Louis Carter of Baytown, Texas, was recently honored as a distinguished alumnus of Lee College in Baytown for his outstanding contributions to his community and the dental profession.



Albert Wasserman

Joseph Cabot of Lathrup Village, Michigan has been elected Vice-President of the American Dental Association. He is a past president of the Michigan Dental Association and maintains a private practice in pedodontics.



Marvin Sniderman

Marvin Sniderman of Pittsburgh has been elected to a three-year term on the Council on Journalism for the American Dental Association. In addition he has been appointed as a consultant to the Editorial Board of the Journal of Dental Practice Administration. He currently serves as Editor of the Pennsylvania Dental Journal.

A. Lynn Ryan, Treasurer for the American Dental Association and ADA Trustee for the Eleventh District, has been elected 1984 President of the American Fund for Dental Health. Other Fellows elected to the Fund's Board were **Raymond P. White**, Vice-President; **Joseph A. Devine**, Board Member; **Joseph P. Cappuccio** and **John M. Faust**, Trustee Advisors.

Harold E. Barlow is Chairman of the Council on Annual Session for the American Dental Association's 1984 Meeting in Atlanta. Dr. Barlow is in general practice in Akron, Ohio and is a past president of the Ohio Dental Association.

Ralph Bellizzi, U. S. Army Colonel stationed at Nuernberg, Germany, has received the Order of Military Medical Merit. He was cited for his outstanding contributions in the area of teaching and as Director of Endodontic Residency Training.



Olaf E. Langland

Olaf E. Langland of San Antonio has been installed as President of the American Academy of Dental Radiology. He is Professor of Radiology at the University of Texas Dental School at San Antonio and a diplomate of the Board of Oral and Maxillofacial Radiology. He has co-authored two textbooks in Dental Radiology.



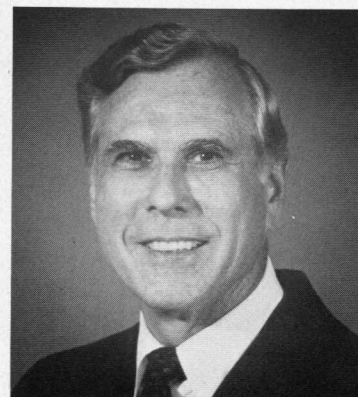
Judson Klooster, Dean of Loma Linda University Dental School, was honored by the Southern California Pierre Fauchard Academy and presented with a plaque in recognition of his contributions to the profession. Pictured above, left to right, are Robert B. Shira, National President of the Pierre Fauchard Academy; Albert M. Weil, Chairman for the event; Dr. Klooster and Floyd E. Dewhirst, former ADA Trustee, who narrated the presentation.

C. Rex Witherspoon of Springfield, Missouri has been named Missouri's 1984 Dentist of the Year. Dr. Witherspoon was recognized for his civic contributions, his service to the state dental association and for serving as editor of the state dental association publication for the past ten years. An oral surgeon, he is associated with an oral surgery group in Springfield.

Manuel I. Weisman of Augusta, Georgia has been appointed full professor of endodontics at the Medical College of Georgia School of Dentistry. He was also re-elected Vice-President of the American Association of Endodontists and Chairman of that organization's Endowment and Memorial Foundation.

Russell V. Brown, Dean of Marquette University School of Dentistry, has been given the prestigious Distinguished Alumnus Award by the Marquette University Dental Alumni Association.

The Columbia University Periodontal Alumni Association presented Distinguished Alumni Awards to eleven individuals, including **Frank Beube**, former director of Periodontics at Columbia; **Paul Goldhaber**, Dean of Harvard University School of Dentistry; **Leonard Hirshfeld**, former clinical professor of periodontics at Columbia; **Ralph S. Kaslick**, Dean at Fairleigh Dickinson School of Dentistry and **Irwin Mandel**, professor of preventive dentistry at Columbia.

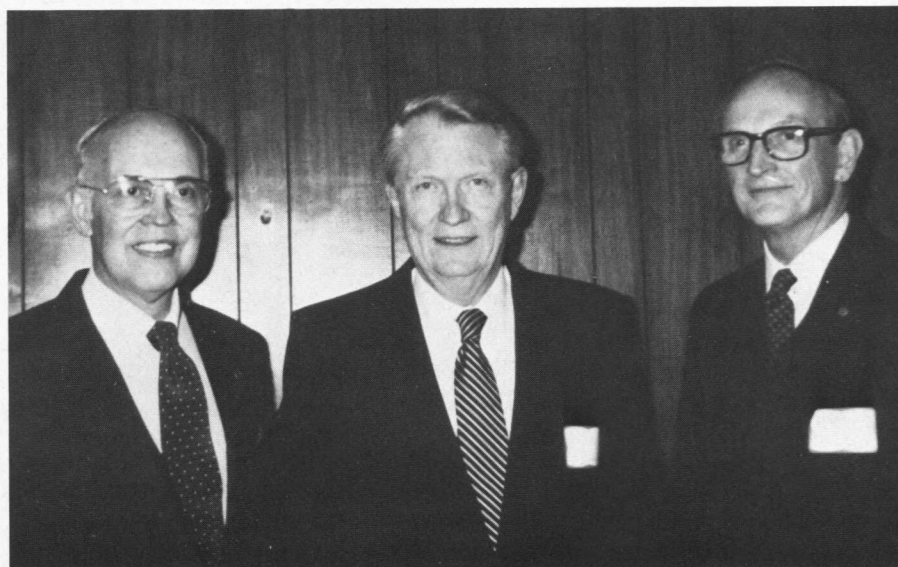


Russell V. Brown

SECTION ACTIVITIES



Dignitaries pictured at the Georgia Section Meeting are, left, James A. Harrell, Sr., ACD Regent for Regency 3, ACD President-Elect Charles W. Fain, Jr., center and Pitman B. Cleaveland, Jr., the Section Secretary-Treasurer.



Officers are pictured at a recent meeting of the Carolina Section in Southern Pines, North Carolina. Left to right are James A. Harrell, Sr., ACD Regent for Regency 3; R. Jack Shankle, Section Chairman and Gordon H. Rovelstad, ACD Executive Director.

Wisconsin



The American College of Dentists Outstanding Table Clinic Award at the Wisconsin Dental Association Meeting was presented by Donald E. Van Scotter, left who was Chairman for the award presentation. Winning clinicians were Drs. Ronald Meyers, center, and Richard Knoff, right.

The Wisconsin Section sponsored an American College of Dentists Outstanding Table Clinic Award at the Wisconsin Dental Association's 114th Annual Session.

Chairman for the selection of the award winner was Donald E. Van Scotter of Milwaukee.

The winning table clinic was "Ten indispensable aids used by endodontists."

Upper Midwest

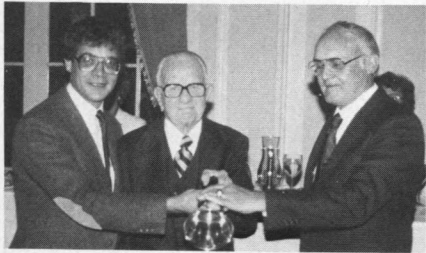
The Upper Midwest Section is doing a placement and replacement survey among Fellows of the Section. The survey is a research project on the diagnostic reasons for initially placing a restoration and the diagnostic reasons for replacing a restoration.

Similar surveys are currently being conducted in other states and countries and the results will be compiled for comparison studies.



Southern California Section Chairman Richard B. Hancock, left, happily presents a check for \$500. from the Section to the American College of Dentists Foundation. Receiving the check, on behalf of the Foundation is ACD Regent Leo E. Young.

Michigan



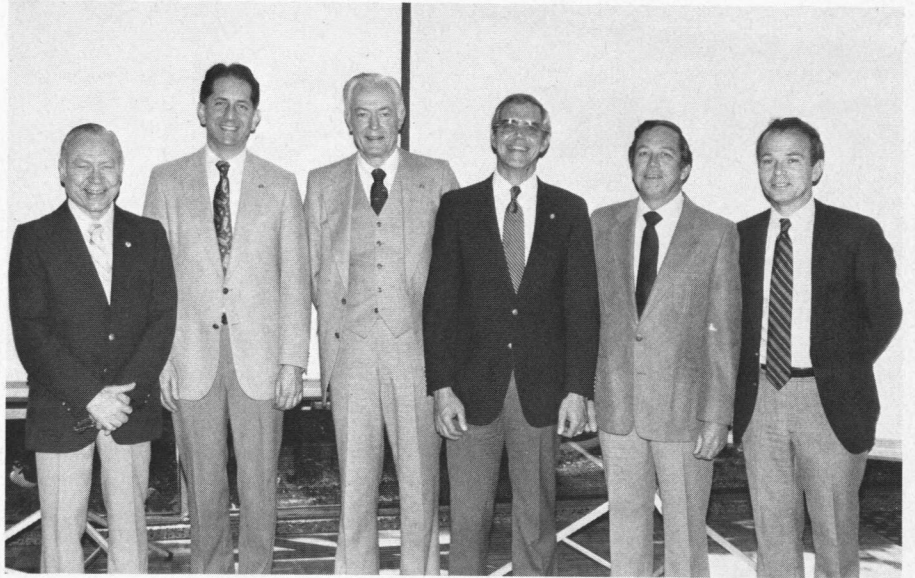
Dr. Vernor "Red" Eman receives the Distinguished Service Award for 1984 from the West Michigan District Dental Society. Left to right are Dan Kemp, president of the West Michigan Dental Society, Dr. Eman, and event chairman Don Hallas.

Fellows in the western part of Michigan have established a Distinguished Service Award to be presented annually to a member of the West Michigan District Dental Society. Fellows act as a nominating committee for the award but the recipient does not have to be a Fellow.

The award was established in 1981 and has become very meaningful to dentists in that area.

Each recipient is presented with a "Silent Bell", an engraved brass bell without a clapper, symbolic of quiet, dedicated contributions made to the profession or community without self-aggrandizement or commercial interests.

Receiving the 1984 Silent Bell was Dr. Vernor "Red" Eman of Grand Rapids, a retired oral surgeon with a long and distinguished career in dentistry.



Pictured at the Southern California Section Meeting are, left to right, Keith P. Blair, Editor of the ACD Journal; Jack F. Conley, 1st Vice Chairman; Regent for Regency 7 Leo E. Young; Section Chairman Richard B. Hancock; 2nd Vice Chairman Richard J. Geyer and John W. Berry, Section Secretary-Treasurer.



