

The JOURNAL  
of the  
AMERICAN COLLEGE  
of DENTISTS

The Public Versus the Profession  
Supply and Demand  
Functional Realignment of  
Oral Health Services  
Treatment Planning

JANUARY 1972

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.

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# NEWS AND COMMENT

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*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.*

## Actions of the Board of Regents

At the annual meeting in Atlantic City recently, the Board of Regents took the following actions:

—Indicated its continued support for the Institute of Advanced Education in Dental Research.

—Requested the Committee on Education to focus its attention on the problems of dental student recruitment, and how the Sections might involve themselves in such activity, and to report to the Board its suggestions for action.

—Assigned to Section Secretaries the responsibility for reporting deaths of Fellows to the Executive office.

—Recommended that the Bylaws be changed to place members in a delinquent status who are in arrears for one year in the payment of annual dues.

—Set up an ad hoc committee on Section activities to study the role of the Sections and consider methods for the nomination of younger members.

—Requested the Executive Committee to study the scope and content of the annual meeting program.

—Referred to the President and Executive Director a motion to implement the American College of Dentists Foundation.

—Directed the Executive Director to study the feasibility of a College-Sponsored Self-Assessment Program.

—Requested the Executive Director to make a feasibility study of a Video-tape recruitment system as the basis for a clearing house for professional relocation and recruitment in dentistry.

—Approved the new nomination forms and recommended the distribution of one to each member, upon request.

—Approved a non-participating retirement plan for full-time salaried employees of the College.

—Passed a resolution of appreciation to the Subcommittee on Dental Research, with particular commendation to its chairman, Dr. David B. Scott and program coordinator, Dr. Kenneth E. Elwell.

—Referred to the Executive Committee the comments made by members on the Personal Profile and Interest Survey.

—Approved the report of the Editorial Board that the Journal continue its policy of not carrying advertising matter.

—Referred to the Committee on Bylaws a recommendation that the Historian be an ex-officio member of the Board of Regents.

—Expressed its thanks and commendations to the retiring officers, President Otto W. Brandhorst, Vice President J. Lorenz Jones and Regent Louis G. Terkla, for their years of service to the College.

## SECTION NEWS

### New York Section

The New York Section held a dinner meeting on December 5, 1971 at the Statler-Hilton Hotel, New York City, in conjunction with the Greater New York Dental Meeting. Dr. William C. Hudson, section chairman presided.

Awards of \$100 savings bonds were presented to two dental students, Paul S. Miller and Donald DeLuke, for scholastic achievement.

The speaker of the evening was Dr. Fairfield Hoban, former Deputy Director of the Peace Corps for Pakistan, who gave a slide-illustrated talk on the political, social and economic conditions in Pakistan.

The new officers of the New York Section are Dr. Lester Eisner, chairman; Dr. Andrew Linz, vice-chairman; Dr. Michael Turoff, secretary-treasurer; and Dr. John Dolce, historian.

### New Jersey Section

The Fall meeting of the New Jersey Section was held at the Holiday Inn, Kenilworth on November 18, 1971.

Dr. Albert Klein of Perth Amboy spoke on "A Guide for the Perplexed: Patient Home Care." He reviewed the literature relating to the prevention of dental caries and periodontal disease, and pinpointed patient techniques for good home care.

Executive Director Bob Nelson has expressed his appreciation for the services and cooperation of the New Jersey Fellows during the recent convocation in Atlantic City.

Section officers are Dr. Brainard Swain, chairman; Dr. L. Deckle McLean, vice-chairman; and Dr. James W. Hipple, secretary-treasurer.

### Philadelphia Section

The Philadelphia Section of the American College of Dentists held a dinner meeting at the Barclay Building on November 2, 1971. Forty-seven members and guests attended.

Those who received Fellowship at the last Convocation of the College were introduced and welcomed to the Section. Doctor William J. Simons of Louisville, Ky. gave an illustrated talk on "Expanded Duties for Dental Assistants." The Section elected officers for the year. They are: Dr. S. Leonard Rosenthal, chairman; Dr. D. Walter Cohen, chairman-elect; Dr. Harold J. Lantz, secretary-treasurer.

The next meeting will be held during the Greater Philadelphia Meeting in March 1972.

### College Has First Husband-Wife Team as Fellows

With the induction to fellowship of Dr. Naomi A. Dunn at the last convocation, the American College of Dentists has its first husband and wife dental team. Dr. Dunn is the wife of Dr. Irving W. Eichenbaum and practices pedodontics with him in New Britain, Connecticut. Although not participating in her nomination, Dr. Eichenbaum had the pleasure of acting as his wife's sponsor during the induction ceremony.

### Christian Dental Society Seeks Equipment and Supplies

The Christian Dental Society, through its Secretary, Fellow Everett C. Claus, has asked the Fellows of the College to consider the contribution of equipment and supplies to this organization, which has established dental clinics in India, Korea, the Congo, Dahomey, Anguilla, Guatemala, Haiti, Peru and Colombia. He is also interested in obtaining volunteers for overseas dental service in these missions.

For further information, write the Christian Dental Society, 5235 Sky Trail, Littleton, Colorado 80123.



## NEWS OF FELLOWS

Dr. Russell I. Todd of Richmond, Kentucky, received the Dentist Citizen of the Year Award at a recent meeting of the American Association of Dental Examiners in Atlantic City, N. J. Dr. Todd is a civic leader, educator, author, historian, radiology research authority and a past president of the AADE.

Dr. Stanley Lotzkar, associate director for operation of the division of dental health of the Public Health Service, has retired after serving 21 years in the service. He will join the University of Florida Dental School.

Dr. Philip M. Hoag, of Aurora, Illinois, has been appointed associate professor and chairman of the Department of Periodontics of the Southern Illinois School of Dental Medicine.

Dr. John W. Stanford, secretary of the ADA Council on Dental Materials and Devices, addressed the Second Annual Conference on Product Liability Prevention recently in Newark, N. J. His topic was "Standardization, self-regulation and acceptance programs." The meeting was sponsored by many groups representing the manufacturing, retailing, law and insurance fields.

Dr. Robert J. Nelsen, ACD Executive Director, has been appointed Chairman of the American Academy of the History of Dentistry's Advisory Committee to the Smithsonian Institution on the History of Dentistry Exhibit. His Committee Members are Dr. N. William Ditzler and Rear Admiral Alfred W. Chandler.

Dr. George E. Emig, associate dean and professor of prosthodontics at Georgetown University School of Dentistry, recently received a certificate of commendation for more than 20 years of outstanding service as consultant in prosthodontics at the Central Dental Laboratory, Veterans Administration Hospital in Washington, D. C.

Dr. Clifton D. Dummett, associate dean and professor of community dentistry at the University of Southern California has been named to serve on the Board of the National Medical Association Foundation, a non-profit corporation sponsored by the National Medical Association to promote programs to provide comprehensive health care of high quality for the nation's inner cities.

*(Continued on Page 62)*

# the JOURNAL of the AMERICAN COLLEGE of DENTISTS

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A QUARTERLY PRESENTING IDEAS IN DENTISTRY

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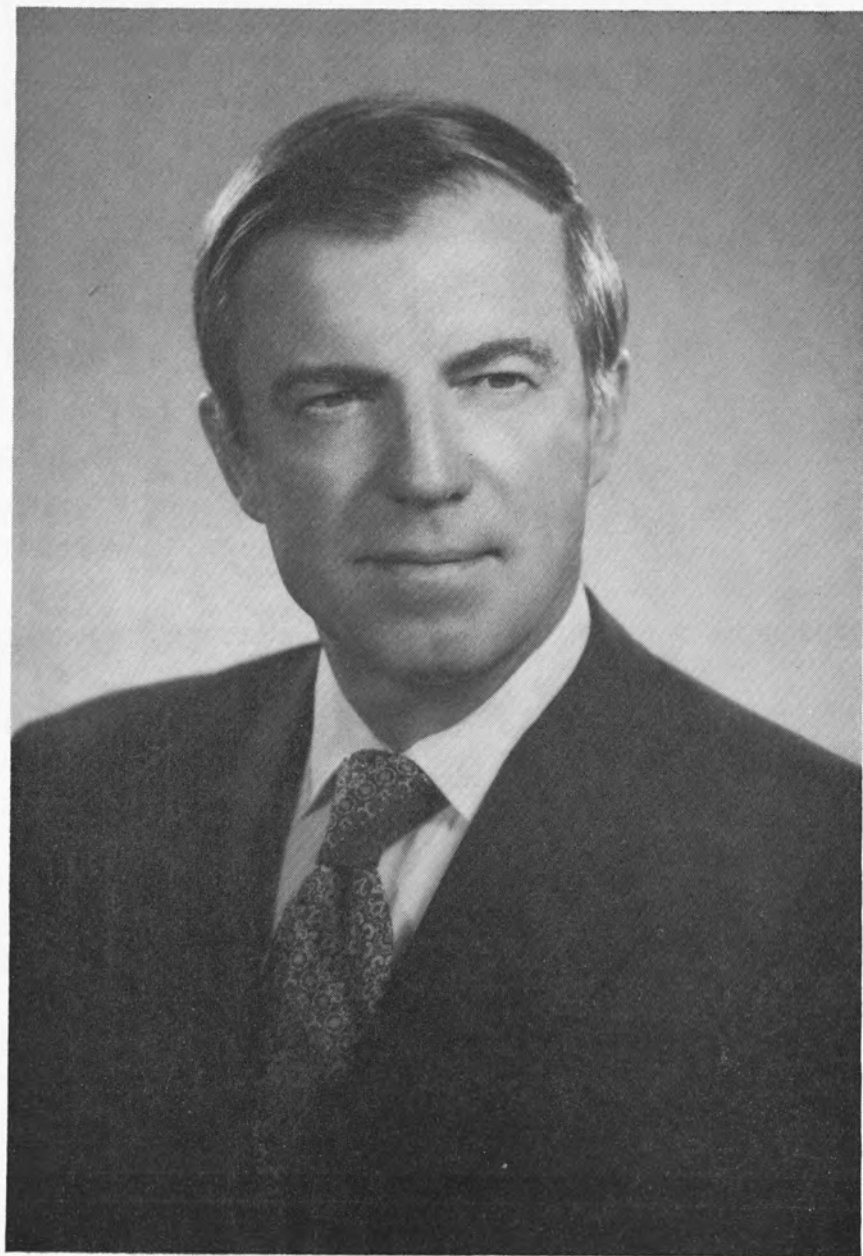
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# Contents for January 1972

