The JOURNAL of the AMERICAN COLLEGE of DENTISTS

Health Manpower and Continuous Progress Education

A Humanistic Orientation in Dental Education

Dental Continuing Education in New England

Peer Review

APRIL 1971

THE JOURNAL OF THE AMERICAN COLLEGE OF DENTISTS is published quarterly—in January, April, July, and October—at 215 S. Tenth Street, Camden, New Jersey 08103. Second class postage paid at Camden, New Jersey.

NEWS AND COMMENT

Section news announcements and items of interest should be sent to the Editor, Dr. Robert I. Kaplan, One South Forge Lane, Cherry Hill, New Jersey 08034.

Board of Regents Actions

The Board of Regents, meeting at the central office recently, took a number of significant actions. The Board—

—approved the articles of incorporation of the American College of Dentists Foundation which has been established for "charitable, literary, scientific and educational purposes, and is authorized to accept, hold, administer, invest and disburse for charitable and educational purposes such funds as it may receive."

—appointed a committee to study the stage setting used at convocations and make recommendations for changes or renovation.

—considered a management and activities audit of the College done by the American Society of Association Executives, and referred it to the Committee on Program Planning.

—commended the Carolinas Section for initiating a pilot program of providing dental information to local libraries.

—approved a new form for obtaining biographic information on Fellows of the College.

—approved new nomination forms and procedures whereby candidates will supply information on their activities on a detachable section of the form. Secrecy must still be maintained however.

—approved a new form for releasing information to the press regarding induction of new Fellows.

—approved the loan of the bust of G. V. Black, now in the central office, to the Smithsonian Institution.

—accepted a portrait of William J. Gies, presented to the College by Executive Director Nelsen.

—reviewed the Action Plan presented by the Committee on Program Planning, and approved changes in committee structure of the College.

—adopted a budget for the next fiscal year.

—unanimously approved the dedication of the 1971 meeting to President Otto W. Brandhorst.

1971 Meeting to Be Held in Atlantic City

The 1971 Meeting and Convocation of the College will be held at the Traymore Hotel, Atlantic City, N. J., on October 10, 1971. Additional information and announcements regarding the College Programs will be sent to the membership as the program develops. All hotel reservations are to be made on the official application form which will be printed in the May, 1971 Journal of the American Dental Association. Hotel reservations *cannot* be made through the American College of Dentists. If you wish to stay at the Traymore, mail your reservation request early in May and mark it "Fellow, American College of Dentists". The Colony Motel, located directly behind the Traymore, is very new and modern. Both are about midway between the Convention Center and the ADA Headquarters Hotel. Make your reservations early, on the official reservation form, which will be printed in the May issue of the JADA.

SECTION NEWS

Tri-State Section

The annual Alumni Seminar and Tri-State Section of the American College of Dentists was held at the Wassell Randolph Student-Alumni Center of the University of Tennessee College of Dentistry on March 4, 5 and 6, 1971.

During the three day sessions, Dr. Jack Wells, dean of the dental school described proposed curriculum changes, and Dr. Harry Klenda discussed case presentation and the use of auxiliaries.

The Tri-State Section is made up of fellows from Arkansas, Mississippi and Tennessee. Dr. Robert P. Denney of Milan, Tennessee, is chairman; Dr. William R. Alstadt of Little Rock, Arkansas, is chairman-elect; Dr. Richard J. Reynolds of Memphis, Tennessee, is secretary-treasurer. Dr. C. W. Nickels of Walnut Ridge is vice-chairman for Arkansas; Dr. Dewitt Lewis of Jackson is vice-chairman for Mississippi, and Dr. Wayne L. McCulley of Cleveland is vice-chairman for Tennessee.

Illinois Section

The Illinois Section met at the Conrad Hilton Hotel on Sunday, February 14, during the annual midwinter meeting of the Chicago Dental Society. The featured speaker was President Otto W. Brandhorst, who talked on the founding and history of the College.

Dr. F. Wayne Graham is section chairman, Dr. William O. Vopata is vice chairman and Dr. Harvey W. Lyon is secretary-treasurer.

New York Section

The exhibit by Professors Mandel and Wottman depicting the diagnosis of some oral and systemic diseases by salivary analyses was sponsored by the New York Section and first shown at the Greater New York meeting in December. It is now on exhibition at Columbia University School of Dental and Oral Surgery.

Our new Project Bookshelf Chairman is:
Dr. Henry Nahoum
Columbia University
School of Dental and Oral Surgery
630 West 168th Street
New York 10032

Any recent texts and publications sent to Dr. Nahoum will be shipped to needy libraries and clinics in foreign lands.

Irving J. Naidorf,
Section Reporter.

NEWS OF FELLOWS

Virginia Commonwealth University Medical College of Virginia School of Dentistry has named its new building in honor of Dr. Harry Lyons, retired dean and past president of the ADA and the American College of Dentists.

Dr. Marvin Sniderman of Pittsburgh has been named editor of the Pennsylvania Dental Journal. He succeeds Dr. Vincent G. Lawlor of Philadelphia who served as editor for 16 years. Dr. Sniderman, a past president of the Odontological Society of Western Pennsylvania, has completed 11 years as editor of this society's bulletin.

Dr. Albert Lee Russell, professor of dental public health at the University of Michigan was presented the H. Trendley Dean Award

at the recent meeting of the International Association for Dental Research, in recognition of his outstanding contributions to dental epidemiology.

Dr. Thomas Wai Sun Wu of San Francisco has been appointed to the Advisory Committee on Dental Health by Elliot L. Richardson, Secretary of the U. S. Department of Health, Education and Welfare.

Dr. George A. Colmer, formerly of Morristown, N. J., has been appointed Director of Dental Services of the Comprehensive Health Care Program of the Department of Pediatrics, University of Miami School of Medicine, Miami, Florida.

Dr. James B. Edwards, Charleston oral surgeon, has won the Republican primary election for the South Carolina congressional seat left vacant by the death of L. Mendel Rivers.

Dr. Donald B. Giddon, associate dean and professor of social dentistry at Tufts University School of Dental Medicine has been appointed an Honorary Fulbright Scholar and is carrying out research at the Odontological Faculty of the University of Gotenborg in Sweden.

Dr. James D. Harrison of St. Louis has been named professor of dentistry and chairman of the Department of Fixed Prosthodontics and Director of Advanced Educational Programs at the new School of Dental Medicine, Southern Illinois University, Edwardsville.

Dr. Clifton O. Dummett of Los Angeles has been promoted to associate dean for extramural affairs at the University of Southern California School of Dentistry. Dr. Dummett is also professor and chairman of community dentistry at USC.

Dr. Charles J. Vincent, former professor and chairman of pedodontics at the Medical College of Virginia is now teaching in Norway at the dental school of the University of Oslo.

Dr. Ray E. Stevens, Jr. of Grand Rapids, Michigan, is president of the American Association of Dental Examiners.

An unusual honor was conferred upon Dr. Frank A. Farrell of Oak Lawn, Illinois, when the semiannual meeting of the American Prosthodontic Society was dedicated to him. The meeting and scientific program in Chicago, Feb. 12 and 13, saluted Dr. Farrell who is past president of APS and the Chicago Dental Society and last year served as second vice president of the American Dental Association.

the JOURNAL of the AMERICAN COLLEGE of DENTISTS

A QUARTERLY PRESENTING IDEAS IN DENTISTRY

ROBERT I. KAPLAN, *Editor*
One South Forge Lane
Cherry Hill, New Jersey 08034

ROBERT J. NELSEN, *Business Manager*
Journal of the American College of Dentists
7316 Wisconsin Ave.
Bethesda, Maryland 20014

Editorial Board—HOMER N. HAKE, *Chairman*
ROBERT L. HEINZE LOUIS G. TERKLA

April 1971

VOLUME 38—NUMBER 2

THE JOURNAL OF THE AMERICAN COLLEGE OF DENTISTS is published quarterly—in January, April, July, and October—by the American College of Dentists, Inc., at Huntzinger Printing Corporation, 215 S. Tenth Street, Camden, New Jersey 08103 • Subscription $10.00 a year; single copies $3.00 • Second class postage paid at Camden, New Jersey • Copyright 1971 by the American College of Dentists, Inc.

All expressions of opinion and statements of supposed fact are published on the authority of the writer over whose signature they appear and are not to be regarded as expressing the views of the American College of Dentists, unless such statements or opinions have been adopted by the American College of Dentists, Inc.

Correspondence relating to the JOURNAL should be addressed to the Editor, One South Forge Lane, Cherry Hill, New Jersey 08034. Changes of address and subscription requests should be addressed to the Business Manager, JOURNAL OF THE AMERICAN COLLEGE OF DENTISTS, 7316 Wisconsin Avenue, Bethesda, Maryland 20014. Reprint requests should be directed to the author.

The JOURNAL is a publication member of the American Association of Dental Editors.

For bibliographic references the JOURNAL title is abbreviated J. Am. Col. Den. and should be followed by the volume number, page, month, and year. The reference for this issue is J. Am. Col. Den. 38:69-128, April 1971.

Contents for April 1971

News and Comment 69

The Treasurer of the College 76

Editorial
Dentistry and National Health Insurance Plans . . 78

Health Manpower and Continuous Progress Education
Richard M. Jacobs, D.D.S., M.P.H., Ph.D. 81

A Humanistic Orientation in Dental Education
Robert L. Kaplan, D.D.S. 89

Dental Continuing Education in New England
Richard M. Ryan, M.S.S.S., M.S.(Hyg.), Allan F. Williams, Ph.D., and Henry Wechsler, Ph.D. 96

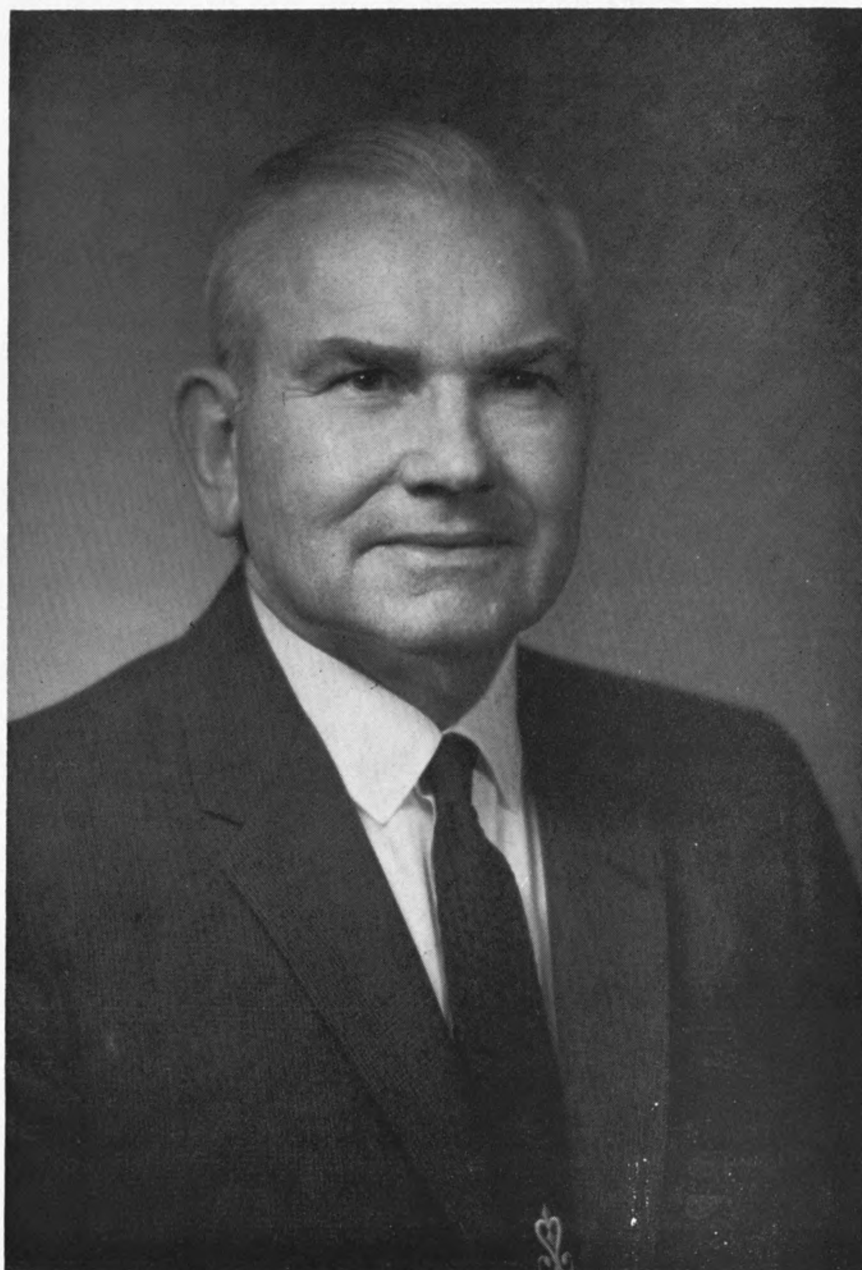
Peer Review
C. Gordon Watson, D.D.S. 103

Honors and Awards 115

Fellowships Conferred 124

Necrology Report 127

Letter to the Editor 128



FRITZ A. PIERSON

Treasurer

The Treasurer of the College

DR. FRITZ A. PIERSON of Lincoln, Nebraska, treasurer of the American College of Dentists, has won recognition as an educator, administrator and civic leader.

Born near Stromsburg, Nebraska, to a farming family who had emigrated from Sweden, he was one of nine children. His education began in a one room country schoolhouse in Polk County and culminated with his graduation from the University of Nebraska College of Dentistry in 1917 as World War I was beginning. Joining the colors, he was commissioned as a dental officer in the 132nd Infantry Regiment. He saw action in three major campaigns in France and after the War remained in the reserve corps, retiring in 1954 as a lieutenant colonel.

He returned to private practice in 1919, opening an office in Lincoln, where he has remained ever since. The University of Nebraska appointed him professor of dental medicine in 1922 and he held this position until his retirement from teaching in 1961.