Charles M. Stebner, left, of Laramie, Wyoming received the "Man of the Year" award from the Colorado Section. A plaque was presented by Miles R. Markley, right. Dr. Stebner addressed the Section Meeting on "The Real Future of Dentistry."

IF YOU DON'T CARE, WHO WILL?

Joseph A. Devine*

The primary reason I went to dental school was to be a doctor, to enjoy the collegiality of belonging to a profession, to enjoy sharing the common goals and concerns of my colleagues, other doctors—other professionals.

But what I see now is each individual dentist worrying about *his* share of the patients. I think that is one of the biggest problems facing dentistry today. Unless we learn again to think—and act—in terms of “we” and “us”, not “me” and “I”, we are going to lose everything.

As an example, I don't want *my* dental school to close. What's the sense of being a famous dental alumni, if you don't have a school? And I don't want *your* dental school to close, either, because more important than my practice is *our* practice—yours *and* mine. Think about this. Because the less selfish we are all able to be at this time, the more successful we will all be.

This attitude throughout the dental profession should be our biggest concern. You are the leaders—and you should be concerned. If you are not concerned, who will be? Concern is a sign of good leadership. I believe we can continue to depend on excellent leadership—so long as we all remember that you cannot lead by coercion. We can only lead by example.

One of the most important examples we can set for our colleagues is through providing a

profitable and professional example for our new graduates. The way we behave toward our young people just out of dental school defines the degree of professionalism we can claim for ourselves.

If you ignore the problems of the young graduate—if you ignore the problem that you think the young graduate poses—that problem will only get worse. If we do not take the responsibility for making their

The way we behave toward our young people just out of dental school defines the degree of professionalism we can claim for ourselves.

transition into the practice of dentistry a professional and profitable one, someone else will. And that someone else may be working under a big sign that says “Sears, Roebuck & Co.”

What can you do? Be nice to them. Is that so hard? Be friendly to them, encourage them, when they show up at meetings. Treat them like colleagues, which they are. Don't sit around and wait for them to go broke, hoping you can inherit their 12 patients. Better you should set an example for them. Show them that you care—and teach them to care about dentistry, too.

If our young graduates develop that kind of conscience about their profession—if they only want to *live* like doctors, rather than really *be* doctors—then the problem is serious. If the dignity that comes with being a doctor doesn't mean as much to them as the income, the

problem is more than serious. It may be fatal.

Schemes cannot succeed if someone doesn't buy them. Dental franchises can't hire from other professions, other crafts. They can't hire pipefitters, or electricians. They have to hire dentists. And they can hire the dentists they do because those dentists don't feel that fee-for-service is providing them enough income, or because they believe the franchise system will provide *more* income. Our responsibility as leaders is to find out why these dentists are going into these systems—and to convince them that our system is better.

Professionalism is not something that someone takes away from us. The Supreme Court of the United States never said that dentists *had* to advertise. The Supreme Court said only that no one could impose sanctions on dentists who advertise. The Federal Trade Commission never said that we *must* have alternate delivery systems. It only said you cannot impose sanctions on people who choose to pay for services in a different manner.

It is not the action of those bodies that leads to the loss of our professionalism. It's not an outside force. The force is within the profession. Stop blaming someone else. Blame yourself.

How did this happen? When I graduated dental school, I thought I would have plenty of patients. I wasn't successful immediately, but that didn't really matter, because I had a very small overhead.

But the young men and women who graduate today owe a tre-

*Joseph A. Devine, DDS, Trustee, Fourteenth District, American Dental Association.

mendous debt for their education, and it costs a small fortune to set up a dental practice. In addition, there is not an abundance of patients, as there were in those days. If those graduates do not become successful in a short span of time, they will turn to the dentists—and the delivery systems—that offer them solace, patients, and the *income* they need. Obviously we would like them to turn to us. But how are we going to know what these young people think, if we don't talk to them?

If we don't invite them to our meetings, how will they learn? Why should they set for themselves the standards of professionalism that someday will qualify them to belong to those Colleges? When the leadership of our profession doesn't care about what happens to these young people, it foretells frightening things for dentistry.

The Supreme Court of the United States never said that dentists *had* to advertise . . . only that no one could impose sanctions on dentists who advertise.

Manpower is certainly an issue we must deal with. The number of dentists in this country is increasing far faster than is the general population. Between 1970 and 1980 the population in this country increased .9 percent, while the dental population increased 2.3 percent. You don't need a calculator to tell you that this is a three-to-one ratio. As of 1982, we had about 55 dentists for every 100,000 people in this

country. In 1985 we'll have almost 58 dentists for every 100,000 people. That's a 7 percent increase in three years.

What does that mean in terms of income? In 1965, dentistry received seven and a half cents of every dollar spent on health care. That's not very much. And it got worse—in 1980, dentistry collected just over 6 cents of that health dollar. We had more dentists and the same number of patients—and that meant each got a smaller percentage of the dollar. In a way, that may be good news. Young men and women coming out of school are much more anxious to buy an existing practice. It's the easiest way to get into the business.

But how are we, the profession, going to deal with this manpower crisis? It may not be necessary to close dental schools. The young people who consider dentistry as a potential career are not dumb. They're looking at a profession that requires eight years of education, costs a small fortune in tuition and involves a huge investment, just to go into business.

My daughter, who is a CPA, is getting her Master's degree in income tax. She's in her second year of the program, and is interviewing for jobs that start at 35 to 37 thousand dollars. She can go out in private practice and command \$100 an hour. With opportunities like that, you really have to be committed to more than making a good living to choose dentistry for a career.

And the young men and women of America are making those

choices. When this country produced too many teachers, college students didn't major in education. When there was a glut of engineers, the engineering schools experienced a big drop in enrollment. The

Between 1970 and 1980 the population in this country increased .9 percent, while the dental population increased 2.3 percent. You don't need a calculator to tell you that this is a three-to-one ratio.

marketplace takes care of these things. When the demand increases again, the enrollment will increase. It's a slow and painful process, but the problem will correct itself. It's already happening.

In the meantime, the licensure system is getting its own share of bad press, from dental students and practicing dentists alike.

In case you didn't know this, the ten fastest growing states in the U.S. are Florida, Texas, California, Colorado, Wyoming, New Mexico, Arizona, Utah and Nevada. People want to move to these states.

So if you want to preserve the licensure system, one of the great gifts given to this profession by the legislators of this country, you are going to have to show you care about it. You are going to have to go to your state Board and tell them what you want them to do. Confront them with the facts. Most important, remind them—and remind yourself—that licensure exists for the protection of the public. Licensure does not simply

exist to protect the profession—it's in place, and working, to protect the public and to *help* our profession.

And there are dentists even in my hometown, I'll admit it, who make this system good and necessary.

First is Dr. Poorwork. He's a dentist only to make the money to do other things. If you forced him to continuing education, the best he could do would be to get from hopeless to inept. He's just not interested in being a dentist. He does amalgams and dentures. His patients reach forty-five and their reward for reaching middle-age is a set of ill-fitting dentures. Then they're phased out of his practice, and he doesn't care. Dr. Poorwork has to be stopped.

Then comes Dr. Overwork. He has five operatories and 17 assistants to do everything except impactions. We have to explain to Dr. Overwork that there is a new category of auxiliaries called "dentists." Dr. Overwork should take a dentist into his office. That way he could make his practice more profitable and increase the value of his estate, because he's going to drop dead anyway. You can't roller skate between five operatories all your life and keep your heart muscle.

And after Dr. Overwork's funeral, the dentist he took in would take on another dentist, because he'd like to live long enough to enjoy his IRA account, and then maybe they'd have to take in another one—and there's two young ones kept away from the entrepreneurs.

Then we have Dr. Allwork. He takes a crash course in orthodontia, spends \$500 for a few bands and becomes an orthodontist. You know, our definitions have changed. Nowadays an orthodontist is a pedodontist who lives in a fluoridated community; interceptive orthodontics is when the general dentist gets the insurance money before the patient is old enough to

see the orthodontist. That's according to Dr. Allwork, anyway.

He treats his patients for two years and they get older, and poorer, and their teeth are crooked, so he sends them off and cannot understand why the orthodontists don't want to adopt them. And you wonder why we have conflict between the general practitioner and the specialist?

Our profession has become accepted and held in high regard because most dentistry is done by

Business in this country is the single largest purchaser of health insurance . . . five to seven percent of our operating costs are going into these benefits.

the general dentist who realizes his limitations. When necessary, he seeks the help of a specialist, and the patient gets the best possible care and retains his respect for the profession.

You must understand that we will defend, with all the resources of this association, your right to practice to the limit of your ability. But that right stops—at the limit of your ability.

Next comes Dr. Oversell, who manages to find in every patient's mouth exactly the amount of dentistry the insurance company will pay for. He's beginning to light up the computers of Connecticut General and Aetna. And when they send out the representatives of Connecticut General and Aetna to find out what's going on, they're not only going to wind up in Dr. Oversell's office. They'll be parked in *your* waiting room, too, asking you what *you* are going to do about him.

Finally, we have Dr. Redoer. When he can't find anything else to do, he wants to take out everybody else's dentistry and replace it.

It is up to us to put a stop to these people. They are part of the system and the system is supposed to function to rectify cases like these.

It's important that we put teeth in the licensure system. It gives great credibility to the Board of Dentistry when they really do stop dentists who harm the public, or who take advantage of the public. Your Board of Dentistry will have an important role to play, too, when someone comes with the latest plan to sell wholesale dentistry. Call it PPOs, IPAs, closed panels—I call it the Scheme on the Month. Why are we seeing this sudden surge of interest in alternative benefit plans?

Let me give you some simple statistics. Business in this country is the single largest purchaser of health insurance. Of the 63 billion dollars spent for health insurance in 1980, 48 billion, almost 80 percent, was paid entirely by the employer. An equal amount was spent on workmen's compensation, medical benefits, taxes, public health, medicare and medicaid. Taxes paid the rest. In this country, today, 50 percent of the people have their health insurance paid entirely by their employers, 40 percent have almost all of it paid by their employer. Only 10 percent pay their own insurance.

