the Journal of the American College of Dentists

National Laws and Dental Care

Dentistry and Government

Action in the Community

Why Dental Editors?

JANUARY 1967

the Journal of the American College of Dentists

A QUARTERLY PRESENTING IDEAS IN DENTISTRY

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Editorials

Involvement and the Individual

It has been said, during the past year, in comment on the new health legislation, that "Things are not ever going to be simple again," and, "There is so much to be done." These statements may be in your mind when you read the panel papers in this January 1967 JOURNAL, and reflect on governmental efforts of the past two years to provide dental care for more citizens. But a much more dynamic thought should dominate and demand attention.

Involvement is a word one sees frequently these days. It can be used here well. All of us must become involved in the planning and providing for an expanded dental health program. Government already is involved, dental schools are facing up to it, and dental organizations are assuming significant leadership.

The adoption of the "American Dental Association Dental Health Program for Children" in November at Dallas, while important and timely, was but one sign of involvement on the national scene. There are others, and there will be still more at that level. But the total planning and solution cannot be decided there alone. Communities differ greatly, each with special and peculiar characteristics, needs, and demands. Thus it will be at the local level, *in the community,* that the confrontation definitely will be. There is where dentists will serve patients; there is where the actual dental care program will be initiated and completed. And that brings the action directly home to each individual one of us.

What will be expected of us? Foremost among many things: acute awareness of responsibility, deliberate willingness to face and accept change, forceful leadership in health planning, full knowledge of and active participation in health activities—assuming the role of a leading and enlightened professional and a responsible citizen in the community.

Pridgen sums up a part of this involvement: "Most of all our profession needs the acceptance by *each dentist* that each individual has the *right* to the good life with optimum dental health as an important part of it." Diefenbach spells out another part: "There is today an unprecedented urgency for the American dental profession to hammer out its position on major public dental issues and to choose the right courses of action."

The reality and necessity of involvement must be accepted. This is not the time for dentists to show the signs of the ostrich syndrome. It is the time for each of us to become wholeheartedly involved in framing the plans for comprehensive personal and environmental health services in which dental care will have a prominent place.—*T.McB.*

What the College Is

Some Fellows have indicated, from time to time, that a short statement would be helpful in answering the question, "What *is* the College?" The following could be an answer:

"The American College of Dentists is a nonprofit organization imbued with the highest ideals for the dental profession and its service to humanity. Toward these ends the College holds meetings, conducts seminars and workshops, fosters research, and carries on studies in associated areas of interest to dentistry and its public services. The College acts as a catalyzing agency to other organizations in an effort to stimulate them to upgrade their services and to keep alert of new developments. The College recognizes, by the conferring of Fellowships, those who contribute to such efforts."

Those who wish to add to this may turn to the inside back cover of the JOURNAL. The objectives of the American College of Dentists appear there in every issue.—*O.W.B.*

OPTIMUM HEALTH: DENTISTRY'S ROLE IN PLANNING THE GOOD LIFE

Introductory Comment

COZIER W. GILMAN, B.S., D.D.S.

This College met at Las Vegas in 1965 two weeks after the adjournment of the first session of the 89th Congress—the Congress that had passed more significant health legislation than any other Congress in our history.

At that meeting, the Director of the Washington Office of the American Dental Association, Mr. Hal M. Christensen, presented an overall picture of the health laws that had just been enacted and reviewed the beginning activities of the federal government in the provision of health care. Kenneth J. Ryan, Chairman of the Council on Dental Health of the ADA, outlined a health care plan by the dental profession. There were three parts in this plan: A National Dental Care Program for Children, A National Dental Program for the Chronically Ill and Aged, and a Dental Care Program for All Citizens of the United States.

Also, at the meeting last year, a panel discussion was presented with the theme of "Optimum Health for the Individual in the Social Order: Planning the Good Life." The panel considered a biocultural perspective oriented to health care, medicine's potential and performance, the financing of health care and the insurance mechanism, and the excellence of health service that must be forthcoming.

All of these papers were published in the JOURNAL OF THE AMERICAN COLLEGE OF DENTISTS for January 1966.

Much has happened on the health care front in the past twelve

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months. The profession has had an opportunity to study the 1965 health laws. Professional and governmental policies have been established, and attitudes have been shaped. The magnitude of the entire national health program is being realized. The role that dentistry must assume is emerging. A new concept of dentistry in total health is appearing. A National Association of Dental Service Plans is in operation. And A National Dental Health Program for Children is being projected by the ADA.

It is no wonder that two Committees of the College—Professional Relations and Dental Health Service—have thought it desirable, in this changing scene, to present a continuation of the 1965 meeting theme. The image and vitality of the profession is related directly to the degree of success we will achieve in carrying out our obligations in planning optimum health care for the citizens of this country. This panel today will explore and discuss the expansion of dental care programs, the thinking behind the planning, the changes that appear imminent, and how we dentists should be looking at all of this.

An apt quote to introduce this discussion is one by Charles F. Kettering: "We must use the past as a guidepost, not as a hitching post—we are not at the beginning. We have but reached the shores of a great unexplored continent. We cannot turn back."

Dental Services Under the Health Laws

DAVID R. WALLACE, B.S., D.D.S., M.P.H.

The multiplicity of legislation and the interpretation of this legislation staggers the imagination of one who actively has been seeking the inclusion of dentistry as a major activity in public health. It seems that all at once dentistry has become foremost in each legislator's mind. This has produced 21 pieces of legislation which affect dentistry; and from what I am able to learn, there is more to come.

There is legislation which will provide treatment for both adults and children.

There is legislation which will provide training of dentists in special areas.

There is legislation which will provide loans and scholarships to dental students.

There is legislation which will strengthen dental education.

There is legislation which will provide facilities for dental treatment.

A brief review of some of this legislation which provides for dental treatment will give you some insight into the demand for services that the dental profession must satisfy.

In the Social Security Amendments of 1965, there are many areas of dental treatment. Under Title XVIII of this law it is possible for dental treatment to be provided for persons over 65 by a dental intern or resident in a hospital. The resident or intern must be participating in a teaching program approved by the Council on Dental Education of the American Dental Association.

Also under the supplementary hospital-surgical insurance a dentist can be paid for surgery related to the jaw, or any structure contiguous to the jaw, and reduction of any fracture of the jaw or any facial bone.

Dr. Wallace is Coordinator, Dental Health Program, New Jersey State Department of Health. He is a member of the Committee on Dental Health Service of the American College of Dentists.

This paper was read at the Dallas Meeting of the American College of Dentists, November 12, 1966.

Title XIX has nothing to do with the Social Security System: like many other federal welfare programs it came into being on a legislative amendment to the original Social Security Act. Financed from general revenues (that is, regular tax dollars), it is essentially a vastly liberalized version of the old Kerr-Mills Law that provided certain kinds of health care to aged poor people over 65. The new version furnishes many of the same benefits that Medicare does, and in addition considerably more.

The real difference is that Medicare benefits the elderly, while Title XIX benefits people of all ages who are too poor to pay for their own medical assistance.

The groups that can be included under a state's Title XIX program are as follows:

(1) All those who have been receiving payments under the four main federal-state public assistance programs: aid to the indigent aged, aid to families with dependent children, aid to the blind, and aid to the permanently and totally disabled.

(2) Crippled, aged or otherwise, handicapped persons who have just enough money to live on—and therefore do not qualify for standard assistance programs—but who have little or nothing left over for medical care.

(3) All children under 21 who could not qualify for public assistance—such as dependent children whose parents are dead, incapacitated, or unemployed—but whose families, though healthy and employed, do not earn enough to pay for medical expenses.

The effect of these three provisions is to make funds available for all medically needy persons under 21 and over 65, as well as to all adults between 21 and 65 who are blind or disabled or members of families with dependent children. In addition, those over 65 who use up their medical benefits can be assured of continued medical aid under Title XIX.

It is up to each state to decide how far it will go in providing free health care for the "medically indigent."

On January 1, 1970, any state which has not qualified for Title XIX will cease to receive federal aid under the old Kerr-Mills program.

Under these same amendments there are increasing amounts of money available to the states for Crippled Children's Services, Maternal and Child Health Services, and Mental Retardation Imple-

menting and Planning. Money is also available for Health of School and Preschool Children.

The Older Americans Act of 1965 provides for full restorative services, including dental care, for those who require institutional care. Grants are available under this act for the provision of dental care.

In the Heart Disease, Cancer, and Stroke Amendments of 1965 dental care is not specifically required. However, it is inconceivable to me that comprehensive treatment could be provided and not include dental services. In cancer programs, dentists should definitely be included since cancer of the oral region has only a five year survival rate of 27 per cent.

The Elementary and Secondary Education Act can be interpreted by the Secretary of Education, on the state level, to permit dental care. Clinics can be set up in public schools and dental treatment provided to certain children. This act can be interpreted broadly by the states.

The Amendments to the Community Health Facilities Act will permit formal grants for dental health. Some dental treatment programs are being developed in the Appalachia region under these amendments. Funds are also available for dental services to migrant workers under these amendments.

The Maternal and Child Health and Mental Retardation Planning Amendments provide for maternal and child health services; maternity and infant care; and crippled children services. Strong emphasis is being placed upon dental care as a part of the services for these people.

In the Economic Opportunity Amendments of 1965, funds for dental treatment can be secured by including this in the grant. Efforts are being made to include dental treatment in all Head Start programs.

The Vocational Rehabilitation Amendments permit dental care as a condition of the person securing gainful employment.

As a part of the Appalachian Regional Development Act, demonstration health facilities can be constructed, equipped, and operated with other federal grant-in-aid programs supplementing this Act.

Two bills, of significance to dentistry, have been passed by the present Congress just recently this year. One is the Demonstration Cities Act, the other the Comprehensive Health Planning and Public

Health Service Amendments of 1966. I have not had the opportunity to review these laws in their entirety, but both can affect dental care programs to a considerable degree.

This in brief will give some idea of the recent legislation in which dental services can be provided. While in most of the legislation dental services are not mandatory, the legislation can be interpreted to include dental care.

The mechanisms for providing dental care will vary with the facilities that are available or can be made available to provide comprehensive dental care.

Some of the dental clinic facilities that might be used are school clinics, dental school clinics, public health clinics, welfare clinics, union clinics, hospital dental clinics, mobile dental clinics, industrial dental clinics, closed panel group practice clinics, and armed service dental clinics. It is worth noting that such facilities as clinics will lend themselves to both quality and quantity control.

If the dental clinics are located in one of the new community health centered hospitals a wide range of dental services will be provided. I can visualize clinics providing all the specialty services in dentistry. A multichair clinic could be established for general dentistry and pedodontics. Facilities for prosthodontics are a necessity since many of the patients on long term care will be senior citizens. The specialties of oral surgery, orthodontics, periodontics, and endodontics will be the special services offered by the hospital. Dentistry for the crippled and handicapped can best be provided in the hospital under a multidisciplined approach.

Clinics in public and parochial schools under the new laws can be developed. From an administrator's point of view, if children are to be provided dental care, a dental clinic in the school is the easiest solution. This would mean a minimal amount of disruption of the school routine. I look for a large number of schools to set up dental clinics as a part of their health services.

Those schools that cannot support a dental clinic could form compacts and purchase dental trailers, which could rotate from school to school. This method of providing dental services to school children has been practiced in some states for many years quite successfully.

Many well organized community health departments now include provision of dental care for the indigent as one of their health ser-

vices. As a result of recent legislation, the amount and scope of dental services provided in community health departments will expand.

The clinics in dental schools will probably not provide much more in volume of services than now, since their mission is to train dentists and auxiliary personnel, not to provide dental services.

There probably will be increasing amounts of dental care provided as fringe benefits by industry and labor unions as the government absorbs the costs of medical care. The mechanisms of providing this care will vary as they do now from closed panel clinics to private dental offices.