Dr. Pierson was elected secretary of the Nebraska Dental Association in 1930 and occupied this position continuously until 1963, with the exception of 1942 and 1943 when he was successively president-elect and president of that organization.

On the national level his service has been outstanding. He was third vice president of the ADA in 1944, and second vice president in 1953. He was a member of the ADA House of Delegates from the Nebraska Dental Association from 1930 to 1957. He served for four years as chairman of the Council on Constitution and Bylaws and for six years as a member of the Board of Trustees. He was the unanimous choice for president-elect in 1963. During his presidency the following year, the ADA's new building was erected, and Dr. Pierson headed the special committee which was in charge of the project.

Elected to fellowship in the American College of Dentists in 1938, he was named to the board of regents in 1946 and became president of the College in 1953. He was named treasurer in 1961. In 1967 he received the William J. Gies Award for his meritorious services to the College.

Dr. Pierson is a member of the Omicron Kappa Upsilon honorary dental society, The Federation Dentaire Internationale, the New York Academy of Dentistry, and is a fellow of the American Association for the Advancement of Science. He is a director of the American Dental Political Action Committee, and was formerly a member of the board of directors of the Lincoln Chamber of Commerce, the Lincoln Y.M.C.A., and the President's Citizens Advisory Committee to the Council on Youth Fitness. He is also a member of various Masonic organizations.

In 1956 the University of Nebraska College of Dentistry honored Dr. Pierson with its distinguished service award for contributions to dentistry and in 1960 the alumni association named him "alumnus of the year." He was elected to the Nebraska Dental Association Hall of Fame in 1967.

Dr. Pierson and his wife, Alberta, take great pride in their three children and eight grandchildren. One son, Fritz, Jr., practices dentistry with his father and serves on the ADA Council on Relief. The other son, Thomas C., a Ph.D., is the director of the music department at Texas A. and I. University. A daughter, Mrs. Harry Fox, lives in Beatrice, Nebraska.

Those who are privileged to know Fritz Pierson recognize that here is no common man. Solid and substantial, forthright and honest in word and deed, he commands the respect of all who know him. Quiet and reserved by nature, soft spoken in manner, he possesses a cheerful optimism in his approach to life's problems and an enthusiasm for dentistry that is the envy of younger men. His long years of unselfish service to many organizations have won him a host of friends in all parts of the country.

The College is fortunate to have Fritz Pierson managing its financial affairs. We wish him many more years of good health and happiness.

Editorial

Dentistry and National Health Insurance Plans

One of the major issues to be considered by Congress this year, and one which will have strong political implications, is the proposal to develop a national health insurance program. We have read a good deal lately in the news media about various proposals being presented to bring medical care to everyone. They differ in methods of administration, operation and financial support, but most of them appear to have one thing in common—they make no provision for dental health care.

Particular interest centers in the plan offered by President Nixon, which would be built basically upon existing health resources of the country and would be operated through the private insurance industry rather than a government agency, as some of the other plans propose. The details are presently being developed, and we can expect to hear more about them as time goes on.

The American Dental Association has consistently opposed government controls over the provision of personal health care services. However, the ADA Board of Trustees at its recent meeting voted to support in principle the administration's national health insurance proposals, with the stipulation that dental care be included.

Dr. John S. Zapp, deputy assistant secretary for health manpower, and special assistant for dental affairs in the Department of Health, Education and Welfare, stated recently that the administration is considering the inclusion of dental care at a later date, but not in the initial legislation. Dr. Zapp has stressed the point, and we would probably agree, that the dental profession is not prepared today to provide the necessary care for everyone if a national health care program were approved. He calls for a complete over-

hauling in the traditional ways that dental care has been provided to the public, and suggests the formation of more group practices and a much wider used of dental auxiliaries, expanding the dental student population, developing mechanisms for peer review, and finding ways to provide for a better distribution of dentists.

It is interesting to note that most, if not all, of these suggestions were considered at the 1967 Workshop on Dental Manpower sponsored by the American College of Dentists in cooperation with the U. S. Public Health Service. Taking as its theme, "Meeting the Dental Needs in the 1970's", the participants, studied the scope and urgency of the manpower problem, methods of providing dental health services, and increasing the productivity of dental personnel. The workshop examined the implications of health legislation, and offered some possible directions for the reorientation of dental health services in the coming decade.

Last year, the American Dental Association, concerned with the implications of national health care proposals, reviewed and updated all of its existing policies. This was done as a background for the ADA Task Force on National Health Programs which was appointed "to design the Association's position with respect to participation of the dental profession in national programs concerned with the delivery of health care to the public." The Task Force, made up of a group of committees coordinated by ADA assistant executive director Viron Diefenbach, is making an in-depth study, according to a recent report and has considered many related subjects including "license reciprocity, functions of dental specialties in the delivery system, factors which escalate costs of dental care, closed panel operations, capitation methods of payment, peer review, methods of quality control, how consumers can best have input into dental programs, and who should be eligible for what services and in what order." In August the final report of the Task Force will be presented to the ADA Board of Trustees, and in October to the House of Delegates for their approval. The profession will then have some definite guidelines for its potential involvement.

We look forward with keen interest to the report, for it should provide a blueprint for the future. We hope that those persons in the administration who are truly concerned about the health and welfare of the public will consider the recommendations and be willing to accept the advice and suggestions of our spokesmen. We firmly believe that no national health insurance plan can be regarded as complete if it fails to include dental health care.

R. I. K.

MAY IS AFDE MONTH
Step Up and
Be Counted

Health Manpower and Continuous Progress Education

How the Output of Our Professional Colleges Can Be Significantly Expanded Without an Increased First-Year Enrollment*

RICHARD M. JACOBS, D.D.S., M.P.H., Ph.D.**

Diagnosing Health Manpower Shortage

AN ANALYSIS of our national expenditures clearly indicates that in the past decade American consumers and government agencies have been diverting increasing amounts of their annual budgets toward the purchase of health care. According to some estimates, by 1975, the spiralling costs of health care services will have surpassed 85 billion dollars, or 8.7 percent of the Gross National Product.[1]

The increasing cost of health care services must be considered synonymous with an imbalance between supply and demand and therefore, stabilization of this disparity can be achieved either by a downward adjustment of the demand or by an expanded supply. On the basis of a purely economic diagnosis it could be postulated that the prices for health care services have not been rising sufficiently to curtail the American consumer's growing "taste" for comprehensive health care. However, rationing of health services by reducing consumer's relative spending power through raising the prices of these services would be totally unacceptable in our contemporary society. In fact, the American consumer does not view health care as an ordinary commodity and, therefore, would not want the allocation of health care resources to be determined entirely by market forces.[2]

Since rationing of health care services would be neither socially acceptable nor equitable, the current imbalance between the supply

* Presented at the 98th Annual Meeting of the American Public Health Association in Houston, Texas, October 28, 1970.

** Formerly, Associate Dean and Curriculum Coordinator; presently, Professor of Orthodontics and Oral Biology, University of Iowa, College of Dentistry, Iowa City, Iowa 52240.

and demand must be rectified by expanding the output of health care services. This could be accomplished by increasing the sheer number as well as the productivity of practicing physicians, dentists and registered nurses. The resulting increase in the availability and accessibility of health care services should be expected to bring about a decline of their relative market price and eventual re-establishment of an economic equilibrium in the health care sector.

Health manpower shortage, though difficult to measure, is known to produce the following three observable socio-economic trends: (1) rapid climb of professional incomes, (2) rise of professional fees and (3) apparent search for less costly substitutes for traditional professional services.[3] All three of those conditions are clearly discernible in our society today, and therefore, on the basis of this working definition, the existence of manpower deficit can be unmistakably diagnosed and the magnitude of manpower requirements can be broadly estimated.

Health Manpower Requirements

According to the projections estimated by the Center for Priority Analysis of the National Planning Association, the manpower requirements for 1975 are 310,000 to 400,000 physicians, 118,000 to 149,000 dentists, and 840,000 to 1,091,000 registered nurses.[4] However, in view of the current ceiling on Health Professions Educational Assistance Act appropriations, it can be anticipated that these manpower goals cannot be attained; at least not by means of the currently ongoing program of new school construction and expansion of the first-year enrollment in existing schools alone. Perhaps, then, we should direct our attention toward yet another approach to the growing manpower deficit through expanding the educational output of our existing institutions without necessarily attempting to enlarge their present first-year enrollment capacity. The proposed approach essentially involves a process designed to increase the efficiency of our educational resources through (1) adopting better management procedures and (2) implementation of certain curricular revisions.

The Principle of Economic Scarcity

In his recent speech on the "State of the Federal Judiciary",[5] Chief Justice Burger made the following remarks which seem to be very relevant to the state of the professional education as well:

> "In the supermarket age we are trying to operate the courts with cracker barrel corner grocer methods and equipment—vintage 1900 . . . More money and more judges alone is not the primary solution. Some

of what is wrong is due to the failure to apply the techniques of modern business to the administration or management of the purely mechanical operation of the courts—of modern record keeping and systems planning for handling the movement of cases. Some is also due to antiquated, rigid procedures which not only permit delay but often encourage it."

There is no doubt that the long overdue application of modern business techniques to administration and management of the educational institutions can significantly increase the manpower output of our professional colleges. Furthermore, if we consider the fact that newly constructed schools, in addition to an initial capital investment of many million dollars, require a continuous expenditure of large sums of money for operation, the cost of increasing the output of the existing colleges may prove to be relatively moderate.

One of the unique aspects of the education industry is that its end product, e.g., graduating physicians or dentists, has no market mechanism and, therefore, it is not easily translated to dollar value scale. However, we should not overlook the fact that economics is not concerned exclusively with money but with all limited resources and for that reason, educational effectiveness of our colleges cannot be considered in isolation.[6] It has been suggested that the quantity and quality of the educational output yielded by our institutions is meaningful only in terms of benefits gained in relation to their cost which involves (1) consumption of physical resources (2) employment of human resources and (3) dissipation of time.[6] This view is based upon the principle of scarcity which represents the central concept of economics. According to this principle, multiple objectives always compete for limited resources, and therefore, available resources must be divided among these objectives in a manner which will produce an opitmum total return.

Need for a Rational Decision-Making Process

It is quite apparent that the principle of scarcity has been ignored by our health industry and education industry, and, as a result, the educational investment of the American taxpayer is not paying its maximum dividend in these sectors of our economy. For example, our university decision-makers, as a rule, function within an information vacuum[7] which almost inevitably means that their decisions are based on vague qualitative judgments and personal hunches. This traditional decision-making process should be replaced by a rational system of (1) setting goals, (2) setting alternatives, and (3) evaluating the results in terms of their costs and the requirements of contemporary society. Such approach is synonymous with the methods of systems analysis which has been successfully used by the Amer-

ican business. I would like to suggest that a similar, systematic approach be applied to various phases of college operations, but especially admissions and curriculum.

College Admissions

Our process of admissions is basically designed to fill the first-year classes of our professional colleges to their full capacity with well qualified students, so that (1) our educational resources are fully utilized and (2) admitted students can successfully complete the prescribed educational programs and then, become proficient physicians or dentists. However, our admissions process, as a rule, does not fulfill these goals adequately. In the first place, in dentistry, though not in medicine, the absence of any centralized coordinating or matching program has been resulting in vacancies in the first-year classes involving, in some years, as many as 150 or 200 available freshman places.[8] These unfilled places correspond to the enrollment capacity of two dental schools now under construction. Such totally unjustified waste of our scarce educational resources could, of course, be basically rectified by establishing a centralized and computerized program for screening applications, which, by the way, had been recommended by the Health Manpower Commission.[9]

Another aspect of our admissions process which should be carefully analyzed are the criteria used for selecting "qualified" students. The existing evidence seems to indicate that students' "suitability" for professional studies is being determined quite arbitrarily, and the prevailing dropout rate, which amounts to 9-10 percent of the enrolled medical and dental students each year, convincingly substantiate this fact. This staggering attrition rate represents not only a loss of approximately 1,000 physicians and 400 dentists each year, but also signifies a wasteful dissipation of public subsidies which, under our present system, are being used unproductively each year to support professional education of 1,400 dropouts.

There is a strong indication that our inability to prognosticate success or lack of success in professional college is partially due to our acceptance of the grade point average and scholastic "aptitude" as our primary predictors. The fact is, however, that not only we do not know how to measure the "grade-getting behavior", but we do not understand the relationship between the undergraduate college achievement to the subsequent success in professional college. Actually, variation in ability accounts only partially for the variation in grades, with the correlation between the two usually not higher than .5.[10] For that reason, it may be necessary to de-emphasize conven-

tional grading and aptitude testing and consider other characteristics of our applicants, primarily those related to their motivation and personality.

Such changes in our admissions criteria would require more extensive utilization of personality theorists, social phychologists, clinical psychologists, counseling psychologists and psychometricians. With their help we could employ various interests inventories and personality inventories to measure the process of translation of our applicants' self-concept into subsequent vocational preferences.[11] As another method of prediction we could use a biographical inventory[12] which may contain a wide variety of questions about applicant's childhood activities, experiences, sources of satisfaction and dissatisfaction, descriptions of the subject's parents, academic experiences, attitudes and interests, value preferences, self-descriptions and self-evaluations. I would like to suggest that the cost of these "psychometric" services would be quite negligible in comparison to the benefits derived from them.

Are We Using Relevant Academic Criteria?

The need for a drastic reassessment of our academic criteria has been brought to focus by a recent study[13] in which 80 parameters of physicians' performance were analyzed on a sample of several hundred Utah physicians. These data revealed that the employed "real-life" yardsticks of "professional productivity" were virtually unrelated to medical and pre-medical grade point averages or to Medical College Admission Test scores. This may very well suggest that we not only admit "wrong" applicants but, perhaps, also promote or flunk our students on the basis of "wrong" academic criteria which have little relevance to professional competence and "success" after graduation.