The system is out of control. It used to be that no one cared, but now, all of a sudden, businesses are saying "Wait a minute! Five to seven percent of our operating costs are going into these benefits." The United Auto Workers have health care benefits that cost the auto industry \$305 a month—per worker.

So naturally everyone is interested in controlling these costs. One way they're doing it is through the development of these alternative benefit systems, like PPOs. Another way they're going at it is through legislation proposed in Congress to tax those health care benefits.

It's your job to tell your patients that you care about rising health costs, and that you care about controlling them—but you have to tell them, too, that you are not the problem.

I don't mind going to hell for my sins, but I won't go for the sins of the hospitals and physicians. I didn't inflate those prices. Dental fees have been lower than the Consumer Price Index for the last decade. Dental benefits work to keep costs down by rewarding preventive health behavior. Ours is the model, not the culprit. Tell people that.

The Rand Study says that if this "health tax" passes, the dentists of America will sustain a 10 percent loss of income. That offends me, and I'm sure it offends you, too. But what offends me even more is that the 92 million people who are able to receive dental care because they have these benefits may be denied that privilege if this law passes.

So you have to care what "they" do to us, and to our professionalism—and you have to care, too, what we do to ourselves. And that brings me to Dr. Press's favorite subject, one that will be the subject of a critical decision for our delegates in Atlanta in November—marketing.

Imagine that you are a shoe salesman, at a convention, and a main topic of concern has been steadily declining shoe sales. I am addressing that convention, and at the end of my speech I invite questions or comments.

The first guy gets up and says, "I think we're training too many shoe salesmen. Let's close one of the shoe salesman schools." I don't think that's the solution.

Somebody else gets up and says, "We're taking in more salemen, lowering the overhead and working longer." When you divide your income, you are working longer—for a lesser hourly wage.

The next one up says, "I have a second shoe store in the suburbs that protected me temporarily, but last week two more guys opened up across the street." So that's not the solution.

The last one to raise his hand says, "I'm jealous of the guys selling specialty and orthopedic shoes. I'm going into that business." And that's not the solution, either.

I used *shoes* as an example for a reason: half of you write to Chicago and tell the Board of Trustees that we don't have "shoemanship" and this whole situation is our fault. That's not true. It's certain that we can't fix the situation, though.

Being intelligent shoe salesmen, you make the rational decision and say, "We have to do something about this. Let's go out and spend some of our dues money and hire some experts and see what they have to say."

I can pretty well predict that they would come back to you with lots of computer printouts and a careful statistical analysis and this is what they would find: About half the people are buying one pair of

Licensure exists for the protection of the public. Licensure does not simply exist to protect the profession.

shoes a year. A lot of people are wearing their shoes too long. And there are a whole lot of people going around barefoot.

And after they explain this to you, they ask, "Now, which of these groups do you want to influence into buying more shoes?" And we say, as professionals interested in the foot care of America, "We want to influence all of them."

Those experts are going to tell you that if will cost a lot of money, and it will take a long time, for what may be an uncertain result.

One thing that really upsets me is to meet a dentist about my age and to have him tell me, "Boy, am I glad to be getting out!" I hate to hear that. And I hate to hear the statement, "I have a hygienist doing half the work, and I have a pretty good thing going and I don't care who follows me in this profession."

I think we have to care. We should do the very best for ourselves and for the young men and women who are going to follow us. In other words—go first class and hang in there. It's the very best we can do—but we have to care enough to do our very best. And if we do, maybe those dentists who don't belong to the ADA will understand that we're doing something for them.

A few months ago I became a grandfather for the first time, grandpa to the grandest grandbaby of all times. I took all my children to Washington over the years, and I am sure that one day my son Patrick will take this wonderful child to the Smithsonian, and they might even wander over to the place they have there as a dental museum. And Patrick will tell my grandson Sean, "Now over there are the hygienists. They treat the public directly. And over here are the denturists. They make dentures for the public directly—not very well, but they do it anyway."

And Sean will look around and then look at his dad and ask, "Where are the dentists?" And his father will say, "Well, they're over there, in the all night Dental Clinic, trying to make a living." And when Sean asks how that happened, Patrick will say, "Your Grandfather says he couldn't persuade them they had to care enough to change." Δ

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"GOING FOR THE GOLD"

Dentistry's Role In The Olympics

I. Lawrence Kerr*

The Summer Games of the 1984 Olympiad marks the end of the first recorded dental activity by the U. S. Olympic Committee.

The "Modern Olympics" denotes the resumption of the Olympic games in 1896. Inspired by the Baron de Coubertin of France in that year, every four years has produced a greater participation by athletes and spectators alike. When the Opening Ceremony occurs in Los Angeles on July 27, 1984, it will mark the beginning of the greatest Olympiad ever recorded.

It is well to record how dentistry has been a part of the preparation of the U. S. participation during the 1984 quadrennial and to describe the future role of the profession.

There is some evidence indicating that a dentist on occasion accompanied the U. S. Olympic team to the site of the games, but no record exists describing any program or treatment. This situation generally describes many of the pre-1980 medicine-related activi-



I. Lawrence Kerr

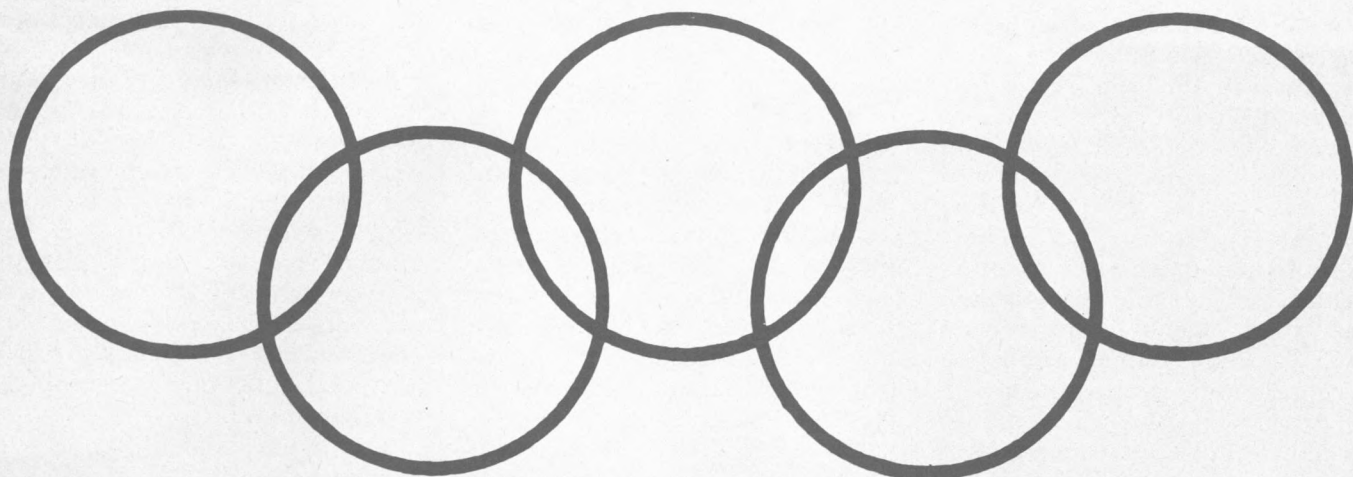
ties. We know that medical delegations have been in attendance as a part of the formal organization of the U.S. Olympic team. The size of the medical delegation is prescribed by the International Olympic Committee.

In 1980, following the decision of the United States not to send a team to Moscow, a whole new reorganization of the role of the U.S. Olympic Committee occurred. Dr. Irving Dardeh, having

been appointed Chairman of a reconstructed Council on Sports Medicine, and dentally oriented, contacted the American Dental Association through the efforts of Dr. Robert Biddington, the Dean of the West Virginia University School of Dentistry. The stimulus by Dr. Biddington was a result of his visit to the newly created U. S. Olympic Training Center in Colorado Springs, Colorado. This effort was strongly urged and supported by Mr. Robert Beeten, now Associate Director of the Council on Sports Medicine. Mr. Beeten's dental interest, as the Chief Athletic Trainer and a former coach, is unmatched in the world of athletics.

Dr. I. Lawrence Kerr, then president of the American Dental Association, was appointed to be the representative of the ADA by the ADA Board of Trustees. A Committee on Dental Health was then established by the Council on Sports Medicine and included Dr. Biddington, who is the current president of the American Association of Dental Schools, and Mr. Nikolaj M. Petrovic, President of the American Dental Trade Association. In addition, Dr. Kerr serves as a member of the Council on Sports Medicine and as Chairman for the Council's Committee on Drugs.

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Several meetings of the Committee on Dental Health produced an approved mission statement and a program of action. The first major effort was to establish a dental facility at the new Olympic Training Center. Through the generous donations of members of the American Dental Trades Association, a modern and complete three-chair clinic has been established and is in use. Budgetary limitations allow a very dedicated, part-time dental hygienist, Ms. Judy Garner, to coordinate the current activities of the Dental Center. Current dental activities there are limited to dental screenings and some oral hygiene services. Members of the Colorado Springs Dental Society have been most gracious in providing emergency care and some remedial care to athletes displaying need. The mutual cooperation of these dentists, under the leadership of Dr. Randolph V. Geoghan, is a paragon of community service.

The reader must fully understand the organization of Olympic activities to comprehend the actions taken so far and those planned for the future.

The entire Olympic effort in the United States is governed by the

Amateur Athletic Act of 1978 and is coordinated by the U. S. Olympic Committee. There are 37 different National Governing Bodies who conduct the development and training of athletes in the separate sports. For instance, the U. S. Boxing Federation exercises autonomous control and effort in the sport of boxing. Each National Governing Body (NGB) may use the facilities of the Training Center in Colorado Springs or the newly established training center in Lake Placid, New York.

Thus any dental health program must be directed toward and through these NGB organizations entailing over a million aspiring athletes.

The placement of the dental program has been slow as a result of this unwieldy organization, but enormous progress has been made. Several hundred athletes have been screened and/or treated as a result of the dental activities in Colorado.

Because of the widespread athletic activities, a National Dental Referral Program has been established. The program contains over 500 dentists who have indicated a willingness to receive those athletes referred for care, and who do

not have their own dentist. As we get closer to the games and needs are identified in those athletes selected for the 1984 Olympic team, the need for this referral program becomes more evident.

