

the Journal
of the
American College
of Dentists

Children's Dental Visits

Student Attitudes

Dental Administrators

Statesmanship in Dentistry

OCTOBER 1967

the Journal of the American College of Dentists

A QUARTERLY PRESENTING IDEAS IN DENTISTRY

T. F. McBRIDE, *Editor*
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Editorials

Responsibilities in Total Dental Health Service

Dentistry exists for the benefit of society as a whole, but most specifically for the well-being of the unit of society—the individual. This purpose of being for the profession is realized ideally through the individual dentist's contribution to the fulfillment of the individual patient's potentialities as a *person*—that is, a human being who possesses individuality which distinguishes him from every other human being. This individuality is colored by occupational, moral, religious, political, cultural, and social overtones.

The contemporary scene is bursting with change in these overtones which permeate the individuality of the patient. To safeguard and fulfill his responsibility to the well-being of the individual patient, it behooves the dentist to reevaluate his role in relation to the changes which are occurring.

The individual practitioner must recognize the changing concepts in regard to mechanisms for meeting the health needs of the individual. One basic change in philosophy is the notion that health care (along with food, clothing, shelter, and education) is no longer a privilege, but a basic right of all citizens. Another concept, long accepted by our society—despite the socio-political philosophy of a number of people to the contrary—is that certain personal rights, particularly for special categories of individuals, can best or only be fulfilled through programs geared for large segments of the population. In recent years this approach has been applied to health care.

Administering the provision of service through large group ar-

rangements under third party sponsorship, and the actual *rendering* of professional service on an individual doctor-patient relationship, are not incompatible mechanisms.

Dentists must be alerted to the fact of the magnitude with which government has become involved in the administration of providing dental services. Individual dentists, particularly those in a position of leadership in the community, should develop an understanding of all government health programs that are operating or projected in the community, and insist, through the component society, that the dental profession be represented on the planning, advisory, and operating boards that have jurisdiction over those dental programs.

The future of the private practitioner in government programs will depend not on broad policy statements and decisions by state or national dental organizations, but by his understanding of and participation in the development of dental care programs at the community level. He must look beyond his 8 x 10 operatory to his total professional responsibility.

The knowing dentist should set the example for his colleagues by not only taking an active part in the planning of these local programs, but also by participating in the private treatment of patients under the programs.

The profession, as a duly organized unit within a broader society, first exists for the well-being of the patient. The profession must emerge from its shell and accept finally the total responsibility for the dental health care of our citizens. Whenever it fails to provide a group seeking care with care, the individuals comprising the profession fail in their responsibility to the individuals within the group seeking the care. Whenever it fails to lead and direct an individual, group, or government seeking to provide dental care, it stands great risk in having a plan developed which is not in the best interest of the recipients of the care or of the profession.

The profile of the profession is being examined. The profession must share in this examination to the fullest, provide change where change is needed, and solve problems where problems exist. Represented by the American Dental Association and its constituent and component societies, the profession must be more aggressive in its approach to government where dental care is involved. The pro-

fession should not be content with merely broad policy statements dealing with the provision of dental care.

The profession should take the lead in seeking legislation designed to provide professionally acceptable comprehensive dental care programs. The profession should demand representation on policy-making and advisory boards at the national and state level where dental care is involved. Competent and knowledgeable members of the profession must be developed to guide the policy-making boards.

Dental associations should develop and use the best communication media and methods to alert and educate dental practitioners in the purpose and problems of government dental programs.

Lay professionals in the health fields should be recruited and employed by dental associations to assist them in achieving their goals.

The profession has a commendable record of service and professional responsibility. However, to the present, its sphere of activity has been rather restricted to relations with a limited number of individual patients and a limited number of health professionals and legislators. Dentistry must now attempt to educate the public at large to its interest in providing the best possible dental care to large segments of the population.

This is no longer a task for a few leaders of the profession. It can be accomplished only by a total effort by all dental practitioners.

ROY T. DUROCHER

BILLY F. PRIDGEN

KENNETH J. RYAN

This summary statement was written by the above members of the ACD Committee on Dental Health Service, and approved by the Committee. The other members of the Committee are David R. Wallace, Chairman, and Milton E. Nicholson, with Donald J. Galagan, B. Duane Moen, and Albert H. Trithart, Consultants.

SOCIAL CONSCIOUSNESS

The dental profession has not been educated to understand the social sciences, and thus we find few dentists taking a place of leadership in the local health affairs. This produces a poor public image of the dentist. He is prosperous, moves in the upper strata of society, and apparently lives as well as or better than most of his patients. He conducts his practice to suit himself rather than the community in which he lives. By and large, whilst he is biologically oriented and technically capable, he is not social conscious.—Gerald H. Leatherman, "After Forty Years." *Northwest. Univ. Bul.*, Feb. 22, 1965, p. 38.

BERTON E. ANDERSON, 1900-1967

Dr. Berton E. Anderson, 67, Seattle, who this year would have completed his four year term as a member of the Board of Regents of the American College of Dentists, died June 26. Fellowship in the College was conferred in 1955.

Dr. Anderson graduated from North Pacific College of Dentistry, now the University of Oregon, in 1925. He was a general practitioner in Seattle until 1948. At that time he was appointed to the faculty of the University of Washington School of Dentistry, shortly becoming assistant dean. He served as associate dean until his retirement in January 1967. In 1955 and 1956 he was acting dean.

He held the following teaching positions: director of admissions, director of postgraduate education, and chairman of the Department of Professional Science and Literature. He was active in student counseling and in teaching dental ethics and practice administration.

He served dental organizations in several positions: president of the Seattle District Dental Society in 1943, secretary of the Washington State Dental Association in 1944, and editor of the *Washington State Dental Journal* 1945-48. He was a member of the House of Delegates of the American Dental Association for ten years beginning in 1938.

He was a member of Omicron Kappa Upsilon and Delta Sigma Delta fraternities. In May of this year Delta Sigma Delta presented a portrait of Dr. Anderson to the School of Dentistry, and established an annual scholarship in his name.

Dr. Anderson is survived by his wife, Emmogene, and a son, Richard, assistant professor of surgery at the University of California Medical School at Davis.

Dean Maurice J. Hickey, following Dr. Anderson's death, stated: "Dr. Anderson's contribution to the School of Dentistry, spanning almost the whole period of its history, was supportive and unassuming. He was a wise counselor to students and faculty alike. . . . The University and the profession will always be in his debt."



The Joy of Commitment

STEPHEN F. DACHI, D.M.D., M.S.D.

WE meet today to mark achievement and to take our leave. We mark achievement with a feeling of pride, for we are pausing in a journey which has been both arduous and rewarding. It has been arduous because our aim of excellence has made it so and our will to achieve it has demanded it. But our rewards are also great, for we can say that what we have gained and what we have learned represent the best that our profession has to offer today. We live in a period of great change for dentistry, and our curriculum has reflected that change. It has opened our eyes to the forward thrust of our profession and has given us a start toward becoming a part of it.

And so at a time like this, we must ask what the future expects of us. What it expects of us if we are to follow the path on which we have taken our first few steps and if we are to be worthy of the standards we have set for ourselves.

We live in the richest nation on earth—yet half our people are in poor oral health. Too many of our children pay the price for this handicap by impaired growth, impaired speech, and impaired appearance; too many of our adults pay the price for this neglect through impaired health and impaired productivity; and too many of our elder citizens pay the price for our failure through a lack of teeth and lack of comfort.

The levels of dentistry have risen steadily; but its benefits have not spread sufficiently. We have blamed it on those who do not value health enough to invest their time and money to attain it—and there are some who do not. We have heard that others lack the will to better themselves or earn the means to do so—and this is also true. But

These remarks were given at the Commencement Convocation, University of Kentucky College of Dentistry, May 8, 1967.

In June of this year Dr. Dachi became Deputy Director of the Peace Corps in Colombia, South America. He had been at the University of Kentucky College of Dentistry since it was established in 1961, serving as Chairman of Oral Diagnosis and Oral Medicine, Head of the Hospital Dental Service, and Coordinator of Continuing Education.

what of their children? What of those who have the will but lack the means to invest large sums for the restoration of oral health for themselves and their families? Of the seven and a half million people currently receiving welfare payments in the United States, two million are over 65. Three and a half million are under 18. And of the remainder, fully one million are the indigent mothers of these children. Nor is this problem limited to the indigent. For many low and middle income families simply cannot meet the ever rising costs of dental health. They cannot meet the costs of repairing the damage accumulated through years of neglect, when there was even less fluoridation, even less health education, and even less tooth preservation than there is today.

What is our duty in the light of these problems? Can a nation which invests \$60 billion a year on arms, and an additional \$10 billion to conquer space, afford to mark its children with the scars of their less fortunate parents and sentence them to the same fate? Can the most highly developed nation in the world waste a part of its youth and squander its resources when half the world is hungry, when thousands cannot read or write, and millions look to us to lend a helping hand? Can we continue to regard health as a privilege, when we have no right to deny it?

We live in a revolutionary age of rising expectations. An age when the people are ready to decide for themselves the level of health they want; an age when the profession can no longer sit back and set its own pace without regard to the felt needs of the community. We no longer have unlimited time to carry out long programs of small improvements. For if the improvement is not visible, if its rate is too slow to make much difference, we must expect to see a growing clash between those who are resolved to block any progress, and those who are forced to consider radical solution.

Let us know with certainty that our labors will be measured, not just by our technical skill, for we have always had much of that, nor by our scientific achievement, which our modern society takes for granted, but by our success in extending the boundaries of health to those who, until now, have not dared aspire to it. For our mandate is not from the man in our chair nor from his family and friends, but from the community to which he belongs. For too long we have heard that we must strive to do what is good for the profession. But the critical issue is not what is good for the profession for its own needs, but what the public needs for its own good. For if a profes-

sion does not serve the society from which it stems, it cannot stem for long the forces which will change it.

The problems of health do not exist by themselves. They are closely related to the total environment, its resources, its culture, and its stage of development. Their solution depends on progress in many fields: improved education, greater productivity, a stronger economy, and concerted social and political action at the community level.

We stand here today in the highest type of health facility yet devised—a modern Medical Center. With its up-to-date equipment, multiple disciplines, and team approach, it represents the final stage in health care. But we have had to traverse many stages to reach it. We have passed from the first stage of health development, the economic infrastructure, the roads, the dams, the telephones, to the second, involving sanitation and the eradication of environmental disease. From the third stage of classical public health procedures such as immunization, health education, and maternal and child care, to the stage of private care and the individual doctor-patient relationship. But our communities are not all at the same stage of development, and we cannot expect them to function at the Medical Center level. Their degrees of achievement have depended on many factors beyond health, and their continued progress similarly depends on the mobilization of all their resources.

Our challenge as we leave here is to find ways in which we can participate in the development of our own communities, in the elevation of their standards and their aspirations for health, in accordance with their means and the resources they have at hand. It is no longer enough to await the individuals who now have the means to seek our service and condemn the others, for they shall soon rise to condemn us for our failure to show the way.

And so, in addition to broadening our private treatment from the relief of pain to its prevention, from the removal of teeth to their preservation, and from an interest in techniques to a concern for general health, we also must accept that our profession extends beyond the walls of our office and that our service to our patients must be matched by our work with others. That we must show concern for the indigent, the handicapped, the aged, and the sick; that we must support health education, the prevention of disease, and the search for ways to make health service available to all; and that, as

active citizens, we must take part in the affairs of vital concern to our communities. But, above all, we must participate in the reorientation of our profession, so that through our leadership it may dedicate itself to these ends, and that it may find its own ways to achieve them. We must take the initiative in leading our profession to solve its own problems, so that the process through which free men seek the delicate balance between freedom and justice may be preserved. We must demonstrate that man's aspirations for health can be achieved best by free men, working within a framework of democratic institutions.

But let the weak be warned and the strong prepared that we will not be met by a galvanic response to our efforts, nor by a swift gathering of ardent spirits, for no establishment ever welcomes the agents of change.

Organized resistance to the future has characterized man's history through his transitions from the horse to the stagecoach, from the railroad to the airplane, and from the chart to the computer. Yet whenever the short range view triumphs over the long, the injury to society is always less than the damage to the welfare of the groups whose immediate interests seem threatened.

We need to broaden ourselves, so that we can accept the differing views of others and have the patience to allow our acts to pass the test of time. We need to be flexible so that ten years from now change will not be as alien to us as it was to those who have passed before us. We need, not a rigid adherence to the past, but a present and probing concern for the future. And we need, most of all, the courage to persevere in the conviction that our cause is right. For life's greatest gains can be made only in proportion to the risks we have the courage to take.