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|  |    |
|--|----|
| NEWS AND COMMENT . . . . .   | 1  |
| PRESIDENT WILLIAM E. BROWN . . . . .   | 8  |
| EDITORIALS   |    |
| PREVENTION—A BROADER VIEW . . . . .  | 10 |
| IMPLICATIONS OF THE FELLOWSHIP DISTRIBUTION TABLE . . . . .                  | 12 |
| FELLOWSHIP DISTRIBUTION TABLE . . . . .                                      | 13 |
| PRINCIPLES UNDERLYING SELECTION TO FELLOWSHIP . . . . .                      | 14 |
| THE PUBLIC VERSUS THE PROFESSION   |    |
| <i>Robert J. Nelsen, D.D.S.</i> . . . . .                                    | 16 |
| SUPPLY AND DEMAND  |    |
| <i>C. Gordon Watson, D.D.S.</i> . . . . .                                    | 21 |
| A PROPOSED FUNCTIONAL REALIGNMENT SYSTEM FOR<br>DELIVERY OF ORAL HEALTH CARE |    |
| <i>Norman F. Gerrie, D.D.S., M.P.H.</i> . . . . .                            | 29 |
| DELAYED VERSUS IMMEDIATE TREATMENT PLANNING                                  |    |
| <i>Carl O. Davis, D.D.S., Ph.D.</i> . . . . .                                | 42 |
| NOW—AN EPILOGUE  |    |
| <i>Frank P. Bowyer, D.D.S.</i> . . . . .                                     | 47 |
| A TRIBUTE TO OTTO W. BRANDHORST  |    |
| <i>Thomas J. Hill, D.D.S.</i> . . . . .                                      | 51 |
| HONORS AND AWARDS . . . . .  | 54 |
| FELLOWSHIPS CONFERRED . . . . .  | 60 |
| NECROLOGY REPORT . . . . .   | 63 |
| LETTERS . . . . .  | 64 |





WILLIAM E. BROWN

President 1971-1972

## President William E. Brown

William E. Brown, dean of the University of Oklahoma School of Dentistry has been chosen as the fifty-second president of the American College of Dentists. Widely known as a lecturer, clinician, writer and educator, he brings to his new office a perceptive approach to the problems that currently beset dentistry, and a sincere desire to find solutions for them.

Born in Benton Harbor, Michigan, he received his undergraduate education and dental degree at the University of Michigan. Graduate study at Michigan led to a Master of Science in dentistry for children. While at school he was elected to Phi Kappa Phi, an all-campus honorary society, and to Omicron Kappa Upsilon honorary dental society.

Following his graduation Dr. Brown joined the Michigan dental faculty, rising over a twenty-four year period from teaching fellow to instructor to assistant and associate professor and finally to full professor and acting chairman of the department of pedodontics. He was director of the Dental Assistants Utilization Training Program for eight years, and served as chairman of the Senate Advisory Committee on University Affairs. From 1962 to 1969 Dr. Brown was associate director of the W. K. Kellogg Foundation Institute of Graduate and Postgraduate Dentistry. When the University of Oklahoma established its dental school, it made a thorough search for an individual who could provide the leadership necessary for so difficult an undertaking, and wisely chose William E. Brown for the position. Moving from Michigan to Oklahoma in 1969, he promptly took charge and has been working vigorously to prepare the school for its first class which will enter in 1973.

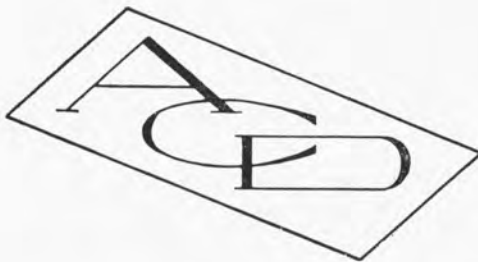
Dr. Brown has a long history of activity in dental organizations. He is a past president of the Washtenaw County Dental Society (1952), the Michigan Society of Dentistry for Children (1954), the American Society of Dentistry for Children (1959), the American Academy of Pedodontics (1963-64), and the Michigan State Dental Association (1968-69). He is a diplomate of the American Board of Pedodontics and former member and chairman of its examining board.

He is the author of more than seventy-five articles published in professional journals, and has served as editor of the University of Michigan Dental Alumni Bulletin and the Journal of the Michigan State Dental Association. His editorials in this latter publication were widely acclaimed, and he was twice the recipient, in 1965 and 1967, of the William J. Gies Editorial Award.

On the national level, he served as a delegate to the American Dental Association for ten years and was a member of the Task Force which in 1966 developed the ADA National Children's Dental Health Program. He has been a consultant to the ADA Council on Dental Education and a member of the Committee on Priorities of the Task Force on National Health Programs.

Dr. Brown has been in wide demand as a speaker on pedodontic topics and subjects relating to dental education, and is known as a lucid and articulate clinician. He has been a member of the Dental Health Research and Education Advisory Committee of the U. S. Public Health Service, and currently serves on the Dental Education Review Committee of the National Institute of Health.

He was inducted into the American College of Dentists in 1958, and served a four year term as a member of the Board of Regents, before moving up to become president-elect last year. He assumed the presidency at the Atlantic City Convocation. The College is fortunate to have as its leader at this critical time a man of the vision of Dean William E. Brown. Under his guidance, we look forward to a productive year.



# *Editorials*

## Prevention—A Broader View

The early seventies may one day go down in dental history as the Era of Prevention. There is a strong thrust toward what is called Preventive Dentistry by many practitioners. Leaders in the movement that has arisen are travelling the length and breadth of the country, preaching with evangelical fervor the techniques of prevention. An organization has been established to promote the concept, and a publication has recently been launched. And all across the land, dental organizations are making prevention the theme of their meetings and conferences.

This interest is of course commendable, but closer inspection reveals that the proponents of the concept are talking mainly about only a limited aspect of prevention—the prevention of dental caries and of periodontal disease through plaque control. In this regard, they may be said to suffer from a form of tunnel vision in seeing only one small part of a broad picture, for there is certainly much more to prevention than just plaque control.

We believe that prevention in dentistry encompasses everything that a dentist does for his patients. When he restores a child's primary molar to anatomic form and function, he is preventing pain and early loss of that tooth and subsequent loss of arch length, which could necessitate future orthodontic treatment. When he restores a tooth for an adult he is preventing its further breakdown, possible loss, and the need for replacement. Every phase of dentistry is geared toward prevention, and it is possible to practice preventive endodontics, prosthodontics and preventive oral surgery. And we know that preventive orthodontics has been advocated for years.

We are concerned that an over-emphasis on plaque control may be leading some of its disciples to neglect the important areas of restorative dentistry. The question has also arisen as to whether it will ever be possible to motivate large segments of our population to the careful regimen required for optimum plaque control. Even a scare campaign may be insufficiently effective, as the opponents of smoking have discovered. Fear of lung cancer has not deterred people from smoking, and fear of tooth decay has not deterred many from eating sweets. We wonder whether it is possible to move great numbers of people to be scrupulous about brushing and flossing their teeth.

We think that there is much to be done in all areas of prevention. In spite of the wide acceptance of water fluoridation as a means of preventing tooth decay, there are still many communities which are not receiving its benefits. Perhaps we should channel some of this evangelical fervor toward influencing state legislatures to mandate water fluoridation for their citizens. That would be promoting prevention in its broadest sense.

So let's set the record straight and look at prevention more thoroughly. There is nothing wrong about promoting plaque control, nor with motivating dentists to teach it and patients to practice it. But let us put things in their proper perspective. A horse is a four-legged animal, but not all four-legged animals are horses. Plaque control is one form of prevention, but prevention is much more than just plaque control.

R. I. K.

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### Words of Wisdom

May there never develop in me the notion that my education is complete but give me strength and leisure and zeal continually to enlarge my knowledge.

—Moses Maimonides (1135-1202)



## Implications of the Fellowship Distribution Table

Executive Director Robert J. Nelsen has prepared a table of the distribution of Fellows of the College by states (page 13), which shows the relative percentages of ADA members who hold fellowship. The table contains some interesting data. Certain areas have rather high percentages. District of Columbia and Maryland top the list, because of the preponderance of Fellows in the federal dental services who are located in those areas. Other states such as Alaska, Idaho, Maine and Utah are in the lowest category of 1% or less. Arkansas, Delaware, Mississippi, Montana, Rhode Island, Tennessee and Texas have relatively high percentages, while Connecticut, Kansas, Vermont and Wisconsin are relatively low.