As part of the total athletic program during the quadrennial, the National Sports Festival is held annually during the first three years. These have been summer events that have been held in Syracuse, Indianapolis and Colorado Springs. Over 3000 athletes participate and the events are viewed by thousands of spectators. For each event, the local sponsors are asked to provide dental emergency services for both the athletes and the spectators. The dental personnel involved included general practitioners and specialists. Coordination for providing care was made by the local dental societies in Colorado Springs and Syracuse. In Indianapolis, the faculty of the University of Indiana School of Dentistry did an equally outstanding service. In each of the events, a number of emergencies occurred involving dental structures. Immediate treatment was rendered and the athletes were returned to participate in the games.

Two international events occurred with some involvement of dentistry. In 1983, the Pan American and World University Games were held. A dental screening and emergency services were rendered to some of the 600 participants going to Venezuela. This was accomplished in a well-equipped dental van. The screening indicated that over 40% of the screened athletes needed dental care, which is representative of this age group. These athletes were referred to their own dentists or to members of the referral program. The dental schools in Caracas were asked to supply any emergency care necessary. There was no dentist member of the medical delegation. This was also true of the group attending the World University Games in Edmonton, Canada where the local community supplied local dentists to provide emergency dental care.

Prior to discussing the dental plans for the Summer Olympics in Los Angeles, several other aspects of the dental activities can be described. Dental education has been given to members of the various national governing bodies. An extensive dental orientation was given to medical representatives of the National Olympic Committees of the Latin and South American countries. Very little dental care is available to the athletes of those nations.

A research activity involving the use of occlusal repositioning appliances was conducted by the Bio-Mechanical Laboratory in Colorado Springs. Preliminary findings did not find ergogenic enhancement.

The American Fund for Dental Health has kindly donated a dental van to the U. S. Olympic Committee. The van is now fully equipped and has been used in several areas. During the preparatory months prior to Summer '84, the van has been used at the various qualifying centers. It is hoped to ascertain the world class athletes during these events. The dental van will be used during this

time for dental screenings. Those athletes requiring care will be urged to complete all their needed treatment before going to Los Angeles.

The International Olympic Committee (IOC) is totally responsible for the games involving over 100 nations. The Los Angeles Organizing Committee is a separate body from the U. S. Olympic Committee. A medical function has been established to provide the medical care for the 12,000 athletes involved and also for the hundreds of thousands of spectators. Since the venues of the various sports will be all over the Southern California area, several medical and dental sites will be involved. Primary sites for services to the athletes will be at polyclinics set up at the University of California at Los Angeles (UCLA) and at the University of Southern California (USC). There, the dental schools will serve as the dental facilities. The rigidly secured Olympic Villages will also be at these university sites.

A large dental team, under the chairmanship of Dr. Tom Kellen of Burbank, California, has been established. Dr. Kellen has recruited a number of colleagues from the Southern California area. The three main sites to be covered are UCLA, USC and Santa Barbara, but assignments will be made for coverage of the entire Olympic area. The United States Olympic Committee (USOC) dental van has been offered for use. Consultations have been sought and rendered from the USOC experience. This author, as Chairman of the USOC Committee on Dental Health, has received many offers for service which have been referred to Dr. Kellen. It is hoped that the Summer 1984 Olympics will provide some basic statistics upon which to plan for the future. Since the Summer 1988 Olympics will be held in Seoul, Korea, it is expected that the Korean Dental Committee will receive much assistance from our experience in 1984.

Policy concerning the dental role

in Los Angeles will be determined by the Los Angeles Olympic Committee (LAOC) Medical Delegation, under the chairmanship of Dr. Anthony Daly, an orthopedic physician. Dr. Kellen, as chairman of the dental team, will be working closely with Dr. Daly. It would appear that the long distances between the event venues will necessitate the use of an extensive communications system, as well as a smooth-functioning transportation system.

The major goal of the USOC Committee on Dental Health is to see that every participating athlete will be in the optimum of dental health before arriving in Los Angeles, thus precluding the need for any other than emergency (trauma) care.

In conjunction with the American Association of Oral and Maxillofacial Surgery, the chairman of the USOC Committee on Dental Health, Dr. Kerr, participated in an extensive tour of the news media, espousing the use of protective devices for athletes of all ages. Special attention was given to the fact that mouth protectors, masks and similar devices should not be used *only* in football or boxing. Participation in other sports such as water polo, ice hockey, field hockey, judo, soccer, basketball and horseback riding have also produced dental injuries. This message was given massive coverage throughout the country and hopefully will prevent many future injuries.

The Olympics has generated intensive interest at this time. The Games will create thousands of hours of messages and inspiration to a sports-minded nation, and to the world. Through the programs described above, it is hoped that the message of dentistry will be brought to the gold medal seeker and to the spectator alike. Δ

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INFORMED CONSENT

Informed Consent Patient Records and the Doctor/Patient Relationship

Ames F. Tryon*

The profession of dentistry is constantly changing. Prior to the 20th century, dentistry was practiced by a heterogeneous assortment of providers with backgrounds varying from no formal training to those who possessed medical degrees. Throughout the early part of the 20th century the art and science of dentistry became better defined and the occupation of dentistry achieved the status of a profession.

Since our emergence as a profession we have participated in the development of biological and technological advances that will improve our abilities to serve the public and affect the way we practice. It is now possible to predict that dental caries and periodontal disease will be eliminated as major disease processes within the foreseeable future. In addition, advances in biomaterials will most likely affect the way we provide restorative and rehabilitative services. It is also possible that advances in genetic engineering will influence the formation of the tissues associated with the oral diseases that our population develops.

Rapid biological and technological changes are often not accompanied by similar changes in social organizational patterns. This is particularly true within occupations that qualify as professions. A recent article by Barzüm discusses some of the key issues facing the profession today. He suggests that professions are so institutionalized that its members often lose site of the fact that their main role is to serve the needs of the public. Members of a profession often think of the profession as "going on forever in the same glorious way, altering itself only as it improves performance by new skill."¹

A major reason that professions do not respond very rapidly to changes in other areas of society is the fact that they enjoy a certain autonomy. To quote Friedson "the only truly important and unique criterion for distinguishing professions from other occupations is the fact of autonomy—a position of legitimate control over work."¹ This autonomy is protected by law and based on public trust. Profes-

The Profession of dentistry is constantly changing and so is the nature of the relationship between dentists and their patients. A dominant issue that is influencing this relationship is that of informed consent. Recent court decisions have supported the idea that all patients deserve the right to informed consent prior to the time services are provided.

sions typically regulate entry into their ranks, as well as the process by which members are educated and licensed. They also control the way their services are provided. Professions will continue to enjoy the support of society as long as lawmakers are convinced that their autonomy is required to enable them to serve the public need.

Our position of autonomy has helped shape the way we relate to our patients. The doctor/patient relationship is characterized by a dominant/subordinate role model. By virtue of our expertise and the patient's relative lack of knowledge about oral health and disease we often exercise unilateral judgments. The doctor collects the data, diagnoses the problem and prescribes the cure. The patient is often forced to take the position of "whatever you think doctor."

Fortunately, the nature of the doctor/patient relationship is changing. Patients are becoming better educated and more aware of the actions that can be taken to preserve their oral health. They are beginning to recognize the fact that there are numerous options available to them and that they can play a more active role in the process of obtaining dental services. The upsurge in dental malpractice suits being filed against dentists supports this observation. Patients and their counsel appear more interested in taking legal action in cases where negligence may be related to a failure to keep the patient better informed of the options available before pursuing a particular course of action.

A major issue that has emerged as a result of the

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desire of patients to have a more central role in determining what dental care is provided for them relates to the concept of informed consent. Dental practitioners that do not assure patients that the consent to services is truly informed are at greater risk of facing malpractice litigation than their counterparts that do use this approach to patient care. The remainder of this paper will deal with the concept of informed consent, its legal implications and present some criteria for integrating informed consent into dental practice.

The Meaning of Informed Consent

There have been several books and papers written on the subject of informed consent. The concept and practice of informed consent has been discussed as it relates to the social organization of health services, the relationship between doctors and patients and more recently as it relates to risk management and malpractice litigation.

Although several definitions and interpretations have been offered for informed consent, they are all based on a single concept. As Tiernary put it, the patient's presence in the dental office does not give the dentist "an unfettered right to do whatever he believes to be in the patient's best interest."³ Instead he suggests that the patient should be the final

The patient's presence in the dental office does not give the dentist an unfettered right to do whatever he believes to be in the patient's best interest.

arbiter of whether or not he will agree or submit to a particular treatment plan or procedure. Going one step further the same author suggests that patients should be able to decide what they want from a dentist even if a particular decision is unwise and it is manifestly in the patients best interest to follow the dentists' advice.

Greater involvement of the patient in the process of decision making requires an alteration in the traditional doctor/patient relationship. The patient becomes a co-therapist rather than a passive participant. The basis for the co-therapist role is an effective system of communication among the providers and receivers of service. In order for the patient to participate more effectively he/she must be knowledgeable enough to make decisions. To quote Murphey:

"informed consent replaces the traditional doctor/patient relationship which the doctor

and patient are unequal bargaining partners in a contract for service. Informed consent gives the patient knowledge that will make him an equal bargaining partner. The essence of the doctor/patient relationship is transformed from status to contract."⁴

Definitions have been offered that specify the conditions under which informed consent is considered to exist. Most definitions are based on three assumptions.⁵ First that consent is obtained after the patient is informed of the risks that may be associated with a particular course of treatment or procedure. Secondly, that the patient is aware of the alternatives to and the reasons for selecting a proposed treatment. Thirdly that the patient is aware of the risks inherent in having no treatment at all.

Murphey would add two more criteria as evidenced by the following:

"It is important to have a written, signed and witnessed consent form to any procedure of substance. The form should be complete with regard to the diagnosis, risks of treatment, the alternatives to treatment and risks of lack of treatment; and it should also state that the patient has been given an opportunity to discuss any further questions with the practitioner."⁶

Rosoff was even more specific in the items that must be disclosed to establish that informed consent has been obtained. He offered the following list:⁷

- (1) A description of the problem or diagnosis.
- (2) The nature and purpose of the proposed treatment for each problem.
- (3) Mention of the risks and consequences of the treatment chosen for a particular problem.
- (4) The probability that the proposed treatments will be successful.
- (5) A list or mention of feasible treatment alternatives.
- (6) A discussion of the prognosis of the proposed treatment is not given.

