

The JOURNAL of the AMERICAN COLLEGE of DENTISTS

Dentistry is Different

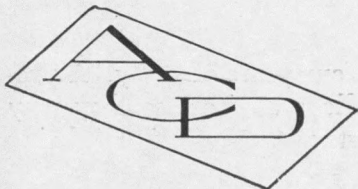
Community Dentistry in
Oral Care of the Aged

Psychological Factors in
The Practice of Dentistry

Performance of Community
Oriented Activities

JULY 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.

Appointment of an Administrative Assistant

Dr. Robert J. Nelsen, Executive Director, has announced the appointment of Mr. Walter H. Biedermann as Administrative Assistant. In his new position, Mr. Biedermann will supervise the business affairs of the College.

Mr. Biedermann comes to the College staff from the Communications Satellite Corporation (Comsat) where he was employed as a general information and research analyst with the Financial and Regulatory Analysis Department. He was responsible for developing detailed service descriptions and defining customer usage of satellite channels and assisted in the development of the Corporation's overall rate structure and pricing policies. While at Comsat, he participated in their intensive management development programs which emphasized all phases of management technique.

A graduate of Susquehanna University with a B.S. degree in Management and Marketing, he served as Vice President and President of the Susquehanna Business Society and was a member of Theta Chi Fraternity. He is a native of Teaneck, New Jersey.

SECTION NEWS

Alabama Section

Members of the planning committee of the Alabama Section met to consider a number of projects.

The section is sustaining the cost of a slide program to be used by colleges and high schools to encourage superior students to enter the profession of dentistry.

It plans to continue presenting a plaque to the student of the senior class at the University of Alabama School of Dentistry who excels in technical excellence during his four years of study. A program to indoctrinate high school and college advisors so they may become informed as to the merits of dentistry as a profession, is being planned.

SIDNEY WEINSTEIN,
Secretary-Treasurer.

New York Section

In May, at the Hotel Syracuse, the New York and Western New York Sections of the American College of Dentists, for the first time, held a joint dinner meeting with Fellows of the International College of Dentists. Dr. Newton White was in charge of arrangements.

Among those present at the meeting were Dr. Carl Laughlin, president-elect of the American Dental Association; Dr. I. Lawrence Kerr, president of the Dental Society of the State of New York; Dr. George Mullen, president-elect of the Dental Society of the State of New York, and Dr. Harold Hillenbrand, president-elect of the Federation Dentaire Internationale.

Dr. Edward Mimmack, Regent of the International College of Dentists, as well as Dr. Laughlin and Dr. Hillenbrand briefly greeted the audience.

The guest speaker, Dr. Marvin A. Rapp, president of Onondaga Community College, gave a most interesting address on "Education for the Seventies".

The new officers of the New York Section of the American College of Dentists were installed. They are: Chairman, William C. Hudson, Jr.; Vice Chairman, Lester L. Eisner; Secretary-Treasurer, Andrew M. Linz; and Historian, John J. Dolce.

New Jersey Section

The New Jersey Section of the American College of Dentists met on April 15 at the Coach and Four Restaurant in Hightstown. Chairman Byron Master presided.

The speaker of the evening was Dr. Robert J. Nelsen, Executive Director of the American College of Dentists. Dr. Nelsen discussed the policies and programs of the College, and described some of the projected plans for the future.

The following section officers were elected: Chairman, Brainerd F. Swain; Vice Chairman, L. Deckle McLean; Secretary-Treasurer, James Hipple.

The New Jersey Section approved the appropriation of \$100 as an award to the outstanding student in the graduating class of each of the dental colleges in the state.

NEWS OF FELLOWS

Twenty-two Fellows of the College are presidents of various state dental associations. They are: Charles E. Wilson, California; Edwin W. Halvorson, Southern California; Henry J. Heim, District of Columbia; Robert B. Hughlett, Florida; Robert P. Repass, Georgia; Pete H. Nishamura, Hawaii; Ralph A. Dickson, Illinois; Richard H. Hamilton, Kansas; Paul W. Evans, Kentucky; Newell G. Monget, Jr., Louisiana; Conrad L. Inman, Jr., Maryland; Arno P. Bommer, Massachusetts; Richard S. Youngs, Michigan; David H. Hallowell, Jr., Mississippi; Robert I. Kaplan, New Jersey; George E. Mullen, New York; Wade H. Breeland, North Carolina; W. Arthur George, Pennsylvania; Robert P. Denney, Tennessee; John D. Wilbank, Texas; Carlton E. Gregory, Virginia; and Coleman Gertler, Wisconsin.

* * *

Dr. Marion W. McCrea was one of six Temple University faculty members honored with \$500 grants from the Christian R. and Mary P. Lindback Foundation for distinguished teaching this year. Dr. McCrea is Gerald D. Timmons professor of dentistry and professor of anatomical sciences at Temple's School of Dentistry. He was recognized as a teacher "whose distinguished career in dental education is recognized nationally, but nowhere better than in the classroom where he has demonstrated unusual skill in communicating the sciences of histology, anatomy and embryology."

He is a 1935 graduate of Ohio State University's Dental School and has a Master of Science degree from the University of Rochester, where he held both Rockefeller and Carnegie fellowships.

* * *

Dr. C. Adam Bock, a 1922 graduate of the School of Dentistry, University of Maryland at Baltimore, received the Distinguished Alumnus Award for 1971 recently at a banquet culminating the school's June Week activities. Dr. Bock is past president of the Middle Atlantic Society of Oral Surgeons, the Baltimore City Dental Society, and the Alumni Association of the Baltimore College of Dental Surgery, and past grand master of the Oriole Alumni Chapter of Psi Omega.

Fifty-year graduates of the University of Maryland School of Dentistry who were honored at the alumni banquet included Fellows Walter Buckey Clemson of Baltimore and Walter W. Stevens of Poughkeepsie, N. Y.

* * *

Dr. Daniel Isaacson, a dental faculty member at the New Jersey College of Medicine and Dentistry, has been honored for his contribution to dental teaching aids by the American Equilibration Society. He received a bronze plaque at a symposium on teaching aids in Chicago.

Dr. Isaacson's presentation covered "A Series of Super 8 Movie Films to Demonstrate Clinical and Laboratory Procedures to Freshman Dental Students."

* * *

Reginald H. Sullens, associate dean at the University of Oklahoma School of Dentistry, was chosen as president-elect of the American Association of Dental Schools during its recent 48th Annual Session.

* * *

Dr. John J. Cane of Phillipsburg, New Jersey, was the recent recipient of the "Outstanding Citizen Award" presented by the Phillipsburg Chamber of Commerce.

* * *

Regent Seymour J. Kreshover, Director of the National Institute for Dental Research, was the principal speaker at a dinner in Boston celebrating Research Week at the Harvard School of Dental Medicine. He spoke on "Dental Research Goals—1970-1980."

* * *

Dr. Donald E. Cooksey of Los Angeles has been named professor of oral surgery at the University of Southern California Dental School. Dr. Cooksey is a former president of the American Board of Oral Surgery, and served for 27 years as a dental officer in the United States Navy.

* * *

Dr. Clifton O. Dummett, associate dean for Extramural Affairs at the University of Southern California Dental School, will be the keynote speaker at the 57th annual meeting of the American Academy of Periodontology in Chicago in October. He will discuss the relationship between community dentistry and periodontics. Herbert J. Bartelstone of Columbia University will participate in the meeting program, speaking on restorative dentistry and the plaque diseases.

Dr. Sigmund Stahl, professor and chairman of periodontics at the University of Southern California School of Dentistry, received the International Association for Dental Research Award for basic research in periodontal disease in Chicago recently.

* * *

Honorary fellow Dr. Russell S. Poor, consultant to the Atomic Energy Commission's Division of Nuclear Education and Training and to the National Institute of Dental Research of the National Institutes of Health, was honored recently by the presentation of his portrait at the University of Florida's J. Hollis Miller Health Center. Dr. Poor directed the University's Medical Center Study in the early 1950's and later served as the first provost of the Health Center.

* * *

Dr. Louis J. Boucher, associate dean of the Medical College of Georgia dental school, has been appointed dean of Fairleigh Dickinson University dental school. Dr. Boucher succeeds Dr. Walter A. Wilson, first dean of the school in Teaneck, N. J., who is retiring.

* * *

Dr. Alvin L. Morris, vice president for administration of the University of Kentucky, was re-elected to a two-year term as president at the annual meeting of the American Fund for Dental Education in Chicago. Re-elected vice president was Dr. William R. Mann, dean of the University of Michigan School of Dentistry. Dr. Harold Hillenbrand, executive director emeritus of the American Dental Association, was elected to the new post of treasurer, as provided in the new bylaws. Dr. Hillenbrand will also continue to serve as chairman of the finance committee. Re-elected as directors were Dr. Maynard K. Hine, chancellor, Indiana University-Purdue University at Indianapolis and Dr. Gerald D. Timmons, a past ADA president, Scottsdale, Arizona.

Among those elected to five-year terms as new trustees were: Dr. Marvin C. Goldstein of Atlanta, Ga.; Dr. Dale F. Roeck, associate dean, Temple University School of Dentistry, Philadelphia; Reginald H. Sullens, associate dean, University of Oklahoma School of Dentistry, Oklahoma City; and Dr. Louis G. Terkla, dean, University of Oregon School of Dentistry, Portland. Dr. Clifton O. Dummett, associate dean, School of Dentistry, University of Southern California, Los Angeles, and Dr. Luther L. Terry, vice president for Medical Affairs, University of Pennsylvania, Philadelphia, were re-elected to five-year terms as trustees.

Portrait of William J. Gies Presented to the College



At the last meeting of the Board of Regents in Bethesda, Executive Director Robert J. Nelsen (left) presented an oil portrait of William J. Gies to the American College of Dentists. President Otto W. Brandhorst (right), accepted the portrait, which will hang in the Central Office. The portrait was done by Peter Nelsen, son of the Executive Director.

Executive Director Has Busy Schedule

Executive Director Robert J. Nelsen has traveled considerably these past few months. In April he spoke at the New Jersey and Minnesota section meetings. In May he addressed the American Society for Experimental Stress Analysis in Salt Lake City, discussing dental diseases and their effect on health; and in the same month met with the ADA Task Force on National Health Programs. On June 2 he attended the Self-Assessment Workshop sponsored by the American Medical Association Council on Medical Education. Later in June he visited the Maryland section in Baltimore. In September he will be in Cleveland with the Ohio section, and in October, addresses the American Society for Metals at its annual meeting in Detroit.