The purpose of this table is not to rate the states according to their relative standings nor to offer commendation to the larger groups or criticism of the smaller.

Mere numbers are no indication of the strength of the states or Sections, for some of the smaller ones are more active than large ones. However, every Section should be interested in bringing into fellowship those men who by their achievements or the clear indication of their potential for achievement, are worthy of belonging to what has been termed "Dentistry's Legion of Honor."

The College must never be considered as a private club, to which fellowship can be attained by being a "nice guy," or by belonging to a particular race or religious group. Such an organization would have little meaning in the world of dentistry today. The College needs the best men available, regardless of creed or color. To get them involved in our work, it becomes the duty of the Sections to seek them out and to nominate them for fellowship. Only then can we maintain the leadership which the profession has come to expect of us.

R. I. K.

## Fellowship Distribution Table

Numbers and relative percentages of Fellows of the American College of Dentists to ADA Membership by States\*

|                               | <i>ACD</i> | <i>ADA</i> | <i>% (±½%)</i> |                     | <i>ACD</i> | <i>ADA</i> | <i>% (±½%)</i> |
|-------------------------------|------------|------------|----------------|---------------------|------------|------------|----------------|
| Alabama .....                 | 39         | 896        | 4%             | Nebraska .....      | 42         | 777        | 5%             |
| Alaska .....                  | 1          | 83         | 1%             | Nevada .....        | 7          | 209        | 3%             |
| Arizona .....                 | 30         | 625        | 5%             | New Hampshire ..    | 11         | 296        | 4%             |
| Arkansas .....                | 35         | 578        | 6%             | New Jersey .....    | 139        | 3,893      | 4%             |
| California .....              | 574        | 10,458     | 5%             | New Mexico .....    | 10         | 313        | 3%             |
| Colorado ....                 | 49         | 1,113      | 4%             | New York .....      | 458        | 12,881     | 4%             |
| Connecticut .....             | 33         | 1,817      | 2%             | North Carolina .... | 65         | 1,441      | 5%             |
| Delaware .....                | 13         | 208        | 6%             | North Dakota .....  | 7          | 241        | 3%             |
| District of<br>Columbia ..... | 73         | 558        | 13%            | Ohio .....          | 139        | 4,418      | 3%             |
| Florida .....                 | 129        | 2,536      | 5%             | Oklahoma .....      | 30         | 870        | 3%             |
| Georgia .....                 | 72         | 1,312      | 5%             | Oregon .....        | 55         | 1,324      | 4%             |
| Hawaii .....                  | 12         | 452        | 3%             | Pennsylvania .....  | 182        | 5,344      | 3%             |
| Idaho .....                   | 1          | 287        | .3%            | Rhode Island .....  | 25         | 432        | 6%             |
| Illinois .....                | 204        | 5,387      | 4%             | South Carolina .... | 19         | 563        | 3%             |
| Indiana .....                 | 57         | 1,912      | 3%             | South Dakota .....  | 8          | 236        | 3%             |
| Iowa .....                    | 50         | 1,359      | 4%             | Tennessee .....     | 82         | 1,340      | 6%             |
| Kansas .....                  | 18         | 889        | 2%             | Texas .....         | 280        | 3,929      | 7%             |
| Kentucky .....                | 53         | 1,183      | 4%             | Utah .....          | 7          | 569        | 1%             |
| Louisiana .....               | 55         | 1,137      | 5%             | Vermont .....       | 3          | 175        | 2%             |
| Maine .....                   | 4          | 332        | 1%             | Virginia .....      | 75         | 1,555      | 5%             |
| Maryland .....                | 124        | 1,349      | 9%             | Washington .....    | 60         | 1,930      | 3%             |
| Massachusetts .....           | 94         | 3,169      | 3%             | West Virginia ..... | 27         | 535        | 5%             |
| Michigan .....                | 129        | 3,968      | 3%             | Wisconsin .....     | 47         | 2,207      | 2%             |
| Minnesota .....               | 121        | 2,299      | 5%             | Wyoming .....       | 7          | 149        | 5%             |
| Mississippi .....             | 82         | 485        | 6%             |                     |            |            |                |
| Missouri .....                | 101        | 1,891      | 5%             |                     |            |            |                |
| Montana .....                 | 21         | 326        | 6%             |                     |            |            |                |

\* Includes Federal Services.

## Principles Underlying Selection to Fellowship in the American College of Dentists

The American College of Dentists may bestow Fellowship on a person who has notably contributed to the advancement of the profession of Dentistry by outstanding accomplishments in one or more areas of: Service to the Profession—Public Service—Education—Research—Clinical Practice—or Literature-Journalism.

A FELLOWSHIP IN THE AMERICAN COLLEGE OF DENTISTS IS A DISTINCTIVE HONOR THAT IS BESTOWED ONLY IF THE ACCOMPLISHMENTS OF THE NOMINEE ARE TRULY OUTSTANDING. In order to maintain the stature of the Fellowship, the College insists that the achievements of each nominee for the honor shall be considered most carefully by those who submit the nomination, by the Committee on Credentials, by the Local Consultants, and by the Board of Regents which awards the honor. A nomination to Fellowship can be submitted by two Fellows in good standing, practicing in the same state of the nominee and who know the nominee well. The Committee on Credentials, consisting of five distinguished members of the College, studies and evaluates the achievements of each nominee.

The Committee on Credentials requests, through the Executive Director, supplemental evidence from local consultants of the professional standing and achievements of each nominee. The Committee must rely largely on the information and representations made to it by Fellows who have had close association with the nominee and know him intimately. For that reason, the greatest responsibility for authentic representation of merited recognition lies with the nominators and with the local consultants.

Both nominators shall feel certain that the nominee's achievements are distinctive contributions to the profession or to society; and they shall realize that age, personality, popularity, and other intangible, subjective factors do not of themselves constitute notable achievement.

## Requirements for Nomination

1. *Nominators' Qualifications:* Both nominators shall be Active Fellows of the American College of Dentists in good standing and hold membership (A.D.A., C.D.A., or equivalent) in the same professional organization as the nominee or be a member of the same professional Federal Corps, Service, or Administration as the nominee. They both shall know the nominee personally and professionally.
2. *Signature Requirements:* The nominators shall complete the nomination in its entirety and accept the obligations of nominating. Both shall sign it and forward it to the Executive Office before February 1st.
3. *Requirement of Secrecy:* The Bylaws of the College require that: *knowledge of the nomination shall be kept inviolate by the nominators.* Evidence that the nominee has been advised that his nomination is being submitted will result in a refusal of the Committee on Credentials to consider it.
4. *Eligibility for Fellowship:*
  - (a) *General:* Not every dentist is eligible for Fellowship. The basic requirement is that there be clear evidence of leadership and contributions beyond the line of duty or that which is normally expected in a practice or in a position.
  - (b) *Educational:* The nominee shall hold a valid D.D.S. or D.M.D. or, if not a dentist, the equivalent in his profession. Further, he shall participate in continuing and refresher courses to assure his keeping abreast of advancements in the profession.
  - (c) *Membership:* The nominee shall hold current membership in the American Dental Association or its equivalent, domestic or foreign, or in an equivalent professional society, if he is not a dentist.
  - (d) *Professional Ethics:* The nominee shall subscribe to the Principles of Ethics of the American Dental Association or the equivalent code of his professional society, if he is not a dentist.
  - (e) *Dental Journalism:* The nominee shall support the principle advocated by the College that dental journalism should be under the control of the profession. He shall agree to publish only in publications approved by the Association of Dental Editors.

# The Public Versus the Profession

## The Interface of Rights and Responsibilities

ROBERT J. NELSEN, D.D.S.\*

MOST of health care consists of the application of varieties of knowledge and skills which can be learned by anyone of appropriate capacity. There occurs no problem upon the assignment of a monetary value to such knowledge and skills and considering them purchasable or salable. With such a connotation they can be used as pledges or benefits in the bargaining systems of labor and industry or of that of voters and politicians. While it may sound strange to consider health service a commodity, in the sense of it being a bargainable fringe benefit of employment along with overalls, hard hat, and coffee break, the image of dentists is approaching that of piecework, craft-oriented entrepreneurs because dental health service is now expressed essentially as fillings, extractions, dentures, etc. Proof of this is to be found in the frequent reference to the professions of health care as "the health industry" and our patients are now being identified in our literature as having the commercial or trade connotation of "the consumer". It is no wonder that the machinations of some participants in health care programs have reverted to the industry-consumer attitude and deportment of "let the buyer beware".

The real loser in this dialectic is obviously the "consumer". His best means of obtaining a professional health service is as the patient protected by the moral values of confidence, trust, obligation, and responsibility. He will not do well as consumer of material fringe benefits, of pre-authorized fillings, dentures, and other rewards however reviewed, regulated, or dispensed. He will receive much better care from a profession than from an industry. Why?