It is obvious that specific criteria have been established in the literature which specify the conditions for obtaining informed consent. These criteria were not merely present as "food for thought." Instead, they were derived from real situations and are thought to represent standards for determining whether patients have been provided with the opportunity to participate in the process of health care or whether they have been denied this opportunity.

Legal Implications of Informed Consent

The process of securing informed consent appears consistent with our main goal of serving the needs of the public. One might have assumed that informed consent, as defined above, has always been part of the routine process of providing dental services. Unfortunately, this has not been the case. A review of the practice planning and management literature will support this observation. Instead interest in the concept of informed consent has been stimulated more by the fact that it has legal implications than

Professions will continue to enjoy the support of society as long as lawmakers are convinced that their autonomy is required to enable them to serve the public need.

anything else. Ursu,⁸ Warshafsky⁹ and Rosoff¹⁰ have all presented excellent summaries of the role played by informed consent in altering the quality of the decisions rendered in malpractice litigation. The reader is referred to these sources for details. This paper will present only the major concepts.

Rosoff presented a review of the changes that have occurred in court cases involving medical malpractice. He pointed out that the professional community standard on "locality rule" has been replaced by the reasonable patient standard.¹¹ Court decisions under the "locality rule" are exemplified by the Natanson versus Kline case. In this instance the defendant was judged on the basis of whether he "proceeded as competent medical men would have done in a similar situation."¹² If his professional colleagues did not routinely use the process of informed consent then the duty of disclosure would have been confined to the standards employed by other professionals in the community.

The new standard by which defendants are judged with regard to disclosure is exemplified by the Canterbury versus Spencer case and the Cooper versus Roberts case. In the former the court ruled as follows:

"every human being of adult years and sound mind has a right to determine what shall be done with his own body." True consent to what happens to one's self is the informed exercise of a choice that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each."¹³

A similar ruling was brought forth in the Cooper versus Roberts case as evidenced by the following quote:

"A more equitable formulation would be: whether the physician disclosed all the facts, risks and alternatives that a reasonable man in the situation which the physician knew or should have known to be the plaintiffs would deem significant in making a decision to undergo the recommended treatment."¹⁴

It is clear that new standards are being used to determine whether patients have been given the opportunity to participate in decisions regarding their own health. The courts have supported the patients right to informed consent and several authors have specified the criteria for determining whether informed consent has been obtained prior to pursuing a course of treatment for a patient. These factors cannot be ignored especially in dentistry where we manage the total oral health needs of our patients and don't confine our care to episodic occurrences.

Patient Records and Informed Consent

The criteria that were discussed above clearly states that written documentation is an essential part of obtaining an informed consent to services. This documentation can be obtained in two ways. It can be incorporated into the regular patient record or obtained separately using a special form. In either case the act of obtaining informed consent should be integrated into the process of data collection, diagnosis and treatment planning.

A review of dental records suggests that we do not routinely obtain informed consent and do not use record keeping systems that can be easily audited. Evidence for this assertion can be obtained from studying some of the books on practice management and from reading the literature on quality assurance. For example, nearly all the studies reported at a recent conference on quality assurance required the use of special data collection tools to obtain information on the quality of the services provided.¹⁵ The patient records of those who participated were inadequate for analytical purposes. One author even stated that half of the records in the practices he studied were deficient.¹⁶

It would appear that our methods for keeping records need to be revised. This is particularly true if we wish to integrate informed consent into the patient record rather than using a separate form.

Therefore, some attention needs to be focused on the quality of our patient records.

In previous reports we described a record keeping system that contains all the elements necessary to document informed consent and adhere to the standards described earlier in this paper. The record keeping system was developed for medicine by Weed¹⁷ and adapted to dentistry by Tryon, et. al.^{18,19,20,21} It has been continuous use in the clinics and faculty practice at the University of Mississippi School of Dentistry since 1975. During this period thousands of patients have been involved in the process of care associated with this record.

Patients should be able to decide what they want from a dentist even if a particular decision is unwise.

As a result of our experience we are prepared to propose some standards for keeping patients records that will facilitate the process of obtaining informed consent. If these standards are adopted there will be little or no question that patients have been offered the opportunity to give an informed consent to dental services.

The following criteria can be used to determine if informed consent has been obtained. They are as follows:

- (1) The record should have a data base that is complete enough to enable the patient to have the information necessary to participate in the decision making process. The data base should also be complete enough to enable the practitioner to manage the total oral health needs of the patient.
- (2) Findings from the data base should be formulated into a complete problem list. Problems should be stated in terms that the patient can understand and portray the patients overall health condition at any given time.
- (3) An initial plan should be written for each problem which contains a description of the alternatives for resolving the problem, the risks of each alternative and the risks of not resolving the problem.
- (4) An integrated treatment plan should be developed for the patient that incorporates the alternatives selected for the resolution of each problem, an outline of the sequence that will be followed in resolving the problems and an estimate of the possible cost of the treatment. The integrated plan should be signed by the patient and a witness and specify that the

integrated plan is based on a full discussion of the alternatives that are outlines in the initial plan.

- (5) A mechanism should be developed for recording progress toward the resolution of each problem, the completion of the treatment plan, alterations in the treatment plan and for recording patient comments throughout the entire process of care.

Patient records constructed in this way provide an excellent resource for audit and study. Records patterned after those used regularly in dental practice are inadequate for these purposes and do not fulfill the criteria stated earlier in this paper.

It is beyond the scope of this paper to present a detailed discussion of each section of our patient record. However, there are a few comments that can be made regarding the various sections of the record and the sequence we use for providing services. Details will be provided in a later paper where we will suggest that national standards need to be developed for dental records that are similar to the standards used to judge other components of our work. Without such standards our records cannot be used for auditing purposes or to provide evidence of our interest in documenting the fact that we have obtained informed consent from our patients.

Sequencing Patient Care to Assure Informed Consent

If patient needs are to be used to document the process of care then an orderly sequence needs to be followed. The system, which is used in our clinics and private practices, contains all the elements described above. A brief discussion of this system will be provided to conclude this manuscript.

A key element in assuring that the patient is able to make decisions is the data base. Our data base includes a complete health history that covers past, current and potential health problems. In addition, we provide a complete oral-facial examination, routinely take vital signs and perform a detailed radiographic interpretation. Furthermore, we routinely perform periodontal probing and plaque analysis and record the findings in a systematic manner. When these data base components are combined with the usual hard tissue examination and initial interview we have a data base that enables us to identify most if not all of the problems that may be of concern to the patient. It is the quality of this data base that enables our patients to be informed.

The data base is used to prepare a complete problem list which serves as the focal point for

planning and facilitating patient involvement. By listing the problems and giving each one an identification number, we are able to systematically discuss how each individual problem can be managed.

Once the problem list is prepared we are able to review each problem separately with the patient and document in writing the alternatives and risks. Patients gain a better understanding of the options and are able to choose the one that best suits their needs. After the options are discussed and the alternatives selected we are able to develop a sequential treatment plan that integrates all problem resolution activities. The patient is then in a position to provide his/her consent to provide the services that were jointly selected. Signatures are obtained and we can move ahead with the confidence that we have assured the patient that the process of informed consent was used.

Our method for recording the information that is exchanged during patient encounters should also be mentioned. We use a structured progress note that permits us to document patient comments and any alterations that are made in the treatment plan that the patient originally signed. The use of structured progress notes further assures the patient that informed consent is a regular part of the office routine.

As a final note it would be appropriate to inform the reader that our system of record keeping and patient care does require more effort than some other systems. We spend more time communicating with patients and more time documenting observations, findings and procedures. However, the time we spend on our records produces better informed patients and reduces the probability that misunderstandings may occur as a result of our intervention into the lives of others.

Summary and Conclusion

In summary, this paper has presented a discussion of the issues associated with the concept of informed consent. It was pointed out that the professionalization of dentistry has resulted in a doctor/patient relationship that is based more on status than contract. However, recent court rulings are affecting this relationship. The precedent has been established which requires that informed consent be obtained prior to most dental treatment.

Subsequently, a method was suggested for using the patient record as a way of assuring that informed consent was obtained. A set of criteria were introduced. In addition, method for sequencing patient care was outlined which facilitates the process. It was pointed out that implementation of the criteria

suggested above would require an alteration in our approach to patient care. As a result we might expect better informed and more satisfied patients who are less likely to question our decisions. Δ

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A TREASURY OF DENTISTRY

Gardner P. H. Foley

Certainly one of the most colorful, interesting and eccentric dentists in the history of American dentistry is Henry Daniel Cogswell. During his lifetime he attracted the attention of not only members of his profession but also of large segments of the population in several areas of the country. The details of his early life parallel those of an impressive number of dentists of the nineteenth century who worked at various humble occupations before selecting dentistry as a profitable and satisfying source of livelihood.

Cogswell was born in Tolland, Conn., in 1820. Following the death of his mother when he was eight years of age, he was taken by his father to live with his grandparents in Orwell, N.Y. On the death of his father the teen-aged Henry returned to New England to work as a mill hand in Willimantic, Conn. His next job was in Central Falls, R.I., as a helper in a brick factory. Moving to the large city of Providence he became apprenticed to a jeweler. When the shop went out of business, Cogswell decided to begin the study of dentistry and secured an apprenticeship in a dental office, a beginning that was to lead him to a career marked by fame and fortune.

In 1847 he began his own practice in Providence, a step that was soon followed by his marriage with Caroline Richards of Central Falls, the daughter of a manufacturer. Taking early action to the stirring news

of the discovery of gold in California, Cogswell sailed for San Francisco in 1849. With a capital of three thousand dollars the adventurous dentist opened an office on California Street.

The time and the place were ideal for a Cogswell, who soon earned a reputation as a capable and prosperous dentist. The gold miners who came to San Francisco for dental services were motivated by unusual purposes. They requested the dentists to use their own gold in filling and decorating their teeth in order that they might thus show their prosperity. A favorite operation was to have teeth extracted so that gold plates could be used to replace their edentulous state. Cogswell retired with a fortune of about two million dollars, accumulated from his earnings in dentistry and his investments in mining stocks and real estate.

