the Journal of the American College of Dentists

Continuing Education—
A Panel Discussion

Methods of Group Practice

Program—
Forty-Ninth Annual Session

JULY 1969

the Journal of the American College of Dentists

A QUARTERLY PRESENTING IDEAS IN DENTISTRY

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Contents for July 1969

STANLEY A. LOVESTEDT
President, 1968-1969

Meet the President

DR. STANLEY A. LOVESTEDT of Rochester, Minnesota, 1968-69 President of the American College of Dentists has had a long and distinguished professional career. His early education was obtained in Sterling, Colorado, and his dental degree from the University of Southern California College of Dentistry.

For the past thirty-one years he has been associated with the Mayo Foundation for Medical Education and Research. Starting with a fellowship in 1938, he was successively Instructor, Assistant Professor, Associate Professor and Head of the Section of Dentistry and Oral Surgery of the Mayo Clinic. Since 1962 he has been Senior Consultant. He holds a Master of Science degree from the University of Minnesota and is a diplomate of the American Board of Oral Surgery.

Dr. Lovestedt has staff appointments at Methodist, Methodist-Worrall, and St. Mary's Hospital in Rochester, and is past president of the Rochester Dental Society and the Southeastern District Dental Society. He is a charter member and past president of the Minnesota Society of Oral Surgeons, a charter member of the American Academy of Oral Pathology, a member of the American Society of Oral Surgeons, and past president of the Minnesota Section of the International Association for Dental Research.

He is a fellow of the American Association for the Advancement of Science and a member of the Minnesota Dental Foundation, American Academy of Oral Roentgenology and American Association of Dental Schools. He holds life membership in the Southern California Alumni Research and Endowment Association, and is a former member of the House of Delegates of the Minnesota State Dental Association. He also belongs to the Mayo Clinic chapter of Sigma Xi, and Omicron Kappa Upsilon honorary dental society.

Dr. Lovestedt has seen military service with the U.S. Army and held the rank of Major while on duty. He is an honorary member of the Philippine College of Dental Surgeons and the Mexican Dental Society.

He has published over forty papers on a wide variety of sub-

jects relating to Oral Surgery, Pathology, Roentgenology, Diagnosis and Therapeutics. He has lectured on these topics before dental groups in all parts of this country and in Mexico and the Philippines.

Particularly noteworthy in recent years has been his work with the Minnesota Division of the American Cancer Society. He is a member of its board of directors and was instrumental in setting up thirteen clinics throughout the state, where over 30,000 persons received oral cancer detection examinations. For these services Dr. Lovestedt was honored by the "Good Neighbor of the Northwest" award by radio station WCCO. In 1964 he received an award of merit from the national organization of the American Cancer Society. He continues his active interest in this field as a member of the liaison committee between the Minnesota State Dental Association and the American Cancer Society.

He is advisor to the Mayo Clinic Medical Explorers post, a medically-oriented group of young men and women who combine the principles of scouting with their special interest.

Dr. Lovestedt is married to the former Seiberta Conklin. They have three children, two married daughters, Mrs. Priscilla Strand, 25, and Mrs. Helen Pye, 23, and a nineteen year old son, Robert, a sophomore at the University of Washington.

Outside of dentistry Dr. Lovestedt's interests lie in photography, music and sailing.

In recognition of his many achievements and his qualities of leadership, the American College of Dentists has chosen wisely in naming Stanley A. Lovestedt as its President this year.

Editorial

Continuing Education—A Way of Life

The statement made many years ago by the noted dental educator, G. V. Black, that "The professional man has no right to be other than a continuous student" is as true today as it ever was. Dr. Black recognized that the education of the dentist did not end upon graduation from school, that it could never be entirely complete. He saw it as an ongoing process, a lifelong endeavor, in effect, a way of life.

In these times of rapid proliferation of scientific knowledge, it has become increasingly difficult for the average dentist to keep abreast of the advances in his field. In order to maintain his competence in the presence of the spate of technical information pouring from laboratories and lecture halls he must read a considerable amount of literature, attend meetings and clinics, and take postgraduate courses at frequent intervals.

The perceptive practitioner who wishes to keep current may set up for himself an informal study program. He will seek knowledge wherever he can find it, and may travel long distances if necessary to attend a meeting, hear a speaker or take a course if he believes such effort will be of benefit. He recognizes that by so doing he will develop a better service to his patients, a better practice, and in the end, a better income. The mental stimulation and intellectual challenge that such study provides may enhance the satisfaction he obtains.

Dental schools have traditionally been the primary sources of continuing education for the dentist-student, but dental organizations and teaching hospitals have begun to play an increasing part. Many of them are providing educational opportunities, but more are still needed. State societies which are not presently involved

have begun to recognize that they have a responsibility to offer programs of study to their members.

There is a movement under way to make postgraduate study a requirement for participation in government-funded dental programs and for the maintenance of one's license. The report of the National Advisory Commission on Health Manpower stated that "Professional societies and state governments should explore the possibility of periodic relicensing of physicians and other health professionals. Relicensure should be granted either upon certification of acceptable performance in continuing education programs or upon the basis of challenge examinations in the practitioner's specialty." The House of Delegates of the American Dental Association is considering similar proposals to "permit constituent societies to require reasonable standards of continuing education for maintenance of membership."

Dentists who have made continuing education a way of life have nothing to fear from these proposals. Others, who have not been living up to their professional responsibilities, would do well to heed the dictum of G. V. Black, lest compulsory study be thrust upon them.

R.I.K.

The American College of Dentists is vitally interested in continuing education and has been since its founding, nearly fifty years ago. One of its purposes, as stated in the preamble to its constitution is "to encourage graduate studies and continuing educational efforts by dentists." Last year the Committee on Education, under the chairmanship of Dr. David Striffler, planned a comprehensive symposium in which the problems of continuing education would be presented and discussed from many aspects. Representatives of medical and dental education, federal and state governments, dental organizations, state boards and private practice were asked to present their opinions and suggestions. The symposium was held at the annual session of the College in Miami Beach last October. In this issue we print all of the papers and comments from that meeting. They deserve the careful attention of all who share a concern for the future of our profession.

The New York Meeting

SATURDAY, OCTOBER 11, 1969

The Starlight Ballroom
Waldorf Astoria Hotel

DENTISTRY TODAY—A PROFESSION IN TRANSITION

For many years, the American College of Dentists has consistently applied its unique resources to examining the needs of the profession in an effort to enhance the effectiveness of oral health service. In so doing, its practice always has been to bring to its annual programs the most knowledgeable and articulate speakers available. The program in New York on Saturday, October 11 continues this tradition by presenting a series of position papers which will examine the scope and performance of dentistry and describe the varieties of care required. These papers will help assign values to those factors of both service and need which must be considered concomitantly by the profession and society in their adjustments to the emerging new concepts of health care. Plan to attend.

9:00 A.M. Panel Discussion—Part I
Moderator—Dr. Frank P. Bowyer

"The Professional Concept—Its History and Meaning to Health Service"—Dr. Maynard K. Hine

"The Structures of Dentistry"—Dr. Gordon Watson

"The Dental Diseases—Their Magnitude, Prevention and Treatment"—Dr. William E. Brown, Jr.

Questions from the Floor—Summary by the Moderator

2:00 P.M. Panel Discussion—Part II
Moderator—Dr. Nathan Kohn

"Dental Practice—Factors Affecting the Delivery of Dental Care"—Dr. Charles F. McDermott

"Dental Auxiliaries"—Dr. Edward L. Green

"Dental Economics"—Dr. William S. Brandhorst

Questions from the Floor—Summary by the Moderator

SUNDAY, OCTOBER 12, 1969

The Starlight Ballroom
Waldorf Astoria Hotel

9:00 A.M. Executive Session

10:30 A.M. "The Fiftieth Anniversary of the American College of Dentists—Its Meaning to Dentistry"—Dr. Henry A. Swanson, Washington, D.C.

10:45 A.M. "Private Practice, Public Programs—New Patterns" —Dr. I. Lawrence Kerr

12:15 P.M. Luncheon—The Sert Room

3:00 P.M. The Convocation—The Grand Ballroom

"The Administration of Dental Care Organizations" —Mr. George Bugbee

Conferring of Fellowships

Presentation of Awards

Evening Meeting

6:30 P.M. Foyer Grand Ballroom

No-Host Cocktails

7:30 P.M. Banquet—The Grand Ballroom

Introduction of Guests

Presentation of Service Key to President Lovestedt

Address: "Leadership Responsibilities of the Professional Family"—Lady Barbara Ward Jackson, Albert Schweitzer Professor in The Humanities—Columbia University

Continuing Education

A Panel Discussion

Moderator: ALVIN L. MORRIS
Vice President, University of Kentucky
Medical Center, Lexington, Kentucky

Participants

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General Practitioner, Coronado, California

Presented at the Forty-Eighth Annual Session of the American College of Dentists, October 26-27, 1968 in Miami Beach, Florida.

Legislation and Social Pressures for Continuing Education

JOHN H. MOXLEY, III, A.B., M.D.*

BEFORE opening the discussion of continuing education for dentists, it may be well to underline the fact that I speak today as a physician whose primary frame of reference is medicine. I am therefore focusing my remarks on continuing education of physicians drawing an occasional parallel with dentistry. I hope that additional points of similarity—and perhaps some dissimilarities—will emerge and provide a basis for discussion later this afternoon.

In evaluating the legislative and social pressures for continuing education in medicine and dentistry today, and in tracing the historical development of these forces, one can come perilously close to concluding that there are none, at least none that can be termed really effective.

This is not quite true, fortunately. There may be difficulty in identifying any single pressure, but one can detect a momentum building up through several minor, subtle pressures that may eventually bring change.

Let us look at the historical record and then turn to the contemporary scene: The past is significant if for no other reason than as a demonstration of the remarkably slow pace at which we have moved.

Prior to 1930, a large percentage of dentists and physicians were graduates of priorietary schools. Few had graduate training. The major effort in continuing education was therefore directed toward correcting the deficiencies of the enrollee's initial education and thereby hopefully making him a safer practitioner.

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* Dr. Moxley is Assistant to the Dean, Harvard Medical School, Boston, Massachusetts.

This paper was presented at a panel discussion "Continuing Education" at the American College of Dentists Forty-Eighth Annual Session, Miami Beach, Florida, October 26, 1968.

It was not until the 30's when the last of the proprietary schools closed, and concurrently graduate specialty programs began to develop rapidly that continuing education came to be viewed as the necessary third stage in what is now called "the continuing or lifelong education of the dentist and physician."

About that time, many of the concepts that are still being considered new or radical came into being, among them the desirability of regionalization and of compulsory re-licensure.

In 1930 the regional responsibility for continuing education of physicians was initiated by three medical schools, the University of Michigan, Albany Medical College, and Tufts University. The description of this event in Michigan would fit beautifully into a 1968 pamphlet describing the regional medical program (1).

In 1932, an AMA Commission on Medical Education proposed remarkably modern ideas relative to continuing education—36 years later, some of their ideas have yet to be acted upon. Excerpts from this report include: 1. The educational sequence from premedical education to retirement from practice should be looked upon broadly as a single problem, not a succession of isolated and unrelated experiences.

2. The continued education of physicians is synonymous with good medical practice and provisions should be made ultimately whereby every physician will be able to continue his education. And they go on to say that the time may come when every physician may be required, in the public interest, to take continuation education courses (2).

The Commission report raised the possibility that compulsion might be necessary to enforce continuing education. This thought apeared again in 1934 when the American Board of Urology was formed. One of the bylaws states that each certificate shall be subject to revocation in the event "that the physician so certified shall at any time have neglected to maintain the degree of competency in the practice of the specialty of urology as set up by the Board and shall refuse to submit to re-examination by the Board." I was unable to find out, however, whether or not the foregoing bylaw has ever been invoked (3).

In 1937, the AMA president spoke of the need, and objectives of, continuing education. He noted that "there is already a trend to-

ward compulsory evidence of postgraduate improvement. There is a possibility of a next step which might be the requirement of the renewal of licensure through evidence or familiarity with the development in medicine by five- or ten-year period examinations."

He then called upon the AMA to assume the leadership and put forth a program demonstrating that it had a definite plan for medical education at all levels (4).

In 1940, the first nationwide study of continuing medical education was published. It led to the decision that the AMA Council on Education was to keep and periodically publish a voluntary listing of continuing education courses. This listing was to remain voluntary and without regard for quality for the next 27 years. Stimulated by the second nationwide study in 1955, the Council, through its Advisory Committee on Continuing Education, has, within the past year, begun an accreditation program.