The delivery of professional care has a significantly important difference from the delivery of other services because the professional, by alignment with others of like calling and with adherence to stated principles and ethics, professes to place the benefit and welfare of another (patient, not customer) prior to his own interest. Should he not do this or should he use his position of trust to personal advantage in any instant or dimension, he immediately suffers a loss which places his enterprise (no matter what or how performed)

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\* Executive Director, American College of Dentists.



in the common marketplace and at the level of the craftsman, tinkerer, worker, or hack. When either a professional or a profession addresses itself first to its own interest or advantage, it harms its most essential prerogative, professional freedom, and becomes subject to external control—which it should. Professional health care absolutely requires the exercise of moral value judgments in every service advocated and performed. This is the important worth of the profession to society. It is for this unique reason that society, in an equitable exchange, assigns to each profession the custody of its own research, education, journalism and delivery of service, plus the freedom of self-government, the establishment of its own ethics, and the supervision of its members' conduct. Because the professional concept in America is so valuable an asset of its social order, admittance to professional status has the protection of laws which are administered by representatives of the profession on examining boards. The laws are for the benefit and protection of the public, not for the advantage of the profession. In each of the fifty states, society, in effect, says to a profession, "For your assurance that moral value judgments will be exercised to the benefit of the public prior to the consideration of your own interests, we set forth laws under which you shall govern admittance to your profession, and further, you shall have total custody and control of your affairs". In the province of dental health the profession of dentistry has this privilege of custody and control and the concomitant responsibility of maintaining itself in good order and meeting its obligations which include the accessibility of dental care for all.

That health care is a right in the context that it be free and be provided upon demand is untenable. No proclamation from any source could effect such a program in a free society. It becomes a right when it is exercised by those who admit to concomitant obligations and responsibilities. Within every free society, there must be an equivalent exchange for each benefit afforded. An act wherein only one side benefits is looked upon as robbery however sophisticated its performance. For this reason when any exchange is proposed between patient and doctor or between society and profession, it must be equitable. The benefit to the patient or society is of course the first dimension to be measured. However, it is not the only dimension involved.

Everyone must have the liberty to approach the profession for care. It is the prime responsibility of a profession to maintain a reasonable availability of care for all who desire it, and to advise society regarding the design and management of institutional care

systems for those whose circumstances require such a source. This care may be provided under the aegis of private practice and be totally between patient and doctor, or it may have modifications through insurance, pre-payment or outright subsidy by government or industry and be made available in institutions. Whatever the system of care, there must be no tampering with the fiducial requirement of an equitable exchange. Should this exchange be distorted either by the profession or by other participants the total arrangement fails.

The professional judgments attending health care embrace all dimensions of elective treatment. The diagnosis speaks for itself for it cites the facts of conditions presented as determined by scientific methods of observation, measurement, or test. Treatment, however, involves multiple value judgments which have the final dimension of what is best for this patient. This does not mean the best there is, but that which, in the context of all attending circumstances, is best suited for this particular patient. The treatment plan must consider age, health, personality, social requirements, mores, economic resources, personal attitudes and responsibilities toward health and appearance. It is the adjudication of all these variables that requires direct involvement of a person who by his contract with society professes to place patient benefit before his own or any other interest. Such decisions become proportionately distorted when the professional judgments of treatment requirements must be adjusted to tables, allowances, fixed costs, specifications, directives, and pre-authorizations. Such commercial aberrations when put upon the professional determinations of health care lead to the demise of the "profession-patient" frame of reference and to the increasingly common, but very wrong, "industry-consumer" attitude toward care.

In addition to being a requirement in treatment planning, the dentists' judgments must pervade the entire spectrum of treatment. The changing circumstance of a treatment itself must be monitored constantly and new judgments made during every facet of care even though much of treatment methodology has a nature akin to art and craft. Just when in treatment important judgments may be required cannot be predicted nor can a specific treatment be adjudged "adequate for the purpose intended" until all attending circumstances are known. When these judgments are coupled directly to the actual treatment, the service is professional and does not require indirect peer review. When the act of treatment is assigned to an auxiliary, or when the result of a treatment is subject to supervision or evaluation, the act is deemed less than professional no matter what apparent status the operator may have.

When society grants a license, it does at that time extract a commitment of responsibility which subsequently should not require peer review. If this licensed person is education in his professional responsibility to society, he will need no peer review. If he is but trained simply to master technique and craft he will turn to his own favor, take liberties with his license, and advantage of his position and privilege. Such privilege and position, when abused, are rescinded by society. The profession which takes advantage of its privilege in self-interest becomes subject to restrictive overlays of regulations and laws which deny freedom. Consequently, the profession, unable to manage its own affairs, loses its position of trust. This becomes evident as professional care becomes more and more subject to allowances, to authorizations, to quality controls, and to peer reviews.

Unless the profession is willing to take issue internally with this impending deterioration of the professional concept and re-establish a more strict adherence to the tenets of true professionalism, it will not retain its position and its privilege of self-government. By succumbing, because of tunnel vision, to the insidious influence of packaged programs and external non-professional dictums, dentistry may not for long continue as a true profession—let alone a great profession.

What can be done? First, immediate and significant attention should be given to programs and discussions in schools and at dental meetings about the meaning and significance of professionalism. The American College of Dentists could well initiate such efforts. Second, make a forthright proclamation of the moral, societal, educational, scientific, technical and structural dimensions of dentistry, not as an entity of itself but as its function in the complex metabolism of our pluralistic society.

This proclamation must be set forth clearly and in simple language, free of restraint and devoid of embellishment, in essence, a scholarly position paper. With this basic frame of reference, an analysis of the performance of dentistry should be published. Such analysis should not be itemized. Itemization leads to a recitation of details in which any effort to assign values to performance will flounder and the dynamics of the profession-society symbiosis will be lost in trivia. This position paper would re-set in a proper order, the several important exchanges between Society and the Profession, giving consideration to the important influences on health care generated by the pluralism of American Society which includes its very broad socio-economic co-ordinates and the unusual freedoms of its peoples in making selections and accepting responsibilities.

Additionally, the cost/benefit/acceptance of current federal, state and local programs could be audited so that these findings can be extrapolated into proposed programs. This will avoid unrealistic objectives and assure that subsequent commitments once made can be realized. Thus, the scope and magnitude of any program may be set against clearly stated facts of related cost/benefit and the potential for its being used by those for whom it was designed. The profession, in its responsibility to the public is as obliged to point out to society important facts and factors of public dental care as is the individual dentist to inform each patient of the details of personal dental care. In presenting or endorsing any public dental care program, the profession must assure that these same moral value judgments apply in programs, guidelines, recommendations, and policies; and that all are clear of profession, labor, industry or government self-interest. Programs of dental care devised entirely outside the profession have the same hazard to society's well being as have self-diagnosis and self-treatment by an individual.

#### CONCLUSIONS

(1) A pluralistic society benefits considerably when it provides for and protects within its organization systems of professions which it can trust. This trust is predicated on the exercise of moral value judgments by the professional group for benefit of the individual and society. This arrangement is secured by the equitable exchange of a trusted, professional responsibility *to* society for professional privilege and honor *from* society.

(2) The most essential requisite is that benefit to patient and society be the first consideration in every instance, but not the only consideration.

(3) A need exists for a scholarly restatement of this basic reciprocity between society and profession and for professionalism to be made more viable in all areas of dentistry.

(4) An assessment should be made of the performance of dentistry in fulfilling its obligations of care. This should reflect the effectiveness of its research, its education, its journalism and its delivery of service. This should be made in the form of a position paper to society and should include a statement of the profession's essential requirements from society.

(6) The report should identify areas of strengths and weaknesses in the reciprocity of society and dentistry. It would illumine the unique advantages of the professional concept to society and in the author's opinion it would point out that moral values must attend the interface of rights and responsibilities in all social-professional relations.

# Supply and Demand\*

## Dentistry's Challenge in a Capitalistic System

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THESE are revolutionary times. Both figuratively and literally, we are seeing revolutionary changes in the structure, the fabric and the function of our basic institutions. In law, in religion, in government, in our cultural attitudes, change is becoming an integral part of our days.

Nowhere is this more true than in health. It is not simply that there is increased demand, increased criticism of delivery systems, increased concern over health care for the poor. It is the simple fact of life that health care is now considered a fundamental right, and the public is demanding that government guarantee that right.

We in the dental profession, particularly in the last two decades, have earned the reputation of being progressive, willing to meet the challenge of providing the best dental care in the world. But now we are at the proverbial crossroads. We must take a serious look at some of the long-held concepts and determine if they match up to today's changing challenge.

Ironically, those who are resisting needed change—in licensure, in delivery systems, in expanded auxiliaries—do so in the name of capitalism and free enterprise. I say they are doing a distinct disservice to the basic tenets of capitalism.

Let's look at some basic economic principles of our capitalist society and see how they relate to dental practice and the public.

In my college days, I read a book on economics called "The Theory of Price," by George J. Stigler of Columbia University. I would like to take some of his philosophy and apply it to dentistry.

For example, he points out that "the higher the price of a commodity, the less of it a consumer will buy." On the other hand,

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"price reductions will attract buyers from lower income classes, and each lower income class is more populous than that immediately above it."

Finally, he states, "when possession of a commodity is highly correlated with income, demand will be elastic."

According to Stigler, then, "this would suggest that medical care, higher education, automobiles and similar commodities and services have elastic demands."

Thus, dentistry—or, to be more exact, dental care—is a service more likely to be sought by those with greater income. It would be foolish to deny that countless studies have borne this theory out. It is those from the lower income consumer groups who are the most in need of care who cannot afford it and do not seek it except as a last resort.

However—and here I am paraphrasing Stigler—government subsidy for the needy and a method of employer-employee contribution for the purchase of health care will have the same effect in the market place as a lowering of price. This will encourage an invasion into the market place by those who have been postponing dental services because of a lack of finances.