Dentistry should look toward functioning through some corporate structure in providing dental services under the new laws. Some of the structures that dentistry can work with are: dental service corporations, hospitals, public health departments, dental schools, welfare departments, insurance companies, group practice, and many others.

This does not indicate in my mind any lessening of the emphasis on private practice as a means of providing dental services. However, I do think that dentistry must accept some method of third party control. There is no doubt that quality and quantity control will be demanded on all programs.

The so-called third party will serve the functions of collecting funds, contracting for service, and handling reimbursements. In dental prepayment so far the third party function has been assumed by closed panel group practices, commercial insurance companies, independent private nonprofit insurance companies, and by dental service corporations.

The type of closed panel practice group we usually think of is that type which is owned and operated by nondental organizations. This closed panel type of clinic has existed for many years, but on a much smaller scale in that only part-time dentists were employed and they provided only limited services. However, in recent years this has all changed. Now closed panel clinics operate with full-time staffs of dentists and the full range of dental services are provided. In spite of the fact that the dental profession continues to attempt to discourage this type of closed panel clinics, some governmental agencies are going ahead developing such clinics for their beneficiaries.

Commercial insurance companies have approached dental coverage with hesitation. Where they have experimented with it has been with

groups and not community wide. Since commercial insurance carriers are in business to show a profit they will probably continue to experiment with dental care until they are assured that providing such coverage can be done profitably. It could be that any large scale governmental dental programs will cause the private insurance industry to be more brave in their coverage of dental care with the assurances that they will not sustain a loss.

Independent private nonprofit insurance companies have apparently been successful in their efforts to bring dental service to more people. One such company is in the New York City area. Most of the coverage this company has provided, however, has been for groups and not individual enrollment. This type of a third party arrangement will probably grow and be one method which can be readily accepted by the profession since it in no way disturbs the dentist-patient relationship.

The dental service corporation which has been developed by the dental profession now provides coverage for the largest number of individuals under any dental care plan. This mechanism promises to grow in scope and can provide services nationwide with the formation of the national association. All groups of consumers can find in dental service corporations an organization which can provide prepaid dental care of high quality more economically than any other mechanism.

Each state will allow, in fact will require, different mechanisms of delivery of dental services. One example of how dental services can be provided under Medical Assistance to the Aged is the contract that has been developed with the Michigan Dental Service Corporation.

One of the necessary mechanisms for each state dental society to have organized is a corporate body, namely a dental service corporation. The corporation can then contract with various groups for provision of care. Speaking as a dental director, I would be most anxious to have a group that I can contract with for the provision of dental services.

To attempt to postulate a formula for all states to follow, we can all realize, is an impossible task. However, a few ideas can be put forth and organized dentistry should develop its own plans, state by state.

If clinics are in existence in the state, the dental society should have some method of establishing standards and enforcing these standards for clinic operation. Such a mechanism is presently being used in New Jersey, in a Council on Dental Clinics. This Council is appointed by the Governor and consists of a representative from the following organizations: State Department of Health, State Department of Institutions and Agencies, State Department of Education, State Dental Society, State Health Officers Association, and the State Hospital Association. There are consultants from the dental schools and the State Board of Dental Examiners who meet with the Council. The purpose of the Council is to establish standards for all dental clinics in operation in the state. The State Board of Dental Examiners has the authority to enforce the standards.

I would urge each state to have some official body to regulate and control dental clinic operations. This body should have a legal mechanism to enforce its regulations.

If the dental profession is to provide the large amount of dental care that we anticipate, we must make maximum use of all auxiliaries. Studies have shown that one dentist with one assistant can increase his productive efforts by 30 per cent, while one dentist with two assistants can increase the amount of work he turns out by 50 per cent.

Every dental school should teach each Junior and Senior student to operate with dental assistants not six weeks, not two or three months, but all of the time during his clinical years in school.

Dentists should develop more group practice arrangements. It is logical, from a business standpoint, to have one common business office with a competent manager. It makes good sense from the standpoint of the patient to be referred to the specialist next door rather than have to go across town. Many are the advantages of a group practice arrangement and I do not need to repeat them. Clinical practice for many has been a solo effort. This type of service has become an anachronism.

If funds are provided, and if dentistry gets its appropriate share of these funds, there should be so much dental care demanded that the dental profession will be overwhelmed with patients.

We, the dental profession, must provide the dental care. No other group or profession is trained to provide this care. Maximum efficien-

cy in our offices must be maintained by all dentists. Our auxiliary help should perform their tasks and dentists should only provide professional services.

If the dentists cannot meet the demand for dental services in the future, then others will do those things dentists now do. Others will fill the teeth of children, others will place fillings in teeth, others will take the impressions, others will make the dentures, in fact, others will take over the dental profession.

If I might make some suggestions to the dental profession, they would be:

1. Gear up to provide more and better dental services.
2. Be willing to adapt to change.
3. Work with governmental agencies to maintain a high standard of dentistry.
4. Establish some corporate structure to work with dentistry and groups requesting care.
5. Develop new and effective methods of providing the best dental services to all people.

The attitude that should be adopted by the profession is well expressed by a paragraph written by Dean Walter A. Wilson, in an alumni bulletin of Fairleigh Dickinson University Dental School:

"What is in store for the dental profession of the future no one would dare predict at this very critical period of health service development. We are witnessing changes, not only in the methods of treatment, but even so in the methods of administering health services. The ever increasing trend toward the entrance of a third party, including state and federal government into health service rendered by the health professions, makes us stop to ponder the future. We need not look with fear and trepidation at the innovations, but we do need to take a hand in the direction of these trends which, if allowed to go unbridled, could eventually curtail the effectiveness of health care for the public. This is our immediate and continuous responsibility."

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The National Dental Health Agenda

VIRON L. DIEFENBACH, D.D.S., M.P.H.

What must the dental profession do and how shall we do it? What will be the scope of our goals? What priorities will we set? Who will determine policy? There is today an unprecedented urgency for the American dental profession to hammer out its position on major public dental issues and to choose the right courses of action.

In an age in which the federal role in health matters has steadily expanded, too many in the health professions erroneously think of national agendas in terms of Congressional calendars. If the title of this presentation has brought you to expect to learn of new surprises in store for the dental profession, you will be disappointed.

I do not think there *are* any surprises in store for the profession. Most of us know full well where the great weaknesses are. Even if, for convenience, we equate national agendas with government programs, surely the whole history of modern health legislation suggests that federal action to overcome health problems is in large part determined by the actions taken by the health professions themselves.

The American Dental Association itself offers an excellent recent example of responsible action which may lead to federal programing —its support of President Johnson's proposal for a national dental health program for children, and the constructive action it had already taken toward that same end prior to the President's statement. Though the President has not yet announced his timetable, a dental health program for children obviously has a high priority by everyone concerned and there are good reasons to expect further action, and soon.

The excellent relationship between the American dental profession, the Congress, and federal agencies is not new. It has worked effectively and in many impressive ways over the years. And yet, it

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This paper was read at the Dallas Meeting of the American College of Dentists, November 12, 1966.

occurs to me that neither the federal government nor the dental profession has ever faced up to the fact that there is not a single national program aimed directly at the nation's overriding dental dilemma.

That dilemma is the unadorned fact that the vast majority of American people, adults as well as children, do not get the dental care they need. During this calendar year, 60 per cent of them will not even see a dentist. For every two people who enter dental offices, three will remain outside. Yet the need for treatment is just as great among the majority who *do not* come as among the minority who do. In fact, the absentees' dental needs are greater because they are victims of neglect as well as disease.

If these people went uncared for because their dental conditions were beyond the scientific reach of treatment, we would regard that as a crisis of major proportions and work overtime for solutions. What the dentally neglected actually represent is the inadequacy of our present methods of financing and delivering dental services. The dental profession today is lagging behind its full capability of providing care to all who need treatment. Our responses thus far have been to look away.

Like Voltaire's Dr. Pangloss, we conclude that no action is called for: "All is for the best in the best of all possible worlds." Nothing is required of us at all.

It seems passing strange to me that we should shy away from so basic a challenge. We have, all of us, long proclaimed that unhampered access to health care is a basic human right, and not the special privilege of few. If the action necessary to assure the exercise of that right reaches beyond the dental office, out into the community and into the arena of social action—then there we as dentists must go. Do not wait to be asked.

Revolutionary? No, evolutionary. It is one of the oldest and the finest traditions of our profession. We do not trace our lineage to the inactive Dr. Pangloss, but to one of his more practical contemporaries, Pierre Fauchard.

Recently I came across this quotation from the works of Fauchard: "The teeth and the other parts of the mouth being subject . . . to so many important diseases, requiring the aid of the most able dentist, it is strange the sovereigns of foreign countries, the heads of republics and also the administration of our own provinces do not

provide for the expenses of sending young surgeons to Paris to be instructed in a part of surgery so essential, and notwithstanding, so ignored and neglected everywhere [else]. . . . These scholars would thereafter inform others and render great service to the nation and their fellow citizens." At the time our friend Pangloss was extolling the virtues of inaction, Fauchard was at work transforming dentistry from a trade of tinkerers into a health profession.

The essence of Fauchard's writing places him solidly in the company of men who direct their attention not to what is, but to the achievement of what should be.

"I hold that man is in the right," said Ibsen, "who is most closely in league with the future." Fauchard *was* in league with the future. And I for one am certain that even under the circumstances of 1966, Fauchard would go where the action ought to be. He would make things happen.

We are the heirs of Fauchard. With such a heritage, it would be the blackest irony if the dental profession, of all the health professions in our country, should at this time elect the Panglossian position.

I do not believe that we will. Our professional philosophy and purpose are too solid. Our modern record is too good. But the fact remains that too many of us are hesitant in accepting our leadership responsibilities in our communities. Too many of us are too tired after a long day to study and think about the socioeconomic problems of our time.

Where we have acted as organized dental groups we have often been self-protective, circumspect, or tentative. Too many of us are too fascinated by our dental offices—the new equipment, new gadgets and technics. Too many of us are satisfied with the commonplace. Oh yes, all of us are in favor of progress. It is only change we resist.

Thousands of dentists, duly examined and licensed, have not once taken a refresher course of any kind. The dental profession cannot allow that to continue. A nationwide system of continuing education for dentists must be developed.

At the undergraduate level of dental education, the curriculums, even in our most progressive schools, are almost identical with the one I knew 20 years ago. Surely we must do something here. And we must produce good teachers and more of them for our schools.

These gaps and weaknesses present the greatest challenges ever for American dentistry. We must get about the business of correcting and improving these weaknesses with some dispatch, for time will not, for very much longer, be on our side. Take Medicare as a starting point. Suppose, all dire predictions to the contrary, Medicare should succeed. What would that imply for dentistry?

We do not currently think of the aged as major purchasers of dental care. Their dental problems are largely neglected and tragically so, for their needs are great. Often they require different treatment technics, and must be treated outside the dental office. The bench strength of clinical experience which hospitals, clinics, and nursing homes gave the physician before Medicare, is not yet available in the same degree to dentists. The locus of dental services for the aged is almost exclusively the private dental office. The solo dental practitioner is still the mode, and many of them do not even work with a chairside assistant. I question how effective our present dental system would be in handling a large increase of aged patients.

Medicare is actually a supplement to the long tested hospital and medical insurance plans which cover some 80 per cent of our population. In dentistry, such broad coverage has yet to be developed, but Medicare undoubtedly will accelerate the demand for dental prepayment. The American people will soon realize that dental care is now the major gap in the total area of health insurance coverage.

It is in the development of a workable national network of dental prepaid programs—dental service corporations and the like—that dentists can perform a valuable service to the nation. And while developing such a system, there is the opportunity to educate the public in dental values—the chance to encourage the 60 per cent who do not see a dentist to do so.