Lock-Step Professional Curriculum

The startling rate of student attrition is not produced exclusively by the academic failures; some students become disenchanted with the rigid, lock-step curricula and, for that reason, withdraw from professional colleges.

Our present educational system seems to be based upon an erroneous assumption that students can be lumped into scholastically homogenous groups. This supposition produced the prevailing pattern of education based upon a concept of teaching "to the middle". The fact is, however, that students placed in the same academic classes reflect a great variety of backgrounds, experiences, interests,

perceptions, abilities, and motivations. As an example, we may cite the results of Medical College Admission Tests between 1960 and 1963, which reveal variation across the schools of about 200 MCAT points. When such a heterogenous mass of students becomes exposed to rigid, lock-step curricula, slow learners experience frustration and high attrition rate while fast learners sense disillusionment due to the lack of intellectual challenge, and frequently withdraw.

Flexible Curriculum

Recognition of differences between individual students greatly complicates the "orderly" system of education, since flexibility means more of everything: more intensive counseling, more intensive interviewing, more alternative courses, more specific objectives and more evaluation.

A conventional professional college curriculum and its scheduling is normally developed by trial and error. This process usually calls for numerous revisions and compromises to accommodate frequent conflicts which, in most cases, are resolved without serious concern for pedagogical considerations. The possibility of developing individualized student programs which would serve both clinical and general educational needs has only become a reality with the advent of electronic data-processing procedures and high speed computers. As a result, systematically and analytically conceived curricular alternatives leading to a definite break with the traditional organization of professional teaching may be for the first time seriously considered.[14, 15]

Continuous Progress Education

A computer-generated, individualized, flexible curriculum should pave the way toward a system of continuous progress education under which students, freed of artificial barriers which presently tend to restrict their academic advance, could pursue education at their own pace. To a rapid learner, a continuous progress curriculum would mean shorter and more efficient education while to a slower learner, it would mean steady growth rather than frustration and eventual academic failure.

On the basis of a preliminary assessment of professional students' academic potential and motivation, we have estimated that a system of continuous progress education would allow 10 per cent of students to attain our educational objectives in 2½ years; 35 percent of students—in 3 years; 25 percent—in 3½ years; 20 percent—in 4 years and finally, 10 percent of students would need 4½ years

to graduate.[14] I would like to stress, however, that acceleration of student progress through continuous progress education should not be confused with an arbitrary shortening of professional curricula which is being advocated by some as a practical measure to increase the supply of professional manpower. In contrast to the scheme of arbitrarily abbreviated programs, the flexible, continuous progress education does not attempt to condense the content of existing curricula; instead, it provides the means to attain clearly defined behavioral curricular objectives by fitting individual, flexible programs to individual students.

Expanded Supply of Professional Manpower

On the basis of the above outlined conservative estimates of our students' "pace-potential", the output of professional colleges could be increased by 16 percent through a system of continuous progress education alone.[14,15] This would mean an additional 1,700 physicians and 680 dentists each year. These "manpower gains" combined with the "manpower saving" achieved by an effective management of college admissions procedures (10 to 12 percent of the first-year enrollment) could, therefore, yield a 26 to 28 percent increase in the educational output of our professional colleges, without altering their present enrollment capacity. This would represent a *supply of an additional 2,700 physicians and 1,200 dentists each year.*

It should be emphasized that this astounding gain in the sheer number of physicians and dentists could be achieved without lowering the quality of our end product. To the contrary, elaborate admissions procedures, relevant and functional educational objectives, student-oriented curricula and carefully validated evaluation criteria—which represent important features of the continuous progress educational system—could be expected to produce enlightened, judicious, considerate and productive physicians and dentists.

The proposed scheme of professional education would, of course, require an initial capital investment associated with the development of a variety of self-instructional and evaluation material. These expenditures would be partially offset, however, by the fact that they would free our teachers from the chore of repetitive lectures, so that, as a consequence, they would be able to devote more time to counseling, academic advising, tutorial sessions and other student-oriented activities. The relative value of these academic innovations could be readily translated to a dollar scale on the basis of the salutary effect they may be expected to have on student attrition rate

and the average duration of professional curriculum—both of which cost money.

Summary

It is quite obvious that if a high quality health care is to be delivered to the nation economically in the context of market-oriented enterprise, both the health industry and the education industry will have to undergo cost-effectiveness-oriented reorganization.

This paper presents a basic blueprint of educational innovations which could increase the output of professional colleges by nearly 30 percent, without the necessity for expanding their enrollment capacity and without lowering the quality of professional education.

REFERENCES

1. Kissick, W. L.: Forecasting Health Manpower Needs: The "Numbers Game" is Obsolete. J. Am. Hosp. Assoc. 41:47-51. 1967.
2. Fein, R.: The Doctor Shortage. An Economic Diagnosis. The Brookings Institution, Washington, D. C. 1967.
3. Rayack, E.: Professional Power and American Medicine: The Economics of the American Medical Association. The World Publishing Company, New York, N. Y. 1967.
4. Health Manpower Perspective. U. S. Department of Health, Education and Welfare. Public Health Service Publication No. 1607. U. S. Government Printing Office. Washington, D. C. 1967.
5. Burger, W. E.: State of the Federal Judiciary. Unpublished Remarks. St. Louis, Missouri. 1970.
6. Hartley, H. J.: Educational Planning-Programming-Budgeting. A Systems Approach. Prentice-Hall, Englewood Cliffs, N. J. 1968.
7. Judy, R. W. and J. B. Levine: A New Tool for Educational Administrators. A Report to the Commission on the Financing of Higher Education. University of Toronto Press. Toronto, Ontario. 1965.
8. Randolph, K. V.: Recruitment of Dental Students: The Problems and Some Possible Solutions. J. Dent. Educ. 25:203-207. 1961.
9. Report of the National Advisory Commission on Health Manpower. Government Printing Office. Washington, D. C. 1967.
10. Campbell, D. P. and C. B. Johansson: Academic Interests, Scholastic Achievements and Eventual Occupations. J. Counsel. Psychol. 13:416-424. 1966.
11. Kirk, B. A., R. W. Cummings and H. R. Hackett: Personal and Vocational Characteristics of Dental Students. Person. Guidance J. 41(6):522-527. Feb. 1963.
12. Taylor, C. W. and R. L. Ellison: Biographical Predictors of Scientific Performance. Science 155:1075-1080. 1967.
13. Taylor, C. W., E. G. Lewis, D. E. Nelson, G. C. Loughmiller and P. B. Price: Syntheses of Multiple Criteria of Physician Performance. J. Med. Ed. 44:1063-1069. 1969.
14. Jacobs, R. M. and N. S. Logan: Flexible Dental Curriculum. I. The Concept of Continuous Progress Education. In Press.
15. Logan, N. S. and R. M. Jacobs: Flexible Dental Curriculum. II. Simulation Model. In Press.

A Humanistic Orientation in Dental Education

ROBERT L. KAPLAN, D.D.S.*

Background

FOR MORE than a hundred years dental educators have concerned themselves with producing technically skilled dentists. In the more recent decades the emphasis has been toward a biologic orientation of these skills. Technical skills must always be a primary concern; however, there are other equally important elements that must be developed permitting students to become effective as dentists, far beyond the view of dentistry possible by total emphasis on technical dental skills, even though physiologically oriented. These elements are more abstract than the measurable technical skills, but fortunately for dentistry, they are in the plans of forward-thinking dental educators.

The qualities expected of future graduates of the new University of Florida College of Dentistry were summed up by Dean José E. Medina in a recent charge to his faculty as they worked together planning programs and developing curriculum. Doctor Medina projects that Florida graduates will, ". . . possess a biologic orientation; be sensitive to the needs of his fellow man; be skillful in all preventive, diagnostic and therapeutic procedures; and above all, be humanistic in their behavior."

This article will attempt to put into concrete terms Doctor Medina's challenging vision. An effort will be made to present a description of some of the elements involved that will produce dentists of technical excellence who are concerned with providing this excellence in a way most favorable to their patients' total health and well-being and in a way that at the same time will be "humanistic" in their behavior.

* Chairman, Advisory Committee to the College of Dentistry, University of Florida.

Needs in Patient Terms

To understand clearly what is involved in this more humanistic outlook, we can begin by thinking of the patient's needs falling within the scope of dentistry. If patients were asked what they thought would be the best dental care they could receive, what might their answer be? If they could express themselves, their answers might be:

"If I have no dental problems, please keep it that way."

"If problems are present with which you can rightfully be concerned, please eliminate them so there will be no problems now, or for my lifetime."

"Please do it with as little demand and risk on my physical and emotional well-being as possible."

"Help me use my parts with maximum pleasure, minimum inconvenience, and as little imposition on my life as possible."

"Don't maximize the minimal and 'nit-pick', but don't let me get into trouble either."

"Understand my fears, and help me overcome them."

"If you must frighten me to motivate me, do it thoughtfully and considerately."

"Understand that behind my poor attitudes toward dental health may be fear and distrust, not lack of education."

If one considers these thoughts as being the actual desires of the patient, one will begin to have a feeling for some basic considerations required in offering the best possible dental care in a humanistic manner. This kind of care begins with a patient-oriented attitude by the dentist, which is not easy to come by, because we as dentists have a certain amount of self-interest in what we do. This self-interest can come in conflict with the best interests of the patient. We also must overcome the handicap of medical and dental sciences becoming more and more complex causing us to focus on technical aspects, rather than on what patients desire from dentistry or medicine.

Characteristics of Mature Practice

The dental student should be taught that the keystone of the most mature practice of dentistry is the realization that, if he practices in a way that will satisfy both the technical and personal needs of his patients, then his own needs will best be satisfied in return, provided the economics of these needs are within the financial ability of the patient to cope with them.

The kind of dentist that Doctor Medina foresees will have an attitude that begins with a respect for the value of each patient's natural dentition in health, as well as a respect for him as a person even if he neglects his mouth. This attitude will be conveyed to the patient in an understanding and reasonable manner, free of inappropriate emotionalism or panic-producing pronouncements. He will be able to practice in a manner oriented to the diagnosis and treatment of the four major areas of therapy. These four areas of major concern are caries, periodontal disease, esthetics, and function as it relates to the patient's comfort and to the destruction, or mutilation, of his teeth and supporting structure. He will also practice with an awareness of tumors, cysts and other more rare diseases.

Interrelationship of Therapy

To this point in progress, traditionally and universally the restoration of cavities and the replacement of missing teeth has been the backbone of the general practice of dentistry. We all recognize this to a degree. But, we must emphasize teaching the inter-relationship between the preparation of cavities, and the restoration of missing teeth, and the relationship of these treatments to each of the other areas of treatment—periodontal disease, esthetics and function. These are serious problems to people who are concerned with their total well-being, even though they may not be able to describe them in these terms. Realistically, the dentist will continue to treat caries and restore missing teeth, but he will do it with considerable thought to the effect these procedures will have on the rate of advance of periodontal disease, and even on the incidence of periodontal disease.

The dental literature constantly refers to the iatrogenic disease implications of restorative dentistry, such as placing biomechanically inappropriate restorations with the consequent deleterious effect on the total health of the mouth. The dental student must be made aware of the high incidence of iatrogenic disease in dental procedures. These are essential considerations he must assess each time he performs mechanical restorative procedures. He must understand and be concerned with the effect these mechanical procedures have on the rate of advance on periodontal disease and on temporomandibular joint disturbances. Dental literature relates that the way restorations have been performed, or the way they have not been accomplished, directly influence the patient's subsequent development of temporomandibular joint disturbances. Also, the way we institute these mechanical procedures affects in a great measure the rate of wear on the dentition. The shifting of tooth positions, muscu-

lar dysfunction, chewing comfort and efficiency, esthetics, and even the self-image a person has of himself following extensive dental procedures, can be altered considerably by what is done to solve one problem. He will be concerned with preventing as much morbidity caused by dental problems as is rationally possible. Ideally, the treatment of caries, periodontal disease, esthetics, and function relate to the application of optimum dental skills; naturally, the thrust of dental education will be toward developing these necessary skills.

Individuality of Treatment

But, this is not enough in dental education, as it is not enough in dental practice. It is a formidable idea, but obsessive dedication to complete dentistry taught as a technical science to be urged compulsively for all, can be destructive. Maturity in attitudes and respect for individual patients and their physical and emotional differences must be foremost in the minds of dentists as they diagnose, recommend, and execute dental therapy. A patient is not a generalization. A patient is a specific, individual problem, and this is one of the characteristics we must accept. For instance, a patient may be treated by a gentle, careful, skillful, pain-free extraction with thoughtful pre-operative sedation. Or the same problem—this same specific tooth problem—could be treated with periodontal therapy, endodontics, occlusal refinement, a post and core to rebuild the basic part of the tooth, and then a porcelain jacket crown, or a three-quarter crown, or an onlay, for this one tooth. There are times when either could be done and the patient's comfort, well-being, self-esteem, and future health would not be altered. There are other times when the choice of what we do is quite important to the emotional and physical well-being. The physician's responsibility is to recognize and treat both physical and emotional disease. The dentist's responsibility is to learn to render dental therapy within the existing physical and emotional status of the patient. The teaching in dental school should reflect this different orientation. Dental students must be taught to be alert and recognize the patient's physical and emotional reactivity both during diagnostic visits and the ensuing treatment. This is what I believe Doctor Medina refers to when he talks of teaching young dentists to be sensitive and humanistic.

As a concrete example; once we begin to understand that a patient whose wife has just had a hysterectomy for a malignancy and has undergone irradiation, and concurrently is facing the added burden of children in college, plus all the worries of potential complications,

and who also has a severe dental problem, simply cannot react to his dental problem as we might wish. He is thinking of his total life situation, and we are thinking of his optimum dental health. How frustrating it can be for a man whom we know can afford dentistry, and who has a real dental problem, and yet seems totally disinterested in us and in dentistry. He *should* be disinterested, and we should understand it. At that particular moment, at that particular point in time, to have optimum dental care for himself is not an overwhelming life problem. But, it is important that he get the dentistry which is right for him under the circumstances.