Thus the decade of the 30's saw progressive development in the theory and significance of continuing education for physicians. Then World War II intervened, and in the postwar period there was a return to the refresher, or reparative, aspects of postgraduate medical education.

Although a setback in the evolutionary development of continuing education, this was not without some long-range benefits in that it did bring dental schools, medical schools, and hospitals to re-examine their individual programs in respect to both quantity and quality, and shifted the major responsibility for continuing education from the professional societies, where it had traditionally lodged, to the universities and their medical schools.

Since 1947, the mode of thought in regard to continuing education for physicians evolved much as it did in the 30's. In 1947, the American Academy of General Practice was organized and as the American Board of Urology had done 13 years before, it built continuing education into its bylaws. This time, however, definitive requirements were adopted as a requirement for maintaining membership. National conferences on continuing education began again to ring with debates about compulsory continuing education. At least two more national studies were done in the 50's, but they added little to those done earlier.

In one recent study, physicians responded to an opinion survey

on continuing education by listing the following reasons for inattendance: 1. Lack of someone to care for their patients while they were away; 2. Cost; 3. The multiplicity of hospital and medical society meetings that each felt compelled to attend (5).

Interestingly, at approximately the same time, careful study by the Department of Postgraduate Medical Education in Kansas indicated that the lack of someone to care for a physician's patients did not seem to have any effect on a physician's activity in regard to continuing education. The study failed to show a significant difference in the number of hours of postgraduate work among physicians who had partners. Furthermore, there was no correlation, positive or negative, between the distance a physician had to travel to courses and the number of hours of course work he took in the three-year period.

Enough of the chronology of the development in continuing education. Let me now turn to the situation today and consider it under three categorical headings: legislative pressures, social pressures, and as part of that professional pressures.

All of you are aware of the changing posture of the federal government in regard to health. The biomedical revolution which began in the late 30's and has been nourished by the federal government, is no longer receiving the attention it once did. Rather the federal establishment is becoming increasingly interested in the interface between health and society with specific emphasis on health manpower and problems involved in the organization and delivery of health care.

In this regard, I would like to touch upon two pieces of legislation: the regional medical programs (P.L. 89-239) and Social Security amendment of 1965 (Medicare and Medicaid) as well as a federal commission report, that of the National Advisory Commission on Health Manpower.

Regional Medical Programs, or RMP, is the legislative product of the report of the National Advisory Commission on Heart Disease, Cancer and Stroke. Although once viewed as a means of concentrated attack on these and related diseases, it has recently been described as "shaping up in many parts of the country as a program of continuing education for doctors, nurses and other personnel." This is largely because the bill requires that prior to

funding, a program must develop "cooperative arrangements among existing health institutions and organizations." Although this bill is provoking increased interest and activity in the field of continuing education, I do not see it alone as a significant pressure for doing so. Indeed, the focus on continuing education stems in part from inability to effect the above "cooperative arrangements" in the direct care areas of the bill. RMP does provide a framework for organizing widespread comprehensive continuing education programs, should pressures be applied. In addition, implementation of RMP has provided the first significant allocation of federal funds for support of continuing education.

In summary, it is a major step in removal of the alleged barrier of inability to pay for continuing education, but it does not provide any direct pressure on health professionals to partake of the offerings.

The Medicare legislation does contain elements of positive pressure. The first of these is the power a large purchaser of health care can exert, through sheer economic force, to demand that certain quality standards be met. The only specific exercise of this power has thus far been in the New York State Medicaid Program, and it involved dentists.

In New York, it was established that in order to qualify for Medicaid reimbursement, dentists had to show evidence of having completed a given number of hours of continuing education each year. The details of this ruling are well known to most all of you and will be reviewed later this afternoon, and I will not review them now. I would like to make two points, first that New York State is far from a typical microcosm. Few states boast people who are as interested in quality care and as influential at the policy level at Rockefeller, Trussell, Folsom, James, and others. On this basis alone, it would be difficult to view the New York action as precedent setting. I know of no evidence that other states are planning to follow. Second, the New York regulation is being challenged. Representative Broyhill of Virginia has introduced legislation that would remove continuing education from Medicaid officials and place it under the jurisdiction of state licensing bodies.

The second aspect of Medicare that could become a direct pres-

sure for continuing education is the Mandatory Utilization Review. This provision, at least at the present time, obviously has a more direct implication for physicians than for dentists. The problem is that in general, utilization review committees are most active and potent in the best hospitals and the better the hospital, the more up-to-date are its physicians. The result is that those physicians already operating at a relatively high level are stimulated to increase their competence whereas those functioning at lower levels of competence remain largely unaffected.

The Health Manpower Commission reviewed the manpower shortage problem in the overall context of techniques of delivery of quality of health care. Continuing education was initially analyzed by the education panel of the Commission. Upon the review of the situation, the panel adopted a recommendation that all health professionals be required to demonstrate periodically maintenance of their judgment and skills.

They recommended that health professionals have the option at defined intervals of either presenting a designated number of continuing education credits, or sitting for reexamination in order to have their license recertified. The panel recommended that the requirements be uniform throughout the nation, and further that continuing education and/or re-examination be in the specialty area of the individual's practice. His license would, of course, designate that area.

As is the usual turn of events, the panel's recommendations were somewhat diluted by the full commission to read as follows:

> Professional societies and state governments should explore the possibility of periodical relicensure of physicians and other health professionals. Relicensure should be granted either upon certification of acceptable performance in continuing education or the basis of challenge examinations in the practitioner's specialty (6).

I do not view the Commission's recommendation as a significant pressure at this time. They did, however, at least in the panel, go beyond simple endorsement of the idea of recertification and outlined the principles of a program of implementation.

It is obvious to anyone reading the popular press that there is a great deal of public ferment over the issues of quality in health care. Almost daily we read of the medical cost crisis, health man-

power shortages, OEO centers, and so forth. The public is generally more informed and is asking more and more questions about health care in general as well as specific requests of individual physicians and dentists.

Some of the current literature such as the book, *The Doctors* by Gross, goes out of its way to condemn the physician. Others, such as the *Sacred Trust* by Harris, originally a series of articles in *The New Yorker* subsequently issued in book form, realistically describe the gigantic efforts of organized medicine to fight adoption of the Medicare legislation.

Television, too, has played a decisive role in increasing the public's interest and information by presenting in dramatic visual terms both medicine's successes and failures. It is ironic that TV, hailed as a major educational tool in 1948 when closed circuit transmission was first demonstrated, has never been adequately used for professional education, but has instead become an instrument of social pressure for continuing education.

These two forms of mass communication, press and TV, have had a cumulative effort in developing a climate of opinion that exerts pressure to improve the health care and thereby stimulates health education.

Dentistry has perhaps felt less public pressure than medicine for obvious reasons, including widespread ignorance of the importance of dental care and the persistent view that dental services are luxury rather than a necessity. These attitudes may change as personal incomes rise. The Manpower Commission predicted that the demand for dental services will increase between 100 and 125 per cent in the decade 1965 to 1975.

At present, however, oral disease has less impact on the public consciousness than the oft quoted statistics pertaining to morbidity and mortality. It is frequently pointed out that despite the technology, despite the increasing percentage of our gross national product allocated to health, the life expectancy of males in the United States is 22nd among the countries of the world having fallen from 13th in the brief interval from 1959 to 1966. Infant mortality rates are also sobering. Whereas our infant mortality has been declining steadily in the last half-century, in 1965 we stood no better than 18th in the world rankings. If we consider

only our Caucasian citizens our position improves slightly from 18th to 12th. The significance of this type of information is much debated among the experts, but nevertheless, the public is becoming more aware, and these statistics are one more thread in the fabric of social pressure.

The most potent social pressure for continuing education of health professionals stems from the common law and turns upon the interpretation of the general rule of the law of torts which states that in order to escape liability in an action of negligence one must exercise the standards of care which would be exercised by a reasonably prudent man acting under similar circumstances.

In more familiar terms, it is the community or locality standard of practice rule. Recently this rule has been subject to reinterpretation particularly in regard to the standard of care of the medical and dental specialist.

Two cases will illustrate. In a ruling in April of this year, the Supreme Judicial Court of Massachusetts modified the locality rule. In rendering the opinion Justice Spaulding stated: "We are of the opinion that the locality rule of *Small vs. Howard* (1880) which measures a physician's conduct by the standards of other doctors in similar communities is unsuited to present day conditions . . . the defendant was a specialist practicing in New Bedford, which is slightly more than 50 miles from Boston, one of the medical centers of the nation . . . this is a far cry from the country doctor who 90 years ago was called upon to perform difficult surgery."

The Court went on to note that in its opinion, the proper standards by which to judge a general practitioner is whether or not he has exercised the degree of care and skill of the average general practitioner, taking into account the advances in the profession and considering the medical resources available to him. The standards for specialists were stated to be the standards of the skill of the average member of the profession practicing the specialty, again considering the medical resources available to him, the Court's ruling cited similar decisions in 19 states (7).

In June of this year, a New Jersey man and wife agreed to accept a $15,000 out of court settlement of a malpractice suit against a dentist. The couple charged that they were treated periodically

by the dentist from 1959 through 1965. During this time, according to their suit, they suffered from "gum disease and resulting bone loss." They alleged that the condition gradually worsened because it was not detected by the dentist during his examination. The consent judgment was approved by the District Court (8). The threat of a malpractice suit frightens virtually every physician and dentist. This kind of decision, when it is repeated throughout the states as it appears it will be, will bring strong punitive pressures to keep up our skills to some sort of a national level.

Of the three influences, legislative, social and professional, the third continues to generate the greatest number of pressures for continuing education of both medicine and dentistry. These professional pressures begin in medical and dental school and carry through in a progressively weakening fashion into the practice years. Medical schools have begun to realize that all basic medicine cannot be jammed into a four-year curriculum.

The result has been the development of a core curriculum supplemented by guided elective and tutorial programs. One of the effects will be that students will begin to take increasing responsibility in planning their education. Hopefully, this will impress upon them not only their limitations but also the process by which they must continue their education throughout their professional careers.

During the first eight to ten postgraduate years the drive for board certification is a very strong pressure upon the majority of doctors and an increasing number of dentists for continuing education. The number of people carrying through for their boards is increasing annually. The pressure leads to continuing education in the form of graduate training and in addition, a period of intensive review in the several weeks to several months prior to the examinations.

Thus far, the boards, with the exception of the American Academy of General Practice, have been reluctant to take the next logical step of requiring periodic recertification. The American Board of Internal Medicine, and I suspect others that I am less familiar with, is reportedly studying mechanisms by which there would be an initial certification followed by periodic recertification either through continuing education credits or retesting in a

person's particular area of expertise. If enacted, this new type of program could become a very potent pressure for continuing education.

Some state medical societies are also becoming increasingly interested in the quality of medical care and in continuing education. For many years the California State Medical Society, with California Physicians' Services (Blue Cross-Blue Shield) has provided an example of peer review which provides an opportunity to improve professional judgment on the necessary and appropriate use of physician services. Under the program, a committee of peers reviews randomly selected cases in which Blue Cross-Blue Shield raises a question.

On the basis of their review, their group may either approve the case, raise questions of the review with the attending physician, or if abuse continues, invoke permanent suspension for participation in Blue Shield. With this type of peer review, physicians are encouraged to maintain high standards or forfeit payment. More important than the economic regulation, however, is the fact that peer review is a professional force which few health professionals are willing to contest. As a consequence, physicians rarely take legal action to attempt to reverse a CPS decision.

Just two months ago, the Oregon State Medical Society took a major step in generating professional pressure for continuing education by passing a resolution requiring members as a condition for retaining their membership, to show periodic evidence of continuing education. To the best of my knowledge, Oregon is the first state medical society to adopt such a resolution. Although details of the amount of education and the frequency of demonstration required have not as yet been spelled out, a significant precedent has been established.

In closing, allow me to emphasize once again that athough there are clearly a growing number of pressures for continuing education, none in and of itself gives any assurance that the majority of medical professionals are adequately maintaining their skills. Indeed, there is evidence to the contrary. For instance, the study of Rosenfield which concluded that 39 to 50 per cent of the cases in two community hospitals received fair or poor care, the study of Lembcke that of all major female pelvic operations performed in

the community hospital, only 30 per cent could be judged to be justified, or the study of Morehead *et al.* which concluded that of 430 patients admitted to 98 different hospitals in New York City, only 57 per cent received optimal medical care.