Report of the Education Committee

The first meeting of the newly constituted Education Committee of the American College of Dentists was held Saturday, May 22, 1971 at the Washington Hilton Hotel in Washington, D. C., with members William K. Collins, William R. Patterson, Dale F. Redig and Harry M. Bohannon, Chairman, in attendance. William E. Brown, President elect and Robert J. Nelsen, Executive Director, also attended.

The meeting was called to explore methods by which the American College of Dentists might contribute to the broad scope of dental education in the future. In preparation for exploring appropriate avenues for contribution, a number of special consultants, representing agencies currently identified with strong support to dental education, had been invited, and were present. They were: John Coady, Secretary of the ADA Council on Dental Education; Joseph Dickinson, Executive Director of the American Fund for Dental Education; John Greene, Director of the Division of Dental Health, of the National Institute of Health; Seymour Kreshover, Director of the National Institute of Dental Research; and John Salley, President of the American Association of Dental Schools.

After careful consideration the committee agreed to recommend to the Regents that the support of the American College of Dentists be focused initially in two areas: 1) student aid and 2) contribution to a national program for the development of educational aids to be used by the practitioner.

Specifically, the Committee recommends that the College:

- 1) Contribute \$25,000 immediately to the new Student Loan Program of the American Fund for Dental Education. This new fund, to be administered nationally, will make available for guaranteed loan 12½ dollars for every dollar contributed. The College would then be directly responsible for the availability of \$312,500 in student loan funds. This is a new program for which funds have as yet to be allocated. Thus, the College can be identified among the first to contribute to this important activity and thereby gain important visibility.

- 2) Approach the National Audio-visual Center in Atlanta with a proposal to co-sponsor a national conference on biocommunications in dentistry. The expertise represented in the membership of the College provides a natural resource of unparalleled excellence for the development and review of audio-visual aids.

Ninth Institute for Advanced Education in Dental Research



Pharmacology and Toxicology in Dental Systems was the topic of the Ninth Institute for Advanced Education in Dental Research, held on May 6, 1971 in Cincinnati, Ohio, under sponsorship of the American College of Dentists.

Shown in the group are, top row, left to right, Trainees: Drs. Gordon J. Conard, Walter L. Gabler, Richard L. Wynn, C. J. Cavalaris, Sebastian G. Ciancio, and J. J. Rasmussen. Middle row: Drs. William S. Seibly, Lawrence Gettleman, James Lim, and Dr. Frank A. DeRenzis. Bottom row, Mentors: Drs. W. L. Guess, Elwood Dillingham, Kenneth R. Elwell (Program Coordinator), Carl C. Smith and John Autian (Chief Mentor).

Additional Mentors (not present for photograph) were Drs. Joseph F. Borzelleca, W. A. Ritschel, William P. Purcell, Joseph P. Buckley, Fayez S. Sayegh, Thomas W. Clarkson, Mr. James Putney and Mr. Ralph Wands.

the JOURNAL of the AMERICAN COLLEGE of DENTISTS

A QUARTERLY PRESENTING IDEAS IN DENTISTRY

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Journal of the American College of Dentists
7316 Wisconsin Ave.
Bethesda, Maryland 20014

July 1971

VOLUME 38—NUMBER 3

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

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.

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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. 38:129-184, July 1971.

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HARVEY S. HUXTABLE

Historian

Historian of the College

Dr. Harvey S. Huxtable, a general practitioner of Mineral Point, Wisconsin, is serving a five-year term as Historian of the American College of Dentists. He was born and received his early education in Mineral Point, and studied dentistry at Northwestern University Dental School, graduating in 1917. The dean of Northwestern, while he was there, was the world renowned Dr. G. V. Black and Dr. Huxtable speaks with pride of studying under this famous teacher.

Joining the Army Dental Corps upon graduation, he served in the First World War, and then entered private practice in Mineral Point in 1918.

Recognizing the need for continuing education and professional organization, Dr. Huxtable co-sponsored a meeting in 1924 which led to the formation of the Southwestern Wisconsin Dental Society. He served as its president the following year.

In 1949 the Governor of Wisconsin appointed him to the State Board of Dental Examiners and successive reappointments led to twelve years of service on the Board. He was elected president of the Wisconsin State Dental Society in 1958, and in 1964 became Speaker of the House of Delegates of the Society for three years.

As a member of the American Association of Dental Examiners, he was appointed to the Council of Dental Education of the American Dental Association in 1957, serving two three-year terms, and becoming chairman of the Council in 1960. For fifteen years he was a member of the ADA House of Delegates, and in 1967 was elected first vice president of the American Dental Association.

Dr. Huxtable holds membership in the Omicron Kappa Upsilon Honorary Dental Society, the American Academy of the History of Dentistry, and continues membership in the American Association of Dental Examiners.

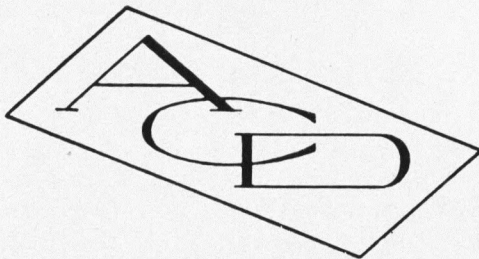
In 1963 he was made an honorary alumnus of Marquette University Dental School and is only the second person to receive such an honor. Dr. Henry Banzhaf, a past president of the American College of Dentists, was the other.

Dr. Huxtable has a long history of community activity. He was president of the Mineral Point school board for ten years, lieutenant governor of the Southwestern Wisconsin District of Kiwanis, and a charter member of the Mineral Point Kiwanis Club. He served as chairman of the Southwestern Wisconsin Music Festival for six years, and as chairman of the Iowa County Centennial Celebration in 1948.

He is a past master of Masonic Lodge No. 1 and past commander of Knights Templar Lodge No. 12 of Wisconsin.

Dr. Huxtable and his wife, Ruth, have three daughters and nine grandchildren. Two of his grandsons are at the University of Wisconsin, one a third-year medical student and the other a first-year pre-medical student. Another grandson is in his pre-dental studies at Ohio University.

Elected to fellowship in the College in 1959, Dr. Huxtable has served on a number of committees. His wide experience in dental organizations has made his services to the College of particular value. In the deliberations of the Board of Regents, the voice of Harvey Huxtable lends wisdom that all have come to respect. His pleasant manner and unfailing good nature have won for him recognition as a gentle man and a gentleman, in the finest sense of the word. We honor him as an exemplar of those traits of character and integrity which the College holds dear.



Editorials

Self-Assessment— The First Step in Peer Review

Dr. Floyd E. Dewhirst, in an editorial in the May, 1971 Journal of the Southern California Dental Association quotes Mr. Thomas S. Moore, Jr., Executive Director of the California Council for Health Plan Alternatives. Mr. Moore says, "It is less important just how performance in the health industry is measured than it is that it be measured and the results be publicly available." Mr. Moore is convinced that public monitoring of all health providers through legislation is the solution. "No voluntary mechanism exists that amounts to anything. Patients are notorious uninformed judges of any kind of medical care," he is quoted as saying.

Mr. Moore, as well as many others, has lost sight of the basic tenet of professional responsibility which is to provide value judgments for another who has no means of evaluating those judgments. In true professional practice, all decisions, judgments (and concomitant services) must be directed, always first to the benefit of the patient. If a valid benefit to the patient is not the intended determinant of the care to be provided, or, if the care is wilfully beneath the capacity of the provider, then the service is not professional but is craft service and the judgments rendered and the service performed are immoral for they are perpetrated in trust and under the protection of professional privilege. Abuse of this trust and privilege has generated demands for peer review. The very substance of peer review can be derived only out of the integrity of the individual professional and the correlative, aggregate integrity of his profession.

If the individual and his profession are to rescind the obligation of effective peer review, then the privilege and position of the profession will be lost. If it becomes necessary for society through legislation to

"protect" the patient by legal code and printed specifications; then the essence of the true professional will vanish, his practice will become livelihood rather than a way of life.

Editor Dewhirst concludes, "Dentistry can no longer be practiced in isolation and peer review procedures must be provided for the recipients of dental care." To this end, the individual first must review his own mode of practice and then join with others of like intent to review and thus renew the full confidence of the public. The first step in peer review is self-assessment.

ROBERT J. NELSEN

National Licensure and Reciprocity

"There is an urgent need for national licensure and for complete reciprocity among all States in the Union," said Dr. Joseph L. Henry, Dean of Howard University College of Dentistry. Speaking at a recent press conference of the National Council for Improvement of Dental Licensure, Dean Henry went on to state, "The fears of overpopulation of professionals as a result of this (national licensure) are groundless. The law of supply and demand will prevail. Meanwhile the mobility of practitioners is greatly limited by the current unrealistic licensure laws."

"There should be automatic licensing of new graduates and periodic review of professionals in practice. . . . The fact of life is that 99.9% of dental graduates become licensed. The inability of the professional to move to areas of need if he wanted to because of licensure restrictions and the cost of taking multiple examinations, prevents bringing care where it is needed most. . . ."

"The development of regional boards which is occurring now is a step toward national licensure and ultimately full reciprocity. But it is going to take too long and will continue to be a road block to proper dispersion among professional personnel in dentistry. Unless the profession and the States move faster toward a more realistic licensure procedure which will protect the public as well as make available to them the resources of the profession, then we can look forward to the federal government stepping in and rewriting the licensure of dental and other professions."

Observers of current trends in dentistry recognize that there is a strong thrust toward more freedom of movement by professionals

through reciprocity in licensure between states. World War II, with its great disruption of dentists and their authority to practice, while in military service, in places other than those in which they had been licensed, gave impetus to the concept that the restrictions provided by State Boards needed to be relaxed, and greater measures of reciprocity be developed. This concept has been influenced by the intervention of a variety of governmental agencies, local, state and national, as "third parties" in the delivery of dental care—whose main function has been to provide funding. They were content to leave the regulation of the profession in the hands of the State Boards. Because of inequities in the distribution of dentists, these agencies have now become interested in means for providing care in areas where, generally for economic reasons, it has been lacking. They are questioning the willingness and ability of the profession to provide the necessary manpower.

Dean Henry's statement sounds a warning that the time has come for the profession to act with dispatch in developing a program of national licensure. His suggestion of automatic licensure of new graduates and periodic review of professionals in practice requires consideration.

R. I. K.

Individual Excellence

Keeping a free society free—and vital and strong—is no job for the half-educated and the slovenly. In a society of free men competence is a primary duty. The man who does his job well tones up the whole society and the man who does a sloppy job—whether he is a janitor or a judge, a surgeon or a mechanic—lowers the tone of all society. But excellence implies more than competence. It implies a striving for the highest standards in every form of life. We need individual excellence in . . . political life, in education, in industry—in short, universally. And not the least, we need excellence in standards of individual conduct.