Such programs demand professional leadership. They demand self-regulation, in terms of quality controls—no one else can determine quality, save the profession itself. They demand objectivity in the development of appropriate fee schedules, which are fair to the dentist—and fair to the patient—and who else but the profession can provide the necessary guidance in determining equitability? Can we give the amount of leadership needed?

We haven't always. We seem sometimes to be afraid of the whole idea of prepayment systems. We regard them as some vague but ominous threat to professional prerogatives. Why?

People who enroll in an organized prepayment plan are simply a group of patients looking for a way to budget and assure themselves of quality care. They are acting in much the same way as dentists and physicians who have organized, also, to secure their professional interests.

As to the source of the payment for care, are we really to assume that fees paid from a group fund, say, or from Social Security benefits earned during a working career, are in some way tainted? Is there some special virtue in the fact that a patient has had to exhaust his savings or borrow money to pay for health care? Does "professional services rendered" by the dentist include examining how the patient obtained the money in his wallet?

I find it much more significant that we now have a vacuum in dental coverages at a time when the market for medical coverages is well-nigh saturated. This, plus the fact that Medicare does set a pattern which the mass of Americans find exciting and reassuring—these are signposts that dentistry can ill afford to ignore. There is no escaping the final demands of the people.

Nor can we ignore the question now being raised about the care of those people who are most desperately dependent on others, not only for care but for the money with which to pay for it. There are a great many publicly sponsored programs directed to these special groups, programs which reach out, often in imaginative ways, to people who once were too easily forgotten and all too often ignored.

We need to think about these public programs, too. Dental benefits in so many of them are left to local option. As often as not, local authorities have opted not to opt. Another sign of public indifference? Or another sign of the weaknesses of our professional leadership?

If we value the service we provide, we should be fighting for the inclusion of comprehensive dental care in all such programs. And, surely, once dentistry is included, we should be working to see to it that the eligible beneficiaries do benefit—by getting the quality care they need.

These problems fall undeniably within the social responsibilities of the dental profession. Yet if we take effective action toward their solution, we are creating a new set of problems—and intensifying some older ones—for the profession itself. For we cannot logically seek to increase demands for care without seeking simultaneously to

increase our capacity to deliver more treatment services.

We have talked long and hard about this question—this need for more facilities, more professional resources. And we have done something constructive about it. The profession's successful support of the Health Professions Educational Assistance Act is now making possible a major expansion in the nation's dental schools. But even if this act remains in effect for the remainder of this decade, we cannot possibly produce all the dentists we need.

We will be training these young men to work with chairside assistants. That is good, but not good enough. For the training, which is supported by federal grants, is not yet long enough, or broad enough, or intensive enough. As for dental auxiliaries, they are too few in number, and we are short of schools and teachers for them, and uncertain, even at this point, about the exact nature of the training they should receive.

Beyond the question of numbers and even beyond the need for professional persistence in keeping dental matters at the forefront of legislative thinking, there is the question of how we do what we do. And in too many dental activities, what we are doing is what we have always done. We are talking about the future, but current actions, particularly as they pertain to our own role as dentists, are almost exclusively cast in terms of yesterday's conditions. The auxiliaries role is just as limited. The division of duties between the dentist and his aides is static.

Research has pointed the way to many practical improvements in professional and auxiliary education and in the patterns of team dentistry. Yet nothing concrete has been done by the profession to make the results of this research a part of the daily practice routine.

We speak of the breakdown in communication between the research laboratory and the dental office. Yet in this age of computers, of electronic marvels, of exciting advances in the art of self-instruction, our profession has not undertaken the national programs which would put all of our knowledge to work in the dentists' offices.

Dentists have noted the tendency at every level of government to underestimate, even overlook, the place of dental health in planning. Yet no effective action by dentists to translate concern into results is clearly evident. Is such a passive role our proper role? Fauchard would not think so.

We have wondered aloud about the rigidity of licensure laws. We have asked ourselves how we can make sure we have kept our professional skills honed and up-to-date. These are crucial questions which bear upon both the quantity and the quality of care we provide. Yet even as we ask them, we shy away from the answers.

So much in the future depends on what we do now. There is so much to be done. There are only a handful of well-equipped dental research facilities, and far too few qualified researchers to fill them or the new ones being built. Federal support is available in so many areas—support to research, both basic and applied; support to education for construction, operation, and even for student scholarships; support for experiments and demonstrations in treatment procedures or diagnostic technics or program operation. But it will be the uses which the profession makes of this support that shapes the future.

As in Fauchard's day, a realistic national agenda must reflect a viable relationship between the dental profession and government. Neither the misdirected optimism of a Pangloss nor the timidity of the unsure should be allowed to weaken that partnership.

"We must work together without arguing—that is the only way to make life bearable." That was Voltaire's answer to inaction. It is about time we heed him.

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Community Health Planning

PERRY J. SANDELL, M.Ed.

The amount of health legislation in the past few years has made it necessary for communities to give more serious consideration to planning for improved health for their citizens. As funds have been made available for health services through federal and state agencies, it has become essential to develop plans in order to receive these funds.

During the last four years, the National Commission on Community Health Services, sponsored by the American Public Health Association and the National Health Council, has made a study of community health needs, resources, and practices.

The Community Action Study Project, one phase of the Commission's work, involved 21 communities across the nation in self-studies of their health services. The purpose of the self-studies was to determine how planning and action could be combined to assure that effective action would ultimately result.

The Report of the National Commission on Community Health Services was the topic of the 1966 National Health Forum held in New York City, May 9 to 11. The Report is based on the reports of the six task forces and the Community Action Study Project, as well as on opinions of the Commission members and community leaders from across the nation.

The Commission Report contains a number of recommendations, some of which are pertinent to our discussion today and which I shall paraphrase for purposes of simplicity.

The Commission recommends that each state have a state health policy and planning commission, advisory and responsible to the governor. It would be representative of governmental, private, and voluntary groups, and would have the responsibility of setting the framework for administration of all health services in the state.

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This paper was read at the Dallas Meeting of the American College of Dentists, November 12, 1966.

Every region, based on communities of solution,* should have a permanent health planning committee, with representative top echelon citizens and professional leaders, responsible for general health services and facilities planning.

The fact that such planning councils are considered essential should serve notice to state dental societies to be alert to their development and to seek immediate representation. In all probability, state health departments will assume responsibility for organizing these councils. Therefore state societies should maintain a close liaison with health departments through the dental divisions so that they will be made aware of developments.

To carry this one step further, the Commission recommends that each community of solution develop and maintain an action-planning mechanism, since this is where major effort must occur in providing health services.

But, of course, dental society planning should not be delayed until these councils are organized.

It is on the community level that it is particularly important that dental societies be involved in action-planning, if dental problems are to be dealt with adequately. Because dental problems are not always obvious to people in a community, it is necessary to convince the community of the facts of the problem, trace the underlying implications of the situation, and involve the power leadership in doing what is necessary to change the situation.

The Commission also stated: "All communities of this nation must take the action necessary to provide comprehensive personal health services of high quality to all people in each community. These services should include those directed toward the promotion of good health, early detection of disease, and the application of established preventive measures."

To accomplish this objective will require increased manpower, availability of new methods of payment, and an educational program designed to inform and motivate the citizens to cooperate effectively in all plans developed.

Special attention must be given to the provision of health care to those who cannot afford to pay for it. As the Commission states,

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* Boundaries within which a health problem can be defined, dealt with, and solved.

". . . . care of the medically indigent must be interpreted in terms of gains and losses . . . to themselves and to the total community . . . in a framework both of humanity and economics."

The Commission made a strong point that the skill and knowledge of the physician—and I am sure it is equally true for the dentist—should be used only in those efforts that cannot be assigned to lesser trained personnel.

I perhaps should say here that, although the Report was directed mainly at medical care, dental care was considered an essential part. From time to time the Commission stressed the importance of dentistry as it relates to comprehensive personal health services.

In speaking directly of dentistry and dental health, the Commission gives strong support to the fluoridation of community water supplies as an effective measure in preventing tooth decay.

Mention is made of and support is given to the 1965 resolution of the American Dental Association which directed agencies of the Association to "develop a national program for children, particularly the needy and underprivileged, in order to make the benefits of modern dental health service available to all children of the nation."

The National Dental Care Program which has been developed by the Association conforms to the philosophy of the Commission's Report since priority is given to preventive services, maintenance care, and education of the public.

The predominant theme of the Report is "comprehensive health service of high quality to all people in each community." When families cannot provide health services for themselves, it becomes a responsibility of the community or the appropriate governmental agency to provide such services. The policies of the Association are consistent with this idea, although the goal of dental care for all has never been realized, for a number of reasons.

The Report of the Commission is the result of the most extensive and intensive study of health services ever made in this country. It will, no doubt, serve as a guide for the development of comprehensive health services for all people. What, then, is its import for the role of the dental society in community health planning?

Many dental societies, along with their health departments, are already engaged in collecting information on the dental disease problem in their communities. Many have cooperated in various community dental programs. Fluoridation is being promoted by many societies. Some have made manpower studies. Some have made efforts

at caring for the dental problems of underprivileged children. Certainly a number of dental societies have been and are conducting programs of public education.

The problem of planning is that all of these activities and more, must be intensified. State dental associations should have accurate information on dental manpower in each county and community in the state; how many dentists can and will take more patients, particularly children; how dental services will be provided where dental manpower is in short supply; how dental manpower can be increased; how well auxiliary personnel are being utilized; how the supply can be increased.

The dental societies, state and local, should have information on the number of children to be served, the number of dentally indigent children, and the status of these children's dental health.

It is important to know what the cost will be to put children on a dental maintenance basis, as well as the subsequent cost of regular care once maintenance care is established.

The dental society should be constantly aware of funds available to provide care for children in community programs. How much money is available and being spent for dental care through Head Start programs? How much is available and being spent for dental care under Title I of the Elementary and Secondary Education Act? What funds and facilities are available through state and local health departments?

State and local dental societies must establish standards for dental care which is or will be provided through tax or privately supported programs. Guidelines have already been developed which will simplify the development of these standards. Standards will depend in part on the funds and the dental manpower which are or can be directed into the program.

Certainly state societies should begin planning, if they have not already done so, to develop methods of administering the financial aspects of the program—that is, the mechanism of paying for dental services.

An equally important consideration in planning is that of keeping the members of the society informed. One method of doing this is to involve as many members as possible in the fact finding and planning activities. The success of any dental health program depends on the cooperation of the practicing dentists. The dentist is more likely

to cooperate if he has had a share in planning the program, or at least if he is kept fully informed.

The dental society will not work alone in collecting information and planning programs. All agencies having responsibility for and interest in health should be involved. State and local health departments and educational agencies can provide much assistance and support. Welfare agencies and local citizens groups have an important stake in the program and must be involved from the beginning.

The reason dental societies should assume leadership in planning and developing programs seems obvious. If the programs are to be acceptable to the profession and beneficial to the public, the group that has the most knowledge about dental health must be intimately involved in the planning. Dental societies cannot escape this responsibility. Furthermore, a dental society that has the facts on dentistry and the dental disease problem in its state or community and can intelligently advise public and private agencies about solutions to the problem is more likely to be listened to.

In summary, there is greater demand for dental care, especially for children, than ever before. More funds are being made available for health services, including dental care, through federal legislation as well as other sources.

Problems of providing dental care are becoming more complex because of unfavorable dentist-population rations in many areas.

There is much information that must be collected and made usable before practical, effective programs can be planned.

All segments of the community must be involved in planning dental health programs if support of the community is expected.

Dental societies, state and local, must begin collecting essential information and developing standards and plans, so that programs acceptable to the profession and the public will evolve.