The explanation for this disheartening finding is that there are at least three sub-groups in the medical profession today. The first is the group who maintain a high level of medical skill regardless of how difficult it is for them to do so. The second is the group who will maintain their skills if it is relatively convenient for them to do so. It is the second group who will be most affected by existing pressures and evolving aggressive attitudes on behalf of continuing education. The third and frightening group is comprised of the dyed-in-the-wool immovables who refuse to take part in continuing education programs regardless of existing pressure or ease of access.

The central question then is, "Can continuing education be really meaningful if we continue to ignore the existence of the latter group?" Presuming that the answer is "No," is there any method short of overt compulsion through the licensing mechanism which can induce this group to maintain its skills at an acceptable level. I regret to say that no matter how I approach the problem I am forced to conclude that the answer is "No."

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The Dentist and Continuing Education—Attitudes and Motivations

DEAN W. DARBY, D.D.S., M.S., PH.D.*

THE introduction to my presentation is a short film, "The University Without Walls." I'll reserve further comment until you have viewed this film.

The film you have just seen briefly described the continuing dental education problem as it exists today: it indicated the need for nationwide, coordinated action and it demonstrated some ways that modern educational technology is being used.

In recent years, the dental profession and the Government have affirmed and reaffirmed their responsibilities for making comprehensive oral health services available to every segment of society. Large sums of money are being invested in comprehensive educational programs as a result of this attitude toward the need for more complete medical and dental care, more physicians and dentists, more productivity, and more and improved educational facilities. The ultimate success of these programs will be measured by the recipient—the patient. His reactions to the services he receives will be the criteria by which the profession's efforts will be judged.

Money alone will not solve our problem! If we are to succeed, individually and professionally, we must be willing to prepare ourselves for, and adapt ourselves to, the future. Continuing education addresses itself directly to this goal; effective continuing education must be made available to every dentist throughout his lifetime of practice. A practical continuing dental education system must be developed to link the frontiers of science with the realities of practice.

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This paper presented at a panel discussion "Continuing Education" at the American College of Dentists Forty-Eighth Annual Session, Miami Beach, Florida, October 26, 1968.

When viewed from the point of view of past experience, the development of an effective continuing education system for over 100,000 dentists scattered across the nation seems to be an educator's nightmare. Many frustrating factors come to mind, such as the lack of teachers, inadequate finances, the absence of an organizational framework within which to work, and an overwhelming variation in the needs of practitioners. Obviously, an educational system that is based on "turn-of-the-century" approaches cannot be used to solve our "space-age" problems. Methods of the past are neither efficient enough nor flexible enough to ensure periodic updating of the nation's practitioners.

Fortunately, new patterns in continuing education have emerged in the past decade as the result of work done by organizations such as dental schools, dental associations, the Federal Government's Regional Medical Programs, the National Library of Medicine, and the Division of Dental Health's Continuing Education Branch,* to mention a few. The question is—has this work changed our thinking or our attitudes about continuing education? Let's see:

1. In the past a dentist's education was considered complete except for special interests when he received his degree. Today, it is recognized that the dentist received his degree at about the midpoint of his educational needs, and that continuing education is a critical part of his professional career.

2. Continuing education, at one time, was considered the individual's problem. Now it is recognized as a problem for the profession as a whole.

3. Continuing education used to be considered in terms of the dentist's needs alone. Now concern for continuing education extends beyond the dentist to include his auxiliaries and other allied health personnel.

4. Not so long ago continuing education was considered a privilege reserved for a select few; those willing and able to travel long distances and spend substantial sums of money. Today, it is considered a necessity—every dentist must have an opportunity to participate, preferably at the community level and at a nominal cost.

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* Department of Health, Education, and Welfare, National Institutes of Health.

5. Years ago the planning of continuing education programs was often left to a single individual who was unfortunate enough to get himself elected as program chairman. He called and wrote everyone he could think of and then sighed with relief when he finally got a name associated with every program date. Consequently, if the needs of the organization were met it was purely accidental. Today it is common to find cooperative continuing education activities between dental societies, study clubs, and educational facilities such as dental schools, community colleges and local hospitals.

6. In the past many dentists were frustrated with continuing education activities because they didn't have any opportunity to express their opinions and needs. Today an effort is being made to obtain the opinions of dentists about continuing education so that more meaningful planning can take place. At long last the private practitioner is being directly involved in determining the nature of the continuing education activities which would increase his knowledge and skills, so that he may provide his patients with the best in modern dental care.

Both the medical and dental professions have recognized the practitioner himself as the best source of information regarding his own educational needs. Extensive surveys have been conducted to determine the physicians' needs, attitudes and opinions about continuing education. Recently a series of surveys has been conducted for the dental profession in Maine, New Hampshire, Massachusetts, Vermont, Rhode Island, Connecticut, and North Carolina to elicit the dental practitioners' opinions about continuing education in the Eastern portion of the United States; and for the Western dentists, surveys were made in Colorado, Montana, Wyoming, Idaho, and in Northern California. From the knowledge gained in these surveys, we can begin to see a picture emerge which will aid us in assuring continuing educational programs which will be dynamic and useful, not sterile.

Let's take a brief look at that picture:

1. Of the dentists queried, approximately 64 per cent responded. This is an unusually high return.

2. The data gathered indicate that approximately 90 per cent of

the dentists are willing to participate in continuing education activities.

3. The four topics ranked highest were: Crown and bridge, prosthetics, periodontics, and practice administration. Other topics ranking high were: general practice, endodontics, new techniques and materials, diagnosis and treatment of emergencies, pre- and post-medication, operative dentistry, oral surgery, and child management.

4. The most preferred education methods were: lecture, demonstration, participation, and seminar. Also ranked high were: clinics and closed-circuit television.

5. Most dentists preferred to attend continuing education courses during the fall and winter months and on Wednesday or over weekends (Saturday and Sunday).

6. Most preferred one- to two-day courses, although many said they would be willing to attend week-long courses. There were a substantial number that indicated they preferred one-day courses once a month.

7. While the majority felt that the dental society should sponsor continuing education activities, many felt that the dental schools should be the sponsor, and a few others indicated they preferred small group sponsorship such as study clubs.

8. The preferred location for continuing education activities varied widely, but the most commonly mentioned locations were: University or dental schools, hospitals or clinics, hotels, and community colleges.

9. There was general agreement that continuing education activities should be held within 75 miles of home, although the dentists in some communities were willing to travel up to 100 miles.

10. In the New England States, Northern California, Colorado, Wyoming, Montana, and Idaho, the three most popular ways of keeping up-to-date were through journals, continuing education courses, and society meetings. In Denver, society meetings and study clubs were the primary sources of continuing education, followed by periodicals and conventions.

11. In the survey of the dentists in Colorado and Wyoming, it was learned that society meetings and study clubs were most often used as sources of continuing education by dentists up to age 55.

Periodicals became a less important source of continuing education as the dentist grew older. However, after age 55, journals again increased in importance. It also was learned in this survey that the young graduate considers his own practice a very important source of continuing education.

12. Participation in continuing education activities varied from under 20 per cent to over 80 per cent, depending on the availability and accessibility of the activity.

13. The most frequently mentioned reasons for *not* attending continuing education activities were: 1. Not enough time; 2. Too far away; 3. Not offered; 4. Too costly; 5. Courses too long.

What are the implications here?

If dentists do not attend continuing education activities because they don't have enough time, they are too far away, or what they want is not offered; and

—if more dentists participate in continuing education activities when they are available and accessible; and

—if they prefer the activities in their own community, or nor more than 75 to 100 miles away; and

—if courses of one to two days in length given on Wednesday or weekends during the fall and winter are most popular; and

—if the educational needs of practicing dentists vary widely; and

—if the majority feels that the dental society or dental school should sponsor continuing education activities; then it may be concluded that what we need is a nationwide, coordinated continuing dental education system that:

1. will provide a sequence of one- to two-day comprehensive, well-organized programs and courses; which

2. are flexible enough to meet the diversified needs of the practicing dentist; and

3. are mobile and economical enough to provide a practical method of reaching the nation's dentists at the community level.

The implications here are that future continuing education systems should provide programs that are planned and presented as a continuum; that is, a continuous process with all elements carefully integrated and under coordinated leadership at all levels.

Some steps in the development of a system of this nature have been demonstrated to the profession and evaluated. Some self-

instructional methods, for example, have proven practical because of mobility, flexibility, economics, and adherence to established learning principles. In addition, certain self-instructional courses can be used by groups or by individuals. Thus far, the use of self-instruction which does adhere to established learning principles has been limited primarily to programed instruction. However, other self-instructional methods are being developed to include simulation, problem solving, case studies, and self-generated group discussion.

Furthermore, self-instruction can be adapted to a variety of media such as books, teaching machines, movies, slide-tape presentations, television, radio and computers.

The organizational and educational technology for developing a nationwide cooperative continuing dental education system is here today. It need only be adapted to dentistry's special needs. There is an urgent need for action—action aimed at cooperative planning among dental societies, institutions and agencies to provide the framework within which continuing dental education programs can be implemented.

And, action must be taken which will provide a dialogue with the practitioners themselves so their education needs will be met.

The question now is—are we, as a dental profession, going to exert our organized efforts and strength so that continuing dental education will move in the direction of better oral health for every segment of our society? Or, are we going to continue merely passing resolutions and going on record as favoring continuing education—then sit back, self-satisfied, until public demands for more comprehensive oral care become so strong that state legislatures, one-by-one, force us to act?

Administration and Evaluation of Continuing Educational Programs

BEN D. BARKER, B.S., D.D.S., M.Ed.*

I AM confident that I can provide very little that is new or useful to this particular audience regarding the administration and evaluation of continuing education programs. Many of you have had far more practical experience than I in these activities. Nonetheless, I have accepted this assignment because I believe our combined experience to date appears to give us little more than a philosophical basis for the planning, conduct and evaluation of continuing education in the future.

As you have heard this afternoon, there are new forces and pressures for continuing education directed to the profession. In addition, we are gaining new insights into the dentist as a professional, particularly his attitudes, his habits and his motivation toward continuing education. Consideration of these and other factors lead us to conclude that provision for the continuous professional renewal of the nation's dentists will require some drastic overhauling of our present delivery system.

The achievement of this goal presumes an expansion of the entire system of continuing dental education along certain lines. We must expand the continuing education opportunities for practicing dentists. There is a need for more geographically accessible courses which are scheduled to minimize conflicts with individual practice requirements.

We must expand the continuing education curriculum, employ different methods and media for its delivery, and we must expand the faculty and associated staff involved in the production of these programs.

We must increase the total professional participation in the

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process by direct involvement of appropriate dental societies, health agencies, hospitals, community colleges, schools of dentistry and practicing dentists.

Our conventional administrative approach to continuing education will not produce programs of this scope and magnitude. The 19th and early 20th century dental student purchased a series of course tickets for his undergraduate dental training in surgical technique, metallurgy, materia medica and so on. Today dental educators urge the importance of learning by doing, problem solving and realistic laboratory experiences to mention a few. The student is said to be the focal point of instruction and we generally scorn the educational practices of 50 years ago. But the modern-day practitioner frequently receives his instruction in the evening, fatigued from a full day's work and a 50-mile drive to hear a lecture, often poorly delivered.

Curiously, the five, ten, or 50-dollar course ticket is a major feature of our "modern" postgraduate course in dentistry. Why is a system, long since rejected as an appropriate means of educating dental students, the predominant practice in continuing education for practitioners? Is the grip of tradition so strong that little change in our approach is possible? All too frequently, the change that occurs in our individual institutions and dental societies with respect to continuing education is not very systematic or carefully planned, but appears largely as the result of imitation, opportunism, or pressure from special interest groups.

There are encouraging signs on the horizon, however. Some schools and dental societies in cooperation with the United States Public Health Service are making advances in the application of current communications technology and the science of learning to the problems of continuing education. However, these are but segments of the administrative considerations essential to the achievement of our presumed goals.

In general, the purpose of administration is to get something accomplished. The accomplishment we are seeking is some change in the practicing professional which will be translated into a better health service for those under his care. Hence, in planning for continuing education, our overriding emphasis should be on what happens in the student's mind, not what the clinician-

teacher does or thinks; on what our student does as a result of his experience, not whether we utilize television, present an illustrated lecture, or sponsor panel discussions. In this framework, learning becomes the key consideration, not instruction. Who should plan continuing education? Student-centered programming will require modification of our approach to planning. All too often, the program chairman, the program committee, or the responsible dental school administrator will announce this or that course or lecture a few weeks in advance. This procedure is often followed by cancellation due to insufficient enrollment or comments about the same old faces in a disappointingly meager audience. The object of our efforts is thus the most frequently overlooked in planning, but on his shoulders rests more than his share of the failure of the system. What is wanted and needed is the joint involvement of all parties in the planning process, particularly the consumers of instruction, whether it be planning for national, regional or local programs. The dental practitioner is in the best position to comment on desired courses, to define areas of critical need, to recommend scheduling, to estimate interest, and knowledgeably discuss the educational level of his society.