PROFESSOR T. EARLE JOHNSON
University of Alabama

Annual Meeting and Convocation
Hotel Traymore - Atlantic City, New Jersey
Sunday, October 10, 1971
PRELIMINARY PROGRAM



DR. JOHN ZAPP

Dr. John Zapp, Special Assistant for Dental Affairs and Deputy Assistant Secretary for Health Manpower will address the College on Sunday morning on

THE RESTRUCTURE OF THE
DELIVERY OF DENTAL HEALTH
SERVICE IN THE UNITED STATES.

Dr. C. Gordon Watson, Executive Director of the American Dental Association will be the Convocation speaker in the afternoon. His topic will be

SUPPLY AND DEMAND:
DENTISTRY'S CHALLENGE
IN A CAPITALISTIC SYSTEM.



DR. C. GORDON WATSON

Both sessions are open to the public, and you are cordially invited to bring your friends and associates to hear these timely and important messages. The business meeting, which will precede Dr. Zapp's address, is open only to Fellows of the College.

The 1971 meeting, by action of the Board of Regents, is dedicated in honor of President Otto W. Brandhorst.

Dentistry is Different

An Overview of the ADA Task Force on National Health Programs

MARY BERNHARDT*

DENTISTRY is different. This may seem to be a truism or a self-serving slogan, but instead it should be a key principle in considering the potential place of dental services in a comprehensive health program. It's also one of the reasons why the American Dental Association formed a Task Force to develop a position for the dental profession on national health programs. Who could better make these judgments than the group of dental leaders supported by experts on other aspects of health—the ADA Task Force on National Health Programs.

From the beginning, it has been the consensus of the Task Force members that some form of national health program is imminent for this country. Projections differ on the time when a national program can be expected and vary with judgments on the political climate and changes in other domestic and foreign affairs. The Task Force members are aware, too, of the semantic implications of "national health insurance". A health program limited in scope, eligibility and services could, for political reasons, be described as a "national health program".

That dentistry is different is demonstrated by the thrust of the proposals for national health programs. All of them are directed toward solution of two critical and dramatic problems in the health system: the spiralling costs of hospitalization and the fragmentation of health care among specialists. Yet neither of these problems is relevant to dentistry. While over-utilization is a major concern in a hospitalization program, a dental program will improve the health of the public only to the extent that it is used. Dental care is not fragmented among specialists, and, in fact, dentistry often suffers

*ADA staff adviser to the Task Force Committee on Quality Review and Payment Methods; Secretary, Council on Dental Health.

from fragmentation when it is separated from other health services in total health programs. Consequently, a national health program tailored to solving these hospital-medical problems may not allow a very good fit for dental health.

A further difference between dentistry and other health services is that prevention in general health care is speculative enough in value to get short shrift in overall health priorities, whereas prevention in dentistry is so effective that it can be measured in reduced costs of care.

A major difference for dentistry: other elements of health care are certain to be included at some level in any national health program. Dental care is one of the health services that can be omitted or limited. Dental services have often been overlooked or limited in so-called comprehensive health care programs for a number of reasons, primarily because of anticipated heavy expenditures.

The efforts of the Task Force are premised on the position that dental services should be included in any national health program. This view is reflected in Association policy on dental health services as an "essential component of health care".

Two of the major national health insurance proposals in the current Congress omit dentistry: the Administration's proposals (the National Health Insurance Standards Act and the Family Health Insurance Plan) and the 1971 version of the American Medical Association's *Medicredit*. Dental care for children of specified ages is included in several of the other proposals, notably the Kennedy-Griffiths Health Security Act and the Healthcare proposal of the Health Insurance Association of America.

DRAFTING THE DENTAL POSITION

The object of the Task Force is not a bill or a specific proposal, such as introduced by the AMA. The result of its deliberations will be a series of recommendations against which dental aspects of any national health proposal can be evaluated. It is likely though that some of the recommendations on delivery of dental care may be referred to the appropriate councils of the ADA for action.

The composition of the Task Force is adapted to making specific dental recommendations as well as comprehending the implications of a national health program for the total health delivery system. The 17-man Task Force is made up of 11 dental leaders (including six general practitioners) and six nondentists. The nondentist members are themselves a knowledgeable group in the health field: a

health economist with special experience in dental prepayment, a labor health and welfare spokesman, past-presidents of the American Public Health Association and the American Dental Trade Association, a hospital administrator and a health insurance industry leader.

The real digging for data, the study and the resulting recommendations were done for the Task Force by five committees. Their charges and chairmen are: priorities of services and review of national health proposals (Dr. Edward A. Cheney); delivery of services (Dr. I. Lawrence Kerr); manpower and educational resources (Dr. Donald J. Galagan); quality review and payment methods (Dr. Roy L. Lindahl); and consumer concerns (Mr. John F. Tomayko of the steelworkers). Each committee has five members from outside the Task Force and a staff advisor from the ADA.

The committees met from three to five times and submitted their reports and recommendations to the Task Force as a whole. The committee reports will be published separately from the Task Force's final report, thus going on permanent record as an examination of the dental field on the brink of a national health program.

SOME FACTS OF DENTISTRY

The committee members in their specific areas faced some facts about the present dental delivery system that dentists in their private practices may forget. A basic fact underlying all deliberations was that the present dentist population and dental delivery system serve less than half the population. This is based on the National Health Survey report that 42 percent of the population sees a dentist in a year. From this it is estimated that perhaps 20-25 per cent receive all necessary dental care.

Another basic consideration is that utilization of dental services, more than other health services, is linked with income and educational levels and other variables. A reasonable assumption in the Task Force's view was that inclusion of dental care in a national health program would promptly increase demand for dental services. This then would dramatically bring into focus the shortage and/or maldistribution of dentists and auxiliaries.

Other premises for committee discussions included the differences for dentistry in health programs, the experience in existing public and private care programs, the limitations of personnel, the need for priorities for provision of care, and the anticipated limitation of funds for benefits over and above hospital-medical services.

The committees' efforts comprise a comprehensive and critical overview of the dental field, identifying and documenting what exists, what should be, what can be and how soon. Other considerations were: what is known, what can be proven, what can be guessed, where the gaps in information are and how they can be filled.

In some subject areas, the committees recommended answers to problems based on existing data. On other subjects, however, the committees recommended questions to be asked. Little hard data is available on the various aspects of methods of payment and delivery of dental care. The Task Force report will probably highlight the areas of the dental delivery system which should be researched so that future policies and guidelines can be based on facts rather than assumptions and opinions.

INPUT FROM OUTSIDE

In addition to dry data gathering, the committees made site visits or heard expert consultants. The committee on manpower met with representatives of auxiliary organizations. The consumer concerns committee visited a community-generated neighborhood health center and a longstanding consumer-sponsored prepaid group practice plan which included dental services in its comprehensive health care. The committee on review and payment methods visited the largest dental service corporation for exposure to its sophisticated and thorough professional review of quality of treatment and the usual and customary nature of fees. This committee also consulted with spokesmen for labor and management groups.

Representatives of the Task Force itself met with spokesmen for the American Dental Trade Association, the dental specialties and national health organizations, including the AMA. It is expected that Task Force representatives will also meet with spokesmen for the major national health insurance proposals.

The ground rule for members of both the Task Force and its committees was that they should not be constrained in their deliberations or recommendations by existing Association policy. This provided them with an opportunity to look objectively at the major issues confronting the dental profession, such as utilization of auxiliaries, licensure, reciprocity, review procedures, closed panel systems, methods of payment, capitation and the accessibility of dental care.

One of the outstanding products of a Task Force committee will be a unique statistical document on present and anticipated dental manpower resources related to needs now and in the future, devel-

oped by the committee on manpower. The data gathering and analysis was performed primarily by the committee's Public Health Service consultants. The Task Force members, in a preliminary review of the document, praised it as an invaluable contribution to dental planning and as an excellent example for other health professional organizations to follow.

Important products of the committee on priorities of services are a statement on the value of oral health and an outline of "an ideal personal dental hygiene program in chronological order."

CONSULTING CONSUMERS THEMSELVES

The consumer concerns committee was unique in itself since it was composed of five individuals who would generally be acknowledged as consumer spokesmen, along with a black dental leader experienced in working with consumer boards in a neighborhood health center. One of the problems in soliciting input from consumers is the identification of individuals who would represent more than themselves as individuals.

The inclusion of a consumers' committee responds to the intense interest of consumers' groups in the health delivery system and their demands for involvement in the system as demonstrated at national meetings held by the National Health Council, the American Medical Association and other health groups. The consumers' committee of the Task Force has been cited by the National Health Council to its other national health professional organization members as an example of an effective process for gaining consumer input into the Association's program. The NHC is urging its membership of national health organizations to formulate permanent mechanisms for involving consumers.

The Task Force committee's consumers are the chairman, Mr. John F. Tomayko, director, pension and insurance department, United Steelworkers of America; Mrs. Erma Angevine, executive director of Consumers Federation of America, representing 190 organizations with a total membership of 40 million consumers; Mr. Jose Chacon, founder of the National Organization on Health Services for the Spanish-Speaking; and Mr. Louis J. Segadelli, associate executive director of Group Health Association of America, a long-established federation of consumer-sponsored health plans.

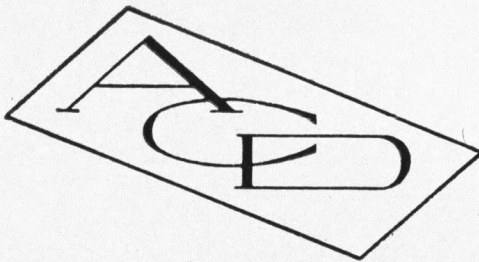
The consumer representatives were invited to give their views on the aspects of dentistry of most interest to them. The elements they were concerned about were the inclusion and priorities of dental

benefits in a national health program, consumer representation, quality and accessibility of care, review committees, information on fees, removal of discrimination, recruitment of dentists and utilization of auxiliaries. One facet of their deliberations conflicted interestingly with accepted American Dental Association and dental public health policy. The consumers were not impressed with the traditional priority for children in comprehensive dental programs when funds are limited. Their preference for priority were the wage-earners.

END RESULT

The recommendations of all these committees and the information provided by other spokesmen and the Task Force itself will be distilled into a final report to be completed by mid-summer for presentation to the Association's House of Delegates at its annual session. In the words of the Task Force coordinator, Dr. Viron Diefenbach, the Task Force will "provide the Association and dentists everywhere with the most carefully thought-out position for dentistry in this era of national health program development". The Task Force report will also identify and document those significant areas in which dentistry is different in a health program.