In the 1870s Cogswell, who had been an active prohibitionist, began the "truant" aspect of his double career. He planned to erect public fountains in various cities to glorify the cause of Temperance. The fountains were built in Bridgeport, Conn., at a cost of about \$4,000 each. They varied in design, but they did have some common feature: sculptured marine and animal life and gargoyles. Several of the fountain structures had a large statute of Cogswell. In one hand he held a temperance pledge; in the other, an empty glass. (The illustration is of a Cogswell San Francisco fountain monument). Around some

of the bases were such chiseled admonitions as "Never Leave Your Work For Others To Do" and "Indefatigable Perseverance With Patient Industry Leads To Fortune." One of the earliest fountains was erected in the Main Street Square of Pawtucket, R.I. in 1880. It was removed to Slater Park in 1903. Also in 1880 a monument was erected in Washington at Pennsylvania Ave. and 7th St., N.W.—"by an eccentric, wealthy dentist who offered fountains of this type emphasizing the purity of water to cities that would accept his gift." The fountain in Central Park, Rockville, Conn., dedicated in 1883, was in 1886 dumped into Snipsic Lake by a group of citizens. It was retrieved and in 1889 reinstalled, but without Cogswell's sculptured presence. The Fall River, Mass., fountain (without the donor's statue) erected in 1884 stood in City Hall Park for seventy-eight years. The Boston fountain was removed in 1894 following ten years of vigorous denunciation of this "caricature of art." The fountain in Rochester, N.Y. was destroyed two years after its dedication in 1883. The Buffalo monument was removed at the "request" of the parishioners of an adjacent church. Soon after the erection of the Dubuque fountain, Cogswell's statue mysteriously disappeared from his pedestal.

There were at least three salient reasons for the antagonistic reception given to Cogswell's gifts to the towns and cities chosen to receive them. The blatantly personal fea-

Henry Cogswell

tures of the inscriptions and the statue of the donor caused the citizens to ridicule the egotism of Cogswell. The inferior quality of the fountains in both design and materials resulted in gradually mounting criticism of them. Then, of course, there was the aggressive opposition of the strongly organized anti-temperance elements among all of the populations concerned with the presence of a Cogswell fountain in their areas of habitation. The intended philanthropist was kindly in his contribution to the public welfare, but he seemed to be very limited in his knowledge of human nature.

Cogswell attained a good reputation in contemporary California dentistry and was recognized as a progressive dentist. He patented several dental devices and invented a procedure for improving the security of dentures. Dr. Loren B. Taber described Cogswell as "Possibly the first man in California to use chloroform as an inhalation anesthetic in a dental operation."

Henry Cogswell, the first dentist to land in San Francisco, offered or made other contributions to the welfare of his adopted state. He proposed to establish a dental college provided it would offer free instruction to the needy and permit young ladies to study dentistry. The very challenging conditions stipulated by Cogswell negated any serious consideration of his proposed gift. However, he did found in San Francisco a Polytechnical College where poor boys could learn a trade. This successful Cogswell benefaction still provides educational services to youths of the area. Another existing Cogswell gift is the Caroline Cogswell Memorial Clock Tower in Central Falls, R.I., erected in 1904.



The fountain and statue of Henry Cogswell in San Francisco, one of a reported 20 such statues erected by him, to combat the forces of evil by glorifying the cause of Temperance.

POSITIVE REINFORCEMENT IN CLINICAL TEACHING AND EVALUATION

Charles F. Rau*

In the mid-1970's the Department of Periodontics of the University of Louisville School of Dentistry modified its traditional approach to teaching by replacing a large segment of lecture material with a self-paced, programmed instructional package incorporating specific criterion-referenced behavioral objectives. As a companion to this information delivery system the clinical teaching program was modified to incorporate the co-therapist relationship described by Landay, et al.¹

The primary objective was to establish a clinical learning environment that provided positive reinforcement for the development of students psychomotor skills and to eliminate behavioral contingencies that might be construed to be punitive.

Quantitative criteria were developed from computer-stored data which had been compiled on previous students performance over several years. Qualitative expectations were collated from the full time and part time faculty members in the Department.

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Clinical teaching and evaluation of dental students should enhance the learning process through positive reinforcement of principles and values. This article presents the elements of a non-threatening approach to clinical teaching and evaluation which nurtures learning and professional development in a collegial atmosphere and which is based on principles that are adaptable to any clinical discipline. The advantages to both faculty and student are discussed. The issues of objectivity and the separation of teaching from evaluation, as well as the value of subjectivity in professional education, are discussed.

In preparing to design a method of teaching and evaluating student performance that was compatible with the non-threatening concept, the following premises were considered: (1) that the clinical environment with responsibility for patient care is stressful to the student beginning training;¹ (2) that clinical teaching is more effective in a collegial environment;¹ (3) that the observations, suggestions and judgments of faculty members with varying experience levels and backgrounds are valuable to the development of a well-rounded teaching program;^{2,3} (4) that teaching should be clearly separated from evaluation and grading;¹ and (5) that superior student performance should be rewarded.⁴

A method of teaching and evaluating clinical performance is described in this paper which has proven to be effective and efficient.⁵

It represents a diametric change from the stressful, threatening atmosphere that many of us experienced as students. The principles can be readily adapted to the unique requirements of any clinical discipline.

Course Requirements

Clinical requirements in dental education are based on the need for students to practice new skill-dependent procedures so that they can master the techniques. Therefore, in this system, the clinic years are regarded as a continuum to allow for differing degrees of speed in learning and development.⁶ To ensure steady progress toward achievement of a student's total educational goal, specific benchmark management and procedural requirements are regularly monitored.⁵ These requirements are

ones which the faculty consider to be absolute minimum expectations that can be met by any student who makes a conscientious effort. In periodontics the requirements are intended to be supportive of other disciplines by providing a source of periodontally healthy patients for restorative care and other needs.

Developing Competency

Competency in clinical dental education equates to the ability to demonstrate sufficient knowledge and skill to satisfy specific performance criteria and to be able to repeat the procedure in a predictable manner. Competency is considered to be the minimum level of acceptable performance. It is a reflection of the level of development of those skills which the student must master to be considered successful. It is the level of achievement that the student must attain to graduate and to be licensed to practice dentistry. The degree of proficiency that a student demonstrates by repeated competent performance of various tasks is interpreted as mastery of the clinical skill.¹

Non-Graded Instruction

Faculty inconsistency in teaching and evaluation has been cited as a frequent source of worry and frus-

tration for students which can negatively affect learning behavior.^{4,7} In this system student performance during routine clinical treatment of patients is not graded, thereby providing a non-threatening environment in which learning can take place. Students are encouraged to seek as much instructor advice or assistance as needed to accomplish any given task. Instructors are expected to perform as co-therapist colleagues and mentors rather than evaluators *per se*. This affords the student numerous opportunities to question and to profit from the varied experiences and philosophical differences of their instructors without fear of criticism or penalty. The students benefit by receiving an immediate critique of their efforts which is not biased by the need for grade assignment or possible instructor variance.^{9,10,11,12} If seemingly confident advice or information is received, students are expected to question and openly seek resolution of the problem before proceeding.

Measurement of Competency

Competency is determined for each student in selected clinical procedures after the procedures have been performed enough times to have been learned. The results of such learning can be measured with minimal subjectivity by using stated criteria which represents

acceptable performance.^{1,13,14,15,16}

Once the basics of a procedure have been learned, a student should be able to predictably perform the procedure in an acceptable fashion when stress-producing elements are eliminated. In this system, evaluation is accomplished through the use of proficiency-determining procedures which the student may elect to perform at any time on any assigned patient. The number of successfully completed proficiency procedures established as representing competency forms the basis for the assignment of academic grades. The procedures can be intermediate steps such as those normally monitored in cavity preparation or in denture fabrication or they can be completed procedures such as a full mouth scaling and root planing in periodontics.

Proficiency Evaluation Procedure

Evaluation to determine student proficiency of any given clinical objective is conducted independent of clinical instruction. Ideally, the student should be evaluated by a faculty member who has not served as a cotherapist-instructor¹ but in small departments this may not always be possible. In these instances the separation of instruction and evaluation serves a most

useful function in retaining the non-threatening environment.

A student may elect to participate in an evaluated exercise at any time he or she feels confident that sufficient experience has been acquired to be able to proceed without instructor assistance in accordance with stated criteria. The faculty person serving as evaluator is so informed before any work is begun, and an appropriate entry is made on the record to indicate an evaluation procedure. The procedure does not have to be accomplished at one sitting. If the procedure is not completed, it is recorded as such, with a notation that no faculty assistance was given. This permits the evaluation process to continue to the next appointment eliminating the pressure that time constraints place on the early development of skills when quality is the primary objective. At the completion of an evaluated procedure, an entry is made in the department's records if the student has met competency requirements. The uniqueness of the system is that there is no penalty assigned for failing to meet the minimal performance criteria.¹ If instructor assistance is required or the criteria are not met, the procedure becomes a non-graded treatment. The student having benefited from the non-threatening learning experience is free to try again without the stigma or penalty of having a failing grade recorded.

Criterion-Referenced Evaluation for Clinical Grading

This system is designed to (1) eliminate penalties for technical deficiencies during the learning process; (2) minimize subjectivity in the grading experience; and (3)

reward the student for superior performance. Criteria established for evaluation should be those which the instructional staff can objectively, uniformly and consistently identify. Criteria for evaluation should be basic and as limited in number as possible consistent with assuring competency determination.^{13,15} The assignment of grades is based on the number of proficiency procedures successfully completed for specifically identified areas of clinical competency. If a student can repeatedly demonstrate successful performance, he or she should be rewarded with a higher grade than the student who satisfies requirements determined by the faculty to demonstrate a minimum level of competency. For example: x number of proficiently performed procedures for competency = C, $x + 2 = B$, $x + 4 = A$. This system can easily accommodate any combination of procedures, criteria and requirements.

Rewarding Superior Performance

When a student has demonstrated mastery by satisfactory completion of a designated number of proficiency evaluation procedures sufficient to earn a letter grade of A, he or she may be rewarded by the elimination of the need for instructor monitoring of various interim steps or procedures that a discipline might otherwise require. This reward is an incentive for the students to complete their requirements in an expeditious and skillful manner. In a comprehensive care program, this has the added benefit of ensuring timely progress in the development of a family of patients needed to meet the clinical requirements in other areas.