Certainly, the proliferation of prepayment and the emergence of Medicare and Medicaid have had a direct relationship to the vastly increased demand of the public for dental care. Dental services are now more available to lower income groups and they are now seeking that care.

Stigler, of course, is speaking of the basic foundation of our capitalistic society—the law of supply and demand. Historically and ideally, the capitalist meets demand by several voluntary actions. First, he competes in the open market. He competes with investment in new capital, by increasing his supply of goods and services, by developing new methods of production.

To make certain his goods or services are competitive, he conducts routine cost control and quality analysis. And, he makes certain the consumer is aware of his product. I am sure, without my spelling it out laboriously, you can see that this portrait of the capitalist fits the dental practitioner very comfortably.

But this is only an ideal, and certainly not all practitioners can approach that ideal. Strangely, the profession often seems to be moving from the concepts of a freely competitive, democratic society to a fettered society marked more by totalitarian thinking than by capitalistic thought.

Let me expand on this point, for I have a distinct message for the individuals I have too often seen who seek to block the path which dentistry must take in the years ahead to become a truly progressive, democratic—and capitalistic—profession.

Dentistry, as it is practiced today, has a rigid system of production. The vast majority of practitioners practice alone, with few auxiliaries. Even with the growing interest in prepaid group practice, health maintenance organizations and other types of organized delivery systems, the average dental practice is a solo practice.

Additionally, free competition is discouraged by dentistry's individual state dental practice laws. These laws effectively establish barriers to free flow of dentists and thereby free flow of goods and services and healthy competition.

Finally, many practitioners oppose methods of cost control and quality control to better serve the consumer.

We must first acknowledge that dentistry is a commodity in the market place. And it is not a commodity which is sought relentlessly by the entire population. Dentistry must, as a capitalistic endeavor, sell itself on the market block.

To face the problem squarely: Dentistry cannot today nor in the future meet the full demands of the public for its services because it not only lacks manpower, but it also has been slow to *put into practice* new methods which would satisfy consumer demands.

For far too long, the profession has been talking about doing something about reciprocal licensure, about expanded duties for specially trained auxiliaries, about group practice, about closed panels. All of these topics of discussion have remained essentially that: Topics of discussion and not subjects for action.

Can this dilemma be solved? I believe it can and I believe the road to solution is already partially paved—by the report and recommendations of the ADA Task Force on National Health Programs.

The recommendations of the Task Force are specific guides to immediate action. If followed, they will take dentistry back from a quagmire of stagnant thinking and into a field of clear reasoning.

If the recommendations are approved this next week by the Association's House of Delegates, dentistry's course will be dramatically changed. And the change should be welcomed by the entire profession.

Let me quote the first paragraph of the Summary of the Task Force Report: "Based on the studies of the five committees and the counsel of members of the Task Force, we recommend a *comprehensive dental health program for all people of the United States regardless of their economic status, geographic location, race, creed, or color*. The dental profession, using all means at its disposal, has a professional responsibility to endeavor to make comprehensive, quality dental care available to everyone. We recognize that such a goal is not attainable in the immediate future because of limited resources, but we are convinced that such a goal is attainable in the United States if resources are provided and administered according to the schedule we propose."

The Task Force places first priority on dental care for children, a recommendation which fully complies with long-standing Association policy. The implementation of this program is a reasonable approach, requiring ten years until all children through the age of 17 are covered. This is surely a sound recommendation.

After the ten year period, all persons over age 65 would be included in the program, according to the Task Force. And the majority of the public would continue to receive care as they do currently.

This is a simple plan of action. It is reasonable, it is temperate, it is progressive. And, the steps necessary to accomplish this program are equally reasonable, temperate and progressive. The changes required by the profession to activate this plan will bring the profession into the mainstream of the 20th century with a dramatic leap.

What are some of the recommendations? First, let me give a general view, before commenting on specific recommendations:

In the words of the Task Force Report: "We urge reforms in dental practice acts and licensure procedures. We recommend improvements in quality and fee review procedures and the institution of disciplinary actions where necessary. Consumers should be represented at all levels of program planning, decision making, and evaluation. We recognize several types of payment systems as being applicable under certain circumstances and we favor patient participation in cost, if necessary, through co-payment rather than deductibles. For the medically and categorically indigent, we recommend that their dental treatment costs be paid from federal general revenues. For employed persons and their dependents, we recommend employer-employee payroll contributions into a fund to be administered by nongovernmental agencies. . . ."

Changes in licensure, consumer representation, manner of practice, methods of funding—all these are areas of disagreement and argument within the profession and all these must be effected unless dentistry wishes to lose its place of high esteem in the health professions.

Let's examine some of these major recommendations of the Task Force as they apply to dentistry's role in a capitalistic society.

First, there is licensure. Our present system more closely mirrors a rigid, totalitarian system than a capitalistic system. As presently constructed, our state dental practice laws create barriers to free flow of services. With the exception of the Northeast Regional Examination, most states require the dentist to take an examination wherever he seeks to practice. This violates a basic principle of democratic capitalism.

If you follow the principles of supply and demand, you recognize that, inevitably, the practitioner will seek to supply his services where there is the greatest demand. And this is far too often prevented by rigid licensing procedures. What does the Task Force say? It commends the concept of regional licensing examinations and states that this idea appears "to be professionally efficient and practical."

Additionally, the report calls for a uniform standard of licensure with national reciprocity between states. The Board of Trustees has indicated that this proposal is "too sweeping" and "unnecessary" and I must concur in their judgment. But a far broader system of licensing, such as that already accomplished through regional examination, is certainly immediately necessary.

The recommendations of the report are made more urgent by the recently released report of the Department of Health, Education and Welfare, calling for some form of national licensing examination for members of the health professions. This report suggests that auxiliaries also be included in a national licensing procedure.

There is no doubt in my mind that national licensure of health professionals will receive increasing attention from federal sources and other public persons and agencies. It is already included in the Kennedy proposal for national health care coverage, although it is included in a different way from the HEW approach.

HEW has signaled its intention to proceed with full speed toward eventual accomplishment of some type of national standardization of licensure. It will begin an accreditation study to include the possibility of establishing a Congressionally chartered public cor-

poration to promote national coordination of accreditation. In my judgment, this is equivalent to creating an agency which would take the first step toward national licensure.

It is clear that dentistry must move with progressive leadership to ameliorate the problems already existent in our system of licensure. We must no longer argue among ourselves about the virtues or evils of a vastly more open system of licensing, we must now turn our attention to implementing some workable method to provide freer movement of dentists. And the regional system is an excellent place to start.

In fact, the ADA Board of Trustees has recommended the House of Delegates approve a recommendation of the Task Force stating that "Regional examinations should be encouraged and tested in all areas of the United States and its territories."

Another tenet of the free society is the inclusion of the consumer in the competitive process. Indeed, today is the day of the consumer and we are daily reminded of this by the consumer advocate who holds the protection and involvement of the consumer as being of overbearing importance in our free society.

As a basic commodity in the public market place, dentistry has an obligation to work for the basic benefit of the public and, indeed, this is the foundation of our stated purpose "to encourage the improvement of the health of the public."

The Task Force has much to say about consumers, including this: "If the dental profession is to make wise decisions on the development of national dental health policies, it is important that dentists know how consumers look at dental care, at the dental profession, and what consumers' concerns are about the organization, delivery, and financing of dental care. We believe that consumers must play a key role at all levels of formulating dental health policy and of monitoring the administration and results of public and private prepayment programs."

Specific recommendations of the Task Force urge that consumer representation be included on all levels of a national dental health program, on appropriate agencies of the American Dental Association, and on review committees. Clearly, the Task Force is echoing current public concern that the consumer have a voice about the products and services he purchases.

The Task Force also discusses group practice and recommends it as one way the profession can offer comprehensive care to the public. It suggests that "a national dental health program should encourage



the development of group practices through tax benefits, guaranteed loans for capital investment, and grants to dental schools to teach students the principles of organizing, developing, and administering group practices of all types."

The Task Force also recommends professional acceptance of closed panels—prepaid group practices—as another method of delivering dental services.

There is a resolution submitted by the ADA Councils on Dental Health and Dental Care Programs which would rescind all previous Association policy on closed panels and, instead, permit the establishment of such practices as components of the delivery system.

Both the Task Force and Councils' report emphasize that prepaid group practices should allow the patient the opportunity to choose either a closed panel or open panel method of practice with the additional alternative of periodic change if the patient wishes.

Certainly, the profession can no longer ignore the fact that closed panels can be as efficient as other types of dental practice in providing service. Professional acceptance of this type of practice will offer the consumer absolute freedom of choice between a closed panel, group practice or solo practice. It is our responsibility as a competitive, capitalistic profession to offer the widest alternatives possible to the public seeking our services.

Expanded-function auxiliaries also come under the careful scrutiny of the Task Force and it has urged "there must be delegation of significant duties of expanded function auxiliaries." Among the several recommendations of the Task Force dealing with auxiliaries are the following:

- That the profession accelerate the training and use of expanded-function auxiliaries;

- That federal support be given to training programs for such auxiliaries;

- That curricula of auxiliary training programs be broadened to permit greater experimentation in expanded functions;

- That greater emphasis in dental school be placed in training students to use expanded-function auxiliaries;

- That dentists and auxiliaries already in practice take formal programs in expanded functions.