We speak of courage—but what can one man do? Can one man make a difference, when working among many? Can one man change the course of tradition, when many are content to observe it? It was one man who had the faith to come here and start the school we leave today; it was one man who had the vision to build this Medical Center in a field of corn; and it was one man who had the courage to commit his State to make this institution a reality.

It was one man who for a thousand days rallied his island nation to stand alone against the greatest armed might ever assembled up to that time; it was one man who during a thousand days changed the course his church had followed for a thousand years; and it was

one man who in a thousand days lit the torch which re-inspired men everywhere to look to America as a symbol of youth and a beacon of freedom.

And so, we have a choice to make. We can be content, reap the rewards of our gains, and succumb to the deadening comforts of affluence too easily attained. Such is the fate of the armchair generals of social change—the passive spectators who turn their backs—those who decry the need and defy those who search for a solution. Or, we can set our sights to the future, we can take the initiative, we can accept the challenges we face and play an active role in meeting them.

Let us not fear to become involved, to become committed to serving our profession and lead it toward the future which it must serve. For by this act of involvement, each individual can begin the life-long process of paying his own dues, being a member in good standing of the society that sustains him. Let us truly profit from our education by applying it to the progress of society and thereby do honor to our profession as well as to ourselves.

Let us not fear the prisoners of the past. For new roads can be built with the stones cast by those who would still the steps of progress. Let us not wonder whether we can make a difference; for we should know that we must. And when we do, our fellow man will not be alone to profit. For we shall also enrich ourselves, knowing that we have been found worthy of his hopes.

In the words of a Nigerian proverb: "When the right hand washes the left, the right hand becomes clean also." President Kennedy once said: "Of those to whom much is given, much is required. And when at some future date the high court of history sits in judgment on each of us, recording whether in our brief span of service we fulfilled our responsibilities, we will be measured by the answers to four questions: Were we truly men of courage? Were we truly men of judgment? Were we truly men of integrity? and Were we truly men of dedication? Mankind waits upon our answer; and many look to see what we will do. We cannot fail their trust. We cannot fail to try."

And so, let us take our leave, not with the sorrow of parting but with the joy of commitment. The commitment to serve our profession well, and the knowledge that in so doing, the interest of our fellow man will truly be our own.

c/o The American Embassy
Bogota, Colombia
South America

Children's Preventive Dental Visits: Influencing Factors

A. STAFFORD METZ, PH.D., and LOUISE G. RICHARDS, PH.D.

ONE important aspect of children's dental care is the practice of making preventive visits to the dentist. The incidence of these preventive visits is clearly related to the socio-economic position of children's families. The National Health Surveys, both in 1957-59, and 1963-64, found this to be true (1). Children in households where either the family income or the education of the head of the household was high more often made visits for examination or cleaning than did children from families where either income or education was low. Children from less advantaged families, on the other hand, more often made the visit for fillings, extractions, or other surgery. The Survey's 1957-59 findings show the joint effect of low income and low education: Children in households where both measures of socio-economic status were low were less likely to go for cleaning or examination than children in families where only one of the two factors was low (2).

The present report examines a third factor that affects children's practices of making preventive dental visits: parents' own practices. Kriesberg and Treiman, in their analysis of the relation of family income to teenagers' preventive dental visits, examined this factor briefly in a tabulation of family income, parents' practices, and teenagers' practices (3). Their data show that if parents go to the dentist preventively, a high proportion (79 per cent) of their teenage children do also. Moreover, the proportion is at this same high level in both high and low income groups. The authors say in their con-

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clusions that parents' practices and attitudes are among the few factors that appear to mitigate the strong influence of family income on teenagers' preventive visits (4).

Many dental health programs are designed to eliminate the income "barrier" to children's preventive care. Kriesberg and Treiman's data suggest that parents' practices may exert a separate, and strong, influence on children's practices. If so, dental health programs need to look for ways to take such knowledge into account in efforts to reach more children.

This report was prepared as a test of the hypothesis suggested by Kriesberg and Treiman's finding. There were several reasons for making a further exploration of this finding. First, Kriesberg and Treiman's finding applies to teenagers only. It is important to learn whether or not the same pattern occurs among children in a range of ages. Second, Kriesberg and Treiman's tabulation was made on a relatively small number of cases. (One percentage figure was based on 14 cases only.) Finally, their tabulation was made with only one of two important indicators of social status: Family income. It is important to learn whether the same effect occurs in families of varying educational levels as well as in families with high or low income.

In the larger study of which Kriesberg and Treiman's teenage cases were a part, data were available on all children up to nineteen years. Data were also available on the educational level of the parent respondent in each family. The number of cases was large enough to test the hypothesis on a wider range of ages, and also to carry out a four-way analysis of relations among parents' preventive visits, family income, education of the parent respondent, and children's preventive visits.

SAMPLE AND DATA

The original study was a nationwide survey, "Public Attitudes and Practices in the Field of Dental Care," carried out in 1959 by the National Opinion Research Center (5). The sample consisted of adult respondents in a representative cross-section of 1,862 households. Each adult respondent was selected at random from all adults in the household. The respondent was asked about his or her own dental practices and also about those of children under nineteen years in the same household. Nine hundred and twelve of the respondents were parents with children under eighteen years. The sam-

ple of these parent respondents was almost equally divided between mothers and fathers.

Children of the ages six to seventeen years and the parent respondent in each of the children's households are the subjects of the present analysis. Children under six years of age were excluded because it was found that a large proportion of them had never been to the dentist. In order to avoid the inflation of results from possible similarity of practices among children in the same family, one child was selected at random in each family. Also eliminated from the sample are parent respondents who reported having no natural teeth. The number of households that qualify for the sample under those conditions is 542; all results reported here are based on that total.

The child's use of the dentist preventively is measured by this question asked of the parent respondent: "Does (child) go to the dentist only when (he, she) needs to, or does (he, she) sometimes go for a checkup, even when there is nothing wrong?" The response "Go for checkup" is used as the indicator of preventive dental visits; the two responses, "Goes only when need to" and "Never been to the dentist" are combined as a single indicator of non-preventive practice.

The measure of family income is the total family income reported by the parent respondent. Level of education in each case is the education of the parent respondent: If the respondent was the father, it is the father's education; if the respondent was the mother, it is the mother's education.

Parents' preventive visits to the dentist are measured by the question quoted above asked of the respondent about his or her own practices. "Go for checkups" indicates preventive utilization of the dentist, and "Go only when need" or "Never been to the dentist" indicate non-preventive utilization.

PROCEDURE

The purpose of the analysis was to test the hypothesis that parents' preventive utilization of the dentist acts as an independent factor in predicting children's preventive utilization of the dentist. The test thus determines whether or not parents' practices affect children's practices above and beyond the influence of family income and parents' level of education.

It was also possible to check certain other factors that might affect children's preventive practices: Sex and age of the child, and sex of the parent respondent. We found virtually no differences in children's preventive visits with the introduction of any of these factors (Tables not shown). Consequently, all boys and girls ages six to seventeen years were combined as "children" and mothers and fathers were combined as "parents."

The method of analysis was first to examine the separate effects of income and parent's education on children's practices, then to examine the effects of the two jointly, and finally to examine the effect of three factors—income, education, and parent's practices—jointly.

On the basis of former analyses and findings from other studies, we expected the separate factors, income and education, to bear a strong relation to children's practices. We also expected the two social status factors, although themselves related, to have some independent and cumulative effect on children's practices. What we did not know was whether or not children's practices are affected by parents' practices independently of the social status factors. It is possible, for example, that income and education may determine both the parents' and the children's practices. It is also possible that parents' practices could represent a link between social class and children's practices. Finally, it could be found that parents' practices affect children's practices independently of the social class factors, in which case we should be interested in the strength of this influence compared with the influences of family income and level of parent's education.

RESULTS

The basic relationships of family income and parent's education to children's preventive visits are found in Table 1. It can be seen that each of the socio-economic indicators has an effect on children's utilization of the dentist. In each case, more children go for preventive visits in families of higher income or education as do children in families with lower income or education. About 50 per cent of the children in the less advantaged families go for preventive visits, compared with about three-fourths of those from families with more income or education.

The result of relating family income and parent's education simul-

TABLE 1
CHILDREN'S PREVENTIVE OR NON-PREVENTIVE UTILIZATION OF
THE DENTIST BY FAMILY INCOME, AND BY PARENT'S EDUCATION

A. Income		
<i>Child's Utilization of the Dentist</i>	<i>Family Income</i>	
	\$6,000 OR MORE	UNDER \$6,000
Preventive	78%	50%
Non-preventive	22	50
Total	100%	100%
Number*	(315)	(225)

B. Parent's Education		
<i>Child's Utilization of the Dentist</i>	<i>Parent's Education</i>	
	12 YEARS OR MORE	LESS THAN 12 YEARS
Preventive	75%	49%
Non-preventive	25	51
Total	100%	100%
Number*	(265)	(259)

* Total numbers add to less than 542 because of incomplete responses.

TABLE 2
CHILDREN'S PREVENTIVE OR NON-PREVENTIVE UTILIZATION OF
THE DENTIST BY FAMILY INCOME AND PARENT'S EDUCATION

<i>Child's Utilization of the Dentist</i>	<i>Parent's Education</i>			
	12 YEARS OR MORE		LESS THAN 12 YEARS	
	<i>Family Income</i>		<i>Family Income</i>	
	\$6,000 or More	Under \$6,000	\$6,000 or More	Under \$6,000
Preventive	85%	63%	65%	43%
Non-preventive	15	37	35	57
Total	100%	100%	100%	100%
Number*	(142)	(123)	(77)	(177)

* Total numbers add to less than 542 because of incomplete responses.

taneously to children's preventive visits is found in Table 2. It can be seen that the influence of family income is still an important one regardless of the amount of education of the parent. The differences between 85 per cent *vs.* 63 per cent, and 65 per cent *vs.* 43 per cent, are about as great as the original difference (78 per cent *vs.* 50 per cent) between income groups (Table 1A). Parent's education also remains as an important influence. High and low levels of parent's education (85 per cent *vs.* 65 per cent, and 63 per cent *vs.* 43 per cent) make almost as much difference as high and low family income.

The result of testing parent's own utilization practices as an additional factor is found in Table 3.

The first and highly important fact to observe is that children whose parents use the dentist preventively are more likely to go to the dentist preventively themselves. The percentages for children going to the dentist preventively are considerably higher for children of parents who make preventive visits than of parents who do not make preventive visits, for all four income and education groups (6).

As expected, income and education continue to influence children's practices. Children in families with high income tend to go for preventive visits more often than children in poorer families for all parental practice and education group categories. Similarly, in families where the parent respondent has high education, children are more likely to make preventive visits to the dentist than when the parent has low education.

The highest proportion of children making preventive visits to

TABLE 3
PER CENT OF CHILDREN USING THE DENTIST PREVENTIVELY
BY FAMILY INCOME, PARENT'S EDUCATION, AND
PARENT'S PREVENTIVE OR NON-PREVENTIVE
UTILIZATION OF THE DENTIST

Parent's Utilization of Dentist	Parent's Education							
	12 YEARS OR MORE				LESS THAN 12 YEARS			
	Family Income				Family Income			
	\$6,000 or More		Under \$6,000		\$6,000 or More		Under \$6,000	
	%	BASE*	%	BASE*	%	BASE*	%	BASE*
Preventive	96	(56)	86	(50)	90	(21)	67	(34)
Non-preventive	73	(48)	48	(65)	57	(44)	32	(114)

* Total numbers add to less than 542 because of incomplete responses.

the dentist occurs in families with high income, high education, and a parent who also makes preventive visits to the dentist (96 per cent). Conversely, the lowest proportion occurs in families with low income, low education, and a parent who does not use the dentist preventively (32 per cent). It can be concluded that all three factors—family income, parent's education, and parent's preventive visits to the dentist—have independent and cumulative effects on children's preventive dental visits.

The question arises, are there any differences in the strength of the relationships of these three factors with children's utilization? A detailed examination of Table 3 shows that the differences for parent's practices are consistently larger than for either family income or parent's education. The average difference for parental practice is 32.25 percentage points whereas the average difference for family income and parent's education is 20.75 and 14.25 respectively. This suggests that the independent effect of family income is somewhat greater than parent's education and, more strikingly, that the effect of parent's practice appears to be nearly as great as the other two combined. The major conclusion to be drawn, then, is that parent's own practice in making preventive dental visits has a greater influence than either family income or parent's education on whether a child will make preventive visits to the dentist.