The weakness of relying solely or largely on outside experts for these determinations and leadership has been recognized for many years in other educational endeavors. The continuing education problems of each dental society can be most satisfactorily solved by extensive participation of the local membership. Moreover, dental societies and dental auxiliary at all levels can and should assume increasing responsibility for the administration of continuing education over and above the customary sponsorship of monthly or annual meetings. Finally, dental schools and other health agencies (e.g., hospitals) are valuable resources in planning, but the initiative properly resides with the organized profession.

The ideal plan for continuing education perhaps will never be developed, but those ultimately charged with this responsibility must inevitably make certain determinations if student-centered instruction is to be their means and learning their ultimate goal. There is a certain logical order to this process which involves initially the identification of the student population. Are these prac-

titioners in urban or rural areas? How many are there? What is the general character of dental practice represented? What is their availability? How widely dispersed are they? What continuing education experience have they had? What is their preference in programs? In methods? What is their attitude toward further study? These and many other factors will be critical determinants in developing educational objectives for the programs.

Most teachers and practitioners rebel at the prospect of developing educational objectives. The task is not overly complex, but is absolutely essential if we are to have any hope of subsequently evaluating our efforts. Simply stated, what do we want our students to do or be able to do after they have participated in the program? Is it desirable that practitioners increase the use of topical fluorides in the communities they serve? Do they wish to increase practitioner awareness and hence earlier diagnosis of oral cancer? Do we wish to increase the utilization of new and better restorative materials and techniques among this group? Are these particular dentists penalizing themselves for lack of further information on the availability of pre-payment plans? Each of these examples would obviously require a different set of circumstances: different faculty, perhaps a different instructional method, even a different facility.

Once objectives are defined for a given interval, curriculum designed (i.e., which courses, the number of courses, their sequence, continuity of subject matter, and so on) the site and needed facilities can be selected, faculty requirements may be set and teaching method determined. Whether to employ group or individual instruction, media selection, and other questions have a way of answering themselves if we clearly know who and where our students are and precisely what we want them to learn.

The intention here is not to oversimplify the resolution of complex problems. It is suggested that a systematic order of developing continuing education flows from consideration of "real life" needs on the part of the dental practitioner to the selection of meaningful learning experiences which respond to this need. How much better this basis for planning than the arbitrary design of a course or selection of programs based on such principles as the personal interest or acquaintance of the program chairman, which clinician has "national stature" and is a drawing card, which

clinician is available, what subject the dentists like best (frequently a valid consideration) or "we have not had this or that specialty featured in a long while."

A word of caution about methods and media. The dental profession possesses no immunity to "methoditis," an inflammation of judgment center, characterized by acute episodes when certain individuals, approximately 35 per cent of all teachers and practitioners, see or hear of new educational communications devices. Associated pain is alleviated by purchase of the device at public or private expense. While no cure is known, the disease is generally controlled by applications of Traditional Ointment, liberally applied by the other 65 per cent of the population under study. Many people become excited over closed circuit television or some other communications mechanism. If we use closed circuit TV to simply deliver additional lectures, we have gained very little other than perhaps the ability to reach a larger audience, so we must select in terms of the needs of the intended program and student group.

Fundamental decisions on content and method are rarely made on the basis of tradition alone. However, long established content and practices are, or should be, subject to just as penetrating scrutiny as proposals for change. A long history of acceptance is not enough by itself to hallow either content or methods. But our methods must change if for no other reason than the shortage of teaching manpower available for continuing education. Any new system which enables us to provide more instruction utilizing the existing teaching force warrants serious consideration.

Appropriate evaluation of continuing education generally implies three distinct functions, program evaluations in terms of the broad goals outlined for the entire program, course evaluation, and participant or student evaluation.

Program evaluation will relate to the objectives outlined by the planning group. These might be goals similar to the proposals presented in the early sections of this paper. If our objective is to increase educational opportunities and increase participation, then measurement and evaluation will be directed to this end. Overall acceptance by those enrolled in the program is a component of this function. Cost feasibility is another.

Perhaps more critical and infinitely more difficult is evaluation

of our educational objectives as they relate to the students or participants. If we state what we expect participants to be able to do, then we have defined certain anticipated outcomes. Most practitioners are loathe to submit to testing procedures reminiscent of their undergraduate days. However, brief inventories eliciting changes in practice habits, adoption of new techniques or other information can be secured. Again, it should be pointed out that the involvement of practicing dentists in the total planning of the program will result in a better understanding of the necessity for evaluation and more favorable attitudes toward acceptance.

Without evaluation there is no orderly or consistent means of improving instruction. The perennial question addressed to any instructional program should be, "how well is the program doing and what it proposes to do?" Before a teacher can approve his work to any great extent, he needs to know the extent to which he has achieved the objectives of his teaching. Evaluation is not a lock step procedure. On the contrary, it is a continuous process of developing techniques, gathering evidence, and interpreting evidence in terms of the objectives of the program and modifying future activity accordingly.

In addition to providing selected faculty for the system, dental schools can and should provide leadership in planning for evaluation of the continuing educational program. The plan should be worked out and agreed upon by the sponsoring society or agency in consultation with representatives of the participants to be served. Several measurement techniques are available or can be developed to accomplish evaluation of continuing education programs. Finally, an essential aspect is student evaluation. No program of continuing education can be completely evaluated without considering the opinions of students currently enrolled. These opinions throw important light on the true picture of the program which can come from no other source.

Why do we need all this talk of objectives? Why bother with evaluation of practitioners? Why not present better courses, better speakers? Why not organize things so that the practitioner loses less time from his practice? Why not get on with more good programs and less talk? And who will pay for all this additional activity?

The answers to these questions raise other questions. If roughly 15 to 20 per cent of the profession routinely engage in continuing education, what are the implications for 100 per cent participation, an emerging possibility? Where are the teachers to be found? Where will we do this? Indeed, we cannot supply this need with existing faculties and resources. And why continue this needless duplication of effort?

Why evaluate? Because the profession must direct its attention and energies to quality control of continuing education—not so many annual hours of exposure. Quality control is gained by carefully planned and precisely conducted evaluation procedures. Moreover, better methods and improved systems may well be more economical, especially from the standpoint of what is learned.

How will we pay for it? To rely on federal funding is problematical, since the present thrust is experimental or a search for "innovation" and funds are severely limited. This cannot be considered as a major resource to attack the problem of continuing education in dentistry on a broad base without an entirely new program of legislation. Vast federal support for continuing education is neither possible nor desirable at this time.

Of course, state schools may be able to ask for budgetary assistance, as many are, for continuing education. If the school's "role" can be cast in the proper light, these requests have a chance. But our schools are obligated to direct their major interest and efforts to replenishing and increasing the nation's dental manpower.

It is my opinion that a well designed continuing education "course" using appropriate media delivered to the properly selected group at the appropriate time and place would not be any more expensive to the practitioner than the present unstructured, hit and miss approach. Possibly a "redirection" of resources could accomplish much of the task. Dental societies often have ample resources—the problem is to use them in the most effective manner.

Each state, through its legislature, grants the dental profession the power to conduct its own affairs. In effect we have had a franchise from the public to do as we please within reasonable limits. Assuming we can all agree that we are responsible for the dental health of the public in return for this trust; and, assuming we all agree that continuing education is the best means of

maintaining and improving the capacity of the profession to render care, then our fiscal responsibility is clear.

In summary, there has been no attempt to provide a blueprint or administrative flow chart for planning and conducting continuing education programs. On the contrary, I hope that I have conveyed the proposition that administration should be the servant of instruction. The approaches taken will vary in each state or area according to the particular needs and resources available. Whatever the area or resources, we should:

1. Reappraise our present system of continuing education.
2. Increase the involvement of practitioners in the planning process.
3. Clearly define our objectives in the future programs.
4. Emphasize quality, not attendance by appropriate evaluation of our programs.
5. Coordinate the efforts of schools, societies and other agencies in the process, and;
6. Assume our professional and financial responsibilities in this area through our organized societies.

I would like to conclude by reading a brief quotation from John Amos Comenius, 1657, in Amsterdam.

The solution we are seeking was better said by John Amos Comenius. To paraphrase him:

> "Let the main object of this, our Didactic, be as follows: To seek and to find a method of instruction by which teachers may teach less, but learners may learn more, by which schools (courses) may be the scene of less noise, aversion, and useless labour, but of more leisure, enjoyment, and solid progress; and through which the . . . community (of dentists) may have less darkness, perplexity, and dissension, but on the other hand, more light, orderliness, peace and rest."*

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* John Amos Comenius, The Great Didactic, Amsterdam, 1657.

Qualifications of Dentists Under the New York State Medicaid Program

DAVID B. AST, D.D.S., M.P.H.*

TITLE XIX of the Social Security Act otherwise known as "Medicaid" requires that each state participating in the program undertake steps to insure high quality of medical care and health services to those eligible for the benefits of the program.

The state law implementing Title XIX gives to the state department of health the responsibility to administer and supervise the medical care and health services furnished under Medicaid.

The state law provides for the establishment of a comprehensive program of Medical Assistance for needy persons so as to assure a uniform high standard of medical assistance throughout the state.

The Health Department acting to carry out its responsibilities under the federal and state laws requires continuing education standards for all providers of medical care who wish to participate in the Medicaid program.

This includes physicians, dentists, podiatrists, optometrists. They must meet continuing education standards.

The Health Department's Counsel in a memorandum of opinion regarding qualifications of dentists participating in the Medicaid program declared: "It is the opinion of the Counsel that the Legislative mandate that high quality standards be promulgated by the Health Department includes the specific authority to certify standards for professional practitioners providing services to needy persons."

The ADA in its Official Policies on Dental Health Programs ap-

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proved by the House of Delegates in 1955 states, and I quote from page 73 of these Policies:

> No. 5—Care provided in tax-supported personal health service programs for the needy should meet as high standards of quality and adequacy as can reasonably be made available to others in the community. *Such standards should be professionally determined by the administrative agency in cooperation with representatives of the professional group concerned.* (Emphasis added.)
>
> No. 6—Persons eligible for service should have the opportunity to receive care from a family physician, dentist or clinic of their own choice, *selected from among those accepted as qualified by the agency responsible for the program.* (Emphasis added.)

Dr. William E. Brown, Jr., professor of dentistry at the University of Michigan, said in a discussion of compulsory continuing education before the State Secretaries Management Conference of the ADA in Chicago in June 1967 that " . . . if service to the public is the primary concern of the profession then every dentist should keep his knowledge current or he may become a liability. Compulsion may be a small price to pay for improved service. . . ."

The National Advisory Commission on Health Manpower in its report of November 1967 to the President noted gaps in the distribution and quality of health care and proposed "Professional societies and state governments should explore the possibility of periodic licensing of physicians and other health professionals." Such licensure would be granted "either on certification of acceptable performance in continuing education programs or upon the basis of challenge examinations in the practitioner's specialty."

The Department of Health which assumed its responsibilities in October 1966 invited the Dental Society of the State of New York in November 1966 to explore the possibility of the Society cooperating with the Department in establishing and maintaining the standards for qualifications for dentists participating in the Medicaid program. The Department was prepared to give the Society a grant to offset any costs to the Society in carrying out these functions. Time does not permit a discussion in this presentation of many meetings, conferences and communications we have had with the Society.

The Health Department has given ample and conclusive evidence of a desire to work in concert with the Dental Society in de-

veloping standards of continuing education. Responsible officers and leaders of the Dental Society have been frustrated by forces and individuals within the Society in their efforts to reach agreement with the Department in jointly establishing and maintaining qualification standards.

At the December 1967 ad interim meeting of the Board of Governors, the President of the State Dental Society commented and I quote from his letter, "I deeply regret that the Executive Committee's actions of September were rescinded. Two subsequent sessions of the Governors have only confused and negated their positive action. By now it would have been possible to have our 'Foundation' operative, in office space of its own, controlled by the Board of Governors as its directors with a director whose main activity would be along 'Continuing Education' activities; this all would be under contract from State Department of Health and no expense to the Dental Society of the State of New York."