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Local Care Programs and the Dentist

BILLY F. PRIDGEN, B.S., D.D.S.

Twenty years ago in our area, local care programs existed for the indigent, and in general fell into one of the two following categories. First, county dental clinics were staffed by volunteer, low-paid, part-time dentists, with an equivalent of one and a half to two dentists serving three clinics in the county. They performed mostly emergency treatment for some of those persons screened and found eligible for care. Programs of the second type were all quite similar to the one that existed in our town and it worked as follows. The head school nurse would call a local dentist and inform him that she had been able to secure $30 from one of the local organizations for dental care. She wanted to know if he would be willing to set aside six hours in one of his days in the near future to care for 12 or 15 of the school children. If he agreed, she would see that on the day he designated, those children, who in her opinion were most in need of dental service, would be brought to his office for treatment. After the doctor had completed his treatment day, a statement sent to the sponsoring organization for that day's dental care, generally brought the $30 payment in by the end of the month. These were the two basic mechanisms for providing local dental care in the late 1940's and before.

There were, of course, clinics in other localities that were not sponsored by the county and, no doubt, care programs that were slightly different from what I have described.

It is important that we analyse these types of programs from the point of view of the patient and the profession. In the clinic situation, the patient received care if he was first screened and found eligible as an indigent, and second if his dental complaint was severe enough to warrant an appointment, and third if there were sufficient personnel to take care of him. The child in the second type of local

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This paper was read at the Dallas Meeting of the American College of Dentists, November 12, 1966.

program received care if in the opinion of one person, the school nurse, he was in most need of care either from neglect by the parents or lack of funds. The nurse's chief concern was the relief of pain, removal of infection, and reduction of absenteeism.

From the standpoint of the doctors participating in these programs in the clinical situation, they worked at a relatively low hourly rate performing dental services limited by the large volume of patients seeking care and the seriousness of their dental problem. In the local office plan, the dentist could perform any services he desired. He had only to bill for the day of service, but of course the payment he received was less than his overhead costs. If he accepted these patients, he was one of only half of the dentists in town that took the responsibility of the school children's care program. The doctor generally was only asked to do this once or twice a month, and this was certainly no great sacrifice. However, often those patients who received treatment on those children's care days became the future responsibility of that dentist when they were not eligible for the local care program, and when their parents had no funds to pay for the care.

For the rest of the population, that is those people not eligible for indigent care, there were no local care programs in our area. They received their dental services in the "usual manner." That is to say, they received that dental care that they felt they could afford. The economics of the family unit was then, and still is for many, a real deterrent to comprehensive dental care. To put it briefly, in the 1940's and before, the population either bought, bartered, or begged, and were screened for, and stood in line for, and sacrificed for, dental service and the majority never received it. This was in a country where better and more dental care is provided than in any other country in the world.

The growing realization that the greatest asset that this country can have is a healthy, well-educated populace brought about, in the 1950's and ever increasingly since then, the demand by individuals, and groups, and governments for comprehensive dental care for all segments of our population. This demand today has brought about an expanded meaning to local care programs. In this day of instant communication and commercial travel approaching the speed of sound, local no longer means one small area, but instead takes on the meaning as applied to the local train—one that stops at every station. Local care programs now might include one company in one

town, or one union throughout the whole state. It may be a multi-million dollar Office of Economic Opportunity project in Watts, or a $2,000 program in a migratory camp in Knightsen. It involves 100 children in a research program in Contra Costa County, and 1,350 children in the Head Start Program in Orange County.

What I am trying to say is that the practicing dentist today considers local care programs to be those programs in which his patients are involved and under which they are eligible for care. A patient coming into his office today may be one of the close to a million people covered by one of the 104 plans now serviced by the California Dental Service, or he may be covered by a self-insured plan, or covered by an insurance company, or he may be one of those eligible under the numerous and ever growing plans of the federal government or the state. To name just a few of the latter, we have had patients eligible for Medicare, MediCal, Migratory Workers, Vista, Head Start, Follow-Up, Continuation, Peace Corps, Local Research Project Recipients, and other programs that I am sure that I have missed. The patients eligible under these various plans may be eligible for very comprehensive care or minimal care. They may require prior authorization or no authorization. They may have to have pre-screening or have no pre-screening. We may be able to determine eligibility before treatment or not know about eligibility until treatment is completed. Their program might cover 70 per cent of their work or 70 per cent of part of it, and 50 per cent of part of it or 75 per cent of part of it, and 55 per cent of part of it or 80 per cent of part of it, or 80 per cent of all of it, or all of it. They may have a yearly deductible, or a patient life-time deductible, or a total family deductible, or total patient deductible. They may have no maximum amount for the patient yearly coverage, or they may have a maximum amount, and that may be $600 or $750 or some other figure. The plan may cover all members of the family, or just children, or have different coverage for the employee than they do for the dependents. They may exclude some services for the first year, or include all services from the start. We may be paid on a table of allowances, on usual and customary fees, or on a fixed fee, or in cases of clinics on an hourly rate. We must use at least six different types of forms, and at least three different methods of charting, and conform to deadlines of from 60 days to 6 months.

How many of our patients are involved in these programs? In our

office today, about 15 per cent of our patients are covered by some type of prepayment plan, and a little less than 10 per cent are under some government plan.

What does this mean to the average practicing dentist? I think that two words might express it—*confused exasperation!* Patients are coming to us in ever increasing numbers covered by various plans. When we should be developing more speed and treatment time to take care of this increase in patient load, even with the hiring of additional help, we are bogged down by paper work.

When we look beyond the mechanics of participation, however, we find benefits to both patient and doctor in these programs. The patient who is eligible under a prepayment program is fast becoming our most sophisticated purchaser of dental care. We find that many employees who were patients before becoming eligible under a plan, now still budget the same dollar amount for dental care and spend it as their share of the treatment, demanding the very best services that we can perform for them and their families. The dentist performing services on these people now, in most cases, must present a comprehensive treatment plan prior to initiation of treatment, and in more cases than not the patient accepts this total treatment plan. In areas of California where there have been large numbers of people participating in prepayment plans, we have found a sudden increase in demand for skilled laboratory technicians, especially in the field of crown and bridge work. I am sure that most dentists in general practice who have a significant number of patients under prepayment plans will attest to the fact that they are now performing more comprehensive care for these patients. To the patient who is eligible for dental care under a government plan, it means for many that for the first time they may seek and secure dental care from the doctor of their choice and without discrimination due to economic inability or for any other cause. I believe it is the intent of most government plans that the providers of services should not be deterred from participating in these programs due to substandard fees. We certainly should all strive to see that usual, customary, and reasonable fees are paid in any program in which we are requested to participate, and for which our patients are eligible.

The dental profession has always been faced with one basic problem and that is to provide all segments of our population with good

comprehensive care. We now have pressures from many segments of our population to see that this problem is solved.

Dentists, like other people, can react to a problem in many ways. One is to ignore it, and hope that it goes away. Another is to recall the desirable aspects of the past when the problem was *apparently* not present, and hope to get back to that time. A third way is to project dire consequences for the future as a result of suggested solutions to the problem, and thereby expend all one's energy on a negative approach. The real and mature approach to a problem is to inspect it sensitively, appraise it, and attempt to solve it in the present.

We have heard much criticism in the past about the average dentist not being properly informed. The dentist of today not only needs knowledge and information, but more important he needs the *will* to be informed and made aware. The goal of a dentally healthy population *can* be attained and in a manner most acceptable to the profession if, and only if, we all not only participate in, but lead in the formation of the plans to make this goal a reality. If dentists allow themselves to be led by negative thinkers, or by those who solve problems using "conventional wisdom," we will see, I am afraid, a rather rapid deterioration of our profession. If on the other hand, we follow the creative and imaginative leadership that we have in our profession and share with them the responsibility of solving our nation's dental problem, we cannot help but grow in stature, accomplishment, and respectability. We have a great profession. Its future is in the hands of each of us.

We often hear it said that with most of the earth having been explored, and most of the mountains climbed, and now with space penetrated by man, there are few challenges left. With all that has been accomplished in the history of man, he has failed to accept the greatest and always present challenge—the understanding and solving of the problems of man himself. Our part of this challenge is the future dental health care of this nation. Dental care programs large and small, private and public, company and union, group and governmental may be the key to the solution to our challenge. This will be true only if they become local care programs. In any program, "where the action is," is at the extreme local level with an individual dentist and his auxiliaries serving an individual patient. If full un-

derstanding and acceptance by the dentist, and full understanding and acceptance of responsibility by the patient at the local level is *not* achieved, then a care program will be only a dental filling station.

The complaint is valid that many of our people have no respect for other people, or public and private property. We cannot expect this to improve unless people develop respect for themselves. The receiving of, and the responsibility for, maintaining comprehensive health care is, in my opinion, a big step in gaining self-respect. Dentistry has not and cannot provide comprehensive dental health care for the total population of our country by itself. Certainly the care programs that were described at the beginning of this paper did not scratch the surface of the needs of the public.

Our profession needs the cooperation of individuals who can and will be responsible for their own care; it needs the cooperation of private enterprise to help others provide for themselves; and it needs government to help provide care that otherwise could not be received —all under the orientation of local dental care programs. We need, and must be part of, community health planning and community action programs.

Most of all our profession needs the acceptance by *each dentist* that each individual has the *right* to the good life with optimum dental health as an important part of it.

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Summary of the Panel Discussion

"Optimum Health: Dentistry's Role in Planning the Good Life"

ARTHUR BUSHEL, A.B., D.D.S., M.P.H.

One temptation in fulfilling an assignment such as this is quite simply to summarize sequentially the foregoing four fine papers. Somehow I have found it possible to resist that temptation. Another temptation is to present a paper of my own. That temptation I can resist only partially. The fact is that I have chosen what my own bias tells me are some of the major points contained in these presentations, and then I blithely have decided to rearrange and improvise on those points. My one concession is the conviction that a summary should be brief. Brevity is my aim. It is my hope that your definition of brevity is not much different from mine.

Dr. Wallace quotes Dean Wilson, Dr. Diefenbach quotes Pierre Fauchard, and Mr. Sandell quotes the National Commission on Community Health Services. I choose to begin with a quote from Dr. Pridgen:

"Dentists, like other people, can react to a problem in many ways. One is to ignore it, and hope that it goes away. Another is to recall the desirable aspects of the past when the problem *apparently* was not present, and hope to get back to that time. A third way is to project dire consequences for the future as a result of suggested solutions to the problem, and thereby expend all one's energy on a negative approach. The real and mature approach to a problem is to inspect it sensitively, appraise it, and attempt to solve it in the present."

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This summary was read at the Dallas Meeting of the American College of Dentists, November 12, 1966.

I recall the mixed reaction in many dental circles when the Kerr-Mills programs in most states did not include dentistry: on one hand, relief that "they" were leaving us alone; on the other hand, hurt professional pride in that "they" apparently did not think dentistry was important enough. More recently, I recall the plea of one dentist who, confronted with Medicaid, asked wistfully, "Why can't things be the way they were?"

Well, they can't, because contrary to the superficial impression, the dentist is not in business for himself. Indeed, things should not be the way they were because, as Dr. Diefenbach points out, some 60 per cent of the population do not get the full benefits of our product. Our product is health. It is as vital as education. Could this country tolerate 60 per cent illiteracy?

In a way, it is really all Mr. Sandell's fault. He and the rest of us, as ambassadors of dental health education, have somehow helped raise the priority which the public places on dental health. At the same time, and perhaps more fundamentally, the public perceives the costs of health services as primary threats to individual and family security. These feelings and these values have been growing for some years, but only recently have they finally burst through the political threshold. We must face the sobering fact, for example, that despite the organized and even bitter resistance of the health professions, Medicare was not only enacted, but it has been consistently described as probably the most popular piece of legislation of this decade. As Dr. Diefenbach has inferred, the public's need will prevail over the profession's objections.