DISCUSSION

With the recent emphasis given to providing dental care in this country, many dental health programs have been developed which offer income-free dental care to children—programs in dental prepayment plans, school dental care services, and welfare services. The elimination of income as a major deterrent on the part of these programs facilitates achieving their explicit purpose, which is to care for the children's current dental needs. If an additional purpose is to encourage the habit of going to the dentist for preventive examination and cleaning, however, the income factor may represent only *one* of the main deterrents to seeking preventive dental care. It may be fully as important to encourage *parents* to follow the practice of making preventive visits, thereby raising the chances that their children will go for the same purpose.

Many dental health education programs are designed to instill preventive attitudes in children themselves, through lectures, proj-

ects, and other methods carried out in schools, clubs, and the like. Again, we suggest that since parents' own practices are an important influence, children's practices may be relatively impervious to change if the efforts are directed to children alone (7).

It is not true, of course, that parents are ignored in efforts to inculcate preventive habits in children. School hygienists, the dental profession, and public health specialists are all aware of the importance of impressing parents with the value of preventive visits for children. What is missing, perhaps, is a concerted effort to motivate parents themselves to take preventive action. Admittedly, this may be a more difficult task, since parents may not see the need for prevention for themselves nearly as readily as they subscribe to it for children.

It is easy to imagine that parents who are pressed for money, or who have not had the benefit of learning middle-class habits in school, can rationalize limited care for their children: "What is good enough for me is good enough for the children," or more generously, "I managed to survive without all those visits to the dentist, so I guess the children will, too." On the other hand, parents who do follow preventive practices, perhaps at some sacrifice, seem to feel it is important enough for their children to go, too.

This analysis has not dealt with possible rationalizations, or any other attitudes that may play a part in the links between income, education, parents' practices, and children's practices. It has, however, pointed to parent utilization as a factor that accounts for rather large differences in children's preventive visits in the very families that often trouble public health workers. The ways of incorporating this knowledge into public health programs may require innovation and experimentation, but radical measures are well worth the effort.

SUMMARY

Social status factors of family income and parents' education are known to be closely related to preventive dental visits of children. The present analysis was undertaken to explore an additional factor, the parent's own preventive practices. Data on preventive or non-preventive use of the dentist were available on children (in the age range from six through seventeen years) and their parents (either mother or father) in a nationwide sample of 542 families.

Considerably more children of parents who go to the dentist pre-

ventively make preventive visits themselves, compared with children of parents who do not go to the dentist for preventive visits. Although both parents' and children's practices are related to family income and parents' education, the effect of parents' own practices also operates independently. Moreover, the influences of parents' practices on children's practices appears to be stronger than either income or education of parents. The socio-economic influences on children are seen most clearly in families where the parents themselves do not make preventive visits.

The effectiveness of dental health programs designed to stimulate preventive visits by children could be enhanced by taking these findings into account. Parents could be brought into service programs as participants, for example, and they themselves could be the targets of educational campaigns to encourage preventive visits.

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5. *Ibid.* pp. 43-44.
6. Kriesberg, Louis, and Beatrice R. Treiman. Socio-economic status and the utilization of dentists' services. *J. Am. Col. Den.* 27:147-65, Sept. 1960.
7. In order to simplify the presentation of the four-variable table, only the percentages of children making preventive visits are displayed. The percentages of children not making preventive visits can be determined in each case by subtracting the reported percentage from 100 per cent.
8. A similar recommendation was made by Kriesberg and Treiman in the 1962 report on teenagers. (Kriesberg and Treiman, 1962, *op. cit.* p. 45.) Their suggestion was to direct educational campaigns at parents to encourage them to send their children to the dentist preventively. Our suggestion differs in that, for maximum effect, we would also encourage the parents *themselves* to seek preventive care.

A Letter of Chapin A. Harris

RALPH W. EDWARDS, D.D.S.

BURTON LEE THORPE (1871-1923) achieved distinction in American dentistry in various ways. He was president of the Missouri State Dental Association (1901-1902); president of the National [American] Dental Association (1909-1910); and one of the organizers and dean of the Barnes Dental College (1903) of St. Louis, Missouri. He also was noted as a dental historian and biographer, and had accumulated a large collection of photographs of prominent dentists and other dental memorabilia.

Six years following his death, his widow, Mrs. Berta Scott Thorpe, gave the collection to Dr. Charles Channing Allen (1862-1930), dean of the Kansas City-Western Dental College, and a close friend of Dr. Thorpe. In this collection was a letter written by Chapin Aaron Harris (1806-1860), one of the founders of the Baltimore College of Dental Surgery. The photographs were placed in display frames so that the collection could be observed, but questionable judgment was used by including the letter among the items exhibited. Written in 1839, the letter was not very legible when it was given to Dr. Allen in 1929, and, when it was placed on display in 1937, its legibility had decreased to where it was very difficult to decipher most of the writing. With the thought of publishing the letter, attempts were made to photograph it, but the results were so unsatisfactory that the plan was abandoned. The light of succeeding years continued to fade the writing so that only the slightest indication of a message remained.

It was in January of 1965 that Miss Dorothy L. Cutting, librarian of the School of Dentistry of the University of Missouri at Kansas City, conceived the idea of submitting the letter to the electrostatic process of a Xerox machine, and after a lapse of 126 years a good image of the original letter was reproduced! (Fig. 1) (Fig. 2)

The holograph letter, written from Baltimore, Maryland, by Dr.

Dr. Edwards is Assistant Clinical Professor of Surgery (Oral), and Lecturer in the History of Medicine, University of Kansas Medical Center.

Baltimore March 15th 1847

Dear Bro.

When I left your house and happy lot, I intended to have written to you ere this, but since my return my time has been so much occupied with the duties of my profession that I have scarcely had a leisure moment. The many kindnesses which I recd. at your hands, and the many pleasant days I spent in your family will ever be connected with the warmest emotions of gratitude and looked back to with an ordinary degree of pleasure.

I spent about two and a half weeks in Warren and Franklin Counties, as you may heard, after I left your house, then returned to Baltimore, where I found my family all well, with the exception of fasting me, for several days previous to my arrival. I was detained about two days on the road, in consequence of bad arrangements, between the cars & the post.

The ornament you gave me I handed to Mr. Jackson, one of our most celebrated Artists. He says he can paint a good portrait from it, and is now engaged in doing it. His charge will be \$30. and the frame will cost 10, I will send it as soon as finished, to Petersburg, agreeably to your directions.

I do not expect to be able to see it North Carolina again before the first of June. This being a season of the year in which I have more to do here than any other.

How does the Anti-Slavery Society come on? Do all of its members hold out faithfully? We would have thought the crop would have been as great. Now you wish like to join me in a social motion. How vastly pleasant it would be, to spend an evening as we were wont to do. While ago I was at your house, I think I often think about it and longed to do it, but can't not say that I have had money.

Logheads of tears although I can assure
 you it has not been a correct
 hour, and at times has caused me to wish
 that I had never joined the society,
 so he plainly have you not some notion
 of withdrawing from the society, I
 must confess I have, but this I do not
 wish you to mention. After I let your
 house I obtained the following names, which
 I have here have to report to the president
 of the society.

To the president of the North
 Carolina Anti Slavery Society

Dear Madam.

The following persons have
 authorized me put their names down as
 members of the A. S. Anti Slavery Society.

Rev. Mr. Burges, Mrs. Burges, Miss Rebecca Burges,
 Miss Mary Jane Burges, James P. Burges, Miss Amy Robert,
 Mr. J. H. Harris, Mrs. Henry Harris, Miss Sarah Blanton, Mrs.
 Edward Alston, Miss Martha Broadbent, Mrs. H. H. Williams,
 Miss A. M. Roberts, Mrs. Mary R. Roberts, Rev. Wm. Branch,
 Mrs. Wm. Branch, Miss Sarah Branch,

I would like to know if it would
 be in accordance with the constitution and by laws

of the society for a member to withdraw, I must
 ask for information, but would not have you
 think that I am at all interested in the matter.
 P.S. To Mr. Harris, write to me on the receipt of this
 and let me know how all of my good friends
 are in North Carolina.

Wm. H. Harris, Esq.
 Littleton Harris Co.
 North Carolina

The Anti Slavery Committee to
 receive most of the proceeds have
 already

Remember me affectionately to your most amiable
 wife, to Alice & Betty, to Mrs. Thomas Harris, also Mr.
 C. & D. Alston, Mrs. Burges, and all my other friends,
 not forgetting Mr. Branch, and in the mean-
 time be pleased to accept my best wishes &
 prayers for your future happiness. Your cordial
 and affectionate friend, Wm. H. Harris

Harris on March 12, 1839, was to Thomas W. Harris,* of Littleton, Warren County, North Carolina. The letter treated of the usual social amenities between relatives and friends and discussed the Anti-Useing Tobacco Society. It appears that Dr. Harris had been addicted to smoking tobacco, and had been persuaded to join the Society and abstain from that practice. It is apparent that his desire to smoke persisted "and at times has caused me to wish that I had never joined the society."

The letter with phonetic spelling and misspelled words as in the original, follows:

Baltimore, March 12, 1839

Dear Bro.

When I left your kind and hosptable roof I intend to have written to you ere this, but since my return my time has been so much occupied with the duties of my profession that I have scarcely had a leasure moment. The many kindnesses which I recd at your hands, and the many pleasant days I spent in your family will ever be rembered with the liveliest emotions of grattitude and looked back to with no ordinary degree of pleasure.

I spent about two and a half weeks in Warren and Franklin Counties, as you may [have] heard, after I left your house, then returned to Baltimore, where I found my family all well. They had been expecting me for several days previous to my arival. I was detained about two days on the road, in consequence of bad arrangements, between the cars & steam boats. The minuature you gave me I handed to Mr. Jackson, one of our most celebrated artists. He says he can paint a good portrait from it, and is now engaged in doing it. His charge will be \$30 and the frame will cost 10, I will send it as soon as finished to Petersburg, agreably to your direction.

I do not expect to be able to visit North Carolina again before the first of June, this being a season of the year in which I have more to do here than any other.

How does the *Anti-Useing Tobacco Society* come on? Do all of its members hold out faithful? Who would have thought the crop would have been so great. Would you not like to join me in a sociable smoke. How vastly pleasant it would be, to spend an evening as we were wont to do while I was at your house. Ah! I often think about

* The letter to Thomas W. Harris begins "Dear Bro." Records indicate that Chapin A. Harris had only two brothers, James and John. Since Chapin A. Harris was a deeply religious man, the salutation "Bro." may have been one of religious significance, as can be noted in the postscript.

it and longed to do it, but cant not say that I have shed many "*hogs-heads of tears*" although I can assure you it has cost me many a soriful hour and at times has caused me to wish that I had never joined the society. To be plain, have you not some notion of withdrawing from the society, for I must confess I have, but this I do not wish you to mention. After I left your house I obtained the following names, which I here beg leave to report to the president of the society.

To the President of the North Carolina *Anti-Useing Tobacco Society*,

Dear Madame,

The following persons have authorized me [to] put their names down as members of the N. C. Anti-Useing Tobacco Society—Rev. Wm. Burges, Mrs. Burges, Miss Rebeca Ann Burges, Miss Mary Jane Burges, James P. Burges, Miss Amy Robert, Mr. Henry Harris, Mrs. Henry Harris, Miss Sarah Clanton, Mrs. Edward Alston, Miss Martha Crouduss, Mrs. H. H. Williams, Miss Ann Brickle, Mrs. Mary B. Alston, Hon. William Branch, Mrs. William Branch, Miss Sarah Bennens.

I would like to know if it would be in accordance with the constitution and by-laws of the society for a member to withdraw? I merely ask for information, but would not have you think that I am at all interested in this matter.

Respectfully yours,

C. A. HARRIS

P. S. To T. W. Harris,

Write to me on the recpt of this and let me know how all of my good friends are in North Carolina. Remember me affectionately to your most amiable wife, to Alice and Betty, to Mrs. Thomas Family, also Mr. E. and T. Alston, Bro. Burges, and all my other friends, not forgetting Mr. Branch, and in the meantime be pleased to accept my best wishes & prayers for your future happiness. Your cordial and affectionate frd & Bro. in Christ,

C. A. HARRIS

On the back of the envelope in which the letter was sent was the message:

The Balto conference commences tomorrow, most of the preachers have arived.

Rainbow Blvd. at 39th Street
Kansas City, Kansas 66103

Dental Students: Relationship Between Social Class, Stress, Achievement, and Attitudes

MARCEL A. FREDERICKS, PH.D., and PAUL MUNDY, PH.D.