It is simply not enough to learn only technical excellence in school, and it is simply not enough to offer only technical excellence in practice. It is essential to consider the total physical and emotional well-being of the patient in deciding which therapy to use at a particular time, and this must be the orientation and objective of a dental education.

Physical and Emotional Differences

There are great differences in the physical and emotional health of patients when they come to the dentist for care. Physical differences include present well-being, plus life expectancy and prognosis. Whenever we speak of optimum dental health and disregard life expectancy and prognosis in applying the remedy, we are not giving optimum dental health care. We are simply rendering optimum dentistry on a vacuum of teeth.

The emotional reactivity of the patient must also be understood. The significance of toothlessness and tooth loss varies tremendously from person to person. The significance of going from a few teeth to no teeth may be the difference between an acceptable psychological balance and a complete emotional breakdown. Extraction of the remaining teeth may not be the primary reason for the emotional reaction, but it can be the triggering mechanism in making a patient's total life situation more difficult from that time on. However, there are others to whom the same loss can be taken with equanimity without effect on their total well-being. These psychological factors cannot be disregarded in the total health picture, and must be taught to students along with technical skills. The recognition of anxiety and the common defense mechanisms against anxiety, and the techniques for establishing satisfactory doctor-patient relationships should be included in dental education. This knowledge will make it easier for both patients and dentists to achieve satisfactory dental goals.

Appropriate Therapy As the Goal

For too long the dental student has been unprepared for the frustrations of patient acceptance, resulting in his acquiescence to the patient's demands for care, or forcing him into inappropriate techniques of treatment presentation. In a humanistic dental practice, diagnosis and treatment is not a matter of acquiescence, or salesmanship, or "case presentation", or pride, or idealism. When patients come to us, we explain treatment procedures, but insist that their selection in therapy be a patient decision. It will always be a patient decision, but a humanistic attitude requires us to help each patient obtain the treatment best for him at a particular time and place. It is helping each patient toward value judgments which take into consideration his dental health, his physical health, and his emotional well-being. This decision should not be a product of a high powered practice administration selling; neither should it be dictated by our own needs, of which we are often unaware but must be taught and understood by the student. It should not even be based on an enthusiastic, but immature, love for saving teeth. We must be aware of the compulsive, idealistic urges that we as therapists possess to render a theoretic ideal and impose it upon people no matter what. The dental student must be taught the behavioral skills to render appropriate dental treatment.

The key word in a humanistic outlook is appropriate therapy. Decisions are value judgments and must be based on doing what is most likely to contribute to the patient's total well-being and comfort. The dental student will soon be able to understand that, strange as it may seem at first, the practice of dentistry oriented this way does not mean less optimum dentistry for fewer people and will not make it more difficult for him to practice successfully. On the contrary, it will permit him to be more effective as a therapist, since these attitudes will lead to more satisfactory doctor-patient relationships.

Summary

In summary, students graduating with this broadened orientation will be taught to practice with optimum skill, understanding and integrity. They will convey, not by words, but by the quality of their contacts with patients, that this is their interest and concern. They will understand that dentistry has a particular niche in the total life situation at a particular time. They will know that the way they

treat caries and restore teeth has much to do with other problems, and that much of dentistry is interrelated. Time, skill and understanding will be their wares as professional men, and they will be able to apply them effectively. They will learn from teaching material specifically oriented to an understanding of behavioral sciences and more especially by the example set by the clinical faculty of the dental school. What they learn in theory will be reinforced, or modified, by their school clinic experiences and the implied or expressed attitudes of their teachers toward the clinic patient.

The aim of Doctor Medina to produce, ". . . graduates who have a biologic orientation, be sensitive to the needs of his fellow men, be skillful in all preventive, diagnostic and therapeutic procedures, and above all to be humanistic in their behavior", is the next logical step in the growth of dentistry as a health profession. It is the kind of idealism that will produce the most effective and adaptable dental graduate. It is a remarkable challenge to any dental faculty.

960 Arthur Godfrey Road
Miami Beach, Florida 33140

Dental Continuing Education in New England

RICHARD M. RYAN, JR., M.S.S.S., M.S. (Hyg.)
ALLAN F. WILLIAMS, Ph.D.
HENRY WECHSLER, Ph.D.

DURING 1967 and 1968 two studies of dental continuing education were conducted by the Medical Foundation. The first was a study of the continuing education experience and interests of dentists in New England.* Information on these topics was collected by means of a mail questionnaire. The second study included an examination of existing continuing education courses in New England, with special emphasis on courses available in remote areas.** Recommendations for dental continuing education in New England were developed as part of this project. In this study, information was collected mainly by means of personal interviews held with dental educators and officers of dental societies in the six New England states.

In collecting information on the above topics, a number of additional issues concerning continuing education were raised. A summary of the information collected on continuing education, and a discussion of these other issues, are presented below. Dentists from each of the six New England states cooperated in the studies, and provided important information on these and other topics. Thus it was possible to consider continuing education in New England from a regional point of view, comparing problems faced by dentists in the different states and making recommendations on the basis of the whole area.

* This study was supported by the health departments of the six New England states.

** This study was carried out under contract P. H. 108-67-188, Division of Dental Health, U. S. Public Health Service. The material reported in this paper does not necessarily reflect the opinions or policy of the Division of Dental Health.

Continuing Education Courses Available

An estimated 450 to 490 continuing dental education presentations were available in 1968 in New England. These are presented by state and sponsor in Table 1. Table 1 also presents the number of dentists in each state. A large proportion (57%) of all continuing education presentations are available in Massachusetts and Connecticut. The courses most frequently offered in New England were Periodontics, Crown and Bridge, Endodontics, Practice Administration, and Operative Dentistry.

The usual method of course delivery was via the lecture method. Participation courses were practically non-existent, even among courses offered by the schools. Demonstration courses were more frequently available in the southern states of Massachusetts, Connecticut, and Rhode Island than the northern states; yet they were infrequently offered in these states as well. Non-personalized methods of course delivery—teaching machines, correspondence courses, movies, and closed-circuit television—were also infrequently used.

Availability of Continuing Education Programs Within States

The greatest activity in continuing education is usually generated around major cities within each state. The percentage of all continuing education presentations by major area where meetings are held in each state is shown in Table 2.

TABLE 1

CONTINUING EDUCATION PROGRAMS IN NEW ENGLAND IN 1968

	Number of State Dental Society Members	Statewide Dental Society Meetings	District Dental Society Meetings	Dental Schools	Meetings By Other Sponsors[1]	Total Presentations
Connecticut	1900	6	118	0	1	125
Maine	320	2	26	0	13	41
Massachusetts	3700	2	61 to 71	52 to 73	11	126 to 157
New Hampshire	270	3	48 to 49	0	25	76 to 77
Rhode Island	450	2	24 to 26	0	13 to 18	39 to 46
Vermont	154	5	25 to 28	0	12	42 to 45

[1] Other sponsors include the Academy of General Dentistry, the New England Dental Society, the American Society of Children's Dentistry, and other such organizations.

TABLE 2

State	Major Area Where Meetings Are Held	% of All Continuing Education Meetings Within the State Presented in Major Area	% of Dentists In That Area
Connecticut	Hartford-New Haven-Fairfield Counties	62%	40.3%
Maine	Portland-Lewiston-Augusta	87%	64.1%
Massachusetts	Greater Boston Area (35-mile radius)	90%	64.5%
New Hampshire	Nashua-Manchester-Concord	73%	43.8%
Rhode Island	Greater Providence (35-mile radius)	100%	50.0%
Vermont	Rutland-Bennington-Burlington	95%	45.5%

Approximately 84 percent of all continuing education presentations in New England were offered in the vicinity of the six major urban areas of the states. Thus courses are not spread evenly throughout the states but are mainly located in one specific area and are not as readily available to dentists located outside these areas. The percentage of dentists located outside these areas is larger than the percentage of courses readily available to them, so they are not getting an equal opportunity. This situation creates problems particularly in the northern states of Vermont, Maine, and New Hampshire, which are large and predominantly rural. Many dentists in geographically remote areas of these states have limited continuing education opportunities in their own area, and severe distance problems (as much as 200 miles for some dentists in Maine) in obtaining continuing education in their own state. Many dentists who were interviewed during the course of the study felt that dentists in geographically remote areas were least adequately served by continuing education programs, and that they constituted a special problem for continuing education planners.

Besides having few continuing education courses, geographically remote areas also tend to have few dentists, relatively poor organization, limited communication, a scarcity of qualified indigenous instructors, limited funds to attract outside speakers, and distance problems in getting to continuing education courses outside their area.

Possible ways to serve the continuing education needs of dentists in remote areas include the encouragement of the development of local study clubs, and the pooling of resources by several contiguous remote areas to bring in speakers for a program held at some central location.

In recent years, emphasis has been placed on teaching machines as an effective way of reaching dentists located in remote areas. While the teaching machine technique is well-suited for reaching these dentists, it must also be taken into consideration that only 3% of the dentists in New England who responded to the questionnaire on continuing education preferences listed teaching machines as one of their three preferences for method of course delivery. This extreme lack of interest may merely indicate unfamiliarity with this technique. Nevertheless it indicates that attention needs to be paid to familiarizing dentists with this technique if it is to be used, or else programs based on this technique are not likely to be popularly received. It may be possible in some cases to combine automated methods of delivery with the personalized methods preferred by dentists, e.g., open circuit television with a panel to answer questions later by telephone conference hookup.

There are some cases in which an area which is geographically remote in its own state is contiguous to an area in another state where courses are more readily available. Lines of communication should be broadened across state lines and dentists in the remote areas should be encouraged to take advantage of this continuing education opportunity.

Publicity for Continuing Education Programs

In many cases in the past there has been duplication of speaker and/or program in neighboring local dental societies. Publicity about programs available is often limited. Frequently, dentists in neighboring states or districts within the states know little about each other's meetings. There were several suggestions received during the course of the study that a clearing house for continuing education, which might also include a speakers' bureau, be established, and that interstate and intrastate continuing dental education committees should be formed to assist in the planning and communication of all continuing education programs. These measures would allow dentists to take advantage of programs other than their own.

The Quality of Continuing Education Programs

There is no information available on the quality of present continuing education programs, or on their effectiveness in getting dentists to utilize correctly newly admitted techniques or information in their practice. Evaluation of continuing education programs in

terms of these goals is sorely needed. It is rarely possible to carry out an evaluation study with adequate control groups and other procedures designed to provide an objective assessment of the continuing education presentation. However, at the very least, feedback information should be collected from participants how useful the course was. This type of information can then be used in planning future programs.

Methods of delivery also need to be compared and evaluated to see which are most effective in communicating the material. Before any one technique is endorsed, a variety of feasible delivery methods should be compared, both automated and non-automated ones. It may be, of course, that one method is most effective for one topic, and another method for other topics.

Continuing Education Course Participants

It was found in the mail questionnaire study undertaken by the Medical Foundation that 77% of the respondents had taken at least one continuing education course previously. A report based on the 1957 survey by the National Opinion Research Center, University of Chicago, showed that over three-fifths had taken at least one continuing course.[1] Although these percentages are quite high, they indicate that a substantial proportion of dentists have never participated in continuing education in their career as a practicing dentist.

In the Medical Foundation study those who had ever taken a course, compared to those who had not, were more likely to be specialists, to have higher incomes, and to be less isolated by virtue of their greater likelihood to be ADA members and to be in a partnership or practice in a dental building rather than practicing alone in a non-dental building. It was also found that while younger and older dentists did not differ on the percentage who had ever taken courses, younger dentists had taken a statistically significant greater number of courses relative to the number of years since their graduation from dental school than had older dentists. In addition, younger dentists had taken a course more recently than had older dentists. Sixty-eight percent of dentists under 40 had taken a course during the previous year, as compared to 50% of those dentists age 40-59, and 29% of those age 60 or over.

O'Shea, in reporting the 1957 NORC data,[2] also found that specialists and those of higher income were more likely to have participated in continuing education programs. It was found by O'Shea

that older dentists were more likely than younger dentists to have ever taken a course, but that younger dentists were more likely to have taken a course recently.

It is not presently possible to tell whether or not a dentist who participates in continuing education programs is maintaining the quality of his dental practice and keeping up with the latest advances in dental care. However, of special concern is that group of dentists with no continuing education experience. These dentists, in view of their relative isolation, lower income, and lack of advanced training, may be considered to be more in need of continuing education than other dentists. Yet they have never taken a course. Continuing education planners should pay special attention to this sub-group, but it is doubtful that they can be successfully reached unless strong demands are made by the dental societies and licensing bodies to gain their participation.

Continuing Education Interests of Dentists

The first study conducted by the Medical Foundation dealt with continuing education interests of dentists. Results of this study have been reported in detail elsewhere[3] and will only be summarized here. A mail questionnaire used to obtain information on this topic was returned by 4114 (61%) of the 6749 active dentists in the six New England states—Connecticut, Massachusetts, Rhode Island, Vermont, New Hampshire, and Maine.

Almost all (94%) of the dentists responding to the questionnaire said that they would participate in a program of continuing education for dentists in their community. These dentists who wanted to take courses tended to prefer courses which would have immediate application in a general practice (e.g., crown and bridge, complete dentures, periodontics, practice administration). They were least interested in radiology, dental public health, and care of special problems. Respondents wanted personalized delivery of courses in the form of demonstration, participation, lecture or discussion. There was very little interest in non-personalized methods of delivery such as teaching machines, correspondence courses, movies, or closed-circuit television. Respondents generally wanted dental societies to sponsor continuing education programs. The preferred locations for courses were local hotels or hospitals and, in those states where one existed, a dental school. Courses would be most convenient for dentists if given on Wednesdays during the winter months and restricted to two days' duration. There was found to be little variation among

states on these continuing education preferences. It was found that the most preferred continuing education topics were generally among those most often presented in the various states. The most frequently expressed preferences for duration of course (no more than two days), sponsorship (dental society), and location (local hotels and local hospitals in states without a dental school; a dental school in Massachusetts and Connecticut) also corresponded to existing courses. The one preference of dentists not met by existing courses was method of delivery. The lecture method, which is most frequently used, was one method preferred by dentists. However, demonstration and participation methods—infrequently used—were more popular.