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Community Dentistry's Contributions to Oral Care of the Aged and Patients in Terminal Illness*

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INTRODUCTION

A LARGE NUMBER of modifications in the philosophy, concept, and practice of dentistry have occurred during the past 30 years. Many of these changes have been instituted in the normal processes of professional progress, but others have come about as a result of external impositions and pressures. One of the main reasons why, in the past, the profession has exhibited little concern about the oral care of senior citizens and mortally sick patients is probably because dentistry is usually accomplished upon a relatively well, willing, able and ambulatory person.

Dentists have been inclined to transfer the total responsibility for patient care to the physician once it was obvious that patients were in dire circumstances, and the possibility of death was real and imminent.

This author's first realization of some of the psycho-social implications of the topic occurred at the Tuskegee, Alabama, Veterans Administration Hospital in 1949 when he was called upon to contribute to the dental identification of a psychiatric patient whose decomposed body had been found in an isolated part of the hospital grounds. From an intensive contemplation about the appropriateness of this task emerged the author's sensitivity and an interest in investigating the role of the dentist under conditions of terminal illness and death.

* Presented at a seminar on oral care of critically ill patients, sponsored by Columbia University, New York City, May 6-8, 1971.

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THE HOSPITAL DEFINED

There was a time when hospitals were regarded as places where patients went to die. After all else had failed and confused medical practitioners had exhausted their stores and sources of scientific cure, patients were sent to hospitals to await the inevitable. From these initial excursions in hopelessness, the medical and health professions have come a long way insofar as hospital functionings are concerned, and today the Council on Medical Education defines a hospital as "an institution suitably located, constructed, organized, managed, and staffed to supply—scientifically, economically, efficiently, and without hindrance—all or any recognized part of the complex requirements for the prevention, diagnosis, and treatment of physical, mental, and the medical aspect of social ills; with functioning facilities for training new workers in the many special professional, technical, and economic fields essential to the discharge of its proper functions; and with adequate contacts with physicians, other hospitals, medical schools, and all accredited health agencies engaged in the better health program."

A currently accepted concept of modern dentistry is one which defines it as an integral part of medicine, primarily concerned with the illnesses affecting the oral cavity, its contents and associated parts. This concern embraces not only the care of healthy tissues, but also the diagnosis and therapy of pathological conditions affecting them, and in addition, the biomechanical restoration of imperfections or missing structures. These functions have become more intricate through the years, and presently, highly trained practitioners and specialties are necessary in order to carry out efficient services. It is essential to keep in mind the rather comprehensive statement describing what a hospital is and what its functionings involve, while discussing the subject of oral care of patients in terminal illness.

Actually, it is in the hospital setting that dentists are most likely to become involved with very sick patients.

ORAL CARE OF THE AGED

Oral care of terminally ill patients needs to be considered probably in the same context with oral care of the aged. It is no secret that general and oral health care of senior citizens have traditionally left much to be desired. In 1950, the author initiated a survey of the dental health status of the patients on what were the custodial wards in the Veterans Administration Hospital, Tuskegee, Alabama, which

was a hospital for patients with psychiatric and neurological disorders. Generally, these were older patients and the oral examinations revealed appalling conditions. The mouths of the majority of these patients displayed obvious personal and professional neglect. Oral malhygiene and soft tissue inflammations were conditions most frequently observed. Today we are seeing similar conditions in many of our nursing homes, which have recently been featured in the news media.

The main criticisms may be directed at the lack of oral sanitation. At least better oral hygiene can be accomplished, even if restorative and replacement procedures are at best, difficult.

Much has been written about the psychosocial problems of senior citizens. Loneliness has occupied as much of their attention as have the physical disabilities usually associated with the aging process. From the dental viewpoint the loss of the natural dentition is probably the most obvious occurrence and the lack of esthetics has as great an impact on the person as the impaired dental function. There are many technical difficulties associated with the fabrication of dentures for extremely resorbed ridges, and there is often some relative lack of functional success. As a result, dentists have not been enthused about placing dentures in aged patients. Many have been known to agree with physicians who have often remarked that it is possible to eat without teeth especially since there are so many foods prepared for edentulous people. This callous statement is comparable to the observance that it is also possible to live with one kidney, an impaired heart, an afunctional lung, one leg, disabled eyes and no testicles! The psychological and physiological aspects of the aging process are closely intertwined and health professionals have a duty to render those services which would make life as comfortable as possible under the existing circumstances.

The concept of "oral care" is an all inclusive one, embracing both therapy and solicitude. It can be defined as the diagnosis, prevention and treatment of oral disease and disability, with a concomitant expression of a conscious concern on the part of the therapist for the anxiety, pain and suffering of the patient in question, and of his or her immediate family.

CLINICAL SERVICES RENDERED

Oral care of patients in terminal illness would consist of much dental intervention, but even more conscious concern. In the case of the former, chances are that the most important function which can

and should be instituted is the maintenance of some degree of oral hygiene and comfort.

In the hospital setting, with patients either in intensive care, or under conditions of total physical disability, the functions of oral comfort and hygiene are accomplished by nurse, aide, dental hygienist, and dentist all working cooperatively, and coordinating dento-oral procedures within the general medical treatment plan.

Periodontics and endodontics are undoubtedly the most frequently called-upon specialties in extensively disabling circumstances. The relative inability of patients to use the oral structures properly, combined with the soft dietary regimen, the lowered tissue resistance and general oral stagnation—these are all factors which promote greater susceptibility to infection, ulceration, pain and oral fetor. The success of instituting periodontal procedures is, of course, dependent upon the extensiveness of the procedures and the patient's condition, so that very often periodontic treatment may have to be limited to oral irrigation, periodontal hydrotherapy, and those phases of oral medical therapeutics which involve the application of and swabbing with medicaments.

Exodontia and minor oral surgery will be necessary when there is pain from extensive dental decay and abscesses. Such procedures must, of course, be carefully evaluated in view of the patient's condition, and the utmost care should be exercised if and when procedures become mandatory.

Major oral surgery is a clinical service which requires very special considerations and consultations. So much depends upon whether it is to be performed on a critically ill person, or if a patient becomes critically ill as a result of extensive oral surgery. Indications, contraindications, associated problems, liabilities and assets of these procedures are not within the purview of this presentation.

Restorative dentistry is another oral health service deserving consideration. Generally speaking, in this type of patient, palliative procedures are advocated. It would seem that the most humane procedure would be the placing of temporary restorations following the removal of as much carious material as possible. The essential point is that great care should be exercised in not subjecting patients to the personal rigors which many restorative dental procedures require.

Insofar as prosthodontics is concerned, the primary services rendered in patients with dental prostheses would include cleaning, polishing, and adjusting the appliances. Replacing defective teeth and clasps of dentures are additional operations which may be ac-

complished. Care of the oral soft tissues and oral comfort are, however, the most important considerations, and involve the removal of debris, soft tissue massage, treatment of minor ulcerations, lacerations and abrasions, and the maintenance of scrupulous cleanliness of the oral cavities of very sick persons.

There are also clinical services which the dental department of the hospital is called upon to render in cases of deceased patients. The author can recall a few hospital cases in which he was contacted by the ward nurse to insert dentures in recently deceased patients. There were difficulties associated with carrying out these procedures after rigor mortis had set in. In so many of these cases, the situations occurred because the dentures could not be immediately located.

There was an unusual case in which an emergency set of dentures had to be constructed by the hospital's prosthodontist for a recently deceased patient, and another instance in which dentures had to be forcefully inserted long after the patient had succumbed, because the family insisted upon the achievement of some semblance of a suitably life-like facial appearance.

It is the responsibility of the dental department to be conversant with the status of seriously ill patients, so that clinicians would be informed as soon as death occurs, and thus be able to carry out any needed procedures without the difficulties previously referred to.

This matter of the appearance of the deceased is apparently an important consideration to the remaining family. It is influenced by custom, religion and other circumstances which probably constitute the reasons why so much time, effort, and money are spent in frantic efforts to camouflage death with cosmetics, flowers, dentures and other paraphernalia.

Relatives are sometimes very insistent that dental prostheses should be in the mouth of the deceased. Many families are unsympathetic with the hospital personnel unable to locate missing dentures. To avoid problems from neglect that become apparent after death, it is necessary to furnish oral care and be aware of the patient's condition up to the time of death. On account of experiences such as these, hospitals have now devised procedures whereby the dental prostheses of very sick patients are removed when necessary, labelled in suitable containers, and stored in easily located cupboards, either on the ward or in the dental clinic.

These considerations encompass the vast majority of clinical services which the dental department of a hospital can and should render to hospitalized, seriously ill persons, and to deceased patients.

It is in the areas of "conscious concern", however, that dentists and their auxiliaries should be able to offer some additional services, many of which have either been taken for granted or have not yet merited serious consideration.

COMMUNITY DENTISTRY'S CONTRIBUTIONS

Community dentistry is involved with the elements of technical proficiency, the biological sciences and social sensitivity. It is with the last of these elements, however, that there is a special concern. The specialty comprises that facet of a health profession engaged in equipping dentists and dental auxiliaries with skills which will enable them to be socially sensitized, scientific practitioners on an interacting population of varied individuals with common interests living in a particular area. To be socially sensitive, dentists must be able to adhere to the maxim of treating patients rather than teeth. They must accept the ethic that all clinical procedures should be influenced by the ideal of retaining the natural dentition for life, and in death.

Like the physician in community medicine, the dentist is being called upon to regard the patient in his total environment rather than merely in terms of his dental complaint. Assistance in modifying that environment whenever necessary is an important additional function of the medical team of which the dentist is an integral member. As long as the dentist sincerely believes that he must work as a part of a team of trained health workers, then it is possible to institute the aforementioned environmental changes.

By virtue of its intrinsic meaning and philosophy, community dentistry is prepared to render substantive contributions to this facet of oral care in terminal patients. It would seem that a very high degree of social sensitivity is involved, for instance, in making a consciously futile visit to the sick patient's bedside.

The overwhelming emphasis upon dentistry's technology has left very little room for identification with these exercises in "conscious futility". There has been so much of the feeling that after dentists have completed a technical service, their work is done, and they can relinquish further responsibility to the patient. The dental "do something" syndrome is inoperative in critically ill circumstances, and so the most likely reaction on the part of the dental operator would probably be frustration. The one feasible way out of the dilemma is for the dentist to be able to shed his professional cocoon

and join with nurse, physician, and minister in feeling and expressing a genuine concern for hopelessly sick persons.