THE social class background of a professional student is a dimension, subtle but important, of his intellectual and non-intellectual faculties. In recent years there have been several interesting studies on the social class origin of medical and dental students.

Research at the professional level of medical schools includes studies done by Fredericks and Mundy (1), Woods, Jacobson, and Netsky (2), who examined social class in terms of medical school performance. Rosinski (3), on the other hand, examined social class in relation to the untapped pool of possible medical school applicants.

Research at the professional level of dental schools includes the work by O'Shea, Lefcowitz, and Gray (4) who focused on the sociologic perspective on the dental student. Quarantelli (5) examined the attitudes of dental students toward specialization and research. More and Kohn (6), on the other hand, concerned themselves with the students' motives for entering dentistry.

Since no previous research has been found which explored the relationships of social class (SC), stress-anxiety responses (SA), academic achievement (AA), and professional attitudes (IPA) in the first year of dental school, it is hoped that the present study might

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Dr. Mundy is Professor and Chairman, Department of Sociology, Loyola University, Chicago, and Lecturer, Department of Psychiatry, Stritch School of Medicine, Loyola University.

This is the second of several papers on dental students; the first was published in the JOURNAL, 34:159-67, July 1967.

provide some indication of how students, at the beginning of their preclinical years, responded to the stresses and anxieties of their environment and the acquiring of the knowledge and technical skills of dentistry. Moreover, if class differences in attitudes toward certain moral and ethical objectives of the profession are found to obtain among dental students at the beginning of their preclinical years of study, this might suggest that some students may possibly experience greater difficulty than others in the acquisition of these attitudes of the profession over a four-year span even assuming intellectual ability to be constant.

In this study, therefore, an attempt is made to examine three empirical questions:

- 1) Do dental students from families of upper-class background have lower stress-anxiety scores in the first year of a dental school than students of lower-class origin?
- 2) Do dental students from families of upper-class background have higher professional attitudes scores in the first year of a dental school than students of lower-class origin?
- 3) What are some of the relationships (if any) among social class, stress-anxiety, and professional attitudes scores, and academic achievement in the first year of a dental school?

It is hypothesized that a) dental students from families of upper-class background have lower SA scores than dental students from families of middle and lower-class background; and b) dental students from families of upper-class background have higher IPA scores than dental students from families of middle and lower-class background.

Stated in their null (negative) forms the above hypotheses read: a) SA scores of upper-class dental students will not differ significantly from those of middle and lower-class students; and b) IPA scores of upper-class dental students will not differ significantly from those of middle and lower-class students. It is assumed that a P (probability) of 0.05 was accepted as significant.

METHODOLOGY

The sample studied consisted of 86 male freshman students attending a Midwestern school of dentistry during the academic year 1965-66. Of the 86 dental students, 77 (90 per cent) were 20-24 years

old, while 8 (9 per cent) were 25-29, and 1 (1 per cent) was 30 or older. Twenty-four per cent of the 86 students had entered dental school after having completed three years or less of undergraduate college. The majority of the students, 57 per cent, had finished a four-year college education; and 19 per cent had more than four years of higher education (not always graduate or professional, however).

Most students in the sample came from rather small, fairly well-educated families living in urban communities at a reasonably high socioeconomic level. Twenty-three per cent of the respondents had German ancestry and 18 per cent were of Italian descent; in both cases the progenitors were primarily from the lower-middle and upper-lower classes.

The study subjects were first divided into five social classes on the basis of Hollingshead's two factor index of social class position,* based on their fathers' education and occupation (7). Since the number of cases in Class II and Class V were too small to allow for statistical analysis of the association between social class and academic achievement in dental school, Class II and Class III were combined in a single category comprised of 35 (40 per cent) subjects and Class IV and V into another comprised of 31 (36 per cent) subjects. Class I remained unchanged with 20 (23 per cent) subjects. Subsequent to the regrouping, the classes were identified simply as 1 (formerly I), 2 (formerly II and III), and 3 (formerly IV and V).

The concept of social class is used throughout this study to refer to the kinds of psychological and social characteristics found differentially distributed among dental students classified by the weighted index of their father's occupation and education.

Stress-anxiety responses of the dental students were measured by Taylor's Personality Scale of Manifest Anxiety (Biographical Inventory). The scores range from 0-50. Low SA scores indicate a low degree of stress-anxiety; high SA scores indicate a corresponding high degree in stress-anxiety (8).

Professional attitudes were analyzed by Rosinski's Student Attitude Inventory. This inventory measures certain intellectual and professional qualities such as the respect for the dignity, self-esteem, and

* These social class positions are: I—upper; II—upper middle; III—lower middle; IV—upper-lower; and V—lower-lower.

value of man. Scoring of each item is accomplished on a five-point scale (0-4) according to the degree of reaction to the attitude statement. When gathered into section scores the polar continuum would be represented by zero at one end and at the other by a positive figure whose magnitude would be 40. Therefore, the maximum score an individual can receive from the 70 attitude-statements in Rosinski's Inventory is 280 (9). Although this inventory has been developed from a medical school setting, the objectives measured are relevant for the dental profession as well as other health professions in general.

Both the Biographical Inventory (measuring SA responses) and the Student Attitude Inventory (measuring IPA) were administered in the first week of class at the beginning of the preclinical school year 1965-1966. More data were obtained from interviews with the study subjects, and also from extensive participant-observations of the students in their school situations and in their living quarters. One of the authors of this paper lived in a dental fraternity affiliated with the institution throughout the school year 1965-66. All these data were subjected to both a qualitative and quantitative analysis. This study does not report as such the relationships between stress-anxiety responses and professional attitudes, since these two variables will be reported in a subsequent article, which treats cynicism-idealism (CI) as well.

FINDINGS

Social Class and SA Scores

The hypothesis that social class is significantly related to stress-anxiety scores at the beginning of the preclinical years of dental school is not supported by the data of Figure 1. It will be observed that subjects in Class 1 have strikingly lower SA scores in contrast to Class 2 and Class 3 students; however, these differences do not approach statistical significance at the .05 level.

SA Scores and First-Year Academic Achievement

An analysis of the study data reveals that in the first semester of the freshman year, there is a significant difference ($p < .05$) between the upper third of the class in academic standing and with the lower third when comparing the SA scores of these groups. However, in the second semester of the freshman year there is no relationship

RELATIONSHIP OF SOCIAL CLASS (SC) AND STRESS-ANXIETY
SCORES (SA) OF STUDENTS IN THEIR FIRST YEAR OF
DENTAL SCHOOL

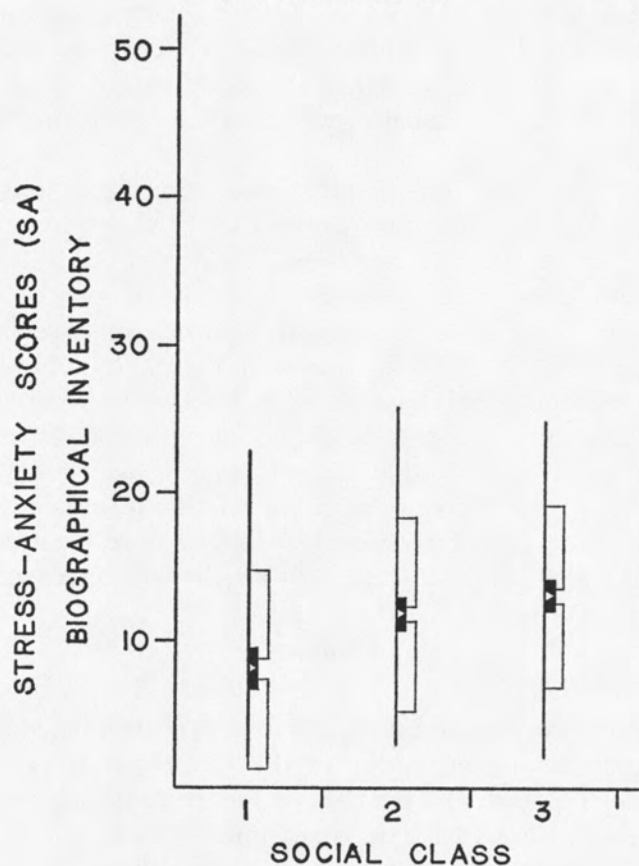


FIGURE 1

The vertical lines indicate the range of variation in SA scores for a given SC; the mean is represented by a small triangle; the blackened part of each bar comprises twice the standard error of the mean on either side of the mean; one-half of each black bar plus the white bar at either end outlines one standard deviation on either side of the mean. Differences are not significant at .05 level.

between the subjects' SA scores and their academic achievement (Table 1).

It would seem, therefore, that many students (with the exception of the upper and lower third in academic standing in the first semester) with high SA scores were relatively low in academic achievement at the conclusion of the first year of dental school. Conversely, many students with lower SA scores exhibited relatively high academic achievement.

Social Class and IPA Scores

The hypothesis that social class is significantly related to IPA scores at the beginning of the preclinical year of dental school is not supported by the data of Figure 2. It will be noted that Class 1 students have higher IPA scores in contrast to Class 2 and 3 respondents with somewhat similar IPA's; however, *t* (test) results indicate that differences do not approach significance at the .05 level.

TABLE 1
RELATIONSHIP BETWEEN ACADEMIC ACHIEVEMENT IN THE
FIRST YEAR OF DENTAL SCHOOL AND STRESS-ANXIETY RESPONSES
AND PROFESSIONAL ATTITUDES

Personality and Attitudinal Variables	Academic Standing in the First-Year Class*									
	FIRST SEMESTER						SECOND SEMESTER			
	1 and 2	2 and 3	1 and 3	1 and 2	2 and 3	1 and 3	1 and 2	2 and 3	1 and 3	
	t Sig.†	t Sig.	t Sig.	t Sig.	t Sig.	t Sig.	t Sig.	t Sig.	t Sig.	
SA (Stress- Anxiety Responses)	1.048 NS	1.170 NS	2.217 S	0.457 NS	-0.148 NS	0.096 NS				
IPA (Profes- sional Attitudes)	0.685 NS	0.677 NS	1.289 NS	-0.117 NS	0.875 NS	0.487 NS				

* Academic standing was divided into thirds: 1 = Upper third, 2 = Middle third, and 3 = Lower third. In the first semester Upper N = 29; Middle N = 30; and Lower N = 27. In the second semester Upper N = 23; Middle N = 24; and Lower N = 38 (One student withdrew during the second semester).

† Sig. = significance

S = significance at .05 level; NS = no significance

t = test used for finding S or NS

RELATIONSHIP OF SOCIAL CLASS (SC) AND PROFESSIONAL ATTITUDES (IPA) OF STUDENTS IN THEIR FIRST YEAR OF DENTAL SCHOOL

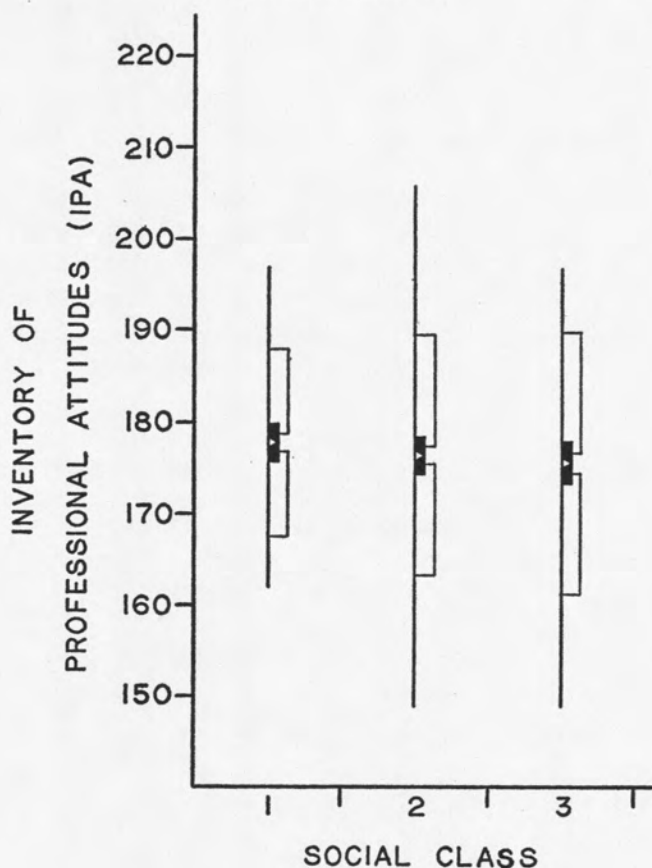


FIGURE 2

The vertical lines indicate the range of variation in IPA scores for a given SC; the mean is represented by a small triangle; the blackened part of each bar comprises twice the standard error of the mean on either side of the mean; one-half of each black bar plus the white bar at either end outlines one standard deviation on either side of the mean. Differences are not significant at .05 level.