Self-Evaluation

An important component of professional training is the acquisition of judgmental and evaluative skills. After graduation a dentist is responsible for continuously evaluating his or her own performance as well as the performance of auxiliaries and office personnel. An additional element of this program requires the student to evaluate his or her own performance using stated criteria as a checklist.¹² This experience in self-evaluation is intended to assist the student in learning to fulfill their continuing responsibility for self-improvement and professional growth.

Discussion

Bohannon and others stated that "teaching philosophy and evaluation methodology should be based on the premise that the ultimate objective of any evaluation procedure is to help the student learn." They described a process whereby this could be achieved.⁸ The evaluation system described in this paper incorporates many of their suggestions and has proven to have many advantages for both students and faculty. For example, instructor-student contact time is more effectively and efficiently spent in teaching rather than grading, which is a particularly important aspect of innovative curricula designed to increase individualization and flexibility of education.¹ Even though most student-mentor interaction will necessarily have judgmental elements, the feedback in this collegial atmosphere is designed to be constructive and to have no punitive overtones. There are no surprises. The student knows when quality has been achieved and when and why it has not. The competency evaluation procedures may

well be considered to be competency confirming procedures because evaluation is simply a means of confirming what the student has learned and is able to perform.

The need for objectivity and inter-rater reliability in the evaluation of student clinical performance has been addressed by several writers.^{4,11,15} Attaining and maintaining these desirable features in dental education is difficult and sometimes impossible.^{7,10,17} In the system described in this paper, inter-rater variability is minimized by the use of simplified but meaningful, specifically-stated behavioral criteria, which are directly related to the procedural goals.^{13,14,15} Hunter pointed out that even though competent dentists vary in practices, testing validity is acquired when interfaculty agreement is translated into a standard for expectation of student performance.³

The method of clinical teaching and evaluation described in this paper is intended to maximize objectivity by ensuring that stated procedures can be criterion referenced and uniformly evaluated. However, the unique role of subjectivity in professional education must be defended.¹⁹ Certain work habits, attitudes, communication skills, interpersonal relationships, social attitudes, judgments and ethical values cannot be readily determined by objective examination but rather require observations and subjective evaluation by experienced instructional personnel. These elements of professionalism impact on the overall quality of the dental service rendered. It is the responsibility of each discipline to evaluate professionalism in the students under their tutelage. The final element of this system provides for the possibility of the raising or lowering of a student's final grade by one letter to recog-

nize superior or substandard performance in the area of professionalism. This component, if utilized, requires a consensus among all departmental faculty who have had sufficient collegial contact with the student to make a meaningful determination.

Conclusion

The value of reinforcement and the negative effects of punishment in education have been addressed by MacKenzie and others.²⁰ A lack of reward and encouragement may be viewed by a student as punishment with many negative consequences. The separation of teaching and evaluation and the personal satisfaction derived from well performed procedures function as self-reinforcing behavioral contingencies in this type of a positive educational environment. △

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LETTERS FROM READERS

Sharing A

Philosophy

That Has

Withstood the

Test of

Time

Open Letter To My Young Dental Colleagues

As I approach another graduation or commencement in my life time—retirement—I wanted to share some philosophy which hopefully can make this period a most exciting and rewarding one. These tenets are basic and have certainly stood the test of time for me.

Firstly, take nothing for granted. Everything must be planned and adhered to, the sooner the better. Above all hold fast to the ethics of your profession—we have been blessed with the greatest. After forty-six years of continuous education, pre-doctoral, doctoral and post doctoral training—being a continuous student—I realize the significance of G.V. Black's admonition.

In conjunction with fulfilling the demands of a dental career do not fail to implement the other must requirements to reach your goals.

Do everything possible to take God's gift of good health and cherish it. Abuse it and you will lose it. Have a well directed and supervised exercise program.

Don't worry about the "Jones". Live your own life style, and avoid the pressures of today's society. Enjoy your family to the fullest. Today is the time to *live, learn, and love*.

Do not become financially overburdened and obligated—something so easy to do. Live a gracious lifestyle within your means.

Forced savings, not greedy investments for the quick return or "strike it rich" concept, is a must in your plans for the future. You will be amazed how your funds will multiply over the years. Your family will be well cared for in every way, including the worrisome obligation of your childrens' education.

Try to be active in professional activities. Volunteer your services. Teach in whatever capacity you can. These involvements will keep you young in body, mind and spirit. Age is a very relative thing. You are truly as young as you feel and believe.

In summary, you need to establish a plan early in life, work the plan, and review it at regular intervals assuring yourself you have not digressed. The basic things in life have stood the test of time. They will continue to do so. If you haven't started, do so today. The years pass swiftly. He who procrastinates is lost in the crowd.

Leon D. Rosenfeld

Professor of Periodontics

Northwestern University Dental School

MARYLAND SECTION'S ACD DAY

Bernard Gordon*

Dedication ceremonies for Hayden-Harris Hall, the new University of Maryland School of Dentistry took place March 6, 1971, 131 years to the day since the founding of the first dental school in the world, the Baltimore College of Dental Surgery.¹ Three months before, on December 3, 1970, at the Maryland Section's Annual Meeting at the Lord Baltimore Hotel in Baltimore, D. Joseph P. Cappuccio, former ADA President, suggested that we assist Dean John Salley in his dedication program and suggested an American College of Dentists Day at the School.² The Policy Committee discussed the feasibility of instituting such a program and presented the following objectives of why the Section should initiate this activity: (1) To get the Section off of "Dead Center" and become more involved in some form of voluntary activity for the dental community. (2) To acquaint the student, the Dental School and the community with the ACD and its purposes. (3) To assist the senior dental student with pertinent issues of the profession from the viewpoint of hard-core professional men.³

*Bernard Gordon, DDS, Editor of the *Journal of the Maryland State Dental Association* was the 1982 Maryland Section Chairman.



Charles T. Pridgeon, the Maryland Section Chairman when the ACD Day was inaugurated in 1972, is still an annual participant.

On January 13, 1972 at the Annual Section Meeting at Hunt Valley Inn, Cockeysville, Maryland, one hour was devoted to a discussion of this issue, under the title of "Old Business". Dr. Irving Abramson said senior dental students needed to know more about the objectives of the College and how it relates to views and concerns of the dental profession. Dr. Robert J. Nelsen, Executive Director of the College, commented that students should get the idea of professionalism. Some speakers questioned whether the students would be

interested; others questioned the planning and whether Dean John Salley would be receptive. It should be pointed out he and his successor Dean Errol Reese, their respective administrations, and faculty have been enthusiastic since our beginnings and have imbued their students with their enthusiasm. Clinics are closed and the faculty provides minimal special student assignments.

The First Annual ACD Day was held in Hayden-Harris Hall on Monday, October 16, 1972. Papers were presented by Dr. Carl A. Laughlin, President of the ADA (*What Dental Organization Has Meant To The Development Of Dentistry In the United States*) and by Dr. William K. Collins, Secretary, North East Regional Board of Dental Examiners (*What Dental Licensure Has Meant To The Development of Dentistry In The United States*). The president of the senior class, Herman J. Schutze conducted an open discussion of the two papers and Dr. Cappuccio gave the summary. The Section sponsored a buffet luncheon; the Dean and Chairman spoke; brochures were distributed. The Program was so well-received that the Section was pleased to involve itself the following year on Monday, October 15, 1973.

The format for this program was similar to the preceding year.

Dr. Clement C. Albert, Executive Board, North East Regional Board of Dental Examiners, spoke on "Are You Prepared to Practice Dentistry?" Dr. Marvin P. Sheldon, a former professor at Howard University School of Dentistry spoke on "What Kind Of Dentist Do I Want To Be?". The president of the class of 1974, Burt A. Jordan, Ph.D., discussed the papers. This session, like its predecessor, was successful. Attending were ninety (90) graduating seniors, twenty (20) Section members, five (5) of whom were participants, and six (6) guests. Among those attending were Dean Salley, Associate Dean Reese, Dr. John Hasler and ACD Executive Director Dr. Robert Nelsen. It was the consensus that this was a

worthy program benefitting all concerned. The annual business meeting minutes of January 10, 1974 reveal that a unanimous consent was recorded to a recommendation that the ACD at the Dental School be an annual project of the Section, that the ACD Day be made a Standing Committee instead of an ad hoc one and that the program planned be reviewed and approved by Section officers. This was the last year that the event was held on a Monday. The program was held on a Thursday the following year and since then it has always been held on a Wednesday afternoon.

In 1974, Dr. Lynden M. Kennedy, President-Elect, ADA spoke on "Current Trends in the Delivery of

Dental Services" and Dr. Robert I. Kaplan, Editor, *Journal of the ACD* spoke on "How to Start a Dental Practice". Mr. Dennis Cambria, 1975 class president was the discussor. Prior to 1975 there was much discussion regarding the format of the program even though the attendance was excellent. Better than 90% of the senior class attended each of the first three ACD Days. A major change occurred on October 15, 1975 when a "Lunch and Learn" type program began and it has continued yearly. Twelve Fellows participated on that date and 138 students attended to hear table talks on specialty and general practice, armed forces practice, public health, etc. Admiral George Selfridge was a participant

MARYLAND SECTION—ACD DAY DATA

Annual	Date	Section Chairman	ACD Day Chairman	Clinician Participants
1st	10/16/72	Charles T. Pridgeon	C. Adam Bock	6
2nd	10/15/73	Ernest B. Nuttall	Marvin P. Sheldon	5
3rd	10/10/74	Joseph P. Cappuccio	Lloyd E. Church	5
4th	10/15/75	Eugene D. Lyon	Joseph H. Seipp, Jr.	12
—	—	Eugene L. Pessagno, Jr.	—	—
5th	10/26/77	Walter Dorn	William Schunick	16
6th	11/01/78	William Schunick	Leonard Rapoport	16
7th	10/31/79	Joe N. Price	John F. Hasler	16
8th	11/05/80	Conrad L. Inman, Jr.	Marvin P. Sheldon	16
9th	10/07/81	Gerson A. Freedman	John F. Hasler	21
10th	10/13/82	Bernard Gordon	John F. Hasler	27
11th	10/26/83	Frank A. Dolle	John F. Hasler	23

ELEVENTH
AMERICAN COLLEGE OF DENTISTS
STUDENTS' DAY



Sponsored by
THE MARYLAND SECTION
OF
THE AMERICAN COLLEGE OF DENTISTS
at the
Medical Teaching
Building at the
University of Maryland at Baltimore
October 26, 1983
1:00 P.M.