It is necessary to realize that communicating with the families of terminal patients is no more the sole responsibility of the nurse or physician or minister, than is health the special domain of the medical doctor alone. The particular health professional member to whom the patient or his family relates is a much more valued contact than was formerly believed. The number of cases in which excellent rapport has been achieved between patient and dentist is significantly large, and would suggest the exploration of just what solace could be rendered and empathy achieved under dire conditions of personal trouble, sorrow, sickness and need.

Because there have been significant qualitative changes in the kinds of general medical and surgical care which critically ill patients have been receiving over the past ten years, it is estimated that there has been a significant reduction in mortality rates. By and large, technological advances in equipment and sophisticated instrumentation have made these reductions possible. But much of the improvement has been due to the medical, nursing and other health personnel to whom a large share of monitoring responsibilities has been delegated. We are familiar with the general and specialized intensive care units in hospitals which have facilitated the grouping of very ill patients in specially designed and fully equipped areas that are continuously under nursing observation and care.

It is in these areas that there has been hopeful experimentation with the use of auxiliary personnel and the spectacular results obtained have convinced administrators that this is a highly recommended way to ease the trials and tribulations of overburdened, numerically inadequate, hospital and health personnel.

Community dentistry has a vital interest in auxiliary utilization and has stimulated much investigation in expanded duties. It would appear that mutually cooperative exchanges and interrelationships should be explored and should result in even greater improvement in care.

PROPOSED SYMPOSIUM

A few years ago while attending a Planning Conference of the California Regional Medical Program Area V, the author presented some of his thoughts concerning oral care of dying patients, and was encouraged by the sympathetic responses elicited. Subsequently he wrote to the chairman of the department of community medicine at the associated medical school inquiring as to the possibility of a

joint sponsorship of a medico-dental "Symposium on Death". It was explained that there was a great need for contributions to understanding the encompassing problems faced by health professionals in decision-making under conditions of urgency, stress and death. The spectacular and jolting effects of such a conference should furnish some contributions to intra and interprofessional communications.

A tentative program was outlined and it included a keynote address by a clergyman-philosopher; position papers by an internist, surgeon, pathologist and psychiatrist; and workshop sessions freely utilizing consultant services, section chairmen and session secretaries from the nursing, dental, social work, psychology, education and other disciplines. In this way participants would have an opportunity to cut across lines of many disciplines, getting them all involved. The response of the chairman was very positive, going so far as to suggest contacting the department of Postgraduate Medical Education since that department would be in a position to supply expertise in the organization and management of such a symposium. Further explorations and plannings were postponed on account of his promotion to the directorship of one of the nation's largest hospitals.

Later, investigations into sponsorship by dental institutions were not fruitful. Recently, there have been more widespread indications of interest from schools impressed with the purposes of such a symposium under dental auspices, and definite possibilities of assistance in its sponsorship. It is of interest to note that an official of one of the organizations previously approached ventured the opinion that the only contributions that dentists could make to the subject of death was dying! In view of the more expansive horizons which the dental profession is presently seeking to encompass, it appears that a revision in such opinions is long overdue.

Contributing to the encouragement of imagination and greater compassions in dentistry are some of the ethical problems that have been generated by and relate to organ transplants and death. Who shall live and who shall die, and who shall decide who merits a transplant and who does not—these are all questions with resounding implications.

It is, of course, quite possible that many of our commonly held conceptions about society's taboos of dying and death are misplaced. In a recent address to the Gerontological Society, James T. Mathieu, a former Presbyterian minister, said that a majority of elderly persons surveyed were not afraid to die. The men and women ques-

tioned ranged in age from 50 through 86 and were found to be well adjusted to, though not preoccupied with death. Most significant was the finding that about 2/3 of the respondents favored withdrawal of all treatments except those designed to maintain comfort and reduce pain in cases in which persons had an incurable ailment, and death was imminent.

CONCLUSION

Some time has been spent in presenting a topic seldom considered and even less discussed among the dental components of the health professions. The dentist's preoccupation with hosts of dental treatment problems has left little time for considering the perplexities of the dying or the dead patient's relatives.

Community dentistry has now forced upon our consciousness the fact that perhaps the subject is one that we need to stop avoiding if we are to fulfill completely our professional obligations to the public.

It is unfortunate that despite the long road we have traversed in scientific accomplishments, there still is a lingering reluctance to confront many of the problems of life and death. It is anachronistic that we should still speak about dying in dignity, and the dignity of death, and putting a person away in style, while we seem to be increasing the indignities perpetrated in life, and have little hesitation in inflicting violence one upon the other, and being rather brutal in our interpersonal relationships. It has been suggested that much of the contemporary mayhem may be the result of an unrealistic attitude towards dying and death.

Hopefully, in stimulating a greater understanding of death's problems and their ramifications we might be able to assist in better understanding the difficulties of life, and thereby ease some of its burdens.

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Psychological Factors in the Practice of Dentistry

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ABOUT fifty years ago, Freud delivered a lecture to students at the University of Vienna about the resistance which people put up to psychoanalytic treatment. After pointing out that their opposition to the treatment is "vigorous and tenacious," Freud went on to say, "How improbable this statement must sound! And yet it is so and . . . it is not without its analogies; for a man who has rushed off to a dentist with a frightful toothache may very well fend him off when he takes his forceps to the decayed tooth." Thanks to the progress made during recent decades in pain control, this analogy has lost some of its sting, but many patients still resist our ministrations.

RESISTANCE

Freud borrowed the term "resistance" from electricity and physics to designate the conscious and unconscious opposition of people to cooperating in a treatment in which they are investing time, money and effort, often at considerable sacrifice. One does not have to share Freud's ideas to recognize that the dentist also encounters vigorous resistance among patients, particularly children, to cooperating with his most conscientious and skillful efforts on their behalf. Although dental health and mental health are not as similar as they sound, growing emphasis on psychological factors in modern dentistry suggest that they are not as unrelated as they are generally assumed to be. Indeed, some basic understanding of behavior is probably more important for the dentist than for practitioners of other healing arts. In addition to the developmental experiences, personal traits and motives of the dentist and his patient, which help to determine the nature of their interaction, their relationship is also influenced—and perhaps to a more dramatic extent—by psychological factors inherent in the dental situation itself.

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Attempts to account for the traditional aversion of the public to dental treatment have brought into focus the irrational nature of many reactions to the dental situation but these alone do not explain widespread avoidance of such treatment. One must attribute some of the neglect of dental problems to the elective nature of the treatment, its cost and similar rational considerations, since for the overwhelming majority of people, dentistry is not a life or death matter.

Expressions of concern about the cost of dental treatment frequently strike one as paradoxical. That is to say, the absolute cost is not the deterrent as much as the thought that the same expenditure would cover something that the potential patient or parent of the patient contemplated with more enthusiasm. If he bluntly announces, "I could have taken a two week vacation with the money it will cost me to fix Johnny's teeth," he is expressing an attitude which many people entertain silently. Human beings are much less disposed to operate according to the so-called reality principle than on the basis of the pleasure principle. Even pain-free dental experiences are rarely placed in the second category. When treatment is not an absolute necessity or otherwise strongly motivated, people tend to approach it as a disagreeable reality balancing it against an investment which will bring more immediate enjoyment when a choice must be made between the two. The widespread avoidance of the treatment suggests the popularity of the pleasure principle.

However, such avoidance is probably just as assiduous among those who can finance dental treatment without any sacrifice of pleasure. How are we to explain the reluctance of people who can well afford the services of a dentist to enter his office as well as deprive their children of dental services? This question can be answered in one word—"fear."

FEAR

Indisputably, fear causes many to shun dental treatment. It also causes many who do commit themselves to it to approach the dental chair with irrational dread. Fear figures prominently, too, in the inability of many people subjecting themselves to treatment to provide the necessary degree of cooperation, which contributes to their being poor patients, at least from our point of view.

Assuming that fear is the correct explanation, the question arises: "Fear of what?" Almost invariably, the patient provides another one word answer: "Pain."

This answer tends to support Miller's opinion that pain innately

produces fear. And fear is usually accompanied by a desire to take flight from the particular situation in which the pain was anticipated or experienced.

The irrationality of fear of dental procedures is best exemplified to me by an experience from my own childhood. I recall most vividly a visit made at the age of ten or eleven to the training camp of Max Baer with my father who was a dental technician, and a dentist friend of his. Baer was then the heavyweight boxing champion of the world and was training for a match with Jim Braddock. My father's friend and my father went to the camp to insert a mouthpiece for Baer, and I happily went along with them. Maxie talked to us, among other things, about a visit he had made to his dentist to have a tooth extracted. He said that it was the most terrifying experience of his life. It was hard for me to believe that a man who administered and received frightful physical punishment as a prizefighter, and who did so without the slightest qualm or hesitation, could be terrified by a dentist. What a contradiction! Yet, every one of us can relate a similar incident.

Many adults tend to attribute their overresponsiveness to the dental environment to vivid recollections of painful dental experiences before the era of local anesthesia. Advances made since then in eliminating or reducing the pain associated with these procedures have not led to a proportionate reduction in their fears, anxieties and apprehensions. The unpleasant emotional charge created by dental experiences which have become archaic, lingers on in many parents. Not infrequently, it is transmitted to their children, even when a parent has no intention of doing so and may be totally unaware that she is communicating her own negative attitude. For example, a mother may transmit her anxieties to her offspring by her irritability or grim demeanor before a dental appointment of her own or one to which she is escorting the brother or sister of the observant child. Another mother reacts to her own apprehensions by an overly enthusiastic approach, detailing to her youthful progeny the impressive rewards that will accrue from his introduction to dentistry. More often than not, the evident anxieties underlying her brave words lend a false note to this type of indoctrination. Its purpose is defeated for still another reason; that is, the concept of future rewards is over the head of the child of say, four or five. Piaget, the Swiss developmental psychologist, points out that abstract ideas of this sort are beyond the intellectual comprehension of children until they reach the age of eleven or so. Concrete evidence is more appropriate for those who are younger.

DENTAL ANXIETY

Anticipatory fears of dental treatment are also implanted or heightened by peer associates of the child. His playmates who have already experienced the "torments of the damned" often manifest an ardent desire to share their impressions of the treatment with the uninitiated youngster. The vivid parlance in which they describe a session in the dental chair can be very convincing. The same is true of the characteristic references to the "ordeal" that the young child hears repeatedly on TV.