RELATIONSHIP OF SOCIAL CLASS (SC) AND ACADEMIC
ACHIEVEMENT (AA) OF STUDENTS IN THEIR FIRST YEAR OF
DENTAL SCHOOL

A = 1 ST SEMESTER

B = 2 ND SEMESTER

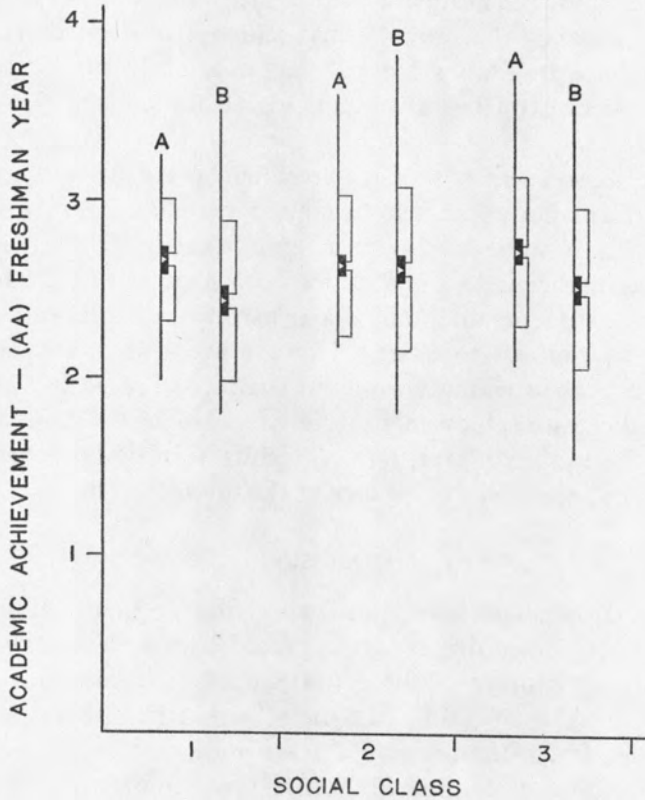


FIGURE 3

The vertical lines indicate the range of variation in academic achievement (4 point system) for a given SC; the mean is represented by a small triangle; the blackened part of each bar comprises twice the standard error of the mean on either side of the mean; one-half of each black bar plus the white bar at either end outlines one standard deviation on either side of the mean. Differences are not significant at .05 level.

IPA Scores and First-Year Academic Achievement

The data presented in Table 1 further indicate that a dental student's IPA scores are not related to his academic achievement in the first year of dental school.

Social Class and Academic Achievement

No significant differences ($p > .05$) were found between social class on the one hand, and academic achievement on the other (Figure 3). It will be observed that, for the first semester of the freshman year, dental students in Classes 1 and 3 fall in slightly similar academic levels in contrast to Class 2 students whose academic achievement is lower.

For the second semester of the freshman year, the pattern of academic performance appears to be similar for Classes 1 and 3 in contrast to Class 2 students whose academic level is greater.

Figure 3 further indicates that, for both semesters of the freshman year, Class 2 students maintained a relatively constant academic performance in contrast to Classes 1 and 3 students, whose academic achievements are strikingly lower in the second semester. However, although there are achievement differences between Classes 1, 2, and 3 during the freshman year, t (test) results indicate that these differences do not approach significance at the .05 level (10).

DISCUSSION

These data seem to hold significance for the first year of dental education. The incoming student is faced with a new environment, namely, the subculture of the dental school. It is largely within the matrix of social relationships in the school setting that the student will acquire and make his own the attitudes and values which will to a great extent determine his future professional role in society.

It appears, however, that nothing the student has previously attempted has prepared him for the stresses and anxieties which a profession contain as a matter of course. The exposure to the vast array of dental instruments, the friendly "advice" given him by upper-class men especially in fraternity settings, the range of materials presented in the first few weeks of class—all seem to increase the pressures placed on any student in the first year of dental school.

This study shows that students in three social classes responded at comparable levels to the initial stresses and anxieties of their en-

vironment, and to certain professional attitudes, to whatever degree these variables can be measured by the instruments utilized in this study or possibly any other instruments.

The lack of class differences in stress-anxiety responses, and in attitudes toward certain moral and ethical objectives of the profession at the beginning of the preclinical level, at this dental school, tend to suggest that students, irrespective of social class background, may not necessarily experience greater difficulty than others in the acquisition of attitudes of the dental profession, even assuming intellectual ability to be constant.

Since many dental schools are involved in a searching analysis of their methods for evaluating applicants and of their educational programs, it seems incumbent upon their faculties to administer the SA and IPA inventories at the very beginning of dental school training and to critically examine these scores in relation to existing admission procedures, curriculum modifications, and the existing norms within the subculture of the dental school environment.

Thus far, the results of this study suggest that lower-social-class background of a dental student should not be even subtly a disqualifying factor for a candidate to dental school, should an admissions committee act on the assumption that the applicant may not be able to adjust to the stresses and anxieties of the dental school environment and the acquiring of the knowledge and values of dentistry. Since the representatives of the three social classes covered in the study came from predominantly white, Catholic, urban settings, further research is required to determine whether or not the results would be similar for all religions and subcultures.

This article deals *in part* with the attitudinal and personality aspects of dental school adjustment in terms of social class. It has not considered as such the cognitive implications of social class upon dental training. This latter dimension was taken up by the authors in a previous paper (10). A subsequent article will deal with additional aspects of the personality and attitudinal ramifications upon dental training.

SUMMARY

Social class and academic achievement in the freshman year of a dental school were studied in relation to stress-anxiety responses and professional attitudes. The study findings indicate the following:

- 1) Social class of dental respondents in the sample was not signifi-

cantly related either to stress-anxiety responses or to professional attitudes at the beginning of the preclinical year at the dental school at which the research was conducted.

2) No significant differences were found between social class and academic achievement.

3) In the first semester of the freshman year, there is a significant difference between the upper third of the class in academic standing and with the lower third when comparing the SA scores of these groups. However, in the second semester of the freshman year there is no relationship between the subjects' SA scores and their academic achievement.

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The Dental Administrator: Past and Future

ALVIN F. GARDNER, D.D.S., PH.D.

A NEW breed of dental administrators will be developing shortly because of the dire need for specialized knowledge in this area. A new type of program is therefore needed to cope with coming problems and to provide the specialized training which is required. This paper describes one approach to developing and training dental administrators.

DENTAL ADMINISTRATORS TODAY

Currently, the dental administrator is selected because of his academic, military, or government background. The factors of educational distinction, management skills, successful experience in business administration, basic skills in administration, and personal and public relations have declined in importance. The dental administrator is now selected because in addition to a respectable life and acceptable dental education he has demonstrated good faith, good manners, good humor, good sense, and is personable and charming. Cheerfulness and optimism are part of his personal and professional attitudes. He has a degree of honesty, sincerity, a feeling for justice, and a scandal-free personal reputation.

The dental schools and dental profession seem generally satisfied with dental administrators as they are. Many dental professional men are complacent and are by no means convinced that they should change. Dental administration will benefit from examination by professional men. There is hope in enlightened professional (dental) criticism. The dental profession should be informed about dental administration, and encouraged to criticize constructively the past and present situation.

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There is hope of progress in dental administration. Scientific study will greatly expand our knowledge of means to ends relationships in dental education through effective administration. Of course, the scientific study of dental administration could be upsetting, since it could lead to some painful revelations. For instance, there is grave concern in dental education about raising standards and getting dental students to work harder. This is a task for future dental administrators. We must never lose sight of our goals while doubling our efforts to raise standards.

What dental administrators need most is scientific knowledge about themselves, of what they do, or of what they fail to do. Dental administrators should study themselves, and focus their attention on development of the individual dental student. They should attempt to determine with respect to each current practice how it favors or hampers progress toward the goal of development of the individual dental student. Each dental administrator should ask the latter questions about his own work. There should be continuing and genuine experimentation with new programs in dental administration, together with a careful analysis and appraisal of results. The latter undertaking can make knowledge of dental education cumulative at last. The inquiry into dental administration will serve dental students directly, by pointing out for them and involving them in, this experimentation. Further, genuine scientific inquiry would provide an inspiration for all members of the dental profession and act to further the major ideals of the American dental tradition, the value of the individual dentist as an end in himself, and the belief in the power of intelligent experimentation to improve him and his society.

What is the optimal environment for dental education, one that satisfies or one that stimulates? The characteristics of the dental student and the objectives of the dental program must both be employed as guides in the design of the latter environment. For instance, achievement of high grades is insufficient evidence that education is taking place. Likewise, failure to obtain high grades may not indicate that education has not taken place; certainly this is true with professional men who later reveal themselves as creative or highly productive. Nearly every dental administrator knows a few dental students to whom the need to achieve high grades ap-

pears to interfere with his real education. Grades have for dental students the function of money in our modern society.

The dental administrator selected because of his academic background is by training, inclination, and by the requirements of his position prior to dental administration, a specialist in a dental basic science or clinical subject. He is generally devoted to the advancement of his specialty by research and teaching, and it is as a specialist that he expects to make his dental career. It is therefore, his natural inclination generally to see the problems of dental education in a somewhat limited perspective.

DENTAL ADMINISTRATORS OF THE FUTURE

The dental administrator of the future will be transformed from a professional man with simply an academic dental background, or a professional man of dental learning, to a professional man of dental management. The future task of the administrator will be to describe the whole field of dental education and dental professional life so that it is intelligible to each of its parts. He must succeed in this task and when he does, his sense of reward will be as great as the magnitude of the service he has rendered. The required change from the academically oriented dental administrator to a professional man with abilities in dental management will not take place rapidly or without strain and numerous conflicts. Dental education has become big business, therefore the dental administrator of the future will have to display numerous distinctions and similarities. The future dental administrator should be above average in his physical vigor and capacity to take it mentally.

The future dental administrator will talk easily but warily, making words do his bidding. He should be an alert professional man, always conscious of the people about him. He should tend to be an extrovert, less wearied than most individuals following human contacts. He should never be allowed to be designated as a mere managerial creature of the dental schools or dental profession.

The future dental administrator must show by his behavior that he stands for something, that he knows how to make valid judgments, and that he has the courage to follow through the action. The administrator of the future must be a wise, just, and good professional man without expecting, or getting, any credit for it. The

future dental administrator must be an individual humble enough and yet secure enough to exhibit to others his doubts, shortcomings, and weaknesses. He must foster understanding and the free but organized search for new forms of dental thinking. Dental education and dental administration should encompass an openness to change. The future dental administrator must generate the willingness to change.

Dental students are in need of development, and show so much potential for development that it is hard to understand how some past dental administrators have been essentially indifferent. The future administrator will become intellectually interested in dental students as developing individuals.

Future administrators will be required to delegate authority much more than their predecessors. There will therefore be created many positions designated as associate and assistant administrators. These administrators will require many special skills and training which must be provided early in their preparation for administration.

These administrators may be prepared for their leadership role in dental education and dental practice by including in their preparation an internship program in dental administration. The following discussion offers the idea of such a program.

INTERNSHIP IN DENTAL ADMINISTRATION

Future leaders in dental education may be prepared for their role in administration by completing an internship in dental administration at various institutions in geographical areas of the United States. These leaders should be privileged to play a role in the administration of the American dental educational system. It is their innate responsibility to make a contribution to the American dental educational scene, or intellectual dental community, through administration at the college level.

The following benefits will accrue from an internship program in dental administration:

1. It will afford the intern the opportunity to be cognizant of and discuss the many problems inherent in the administration of a dental college;
2. It will afford the intern the opportunity to solve dental college administrative problems through private discussions, closed and open meetings with specific groups or organizations by means of individual participation;

3. It will afford an opportunity to obtain experience with respect to the recruitment of better dental students and dental faculty members. Every dental college faces the task of recruiting and educating its prospective students and faculty. However, the latter task is based upon creating an intellectual dental community and not a dental business corporation;

4. It will afford an opportunity for a greater degree of exposure to dental college or university administration and provide a favorable background upon which the intern may make a clear-cut decision involving an increased commitment toward dental college administration. At the conclusion of the internship such a decision should be forthcoming without too much doubt or consideration of alternatives. The internship will be responsible for definiteness of plans to continue in dental college administration. If the intern knows what it is like to be an administrator and still desires to be one, he should be considered for the administrative position.