All this is not to say that the anonymous public and its elected representatives are infallible, nor indeed usually right. They are not equipped to evaluate all of the problems inherent in the 21 pieces of legislation described by Dr. Wallace. They are not even too concerned with our ability to deliver the care mandated in this legislation. It has been decided that dental care is to be provided to this or that segment of the community and to be paid for through this or that mechanism, and we are simply asked to work out the details. Our influence and our success might be greater if we devoted more effort toward influencing instead of resisting health legislation. The drive of the American Dental Association for a National Children's Dental Health Program represents a refreshing new departure.

There are signs of a new awareness of the outside world on the part of dentistry and dentists at the national and local level both.

We have heard much here about the need for planning, and properly so. Planning is not a unilateral activity. The consumer must tell us what he wants and we must tell him, or his government, what is achievable and at what costs. In short, we need to maintain a constant dialogue to better understand each other. And I am afraid that we must be prepared to adjust our system of delivering services so long as we do not compromise the quality of our professional services.

Dr. Diefenbach wonders why the source of payment should make a difference to the dentist—even if some "paperwork" is involved. I ask why many dentists still resist the prospect of working alongside another dentist in a group practice arrangement? And why the resistance in some quarters to relinquish to aides time-consuming, routine procedures which would not seem to warrant the personal attention of the doctor? Now the long predicted dental manpower shortage is upon us. Is it not interesting how the pressure of reality is often required to move us toward rationality!

On another front, several references have been made here to the question of quality of care. It has long been held that quality of health service is best assured by placing it in the hands of superbly trained people. In this connection we have insisted that dental education is not complete after four years of dental school. Accordingly, we have urged graduates to pursue dental internships and continuing education programs apart from any specialty aspirations. Our success has been modest. There are indications that with government's increased role as the third party, there will be greater insistence on such training as a requirement for participation in some programs. All this in addition to the direct spot-check of the product we deliver. We are dealing here with public accountability. This sort of thing can complicate our lives, and even result in some inequities. But quality control, as outlined by Dr. Wallace, should remain in the hands of dentists. Indeed, no one else can really do the job.

The real payoff in all of this is at the local level. Mr. Sandell and Dr. Pridgen properly have placed the emphasis on planning and the will to make the plan work. Dr. Wallace points out that different patterns are required in different areas, and Dr. Diefenbach con-

cludes that it will be the uses which the dental profession makes of this federal support that shapes the future. The challenges are equalled by the opportunities.

Better organization, more efficient operation, more manpower, assessment of need, promotion of utilization, and evaluation of total resources all come into play. The hospital dental program needs a look. Where does the dental school fit in? Where will the school get the "clinical material" if the indigent and medically indigent fit into private practice? Perhaps the school should decentralize and join forces with the hospital, the health department, and the nursing home.

The problems before us are not simple. The pressures from within and without are formidable. But dentistry cannot remain static in a rapidly changing world. It may even be that a new breed of dentist —the non-solo practitioner—may begin to dominate the scene.

We now have the responsibility of implementing the mandate to extend our services to a larger number of persons. If their better dental health is our aim, we cannot avoid that responsibility or ignore that mandate. Let us plan together with the outside world. There are lots of very nice people out there. Remember, in relation to professions other than dentistry, we are all laymen.

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Why Dental Editors?

RALPH H. ROSENBLUM, B.A., D.D.S.

THE President's Ballroom of the Neil House in downtown Columbus, Ohio, was loaded, that afternoon, with dentists. It was the last day of the Centennial meeting of the Ohio State Dental Association, which had attracted 1,500 dentists during the week. It was also Table Clinic Day, and it seemed as if each of the 1,500 had come to the Ballroom and brought a friend.

The crowds around 36 of the 37 tables were three and four deep. The other table clinic was in a prominent position and well spotlighted, but it didn't have a crowd. In fact, there were hardly any visitors. It was my table clinic.

The title was "Editing a Dental Society Bulletin." In addition to an exhibit of corrected copy, galley proofs, page proofs, and zinc line engravings, there was a three-foot-high screen bearing dental journals and a label with this message:

—So much paper crosses the dentist's desk daily that it is a wonder any of it gets read.

—But the local bulletin should be one of the things he reads. It is one of the few ways in which the dental society can unite and inform its members.

—How do you get a busy dentist to look through his bulletin, let alone take time to read it?

—This is the job of the bulletin editors.

—The editors must provide timely information which is written in direct uncomplicated language . . . features and photographs which are varied and interesting . . . typography and layout that invite easy reading.

Dr. Rosenblum is editor of the *Bulletin of the Columbus Dental Society* (Ohio).

This paper was used as the basis for a presentation on principles in editing by Professors Paul Barton and Campbell B. Tichener, School of Journalism, Ohio State University, at the Meeting of the American Association of Dental Editors, November 12, 1966, Dallas.

—A successful bulletin is widely read and helps the dentist in his work . . . it helps him to identify with organized dentistry . . . it helps the individual dentist and his profession to continue to grow in competence and stature.

—And the public will be well served.

The message expressed my feelings about the function and importance of dental publications. I thought it was reasonably direct and clear. But nobody read it, except a couple of my friends whom I trapped before they could move away toward other clinics.

My clinic probably could have been presented more effectively. Maybe the emphasis was on the wrong things, although I doubt it. I just think that a clinic on editing dental society bulletins doesn't have much appeal at a general dental meeting. Still, I'm convinced that the job of editing a dental publication is an important one, and that's why I'm writing this article.

Let me say right here that I am not a veteran dental editor with ink stains up to my elbows. I've been an editor only about two years, and my publication is a small bulletin for a local dental society. Yet my brief experience in the field has given me a glimpse of some of the problems and a few possible solutions. In my recommendations, I lay no claim to originality. Others have pointed to the same problems and urged similar remedies. But I feel that these points need stressing.

Who are the editors? How are they selected? In some societies the editorship is just one of the "chairs" to go through on the way up towards the presidency. In other societies, the editor turns out to be the first man willing to take the job. In others, the editor is a man who is sincerely interested in the job for its own sake, and he may remain an editor for many years.

Any editor's success, of course, depends upon his interest in the job. A "moving through the chairs" editor, if he really interests himself in the publication, can do a lot for it and his readers in his one-year tenure. So can the casual editorial draftee. And that long-term editor can make a solid contribution, if he can keep from going stale.

Sometimes the editor doesn't do much editing at all. He may take secretaries' reports and meeting announcements, some canned news from the ADA or the U. S. Public Health Service, and a guest editorial or scientific article lifted from another publication, and there's his bulletin. He may not even do this much. Maybe he'll write an

editorial and ship it and everything else down to a central office where a secretary or editorial assistant edits the material and follows through with the printer.

But the really serious, conscientious editor avoids this approach. Such an editor functions as the society's discussion leader. He stimulates thought through his editorials and his choice of general content. He reflects the policy of the society's officers and council. He translates official policy into news stories, editorials and feature articles. He helps voice the feelings of the general membership by inviting and printing letters to the editor and guest writings from the members. He introduces opinion from outside the local society by his selection of occasional guest editorials.

By inducing his colleagues to submit informative articles dealing with their special fields and by selecting pertinent material to reprint, he acts as a sort of unofficial dean of continuing education in his area. In effect, he solicits lectures to be delivered to his readers. In soliciting contributions, he also becomes a talent scout for prospective writers in the profession. He can give these new writers a forum and can help them with their writing techniques. In cooperation with the dental college in his area, he can encourage dental students to write.

Any dental society which wants to make the most of its assets certainly needs the help of a good editor and a strong publication. The officers and council can put together a progressive and realistic program. They can discuss it and explain it to those members who attend the general meeting. But they should bear in mind that the publication goes to *all* the members. If it is a good one, most members will develop the habit of reading it and believing in it. And this is the life of a strong society—having a medium of communication that members read and depend upon. Creating such a medium is the job of the editor—and of the whole society.

There are various ways in which the society can help the editor to produce the best possible publication. For one thing, the dental editor can be more effective working from the inside rather than the outside of the society administration. The American College of Dentists, the Council on Journalism of the American Dental Association, and the American Association of Dental Editors have recommended that dental society editors be invited to sit in on executive meetings. Many societies make the editor an officer but he

doesn't always have a vote. As it happens, the Columbus Dental Society makes its editor a voting member of the council. The editor is appointed by the new president of the society each September. There is no guaranteed term of office, though in the last 13 years, two editors have served five years each; one has served for a year; and the present editor is still going after two.

The society should pay the editor something. If he does a good job with the publication, it's worth encouraging him to continue. After you've given him your praise and a plaque or maybe a pen and pencil set, you might think about giving him something else. That something else can be money or travel expenses to meetings or membership and subscription expenses. After all, it took a lot of doing to train the editor. He has put a lot of time into his job, time that has bitten into his office practice and home life. After a couple of years he may feel that he has made his contribution, and decide to trade his typewriter in on a new golf bag. A little extra incentive might make the difference.

Few local societies pay their editors; most state associations do. The Columbus Dental Society pays AADE dues for the editor and his associates. It also pays $100 to send the editor to the yearly Conference on Journalism each Spring. As our dental publications become more appreciated and the editors' jobs more demanding, all dental societies probably should give their editors some sort of salary or "honorarium," plus paying their way to selected meetings.

The society should also consider subsidizing the bulletin to supplement advertising revenue. A well printed publication with adequate coverage of dental activity usually costs more money than the sale of advertising can provide.

As important as any of these considerations is the matter of giving the editor some measure of editorial freedom.

"Yes, you can have freedom of the press; but don't forget, we can fire you." These chastening words, spoken in tones of friendly caution, came from a state dental association officer. He was speaking to a newly appointed editor.

It sounds undemocratic. It is undemocratic. But it is reality. An editor can get fired if he ranges too far from consensus. He is appointed to communicate his governing body's actions and opinion. On the other hand, he also represents his entire profession and when he

believes that dentistry is not being well served or could be better served, then he may want to speak against an official position.

Conscience and reality battle it out. Most of the time, the demands of both can be satisfied.

A secure, confident dental society should be able to tolerate responsible criticism from its editor, in the knowledge that the airing of various opinions will benefit the profession.

And, on his part, the editor should keep in mind the reason why the society created the post of editor in the first place—to communicate the society's positions and programs. He may then temper an urge to shoot from the hip. He may modify some of the words he uses in criticism.

Well, there it is—a summary of my thinking on my favorite part-time job, dental editing. I hope that it will spur other editors and perhaps other leaders of the profession to voice their views on these subjects. I even hope that a table clinic on dental publications may someday be an accepted exhibit at dental meetings. I have one at home, slightly used.

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Bibliographic Reference Study Of a Dental Journal

KENNETH C. LYNN, D.D.S. and ROBERT J. ROSENBERG

STUDY of the references used by authors of articles in dental journals should reflect in some measure the publications that they read. This knowledge has great practical value to the biomedical library. It may be a matter of acquiring the most frequently cited journals within a limited budget, or of arranging the collection for greater convenience. At the National Library of Medicine, where much of the world's biomedical literature is processed by computers to prepare reference tools like *Index Medicus* and the *Index to Dental Literature,* this information is even more useful.

The most recent citation count, or analysis of the bibliographic references of the dental literature that we could find, conducted by John W. Howard* covered 244 of the leading articles that appeared in volumes 40 through 44 of the *Journal of the American Dental Association* from January of 1950 through June of 1952. For comparative purposes we chose to study the same publication, about fifteen years later, for the period from July 1964 through June 1966. Our study included 206 of the leading articles in volumes 69 through 72.