There are several other recommendations of the Task Force which call for action and, to save time, I will list them in an abbreviated fashion:

- The profession must establish effective peer and quality review procedures and committees, dealing with program design and ad-

ministration, quality of services rendered, fee questions and utilization of services;

—Liberal federal support should be given to students and practitioners to encourage them to practice in under served areas;

—Preventive dental practices should be given full encouragement and top priority in any national dental health program;

—Dental societies should establish service corporations, emergency dental services, review and referral committees;

—Federal support should be given to the recruitment of talented young men and women, especially those from minority groups, into dentistry;

—Dental schools and dental auxiliary training programs should receive substantially increased federal support for development, renovation and expansion of existing facilities as well as for the creation of new facilities and programs;

—Community health centers, which include dental services, should be encouraged;

—Dentists should be required to show, periodically, evidence of continuing education;

—Dental benefits for the poor should be financed through general federal revenues and dental benefits for the employed should be funded through payroll deduction through employer-employee participation;

—Non-governmental agencies should be the carriers of choice for the dental component of a national dental health care program.

As I stated earlier, dentistry stands at a crossroads and we must re-examine our policies in light of the changing—and challenging—world we live in. I am convinced the recommendations of the ADA Task Force on National Health Programs clearly illumines the path which dentistry must follow in the years ahead to remain progressive and responsive to itself and its public.

Unless we remain progressive, and remove the rigidity which envelops our licensing laws, our delivery system and our methods of treatment, we will lose our recognition as a truly essential health service. It is only through progressive action that the profession will, in the final analysis, remain free in our democratic society.

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# A Proposed Functional Realignment System for Delivery of Oral Health Services

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AS THE DISCOURSE proceeds and grows regarding expanded functions for trained dental auxiliaries as a partial solution of our dental manpower shortage, increasing difficulty may be found in accepting without question the rationale under which the dental profession in this country justifies its opposition to permitting dental auxiliaries to perform those patient services which involve intra-oral cutting of hard or soft tissues. Such services are sometimes described as "irreversible", or as "any duty that might give an unfavorable biological response". They are considered to be "procedures which require the professional judgment of a dentist" in order "to protect the public". The functions under discussion as unsuitable for trained auxiliaries appear to be associated with restorative procedures mainly, with some attention to certain preventive services, but oral surgery, such as extraction of teeth, is never mentioned as though unthinkable.

It is my impression that some dentists today seem to be concerned only with the perpetuation of a system which will balance nicely the present demand for care with the dentist manpower presently available to meet the demand. Yet we all know that the effective demand is almost the visible tip of the iceberg of total need. When we continue to ignore the needs of those who, for various reasons, are not part of the effective demand, we are defaulting on our professional health responsibilities to the total population. It would appear, then, that any real effort to develop a more adequate system for delivery of oral health services to meet the needs of the total population should be designed for that purpose, rather than to persist blindly

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in the perpetuation of a pattern of dental manpower usage that is demonstrating its inability to keep pace even with the demand.

Dental care is increasingly provided by teams of dental personnel working in organized frameworks. Accordingly, in its efforts to overcome one of the more obvious defects and relieve the strain on the present conventional dental care delivery system the dental profession at this time seems to be favoring use of auxiliaries to perform a variety of procedures calculated to increase the productivity of the dentist, such as applying the rubber dam; applying the matrix; and inserting, carving and polishing plastic fillings in cavities prepared by the dentist. Research has demonstrated that auxiliaries can be trained to perform these functions to an acceptable standard of quality,<sup>1,2,3,4,5,6</sup> and efforts are being made to secure changes in some state dental practice acts that will permit trained auxiliaries to perform selected services for patients under the direct supervision of the dentist. It is anticipated that widespread use of such trained auxiliaries will enable the dental profession to provide more care for more people, thereby tending to reduce the problem of dental need. Furthermore, as a not inconsiderable factor in gaining acceptance by the dental profession, expansion of auxiliary functions under this conservative approach can be applied with some degree of success because it could be accomplished with relatively minor adjustment of the present system of dental practice for the delivery of oral health services.

Opposition within the dental profession to use of auxiliaries trained in these limited ways tends to be diminishing, because the delegation of these supportive types of procedures offers no threat to the professional security of the dentist. The dentist retains as his function the preparation of the tooth to receive a filling, presumably a skill which is beyond the training capacity of an auxiliary. More importantly, perhaps, cavity preparation is reserved by the dentist because it is a major feature of one of the two most prominent professional functions (the other is tooth extraction) which commonly identify the dentist to the public as the provider of a health service, and that constitute the main reasons why his services are sought by the public. By and large, also, these two functions provide the major sources of his professional income, and are the basis of his economic security.

On the other hand, if auxiliaries were to be trained to both prepare cavities and fill them, one of the two principal oral health services would either have to be shared with the auxiliary or relinquished to the auxiliary altogether. In either instance, the dentist

would (and should) be deeply concerned, and would ask himself, "Now what am I supposed to do?" Lacking highly visible alternative professional functions of popularly recognized importance in oral health care, and that require a higher level of training than that required to diagnose dental caries and prepare and fill cavities, today's dentist would (and does) resist any usurpation of his functions by auxiliary dental personnel which would infringe on his control of the area of restorative dentistry. He is willing, however, to permit trained auxiliaries to fill the cavity he prepares, because thereby he retains control of the total restorative procedure by reserving for himself the essential step of preparing the cavity, and thus convincing the patient that his personal participation at some point is essential to the treatment.

There appear to be two major reasons, then, why the dental profession is reluctant to tolerate any marked change in the delivery system from the prevailing pattern of dental practice. Both reasons are derived from well-founded fears: in one instance by fear of professional competition from another dental professional trained in either or both of the two oral health functions which are most needed by the public; in the other instance by fear for loss of economic security.

Under the present delivery system for providing oral health services to the public, based as it is on restorations and extractions, the dental profession would be out of its collective mind if it consented to any other approach to utilization of auxiliaries trained in expanded functions than the restricted one currently favored. If, on the other hand, the dental profession could see an acceptable modification of the present delivery system that would retain in the hands of the dentist complete control of the practice of dentistry, enhance his professional status, and provide more dental care of high quality for more people through utilization of trained auxiliaries, it is possible that the dental profession would consider change in the present delivery system. The change I am about to propose could provide the acceptable alternative described.

Much of the controversy expected to attend any effort to change the existing system of dental practice might be reduced if the proposed change could meet a demanding set of criteria which professed to solve a troublesome problem to the advantage of everyone concerned. Accordingly, the following criteria are offered as minimum requirements in support of acceptable change in the present system of dental practice.



## CRITERIA FOR ACCEPTABLE CHANGE

Any proposed change should:

1. Anticipate the nature and requirements of dental training and practice of the future.
2. Act positively to meet the problem of the need for dental care in the total population by increasing the effective dental manpower to provide care.
3. Produce the required increase in manpower in the shortest possible time and at the least cost for training, when compared to other approaches.
4. Not lower the existing standards of care, but rather benefit the patient by providing an improved level of health service.
5. Encourage continuing improvement in the scientific and professional aspects of oral health service without impairing ongoing advance in the technical achievements of clinical dentistry.
6. Be adaptable to and meet the operational requirements of any system for providing oral health care services.
7. Be susceptible to application over time at a rate adjustable to any factors which would expedite or delay application.
8. Act to reduce the cost per unit of routine care provided.
9. Be accomplished without endangering either the professional or economic security of the dentist.
10. Be implemented while permitting the co-existence and undisturbed continuation of the present system of dental practice for those dentists who prefer it.
11. Provide the basis for a training ladder which would permit and encourage professional development and advancement.

There are three elements of change involved in the proposed system: The first is concerned with the scope of functions of the graduate dentist, the second with the predoctoral training of the dentist, and the third with the scope of functions of one of the present three kinds of auxiliaries. All three elements of change are interdependent and essential to the objectives sought. The proposal is derived from the strong belief that efforts to provide more dental care for more people under the present system of practice, under which our short supply of dentists insists on personally providing too many routine patient services, are due to fall far short of meeting the need in the future. Obviously, more manpower is required, and, in the light of the limitations of money and time on our ability to train enough dentists it is incumbent on the profession to examine, more carefully than has been the case to date, the potential which lies in expanding the manpower base by training auxiliaries, who can be trained in large numbers in less time and at less cost per trainee than would be required to train the numbers of dentists



needed. At least one auxiliary, however, would need to be trained to provide the kind of services which would make a significant contribution to meeting the need for care, and be able to perform these functions independently of the personal participation of the dentist, even though working under the direction and supervision of the dentist. Thus far every viable proposal for use of expanded-functions auxiliaries in significant ways (such as in restorative dentistry) has entailed the personal participation of the dentist in performance of the function.

The proposed approach would retain the dentist as the key professional person who would be responsible ultimately for the type and quality of patient care provided. His professional functions, however, would be altered substantially, mainly as the result of his delegation to trained auxiliaries of responsibility for providing all *routine* patient services, of which restorative care (fillings), oral surgery (extractions) and certain kinds of preventive dentistry (dental prophylaxis, topical fluoride applications, occlusal sealants, patient education) would be the most important delegated routine services. The specific nature of these routine services will be considered later in this presentation under the functions of trained auxiliaries. The important point to be made here is that no serious impact will be made on improving the manpower base until the dentist relinquishes to adequately trained auxiliaries responsibility for the performance of *all routine functions*, including fillings and extractions.