Correspondence Between Continuing Education Interests of Dentists and Their Needs

There is no easy way of determining what are the continuing education needs of dentists, i.e., the areas of dentistry in which the dentist most needs instruction in order to improve the quality of his practice and/or keep his methods up-to-date. This can only be done by examining the dental work done by a dentist on a sample of patients presenting various problems. Nevertheless, it is unlikely that there is a one-to-one correspondence between interests and needs. Several dentists who were interviewed felt that while dentists needed the "bread and butter" courses which they preferred, they also needed courses which were rarely presented, such as Care of Special Problems, Diagnosis, Anesthesia, and Radiology.

One realistic solution to this situation is to have dentists assess their own needs informally. At dental society meetings, interested dentists could fill out a check-list which would ask about the frequency with which the dentist is called upon to deal with various types of dental problems in his practice; the techniques or areas of dental care which the dentist feels he most needs improvement in, or instruction in the latest methods; and the types of programs on continuing education in which he is most interested in participating. These check-lists could be filled out anonymously, and used by continuing education program planners who would be able to select topics that dentists both needed and were interested in. One problem in this method is that it assumes that the practitioner is aware of his own needs. Yet, imperfect as it is, it is an improvement over current methods of topic selection.

(Continued on Page 126)

Peer Review*

C. GORDON WATSON, D.D.S.†

IN THE DECADE since I concluded practice to enter the field of administration, the dental profession has been bombarded with new words, names and phrases which in one way or another describe new elements in financing and providing dental care.

Ten years ago the following terms would have been meaningless to most of us: prepaid dental care, pre-authorization, 5 percent withhold, standardized claim forms, Medicaid and Medicare, dental service corporations, Delta Dental Plans Association, comprehensive health planning, quality control, mediation, third party payment, usual, customary and reasonable fees, table of allowances, Headstart, National Health Insurance, Regional Medical Programs and Health Maintenance Organizations.

No doubt we all react differently to these phrases depending on our own experience and involvement. To those who have had vast experience in prepaid dental care, as have our colleagues on the West Coast and Hawaii, most of these terms are no longer cause for concern or fear. However, to those dentists who have had little experience in pre-paid dental care, the fear of the unknown and unfamiliar will prevail until some first-hand experience is gained.

You may have noticed one significant omission from the list—Peer Review; or, as the current Congress refers to it, Professional Standards Review Organizations. Even in those states where prepaid dental care has been a part of dental financing for ten to fifteen years peer review is not well understood. In some states limited attempts have been made to implement the peer review mechanism.

To the profession as a whole, however, implication of the need for peer review is distasteful, unwanted, feared and most of all misunderstood by most dentists. Perhaps the major reason for this feeling is that as members of the health team, dentists have tradi-

* Presented at the Conference of State Society Officers, November 8, 1970, Las Vegas, Nevada.

† Executive Director, American Dental Association.

tionally functioned in an environment more isolated from observation than any of the rest. Most medical doctors are under observation by their peers because of their involvement in hospitals and extended care facilities which have many rules and procedures which bring the quality of the physician's services under surveillance.

The advent of Medicare and Medicaid with their accompanying regulations for quality and utilization review has brought about the expanded use of peer review by our medical colleagues. Some state legislators have included dentistry as a Title XIX benefit and in such instances dentistry along with medicine has been required to provide some method of evaluating the quality of services rendered.

Apart from government-sponsored programs, the rapid growth of privately-sponsored prepaid dental programs is placing upon the profession the responsibility of insuring high quality dentistry and of providing some system to justify fees when the usual, customary and reasonable fee concept is used.

No doubt many state society officers question the appropriateness of this subject on today's program. To those who may have this opinion may I assure you that all evidence points to the fact that "peer review" will soon be an everyday part of our lives in dentistry. Let's take a few minutes to consider some of the evidence.

Public Demands for Quality and Cost Control

In recent years there have been published many comments from a variety of sources which document the public's demand for methods to insure the quality and control the costs of health care plans.

Last February in a Chicago newspaper under the headline "Hint Medicare Fraud", it was reported that the U. S. Senate Finance Committee staff proposed that the government develop a schedule of maximum fees for physicians to help curb soaring costs of Medicare and Medicaid. This suggestion was the key recommendation in a far-ranging 323 page report which examined the problems of "the rapid and continuing escalation in the costs of health care", and criticized the way the two government programs have been administered.

In addition to criticizing government agencies, the report accuses doctors, hospitals, nursing homes, and insurance intermediaries of wrongdoing, ranging from fraud to waste and inefficiency. The report further noted that "people are being priced out of the private health insurance market as a result of the frequent and substantial premium increases required to meet the ever-greater costs of health care".

The report recommended that, as an interim measure, the insurance carrier serving as a Medicare intermediary, such as Blue Shield, set as a Medicare maximum the average payment it now makes under all its private contracts for a given service or procedure.

As an apparent answer to the charges made in the Chicago newspaper, an article entitled "Society Tells Plan to Curb Medical Cost" appeared in the same paper within the next few days. It stated that the Illinois State Medical Society had just established a plan to curb wasteful medical practices. The Society claimed that the new plan can reduce state medical costs by 10 to 20 percent.

What was the plan? You guessed it, a peer review system. The article explains that all physicians will submit to an evaluation of their charges and their medical practices by an "impartial" committee of physicians when a complaint is made against them. The medical society claimed that the program was designed "to conserve the patient's health care dollar, assure appropriate use of health care personnel and facilities, and maintain high standards of medical practice".

Organized Labor's Interest

Two representatives of organized labor are quoted now to represent labor's position on the subject. Both quotes are from representatives of the AFL-CIO. The President of the Union, Mr. George Meany, had this to say:

> We are perfectly willing to leave the treatment of illness to members of the medical profession. That's their business. That's what they're trained to do—for long years and usually at considerable expense.
>
> While we think medical treatment is the doctor's business, the health of Americans is the nation's business. And, more specifically, the health of workers is a major concern of the trade union movement.

In adding his own opinion, Mr. Andrew J. Biemiller, director of the AFL-CIO's Department of Legislation, told a January, 1970 meeting of the Philadelphia Medical Society:

> We believe you doctors ought to have the opportunity to practice medicine to the fullest extent of your abilities and dedication. We believe you ought to have maximum opportunity to make the quality of health care in this country the very best in the world. For we are concerned about quality, too. After all, it is our bodies, our health and our lives that you are dealing with.
>
> We believe doctors deserve an income commensurate with their talents and their services. We don't object to this. How could we? In the labor movement, we try to obtain decent incomes for as many people as possible on much the same basis.

> But as we see it, this does not excuse some, or even a few doctors, of taking advantage of their unique position to arbitrarily charge excessive fees for their services.

In the January, 1970 issue of *Fortune Magazine* as a part of a feature article on the American health care system *Fortune* stated the problem this way:

> The financial distortions, the inequities, and the managerial redundancies in the system are of a kind that no competent executive could fail to see, or would be willing to tolerate for long.
>
> The conversion to modern methods, and the institution of some degree of efficiency that Americans have reached in other realms, would probably effect enough saving so that good care could be brought to every American—with very little increase in costs.
>
> Nobody except other physicians should tell physicians how to practice medicine. But the *management* of medical care has become too important to leave to doctors, who are, after all, not managers to begin with.

White House Report on Health Care Needs

The demand for quality and fiscal control in the health field is issued in the July, 1969 "White House Report on Health Care Needs":

> We will ask and challenge the physicians, dentists and other practitioners of the nation, through their national societies, and through the county associations, to establish procedures to review the utilization by their members in all instances to less expensive type of care; and to discipline those who are involved in abuses.

As an apparent follow-up the Department of Health, Education and Welfare issued a policy statement which required state programs, by July 1, 1970, to show an effective system of utilization and quality control, including provision for the disqualification of practitioners who are found to have defrauded, overutilized, or otherwise abused the program.

National Commission on Health Manpower

The need for peer review procedures to evaluate the quality of health services has been recognized for some time. In November, 1967, the National Commission on Health Manpower recommended, "that professional societies, health insurance organizations, and government should extend the development and effective use of a variety of peer review procedures in maintaining high quality health and medical care. These procedures should incorporate the following principles: (1) Peer review should be performed at the local level

with professional societies acting as sponsors and supervisors. (2) Assurance must be provided that the evaluation groups perform their tasks in as impartial and effective manner. (3) Emphasis should be placed on assuring high quality of performance and on discovering and preventing unsatisfactory performance".

Professional Standards Review Organizations

In the current session of the Congress, Senator Wallace Bennett (R-Utah) has introduced amendments to Titles XVIII and XIX which would establish Professional Standards Review Organizations to help control the Medicare and Medicaid programs. As originally written the amendment provided that medical society committees would have sole authority to review hospital, medical, dental and other health programs related to the Medicare and Medicaid acts.

After discussion with Senator Bennett's staff by the Association's Washington Office representatives agreement has been reached to modify the amendment so that only dentists will review dental programs. The Bennett Amendment has been subject to other modifications, but the latest version has provisions for the establishment of Professional Standards Review Organizations at local and state levels. Each would include practicing medical doctors. Peer panels would be composed of physicians who would hire, for example, medical doctors to audit work of other physicians, dentists to check dentists and therapists to check therapists.

American Dental Association's Policy on Peer Review

In 1967 the House of Delegates approved the statement *Dental Society Review Committees* (*Trans.* 1967:324) which had been proposed by the Council on Dental Care Programs. The 1967 policy statement limited the activities of Review Committees to a determination of the relevancy of the usual, customary and reasonable fee and of treatment procedures to the terms of the contract. Review of the quality of care was specifically excluded as a function of the committees in the initial policy statement. However, in 1969 the House approved modifications of the original statement (*Trans.* 1969:319) which brought quality assessment within the purview of review committees.

The Council on Dental Care Programs has received many requests for clarification on the subject of quality assessment and therefore is recommending further modification of the Association's policy statement (*Supplement 1* 1970:16) to the House of Delegates here

in Las Vegas. I personally support the further modifications as recommended for I believe they will assist constituent and component societies in their responsibilities.

A complete understanding of the Association's policy and recommendations with respect to Peer Review can best be accomplished, in my view, by quoting the policy in its complete form. I will take the liberty of quoting the document being proposed for the House's approval this week, for unless we consider quality control as a responsibility of peer review we will fall short of the responsibility which the public demands of us.

Dental Society Review Committee*

The functions of review committees are to determine the relevancy of the usual, customary and reasonable fees, of treatment procedures to the terms of the contract, and may include assessment of quality of services rendered. However, these functions shall not include setting fees, determining practice or interfering in the dentist-patient relationship.

Dental societies should assume leadership in establishing professional review committees for prepayment programs. The dental society review committee, as an established mechanism of organized dentistry, should provide for the review of reasonable differences of opinion between a third party agency and a dentist. Third party agencies may include insurance carriers, dental service corporations, administrators of health and welfare trusts and government agencies.

The purpose of review committees is to provide positive assurances of quality care for all participating dentists and dental societies as well as the patients they serve. To guide dental societies in establishing review committees, consideration of the following principles is recommended:

1. The committee should be established as an official agency of the sponsoring constituent or component society.
2. The committee membership should include representation of all relevant fields of dental practice as members or consultants.
3. The committee should consider problems submitted by dentists and third party agencies.
4. The committee should not be vested with disciplinary authority.
5. The committee through the sponsoring dental society should have available formal criteria for the determination of usual, customary and reasonable fees.

* As proposed by the Council on Dental Care Programs (*Supplement 1* 1970-16).

6. The committee should utilize standard procedures and forms in obtaining data required for adequate evaluation.
7. The committee should provide information on its purposes and functions to all members of the sponsoring society.
8. The committee should not consider cases in litigation, cases in which all benefits have been paid or in which treatment has been completed over one year.
9. The committee should have as consultants representatives of third party agencies and the state Health Insurance Council.
10. The committee should not review differences between patients and dentists.

The following guidelines are suggested to assist dental societies in implementing the foregoing principles:

Organization

The review committee should be a permanent committee of the state dental society with appropriate status and liaison with related committees. It could be a subcommittee of the committee on dental care programs or other agency charged with the responsibility for maintaining liaison between the dental profession and third party agencies. In some states, review activities may be sufficient to warrant establishment of review committees at component levels.

A clear delineation should be made between the review committee and the grievance or counselling committee. The review committee is an advisory committee, with no disciplinary functions. Reports on cases indicating a need for disciplinary procedures may be referred to another appropriate committee. Patient management and dentist-patient problems should not be within the purview of the review committee.

Composition

The committee should be composed of dentists in practice for a considerable number of years and whose professional judgment is respected. Terms on the committee should be staggered to assure continuity of experience.

Submission Procedures

It is recommended that dentists and third party agencies submit all cases initially to the state review committee for possible referral to component committees.

The dentist involved in the case should have the opportunity to consult with or be consulted by the committee during its review of the case. The recommendation of the committee should be sent to the

dentist and to the third party agency. Interested parties should be informed that an appeal mechanism is available.

Before the committee accepts a case submitted by a third party agency, the agency must have discussed the claim with the dentist to obtain the facts and have attempted to resolve the problem without recourse to the review committee. The third party agency should submit all documents to the review committee, along with information on whether the case involved complications or unusual circumstances.

The third party agency may notify the patient of a delay in payment of a claim but should not indicate to the patient that the case has been referred to a review committee. When a decision is reported, the third party agency should process the claim for payment.

Assessment of Quality

The quality of prepaid dental programs is the logical concern of the dental profession. Assessment of quality may be of several types: (a) assessment of the quality of treatment services; (b) assessment of the dental health benefits of the entire program and (c) assessment of the administration and efficiency of the program.