He further stated "Here we are five months later, nothing has been accomplished, our members will be unhappy with the methods set up by the resolution. The Secretary is burdened with additional tasks, which he does not need.

"Frankly, I think we are avoiding responsibility, procrastinating and not acting in accordance to our professional stature."

The Department therefore established its own standards. If a general practitioner is an active or attending staff member at a hospital holding a valid operating certificate from the New York State Department of Health or if he is an active member in good standing of the Academy of General Practice, he is automatically qualified. Otherwise, he must give evidence of completion of 75 hours of continuing education over a three-year period based on standards approved by the Commissioner of Health. One third of these 75 hours must be completed within one year prior to approval.

In August 1967, the Commissioner of Health wrote to every dentist in the State advising him of the regulations and advising him that "This Department will do all that it can, working in cooperation with the Dental Society of the State of New York, to make it possible for all dentists to meet these requirements with as little

difficulty as is possible." The deadline for qualifying was April 1, 1968.

On November 15, 1967 the Assistant Commissioner for Health Manpower sent each dentist a form for Identification of Qualifications of Dentists who wish to participate in the Medical Assistance Program.

The Department was still hopeful that the Society would want to evaluate these standards for the dentists in New York State but following the December 1967 ad interim meeting of the Board of Governors it was evident that the Department of Health would have to carry the ball unilaterally.

Because of the delays in arriving at a modus operandi the effective date for qualifying was extended to October 1, 1968.

In the meantime, two district dental societies have recently brought suit to enjoin the Department from implementing its continued education requirements.

As is usual in such circumstances, the Court issued a temporary injunction, pending its decision on a permanent injunction, until the case is adjudicated. This injunction relates exclusively to the second and tenth district dental societies' members.

All other dentists in New York State must comply with the established regulations if they wish to treat Medicaid eligible patients and to be compensated for these services.

I am sure that there are many aspects of this which I have not been able to cover with you and I shall be happy to try to elaborate during the discussion period.

How Does the Academy of General Dentistry Rate Courses?; How Does It Give Credits?; How Does It Cooperate With Groups That Sponsor Courses?

S. SOL FLORES, D.M.D., D.D.S.*

THE objectives of the Academy of General Dentistry as originally presented 16 years ago, was to promote and encourage continuing education.

The requirements for membership were to have a minimum of 50 hours of accredited postgraduate education within a period of three years in order for one to maintain his membership.

Five years later it was felt that this 50 hours should be increased, and the Board of Directors of the Academy soon provided a program known as the Fellowship Program after completion of 500 credit hours.

Very recently, the Academy has also sponsored a Mastership Program which, in addition to the 500 allocated hours for the Fellowship Program, would have an additional 600 hours of formal postgraduate education.

Now, how does this work? How does the Academy of General Dentistry rate courses?

Lectures and courses attended for credit toward maintaining membership and toward credit for Fellowship and Mastership are either, one, informal; two, formal; three, miscellaneous, and four, teaching and publications.

Now, the informal; these are courses or lectures given by dental school faculty members outside the university or dental school on an extension basis.

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These comments presented at a panel discussion "Continuing Education" of the American College of Dentists Forty-Eighth Annual Session, Miami Beach, Florida, October 26, 1968.

This also includes the lectures and courses given by other than members of the dental school faculty which are sponsored by dental societies, dental study clubs.

The lecturer or the essayist must, however, be in the approved listing of the Academy. This may include retired members of the dental school faculty and members who are designated on a yearly basis.

The formal courses; these are primarily the courses offered by the universities. These courses must have specific relationship to dental education, to dental research or dental practice.

Miscellaneous programs are specific categories not listed above. For example, hospital internship training and armed forces internship programs are evaluated by the accreditation committee of the Academy.

The teaching and the publication part of this Academy are also recognized. Lectures, clinics, publications given by Academy members are appropriately evaluated on an individual basis by the accreditation committee.

These are subdivided into research papers and others related to dental practice and dental education.

The second question that I am supposed to answer this afternoon is: How does it give credit? A clock hour course constitutes an accredited hour provided the lecture or subject is taught at an approved dental school, medical school, national, state or local dental society, or hospital teaching institution.

Qualified dental school faculty members are accredited lecturers and clinicians in addition to the approved listing of the Academy.

Now, to simplify our bookkeeping, the recording of accreditation hours is as follows: Group one will consist of the formal studies in basic or clinical sciences.

Group two includes the hospital attendance under university affiliation, teaching full time or part time in a dental school and lectures given by its members and also the articles that have been published.

Teaching full time or part time is accepted for membership as Fellowship.

For nonfaculty members, the Academy credits six hours of each hour lectures, which means five hours for preparation, plus one hour of its delivery.

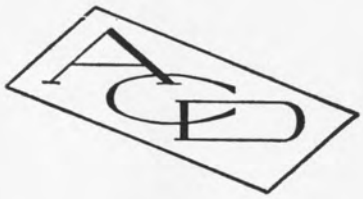
In the case of a repeated lecture, an hour's credit is given.

Every year the academy issues cards to its members which simply indicate the lectures, the location and the lecturer, and it is specified that the lecturer must sign this card, so when it is submitted to the National Office in Chicago, this is recorded in the index file of each individual member.

In Philadelphia, they are doing this now with the IBM machine.

The third question that I have is: How does it cooperate with groups that serve as auspices for courses? These groups are, of course, the usually established study clubs with limited membership, and the Academy has issued an unlimited number of invitations for membership to the Academy.

At the same time, the Academy has encouraged each member of these societies and clubs, to take postgraduate education whenever possible, and finally gain credits for courses taken by the members of the Academy if the lecturer is an accredited faculty member.



What Is the Position of the American Association of Dental Examiners on Continuing Education as a Requirement for Re-licensure?

JOHN E. DALTON, D.D.S.*

SINCE the American Association of Dental Examiners is even now in session—the 85th annual meeting—let me give you the resolution passed last year, which expresses the composite thinking of its member agencies:

> WHEREAS, Public dental health programs are in some instances requiring continued education for participation and reimbursement in these programs; therefore, be it
>
> *Resolved,* That the member agencies of the American Association of Dental Examiners are urged to begin immediately studies of the problem to prepare the entire profession to meet possible future requirements.

Since this resolution is from the members of the American Association of Dental Examiners, it reflects the thinking of people who are responsible by law to protect the public health, safety, and welfare of all of the people in their jurisdiction. The awareness of the legislative problems in their individual areas . . . the awareness that only by legislative prerogative do we hold the monopoly to practice dentistry, . . . makes this composite resolution most meaningful in the study of this subject.

Discussions on continuing education are found in the deliberations of this group for many years just as it has been the topic of discussion and debate within the American College of Dentists for years.

To bring you some insight into the current thinking of the individual agencies making up the American Association of Dental Examiners, we polled them during this past month just for this

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* Dr. Dalton is a member, Florida State Board of Dentistry, West Palm Beach, Florida.

These comments presented at a panel discussion "Continuing Education" at the American College of Dentists Forty-Eighth Annual Session, Miami Beach, Florida, October 26, 1968.

occasion. Let me express my gratitude to them that 42 agencies out of 53 responded within a three-week period.

I think that Dr. Darby would agree that this is a pretty good return. Let me summarize this, which is not to be construed as an official opinion of our Board or the American Association of Dental Examiners, but rather as background information to further clarify the total study of continuing education.

On the question: "Does your state now require any continuing education as a prerequisite for relicensure?" All said "no."

When asked if they thought that such a requirement would be instituted in the foreseeable future, approximately 25 per cent *did* anticipate it would, and when asked if they foresaw any great difficulty in its administration, about 85 per cent did expect problems.

Most boards stated that they would, under our rules and regulations, have to set the standards of continuing education, but that they would look upon guidelines or standards set elsewhere as useful in establishing their own.

On the question of whether or not continuing education was successful in their state on a voluntary basis, the answers were varied, but it is obvious to deduce that certainly it is far from perfect.

Also, this reflects the response to the question as to whether the distribution of these programs was adequate geographically.

Most states also felt the clinical facilities for continuing education programs were limited for all their practitioners.

Now, the question that drew the most response in regard to side comments was: "What is the consensus of your board in whether continuing education should be voluntary or by legislation?" At this time, a little more than two thirds of the responding agencies felt it should be voluntary.

A few states, however, are actively discussing means of implementing programs through legislative means. Just what overall direction will be seems to be obscure and will remain so until many of the problems are solved or clarified.

The brevity of the report in no way indicates the tremendous amount of study that individual boards and the AADE have given this subject, but specific positions have not as yet jelled in many cases.

What Is the Attitude of the American Association of Dental Schools on Continuing Education as a Requirement for Re-licensure?

CHARLES A. McCALLUM, JR., D.M.D., M.D.*

CONTINUING education can be added to the cliche about home, country and motherhood as things to which most of us subscribe, including the American Association of Dental Schools.

With respect to continuing education and licensure, the AADS has simply endorsed the position of the Council on Dental Education of the ADA. I shall leave the nuances of the ADA's position for Mr. Sullens to discuss.

I would like to comment on licensure as it relates to dental education and then conclude with a few remarks about re-licensure.

None of the following statements have official status. The thoughts are mine and they partially delineate some of the parameters of the problem. They indicate only a few of the issues that ought to be debated.

Historically, there is evidence that licensure and health professions accompany the development of professional educational institutions, and that the initial pleas for licensure and the establishment of standards and regulations were usually initiated by practitioners in a profession rather than by the consuming public.

Dental schools stood to profit by the elimination of preceptorships. History offers proof, too, that deaning or, more correctly, ownership of a dental school was indeed profitable—once upon a time.

Times have changed. For one thing, dental schools are no longer

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* Dr. McCallum is Dean, University of Alabama School of Dentistry, and President-Elect, American Association of Dental Schools, Birmingham, Alabama.

These comments presented at a panel discussion "Continuing Education" at the American College of Dentists Forty-Eighth Annual Session, Miami Beach, Florida, October 26, 1968.

money makers. For another, the conditions which created demands for licensing laws at the start no longer exist.

Thus, 17th and 18th century laws are not the solution for 20th and 21st century problems.

Moreover, dental schools of today, as genuine members of the university family, are of the highest quality ever. So is the quality of the average dental student.

Although the ability of the neophyte varies, it makes little sense to examine him only at the peak of his academic training. Whether he knows a given amount of subject matter at the time of examination in no way ensures anyone that he will have that knowledge a month, a year, or a decade later—if indeed, the knowledge is worth having a decade later.

Most everyone recognizes that the knowledge explosion assures that about half of what a student learns today will be obsolete ten years hence.

The indefensibility of current licensure practices is compounded by the fact that they act as a barrier to innovations in the undergraduate and graduate education of dentists.

Equally obstructive, they retard innovations in new uses for new kinds of manpower and new patterns for delivering dental care.

Because access to the best attainable dental care is rapidly becoming a national political right of the American people as a result of their effective demands on Congress and the states, there is need to consider development of a national common health market—of high quality health service. This is to say that 50 state boards with 50 philosophies and procedures not only limit manpower movement but also guarantee unequal standards.

By sheer application, it might be possible to obtain uniform quality standards through the separate practice acts of the 50 states or through federal standards which could be promulgated pursuant to the provider-certification mechanisms under the several federal laws.

The latter possibility, federal standards by fiats of state health or welfare agencies, appeals to no one in the professions, including me.

In the long run, even a single national standard seems threatening, for eventually it could become inured toward change also.

As for re-licensure, a basic problem exists: just because a practitioner has knowledge of certain research, therapeutic measures, and so on, does not mean that that knowledge is or will be applied.

Nonetheless, the principal objective of continuing education as the basis for re-licensure is to favorably influence attitudes, knowledge and performance. Continual study ought to be made easy, as well as economically and ethically attractive.

Good judgment and common sense indicate that the application of a re-licensure system to all dentists effective at a given time will create many unnecessary objections.

More reasonable is a plan that will exempt all present license holders and begin by awarding future graduates a license for a limited period, say seven years, after which time they will have to show proof that they have kept up.

Assuming that a minimal number of hours of instruction is to be required annually between requalifying dates, great care must be taken that all qualifying educational experiences are the responsibility of, and are given under the aegis of bona fide educational institutions.

It is time to do away with the pseudoscientific teachers of questionable ethics.

Dental schools should not be expected to assume the financial burden of the teaching load associated with re-licensure. Such programs should be self-supporting; course offerings, and the time when they are available should encompass a wide variety of choices. The same thought applies to the places where the teaching is accomplished. In short, every effort should be made to offer the professions attractive continuing education packages.