5. It will afford the opportunity to determine career plans and preferences for dental administration. The intern should proceed with a singleness of purpose toward the goal of becoming an administrator. It is, therefore, essential that the intern gain a complete understanding of the manner in which the dental administrator spends his time. The experimental learning experience encountered will encourage the intern to add to dental college administration by studying the work of others and equipping himself to solve current and future dental administrative problems as well as giving adequate consideration to their prevention; and

6. It will afford the intern the opportunity to determine by practical experience what vehicles are necessary to achieve administrative objectives based upon dental education and scholarship. Education and scholarship are vital qualifications for the dental college administrator.

The intern in dental administration should be prepared to go forward and build new patterns of service to dental administration. An internship program should build leaders in academic administration who are ready to challenge the old and thus build for the future. Therefore, the dental administrator's aim is not related to securing bigger and more prosperous dental colleges.

An internship program should provide breadth of viewpoint, and quickness and alertness of mind, thus making the intern professionally creative as an administrator. The dental college administrator

should not be limited to his balance sheet and public relations. Academically oriented individuals are currently available who seek primarily professional creativity in dental administration. An internship program in administration will afford the latter individuals the opportunity of collaborating effectively with other disciplines, i.e., the humanities and sciences, and thus will fulfill the conception of a central unity not only of dental knowledge but also of man.

It is recognized that the development of a comprehensive program as provided by the internship program in dental administration gives new dimension and provides a challenge to future administrators. Such a program should provide improvements in the standards of dental college administrators particularly if such a program is skillfully guided by leadership that is well chosen and actively supported. The reward as active members in such an endeavor should be the satisfaction of participating in the advancement of a vital service based upon dental education and dental scholarship in the community of man.

The preparation of the dental administrator in 1975 should be initiated today by the establishment of an internship program in dental administration. It is important and perhaps imperative that the dental administrators who draw from the reservoir of existing knowledge repay their debt by adding new knowledge to that reservoir.

SUMMARY AND CONCLUSIONS

An individual is a good dental administrator to the extent that his mind produces and utilizes the dental insights into himself, into dental education, into society, that is required for anticipating and solving the problems of dental education and living a full, productive, and useful life. Every new rational venture in dental administration creates a new professional system.

A relatively low to moderate esteem for excellence in dental administration prevails in the United States. A high degree of dental articulate reflectiveness in dental administration is considered by some individuals as something peculiar to a special breed of mankind who are not to be initiated. The future dental administrator should desire to achieve mastery of his personal and social anxieties and develop the courage to define for himself what kind of life he desires to live. He will generally have a preference for a life of long-

term humanitarian solidarity with his fellowmen in preference to a lonelier life in quest of more self-centered, short-term goals.

There have been few fundamental innovations in dental administration during the past 25-30 years. A barrier to progress and reform in dental administration is the fact that some individuals make concerted change of any kind exceedingly difficult. Another important barrier to reform is the lack of scientific basis for the practice of dental administration. Dental administrators represent much of what it is that dental students are supposed to become. As leaders in dentistry, dental administrators must embody its aims and ideals, and cannot be merely the mechanics who keep the machinery working. Self-revelation is the surest path to self-awareness; and without it, change is impossible in dental administration. The goal of the future dental administrator should be optimal individual development. This can, in part, be achieved by an initial internship in dental administration.

An internship in dental administration is proposed as a partial means of preparing future administrators for the complex tasks which will confront them. The internship is proposed because of the mounting responsibilities which demand special skills, training, and experience.

An internship program in dental administration may very likely be the beginning of the preparation required to adequately equip the dentist for practice in 1975.

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Statesmanship in Dentistry

A Panel Discussion

THE presentations in this panel discussion were read at the annual meeting of the Tri-State Section of the American College of Dentists (Arkansas, Mississippi, and Tennessee), December 3, 1966, at Memphis.

Shailer Peterson, Ph.D., the panel moderator, is the Dean of the University of Tennessee College of Dentistry. He has served as secretary of the National Board of Dental Examiners, secretary of the American Dental Association Council on Dental Education, and assistant secretary of the ADA in charge of Educational affairs.

William R. Alstadt, D.D.S., an orthodontist, is a past president of the American Dental Association. Currently, he is the Dental Consultant to the Arkansas State Welfare Department and Chairman of the Arkansas Civil Service Commission.

Marshall M. Fortenberry, D.D.S., a general practitioner, is active in many civic, church, and dental organizations and groups.

Faustin N. Weber, D.D.S., M.S., is Professor and Chairman of the Department of Orthodontics at the University of Tennessee College of Dentistry.

Frank P. Bowyer, D.D.S., an orthodontist, also was a panelist; his remarks were not prepared for publication. (The interested reader is referred to an earlier paper by Dr. Bowyer, "The Dentist: A Citizen," in the JOURNAL, July, 1964.) He is a former Regent and now Vice-President of the American College of Dentists, a past president of the American Association of Orthodontists, a member of the Board of Trustees of the University of Tennessee, and is active in civic affairs.



Introductory Remarks

SHAILER PETERSON, PH.D.

“STATESMANSHIP in Dentistry” will not immediately suggest exactly what the Program Committee had in mind when this topic was chosen. As a matter of fact, very few articles have been written on this theme as it applies to dentistry; certainly too little attention and thought has been given to this subject.

It is true that the key to the science and art of dentistry rests in the services that are rendered by the individual dentist to his patients. The obligation of the entire dental profession, of course, encompasses dental services for the entire nation. Some dentists may believe, at first glance, that when we have considered the ways and the means of getting high quality dental service to as many patients as possible, and when we have educated the citizenry to the need for dental care, that we have completed or exhausted our obligations.

Some dentists may even feel that the term statesmanship is important only in the field of government; and that the terms statesmanship and politics are even beneath the dignity of the dental profession to discuss.

I hope that by the close of this discussion all of you will agree that the profession of dentistry cannot afford to forget the importance of both statesmanship and politics. I hope also that you will all agree that unless we continue to grow, recruit, and to train our own specialists in politics and in statesmanship, dentistry itself may one day be in danger of losing its birthright.

The whole dental profession cannot exist without each one of its members providing superior services, individually and collectively, to the citizens of all communities. However, on the other hand, individual dentists will have no profession to which to belong, unless the profession is organized and unless this organization is under the watchful guidance and influence of experts in statesmanship and in politics.

The individual dentist, and all of the other members of the dental health team, must realize that no matter how competent they are individually or even how competent their own complicated of-

fice practice becomes, their continuing rights and privileges cannot be left to chance. Also, just because dentistry rightly deserves all of the rights and the privileges which it has earned and won, the fact that these rights are deserved does not protect them from attack and from outside threats to destroy them and to reduce their status.

Yes, individual dentists are organized. The profession is organized. But organization into groups or clubs or societies is only a beginning. It is important to consider how they are organized; for what they are organized; what they hope to accomplish; and equally important—the leadership these groups and societies have.

When the first study group for gold foil or for some other special practice group was organized, this would have been organized primarily to enable men of similar interests to improve themselves through an organized exchanging of ideas. On the other hand, when the first dental society or a dental association was formed, it is very possible that some of the aims and objectives of these groups were also to exchange ideas to help all of the group members to be better informed on dental technics. As a matter of fact, even today all dental associations and dental societies consider it as part of their responsibility to sponsor table clinics, lectures, and continuing education programs to help all of their members render a better dental service to all of their patients.

The topic under discussion deals basically with the additional responsibilities of dental societies and dental associations when they consider the growth and the development of their organized profession. Also, when they think of the responsibilities of organized dentistry to other professional organizations, and when they think of the long range future of the profession as it affects the communities, the geographic areas, the nation, and the world. Also, when they think of the means by which, as associations and societies, they can grow and develop most effectively and efficiently.

In the same way that a dental fraternity is a professional fraternity as opposed to a social fraternity, so is a dental society a truly professional group different than a social club or hobby organization.

All clubs or groups of any kind need and require "organization." Both clubs and associations have their officers, and many also have their various committees with specific jobs to be done. However, this is exactly where the similarities begin to change drastically and dramatically.

The officers of any kind of an organization help the conduct of a meeting to have order and meaning. The officers of a professional organization such as a dental society association have many added functions and responsibilities, and the conducting of meetings becomes small and minor by comparison with the other duties.

One has only to attend a single meeting of the American Dental Association, such as the recent one in Dallas, or of the Tennessee State Dental Association, or of the Memphis Dental Society, to realize the tremendous complexity of problems that are brought annually to the attention of the membership through the leadership of the officers, committees, and councils. One has only to observe the Annual Session of the American Dental Association and compare the scope of its activities and its organization with that of an Annual Session of the American Dental Association ten, fifteen, or twenty years ago. From such comparisons one can immediately see the tremendous and phenomenal growth that has taken place in the dental profession and more specifically in organized dentistry. Perhaps to use a trite phrase, dentistry "has become big business."

The management of the affairs of dentistry today is quite different than it was twenty-five or fifty years ago. More important, the business of handling the affairs of dentistry ten years hence, in 1976, will show an even greater growth and change than in the last twenty-five years.

Therefore, it is important that at this Tri-State Section meeting of the American College of Dentists, that it becomes significant and important for us to discuss how we can all help the potential dental leaders of the future be fully prepared to handle the complicated problems they are bound to face.

We have on our panel today, four dental leaders whom you all know for the contributions that they have made and are making to organized dentistry. We want to challenge them in several ways so that they might give their advice as to how dentistry in the Tri-State area can be best prepared for the future demands that organized dentistry in these states will face. We want to pick the brains and the talents of these men, and learn what advice they would give to a young, recent graduate upon whose shoulders the burden of running a dental society will fall in the future. We want to find out from them what sage advice they can give to our present dental society officers both in regard to caring for today's problems, and also

what responsibility do our society's officers have today in training the officers of the future. Also, what responsibilities does our own University of Tennessee College of Dentistry have in helping to ready our graduates for a professional life in the future, and for a useful and important place in our dental societies.

Let us take a look at what Webster has to say about this attribute of "statesmanship":

Statesmanship—1: the art of practice of conducting governmental affairs; political leadership (those who are fit for the highest duties of—such as the final choice of means and ends); 2: leadership characterized by wisdom, breadth of vision, or regard for the general welfare rather than partisan interest.

You will notice here the emphasis that is placed on "leadership," dealing with the highest duties, making final decisions, the traits of wisdom, and breadth of vision. Notice particularly the reference to the "regard for the general welfare."

The term "politician" will also come to mind when discussing "statesmanship." The two terms are not at all synonymous but they have similarities. As a matter of fact, a true "statesman" really must be a good "politician." While all good "statesmen" are good "politicians," not all "politicians" would necessarily be good "statesmen." Let us take a good look at what Webster says about a "politician":

Politician—one versed in the art or science of government; one actively engaged in conducting the business of a government; one skilled or experienced in politics.

There are other definitions that refer to "party politics." Other phases of the term "politic" emphasize the attributes of shrewdness, ingenuity, and skills of organization and leadership.

We need also to challenge our panel members with some guidelines that they may wish to use for the selection of potential leaders, potential statesmen. No one knows whether there can be an aptitude test constructed that would select the potential statesmen from those who would be less suited to this special kind of talent and activity. Lest someone misunderstand this matter of selection, it should be emphasized that every member of the dental profession, of course, needs to acquire a good understanding of the operation of his own professional association. However, this does not mean that 100 per cent of the membership will be interested in giving the time, the dedication, and the tireless effort to assuming positions of leadership

and statesmanship for his association or society. The statesmanlike leaders will want to have a well informed membership. Also an efficiently conducted society will, of course, need to make optimum use of a large percentage of its membership. But, not everyone can be a president, and not everyone will seek this kind of responsibility.

Perhaps we shall never be able to instill "statesmanship" into a young student or a young dentist anymore than we can give courses that will guarantee that the student will learn how to be conscientious, or that he will have a driving enthusiasm to be a success. Perhaps too, we shall never be able to develop a test or an examination which tells us that we have a "statesman" any more than we can now give a test that will assure us that we have an honest, sincere, ethical, and dedicated individual.

However, dentistry—as a profession—has a real need for statesmen, whether we are able to test for this trait or whether we are able to give courses and instruction that will help a person to attain statesmanship. Dentistry has such a burning need for statesmen that its schools and its societies must find ways of aiding the potential statesman obtain the help and experience he will need.