In establishing review committees in prepayment programs, dental societies should consider assigning to them assessment of quality of treatment services. Some methods now being used to assess quality of treatment services include:

1. Follow-up and evaluation of patient complaints
2. Evaluation of complaints of second-treating dentists
3. Random post-operative screening of patients
4. Review of records for adequate history, treatment plan and recording of services provided
5. Statistical audits
6. Review of post-operative bitewing radiographs

In addition to the assessment of quality of treatment services which a review committee may conduct, there is need for overall evaluation of prepaid programs which many societies are now doing. In this respect, constituent societies have the responsibility for evaluating quality from the viewpoint of general effectiveness and administrative efficiency and economy of dental prepayment plans which come within their jurisdiction. The evaluation criteria applied should be consistent with standards that have been approved at the national level.

Appeal Mechanism

The state society should establish a mechanism for appeal from decisions of the review committee. Decisions of a component review committee may be appealed to the state review committee.

Publicity

The functions of the committee should be publicized to the membership of the state society to foster understanding of prepayment procedures. There should be no publicity to the general public. The committee should not publicize its disposition of specific cases to the profession.

The state society should notify third party agencies of the review committee's availability. Notification of the existence of the committee should be made to the Council on Dental Care Programs of the American Dental Association, the Health Insurance Council and the National Association of Dental Service Plans.

Conclusion

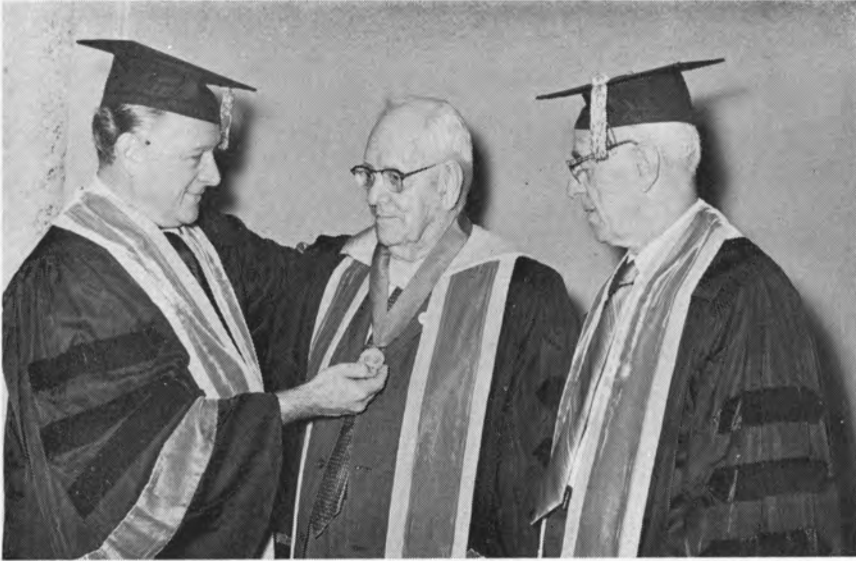
Before concluding I wish to make a comment in the form of a "word of warning". In my own experience in observing component review committee reports being returned to constituent societies for transmittal to service corporations there appears to be a tendency for committees to protect their colleagues rather than function in a true peer review capacity. This tendency is pure "white wash" and should be avoided like the plague. I can think of no single action which will destroy good relations between the profession and its public than for peer review committees to degenerate into "peer justification committees"—a term coined by Dr. John Zapp.

Finally, may I take this opportunity to thank the officers of the Conference for this opportunity to speak on a topic which I believe to be relevant and timely.

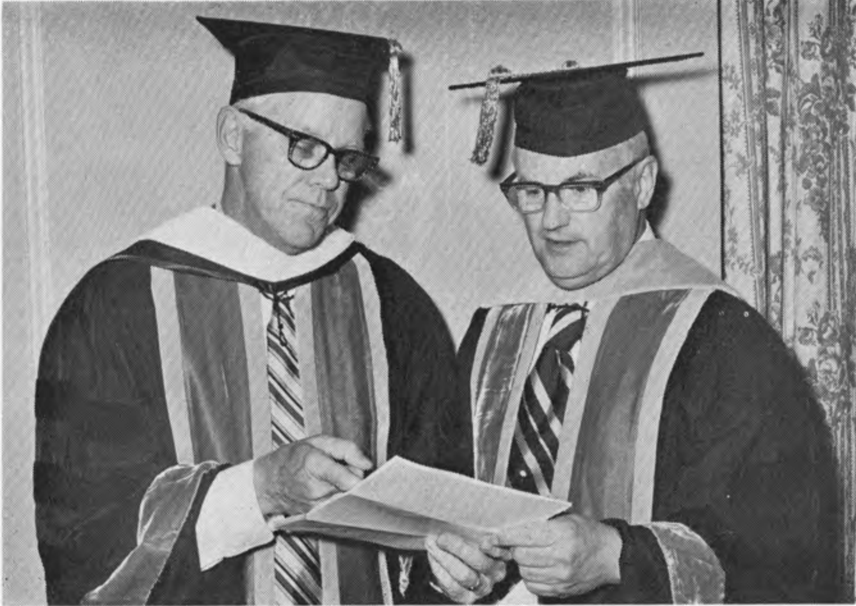
211 E. Chicago Avenue
Chicago, Illinois 60611

New Officers and Regents

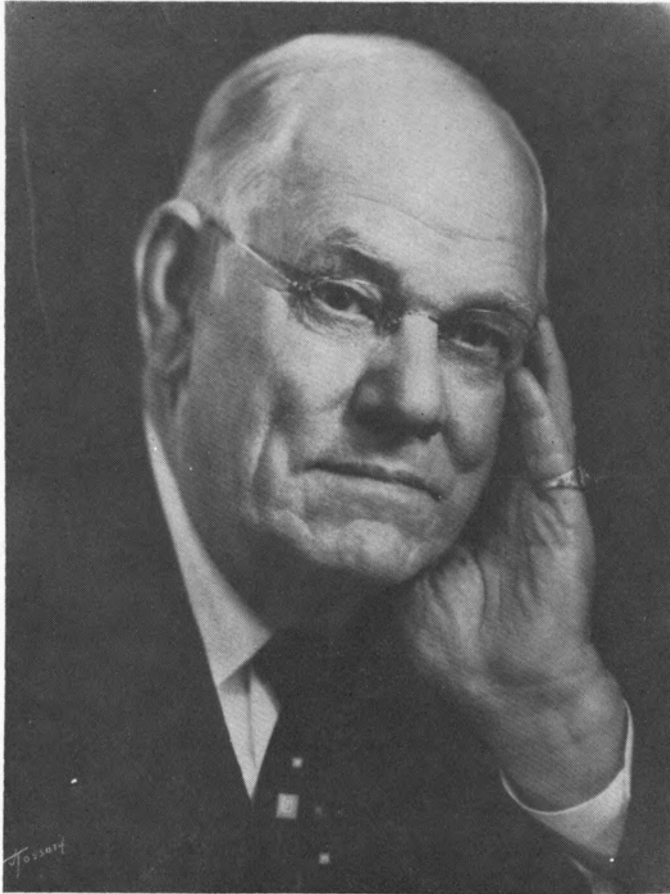
Newly elected Officers and Regents who took office in Las Vegas are, left to right, Regent James L. Cassidy, Vice President J. Lorenz Jones, President Otto W. Brandhorst, and Regent Charles F. McDermott.



President Frank P. Bowyer presents the American College of Dentists Award for Excellence to Dr. J. Ben Robinson. Historian of the College and Special Award Committee Chairman Harvey S. Huxtable, at right, read the citation.



Past President Philip E. Blackerby, who presented the convocation address, with Secretary Robert J. Nelsen.



J. BEN ROBINSON

Honors and Awards

J. Ben Robinson Receives Award for Excellence

THE American College of Dentists Award for Excellence, a gold medal, was presented to Dr. J. Ben Robinson at the College Convocation in Las Vegas. Historian Harvey S. Huxtable read the following citation:

"Dr. J. Ben Robinson, Dean Emeritus of the Baltimore College of Dental Surgery, Dental School, of the University of Maryland, and Dean Emeritus of the School of Dentistry of the University of West Virginia, has had a most distinguished career in the profession of dentistry over the past fifty-six years.

A native of Clarksburg, West Virginia, Dr. Robinson graduated from the University of Maryland in 1914, *summa cum laude*. He remained there as an Instructor in Operative Dentistry, advancing to the rank of Professor and Dean of the College of Dentistry. After twenty-nine years as Dean, he turned to the University of West Virginia to help establish and develop a new dental school there, serving as Dean of the College of Dentistry of West Virginia.

Dr. Robinson has contributed significantly to dental education as well as to the dental literature. He has served his profession with distinction in many capacities including the high offices of President of the American College of Dentists, President of the American Dental Association, President of the American Association of Dental Schools, President of the American Association of the History of Dentistry, President of the Maryland State Dental Association, and as Supreme Grand Master of the Psi Omega Fraternity. He has been the recipient of many awards including the William John Gies Award of the Award of the College (1956).

Dr. Robinson has demonstrated sincerity and dedication as a responsible citizen, having served for two six year terms as a member of the Board of School Commissioners of Baltimore City, as a member of the Board of Recreation and Parks of Baltimore City, as advisory member of the National Selective Service, as a member of the Commission to study the Medical Department of the Army, as Advisor to Dental Education to the War Manpower Com-

mission, World War II, as the State Department Goodwill Representative to the Mexican Medical Congress and as Dental Advisor to the Library of the Surgeon General.

On this occasion, a special award is presented to him for he has best displayed the qualities expected of a Fellow of the College and he has demonstrated meritorious achievement while serving his profession, his community and his country. This award, the AMERICAN COLLEGE OF DENTISTS AWARD FOR EXCELLENCE, therefore is given in recognition of outstanding contributions to the art and science of dentistry, its practice, education, research and organizations; and further for outstanding service to his community and his country with a broad appreciation of the arts and literature of humanity."

Acknowledgment By Dr. Robinson

In accepting the award, Dr. Robinson made the following remarks: "I am happy to be able to join with the fellows of the College in observing the semicentennial anniversary of its founding. I share with all those present a sense of pride in the success the College has had during the past 50 years in establishing the strong position it now holds in the forefront of dental progress.

The impressive ceremonies that mark this the 50th convocation of the College; the thoughtful discussions of important problems of vital concern to the future of dentistry which you have heard during previous sessions of this meeting; and the historical exhibits and dramatic portrayals of its historic achievements which you have been privileged to see, testify to the continuing worthwhile activities of the College and fully justify the pride you take in its recognized strength, quality and usefulness.

As your thoughts are focused upon the present happy state of the College, my thoughts turn to its early days, particularly to conditions as they were at the time of its third convocation held 47 years ago at which I was made a fellow.

Colorful pageantry and symbolic rituals as they are being observed here today were then lacking; there was no capacity audience composed of enthusiastic friends of the candidates and the College; candidates for fellowship had been selected impromptu by the Board of Regents at an earlier meeting held for the purpose, and individual members of the Board acted as mentors for those candidates whom they had nominated for election. I was honored to have had as my mentor one of the principal founders who was then president of the

College, Dr. H. Edmund Friesell. There were no personal sponsors to accompany the candidate; no formal capping of the neophyte and no investing him with the distinctive College gown. The convocation ceremonies consisted of a short orientation address by the president, the charge to the candidates and their pledge of loyalty to the ideals and purposes of the College.

From these very simple but determined beginnings the College has moved steadily forward and upward to reach its present highly esteemed position among other leading dental organizations. Surely its meaningful growth demonstrates the truth of the old adage, 'Great oaks from little acorns grow.'

I am honored to have been selected to receive from the College on this historic occasion its special Award for Excellence. It is the high point in my professional career and a heartwarming experience that will remain bright in my thoughts to the end.

The term 'excellence' as used to form a title for the award has a particular significance. Excellence in performance means achievement of a superior or surpassing quality. It is not a concrete entity ready at hand to respond to the call of those who would acquire it merely by wishing for it. Concerning it, an early American author wrote, 'Of this be assured, I speak from observation a certain truth: *There is no excellence without great labor*. It is the fiat of fate from which no genius can absolve you'.

I would hesitate to claim that I have achieved any high degree of excellence in doing my part for my profession. But the record will show that I have labored diligently in cooperation with many others of my generation, hopefully to improve the professional quality and social usefulness of dentistry. May I then accept this prized medal, which I shall always cherish, as a special Award for Earnest Effort.

During my active days I tried as best I could to be good to my profession; in turn, it responded generously by being exceedingly good to me. Therefore, I can say with assurance to the neophytes who were made fellows of the College this afternoon, if you will earnestly devote your time, your talents and your energies to continuing the advancement of the usefulness of dentistry, and if you are motivated by an active sense of duty, a clear sense of personal responsibility and an *unyielding* sense of loyalty to the high purposes of your profession, it will be good to you also.

Again, I thank you, my friends, for the high honor you have bestowed upon me, and wish God speed for all of you in all your future undertakings."

Citation for the William John Gies Award to B. Holly Broadbent, Sr.

Presented by President-elect Otto W. Brandhorst

It is a pleasure to present Dr. B. Holly Broadbent, Sr., for the William John Gies Award. Dr. Broadbent's field of activity has been orthodontics and his particular area of special interest has been the roentgenographic cephalo investigations of the norm and growth of the face of a healthy child from 3 months to adulthood. He has done a remarkable job and holds the respect and admiration of his confreres.

He has been the Associate Director of the Bolton Study of the Development of the Face of growing children since 1929.

He was the recipient of the D.D.D. degree from the University of Glasgow (Royal Faculty of Physicians and Surgeons) in 1954 and the honorary degree of D.Sc., from the University of Dublin, Trinity College of Dublin, Ireland in 1960.

Dr. Broadbent was Professor and Head of the Department of Dento-Facial Morphology, 1948 to 1965. He was Demonstrator in Anatomy at the Western Reserve University Medical School, 1919 to 1937; Research Fellow, 1938-1949 and Clinical Professor, Dento-Facial Anatomy Department, 1957 to 1965, Emeritus status.