Children manifest fear of dentistry for still another reason. Let me illustrate. Very recently, twelve-year-old Heidi, whom I have known since she was five or six, was explaining to me why it was she "worried" about her dental appointments. She was sure it wasn't because she was afraid of being hurt. To emphasize this fact, Heidi pointed out that she let her daddy give her "shots" when she was sick, and while she didn't take delight in them, they didn't frighten her either. Heidi frowned with the effort of concentration as she groped for the right words. She finally said hesitantly: "I think it is the things that I don't know about that scare me most."

Heidi's interpretation of her inner feelings while perhaps unsophisticated were perceptive. Her description was not far from what Jersild considers to be the prototype of unlearned fear. He postulated that those circumstances giving rise to natural fears are any intense, sudden, unexpected, or novel stimuli, or any condition which demands some kind of adaptation for which the organism is unprepared. He further clarified this phenomenon by pointing out that whether or not a certain stimulus evokes fear depends not only on the nature of the stimulus, but the total setting in which it occurs. For example, the hasty introduction even of a rubber prophylaxis cup might very well elicit a negative response from a young dental patient, whereas, given the opportunity to assimilate his new experiences, this same neophyte would accept intricate manipulations with aplomb. To cite another example, a child in the protective confines of his own home might not so much as raise an eyebrow were a door to slam unexpectedly. This very same door slam in the unfamiliar atmosphere of a dental office could so startle the youngster that for the rest of his appointment he would respond obstructively to even the most innocuous procedure.

It is an unfortunate truth that for children of all ages, some degree of unpleasantness is entailed in the practical necessities and routine procedures of dentistry. High-pitched noises and the vibration of

burs, disagreeable-tasting medicaments and pressures of various sorts, the experience of being immobilized in the dental chair, often in a cramped or horizontal position with dentist and assistant peering down, these are familiar elements in a child's fear of going to the dentist. The feeling of helplessness is exemplified in the question many children ask of their dentists before seating themselves: "What are you going to do to me today?"

It is impossible to account for the extensive and intense nature of "dental anxiety" or odontophobia, a term coined by the psychoanalyst Coriat, purely on the basis of rational and conscious perceptions of the dental situation. Certain emotional reactions which it tends to stimulate in the young patient, as well as psychologically significant experiences undergone during the impressionable years of childhood also merit consideration. The youngster himself is rarely aware of the basis for these reactions.

But let us start off with a common observation: children tend to react negatively to any therapeutic manipulation within the body. Thus, the dentist immediately encounters a formidable stumbling block. The area into which he intrudes, and in which his procedures stimulated disagreeable and occasionally painful sensations, has special vulnerabilities. It is linked in the child's psyche with the meeting of the paramount survival needs of infancy, with the earliest sensations, satisfactions, and perceptions of the world. The oral cavity has been referred to as the primal cavity or "primary pleasure zone." It is so significant to the infant's personality development and behavior later in life that a psychoanalyst by the name of Hoffer has even introduced the concept of ego or "mouth self."

SIGNIFICANCE OF THE ORAL CAVITY

According to psychoanalytic dicta, the oral cavity is a source of erotic pleasure for the infant and interference with his oral gratification can have a profoundly negative effect on the growth of his personality. One does not have to accept this concept, however, to recognize that the oral cavity does play a major role in personality development. Dental procedures that cause little or no physical discomfort can be threatening to a patient of tender years simply because the locus of treatment is in an area that he innately needs to protect.

The intake of oxygen and nourishment, the quenching of thirst, and the discharge of tensions through crying, are obvious physiological concomitants of the psychological needs mediated through

the oral cavity. Here are first experienced taste, temperature, touch, smell, and the special sensitivities involved in swallowing. It has been postulated that cognitive processes begin with the awareness of these inner sensations.

We get some appreciation of the significance of the oral cavity just by observing an infant. We can see him investigating the size, shape, taste and texture of everything that comes within his grasp. The mouth is his first means of expressing his feelings, or recognizing familiar objects, of indicating pleasure and displeasure, of making known his needs. It also plays a crucial role in the development of an affective relationship between infant and mother, for it is through the feeding experience that she has an opportunity to make known her love. The infant for his part, acquires a sense of security when his hunger pangs are relieved and also because the fondling, caressing, support, tactile stimulation, warmth and comforting are extremely pleasurable to him. Kleiser and later McDermott have expressed the notion that this sense of security could be re-established if a dentist were to feed a child during treatment. Undoubtedly, there are some children whose comfort would be enhanced if they were offered and accepted a snack during the visit.

It can be seen then, that interference with oral activities is, in effect, interference with the infant's contact with the world as he knows it, and is extremely threatening at this stage of life.

Though vestiges of the anxiety originally aroused remain hidden in the mind, psychologists allude to them in trying to account for the element of threat injected into subsequent situations which entail an intrusion into the oral cavity. Some of this pervasive and unrealistic anxiety is attributed to the fact that the dental situation symbolizes punitive aspects of the developmental experience, thus evoking emotions which psychanalysts identify with the psychic pain of childhood. You are probably aware that according to psychoanalytic theorists, young children are in the process of resolving, or have just resolved, a weighty dilemma. They become aware of a strong affectional interest in the parent of the opposite sex and ambivalent emotions for the parent of their own sex with whom they interact in a spirit of rivalry. Youngsters at this stage of development are greatly concerned with their own well-being, which they regard as threatened by the reactions of the parent to their own hostility. Feelings of guilt plague them and associated with these are fears of being dismembered by the offended parent. Freudians attach symbolic significance to the teeth and it is their notion that childhood fears of dismemberment are frequently projected onto them. While I do not

wish to belabor these ideas, just observe how an apprehensive child (or even an apprehensive but uninhibited adult) will tend to clutch that more remote area protectively while you are treating his mouth. This protective position becomes more understandable if one can accept the concept of dismemberment.

REGRESSIVE BEHAVIOR

In view of the broad constellation of rational and irrational fears catalyzed by the dental situation, it is safe to make the assumption that it often exposes the patient to considerable stress. And stressful situations characteristically reactivate infantile patterns of emotional response—that is, regressive behavior. The partial or symbolic return to outgrown reaction patterns is most prominently associated with severe psychiatric and physical illness, but the phenomenon of regression is also manifested by the normal person—adult or child—in sleep and play and a variety of stressful circumstances.

It is hardly necessary that one be a trained observer to note that the behavior of some children in the dental office has its infantile aspects. This includes those children who treat the dentist and his office associates antagonistically, have temper tantrums, kick, scream, hold their breath until cyanotic, retch or vomit. In this regard, I am reminded of my first meeting with Eddie, a youngster who by the age of five had made a shambles of an impressive number of dental offices. At our first visit, Eddie's father was forced to carry him kicking and screaming into the treatment room, where he deposited him in the dental chair and retreated rapidly back to the reception room. Eddie continued to scream for a few minutes. Then, without any warning, he took off his glasses and threw them toward the corner of the room. Fortunately, they were unbreakable. Next he took off his shoes and hurled them one after the other, in the same direction. Finally he unbuttoned and pulled off his shirt and flung it toward the glasses and shoes. Modesty, I presume, prevented Eddie from undressing further. Throughout this extraordinary performance he maintained an attitude of total defiance, but did not utter a word.

Eddie was, in psychological jargon, acting out, and acting-out behavior is recognized as a defensive reaction to a threatening situation.

Regressive behavior as a means of avoiding reality fortunately has its more passive aspects. For example, it is not uncommon for a child to fall asleep during operative procedures, particularly when

rubber dam is employed. Such behavior has been termed "somnolent detachment" by Sullivan, who pointed out that an infant tends to veer away from those objects or activities that increase anxiety, and failing in that, he tends to fall asleep.

TRANSFERENCE

A concept related to regression probably sheds a stronger light on the child's attitudes towards the person whose procedures arouse his conscious and unconscious fears. Some practitioners have reacted unfavorably to the notion that transference operates in the dental situation because it is best known as the pivotal factor in psychoanalytic treatment. However, in introducing the concept, Freud stressed the fact that transference is a "universal phenomenon of the human mind." As in other situations in which one person seeks and receives the help of another, transference can operate in dentistry. As the expert or authority figure, the dentist is endowed with qualities and powers which the child perceives in his own parents and becomes the recipient of attitudes and feelings which the child develops in his relation with his parents. The special anxieties, feelings of helplessness and dependency in a youngster undergoing dental treatment encourage transference attitudes. These attitudes, in turn, activate adjustment patterns which help to determine whether the dentist will be reacted to as a benign or punitive father figure. His powers to heal or hurt are thus exaggerated, depending on whether the attitude is positive or negative.

When the transference-like interaction is positive, it is instructive to observe how identification operates. Identification is a psychological mechanism associated with childhood learning. Patients tend to identify with the dentist's attitudes about their performance and dental needs. They put themselves in his shoes, so to speak, in appraising their own behavior during the treatment. The desire to be rated as a "good" patient and to gain the dentist's respect underlies efforts to comply with his instructions and prohibitions. This striving, in the view of the psychologists, also helps the patient to master his irrational anxieties.

OTHER MOTIVATING FACTORS

Of course, strong motivations for undergoing a dental procedure also help patients to master their fears and accept necessary discomfort. Fear becomes relatively inconsequential when a youngster is

bent on improving his well-being, personal appearance, and sense of self-esteem. Children with a normal degree of narcissism in their personality illustrate repeatedly that fear moves down in the hierarchy of human emotions when other feelings are placed on a higher pedestal. This phenomenon can be constructively exploited to lighten the discomfort of the treatment. For example, when a child has to have a tooth extracted, I point out that the replacement with a space maintainer is much more than a substitution. The idea that it is more desirable than the original—stronger, harder, and more durable—usually helps the child reconcile himself to the loss of his own tooth and also alleviates the discomfort of the extraction. Often he looks forward with delight to the acquisition.

While this paper focuses on psychological factors related to the child, it is not inappropriate to point out in passing that there are two psyches involved in dental treatment. The needs of both, as well as the nature of the dental problem mold their interaction. What can be achieved when professional knowledge and skills are applied to meet the needs of another human being depends to some extent on the gratification of the practitioner's own needs in the relationship. And self-understanding is an essential ingredient for understanding the patient.

ATTITUDES OF THE DENTIST

Psychological studies of dental students suggest that people who make dentistry their profession are orderly and methodical by nature; they also have some tendency toward rigidity and inflexibility, and demonstrate a need to operate autonomously. A close tie with a repressive authoritative male figure to whom aggression could not be expressed directly figures in the developmental experience of the dental students under study—they found it difficult to relate to authority figures and to deal with direct expressions of aggression.

It is impossible to determine how accurately the observations just summarized reflect prevalent attitudes and behavior patterns of dental practitioners today. However, the findings suggest that some dentists, at least, may find it difficult to cope with situations which call for flexible handling of the patient. The findings also suggest that the dentist is, on the whole, comfortable in the role of an authority figure, but he would prefer to play the role in a particular way, usually within the normal limits, but not always, of course.