TENTH
AMERICAN COLLEGE OF DENTISTS
STUDENTS' DAY



Sponsored by
THE MARYLAND SECTION
OF
THE AMERICAN COLLEGE OF DENTISTS
at the
Atrium - Medical School Teaching Facility
University of Maryland at Baltimore
October 13, 1982
1:00 P.M.

NINTH
AMERICAN COLLEGE OF DENTISTS
STUDENTS' DAY



SPONSORED BY
THE MARYLAND SECTION
OF
THE AMERICAN COLLEGE OF DENTISTS
at the
ATRIUM-MEDICAL SCHOOL TEACHING FACILITY
UNIVERSITY OF MARYLAND AT BALTIMORE
OCTOBER 7, 1981
1:00 P.M.

EIGHTH
AMERICAN COLLEGE OF DENTISTS DAY



SPONSORED BY
THE MARYLAND SECTION
OF
THE AMERICAN COLLEGE OF DENTISTS
at the
TERRACE ROOM - BALTIMORE
UNIVERSITY OF MARYLAND AT BALTIMORE
WEDNESDAY, NOVEMBER 5, 1980
1:00 P.M.

THE MARYLAND SECTION
OF THE
AMERICAN COLLEGE OF DENTISTS



ANNUAL
AMERICAN COLLEGE OF DENTISTS DAY

SEVENTH
AMERICAN COLLEGE OF DENTISTS DAY



SPONSORED BY
THE MARYLAND SECTION
OF
THE AMERICAN COLLEGE OF DENTISTS
at the
TERRACE ROOM - BALTIMORE UNION
UNIVERSITY OF MARYLAND AT BALTIMORE
WEDNESDAY, OCTOBER 31, 1979
1:00 P.M.

THE MARYLAND SECTION
OF THE
AMERICAN COLLEGE OF DENTISTS



First Annual

AMERICAN COLLEGE OF DENTISTS DAY

Hayden-Harris Hall
University of Maryland
School of Dentistry

Monday, October 16, 1972
1:00 P.M.

THE MARYLAND SECTION
OF THE
AMERICAN COLLEGE OF DENTISTS



THIRD ANNUAL
AMERICAN COLLEGE OF DENTISTS DAY
Hayden-Harris Hall
University of Maryland
School of Dentistry
Thursday, October 15, 1975
1:00 P.M.

THE MARYLAND SECTION
OF THE
AMERICAN COLLEGE OF DENTISTS

SIXTH ANNUAL
AMERICAN COLLEGE OF DENTISTS DAY



Sponsored by
The Maryland Section
of
The American College of Dentists
at the
Hayden-Harris Hall
Baltimore College of Dental Surgery
Dental School, University of Maryland at Baltimore
Wednesday, November 1, 1978
Student Lounge - 1:00 p.m.

FIFTH ANNUAL
AMERICAN COLLEGE OF DENTISTS DAY



Sponsored by
The Maryland Section
of
The American College of Dentists
at the
Hayden-Harris Hall
Baltimore College of Dental Surgery
Dental School, University of Maryland at Baltimore
Wednesday, October 26, 1977
Student Lounge - 1:30 p.m.



FOURTH ANNUAL
AMERICAN COLLEGE OF DENTISTS DAY
Hayden-Harris Hall
University of Maryland
School of Dentistry
Wednesday, October 15, 1975
1:00 P.M.

and the session lasted 45 minutes past our usual allotted 3 hour time limit because the students continued asking questions.

No ACD Day was held in 1976 because the Maryland Section held its First J. Ben Robinson Lecture. This Lecture is held triannually. The program's first guest lecturer was Professor Gardner P.H. Foley and his title was "The Discovery of Dental History as a Recorder of the Usable Past". The Lecture was held in the John Eager Howard Hall on November 4, 1976. Chairman Pessagno commenting in his annual report stated: "We found it feasible to cancel our Annual ACD Day consisting of lunch and a program for the senior dental students. The date of this would have been too close to the J. Ben Robinson Lecture and the mechanics and committee requirements would have resulted in a sort of top heavy arrangement and possibly the placing of too many demands on our

membership. We heartily recommend the continuance of this function." So the program continued on October 26, 1977. The brochure stated: "Select a Topic—Enjoy a "Rap" Session With An Experienced Practitioner". We had a full house. The Sixth Annual was the last held in Hayden-Harris Hall. We moved nearby the following year to the Terrace Room of the Baltimore Union Building where we held the affair until 1981 when we again moved, but this time one block away to the Atrium-Medical School Teaching Facility where we have a larger and more appropriate room to accommodate the increased number of senior dental and dental hygiene students.

The brochure for the Sixth Annual ACD Day shows we had sixteen (16) speaker-participants; the minutes show 150 participated. One hundred sixty-six students plus twenty-six (26) Fellows who attended the Seventh underwent an

unusual experience. The fire alarm accidentally sounded, shortening the program thirty minutes.

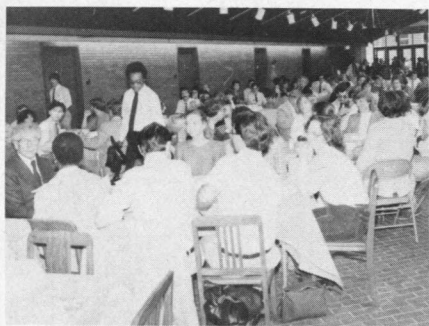
In 1980, Dr. Marvin P. Sheldon again became the Committee Chairman and this individual remains one of those who have participated in most ACD Days. Records of the Section reveal that at least ten others have been regular participants. It was during the 1980 meeting that the Committee instituted an Invocation to the program. One hundred thirty-five students and thirty-five (35) Fellows attended including sixteen (16) clinicians. At our annual business meeting on November 13, 1980, Dr. Joe Price commenting on his talk before Section officers at the American College Meeting in New Orleans said, "Maryland's program at that time was unique." We think it still is. Our 1981 Chairman appointed Dr. John T. Hasler as his Committee Chairman for the Ninth Annual ACD Day and he has remained in this post for the last three years.

We did not budget enough money to cover our 1982 affair. This was the same year our Third J. Ben Robinson Lecture was held. Our expenses jumped because we had more students and clinicians than at any prior meeting and our lunches were more expensive, too. Two hundred fifty attended. At our annual business meeting in December of that year our membership voted unanimously to tax each active member \$10 to make up the deficit.

It is always the Committee Chairman's responsibility to secure a



Marvin P. Sheldon, right, is a regular participant on each ACD Day.



250 attended the 10th Annual ACD Day in the Atrium—Medical School Training Facility at Baltimore, Maryland.

date on the Dental School's academic calendar, usually a year in advance. He is also responsible for securing the required speakers, inviting the seniors, making the proper table arrangements, having signs printed for each table and contracting the caterer. The Section Chairman usually appoints a five member committee and at least one is a faculty member. All clinicians are Section members who give up at least one-half day of their practices; some who come from the greater distances of Eastern and Western Maryland lose one full day from their practice. They are proud of their part because this is a stimulating and profitable event evoking considerable dialogue between themselves and the students, and serves to help mold and pattern the students' attitudes and assist in influencing their professional lives.

Our public relations image for the Section locally and nationally

has been enhanced by the Program. Executive Director, Dr. Gordon Rovelstad has appeared on the Program each year since his appointment. A brief write-up has appeared frequently in *The Journal of the American College of Dentists*. Articles have appeared in the *Alma Mater*, the alumni publication of the Baltimore College of Dental Surgery, Dental School, University of Maryland; *The Probe*, the Dental School student newspaper, and in *Happenings*, a University of Maryland publication. The Maryland State Dental Association's *Newsletter* and *Journal* have frequently carried releases of ACD Day so that we might receive the greatest possible exposure.

Fellows have spoken on a variety of topics regarding general and specialized practice, including record keeping, insurance, professionalism, hiring auxiliaries, income tax and withholding for the new dentist, Northeast Regional Boards, associateships, dental organizations, drugs in dentistry, etc. We frequently inquire what the students would like us to discuss. Our clinicians seldom refuse the invitation to participate and they are willing to speak on any subject whether in their primary domain or not. For the last three years attendance for our senior dental and dental hygiene students has ranged from 95 to 100%. Those statistics are better than the student's actual classroom and clinic attendance.

In each of our brochures is a statement, "What is the American College of Dentists?" It says, "The

American College of Dentists is a non-profit organization imbued with the highest ideals for the dental profession and its service to humanity. Towards these ends, it holds meetings, conducts seminars and workshops, fosters research, and carries on studies in associate areas of interest and its public services. It acts as a catalyzing agency to other organizations in an effort to stimulate them to upgrade their services and keep alert to new developments. It recognizes, through Fellowship in the College, those who contribute to such efforts."

We are bringing organized dentistry's view to the students on the pressing problems facing the profession. We have brought them some of the most outstanding and articulate leaders of our profession. We have demonstrated that we care. It has been the finest example of what the Maryland Section can accomplish. This program has developed far beyond our expectations.

As Dr. Robert Nelsen so aptly said in "Comment" on page 3 of Volume 2, Number 3 of the *ACD News and Views* for August, 1974: "In the profession, the sudden metamorphosis of student to practitioner has a potential for significantly great harm. The novice dentist must be influenced at this time by the profession and not the business community, so that the economic considerations necessary to establishing a practice do not supervene his mandatory professional obligations. These antagonisms are a considerable danger to

his professional development at this transition period. As self-interest and financial return view with the less apparent, but more regarding features of a professional life-style, the guiding influence of the organized profession must become more effective." Δ

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1. *Journal of the MSDA*, Vol. 13, No. 3, December 1970, p. 192.
2. Minutes of the Maryland Section, 1970-1983.
3. Committee Reports of the Maryland Section, 1970-1983.

STATEMENT OF OWNERSHIP AND CIRCULATION

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The Journal of the American College of Dentists is published quarterly 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. It is the official publication of the American College of Dentists which invites submission of essays, editorials, reports of original research, new ideas, and statements of opinion pertinent to dentistry. Papers do not necessarily represent the views of the Editor or the American College of Dentists.

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2. White, E. M., Sometimes an A is Really an F. *The Chronicle of Higher Education*, 9:24, February 3, 1975.

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