Our dental statesmen of the future must have clairvoyant powers to help them anticipate needs even before they exist. They must also have a measure of ESP to help them anticipate the arguments or the claims of the opposition, so that they can prepare a good case for their own profession. These men must be expert in their public relations, not only with the members of their own profession, but also with the public, and the members of the other professions. They must be able to debate in public, think and respond quickly and accurately, and be able to explain complicated and technical concepts in language that the laymen and the opposition will correctly understand. They must be persuasive, and slow to anger when irritated by their opponents.

Each of the men on this panel has been asked to search the background of his experiences and to give some of his observations on this theme. We do not anticipate that we can exhaust this problem today, but we do hope that this stimulation may bring about a series of many discussions and conferences on this most important topic.

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The Qualities of Leadership

WILLIAM R. ALSTADT, D.D.S.

THIS theme, "Statesmanship in Dentistry," is a provocative one; and, I believe, a realistic one for us to analyze carefully and see where we have been, where we are now, and where we are going. Of course, we all envisage statesmanship on a national level as individuals of the stature of Abraham Lincoln, Franklin D. Roosevelt, Winston Churchill, Carlos Romulo, and many others who have earned the title. We can and do have statesmen in dentistry, and while they are not nearly so widely known as some national or international figures, their responsibilities in the profession are important.

I realize that you are familiar with several interpretations of statesmanship; to me, statesmanship means leadership—not necessarily political, even though this is certainly possible, but leadership of a high caliber that benefits the American public as well as the profession. Such leadership must be able to enjoy plaudits and endure criticism with the same aplomb.

Some of you have heard me state on previous occasions—and this I sincerely believe—that all of us are first, American citizens. We are second, dentists; and third, we may be dental specialists or administrators, or in some other category pertaining to the profession. I am going to give several quotations from various persons whom I consider learned individuals, and who, in my opinion, have provided statesmanship qualities.

In regard to the basic analysis of our being American citizens, I

I do not choose to be a common man. It is my right to be uncommon—if I can. I seek opportunity—not security. I do not wish to be a kept citizen, humbled and dulled by having the state look after me. I want to take the calculated risk; to dream and to build, to fail and to succeed. I refuse to barter incentive for a dole. I prefer the challenges of life to the guaranteed existence; the thrill of fulfillment to the stale calm of utopia.

I will not trade freedom for beneficence nor my dignity for a handout. I will never cower before any master nor bend to any threat. It is my heritage to stand erect, proud and unafraid; to think and act for myself, enjoy the benefit of my creations and to face the world boldly and say, this I have done.

All of this is what it means to be an American.

will first read a quotation from Dean Alfange entitled "My Creed."

And second, being a dentist, with the responsibilities of trying to improve the education of dentists so that we will be able to provide better dental health services to the people whom we are privileged to serve, we are in a position somewhat like that portrayed by Lewis Carroll in "Through the Looking Glass," when the Red Queen said to Alice, "Now, here, you see it takes all the running you can do to keep in the same place. If you want to get somewhere else, you must run at least twice as fast as that!"

The economic, industrial, sociological, scientific, and professional development of any phase of American life—including dentistry—has somewhat the same aspect that Alice found in "Wonderland." To stand still is to fall behind as the economic, industrial, sociological, scientific, and professional expansion of this and other nations proceeds. To "get somewhere" requires a faster than national or international rate of growth.

The dental profession has an obligation to the American public to continue "getting somewhere." We have solved many problems, and we still have many unsolved problems; but we are trying, and we will continue to keep trying to elevate the dental health of our people, and in so doing, we are definitely contributing to the general health advancement of the public.

And third, dental specialists, administrators, and other personnel in the dental health field have basically the same obligation to provide the outstanding leadership that statesmanship demands.

It is unfortunate—nor do I know any easy solution—but I repeat, that it is unfortunate that dental schools, at least to my knowledge, do not train students or instructors how to be good and knowledgeable in these areas. One of the problems in the past few years, and it is still with us, is improving the image of the individual dentist and the profession as a whole to our fellow citizens. Too often we are criticized, not because we do not perform fine dental health services, but because too many of us do not take an active interest in the affairs of our nation, our state, or our community. Abraham Lincoln once said, "Public opinion is everything; with public opinion, nothing can fail, without it nothing can succeed."

I take time here to pay tribute to those unselfish members of our profession, be they general practitioners or specialists, or any category allied with dentistry, who do somehow or other make time to

serve on various boards and commissions, to head charitable drives, to take leadership responsibilities in churches, Boy Scouts, school board activities, and in government positions. These men know what statesmanship is because they are actually practicing it. We need more of our fellow dentists to take part in the events of America at all levels.

I urge that dentists take a more active interest in national, state, and local politics, because remember, "the man who takes no part in politics is governed by the one who does."

The dental profession is now of age. We have great potentials, but we must provide the ideals and the actions to achieve these potentials. Albert Schweitzer once said:

The power of ideals is incalculable. We see no power in a drop of water. But let it get into a crack in the rock, and be turned to ice, and it splits the rock; turned into steam, it drives the pistons of the most powerful engines. Something has happened to it which makes active and effective the power that is latent in it.

So it is with ideals. Ideals are thoughts. So long as they exist merely as thoughts, the power latent in them remains ineffective, however great the enthusiasm, and however strong the conviction with which the thought is held. Their power becomes effective only when they are taken up into some refined human personality.

Statesmanship on all levels is derived from that inner spark of honesty and truth that demands that you speak when you have to speak; to act when you have to act—such speech or actions being in behalf of the welfare of others and without personal regard for self.

Today on all levels we are seeing many changes occurring in the dental health fields. As just one illustration, I think most of you would be astounded to know that the Health Insurance Institute stated that there were 524 dental plans in the United States at the end of 1965. Persons protected numbered two million. And I quote further:

Insurance companies, dental societies, labor unions, consumer groups and non-profit insurance corporations largely comprise the formal insuring organizations providing this protection in 30 states.

About 30 insurance companies protected an estimated 550,579 under 88 group programs, according to a PHS report. This coverage figure does not include individual and family dental insurance programs provided by some insurance companies.

Most group dental programs provide insured persons with benefits to help pay for such items as oral examinations, dental X-rays, routine cleaning, fillings, extractions, inlays, bridges, dentures, oral surgery, anesthesia, treatment of periodontal disease, root canal therapy, and orthodontics.

We have many problems facing us, and being one of you, I think that I have the right to criticize—because I well remember that should I point my finger at one individual that three are pointed back at me—but my honest criticism is that too many of our dentists do not read. Too many of us are quite up to date on sports events, on the comics, and we have sort of a hazy idea of international and national problems. But we do not read many of our fine dental journals and other publications that are trying to keep us abreast of the times. We exemplify the old saying that has always been a bugaboo to man—that anonymous saying: “Lost, yesterday, somewhere between sunrise and sunset, two golden hours, each set with sixty diamond minutes. No reward is offered for they are gone forever.”

Statesmanship is not luck—it is knowledge—it is power—it is the regard for all the great humane values of civilization, and it is the inner sense of people who are responsible and who feel their responsibilities toward others.

I think you will agree that this subject of statesmanship is a difficult one to portray, and I hope you understand that I have tried to take advantage of quoting you the wisdom of others.

Someone aptly has said that there are really only two kinds of people—those who are part of the problem and those who are part of the solution. Well, what about you?

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This “image” that I speak of is simply the mental picture which the great bulk of the American public has when you say the words “dentists” or “dental treatment.” This image is not bad. This image is improving. The past two decades . . . have seen great improvement. But the improvement comes too slowly. The image is either blurred or twisted in the minds of too large a segment of the public. The causes are many. . . . The finger of blame points with increasing frequency at the many, many practicing dentists who have forgotten that they are citizens first, and dentists second; who have forgotten that they are members of the community as well as of the profession; who have forgotten the debt they owe to their professional ancestors; who have forgotten their debt to humankind.—Peter C. Goulding (Director, Bureau of Public Information, American Dental Association) in an address at the Jan. 20, 1963, annual meeting of the Arizona State Dental Association.

Our Community Responsibility

MASHALL M. FORTENBERRY, D.D.S.

OFTEN in our profession we listen, but do not hear. We are really too busy in our own little world to heed to the calls of the public and civic needs of our community.

No man is an island unto himself. The dentist and dental profession cannot lead an existence apart from that of the community or the country in which he lives. Although the dentist's prime responsibility is rendering professional service, as is stated in the American Dental Association "Principles of Ethics," his total responsibility has a number of other important aspects.

To discuss this subject with you is like the minister who was preaching to his congregation about not coming to church. After dwelling on this subject at much length, one man stood up and said "Preacher, we are always here. The people you should preach to about not coming to church are not here."

One of the requirements for membership in this organization is that of being a civic leader and accepting community responsibility. So what I have to say is really directed in all probability to the members of the dental profession who are not here.

The dental profession as a whole sometimes becomes complacent toward civic responsibility, and the next step in the line of deterioration after complacency is total apathy. I ask you what are we, as members of the profession, doing to stop this apostasy—total desertion, if you please—from our civic responsibility? Somewhere along the line often the dentist has failed to be indoctrinated regarding this responsibility. He should be made cognizant of the fact that it is his duty to put back a portion of his time and efforts into the community from which he derives his livelihood.

The dentist should be a real joiner. He should join everything in the community that is progressive and in which he might share an interest. When asked to serve in any capacity on any worthwhile project, he should give of his time, efforts, and talents. We have many men in our profession who have distinguished themselves in

public, civic, business, and religious affairs—Red Cross, Boy Scouts, United Fund, public offices, Y.M.C.A., Boys Clubs, and numerous civic clubs to name but a few. We should not wait to be asked to serve, but should offer ourselves for service instead.

All too often there is great need for statesmanship, not only for dentists in community affairs but within our own profession. In some of our own members there is a complete lack of active statesmanship in organized dentistry.

Unfortunately we have many practicing dentists outside of organized dentistry. Prior to receiving his dental degree it should be inculcated in the student that he should always and forever be a part of organized dentistry.

Most dentists are aware of the need of statesmanship in dentistry, and are doing something about it. I would like to challenge each one here to talk to his fellow dentists who are not doing their share to bring the profession to its deserved and expected level in the communities in which we live.

In older civilizations, many times the cultures and social responsibilities were in advance of technological aspects, but in this modern day our technology has made more progress than has our acceptance of our social responsibility. We may be failing to fulfill our responsibilities as citizens of our community.

The story of the Three Wise Men is familiar to all. They journeyed to Bethlehem, worshipped the King, presented their gifts, and then returned to their home countries. It has been said that they rode away into historic darkness, for we hear of no further deeds by these men. All too often a similar sad story exists today. Some men journey to dental school, absorb a wealth of dental education, and then return to their home countries. Unfortunately, many of these men, too, disappear into darkness, and neither organized dentistry nor the community in which they live hear of further deeds by these men.

We should be aware of the increased obligations of leadership and participation in modern society which must be undertaken by the profession. When we assume our responsibility it will have a healthy effect on the profession, on the individual members of the profession, and on society in general. The entire area of social responsibility also must be considered as a part of the ethical obligation of the dentist. The dentist in turn can gain a great measure of personal

satisfaction from his contributions in these broad areas of community, civic, and social service. The civic-minded dentist will soon discover that people are interested in him not only for his efficiency as a dentist and professional man, but because of his interests and activities in the community. Our contributions should be mental, physical, spiritual, and financial. These are all important and we should participate in every one to the best of our ability and capacity. We must stimulate and encourage all members of the profession, at the grassroots level, to participate in the functioning of local dental societies. It is here that leadership and statesmanship are developed. It would behoove all of us to do more than we have done in the past.

Over the years we have done a superb job in developing scientific leadership, and in the distribution of professional knowledge to our members. However, except for a comparatively small group, we are falling flat on our face generally in assuming the statesmanlike leadership in civic, social, and political areas in which we are becoming increasingly involved, and which may eventually determine the success or failure of dentistry as a major health service in the eyes of the public.

The dentist has two obligations—first, providing a professional service to the public, and second, the recognition, acceptance, and fulfillment of our social, civic, political, religious, and community responsibilities. In discharging these two obligations to the best of our ability, we all will become better citizens in our community.