The results of this study are shown in the following table. The journal names shown are those used by the authors and no attempt was made to adjust for changes in titles. For example, the *American Journal of Orthodontics and Oral Surgery* became the *American Journal of Orthodontics* and *Oral Surgery, Oral Medicine, and Oral Pathology*. All three titles appear in the table.

Dr. Lynn is Coordinator for Dental Affairs, National Library of Medicine, Bethesda, Maryland. He has been with the U. S. Public Health Service since 1956.

Mr. Rosenberg is a Junior predental student at the University of Maryland. In Summer, 1966, he was a Commissioned Officer in the USPHS Student Training and Extern Program assigned to the National Library of Medicine. Previously, he had been a Summer employee at the Library.

* Howard, John W. Periodical references in a general dental journal. J. Amer. Col. Den. 31:104-19, April 1964.

TABLE

Citation Count of Articles in the *Journal of the American Dental Association*, Volumes 69-72. (* Indicates Periodicals Published Outside the United States.)

Rank	*Title*	*Number of Citations*	*Per Cent of Total Citations*
1	Journal of the American Dental Association	386	11.40
2	Journal of Dental Research	297	8.77
3	Oral Surgery, Oral Medicine and Oral Pathology	195	5.76
4	Journal of Periodontology	128	3.78
5	Journal of Prosthetic Dentistry	105	3.10
6	*Archives of Oral Biology	100	2.95
7	*British Dental Journal	65	1.92
8	*Acta Odontologica Scandinavica	49	1.44
9	International Association for Dental Research Program and Abstracts of Papers	48	1.41
10	American Journal of Orthodontics	41	1.21
11	Journal of Dentistry for Children	37	1.09
12	*International Dental Journal	32	.94
	Journal of the Southern California State Dental Association	32	.94
13	Public Health Reports	30	.88
14	Journal of the American Society of Periodontists	29	.85
15	Dental Clinics of North America	28	.82
	Journal of Oral Surgery	28	.82
16	Dental Progress	27	.79
	Journal of the American Medical Association	27	.79
	Journal of Oral Surgery, Anesthesia and Hospital Dental Service	27	.79
17	Angle Orthodontist	25	.73
	*Australian Dental Journal	25	.73
18	New York State Dental Journal	23	.67
19	Science	21	.62
20	*Journal of the Canadian Dental Association	19	.56
21	Acta Cytologica (Baltimore)	17	.50
	Cancer	17	.50
	*Nature	17	.50
22	Journal of Bacteriology	16	.47
23	American Journal of Orthodontics and Oral Surgery	15	.44
	Dental Cosmos	15	.44
24	Dental Abstracts	14	.41
	Journal of Oral Therapeutics and Pharmacology	14	.41
	*Odontologisk Revy	14	.41
25	American Journal of Roentgenology, Radium Therapy and Nuclear Medicine	13	.38
	Journal of Dental Medicine	13	.38
	New England Journal of Medicine	13	.38
26	*Odontologisk Tidskrift	12	.35

TABLE *(Continued)*

Rank	Title	Number of Citations	Per Cent of Total Citations
27	*Lancet	11	.32
	New York Journal of Dentistry	11	.32
	Proceedings of the Society for Experimental Biology and Medicine	11	.32
28	Anatomical Record	10	.29
29	*The following 6 journals were each cited 9 times*	54	1.59
	America Journal of Pathology		
	American Journal of Public Health and the Nation's Health		
	*Dental Practitioner and Dental Record		
	*Deutsche Zahnärztliche Zeitschrift		
	Journal of Investigative Dermatology		
	*New Zealand Dental Journal		
30	*The following 7 journals were each cited 8 times*	56	1.65
	Annals of the New York Academy of Sciences		
	Archives of Otolaryngology		
	*British Medical Journal		
	Dental Digest		
	Journal of Biological Chemistry		
	Journal of Pediatrics		
	Surgery, Gynecology and Obstetrics		
31	*The following 4 journals were each cited 7 times*	28	.82
	Archives of Pathology		
	Journal of Ultrastructure Research		
	Scientific American		
	*Tandlaegebladet		
32	*The following 6 journals were each cited 6 times*	36	1.06
	American Journal of Physiology		
	American Journal of Surgery		
	Archives of Dermatology		
	*Bulletin du Groupement International pour la Recherche Scientifique en Stomatologie		
	*Proceedings of the Royal Society of Medicine		
	Radiology		
33	*The following 12 Journals were each cited 5 times*	60	1.77
	American Journal of Anatomy		
	Archives of Surgery		
	Biochemical and Biophysical Research Communications		
	*Biochimica et Biophysica Acta		
	*Journal of the All-India Dental Association		
	Journal of the American College of Dentists		
	Journal of the Indiana State Dental Association		

TABLE *(Continued)*

Rank	Title	Number of Citations	Per Cent of Total Citations
	Journal of the Michigan State Dental Association		
	*Journal of the Nihon University School of Dentistry		
	Northwest Dentistry		
	Nuclear Science Abstracts		
	Proceedings of the National Academy of Sciences of the United States of America		
34	*The following 20 journals were each cited 4 times*	81	2.36
	American Journal of Clinical Pathology		
	American Journal of Dental Science		
	Anesthesiology		
	Annals of Internal Medicine		
	Archives of Dermatology and Syphilology		
	*Bulletin of the Tokyo Medical and Dental University		
	Chronicle of the Omaha District Dental Society		
	Cold Spring Harbor Symposia on Quantitative Biology		
	*Helvetica Odontologica Acta		
	*Indian Journal of Medical Sciences		
	Journal of the California State Dental Association		
	Journal of the Indiana State Medical Association		
	Journal of the Missouri State Dental Association		
	Journal of Social Issues		
	New York State Journal of Medicine		
	Nutrition Reviews		
	*Paradontologie		
	Periodontics		
	Radiation Research		
	*Radiobiologia, Radioterapia e Fisica Medica		
	*Suomen Hammaslääkäriseuran Tormituksia		
35	*The following 38 journals were each cited 3 times*	114	3.36
	American Journal of Medical Sciences		
	Annuals of Otology, Rhinology and Laryngology		
	Archives of Internal Medicine		
	Bacteriological Reviews		
	*Biochemical Journal		
	*British Journal of Dermatology		
	Cancer Research		
	Federation Proceedings		

TABLE *(Continued)*

Rank	*Title*	*Number of Citations*	*Per Cent of Total Citations*
	*Forschritte der Kiefer- und Gesichts-Chirurgie		
	Illinois Dental Journal		
	Journal of the American Ceramic Society		
	Journal of the American Water Works Association		
	Journal of Applied Physics		
	Journal of Bone and Joint Surgery		
	Journal of Cell Biology		
	Journal of the Colorado Dental Association		
	*Journal of the Indian Medical Association		
	Journal of Infectious Diseases		
	Journal of Medical Education		
	Journal of Neurophysiology		
	Journal of Nutrition		
	*Journal of Physiology		
	*Life Sciences		
	*Minerva Medica		
	Oral Health		
	Pennsylvania Dental Journal		
	Physiological Reviews		
	Plastic and Reconstructive Surgery		
	Public Health Dentistry		
	*Revue de Stomatologie		
	*Sabouraudia; Journal of the International Society for Human and Animal Mycology		
	*Schweizerische Medizinische Wochenschrift		
	*Schweizerische Monattsschrift fur Zahnheilkunde		
	*Semaine des Hôpitaux de Paris		
	*Strahlentherapie		
	Texas Dental Journal		
	*Zeitschrift für Stomatologie		
36	*The following 71 journals were each cited 2 times*	142	4.19
	*Acta Anaesthesiologica Scandinavica		
	*Acta Chirurgica Scandinavica		
	*Acta Medica Scandinavica		
	*Acta Obstetrica et Gynecologica Scandinavica		
	Alpha Omega		
	Alumni Bulletin of the Indiana University School of Dentistry		
	American Journal of Diseases of Children		
	American Journal of Medical Electronics		
	American Journal of Medicine		
	American Journal of Physical Anthropology		
	American Journal of Psychiatry		

TABLE *(Continued)*

Rank	*Title*	*Number of Citations*	*Per Cent of Total Citations*
	American Orthodontist		
	American Scientist		
	*Annales d'Histochimie		
	Annals of Dentistry		
	Annals of Surgery		
	Applied Optics		
	Archives of Environmental Health		
	*Boletin de la Sociedad Venezolana de Cirugía		
	*British Journal of Radiology		
	*Bulletin of Tokyo Dental College		
	CA; Cancer Journal of Clinicians		
	*Canadian Journal of Public Health		
	*Comptes Rendus Hebdomadaires des Séances de l'Académie des Sciences		
	*DDZ; das Deutsche Zahnärzteblatt		
	Dental Health		
	Dental Outlook		
	*Dental Record		
	Dental Survey		
	Diabetes		
	Experimental Cell Research		
	*Helvetica Physiologica et Pharmacologica Acta		
	Journal of the Alabama Dental Association		
	Journal of the Allied Dental Societies		
	Journal of the American Dental Association and Dental Cosmos		
	Journal of the American Statistical Association		
	Journal of Colloid Science		
	*Journal of the Dental Association of South Africa		
	Journal of the District of Columbia Dental Society		
	Journal of the Florida Medical Association		
	Journal of Gerontology		
	Journal of the Kansas State Dental Association		
	Journal of Laboratory and Clinical Medicine		
	*Journal of Molecular Biology		
	Journal of the Mount Sinai Hospital, New York		
	Journal of the National Dental Association		
	Journal of Neurosurgery		
	Journal of the Optical Society of America		
	Journal of Research of the National Bureau of Standards		

TABLE *(Continued)*

Rank	*Title*	*Number of Citations*	*Per Cent of Total Citations*
	Journal of the Tennessee State Dental Association		
	Mayo Clinic Bulletin		
	Medicine (Baltimore)		
	*Meditsinskaia Radiologiia		
	Military Medicine		
	Modern Plastics		
	*Naturwissenschaftliche Gesellschaft Winterthur Mitteilungen		
	Obstetrics and Gynecology		
	Oregon State College of Agriculture Experimental Station Technical Bulletin		
	Pediatrics		
	*Practica Oto-Rhino-Laryngologica		
	*Presse Médicale		
	Public Opinion Quarterly		
	Quarterly Bulletin of the Wisconsin State Board of Health		
	*Quarterly Journal of Experimental Physiology and Cognate Medical Sciences		
	*Rassegna Clinico-Scientifica		
	*Revue d'Odonto-Stomatologie		
	*Shikwa Gakuho		
	*Svensk Tandläkare-Tidskrift		
	United States Naval Radiological Defense Laboratory Technical Reports		
	*Zahnarztliche Mitteilungen		
	*Zentralblatt für Chirurgie		
37	*The following 216 journals were each cited once*	216	6.39
	ADA News Letter		
	*Acta Anatomica		
	*Acta Chirurgica Patavina		
	*Acta Dermatologica		
	*Acta Morphologica Academiae Scientiarum Hungaricae		
	*Acta Ophthalmologica		
	*Acta Pathologica et Microbiologica Scandinavica		
	*Acta Pediátrica Española		
	*Acta Physiologica Scandinavica		
	*Acta Psychiatrica et Neurologica Scandinavica		
	*Acta; Unio Internationalis Contra Cancrum		
	Administrative Science Quarterly		
	Advances in Oral Biology		
	Advances in Pediatrics		