He was or is Clinical Lecturer at the following schools:

University of Illinois, 1933-1946 and 1965
Northwestern University, 1942 to 1946
University of Pennsylvania, 1948 to present
Walter Reed Army Medical Center, 1950 to present

Dr. Broadbent is a member of many organizations, holding honorary membership in many of them. He has given more than 300 lectures and clinics in the United States and Europe.

He was a member of the White House Conference on Child Health and Protection in 1930.

Dr. Broadbent has been the recipient of many honors and awards:

Citation, First International Congress of Orthodontia, 1942
Ketcham Award, American Board of Orthodontics, 1944
Eagle Scout Silver Beaver Award, Boy Scouts of America, 1932
Centennial Award, Northwestern University, 1951
Callahan Award, Ohio State Dental Society, 1952
Honorary Membership, European Orthodontic Society
Honorary Presidency—XII International Dental Congress, F.D.I., 1951
Honorary Membership—German Society of Orthopedics, 1959

Honorary Alumnus—Graduate Department of Orthodontics:
University of Illinois
Northwestern University
University of Tennessee
University of the Pacific
Distinguished Service Award: Great Lakes Society of Orthodontists, 1965
Centennial Citation: Ohio State Dental Society, 1966
Outstanding Alumnus: Western Reserve University School of Dentistry, 1965
Honorary Fellow, F.C.S., Royal College of Surgeons, London, England, 1966
Fifty-Year Veteran Scout, The Boy Scouts of America, 1960

Dr. Broadbent is most deserving of the William John Gies Award. (Dr. Carl Stark accepted the award for Dr. Broadbent.)

CITATION FOR THE WILLIAM JOHN GIES AWARD TO HERBERT KURTZ COOPER

Presented by Regent Seymour J. Kreshover

Dr. Herbert Kurtz Cooper, founder and Director-Emeritus of the Lancaster Cleft Palate Clinic and Herbert K. Cooper Institute for Research, Education and Rehabilitation—with a lifetime of devotion to his profession of dentistry; with great foresight, skill and perseverance; at much personal sacrifice; and with rare humanitarian instincts—has brought to a pinnacle of eminence an institution dedicated to excellence in research, education and service to society.

By adding important new knowledge to the better understanding of oral-facial abnormalities and defects and their associated communicative disorders, and by contributing significant new concepts to the complex problems of rehabilitation, Herbert Cooper has brought relief from suffering and disability to countless afflicted young children and adults, and hope and comfort to their loved ones.

Such rare qualities of skill and leadership have been sought on behalf of many endeavors—both professional and civic. These have included directorship of the Dental Department of the Milton Hershey School; supervision of the University of Pennsylvania Training Program in Cleft Palate Therapy for Rehabilitation; consultancy to the Department of Medicine and Surgery of the U. S. Veterans Administration and to the National Institute of Dental Research; and membership on the Advisory Health Board of the Commonwealth of Pennsylvania.

Among the many expressions of recognition and honors bestowed on Herbert Cooper are Honorary Degrees from three universities; the Sertoma International Award for Service to Mankind; the Washington University Citation for Service to Mankind; the Pennsylvania Award of Excellence in the field of Life Sciences; the Benjamin Rush, Henry Spenadel Callahan and Albert H. Ketcham awards.

Herbert K. Cooper, by his distinguished performance in the service of a noble profession, has indeed added luster to this College, and is accordingly recognized by the conferring of the Gies Award.

(Dr. Harold Terry accepted the award for Dr. Cooper, who was unable to be present.)

Citation for the William John Gies Award to George M. Hollenback

Presented by Regent James P. Vernetti

Dr. Hollenback was born in Coldwater, Kansas on September 27, 1886. He received his D.D.S. degree from the University of Kansas City (now University of Missouri at Kansas City) School of Dentistry in 1912 and his M.S.D. degree from Northwestern University Dental School in 1945. He is also the recipient of an Honorary D.Sc. degree from the University of the Pacific in 1964.

Dr. Hollenback's life has been devoted to metallurgical Research and to reporting his findings to the profession. He has to his credit more than a hundred scientific papers.

On this our 50th Anniversary with all its history, note that Dr. Hollenback wrote his first paper published in the Journal of the National Dental Association in 1918—52 years ago. The subject: Dental Organization—certainly a timely topic at that time.

He is the recipient of many honors, honorary memberships, and awards from the dental profession. To name only a few, let me say that he has received 3 Fellowships—in our American College in 1930—in the American Association for Advancement of Science in 1954—and in the International College of Dentists in 1967. Also Oku in 1926, Dentistry Man of the Year—University of Kansas, 1951, Alumnus of the Year—University of Missouri, 1963, and would you believe he was also a President of the Montana State Dental Association.

His involvement in dental education has been long and varied. From 1920 to 1923 he was Professor of fixed prosthetics and head of the Department, at the University of Southern California, School

of Dentistry, Los Angeles, California, and Professor in the Department of Dental Materials in 1949. He was visiting Professor of Dentistry at the College of Physicians and Surgeons, School of Dentistry, San Francisco, California (now the University of the Pacific College of Dentistry) and Professor of Dental Materials at the same school in 1962. He was Associate Professor of Dentistry at Loma Linda Universtiy School of Dentistry, Loma Linda, California, in 1957-60 and member of the undergraduate and graduate faculty of the School of Graduate Studies in 1960, as well as Professor of Restorative Dentistry, 1960-1966.

In 1959 he was Assistant Professor of Operative Dentistry at the School of Dentistry, Loyola University, Chicago, Illinois, and in 1962 was named Associate Professor at the same school.

In 1962 he was made Professor Emeritus at the School of Dentistry, University of Kansas City (now University of Missouri) at Kansas City, Missouri.

Since 1947 he has been the Director of the George M. Hollenback Research Associations, Encino, California, where today at 84 he still daily plans and supervises primarily metallurgical projects which are not only forward thinking but practical in nature. His many years as a general practitioner (48 to be exact), makes him cognizant of the problems at the dental chair.

With all the recognitions and honors bestowed upon this man the greatest praise that can be directed his way would be that his interest and dedication for dentistry has never ceased, and no doubt never will.

It is with honor and pleasure, Mr. President, that I present one of dentistry's most dedicated men—Dr. George M. Hollenback.

Citation for the William John Gies Award to Philip Jay

Presented by Regent William E. Brown

Dr. Philip Jay was one of the pioneers in the dental research field and helped build the foundation on which it moved forward.

Dr. Jay received his D.D.S. degree from the University of Michigan in 1923 and his M.S. degree in Bacteriology from the same institution one year later. He holds the rank of Professor of Dentistry there. His particular interest lies in the field of research in dental caries.

He served as Associate in Bacteriology under Dr. Stanhope Bayne-Jones in the School of Medicine and Dentistry, Rochester, New York, for a short time before becoming affiliated with the dental faculty at the University of Michigan.

Dr. Jay established the first dental caries control laboratory, which became the source of information on caries and its treatment for both the dental and medical professions. He has traveled widely to make available his knowledge of caries and other lesions of the oral cavity as well.

In 1941, Washington University in St. Louis, Mo., conferred the honorary degree of Doctor of Science upon him. In presenting him for this award, his citation stated:

> "Dr. Philip Jay has for many years appreciated the necessity for research in the fundamental sciences as applied to his chosen profession. He has contributed significantly toward elucidating the etiology of dental caries. His investigations of the role played by bacteria in this pathological process have made him an outstanding authority, whose contributions to the scientific literature of dentistry are widely recognized."

Mr. President, it is with great pleasure that I present Dr. Philip Jay for the William John Gies Award.

Citation for the Award of Merit to Andrew M. Howe

Presented by Regent Ralph Boelsche

Mr. Howe was born in Memphis, Tennessee, but is now living in Winnetka, Illinois, a suburb of Chicago, where he has developed a large acquaintance and a host of friends. He started his career as a journalist and editor. For many years he worked in the field of advertising before joining the Wm. Wrigley Jr. Company which he served, prior to his recent retirement, as Research Adjutant, Director of Special Projects, Director of Contributions and Memberships and a member of the Board of Directors.

His knowledge and skill in the fields of advertising, promotion and administration has been of great value in the planning and promotion of the American Fund for Dental Education, of which he is Immediate Past President and a member of the Board of Directors. He also is an individual member of the American Association of Dental Schools and a supporting member of the Federation Dentaire Internationale.

In 1966, the National Dental Association conferred its Humanitarian Award upon him and the American Dental Association made him an Honorary Member. In 1968, the National Dental Association also made him an Honorary Member.

Mr. President, it is a pleasure, on behalf of the Board of Regents, to present Mr. Howe for the Award of Merit of the American College of Dentists.

Citation for the Award of Merit to Henry M. Thornton

Presented by Regent Robert Heinze

Mr. Henry M. Thornton was educated at St. George's School in Newport, Rhode Island, and at Princeton University. He became President of the Dentists' Supply Company of New York in 1955 and is presently also president of the American Dental Trades Association.

He is a member of the Board of Directors of the American Fund for Dental Education, Inc.

With his assistance, the members of the American Dental Trades Association in 1960, contributed $125,000 to the program of the Fund for Dental Education, Inc., the largest contribution received to date, from any one source. In his work with the American Dental Trades Association, Mr. Thornton has succeeded in bringing about closer and more productive relations between the industry and the profession. His leadership in supporting all phases of dental education and his many other dental and civic activities have enabled him to contribute significantly to the art and science of dentistry.

Mr. President, on behalf of the Board of Regents and with great pleasure I present Mr. Henry Thornton for the Award of Merit of the American College of Dentists.

Names Engraved on the Mace

In honor of their outstanding services to the College, the following Fellows have had their names inscribed upon the Ceremonial Mace:

Philip E. Blackerby
Otto W. Brandhorst
H. Trendley Dean
Willard C. Fleming
Harold Hillenbrand
Maynard K. Hine
Frederick McKay
J. Ben Robinson
Henry A. Swanson

Fellowships Conferred

Fellowship in the American College of Dentists was conferred upon the following persons at the Annual Convocation in Las Vegas, Nevada, on Sunday, November 8, 1970.

Richard M. Adams, Greenbrae, Calif.
Clement Alfred, Flint, Mich.
Ernest Ambrose, Montreal, Canada
Irving I. Anderman, Middletown, N. Y.
George W. Argentieri, Jamaica, N. Y.
Eugene K. Ausbrook, East St. Louis, Ill.
Ernest G. Baker, Oakland, Calif.
Ralph B. Barden, Wilmington, N. C.
James W. Barnett, Amarillo, Texas
Stephen O. Bartlett, Rockville, Md.
Simon L. Baumgarten, St. Louis, Mo.
Bruce H. Bell, Gainesville, Fla.
Hubert J. Bell, Jr., Boulder, Colo.
Victor E. Beresin, Philadelphia, Pa.
I. Frank Boscarelli, New York, N. Y.
Rafael L. Bowen, Washington, D.C.
Donald F. Bowers, Jr., Augusta, Ga.
Robert J. Bruckner, Portland, Ore.
Theodore M. Budnick, Houston, Texas
Paul S. Butcher, Dearborn Heights, Mich.
Varoujan M. Chalian, Indianapolis, Ind.
Simon Civjan, Silver Spring, Md.
Everett N. Cobb, Washington, D.C.
George M. Cone, Osceola, Ark.
William Coon, Vallejo, Calif.
Gilbert Daniels, Gilmer, Texas
Richard W. DeChamplain,
APO San Francisco, Calif.
Carlo A. DeLaurentis, Coronado, Calif.
Joseph P. Desimone, South Gate, Calif.
Thomas DeStefano, Union City, N. J.
Anthony DiMango, Brooklyn, N. Y.
Rocco J. DiPaolo, Massapequa, N. Y.
Robert B. Dixon, Austin, Texas
Alan R. Docking, Melbourne, Australia
David Dyen, Philadelphia, Pa.
Harold S. Eberhardt, Minneapolis, Minn.
William O. Engler, Cape May, N. J.
Leon J. English, Arcadia, Wis.
Arnold S. Feldman, Baltimore, Md.
Norman C. Ferguson,
New Westminster, B. C., Canada
Joseph E. Fiasconaro, Lake Success, N. Y.
W. Clinton Fisher, Chicago, Ill.
Rupert E. Fixott, Sunnyvale, Calif.
Robert G. Fodor, St. Louis, Mo.
Don Jack Fong, Amarillo, Texas
James K. Foster, Houston, Texas
Sidney R. Francis, San Francisco, Calif.
Jacob Freedland, Charlotte, N. C.
Martin Garron, Long Beach, Calif.
Richard A. Gette, Girard, Pa.
Abraham Gindea, Brooklyn, N. Y.
Robert P. Gray, Lake Oswego, Ore.
Troy A. Gray, Newport, Ark.
Norman H. C. Griffiths, Washington, D.C.
Gerald R. Guine, Alexandria, Va.
Anna T. Hampel, Minneapolis, Minn.
John C. Hardin, Shreveport, La.
Rexford E. Hardin, Toledo, Ohio
David L. Heinrich, Victoria, Texas
Maxwell Henkin, Jamaica, N. Y.
Ernest Herman, Brooklyn, N. Y.
Phillip M. Hoag, Aurora, Ill.
Raymond H. Holekamp, Kerrville, Texas
Murray W. Holland, Chapel Hill, N. C.
Aris Hoplamazian, Detroit, Mich.
Ernest S. Horany, Lynwood, Calif.
Thomas M. Horton, Columbus, Ga.
John M. Hughes, Hayward, Calif.
James H. Inglis, Palo Alto, Calif.
Robert J. Isaacson, Minneapolis, Minn.
Robert B. Jans, Evanston, Ill.
William A. Jennings, Alameda, Calif.
Albert C. Jerman, Brooks AFB, Texas
Francis S. Johnson, Santa Barbara, Calif.
James D. Johnson, Oak Ridge, Tenn.
William T. Jones, Houston, Texas
Harold V. Jordan, Wellesley, Mass.
Francis X. Judge, New Rochelle, N. Y.