I would like to relate a story: Christ was slowly making His way to Jerusalem, the place where He was to be sentenced to die. As He would pass through small towns and all along the way, crowds of people would line the roads and streets just to get a glimpse of this Man. There was a woman who was ill and had been for several years, and had visited every known physician in her area and all to no avail. She chanced to hear that Christ was coming through her area. She was delighted because she knew within her heart that should she get to talk to Him that He would heal her. She stationed herself beside the route that Christ was to pass, and on arrival at this point she found that the crowds were already gathering and that He was soon to pass. She grew anxious as He neared, and soon realized that it would be impossible to speak to Him because of the mass of people. Her heart was heavy, but she thought that if she should just

be able to touch the hem of His garment as He passed that she would be cured of her dreaded disease. Just as Christ drew even with her, she gave a lunge and did touch the hem of His garment and was healed. Just touching the hem of His garment had a tremendous influence on this woman.

Now I say to you succinctly, every day that we live, many people, young and old—many that we never know about, in fact many more that we do not know about than we do—touch the hem of the garment of our lives and it too has an influence on them. I wonder if it influences them the way we would like to have them influenced. Do we influence them in such a way that they can say, and will want to say truthfully and sincerely, that there is truly a man who epitomizes statesmanship in dentistry?

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A GENERAL EDUCATION

In our modern higher education, we have, I believe, three principal difficulties. First, in its practical aspect, we simply are not providing it to sufficient numbers of young men and women.

Second, we are not as proficient as we should be in providing a broad citizenship education to those who specialize in many technical fields. And third, even in liberal education, we have permitted it to become too much a specialization, rather than a broad, liberating influence on the mind, the attitude, the character of all students.

What we need is general education, combining the liberal and practical, which helps a student achieve the solid foundation of understanding—understanding of man's social institutions, of man's art and culture, and of the physical and biological and spiritual world in which he lives. It is an education that helps each individual learn how to relate one relevant fact to another; to get the total of relevant facts affecting a given situation in perspective; and to reason critically and with objectivity and moral conscience toward solutions to those situations or problems.

I repeat: this kind of education is sorely needed in this country—and throughout the world.—Dwight D. Eisenhower.

Leadership Through Recruitment and Education

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IF we paraphrase Webster's definition of "statesmanship," quoted by our moderator, and apply it to the topic of this panel discussion, we might say that *statesmanship in dentistry* is the art or practice of conducting dental affairs by a man versed in the workings of organized dentistry, especially by one who shows wisdom in formulating, treating, or directing dental policy. Such an individual would undoubtedly exhibit the qualities of leadership which Dr. Peterson said Webster applied to the word, " . . . wisdom, breadth of vision, or regard for the general welfare rather than partisan interest."

For our purpose during this discussion we may agree that *statesmanship in dentistry* and *leadership in dentistry* are synonymic, because the dental statesman usually becomes the dental leader. However, we must hasten to add that while most dentists who possess the qualities of dental statesmanship are soon recognized by their peers as having these characteristics, and are placed in positions where their leadership may be exercised, all dental leaders are not dental statesmen. To assure a brilliant future for our profession that is even more promising than its bright present or its glorious past, it behooves us to see that the men we choose for our dental leaders are indeed possessors of those qualities of leadership that we associate with dental statesmanship.

The need for statesmanship in dentistry has never been more manifest than it is today. Ryan's observation (1) that "The present Washington Administration's preoccupation with social welfare—particularly its emphasis on health care—makes it mandatory that, once again, the dental profession examine its policies and attitudes in regard to extending dental care to a larger segment of our population," shows the urgent necessity of having today's dental leadership come forward with what he calls ". . . positive, aggressive action in developing dental care programs." Ryan's further statements that "the profession is long on policy but short on action," and ". . . the profession cannot stand on dead center. We must move or be moved," emphasize the urgency of having dental leadership step forward to lead the profession, because we can no longer afford to play

the role of "casual bystanders in the social revolution going on about us."

If there is a need for statesmanship in dentistry today, is it likely that the need for it will be any less tomorrow? I believe not; on the contrary, we are certain to be subjected to increasing pressures from government, labor, management, and other groups, to extend our dental services to a larger number of people than enjoy these services today. In these expanded dental care programs, if the traditional doctor-patient relationship is to be maintained, and if we are to preserve the heritage of our professional status, dental leaders must come forward with the blueprints for dental health programs that are "... reasonably responsive to the changing demands and needs of our people" (2).

"The time has come for positive aggressive action in developing dental care programs. We can no longer afford the role of interested spectators in the social revolution" (1).

Let us hope that dentistry and dental leadership will prove equal to the challenge that confronts us. May we profit from the experience of our colleagues in medicine and be ready to offer voluntary programs that have been developed by the profession "... before government takes the initiative and develops their own programs—as happened in Medicare" (1).

Some of the qualities that characterize leadership are a part of the individual's genetic endowment, others are acquired through study, training, and experience. While we are unable to control the genetic factors which determine leadership, we are in a position to encourage the study as well as provide the training and experience necessary to develop qualities of leadership.

Dentistry should begin to develop its future leaders and dental statesmen early, starting with a recruitment program that attracts superior young men and women to careers in dentistry. Dentistry is not getting its proportionate share of the able students who are choosing professional or scientific fields of study. According to Peterson there are three reasons for this: "... the high cost of a dental education, the length of time needed for it, and the rapidly developing opportunities in other scientific fields" (3).

It is certainly unnecessary to amplify to this group the statement that dental education is costly. Indeed, it may well be the most costly type of advanced training that one can elect. Furthermore, there are fewer scholarships available to help support the dental student than

in other doctoral or graduate programs of study. Also, the many hours spent in laboratories, clinics, lecture halls, and in class preparation, so completely occupy the student's time, there is little opportunity for him to use outside employment to help finance his education.

It is true that the number of student loan funds and the amount of money available from these funds to support dental students are increasing. It is also true that federal funds are now available to help finance education in the health professions, but Bunnell warns that a "... bit of fantasy which is far too widespread these days is the conviction that any able student who aspires to a health career can find ample aid to finance his training" (4).

It is not likely that in the foreseeable future we shall be able to resolve the second difficulty associated with attempts to attract more young men to the study of dentistry—length of time needed for a dental education. Indeed, there are some dental educators who believe that the present four-year curriculum in dentistry is not long enough to teach the essential body of knowledge that the well-trained dentist should possess upon graduation from dental college. There are suggestions that the course of study be lengthened one year. One plan calls for the additional year being added to the predental program, with some of the basic science courses, that are now a part of the professional curriculum, being given at that level (5).

The third problem associated with attempts to recruit superior young men and women for careers in dentistry is of fairly recent origin, and is a product of the Space Age and the attention drawn to the physical sciences and technology. "In the past," Hood observed, "the number of fields open to the able young person with scientific interests was more limited than at present. Two such fields that did offer many opportunities were medicine and dentistry" (6). Today, however, there are unlimited opportunities for persons with training in any one of the many branches of physics, chemistry, or engineering; therefore, dentistry, as well as medicine, is competing with these fields of science as the career choice of the capable young college student. In many instances, dentistry is coming away from this competition the loser. Recruitment programs at the national and state levels are helpful and should be expanded, but the most effective recruitment technique continues to be the person-to-person contact: the individual dentist counseling the promising student, especially at high school level.

Local dental societies might well consider a program of recruitment one of the most important projects on their calendar. Unfortunately, many local dental societies do not consider dental student recruitment a part of their society activity.

After the student qualifies for the study of dentistry, our next opportunity for developing dental statesmen comes while we have our future dentists enrolled as dental students. In this era of changing dental curricula, one change that dental educators may wish to consider is the establishment of a course, which will have as its objective, teaching the elements of dental leadership.

There are some facts relative to the operation of organized dentistry that could be taught to undergraduate dental students. Visiting faculty, drawn from the ranks of dentists in the area who have been outstanding dental leaders, could be used to give the instruction. Such a course would most appropriately be fitted into the schedule of the senior dental student.

Once the student graduates and enters the practice of dentistry, our efforts to train him for dental statesmanship should not cease. If the society has an effective program of indoctrination for its new members, there is an excellent opportunity of directing the enthusiasm and vigor of the new, young member of organized dentistry into channels that will lead to the development of future dental leaders.

Effectively indoctrinating new members arouses their interest in society activities and makes them truly active members of organized dentistry from the first moment they join.

One of the best programs of indoctrination used by a component society that we know of is employed by the members of the Second District Dental Society of Tennessee. The author of their program of indoctrination (7) is Dr. W. L. Lockett, Knoxville.

Editorial comment (8) in the journal in which this program of indoctrination was described, noted that it provided the new member with "pertinent data about the American Dental Association, the Tennessee State Dental Association, and the Second District Dental Society," and therefore "indoctrination of new members is . . . no desultory, unsystematic, or inconsequential procedure, but a process or orientation that fits the neophyte into his proper place in the dental society and immediately provides him with a comprehension and perspective of its workings that would otherwise take years to acquire."

From the base of a good indoctrination it is easy to interest new

members in the work of the dental society; assigning them minor roles on various committees is the next step in the development of future dental leaders. After a period of training and the acquisition of experience, in due time the young member is given a more responsible role in society affairs and, if he has the abilities, he may metamorphose into a dental leader.

There is still another device that needs more exploitation in the development of dental leadership: continuation courses, given in dental schools, that would train the dentist in the elements of dental statesmanship. Such courses could be given by a visiting faculty composed of dentists who are themselves recognized leaders in their profession. Borrowing on the knowledge and experience of these men could become a technique of developing dental leaders in a shorter period of time.

The need for statesmanship in dentistry has never been more manifest than it is today. The social revolution that has enveloped our society requires, among other changes, the development of adequate dental care programs that are "... reasonably responsive to the changing demands and needs of our people" (2). These programs must be developed and administered by men who are dental statesmen.

The profession shall desperately need dental statesmen to preserve our professional heritage. Several methods of developing this statesmanship in dentistry have been suggested.

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Proposal for a Geriatric Dental Aide

JAMES S. BENNETT, D.M.D., M.S.

IN the coming years it is expected that there will be a greater demand for geriatric dental services than available dental personnel to fulfill these needs. This will evolve as a result of several situations: (1) An increasing number of people reaching the elderly periods of life in various stages of dental disrepair; (2) An increasing desire of elderly people for oral health maintenance; and, (3) An increasing demand from the individual and from government agencies for more complete and comprehensive dental service. These situations are created in part by increased dental health education, numerous insurance plans and, hopefully, a true desire for better oral health. The development of a special dental auxiliary for aiding the dental profession in managing geriatric dental problems would seem to be feasible, economical, and worthwhile.

In considering the essential criteria for such a dental auxiliary, it is thought that he should be of middle age or older, a person who could empathize with older people and their dental problems. He should be willing to undertake a situation where the work demand would not be particularly burdensome, but would require patience and persistence. The duties of this auxiliary person would place him on a full-time basis in nursing homes, hospitals, convalescent hospitals, or even in private homes, to administer and control regimens of oral hygiene as prescribed by the dentist. He should have practical training similar to, but less extensive than that of the dental hygienist. Unlike the dental hygienist, however, he would not be trained to carry out special duties that require the supervision of a dentist. His duties would consist of:

- (1) Teaching patients to use the various devices for oral care and cleanliness: toothbrushes, water irrigation, tissue massage, dental floss, etc.
- (2) Routinely following up the patient in his oral care.
- (3) Instructing patients of the basis and rationale for maintaining oral hygiene.

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- (4) Rendering oral care measures where required by the physical state of the patient:
 - (a) Toothbrushing
 - (b) Gingival massage
 - (c) Water irrigation treatment
 - (d) Care of prosthetic appliances
- (5) Scheduling patients with a dental facility of patients' choice, or arranging for in-patient dental care. Keeping interim records of patients' dental status for the dentist.
- (6) Fabricating or altering dental devices for oral hygiene so that modification of the appliance would render it more usable to the patient.
- (7) Assisting in the use of other oral hygiene adjuncts such as mouthwashes, disclosing wafers, etc.

It is recognized that persons in the nursing profession are given some training in oral health measures; however, they are generally too busy to assist the institutionalized person to achieve a level of oral hygiene on a continuing basis that would be acceptable to the dental profession.

The training of a retirement (or pre-retirement) aged person as a geriatric dental aide would serve not only to establish a means of supervised oral management for the elderly, but would also fulfill a need that has often been expressed in geriatric study circles: that where possible, elderly people should be retrained, rehabilitated, and placed in situations where they can continue to be useful and productive in their retirement years.

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EDITORIAL OVERSIGHT

The editorial comment "How Much Is It Worth??" in the July 1967 JOURNAL, page 185, reprinted from the *Odontological Bulletin*, should have listed David H. Ehrlich as co-author with Marvin Sniderman. This was an inadvertent omission. Dr. Sniderman is editor of the *Bulletin*, and Dr. Ehrlich is associate editor.

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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.