#### CHANGES IN SCOPE OF FUNCTIONS OF THE GRADUATE DENTIST

To answer the question raised earlier, "Now what am *I* to do?" it is proposed that the following functions constitute those of the general dentist of the future:

1. Examine patients.
2. Diagnose oral pathology.
3. Plan treatment.
4. Delegate routine treatment to trained auxiliaries.
5. Supervise auxiliary personnel.
6. Perform oral health services which require a higher level of skill than that of trained auxiliaries, but are not of the level of skill required for specialist services.
7. Refer patients for specialized treatment by highly trained dental specialists.
8. Provide appropriate kinds of patient education.

At first glance this list of functions, with the exception of number 6, appears to assign to the general dentist a stringently limited

and almost perfunctory scope of function. It removes from his personal performance the two mostly routine functions, fillings and extractions, which presently occupy most of his professional time, and leaves to him little more than the functions of examination, diagnosis, and treatment planning, which are frequently viewed as the unavoidable preliminaries to the real business of being a dentist. This interpretation is entirely correct if the proposed alignment of dentist functions is viewed in the light of current predoctoral training and graduate practice; the dentist would be placed in the pedestrian position of performing a kind of triage on patient needs, and then turning patients over to others for the provision of most of the services required. If the only change was simply the delegation of restorative and extraction functions to trained auxiliaries, accomplished by deleting them from the functions of the dentist and adding them to those of the auxiliary, it would make possible an increase in services, but without necessarily achieving concurrent expansion of the dentist's services to patients in areas that require a higher level of skill.

To overcome the obvious unacceptability to the dental profession of such a simple realignment of functions, and to retain, if not improve, the professional status of the dentist, it would become essential to so modify the system of practice that the role of the dentist would be not only unimpaired, but placed in a position of improved perspective in relation to the roles of other dental personnel. To accomplish this objective would require acceptance by the dental profession of a new concept of the practice of dentistry which would require fundamental changes in predoctoral training.

Before considering possible changes in the predoctoral training of dentists, let us first examine in turn the proposed list of dentist functions of the future to see what responsibilities would be entailed in their conduct.

1. *Examine patients.* The whole purpose of the oral examination is to gather information regarding the oral health status of the individual which may then be used to diagnose pathology. If the interests of the patient are to be well served, it is incumbent on the examiner to secure all information which will enable him to reach conclusions relevant to proper and adequate diagnosis. Since the diagnosis will determine the treatment plan, and whether the required treatment is to be performed by the dentist, by the dental specialist, or by a trained auxiliary, or shared between them, it is important that the examination be comprehensive enough to afford

a sound basis for this decision. Obviously, under these circumstances, the examination cannot be perfunctory, but must draw upon and apply a considerable depth of knowledge of oral pathology and of the procedures and techniques employed in the examination process.

2. *Diagnose oral pathology.* Although depth of knowledge regarding oral pathology is essential to diagnosis, at this level the general dentist need not possess the extensive knowledge of oral pathology in the depth possessed by specialists in all the specialties of clinical dentistry.

3. *Plan treatment.* The scope of treatment planning by the general dentist should encompass the patient care services for which he would have primary responsibility, and would include those non-routine services which he would render himself and those routine services that he would delegate to the trained auxiliary. If his treatment plan would affect, or be affected by, treatment to be provided by one or more specialists, then referral of the patient for further examination and diagnosis by the specialist would be indicated, with joint consultation when required, so that the total needs of the patient would be considered. Together, diagnosis and treatment planning should lead to these conclusions:

- a. Decision as to the non-routine services that the general dentist will provide personally for the patient.
- b. Decision as to the routine services that the general dentist will delegate to a trained auxiliary.
- c. Decision as to the services that will require referral to one or more dental specialists.

This decision-making process is in effect today except that the general dentist retains for himself almost invariably the provision of routine restorative services (or at least the cavity preparation under current proposals for expanded auxiliary functions), as well as the routine types of extraction of deciduous and permanent teeth.

4. *Delegate routine treatment to trained auxiliaries.* It is not enough to delegate to trained auxiliaries an assortment of incidental services, such as prophylaxis, placement of rubber dam and matrix, placement of fillings, and patient education. Admittedly, by so doing the dentist is freed to some extent to concentrate his time on other services which require a higher level of skill and knowledge than is possessed by the auxiliary, and thereby to some degree more patients receive more services. However, only by relinquishing to

trained auxiliaries *all the routine services*, including all steps in the process of restoring teeth with plastic materials and the routine extraction of teeth, will the practice of dentistry be structured along the most efficient and productive lines.

5. *Supervise auxiliary personnel.* The most demanding management function in any operation involving two or more people is that of directing and supervising the work of others. Successful performance of this function, with consequent smoothness of working relationships and high productivity of the supervised worker, is the result of knowing and understanding the management principles involved, and competency in their application. Conversely, poor supervision of subordinate personnel is reflected in misunderstanding, resentment, low productivity, lack of job satisfaction, high turnover of personnel, and difficulty in recruitment. When supervision is deficient, more is at stake than any possible decrease in income or number of units of service produced; the health of the patient is the most serious possible casualty. It is important then, that the dentist both know and apply conscientiously the management principles concerned in personnel supervision, as well as supervise the clinical competency of subordinate personnel for whose performance he is responsible.

6. *Perform oral health services which require a higher level of skill than that of trained auxiliaries, but are not of level of skill required for specialist services.* If, under the proposed delivery system, the general practitioner should delegate all routine services to trained auxiliaries, there remains an area of more demanding services for which his training is particularly suitable. Examples of these services include: gold inlays and gold foil restorations; crowns; fixed bridges; partial and full dentures; interceptive orthodontics; treatment of oral infection; treatment of hyperemic pulps and fractured incisors; periodontal treatment; space maintainers; treatment of soft tissue lesions; endodontic treatment, and apicoectomy.

7. *Refer patients for specialized treatment by highly trained dental specialists.* Ordinarily, the dentist in general practice refers to dental specialists of various kinds the patients whose requirements either mandate the care of the highly trained specialist, or are of kinds which the general practitioner does not care to perform or in which he is not particularly competent. An example of the latter is referral for routine extractions that are then performed by the highly trained specialist and at specialist fees, thus increasing the cost of a routine service unnecessarily.

The average general practitioner seldom possesses the level of competency in any special area of dentistry which is equivalent to that of a dental specialist in that field. If he does have such skill, there is no reason why he should not apply it. In other instances, however, patients with unusual needs would be referred to specialists.

8. *Provide appropriate kinds of patient education.* The attainment of optimal oral health becomes possible only when two conditions are met. First, the individual must follow consistently and on a sustained lifelong basis certain personal health practices which only he can carry out. Some examples of these practices are regular visits to the dentist beginning early in life for examination, diagnosis, and needed care; toothbrushing and use of floss for plaque removal; use of a fluoride-containing dentifrice; restricted consumption of cariogenic foods. Secondly, the individual must receive certain oral health services which can be performed for him only by a professionally trained person. Examples of these services are: oral examination and diagnosis; prophylaxis; topical fluoride applications; occlusal sealants; restorations; oral surgery; orthodontic, endodontic, and periodontic treatment. The dentist has the obligation to inform his patients of the requirements for optimal oral health, emphasizing the patients' responsibility for following good personal oral health practices, including regular visits to the dentist. The patient will need professional instruction and ongoing supervision in toothbrushing and use of dental floss, and in dietary control of dental caries.

The dentist who is concerned that his patients will have every opportunity to learn about their personal responsibilities for their oral health will make certain that such information is imparted to patients, even though this function may be shared with trained auxiliaries.

#### CHANGES IN PREDOCTORAL TRAINING

These proposed changes in the functions of the general dentist would not take place automatically and successfully with the simple realignment of service functions. The professional demands of the new role would require corresponding changes in the predoctoral training of the dentist to prepare him for new kinds of responsibilities. Accordingly, future dental student training would emphasize more strongly the areas of patient examination and diagnosis of oral pathology, and of treatment planning. The student



would be trained in some depth in management skills, including practice management and the management principles applicable to increased responsibilities in the supervision of auxiliary personnel. Instruction in this area would be provided by faculty members drawn from the field of business management. Students would receive training in the usual clinical areas, but emphasis would be much greater relatively on learning the skills required to provide non-routine clinical care services. Another area of more intensive instruction and experience than is generally the case today would be in utilization of trained chairside assistants. Throughout his training the student would learn how health status is affected by both lay and professional attitudes and behavior, and he would learn and gain experience in techniques of individual and group lay education for optimal oral health.

#### CHANGES IN SCOPE OF FUNCTION OF THE DENTAL HYGIENIST

Three kinds of trained auxiliaries, all of which exist by name today, are considered to be appropriate for the proposed system. The three auxiliaries are the dental hygienist, the chairside dental assistant, and the dental assistant. Only the training and functions of the dental hygienist would be modified to any substantial degree. Because of the expanded functions of the dental hygienist, however, it would be helpful for her to have one or more dental assistants to perform the non-professional functions entailed in providing patient care services, and to assist in providing clinical care.

The training of the dental hygienist would be designed to enable her to perform the following functions for patients of all ages under the immediate or general supervision of a dentist:

1. Perform oral examinations (primarily an observation or screening function).
2. Diagnose dental caries.
3. Relieve pain.
4. Prepare cavities, place, carve and finish plastic restorations.
5. Extract deciduous and permanent teeth under local anesthesia.
6. Provide preventive dentistry, including patient education in good personal oral health practices; prophylaxis; topical fluoride treatment; application of occlusal sealants.
7. Refer to a dentist all patients with need for non-routine dental services. (If working independently under the general supervision of a dentist or supervising dental hygienist.)