Jack L. Kabcenell, Rye, N. Y.
Kanemi Kanazawa, Honolulu, Hawaii
Irving N. Kaplan, Akron, Ohio
Julian L. Kelly, Atlanta, Ga.
Walker W. Kemper, Jr., Indianapolis, Ind.
Warren G. Kennard, Hutchinson, Kan.
Haler E. Kennedy, Topeka, Kan.
Bruce A. Keyworth, St. Paul, Minn.
Alice Corpe Kinninger, Pasadena, Calif.
Ernest T. Klein, Denver, Colo.
Gale Kloeffler, Los Angeles, Calif.
Judson Klooster, Loma Linda, Calif.
Milton J. Knapp, Tacoma, Wash.
Avrom Kniaz, Milwaukee, Wis.
Norman A. Korn, Minneapolis, Minn.
Robert A. Kutz, Decatur, Ga.
George A. Lammie, Warwickshire, England
T. Wayne Lanier, Ft. Smith, Ark.
Dominick C. Larato, Newington, Conn.
Gustave Lasoff, Flushing, N. Y.
James H. Lee, Goldsboro, N. C.
Victor Lenchner, Miami Beach, Fla.
Norman Lieb, Maplewood, N. J.
Clifford Loader, Delano, Calif.
Cesare Luzi, Rome, Italy
Robert T. Maberry, Ft. Worth, Texas
George R. McCulloch, Yakima, Wash.
Leonard L. McEvoy, Los Angeles, Calif.
Paul H. McFarland, Jr.,
APO New York, N. Y.
John W. McLean,
London, W.C., 1, England
Lewis E. Martin, Downey, Calif.
Robert A. Mathews, Nashville, Tenn.
Joseph Mayner, Millburn, N. J.
Daniel T. Meadows, Birmingham, Ala.
Victor H. Mercer, Indianapolis, Ind.
I. Franklin Miller, New York, N. Y.
John C. Mitchem, Portland, Ore.
George W. Mosley, Geneva, Ill.
William J. Mouret, Jr., New Orleans, La.
Hunter D. Mullis, Monroe, La.
Henry I. Nahoum, New York, N. Y.
Seymour L. Nash, New York, N. Y.
P. Sidney Neuwirth, Peoria, Ill.
Tom R. Nicholls, Norfolk, Va.
Pete H. Nishimura, Honolulu, Hawaii
James P. Norris, Catonsville, Md.
Robert Y. Norton, Sydney, Australia
James E. Overberger, Morgantown, W. Va.
Lawrence O. Owens, Spokane, Wash.
William W. Paden, Alameda, Calif.
Argero E. Pappas, Houston, Texas
Charles S. Paraskis, Brookville, Mass.
Herbert M. Parker, New York, N. Y.
Clyde R. Parks, Belmont, Calif.
John K. Paul, APO New York, N. Y.
George Sanderson Payne,
Santa Rosa, Calif.
Jack Perlow, Flushing, N. Y.
John Broman Pike, St. Cloud, Minn.
Basil Martin Plumb,
Vancouver, 1, B. C., Canada
Robert J. Pollock, Sr., Oak Park, Ill.
Gibbs M. Prevost, Knoxville, Tenn.
Mark A. Price, Monroe, La.
Calvin A. Reeman, Paterson, N. J.
Thomas G. Reichert, St. Cloud, Minn.
Donald C. Reynolds, Bethesda, Md.
R. Earl Robinson, San Mateo, Calif.
John D. Roche, Kalispell, Mont.
G. Robert Rogers, Riverside, Calif.
Anthony D. Romano, Jr., Pine City, Minn.
Leo W. Roohan, Jr., Saratoga Springs, N. Y.
Morton Rosenbluth, Miami Beach, Fla.
Leon D. Rosenfeld, Skokie, Ill.
Albert E. Rosenthal, Miami, Fla.
David K. Rowe, Memphis, Tenn.
John Gregory Ryan,
Vancouver, B. C., Canada
Harvey S. Salb, Ft. Lee, N. J.
Frederic Savedoff, Jamaica, N. Y.
Russell W. Schabel, San Anselmo, Calif.
Carl Emil Schow, Jr., Galveston, Texas
R. Lorne Scott, Brantford, Ontario, Canada
Raylor B. Scott, Stillwater, Okla.
Howard Brent Shepard, Chicago, Ill.
Walter L. Shepard, APO New York, N. Y.
T. Edgar Sikes, Jr., Greensboro, N. C.
Bernell E. Simmons, McComb, Miss.
Ernest W. Small, Chevy Chase, Md.
Richard C. Spayde, Cleveland, Ohio
Eric Stafne, St. Paul, Minn.
Bruce E. Stansbury, Augusta, Ga.
Murray Stein, Shaker Heights, Ohio
Kenneth L. Stewart, San Antonio, Texas
Evelyn M. Strange, Portland, Ore.
Jack H. Swepston, Dallas, Texas
Nicholas E. Tapp, Milwaukee, Wis.
Robert J. Taylor, Washington, D. C.

Torsten E. Telander, Stockholm, Sweden
Harley Thayer, Woodland Hills, Calif.
Hugh B. Tilson, San Antonio, Texas
Kimble A. Traeger, Seguin, Texas
William Travis, Dearborn, Mich.
Coleman R. Tuckson, Washington, D. C.
Vern M. Tueller, Concord, Calif.
Ralph S. Vescio, Syracuse, N. Y.
Anthony A. Vito, Philadelphia, Pa.
Isadore L. Voda, Las Vegas, N. M.
Lyman E. Wagers, Lexington, Ky.
Donald C. Wallace, Greenbrae, Calif.
John W. Wallace, Atlanta, Ga.
Abraham W. Ward, San Francisco, Calif.
Albert Wasserman, San Mateo, Calif.
John T. Weatherall, Texas City, Texas
Ralph B. Weil, Brooklyn, N. Y.
Franklin S. Weine, Chicago, Ill.
William B. Wescott, Oregon City, Ore.
Felix K. West, Clarksdale, Miss.
J. D. Whisenand, Iowa City, Iowa
Ramon S. Wilcox, San Francisco, Calif.
Arthur C. Williams, New York, N. Y.
W. Ira Williams, Stuart, Fla.
W. Kenneth Williams, New York, N. Y.
William S. Wilson, Sacramento, Calif.

DENTAL CONTINUING EDUCATION IN NEW ENGLAND

(Continued from Page 102)

REFERENCES

1. O'Shea, Robert M., and Black, Shirlene: "Short Courses for Dentists: Some Survey Results." *J. Am Col. Den.* 32: 32-41, Jan. 1965.

2. O'Shea, Robert M., Gray, Shirlene B., and Treiman, Beatrice: "Taking Refresher Courses: Some Related Factors." *J. Am. Col. Den.* 32: 320-331, Oct. 1965.

3. Wechsler, Henry, Williams, A. F., Calisti, Louis J. P., Dunning, James M., and Lucas, Robert J.: "Continuing Education and New England Dentists: A Questionnaire Survey." *J. Am. Dent. Assoc.* 78, #3, 573-576, March 1969.

Richard M. Ryan, Jr. was a research associate at the Medical Foundation at the time of the dental continuing education studies. His degrees include a M.S.S.S. from the Boston School of Social Work, and a M.S. in Hygiene from the Harvard School of Public Health. He is currently a doctoral candidate in the Department of Health Services Administration, Harvard School of Public Health.

Dr. Allan F. Williams is Dental Studies Program Director at the Medical Foundation, Inc. He holds a doctorate in social psychology from Harvard University.

Dr. Henry Wechsler is Research Director at the Medical Foundation. He holds a doctorate in social psychology from Harvard University and is currently a lecturer in social psychology at the Harvard School of Public Health.

Necrology Report

The following Fellows are deceased since the 1969 convocation:

Charles H. Alter, Claremont, Calif.
Andrew J. Asch, New York, N. Y.
Charles R. Baker, Evanston, Ill.
Mathew Besdine, Brooklyn, N. Y.
Raymond L. Blancheri, Encinitas, Calif.
Ralph J. Bowman, New York, N. Y.
George A. Buckley, Garden City, N. Y.
J. Frank Burke, Sea Girt, N. J.
Frank C. Carothers, Garnett, Kan.
Theodore R. Champlin, Plainfield, N. J.
Ernest Charron, Montreal, Can.
Wyatt B. Childs, Macon, Ga.
George W. Christansen, Grosse Point, Mich.
Orville B. Coomer, Louisville, Ky.
Harley E. Courtney, Farmington, Iowa
James M. Courtney, Cleveland, Ohio
Angelo D'Amico, Sacramento, Calif.
William A. Dickson, Minneapolis, Minn.
George J. Dwire, Colorado Springs, Colo.
George D. Estes, Minneapolis, Minn.
Daniel E. Gallagher, Parkersburg, W. Va.
Benjamin H. Genn, Pittsfield, Mass.
Richard F. Gilmore, Grand Junction, Colo.
William M. Greenhut, New York, N. Y.
Irving Grenadier, Bronx, N. Y.
Fred E. Gulick, Portland, Ore.
Lloyd C. Gyllenborg, Delray Beach, Fla.
Robert E. Hampson, Seattle, Wash.
Lee A. Harker, Minneapolis, Minn.
Neal Anthony Harper, Columbus, Ohio
Edgar Haynes, Indianapolis, Ind.
Samuel Hemley, New York, N. Y.
Nicholas Ippolito, Floral Park, N. Y.
Gustaf B. Johnson, Brooklyn, N. Y.
Joseph E. Johnson, Louisville, Ky.
Sanford N. Kauffman, Sacramento, Calif.
Alfred L. Kohn, New York, N. Y.
William C. Kranz, Lexington, Ky.
Joseph S. Landa, New York, N. Y.
Ernest T. Lewis, Pittsburgh, Pa.
Chester H. Longley, Little Falls, Minn.
C. Edward Martinek, Detroit, Mich.
Charles P. Mayhall, Harlan, Ky.
Charles F. McKivergan, Providence, R. I.
Louis C. Meier, Fort Lauderdale, Fla.
Obed H. Moen, Watertown, Wis.
Francis D. Murphy, San Francisco, Calif.
Rulon W. Openshaw, Los Angeles, Calif.
Arthur R. Poag, Hamilton, Ont., Can.
M. Webster Prince, Redlands, Calif.
Henry D. Rohrer, Rochester, N. Y.
E. Wayne Satterfield, Athens, Ga.
Oliver J. Shaffer, El Paso, Tex.
Earle S. Smith, Wilkes-Barre, Pa.
Freeman H. Smith, Jr., Hammondsport, N. Y
J. Donald Shriber, Los Angeles, Calif.
Lawrence D. Sullivan, Carson City, Nev.
William F. Swanson, Pittsburgh, Pa.
Gordon L. Teall, Hiawatha, Kan.
Robert P. Thomas, Louisville, Ky.
Doran S. Thorn, Bradenton, Fla.
Albert H. Throndson, San Francisco, Calif.
William J. Tuckfield, Melbourne, Victoria, Aus.
Juanita Wade, Dallas, Tex.
James C. Wallace, Jr., Chicago, Ill.
Edward R. White, Jersey City, N. J.
Bruce F. Wilkinson, Tyler, Tex.
William R. Wolfe, Jr., Louisville, Ky.
Earl Zimmer, Colorado Springs, Colo.
John H. Dawe, Honolulu, Hawaii

LETTER TO THE EDITOR

Dear Dr. Kaplan:

A writer with whom I am acquainted recently had an article rejected by a dental journal because it did not "adhere to textbook theories". Another dentist had a paper rejected because it was not based on "sound scientific criteria". Another article was refused publication because it was not in "agreement with authorities in the field". In each case all references cited and all experimental data listed were from leading journals by reputable scientists. If this happens to a few of us, it has probably happened to many others. It is time to speak out and for our leadership to listen.

Since when are editors and consultants so omniscient that there can be no valid differences of opinion or varied interpretation of data? Are the lastest advances in the basic sciences so remote that they cannot be applied to every-day practice? Are we to change our beliefs only when the "authorities" tell us we may?

This type of thinking will stifle real changes for years to come. Suppression of new concepts will suffocate the scientist who dares to challenge. Are we so self-righteous that only established principles may reach the printed page? Who establishes concepts and principles? Are authorities and text-books always right?

What is there to be afraid of? If the new principles are bad, they will wither and die. If the ideas are good, the profession will reap immeasurable rewards. If the proponent of a new concept is tenacious, his thoughts will eventually be published in a non-dental journal even though its application is in the dental field.

We willingly examine 1000 biopsies with the thought that if we find even one case of curable cancer, it was worth the effort. Are ideas so malignantly contagious or uncurable that we may not examine all of them?

Imaginative men have no trouble finding a job. Brain storming sessions will examine many notions to find one or two good new ideas.

When the leaders of our profession smother those of us who have different thoughts, our profession lies decadent. Our journals should encourage an exchange of divergent views, the traditional as well as the unorthodox. So many journals publish so much, it is not unusual for important advances to pass unnoticed by many for too long.

The function of an editor is to get new ideas in print. The purpose of research laboratories is to determine which ideas are valid. New knowledge can convert current concepts to interesting historical data.

Changing times, mores, concepts, knowledge, dentistry . . . we feel it everywhere. Our profession is mature enough to initiate necessary changes from within if we do not strangle new, or even unpopular, concepts.

Sincerely,

George V. Lesser, D.D.S.,
142 Niagara Falls Blvd.,
Buffalo, N. Y. 14214.

The Objectives of the American College of Dentists

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

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

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

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

(d) To encourage, stimulate and promote research;

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

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

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

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

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

Revision adopted November 9, 1970.

AMERICAN · COLLEGE · OF · DENTISTS
PROGRESSIONI · SCIENTIAE · DENTIUM · CURANDORUM · HUMANITATIS · CAUSA · DEDICATUM
FOUNDED 1920