TABLE *(Continued)*

Rank	*Title*	*Number of Citations*	*Per Cent of Total Citations*
	Alabama Journal of Medical Science		
	American Dental Association Transactions		
	American Heart Journal		
	American Journal of Digestive Diseases		
	American Journal of Epidemiology		
	American Journal of Hospital Pharmacy		
	American Journal of Hygiene		
	American Journal of Sociology		
	American Journal of Tropical Medicine and Hygiene		
	American Sociological Review		
	*Anaesthesist		
	*Anais da Faculdade de Odontologia e Farmácia da Universidade de Minas Gerais		
	Analytical Chemistry		
	Anesthesia and Analgesia; Current Researches		
	*Annales de Dermatologie et de Syphiligraphie		
	*Annales Odonto-Stomatologiques		
	*Annali Italiani di Chirurgia		
	*Annali di Stomatologia		
	Annals of Chemistry		
	Annual Review of Biochemistry		
	Annual Review of Microbiology		
	Archives of Biochemistry and Biophysics		
	Archives of Internal Medicine		
	Archives of Neurology and Psychiatry		
	Archives of Ophthalmology		
	Archives of Pediatrics		
	Archives of Physical Medicine and Rehabilitation		
	*Arkiv für Fysik		
	Biochemistry		
	*Biologica (Santiago)		
	*Biologisches Zentralblatt		
	Biophysical Journal		
	Blue Cross Reports		
	*British Journal of Clinical Practice		
	*British Journal of Experimental Pathology		
	*British Journal of Pharmacology and Chemotherapy		
	*British Journal of Surgery		
	*British Journal of Venereal Diseases		
	Bulletin of the Academy of General Dentistry		
	Bulletin of the Akron Dental Society		

TABLE *(Continued)*

Rank	*Title*	*Number of Citations*	*Per Cent of Total Citations*
	Bulletin of the American Association for the Advancement of Science		
	Bulletin of the American Association of Public Health Dentists		
	*Bulletin de l'Association des Anatomistes		
	Bulletin of the Hospital for Joint Diseases		
	Bulletin of the Johns Hopkins Hospital		
	Bulletin of the Massachusetts Dental Hygienists Association		
	Bulletin of the St. Louis Dental Society		
	California Medicine		
	*Canadian Anaesthetist's Society Journal		
	*Canadian Journal of Microbiology		
	*Canadian Journal of Research		
	Cancer Cytology		
	Child Development		
	Columbia Engineering Quarterly		
	*Comptes Rendus des Seances de la Société de Biologie et de Ses Filiales		
	*Congrès de Medicine Légale de Langue Francaise		
	Consumer Bulletin		
	Crushed Stone Journal		
	Dental Assistant		
	Dental Health Coordinator		
	Dental Items of Interest		
	Dental Student's Magazine		
	*Deutsche Medizinische Wochenschrift		
	*Deutsche Monatsschrift für Zahnheilkunde		
	*Doklady Academii Nauk SSSR		
	*Egyptian Dental Journal		
	*Experimental Medicine and Surgery		
	Ear, Eye, Nose and Throat Quarterly		
	Fortnightly Review of the Chicago Dental Society		
	*Frankfurter Zeitschrift für Pathologie		
	GP (Kansas City, Mo.)		
	Gastroenterology		
	*Gazette des Hôpitaux Civils et Militaires (Paris)		
	Geriatrics		
	*Hals- Nasen- und Ohrenarzt		
	*Health Education Journal		
	Health Physics		
	*Helvetica Chimica Acta		

TABLE *(Continued)*

Rank	*Title*	*Number of Citations*	*Per Cent of Total Citations*
	Hospital Forum		
	Howard University Dental Alumni Bulletin		
	*Indian Dental Abstracts		
	*Indian Journal of Pathology and Bacteriology		
	*Indian Medical Gazette		
	Industrial and Engineering Chemistry		
	Industrial Medicine		
	Inquiry		
	International Journal of Orthodontics and Dentistry for Children		
	Iowa Dental Bulletin		
	Iowa Dental Journal		
	*Japanese Journal of Medical Progress		
	Joint Committee on Accreditation of Hospitals Bulletin		
	Journal of Allergy		
	Journal of the American Dental Society of Anesthesiology		
	Journal of the American Dietetic Association		
	Journal of the American Osteopathic Association		
	*Journal of Anatomy		
	Journal of Applied Physiology		
	Journal of Biophysical and Biochemical Cytology		
	Journal of Cellular and Comparative Physiology		
	Journal of Chronic Diseases		
	*Journal of Clinical Pathology		
	Journal of the Connecticut Dental Association		
	Journal of Dairy Science		
	Journal of Dental Education		
	*Journal of Dentistry (Tokyo)		
	Journal of Endodontia		
	Journal of Experimental Education		
	Journal of Experimental Medicine		
	Journal of the Florida State Dental Society		
	Journal of Health and Human Behavior		
	*Journal of Hygiene		
	Journal of Immunology		
	Journal of Implant Dentistry		
	Journal of Industrial Hygiene and Toxicology		
	*Journal of the Japan Dental Association		
	*Journal of the Japan Research Society of Dental Materials and Applications		

TABLE *(Continued)*

Rank	*Title*	*Number of Citations*	*Per Cent of Total Citations*
	*Journal of Laryngology and Otology		
	Journal of the Maryland State Dental Association		
	*Journal of Medical Genetics		
	Journal of Metals		
	Journal of the Mississippi Dental Association		
	Journal of the National Cancer Institute		
	Journal of the Nebraska State Dental Association		
	*Journal of Neurology and Psychopathology		
	Journal of Neuropathology and Experimental Neurology		
	Journal of the New Jersey State Dental Society		
	Journal of the North Carolina Dental Society		
	Journal of Occupational Medicine		
	Journal of the Oklahoma State Dental Association		
	Journal of the Oklahoma State Medical Association		
	*Journal of Pathology and Bacteriology		
	Journal of Polymer Science		
	Journal of Public Health		
	Journal of Radiology		
	Journal of the Society of Motion Picture and Television Engineers		
	Journal of Speech and Hearing Disorders		
	*Journal of Tropical Medicine and Hygiene		
	Journal of the Western Society of Periodontology		
	*Kunststoffe		
	Laboratory Primate Newsletter		
	Laryngoscope		
	*Makromolekulare Chemie		
	*Medical and Biological Illustration		
	Medical Clinics of North America		
	*Medical Journal of Australia		
	*Minerva Medica		
	*Morphologisches Jahrbuch		
	National Cancer Institute Monographs		
	National Underwriter		
	*Nederlands Tijdschrift voor Tandheelkunde		
	*New Scientist		
	*Norske Tannlaegeforenings Tidende		
	*Nutrition News		
	*Odontology Journal of Nippon Dental College		
	Ohio Dental Journal		
	*Okajimas Folia Anatomica Japonica		

TABLE *(Continued)*

Rank	*Title*	*Number of Citations*	*Per Cent of Total Citations*
	Oral Hygiene		
	Pediatric Clinics of North America		
	*Philosophical Magazine (London)		
	Physical Review		
	Presbyterian-St. Luke's Hospital Medical Bulletin		
	*Progress in Biophysics and Biophysical Chemistry		
	Progress in Health Services		
	Psychological Bulletin		
	Public Relations Journal		
	*Rassegna Trimestrale di Odontoiatria		
	*Revista de la Asociación Odontológica Argentina		
	*Revista de la Universidad del Zulia		
	*Revue Belge de Medicine Dentaire		
	*Revue Belge de Science Dentaire		
	Rhode Island Medical Journal		
	*Revista Ciba		
	Rubber World		
	*Schweizerische Zeitschrift für Pathologie und Bakteriologie		
	*Schweizerische Zeitschrift für Zahnheilkunde		
	Social Security Bulletin		
	*South African Medical Journal		
	*Stoma		
	Surgical Forum, Clinical Congress of the American College of Surgeons		
	*Sveriges Tandläkarförbunds Tidning		
	Texas Reports of Biology and Medicine		
	Transactions of the American Academy of Ophthalmology and Otolaryngology		
	Transactions of the American Society for Metals		
	*Transactions of the Canadian Ophthalmological Society		
	*Transactions of the Clinical Society of London		
	*Transactions of the Medico-Chirurgical Society of Edinburgh		
	Transactions of the National Tuberculosis Association		
	Transactions of the New York Academy of Sciences		
	*Transactions of the Royal Schools of Dentistry, Stockholm and Umeå		
	United States Naval Medical Bulletin		

TABLE *(Continued)*

Rank	*Title*	*Number of Citations*	*Per Cent of Total Citations*
	*University of Queensland Paper, Department of Dentistry		
	*Verhandlungen der Deutsche Pathologische Gesellschaft		
	*Vierteljahrsschrift für Dermatologie und Syphilis		
	*Virchows Archiv für Pathologische Anatomie und Physiologie und für Klinische Medizin		
	Washington University Dental Journal		
	*Welding Research		
	Western Journal of Surgery, Obstetrics and Gynecology		
	Yale Medical Journal		
	Total, 422 periodical titles	2,842	83.96
	Total, non-periodical sources	543	16.04
	GRAND TOTAL	3,385	100.00

Non-periodical references such as books, personal communications, reports, and so on accounted for only 16.0 per cent of the citations in our study. These same sources of information provided 21.1 per cent of the citations in the Howard Report.

Today's authors tend to use more recent literature. The bulk of the references (79.9 per cent) are not more than ten years old as compared to only 57.0 per cent for the same time span fifteen years ago. It was interesting to observe that at the other end of the scale, eleven references were to publications over 100 years old.

We were encouraged to see the diversity of publications cited by dental authors. Two-thirds (67.1 per cent) of the periodicals mentioned were non-dental and even non-biomedical—journals on welding, rubber, public relations, metals, dairy science, and many others were cited.

Also, there appears to have been a noticeable expansion of the number of dental journals. Fifteen years ago, twelve dental journals provided 50.0 per cent of the references. In our study it took twenty dental journals to contribute one-half of the references. Another indication of this trend was evidenced by the fact that the *Journal of the American Dental Association* was referred to 23.6 per cent of the time in the 1950's and only 13.6 per cent of the time in our study.

Also, while we surveyed fewer articles, our list contained 71 additional journal titles.

Our authors relied on journals published outside the United States for 25.0 per cent of their references, a 16.0 per cent increase over fifteen years ago.

This study of the bibliographic references used by the authors of dental articles can provide useful information to the user of scientific literature as well as to the biomedical library.

We conclude that authors of dental articles today:

1. are relying more on the periodical literature for their information,
2. are using the more recent articles (under ten years old) for reference,
3. are not limited to a few dental publications, but are using authoritative articles in more journals, in non-dental and non-biomedical journals, and in journals published outside the United States.

8600 Wisconsin Avenue
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NATIONAL LIBRARY OF MEDICINE

The National Library of Medicine (NLM) has a Congressional mandate to apply its information resources broadly to the advance of medical and health-related sciences. NLM collects, organizes, and disseminates biomedical information to health scientists, educators, and practitioners, and administers extramural programs designed to strengthen existing, and develop new, medical library services in the United States.

To meet the increasing needs of the health professions and to handle the increasing volume of biomedical information, NLM developed the computed-based Medical Literature Analysis and Retrieval System (MEDLARS). This is used to index, process, store, and retrieve citations to articles in 2,400 of the world's biomedical journals. MEDLARS compiles and composes the Library's monthly *Index Medicus* and related publications, including the *Index to Dental Literature*. The computer also produces demand search bibliographies in answer to complex questions that cannot be handled effectively by existing printed indexes.

The NLM collection, which totals nearly 1,300,000 books, journals, theses, pamphlets, prints, and microfilms, was started in 1836 as the "Library of the Surgeon General's Office" (Army). It developed as a national resource under Dr. John Shaw Billings, Librarian from 1865 to 1895. Named "Army Medical Library" in 1922 and "Armed Forces Medical Library" in 1952, it became the "National Library of Medicine" and was made part of the U. S. Public Health Service in 1956.

Looks at Books

OPERATIVE DENTISTRY. By Louis C. Schultz, D.D.S., M.S., and 8 contributing authors. 296 pp. Philadelphia: Lea & Febiger. 1966. $14.00.