There is, for example, the omnipotent authority figure who presents to the child his "ground rules" for acceptable behavior with

the ultimatum: my way or not at all. He fails to allow the child any latitude. He sees no need to compromise. Nonetheless, there are times when compromise and modification are required in order to gain cooperation. A youngster will appreciate consideration of his feelings in the matter. He should be encouraged to participate in his treatment and be permitted to make some routine decisions, whenever possible.

The practitioner who shuns the role of authority figure with all of his patients may also run into difficulties. For children with strong dependency needs, the "loving father figure" provides essential assurance and support, but the same posture is ineffectual with patients who need firmness, guidance and direction. Some children interpret an overly sympathetic attitude as a sign of weakness and are thus encouraged to test the limits of the dentist's patience with unreasonable demands. Among these children, a more rigidly structured appointment and a "stronger" authority figure commands more respect. Management is rarely a serious problem for the dentist who operates flexibly in the authority role to meet the needs of the individual patient in the immediate situation.

Solutions to some obstacles in the establishment of good interpersonal relations with very young dental patients are still in the exploratory stage. One of the unsettled issues is whether the parent should remain in the treatment room with the child. It is generally recognized that so-called separation fears or fears of abandonment are very destructive emotions and can lead to unmanageable behavior when mobilized in a young child. For this reason, some practitioners welcome the mother's presence as an aid, even a necessity when a pre-school child is in the chair. I shall leave the discussion of the pros and cons of this policy for another time. I would like to point out, however, that when the parent is not present to act as a "go between" a mother figure should be present. The mother figure is, of course, the dental assistant. Her primary responsibility at this juncture is to look after the youngster's psychological comfort. Her presence allows him to relate to someone as he relates to his mother. His acceptance of her provides him with an emotionally supportive adult in a strange and stressful environment.

The usefulness of the dental assistant as a "mother substitute" is based on the ability and tendency of individuals to transfer feelings developed for one person to another person. A similar phenomenon reflects the ability and tendency of human beings to use one object as a representation or abstraction of another object. The mental mecha-

nism involved in this process may be used to advantage by the practitioner who introduces inanimate objects which will ease the stress of the treatment by stimulating "symbolic thoughts" in the patient. This idea is inherent in the origin of the word symbol. It is rooted in the Greek *symbolon*, which means a mark or a token.

SYMBOLISM

Psychoanalytic theorists have defined symbol as an "image which has meaning distinct from its immediate content." They refer to a symbol whose meaning is known to the patient as a "conscious" or primary symbol, and one whose meaning is veiled to the patient as an "unconscious" or secondary symbol. The capacity to accept symbols varies greatly, not only among individuals, but at different periods of life as well.

These same theorists also state that certain games are symbolic reproductions of painful experiences with the sole aim of digesting and assimilating them. The case of Mark illustrates primary and secondary symbolism in operation. Rampant caries prompted Mark's mother to seek dental treatment for him when he was three years, four months old. Mark's intolerance of any dental procedure was inappropriate even for his age and was probably related to an extensive medical history, which included recurrent attacks of asthma requiring hospitalization, as well as a herniorrhaphy at the age of two. He gave indications of having been overindulged by his parents, an understandable circumstance in view of his physical frailty as well as the fact that he was the "baby" of the family, the youngest of four boys. Over several visits Mark learned to provide the degree of cooperation necessary for successful treatment. During this "introductory period" he appeared to draw comfort from his mother's purse, which regularly accompanied him into the treatment room. Mark apparently recognized that possession of his mother's purse was a realistic guarantee of her presence nearby and by associating this object with his mother, Mark was able to draw from it in the treatment room the comfort and sense of security her physical presence would have given him. The purse never left his grasp during the visit as he sat in the dental chair. In effect, he was holding onto his mother.

Other children deal with a similar situation less dependently. They symbolically recreate treatment by "playing dentist." The living-over of anxiety-provoking experiences with other children or

inanimate playmates, especially dolls or stuffed toys, gives a young child opportunities to rid himself of his traumatic ideas about the experience he has just undergone. In the process he releases some of the tension that was created. Often he projects it onto his play companions. Moreover, stepping into the shoes of an authority figure who has just subjected him to an emotionally stressful procedure is especially comforting to a youngster who has hardly outgrown his own infantile feelings of omnipotence.

UNDERSTANDING THE PATIENT

It is my impression that the treatment of children by an understanding parent figure has major implications in the practice of dentistry. The child is always a captive patient, and whether he continues to feel like one when he grows up depends to a great extent on his early dental experiences. Too many management problems encountered in practice stem from the fact that initial experiences were with individuals who did not understand how to form a good relationship with a child or were simply unwilling to make the necessary effort to do so.

But today we have sufficient understanding to prevent the management problems we once created. The task, in essence, is to transform the captive into a cooperative patient. This is also the key road to improving the public image of the dentist.

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(Continued on page 184)

The Performance of Community Oriented Activities by Specialist and Generalist Dental Practitioners*

H. BARRY WALDMAN, D.D.S., M.P.H., PH.D.**

THE DENTAL PROFESSION traditionally has been concerned with the restoration, removal, and replacement of teeth and the care of their supporting tissue. However, Young and Striffler,¹ Gleeson et al.,² Calisti and Kramer,³ and many others speak of a need to extend the dental practitioner's view beyond the individual patient. While the dental profession *has not* evolved a specific definition of this responsibility beyond the individual patient, the tendency is to generalize this responsibility by calling for the development of dental practitioners who are community minded and socially conscious.

The dental educators of today are no longer concerned with simply producing a technically competent practitioner. Durocher⁴ and Young and Zwemer⁵ express this new orientation in terms of the need for "technically competent, biologically oriented and socially sensitive" practitioners. However, Counsell⁶ reports in his review of the literature that the dental student and practitioner have been characterized by many investigators as conservative, conforming, unconsciously aggressive, persistent, methodical, somewhat rigid and inflexible, and with motives of upward mobility and financial betterment.

Given this composite picture of an "average" dental student and practitioner, and an awareness of rising community expectations and demands for professional leadership and health services, dental educators have sought to sensitize the practitioner to the total community within which he maintains a "secluded" private practice. One method employed has been to encourage dental school applicants to emphasize liberal arts and social science undergraduate pre-

* Support for this research project was provided by a National Institute of Health Fellowship, No. 2-503-DH-35,158, Division of Dental Health.

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dental courses beyond the minimum requirements established for admission to schools of dentistry. However, this attempt to stimulate a practitioner's participation in community oriented activities has been carried out with limited justification of the value of a broadened education and limited consideration of how the type of dental practice—specifically, specialty and general practice—may affect the practitioner's subsequent involvement in community oriented activities.

As part of a comprehensive study to consider the relation between predental course emphasis and the subsequent performance of community oriented activities by private dental practitioners,⁷ an effort was made to describe the modifying effect of specialty and general practice on the relation between a "liberal arts"* and "extended science"** predental education and the practitioner's subsequent performance of community oriented activities. It has been reported by this writer⁸ that "liberal arts" practitioners are more involved than their "extended science" colleagues in other-than-practice-oriented community services (other than direct dental care—dental society, civic, and educational activities). The concern of this report is with the performance of community oriented activities by specialist and generalist dental practitioners.

The specialist, by the nature of his activities, would tend to be more fully involved in community oriented activities since:

1. his particular specialty is the usual concern of community dental programs—programs for children (specifically the pedodontist and orthodontist),
2. as a specialist he is more qualified in particular areas of dentistry and is sought after for a teaching role in schools of dentistry,
3. by definition he is involved in community oriented activities (specifically the public health dentist), and
4. he requires professional exposure to "advertise" his specialty, in addition to dental society contacts, and will tend to participate in activities that afford him this opportunity (e.g., the pedodontist who lectures before P.T.A. groups).

For these reasons it was hypothesized that specialists exhibit greater performance of community oriented activities than their general practitioner colleagues.

* That individual who, as a predental student, majored in or emphasized the liberal arts and social sciences beyond the minimum requirements established by the Council on Dental Education of the ADA for admission to schools of dentistry. (The 1970 House of Delegates eliminated specific requirements for admission to schools of dentistry.)

** That individual who, as a predental student, majored in or emphasized the traditional scientific fields of biology, chemistry, physics, mathematics, and related areas beyond the minimum requirements established for admission to schools of dentistry.

THE STUDY

A one-third systematic selection of private dental practitioners who were active or life members of a large midwestern dental society and who had been graduated from the two schools of dentistry—one a privately controlled institution, and the other, a state institution—which provided 90 percent of all dental practitioners for the community, were selected for study. The study was based upon responses to a short mailed questionnaire—with telephone follow-up of non-respondents—which asked about the practitioner's undergraduate predental education, participation in community oriented activities, and practice characteristics. Of the defined sample of 261 practitioners, 235 practitioners, or 90.1 percent, responded to the questionnaire or follow-up interview.

Based upon the information supplied by respondents about their predental course emphasis, 78 practitioners, or 33.2 percent, were recorded as "liberal arts" ("l.a.") practitioners, and 157, or 66.8 percent, were recorded as "extended science" ("e.s.") practitioners.*

Community oriented activities were considered in terms of three general categories of practice (or clinical) oriented activities:

- dental care (in office)—e.g., Head Start activities
- dental care (out of office)—e.g., health department dental clinic activities
- hospital activities

and three general categories of other-than-practice-oriented activities:

- civic—e.g., service clubs, political group activities
- educational—e.g., dental school teaching
- dental society activities

Practitioners were asked to record their performance (in hours—for the previous two months) of community oriented activities in terms of these six categories of activity. Since the performance of various activities may be closely related, a series of combinations of categories (or scales) were developed where respondents indicated the associated performance of two or more activities ($p \leq .05$). Two practice oriented and one other-than-practice-oriented scales were so developed.

Scale A—dental service (in office) + dental service (out of office) activities

Scale B—dental service (out of office) + hospital activities

Scale C—dental society + educational + civic activities

* A detailed presentation of the specifics of the categorizing procedures, and the development of the scales of community activity (discussed in the next section) have been reported by this writer.⁹

The Mann-Whitney U testing procedures¹⁰ were separately carried out for "l.a." and "e.s." practitioners to test the hypothesis of no systematic difference between the performance of community oriented activities by generalist and specialist practitioners. The number and percent of practitioners in the higher halves of the ranks of activity were used to determine the direction of any differences that were noted. The results of these procedures are graphically presented in Chart I. The presentation is in terms of the percent of "l.a." and "e.s." practitioners in the higher half of the respective rankings of community oriented activity as measured by the scales of community activity.