Finally, it seems self-evident that continuing education will never come into its own, will never be much more than a frill, and will never reach a large proportion of practitioners, without a system that puts a premium on maintaining professional excellence.

What Is the Present ADA Situation?; What Will It Ask the House of Delegates to Do With Pending Resolutions to Be Submitted?

REGINALD H. SULLENS, M.ED.*

THE degree of importance attached to continuing education by the American Dental Association is, I believe, illustrated clearly by the fact the very first section of the PRINCIPLES OF ETHICS contains the following statement:

> Every dentist has the obligation of keeping his knowledge and skill freshened by continuing education through all of his professional life.

In one form or another, this ethical precept has been supported by the American Dental Association since its founding.

More recently, particularly since 1966, the Association has been concerned with the establishment of more specific policies related to continuing education and will be so concerned during the session of the House of Delegates which begins Monday.

In 1966, the attention of the House of Delegates was called to the proposed regulations related to the participation of dentists in publicly funded programs (Title XIX) in the state of New York, as has been described by Dr. Ast earlier in this panel discussion. As a result of this concern, a resolution was presented to the House of Delegates which, after discussion and revision by the House, was adopted in the following form:

> *Resolved,* That the American Dental Association support the position that the determination of the qualifications of the individual dentist participating in publicly funded health programs should be the prerogative

* Mr. Sullens is Assistant Secretary for Educational Affairs and Secretary, Council on Dental Education, American Dental Association, Chicago, Illinois.

These comments presented at a panel discussion "Continuing Education" at the American College of Dentists Forty-Eighth Annual Session, Miami Beach, Florida, October 26, 1968.

of governing bodies of component and constituent dental societies and state dental examining boards.

In the following year, 1967, the Council on Dental Education presented to the House of Delegates a "Statement on Dental and Dental Hygiene Licensure" which included a recommendation that constituent dental societies, in consultation with state boards of dentistry, should take immediate and aggressive steps to develop mechanisms to insure the continued competence of all dentists licensed in their jurisdiction.

It was further suggested that such steps might include consideration of requiring continuing education for licensure renewal under provisions developed within each of the individual states.

This recommendation was debated extensively by the House of Delegates, with the final result that the recommendation of the Council was recommitted for further study and report to the 1968 House of Delegates.

The report of the 1967 Reference Committee on Dental Education and Hospitals supported the desirability of dental boards and constituent dental societies developing mechanisms to insure the continued competence of dental practitioners but expressed concern about the suggestion that continuing education be considered as a condition for licensure renewal.

During the past year, the Council on Dental Education considered the subject of continuing education at both of its regular meetings and reaffirmed the importance of the American Dental Association's adopting a policy which encourages agencies of the dental profession to develop programs that will help assure the continued competence of dental practitioners. The Council has, therefore, submitted the following resolution to the 1968 session of the House of Delegates:

This is essentially the same resolution that was recommitted last year:

> *Resolved,* That state boards of dentistry, in consultation with constituent dental societies, are urged to develop mechanisms to insure the continued competence of all dentists licensed in their jurisdiction.

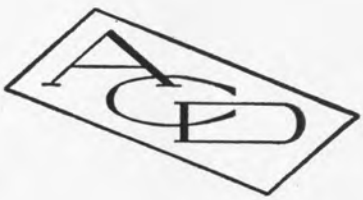
It was apparent during the 1967 session of the House of Delegates that a substantial part of the concern of the House of Delegates about the recommendation on continuing education resulted

from the suggestion that the agencies which must ultimately administer a program of continuing education—that is constituent dental societies and state boards of dental examiners—might consider a requirement of continuing education for licensure renewal.

In its 1968 annual report, the Council attempts to clarify this issue with the following statements:

> The Council feels strongly that the final determination of the requirements and procedures to be utilized by agencies of the dental profession to promote and assure continued competence must be the responsibility of state societies and dental examining boards. It should be the prerogative of the boards and constituent societies to determine the amount of continuing education that should be expected of the practitioners in their states. It should be their prerogative to decide whether continuing education should be required for licensure renewal.
>
> It should be their prerogative to establish the effective date of any continuing education requirement and to set the policies needed to administer a program equitably for all licensed practitioners in their jurisdictions.

The determination of the mechanism to be used and the resolution of the many problems, and there are many, many problems which are clearly inherent in the development of a professionally guided program, are left to the discretion of the agencies which have this responsibility, but the Council on Dental Education feels that the profession must express its support of this policy and we hope the House of Delegates will express such support this year.



What Is the Consumer's Viewpoint?; Should He Have a Voice in Program Planning?

JAMES P. VERNETTI, D.D.S.*

AS the panel was lunching today in preparation for this meeting Dr. Brandhorst put his hands on my shoulders and said, "Jim, you are going to speak for the consumer. I want you to give them Hell."

Dr. Brandhorst was sincere in wanting the viewpoint of the general practitioner fully presented. I humbly accept the assignment.

My illustrious colleagues on this panel have vividly pointed out the need for the subject on which we speak, the administration and evaluation of same, the legal pitfalls and pressures, and the attitudes of various dental organizations toward continuing education.

My assignment is to present the role of the general practitioner. Since the need for continuing education for all dentists has become fact and should be a way of life it is only logical that the biggest consumer, the general practitioner, have a say in the program.

Presently, continuing education in dentistry is mostly on a voluntary basis, but the future may reveal a different picture because of federal, state and, I add, dental service plans.

The future of dentistry may be at stake, so naturally it behooves every dentist to give serious consideration to constantly improving his ability.

These are not just idle words. We have heard the story about the New York State Medicaid program.

Let met tell you of the situation occurring in the state of Cali-

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* Dr. Vernetti is a General Practitioner, Coronado, California.

These comments presented at a panel discussion "Continuing Education" at the American College of Dentists Forty-Eighth Annual Session, Miami Beach, Florida, October 26, 1968.

fornia: There is a bill before our legislature which would allow persons trained in the healing arts who have graduated from foreign schools and are licensed in a foreign country, to take the California licensing examination.

This bill is being pushed by the Philippine Dental Society of California, the Philippine American JC's, the San Francisco City and County Employees Unions, the Spanish-speaking Unity Council of Alameda County, NAACP and others.

You may ask: What does this bill have to do with continuing education?

The answer is only an indirect one. The proponents of the bill make the point that many dentists in California passed a licensing examination 30 or 40 years ago and since that time they have had no reason to show further proof of their competency.

Would not a more recent graduate, even from a foreign dental school, be as capable? Remember, this reasoning is being directed to lay people, not to members of the profession who know better.

Organized dentistry would be in a more favorable position if we could add to the state board examination a requirement that each dentist must take "X" number of hours yearly in recognized postgraduate work. We would then have a strong case, and I am convinced that we would be the envy of all here and abroad.

I prepared this paper some time ago, and just last Sunday, as Dr. Moxley has told us, I read in *Parade* magazine, which has national distribution, the following:

> "The Oregon Medical Association recently became the first state medical society to require continuing education for its members. . . .
>
> The trouble with many physicians today, especially in small towns far removed from educational centers, is that they still practice the type of medicine learned 20 and 30 years ago."

I have spoken with many dentists about postgraduate education even before I was assigned to this panel, and my conclusion would be that most of them favor the idea of voluntary continuing education as a requisite for continuing licensure, and they are very enthusiastic about it when they learn the story that we have heard here about the New York program and many other situations.

However, very few of them are in favor of a reexamination.

Now, to the second part of the question: Since the general prac-

titioner is the biggest consumer it is only logical that he should have a say in the programs planned in continuing education.

The complaint heard frequently is that the courses fall by the wayside because they do not appeal to the practitioner.

Naturally all of us have our certain likes and dislikes; and those we most enjoy are the courses in which we usually enroll. I have found the courses offered to be varied in content so as to appeal to the big majority of dentists.

However, it is interesting to note that practice management most generally draws the largest audience.

In the past six weeks, without any solicitation, I have received notification of courses from five different sources.

They came from New York University, the University of Southern California, the University of California Extension, Loma Linda University, and the Academy of General Dentistry, and included courses all the way from Alabama to Michigan, and from New York to California. The subject matter covered gold foil, x-ray, restorative dentistry, periodontia, etc., etc.—you name it!

Add to this one's own local society postgraduate courses, and one has a multitude of subjects from which to choose. The material is available but are dentists taking advantage of the opportunities?

I would say the answer is "No."

The check in our area shows that in three organizations that offered courses, on the average, not over 10 per cent of the dentists participate. The Survey of Dentistry points out the rather deplorable fact that only 8 per cent of our dentists attend courses offered through continuing education programs or dental schools throughout the United States.

These statistics do not even take into consideration the repeat participants, which could make the figure even more depressing. Of course I know that in cases where there is much publicity and stimulation, you might find the participation higher than 10 and maybe even 20 per cent, but what we are talking of here is something that should be nearly 100 per cent.

My colleagues mentioned that they would need more teachers, and there is no doubt about that. I am involved on a part time basis in a teaching institution, and I know the difficulty in getting competent teachers. However, part of the answer could be in the

increased class enrollment. Would it not be just as easy for an instructor to talk to an entirely filled room as to one just partially filled?

We can overcome the problem of teachers for I am sure there would be many general practitioners who could become excellent teachers with just a little bit of motivation. This motivation could come, as Dr. Flores mentioned, by giving credit for teaching as well as taking the course.

It might be of value to enumerate the opportunities offered in our San Diego area, even though it is somewhat isolated. The educational committee of the local dental society, offers a six-hour course each month from 2:00 o'clock until 5:00 o'clock in the afternoon, and from 7:00 o'clock to 10:00 o'clock in the evening with time out for dinner and discussion with the speaker.

The cost is $25.00 and covers subjects primarily on the clinical and technical sciences. Practice management is also included here.

A second group, the San Diego Dental Seminar was formed some 12 years ago. This group is not under the auspices but has the sanction and approval of our local dental society.

The courses offered here are primarily the motivation, human behavior, and biological sciences.

These courses are offered once a month and cost $20.00 per six-hour course with a $20.00 a year registration fee. At the end of the year, regular members are given a bonus course at no cost.

Excellent speakers have been brought to our community on this basis.

These two committees show what can be done by cooperation on the local level—one bringing subjects of a technical nature, the other biological.

In addition to this, we have four local study clubs, in gold foil, gnathology, periodontics, and endodontics. Our men are exposed to almost anything they may need to improve their dentistry, and the nice part is that they do have a say in the program. The dental society membership is polled on occasions as to the courses the members would prefer.

We are also fortunate enough to have three dental schools within 140 miles and this offers still another outlet, so there is no rea-

son in our particular area why we should not have continuing education as a prerequisite. I realize that all sections of the United States are not as fortunate as we. However, I am convinced that any area can obtain and present worthwhile continuing education programs to their membership.

If the general dentist in the United States is to retain his world leadership, he must attend such programs. Speaking on the subject of continuing education, one must give tremendous credit to the Academy of General Dentistry for the active part this organization is taking in this field.

So I say to you that the courses are available, facilities, equipment and teaching aids are of the finest, and most instructors are quite competent. If this is so, why are only 8 or 10 per cent of all dentists participating?

What can we do to stimulate the interest of dentists in a voluntary plan for continuing education? That, to me, is the question and a worthwhile challenge for an organization such as the American College of Dentists, but if we are going to act, we have to act quickly.

Re-licensure is one of the most important problems facing the future of dentistry. Will we, as a profession, react with the often seen complacency, or will we tackle the matter with vigor and enthusiasm?

The latter, I hope. When the problems of courses, of attendance, of governing bodies, of non-member participation, of legislation, the number of hours, et cetera, et cetera, all of these are discussed, the general practitioner *must be well represented* on the various planning committees.

Discussion of Questions From the Floor and Summary by the Moderator

ALVIN L. MORRIS, D.D.S., PH.D.*

Dr. Morris: Dr. Ast. I received five cards which were brought to me from the audience and three of them concern New York State and your particular problem. Basically the questions ask: has not a governmental agency arbitrarily assumed responsibilities which are the prerogative of the state board?

Dr. Ast: The answer to that is, "Yes," but the New York State Department of Health cannot mandate professional continuing education requirements as they affect the entire population, but where it is administering a tax program, there it does have jurisdiction, but let me make one other comment that may anticipate some of the questions that you have.

You have heard from a number of panelists here, and I am sure that this is an almost unanimous opinion that the determination of the qualifications of dentists should be by the boards of dental examiners.

Let me state unequivocally that the New York State Department of Health's position is that if and when the State Board of Dental Examiners in New York undertakes this responsibility the State Department of Health will move out of this field.