This book of ten chapters has nine contributing authors. These are distinguished clinicians, researchers, and teachers of the Department of Operative Dentistry at the University of Michigan School of Dentistry. In addition to Dr. Schultz they include: Gerald T. Charbeneau, D.D.S., M.S., Robert E. Doerr, D.D.S., M.S., Charles B. Cartwright, D.D.S., M.S., Frank W. Comstock, D.D.S., M.S., Fred W. Kahler, Jr., D.D.S., M.S., Ross D. Margeson, D.D.S., M.S., Donald L. Hellman, D.D.S., and Daniel T. Snyder, D.D.S.

The text is geared to the undergraduate student, and to this end it has accomplished its purpose. It is written in such a manner that it may also be of value at the graduate level, and serve as a reference work for the practitioner.

Fundamental concepts of operative procedures, cavity instrumentation, general operative treatment procedures, amalgam, silicate, gold inlays, cohesive gold, porcelain technics, and finally diagnostic and treatment planning procedures are described.

In the dental curriculum, operative dentistry reflects a diversity of technics and philosophies. Sectionalism is inherent and no attempt is made in this book to develop a consensus of different ideas other than those being taught at Michigan. A basic conservative philosophy directed by the teaching staff is presented.

Most of the text is authoritative, well written, and critical with excellent, though not exhaustive coverage, of this subject matter and references. The main technique of the book is to range over the various approaches to cavity designs, describing each in modern concepts, bringing forth various accepted basic techniques of the past.

Selected reading references are listed alphabetically at the end of each chapter. In addition, an Index-Product list of manufacturers and materials used in the prescribed techniques are included; this is certain to be of use to the neophyte operator.

The authors are to be commended for making this book available. It should have a place in every practitioner's library.—*Robert G. Fodor, D.D.S., Associate Professor of Operative Dentistry, St. Louis University.*

ENDODONTICS

ENDODONTIC PRACTICE. By Louis I. Grossman, D.D.S., Dr. med. dent. 6th Ed. 477 pp. Philadelphia: Lea & Febiger. 1965. $9.50.

In an ever changing and growing specialty, the previous editions of this book have remained one of the standards in the teaching and practice of endodontics. The first edition appeared over 25 years ago at a time when this specialty was just emerging from two decades of neglect and disfavor. It has been revised about every five years, and has been translated into Portuguese and Spanish.

This 6th edition has been completely revised, many new illustrations have been added, and two new chapters have been included. The area of endodontics is covered in comprehensive detail from clinical diagnostic methods through selection of cases and completion of treatment. Discussed at

length are diseases of the pulp and periapical tissues; pulp capping, pulpotomy, pulp mummification, and pulpectomy; rationale and principles of endodontic treatment; anatomy of the pulp cavity; preparation, irrigation, sterilization and filling of the root canal; and bacteriologic examination. The book also offers material on root resection, treatment of fractured and traumatized anterior teeth; and bleaching of discolored pulpless teeth.

The new chapter, "Endodontal-Periodontal Therapy," brings attention to the various problems associated with interrelated pulpal and periodontal involvements. It discusses their relationship in terms of disease of the attachment apparatus, hemisection, accessory canals, and the split tooth. It shows that combined treatment, when indicated, can preserve such teeth or roots in health. The other new chapter, listed as an Appendix, presents a list of useful aids to endodontic practice. These are practical and time saving hints which have developed from clinical practice and can make the endodontic operation smoother and more effective.

As the title "Endodontic Practice" implies, this book is designed to serve as a handbook and guide in all aspects of endodontic technique. In view of the author's long experience and association with endodontics, and his recognition as a leading authority on the subject, it follows that this book should be a valuable addition to any dentist's library and a useful guide in the performance of his endodontic service.

THE DENTAL PULP. By Samuel Seltzer, D.D.S., and I. B. Bender, D.D.S. 272 pp. Philadelphia: J. B. Lippincott Co. 1965. $12.00.

This book is a detailed study of the dental pulp with the idea of furnishing either the practicing dentist or student a basis for proper diagnosis and conservative treatment of conditions affecting this tissue. The authors have approached the subject comprehensively to include complete consideration of the structure, function, composition, physiology, and histopathology of the pulp.

To provide an understanding of the kind of tissue of which the pulp is composed, the first six chapters deal extensively with embryogenesis of pulp and dentin, connective tissue, blood and nerve supplies of the pulp, and pain perception. This is followed by discussions on pulpal inflammation, the effects of manipulative dental procedures, and the processes of caries, erosion, and attrition as they affect the pulp. The authors have shown how the pulp reacts to injuries caused by various forms of irritants: microbial, mechanical, chemical, thermal, and radiant with an inflammatory response similar to that of any other connective tissue. Emphasis is directed to evidence of the great recuperative powers of the pulp which is contrary to the earlier belief that, once injured, it could not recover. Carious and mechanical pulp exposures are discussed in reference to indications and contraindications for pulp capping, pulpotomy, root canal treatment, or extraction. Interrelationships, effects, and correlations of pulp and periodontal disease are considered. Retrogressive and age changes are also discussed.

The final three chapters pertain to the histologic classification of pulp diseases, clinical and differential diagnosis. An understanding of this material should serve to reduce significantly the diagnostic problems one often encounters. To make this study more meaningful, it is accompanied by analytic interpretation of scientific data provided by biochemistry, histochemistry, electrophoresis, electron-microscopy, and radioautography.

There are numerous illustrations, photomicrographs of excellent quality, and references to the works of other investigators. The correlations of clinical findings to histologic diagnosis are calculated to stimulate interest in the biology of the dental pulp and help bridge the gap between the basic sciences and clinical practice.

AN ATLAS OF PULPAL AND PERIAPICAL BIOLOGY. By Alfred L. Ogilvie, D.D.S., M.S., and John I. Ingle, D.D.S., M.S.D. 169 pp. Philadelphia: Lea & Febiger. 1965. $5.00.

Dentists must have intimate and extraordinary knowledge of the principal source of pain within the mouth—the dental pulp. Their libraries should certainly include such material that is presented in this atlas. Because this volume is devoted entirely to pulpal and periapical biology, it should be of interest to almost any group within dentistry.

Four chapters of Ingle's text *Endodontics* have been excerpted to compose this atlas. Its contents deal effectively with the histology of the pulp, the etiology of pulpal inflammation and necrosis, pulpal pathosis, and periapical pathosis. Strongly pictorial in content, an exceptional selection of clinical photographs, roentgenograms, photomicrographs, and line drawings are used.

The authors have presented descriptions and discussions of the pulp and periapical area, showing how they appear in conditions of health and disease. Also, they have examined the changes that occur during the course of disease. Features of the book include a consideration of pulpal circulation, innervation, and pulp repair; the influence of restorative procedures and materials on the health of the pulp; and correlation of endodontic diagnosis of periapical disease with the histopathology of the periapex. Emphasis is placed on the continuity and interdependence of the pulp and periapex.

An attractive feature of this atlas is its low cost, made possible by retaining the chapter numbers and pagination of the original text. It is hoped that this economical aspect may serve to promote its wider distribution and use. The format includes large pages (8½ x 11 inches), extensive illustrations and easily readable text.

(These three reviews were prepared by George R. Wiseheart, B.F.A., D.D.S., Instructor, Clinical Dental Medicine, Washington University, School of Dentistry, St. Louis.)

THEORY AND PRACTICE OF CROWN AND BRIDGE PROSTHODONTICS. By Stanley D. Tylman, A.B., D.D.S., M.S. 5th Ed. 1249 pp. St. Louis: C. V. Mosby Co. 1965. $18.00.

The 5th edition of this book offers students and practicing dentists complete coverage of all phases of crown and bridge procedures available. The text represents many years of devoted service that Dr. Tylman has rendered to teachers and the profession.

This book effectively coordinates biological principles with the technical procedures for fixed partial dentures. However, as a teaching text, I feel the book is too voluminous for effective utilization in the class room and laboratory. Many of the procedures presented can be completed with simpler and more accurate techniques that are much less time consuming than those presented. For example, Chapter 35 presents material on construction of Richmond and Davis dowel crowns that are in little use today.

Despite these problems, the text should be in everyone's library for the many current procedures that are dis-

cussed in a concise and excellent manner. Revision of the chapters on porcelain-to-metal and new advances in high-speed instruments are good examples.

Two contributing authors have been added since the 4th edition. Dr. George Moulton has contributed an excellent chapter on the use of the Hanau University Articulator Model 130-21. Two chapters were contributed by R. E. Brumfield concerning the mechanics of dental bridges from an engineering viewpoint. These were added to stimulate study and research in this area. They are difficult to read without an engineering background. This area certainly is deserving of much thought and investigation to meet the needs of fixed partial dentures in the future.

I would recommend this book as a needed and useful reference text.—*James D. Harrison, D.D.S., M.Sc., A.M., Chairman, Department of Crown and Bridge, St. Louis University.*

CAVITY PREPARATION AND IMPRESSION TAKING. By James D. Harrison, D.D.S., M.Sc., M.A. and Arlon G. Podshadley, D.D.S., M.S. in Dent. 92 pp. St. Louis: C. V. Mosby Co. 1965. $5.75.

This manual presents basic principles in cavity preparation and elastic impression procedures. It has been developed using a programmed text that presents information to the user and requires him to answer questions. The answers are immediately confirmed, and if they are correct, the user can proceed. If the answer is incorrect, the user can re-study the previous "frame" and confirm the correct answer. This procedure completes a learning experience. The information is presented in frames that build the user's knowledge from the simple to more complex facts.

The text can be used to present this segment of information, when needed, in a teaching program. The programming format is linear and contains some frames that are sometimes elementary, but the objectives of the text are well achieved.

The self-instructional exercises illustrate the potential of programmed learning that can be used as a teaching tool and free the teacher for more student contact.—*T.McB.*

ACCEPTED DENTAL REMEDIES—1967. By the Council on Dental Therapeutics, American Dental Association. 32nd Ed. 287 pp. Available from Order Department, ADA, 211 East Chicago Ave., Chicago, Ill. 60611. $3.00.

This "handbook of dental therapeutics" is designed to give the practicing dentist current data on useful drugs, and the manner in which they should be employed. ADR also lists possible side reactions which may occur, and interactions between drugs.

Information is supplied regarding special consideration to be given patients receiving medical care, and measures to be taken when life-threatened situations occur in the dental office.

Continued and updated are the sections on "Therapeutics Aids" and "Therapeutic Guides." The former contains certain significant aids to general treatment procedures; the latter is a quick guide to agents which have application to certain clinical problems. The chapter, "Current Therapeutic Trends," is intended to keep the dentist informed of the status of many of the drugs that he is hearing about in the rapidly changing field of therapeutics.

ADR has grown to be a resource book that should prove indispensable in the modern dental office.—*T.McB.*

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CONTRIBUTED PAPERS
MEDICAL CARE SECTION PROGRAM
95TH ANNUAL MEETING—AMERICAN PUBLIC HEALTH ASSOCIATION
MIAMI BEACH, FLORIDA, OCTOBER 23-27, 1967

Authors of papers for possible inclusion in the Medical Care Section Program of the 1967 meeting of the American Public Health Association should write to Donald C. Riedel, Ph.D., Associate Professor of Public Health, Yale University School of Medicine, 60 College Street, New Haven, Connecticut 06504, to obtain standard abstract forms. Two types of papers will be considered: research reports and descriptions of programs or demonstrations. The deadline for submitting abstracts is April 14, 1967. Authors of papers selected for the program will be notified of the fact in early June.

The Objectives of the American College of Dentists

The American College of Dentists, in order to promote the highest ideals in dental 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 development and use of measures for the control and prevention of oral disorders;

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

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

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

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

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

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

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

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

(j) 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.

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

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