As reported in Chart I, the effect of specialist and generalist practice on the relation between undergraduate predental education and the performance of community oriented activities was found to be:

For "liberal arts" practitioners

1. Specialists are more active than generalists in the performance of practice oriented community activities (Scale A).
2. No difference* between specialists and generalists in the performance of other-than-practice-oriented community activities (Scale C).

For "extended science" practitioners

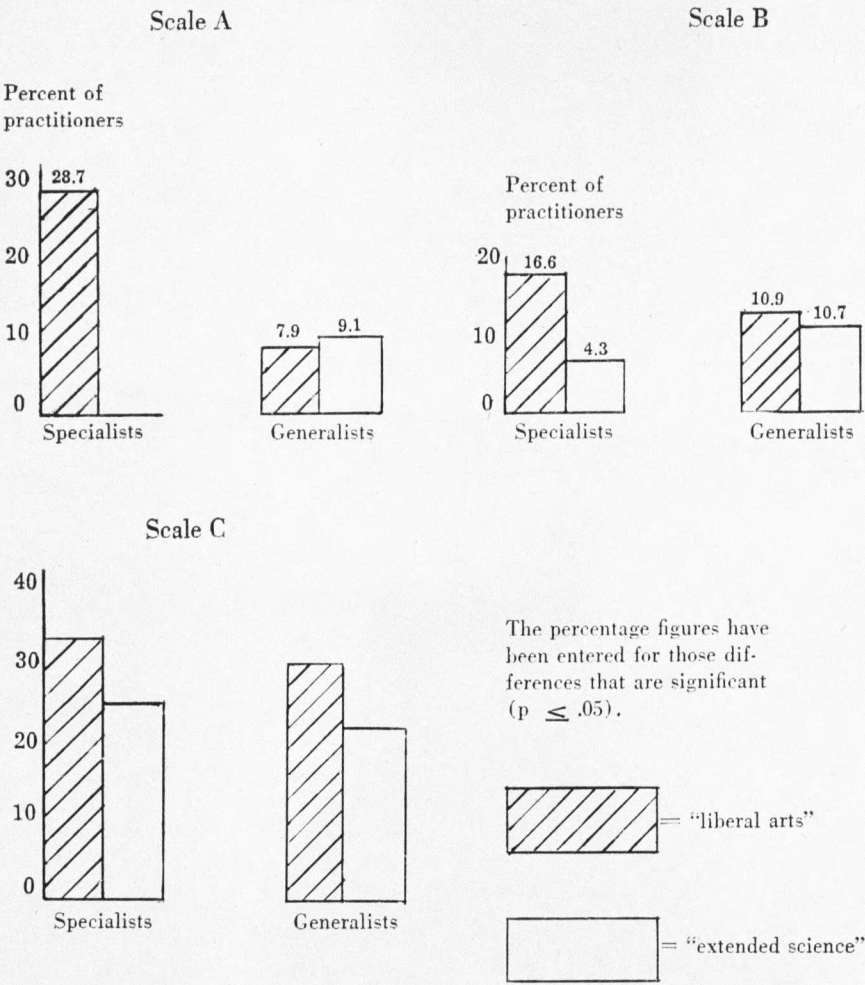
1. Generalists are more active than specialists in the performance of practice oriented community activities (Scales A and B).
2. No difference* between specialists and generalists in the performance of other-than-practice-oriented community activities (Scale C).

It had been hypothesized that general practitioners would be less involved than specialist practitioners in the performance of community oriented activities. This hypothesis, therefore, was confirmed for "l.a." practitioners, only as measured by one of the scales of practice oriented community activities (Scale A) and was not confirmed for "e.s." practitioners as measured by all three scales of community activity. And further, a relation opposite to that which had been hypothesized was found for "e.s." practitioners; i.e., "e.s." generalist practitioners outperformed "e.s." specialist practitioners as measured by both practice oriented scales of community activity (Scales A and B).

One possible explanation for the "e.s." specialist-generalist findings could be that "e.s." specialists had altered their "usual" community activity performance patterns—as represented by "e.s." generalists (or could always have been different). If this were the case,

* At the .05 level.

Chart I THE PERCENT OF "L.A." AND "E.S." PRACTITIONERS IN THE HIGHER HALF OF THE RANKINGS OF COMMUNITY ACTIVITY BY SPECIALIST AND GENERALIST PRACTICE AS MEASURED BY THE SCALES OF COMMUNITY ACTIVITY.



then as a result of the preoccupation by "e.s." specialists with other-than-practice-oriented activities, "e.s." generalists could report more practice oriented activities than "e.s." specialists.*

If this interpretation were correct (and "e.s." specialists did not simply reduce their performance of community oriented activities) then it could follow that:

1. there is no difference between the performance of community oriented activities by "l.a." (specialist + generalist) practitioners and "e.s." specialists, and
2. "e.s." generalists are less involved than "l.a." (specialist + generalist) practitioners in other-than-practice-oriented community activities.

The Mann-Whitney U testing procedures were used to test the respective hypotheses with the number and percent of practitioners in the higher halves of the ranks of community used to determine the direction of any differences that were noted. The results of these procedures are reported in Table I.

The results of these procedures (Table I) indicated that, as measured by all three scales of community activity, there was no difference between the performance of community oriented activities by "l.a." (specialists + generalists) and "e.s." specialist ($p \geq .12$). A difference was noted, as measured by Scale C, between the performance of other-than-practice-oriented community activities by "l.a." (specialists + generalists) and "e.s." generalists in terms of

Table I. Mann-Whitney U values, associated probabilities, and direction of differences for a comparison of the performance of community oriented activities by "l.a." (specialist + generalist) practitioners and "e.s." specialists, and "e.s." generalists by the scales of community activity.

	"L.a." (specialists + generalists) and "e.s." specialists		"L.a." (specialists + generalists) and "e.s." generalists		Direction of difference
	U value	Prob.	U value	Prob.	
Scale A	1139	.12	5022	.44	
Scale B	916	.32	5245	.20	
Scale C	1057	.38	4443	.05	"l.a." > "e.s." generalists

* It should be noted that the following discussion and procedures were carried out for exploratory purposes and not to evaluate various hypotheses that had been developed prior to the collection of respondent data. It was felt that such a review might provide some answers to the questions raised in the general study, and more importantly, it might provide direction to future study of the performance of community oriented activities by dental practitioners.

"l.a." practitioners outperforming "e.s." generalists ($p = .05$).

The results of the comparisons of the performance of activities by "liberal arts" practitioners and "extended science" specialists and generalists would thus indicate that a possible explanation for generalists outperforming specialists in practice oriented activities is that "extended science" specialists are more involved in the performance of other-than-practice-oriented community activities.

However, it must again be noted that this discussion was of an exploratory nature and the interpretations were developed during the process of the analysis of the data. Nevertheless, the findings could serve as general indicators for future study of the performance of community oriented activities by private dental practitioners.

The results of this study would indicate that while categorizing dentists as "liberal arts" and "extended science" practitioners may be useful for establishing a general relation between undergraduate predental education and the subsequent performance of community oriented activities, one may not assume that practitioners will be uniformly involved in community oriented activities regardless of the type of their practice.

SUMMARY

A study was made of the modifying effect of specialty and general practice on the relation between a "liberal arts" predental emphasis—emphasis in the liberal arts and social sciences—and an "extended science" predental course emphasis—emphasis in the physical and natural science—and a practitioner's subsequent involvement in community oriented activities.

The results of the analysis indicated that "liberal arts" specialists, and "extended science" generalists are more involved than their respective generalist and specialist counterparts in community oriented activities. One possible explanation for these particular findings was reviewed.

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Book Review

THE AMERICAN COLLEGE OF DENTISTS: ITS HISTORY, ORGANIZATION, OBJECTIVES, AND HOW IT FUNCTIONS, Otto W. Brandhorst, D.D.S., 571 pages, John S. Swift Co., St. Louis, 1971, \$15.00.

In his introduction, Dr. Brandhorst states, "The purpose in writing this book is to record the efforts that have been put forth over the past fifty years in the establishing of an honorary organization in the dental profession, which would have for its purpose the highest professional ideals". The author has recorded those efforts admirably in this monumental work.

The book is not merely a history, it is more accurately an encyclopedia of the College. It covers every aspect of the founding, development, growth, functions, policies, programs and activities of the organization. There are chapters on the nomination and election procedures, conferring of fellowships, the regalia, insignia and symbols, the officers who have led the College for each year of the past half century, and brief descriptions of significant events of each year. There are chapters on committee activities, projects of the College, its literature. It contains the citations for honorary fellowships, and awards of merit, vignettes of the recipients of the William J. Gies Award, and a large section of "Profiles in Science" which resembles a "Who's Who in Dentistry," for it includes every important figure in the profession for the past fifty years.

The book is replete with illustrations, and lists the names of every person inducted into fellowship since the founding. It is a volume to treasure and to turn to again and again when seeking information about the College.

Its compilation may be considered the crowning achievement of Otto W. Brandhorst's long and distinguished career. It belongs in the library of every Fellow of the College.

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THEORIES AND TECHNIQUES OF ORAL IMPLANTOLOGY, by Leonard Linkow, D.D.S., and Raphael Chercheve, edited and illustrated by Maureen Jones, 2 volumes, 708 pages, 2,234 illustrations in 1,631 figures. C. V. Mosby Co., St. Louis, 1970. \$65.

This two-volume text contains a wealth of information on the newly developing science of implantology. It covers the entire field of endosseous and subperiosteal implants, and includes the many variations of each, their indications, rationale and technique.

While no book can ever substitute for a postgraduate course, this text offers a good approach to a do-it-yourself study program. It is written simply, in an easy-to-understand style.

It is necessary to approach the subject of implantology with a great amount of caution, for implants are not a panacea for all denture problems.

Some of the techniques discussed and explained, such as vent plants and tripodial pins do not have the promise that the newer blade plants hold, and may not stand the test of time, but their inclusion in the books is justified as

a description of a stage in the development of implantology. The authors have treated more than 2000 cases, and while claiming a large measure of success, do not hesitate to discuss the causes of implant failure, and point out pitfalls to be avoided.

Anyone interested in learning about implantology will find all the information he seeks in the pages of these books.

PAUL G. ZACKON

PSYCHOLOGICAL FACTORS IN DENTAL PRACTICE

(Continued from page 172)

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THE PERFORMANCE OF COMMUNITY ORIENTED ACTIVITIES

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The Objectives of the American College of Dentists

The American College of Dentists in order to promote the highest ideals in 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.