The New York State Board of Dental Examiners has submitted to the State Dental Society a resolution requesting guidance by the Society as to whether or not the Board of Dental Examiners should move in the direction of compulsory continuing education, the demonstration of compulsory continuing education for recertification of licensure.

If this should come to pass, the State Department of Health would, without question, move out of this field. It is only because

* Dr. Morris is Assistant Vice-President of Medical Center, University of Kentucky, Lexington, Kentucky.

These comments presented at a panel discussion "Continuing Education" at the American College of Dentists Forty-Eighth Annual Session, Miami Beach, Florida, October 26, 1968.

the Department has the responsibility at this time to administer the health aspects of the Medicaid program, and among its responsibilities, is to assure high quality health services that it has been forced into this situation of requiring evidence of continuing education.

Had the State Dental Society undertaken the responsibility as it had been requested, the Society would have determined what the standards should be.

The implementation would, of necessity, have to be through the Department of Health or other official agencies, but thus far the Department of Health has had to move unilaterally, not because it wanted to, but because it had no choice.

Dr. Morris: Mr. Sullens, do you want to comment?

Mr. Sullens: One short comment related to this: I think there was a substantial misunderstanding last year with respect to the reasons for the resolution of the Council on Dental Education. I think what Dr. Ast has just said indicates as clearly as I could possibly explain the reasons the CDE felt that the House of Delegates should take a position on this important issue.

We believe that the dental profession should assume this responsibility and it should not be assumed by these other agencies.

If the dental profession does not do this, through the state boards and state societies, it will be done at it is done in the State of New York.

I do not know how to make this point more clearly with respect to the resolution that the House of Delegates will consider sometime Wednesday or Thursday of next week.

Dr. Morris: We will take one question.

A Member: I wonder why this information was not brought before the House of Delegates (ADA—Ed.) at their meeting.

I have been a delegate for five years, and this has not been presented to the House of Delegates, what I heard Dr. Ast say.

I am at a loss to know why this side of it has not been presented.

Mr. Sullens: It was presented to the Reference Committee and I thought it was presented to the House, but obviously it was not presented clearly. There is no question about this. I think there was much confusion about this issue. This is the reason the Council has brought essentially the same resolution back to the House this year.

Dr. Morris: Are there any quality control mechanisms other than compulsory continuing education? I think that Dr. Moxley referred several times to peer evaluation. Cannot competency be judged by a panel of peers?

Dr. Ast: May I comment on that point? The purpose of continuing education, as we see it today, is to assure that the practitioners are current. The complexity of the health services, the rapidity with which new ideas, both in diagnosis and treatment are being brought to the attention of the professions; these come in such force and so quickly and are of such magnitude that if a man does not continue in his educational experience, it is impossible for him to keep current.

Now, this is all that continuing education really means. If he keeps current, we have reason to believe that he will use his current knowledge in providing high quality service.

It is true there are other techniques. We can do spot checking to see the quality of service that is being rendered, but this is one method.

Summary

Alvin L. Morris

This panel discussion has addressed itself broadly to the subject of continuing education. Following three position papers on fundamental aspects of the subject, the viewpoints of various segments of the profession were presented in six brief reports.

Dr. Moxley, in discussing "Legislation and Social Pressures for Continuing Education," presented a brief but excellent history on the development of continuing education as part of professional life. It was of interest to learn that compulsory continuing education for physicians began to receive emphasis in the early 1930's.

In discussing legislation, Dr. Moxley commented upon the elements of pressure contained in the Regional Medical Programs and Medicare legislation as well as the anticipated impact of the Health Manpower Commission report. He expressed the interesting view that indirect pressures have evolved from the extent to which the general public gains attitudes toward the quality of health care through television and the press. An additional social pressure which will encourage health practitioners to seek continuing education is the result of recent court action associated with

malpractice litigation. The courts have demonstrated a definite trend to judge standards of practice on a national rather than local basis.

Dr. Moxley also identified the further emphasis on specialization and board certification and the trend toward peer review (as an element of third party agreements) as examples of professional pressures influencing continuing education.

Dr. Moxley acknowledged the existence of at least three subgroups in the medical profession today. The first maintain a high level of professional skill and knowledge regardless of the difficulties involved, the second maintain skills only if it is relatively convenient to do so, and the third, described as "immovables," refuse to take part in continuing education regardless of pressures or availability. The relevance of this classification to dentistry is obvious.

Dr. Darby, in discussing "Attitudes and Motivation," made the important observation that the ultimate success of programs to encourage continuing education will be measured by the recipient —the patient. It is the patient's reactions to the services he receives that will be the criteria by which the profession's efforts will be judged.

Dr. Darby presented a list which depicted the extent to which dentists' attitudes about continuing education have been changing. He then shared the results of surveys which determined the opinions of dentists from the New England and western areas of the country. Ninety per cent of the respondents expressed a willingness to participate in continuing education but the level of their participation was subject to influence by such factors as subject matter presented, length of course, travel distance required, and portion of the week involved.

Dr. Darby expressed the need and the value of a nation-wide coordination of a continuing education program for the profession. He further emphasized the potential for self-instruction methods of presentation in such programs.

Dr. Barker, in speaking on the "Administration and Evaluation of Continuing Education Programs," insisted that our overriding emphasis should be on what happens in the student's mind, not what the clinician-teacher does or thinks. In this framework, learning becomes the key consideration, not instruction.

Dr. Barker gave excellent support for the view that the practicing dentist should have a very important role in both the planning and the evaluation of the continuing education efforts of the profession.

During the entire period of panel presentations and discussion, a great interest in the implementation of the Medicaid program in New York State was in evidence. Dr. David Ast gave an excellent review of the issues involved as well as actions taken by the State Health Department and the Dental Society of the state.

The Health Department, acting to carry out its responsibilities under federal and state laws, requires continuing education standards for all providers of health care who wish to participate in the Medicaid programs. It was of interest to learn that the Dental Society was offered the option of establishing and maintaining standards through continuing education—even aided by financial support from the state. When efforts failed to obtain the leadership of organized dentistry the Health Department established its own standards which have resulted in controversy and court action.

Dr. Flores gave a concise view of the objectives of the Academy of General Dentistry which has been the pioneering organization of the profession in encouraging participation in continuing education. The implementation of a program whereby such participation is utilized to maintain good standing and academy membership was explained in detail.

Dr. Dalton presented information gained through a survey presented to members of the American Association of Dental Examiners. Of 42 state boards responding, none require continuing education as a requirement for re-licensure. It was of interest that 25 per cent of these anticipated that such a requirement would be instituted in the foreseeable future—but not without difficulties. Two-thirds of those responding to Dr. Dalton clearly favored a voluntary approach to future programs to encourage participation in continuing education.

Dr. McCallum pointed out that the official posture of the American Association of Dental Schools is one of endorsement of the position of the Council on Dental Education of the American Dental Association. In sharing some of his personal views, Dr. McCal-

lum made the penetrating observation that the indefensibility of current licensure practices is compounded by the fact that they act as a barrier to innovations in the undergraduate and graduate education of dentists. Equally obstructive, they retard innovations in new uses for new kinds of manpower and new patterns for delivering dental care. Dr. McCallum made a call for the development of a national common health market of high quality health service. He pointed out that 50 state boards with 50 philosophies and procedures not only limit manpower movement but also guarantee unequal standards.

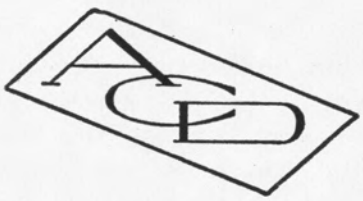
Mr. Sullens reviewed and restated the generic position of the American Dental Association; namely, that every dentist has the obligation to participate in continuing education. The House of Delegates has resolved that the determination of the qualification of individual dentists participating in publicly-funded health programs should be the prerogative of dental societies and dental examining boards. The House of Delegates, however, has thus far been reluctant to act favorably on recommendations from the Council on Dental Education that continuing education be considered as a condition for licensure renewal.

Speaking on behalf of the consumer, the practicing dentist, Dr. Vernetti stated his opinion that, in general, dentists favor voluntary participation in continuing education, but they do not favor any restrictions on re-licensure. Reflecting on the circumstances in Southern California, Dr. Vernetti gave evidence demonstrating that continuing educational opportunities are readily available. In spite of this, however, only about 10 per cent of the dentists take advantage of the opportunities. He pointed out that such a pattern of involvement and the lack of formal continuing education requirements for dentists in California were compromising the profession's position in resisting proposed legislation for the licensing of foreign dentists.

Dr. Vernetti emphasized that there is an appropriate and important role for the practicing dentist in the planning of directions for the future.

In concluding the panel, it was acknowledged that the dental profession has a problem and faces challenges in the area of continuing education. The problem is not going to go away and

there will be controversy associated with attempts to meet the challenges. The important thing to acknowledge now is that we no longer have the choice of doing nothing—largely the pattern of the past. We have reached the point where the risk of doing nothing is greater than the risk of taking action. I am convinced that act we must, and act we will, and regardless of what segment of the profession we represent, things just aren't going to be the same.



Methods of Group Practice*

HARVEY SARNER, LL.B.†

I AM not before you this morning to attempt to encourage you to enter group practice, nor am I here for the purpose of setting forth the benefits of group practice. I leave that for those who are already in group practice—their enthusiasm speaks well for their decision and they are noted proselytizers. The benefits of group practice which I mention are only those which touch upon my theme—Methods of Group Practice. For those of you who might be interested in Genesis, the benefits of group practice, a short bibliography is appended to this paper.

What Is Group Practice?

Group practice needs some definition because it has a common definition which is not accurate. Group practice in some quarters, notable labor and government, seems to automatically and unequivocally mean some form of a closed panel practice. This same erroneous definition is used in some medical circles. Whatever the reason, the term has become synonymous with closed panels to some people. In reading literature on this subject, especially when there is discussion of methods of payment, the phrase "group practice" is assumed to mean a prepayment facility.

This definition is erroneous because there is nothing in the term "group practice" or in the nature of group practice which automatically says that this is a closed panel or that some specific form or method of payment is a part of the concept of group practice.

This tells us what it isn't, but what is a group practice? The American Dental Association offers no definition. The Code of Ethics of one constituent society offers a definition which is confusing because it speaks of dentists in association with other health professions. That definition is bad for two reasons. It er-

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† Mr. Sarner is the secretary of the Judicial Council of the American Dental Association.

roneously suggests a group which can practice more than one profession and it uses the word "association," a form of the word "associate," the only word in the area of group practice which is harder to define than the term "group practice."

I have seen some definitions of group practice, acceptable in the sense that their conclusions are true. They are statements of the benefits of group practice, e.g., "the practitioner can enhance and give greater distribution to his abilities." This does not say what a group practice is, it is merely a statement of the benefits of group practice.

My definition of group practice, and I have no fear in offering it because there is a void, is "any system of dental practice wherein two or more dentists share income from their practice of dentistry." I would omit from group practice all expense-sharing arrangements but I would include employment, partnerships and corporations. Perhaps my definition is too "commercial" but I haven't found a more accurate one. Let's see as we proceed this morning whether my definition stands up.

Associates

This brings me to the second definition. The most common form of group practice in dentistry today is an associate arrangement. I will not attempt to define "associate" for you because that term isn't definable. There is no recognizable legal entity known as an associate. A group practice arrangement is a legal relationship but there is no legal form known as an associate arrangement.

I will venture a guess as to why the term "associate" is used. To some ears, it is softer than saying "salaried employee" or "commission employee." When one dentist works for another on a salary or a commission basis or on an expense-sharing basis, the term "associate" is often used. But it is the nature of the relationship that is meaningful—not the fact that the word "associate" is used rather than "employee" to soothe the sensitivities of the professional man who happens to be an employee. In the partnership, the word "associate" is often used instead of "partner," perhaps in the belief that one word sounds more professional than another. And let us not underestimate the sound of a word and the impact it might have in arousing prejudice—just say "corporation" to dentists in some parts of the country and you will see a

reversion to their childhood response to the simple word I spell "B - O - O." For today, let's forget "associate" and look into the real relationship it might describe.

Group Practice

In separating the Methods of Group Practice into their legal categories, let us first separate the groups formed for the purpose of practicing dentistry from groups formed for a separate but related purpose. A group formed for the purpose of constructing and owning a building, perhaps as a group practice facility, is not the same thing as a group formed for the purpose of rendering professional service. For example, six dentists may form a corporation for the purpose of constructing a building. The fact they are in this real estate group does not mean that they are in group practice. They can be in a group practice and also own a building and they can own the building as a group while they individually operate their own practices. The group for owning the building can also be the same group as conducts a practice or each man in the building-owning group can be in solo practice. To illustrate this point, consider the state laws against corporate practice and those against physicians and dentists entering into a group for the practice of their professions. This does not prevent a group of dentists from forming a corporation for the purpose of owning a building nor does this prevent a mixed group of dentists and physicians from forming a group, corporate or otherwise, from owning a building.

Now that we have separated group practice into those that involve dental prepayment and those that do not relate to prepayment and we have separated groups into those that are for the purpose of practicing dentistry from those which are formed for the purpose of constructing a practice facility, we can get into the various Methods of Group Practice.

Professional Corporation or Professional Association

Since 1961, more than half the states have enacted so-called professional corporation and professional association statutes (there is no practical difference between the two) which permit dentists and other professionals to practice as a corporation. The professional corporation or the professional association is something of a hybrid, born during the period when the chances of the Keogh

Law being enacted seemed slim. The statutes came into being to permit professionals to get tax-qualified retirement plans which have been denied them because they were not corporate employees. Although four recent court decisions have held the groups to bona fide corporations, the IRS continues to resist treating these groups as corporations for tax purposes. I believe that when the benefits of incorporation are more fully appreciated by the professions there will be a clamor for laws which will permit complete incorporation and not the pseudo-incorporation seen in some of the existing professional corporation laws.

Professionalism and Group Practice

One of the strong prejudices against group practice is the prejudice that professionalism cannot suffice in this climate. I call this a prejudice because prejudice, as defined by Webster, is a judgment or opinion rendered without due examination, a decision based on other grounds than reason.

The demonstrative fact of non-interference with professionalism is the fact that the form of practice, be it corporate, employment, partnership or what have you, is outside the domain of the patient's interest and outside the scope of discussions with the patient. I am not suggesting that this is a fact that need be hidden but rather that this fact, whether it's employment, partnership or corporation is, in plain language, none of the patient's business. Each doctor should treat his patients as he has always treated his patients, and if he elects to file his tax return as a corporation or as a partnership it is without materiality to the patient.

From the other standpoint, whatever abuses there could exist in group practice could exist in solo practice—it is the individual and his manner of practice that will result in a diminution of professionalism, not the form of the legal agreements between the dentist and his fellow dentists.

Written Agreement

Whatever the group practice, even if it be between father and son, brother and brother or lifetime friends, it should be based upon a written agreement. It is not an insult to the strong, personal relationship to recommend the written agreement—it is a way of saying that the personal relationship is so strong that it should be maintained and the best way to protect it is by using a

written agreement prepared by an attorney. The written agreement is protection against innocent misunderstandings as much as against intentional deception. It is the argument settlor rather than resorting to the loud voices of the partners or the skills of their personal attorneys. One suggestion in preparing the agreement—one disinterested attorney should be asked to prepare the entire agreement. Each partner may wish to consult his accountant and attorney in advance, but one attorney should be in the position to prepare the agreement and he should be in the employ of the group collectively and not in the employ of one participant.

Inter-Professional Groups

To this point the only discussion of interprofessional groups has been limited to groups which are formed for the purpose of owning and operating a business. This is not prohibited by state law. But when it comes to a group formed for the practice of the health professions, the dentist is usually on the outside. How often do we see a group of seven or eight physicians and a dentist in a building that they own jointly with all the physicians in a partnership and the dentist in a solo practice? This is due to the provisions in the medical and dental practice acts which prohibit some one other than a licensee from sharing in the general income from the practice of the profession. Undoubtedly these laws were enacted to prevent the paramedical and paradental personnel from managing and controlling professional practice, but the result is that the laws of all fifty states prohibit a dentist and a physician from gathering in a partnership or other group practice. It seems to me that no useful purpose is served by these laws and that they result in the dentist being an outsider when he should be an active member of the health team. From my own experience, I recall a highly qualified oral surgeon who was invited to join a group of physicians and surgeons as a full partner in a group practice. When the attorneys drew up the agreement, they finally found out that this kind of partnership was prohibited by the state medical and dental laws. When the problem was presented to me, I had to agree—no marriage of dentist and physician was permissible under the state miscegenation law. Oh, the dentist was invited into the building and he shared some expenses with the physicians, but he remained an outsider—a second class doctor. It

does not take any crystal ball to predict that within the foreseeable future there will be a movement towards permitting physicians and dentists to work together in group practices.

Partnership

Perhaps the most common is the partnership—the legal relation of being partners. A partnership can be defined as an arrangement for distributing the expenses and income from the practice of dentistry. Perhaps the most important part of this definition is the fact that a partnership involves the distribution of income. This is what distinguishes a partnership from an expense-sharing arrangement. The following are some of the legal facts of life about a partnership:

—If a group meets the definition of a partnership, then it is a partnership according to law even if the members choose to call it something else.

—In a partnership each partner is considered to own an undivided share of the entire partnership. If the partnership assets are not sufficient to pay partnership bills, the private assets of each partner are subject to being attached to pay partnership bills.

—Partnerships are not necessarily equal partners.

—A partnership for the construction of the building can include dentists and non-dentists. A partnership for the practice of dentistry, according to state law, can consist only of dentist partners.

—A partnership ends when one partner dies, one leaves the partnership or when the group decides to take a new partner into the fold.

Expense Sharing

When two dentists agree to pool their purchasing power in buying supplies or in hiring employees, they are not in partnership practice. Each owns his own practice and they merely share some common expenses. This is not a group practice.

Employment

When one dentist hires another to work in his office, then there is a group practice because more than one, a group, is providing professional services. Employment is therefore one form of group practice. There is employment even though the junior dentist maintains his professional independence in his treatment of patients. So long as one dentist owns the practice and another is paid by him for services rendered, then there is the form of group practice known as employment.

The existence of the employment group does not depend upon the method of paying the junior member for services rendered.

He can be an employee if he is paid a salary or a percentage of the income that comes in due to his work. If the employee's income is a percentage of the gross dollars earned by the two dentists, he is still an employee although, at this point, he might be nearing a partnership. What keeps it from being a partnership would be that he is being paid a wage, dependent upon gross income. If he received a percentage of all income during the year, including the increase in net worth of the practice, then he would probably be a partner. Thus it is possible that a partnership sometimes results even though the parties originally intended only to have an employment relation. If the junior man shares in all instances of income, then there is a partnership even though they are obviously not equal partners.

Rental Space

If the young associate rents space from the senior man by paying as rental a percentage of what he brings in, paying his own laboratory bills and disposable supplies and he maintains his own control over hours, manner of practice, etc., then you could say that he is not an employee—he is a tenant. The main difference between the tenant and the employee is the availability of the senior man to direct and control. I freely admit that borderline cases are very possible. If there is a tenant relationship, then there is no group practice—one man is merely leasing floor space and equipment to another . . . no group practice.

Combination of Partners and Employees

It is possible to have a group practice combining partners and employees. For example, the partners may be Drs. A, B and C and they may employ Dr. D on a percentage basis. Doctor D, then, is an employee of the three partners. In many ways his position is not unlike that of the other traditional employees in a dental office. If at some later date A, B and C decide to take D in as a partner, i.e., he will get a percentage of partnership income instead of a share of what he brings in, then the ABC partnership is dissolved and a new partnership, ABCD, is created.

Corporations

A most logical form of group practice which is barely making its presence felt in dentistry is the corporation. The prejudice

against corporations is undoubtedly a throwback to Painless You-Know-Who. The advantage of a corporate practice is that the entity lasts even though the participating dentists come and go. It is easier to allocate shares to and among the participating dentists. One disadvantage of corporate practice is the corporation taxes imposed by each state. However, a corporation does not necessarily pay corporate income taxes to the federal government because the tax law permits corporations with a relatively small number of participating stockholders to elect to be taxed as a partnership, which means that corporate and double taxation can be avoided.

The corporation creates needless fears that this will permit dentistry to fall into the hands of the layman. This is avoided by the easy requirement that only dentists can hold shares and these dentists must be the ones the corporation has hired to practice dentistry. In my opinion, none of the traditional bias against corporate practice holds up today—except for the fact that the state laws prohibit corporate practice. To engage in the corporate practice of dentistry would undoubtedly require enactment of new laws in many states.

In summary fashion, this has been a run through of the various forms of group practice, but there are two additional points I wish to make. First, I wish I could say, "If you want additional information and assistance in this area just write to the American Dental Association." This is a new area for the Association, one we are just beginning to look at. The information is slim but whatever we have is available to you. A small package library from the Association's Bureau of Library and Indexing Services on the subject of group practice.

One bright note is that a conference on group practice is being planned by the Association for sometime next summer. It will probably be a part of a dental health conference and be subdivided for those already in group practice and for those considering this form of practice. The present plan is to ask those people who have been in successful group practice to share some of their knowledge.

We are still in the first stages of information gathering and the gathering and distributing of information—a clearing house of a

kind, is probably the Association's role in this area. I see the swing to group practice as one of the major changes in the method of dental practice within the next ten years and I, for one, intend to get further and more deeply involved in this subject.

The second and final point I want to make is that my failure to go into the benefits of group practice, the sales pitch for giving up solo practice, is not out of indifference but rather out of assignment—my assignment was Methods of Practice. If we were to talk about benefits of group practice we could spend the remainder of the day on that subject because the benefits are almost inexhaustive.

The whys of group practice should be obvious, I hope I have left you with some insight into the ways of group practice.

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Eighth Annual Institute for Advanced Education in Dental Research

APRIL 27-MAY 8, 1970
OCTOBER, 1970

NEUROBIOLOGY AND THE TRIGEMINAL SYSTEM

THE subject for the 1970 sessions of the Institute for Advanced Education in Dental Research will be *Neurobiology and the Trigeminal System*. Dr. Andrew D. Dixon, Assistant Dean for Research of the University of North Carolina Dental Research Center will be the principal mentor. The first session (two weeks) will be held from April 27 to May 8, 1970 at the Carrousel Inn, Cincinnati, Ohio. The second session (one week) will be held in Chicago at the American Dental Association headquarters building, on dates in October to be announced later.

Although it is planned to include consideration of relevant structural, functional and clinical aspects of the nervous system in general, emphasis will be on discussion of the trigeminal pathway. Attention will be given to contemporary experimental techniques for investigation of the innervation of the oro-facial apparatus.

The Institute, developed by the Committee on Research of the American College of Dentists, has as its objective the advanced training of experienced researchers. By giving them the opportunity to gather together under the guidance of a group of recognized senior scientists acting as mentors, and discuss their research interests, problems and goals, it was hoped that the participants, all with related but not necessarily identical interests, would gain a better understanding of dentistry's problems and possible ways of solving them. Consideration of the specific details of each participant's own research activity would contribute to an insight into its significance and possible future direction, as well as into new and advanced approaches which might be applied.

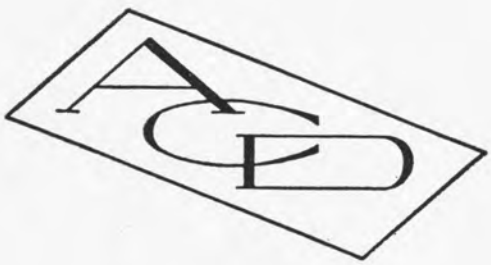
This is the Institute's eighth year under support by a training grant from the National Institute of Dental Research. Determination of annual program content, invitation of senior mentors, and

selection of trainees are the responsibility of the Subcommittee on Research of the American College of Dentists.

Programs are kept flexible. Mentors are invited on the basis of stature and competence in the field, and for their community of interest with the participants. They are drawn from the ranks of general science as well as from dental research centers. In choosing trainees, consideration is given to past accomplishment and future promise, and the ability to add to the dialogue of the curriculum An effort is made to achieve a balance between the various disciplines related to the study areas. Usually the group chosen consists of ten to twelve trainees and four mentors, with senior participants added as special needs arise.

Research workers interested in attending should send a letter of application before November 1, 1969, to Dr. Robert J. Nelsen, Secretary, American College of Dentists, 4236 Lindell Blvd., St. Louis, Missouri 63108. Material submitted should include a curriculum vitae, list of pertinent publications, and a detailed account of previous and present activities in the subject field; also a statement of the type of discussion topics that would be most useful to the applicant's interests.

The Institute reimburses trainees for their travel expenses and pays a stipend based on cost of living.



The Objectives of the American College of Dentists

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

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

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

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

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

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

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

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

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

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

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

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