The proposed changes in the alignment of professional patient care functions, as they are shared by the dentist and auxiliary personnel, would carry the requirement that under no ordinary circumstances will the auxiliary provide patient care except as delegated



and directly supervised by the dentist. The one exception to this requirement would apply to dental hygienists who were trained to perform routine clinical services and employed in publicly-supported dental programs under working circumstances which would make direct supervision by a dentist impractical and unrealistic.

For instance, to exemplify the exception, let us assume that a dental program is established in a school system to provide routine care for children. One or more trained, experienced dental hygienists would be employed to provide routine services in one or more clinical facilities each located in a single school. If the number of hygienists was small, and they were located either full time or part time in separate schools, it would be uneconomical and impractical to have a full time dentist at each school to supervise them. If the number of hygienists was large, and they were located on an itinerant schedule which operated in schools over a large, rural, geographic area, it would again be costly and impractical to have each hygienist working under direct supervision of a dentist. Since a degree of supervision would be required for clinical and administrative reasons, a supervising dental hygienist could serve this purpose. In any case, the overall administrative supervisory function should be carried out by a full time or part time dentist. In support of this view we need only to look at the precedent established for precisely the same type of program by the fifty years of successful operation of the New Zealand dental nurse program.<sup>7 8 9</sup>

This exception does not establish inconsistent working requirements for the same dental hygienist, depending on who employs her. It does, however, reflect realistically the conditions applying to where she works, the character of the patients served, and the type of services provided. There is reason to believe that this form of independent practice by the hygienist would be most applicable in low-income and/or rural areas where there are limitations on money and dental manpower, and where the alternative could be no care at all.

The proposed change in alignment of functions between the dentist and dental hygienist is considered to meet the ten criteria listed as requirements essential to acceptance of change by the dental profession, and would accomplish these constructive purposes:

- a. An adequate increase in dental manpower could be attained in a shorter time and at less cost than for training dentists.
- b. Remuneration of auxiliaries who were trained as proposed would be lower than the remuneration of dentists who would perform comparable routine services for patients.

- c. The total productivity of dentistry would be markedly increased, and more people would receive more dental services.
- d. Publicly supported programs staffed by dental hygienists who would provide routine dental care, including preventive dentistry, plastic filling restorations, and extractions, would become feasible in rural and urban areas lacking in economic and cultural attraction to resident dentists.
- e. Dentists who preferred the present system of practice would not be compelled to accept the new system. Both systems could co-exist. Post-graduate training could be made available for graduate dentists to enable them to adapt their practices to the new system.
- f. There would be no threat to the economic security of the dentists because the dental hygienist would be permitted to provide routine patient care only when delegated to do so by the dentist.
- g. There would be no threat to the professional security of the dentist because his professional services would no longer be mainly routine in nature, but would be in areas of care which required a higher level of training and skill.
- h. The standards of dental care would be improved. Few general dentists are equally and highly competent in performing the total range of patient care services which fall below the level of skill required of the specialist. Under the proposed realignment of functions, the general dentist would restrict his services to those difficult cases that required a relatively high level of skill, with consequent ongoing opportunity to improve his judgment and competency through more intensive training and experience in more demanding areas of patient care.
- i. Dentistry would have an opportunity to provide a higher level of total patient care, because the general dentist, the trained dental auxiliary, and the dental specialist would each concentrate his professionally coordinated efforts on an appropriate range of patient services at a level of knowledge and skill for which he had been trained.
- j. The proposed distribution of functions is amenable to application in any form of practice involving general dentistry, whether solo or group, or a group practice or clinic with or without specialists on the staff.
- k. The training, qualifications and scope of practice of dental specialists would remain unchanged, with the exception of the oral surgeon who extracted teeth. In this instance, the only referrals for extraction by the general dentist would be of cases for which the services of the specialist were mandatory, or in which removal of routine types of teeth would be incidental to more complex surgery. In consequence, the overall costs of tooth extractions performed by the oral surgeon, whether paid for by the individual or through a third party arrangement, would be reduced by an amount reflecting the cost of routine extractions performed by auxiliaries.
- l. It would create no new category of dental auxiliary personnel until existing auxiliaries are used to the fullest capacity of their potential for training.
- m. A ladder for professional development and advancement in the field of dentistry would become feasible, with progressively more demanding training requirements clearly related to permit the trained dental as-

sistant to move up to trained chairside assistant, to trained dental hygienist, to general dentist, to dental specialist.

The proposed realignment of functions retains the general dental practitioner at the center of the dental services delivery system as the key professional with primary and overall responsibility for the oral health of patients over their lifetimes. While the proposed system divides performance of the needed services among several dental professionals, the total care of a patient is coordinated at a central position rather than fragmented among scattered components of independent sub-specialists and specialists.

It should be apparent at this point that the delegation of all routine functions to auxiliaries need not diminish the authoritative professional role of the dentist. The provision of more services to more people would become possible, and the dentist would become truly free to devote all his time to providing services that required a high level of training and skill. In addition, the oral health of the patient would benefit through increased application by the dentist of modern scientifically based health knowledge and standards as much as by his technical clinical skills. His professional self-esteem would be enhanced by the knowledge that he was no longer a tooth puller, a tooth filler, and a plate man, and his public image as a health professional would improve accordingly and deservedly.

#### CONCLUSION

This paper has explored the possibility of realigning the functions that the dentist performs so that less demanding, routine tasks can be delegated to other trained dental personnel. The dentist would delegate only those functions that another could be trained to do as well. By so delegating the dentist would be freed to perform more demanding tasks that required a higher level of training. The net result could be the desired end of more oral health services for more people attained through a more realistic realignment of the functions required to provide the services than is presently the case.

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*(Continued on Page 62)*

# Delayed Versus Immediate Treatment Planning

CARL O. DAVIS, D.D.S., Ph.D.\*

IT HAS BEEN customary for dental practitioners to divide the diagnosis and treatment planning phases of dentistry into two or more appointments. Until recently, this was mandatory for proper time utilization for both the patient and dentist. The availability of machines that automatically develop and dry films has eliminated the time consuming wait between these procedures.

Authorities in the field of practice management and dental diagnosis have, nevertheless, stated that treatment planning and diagnosis should not be attempted at the same appointment and it has been inferred that the quality of the treatment plan can be improved if a time lag of several days can intervene between the initial examination and the formulation of the plan.

Recognizing that other factors (laboratory procedures, psychological conditioning and evaluation) may be relevant, an attempt was made to determine if a segmented sequence of examining and planning was superior to a single appointment for these procedures.

## LITERATURE REVIEW

Kirby stated positively that the evaluation of material taken in the history and examination period must never occur at the same session.<sup>1</sup> His advice was that the dentist should retire to the consultation room with the study models, the x-rays—dried and mounted, the patient's history and any other available data. Here, in a solitary and unhurried atmosphere, the dentist should arrive at his treatment decision. He suggested that the decision be based upon the dental problem itself, by an analysis of the patient by the

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dentist as expressed in the history consultation and financial considerations. Kirby re-emphasized that this diagnostic step should be a complete and separate stage in solving the patient's problem and should never be fused or blended with any other step.

Stinaff agreed with Kirby and stated that it is neither fair nor proper to use the examination appointment to perform a case presentation in which the patient is given the opportunity to accept or reject the recommended treatment plan.<sup>2</sup> He suggested that between the first and second appointments, the dentist must arrive at a diagnosis and prognosis that are as complete as possible.

Cinotti and Grieder concurred that the initial examination and the case presentation should consist of two separate appointments.<sup>3</sup> Kilpatrick, in a book dedicated to work simplification, listed a suggested routine for case presentation that used the first appointment to let the patient talk, take the personal history and do a small amount of dentistry if possible.<sup>4</sup> The second appointment was used for carrying out patient education, giving the case presentation and establishing a payment plan. Treatment was started the third appointment.

Thoma and Robinson went a step further. For the new patient entering the dentist's practice, they found that as many as three appointments were needed before case presentation.<sup>5</sup>

The use of multiple diagnostic aids in arriving at a correct treatment plan was shown by Fixott.<sup>6</sup> Supler agreed that radiographs must be supplemented by other accepted methods of diagnosis.<sup>7</sup>

## METHOD

**THE SAMPLE:** Rosters of senior classes from four dental schools were used to select subjects for the experiment. All students were assigned numbers, and two groups of twelve subjects were chosen using a table of random digits. The groups were labeled "Immediate Planning," and "Delayed Planning."

**TEST INSTRUMENT:** A complex dental case was selected which had numerous treatment alternatives. The simulation of an actual patient was produced using mounted study models, periapical, bite-wing, and panoramic radiographs, completed medical and dental histories, and thorough charts with all clinical and laboratory findings.

A board of experts validated and ranked five treatments of choice for the patient. From a battery of test questions approved by the experts, individual tests for each specific treatment were constructed.



Scoring weights were determined by the rankings of the treatments, and these weights were reflected in the number of questions on the different tests.

Thus, subjects were permitted to examine all the diagnostic aids and select the best treatment for the particular patient. Depending upon this response, an objective test on that specific treatment choice was then administered. The best treatment had a test with correspondingly more questions and the possibility of a higher score overall. In contrast, fewer questions were asked of those subjects who selected the poorer treatments, thus placing an upper limit on the obtained raw score. No lower limit was established. Questions measured ability to properly handle the treatment in regard to materials, sequence, mechanics, esthetics and physiology.

*TEST ADMINISTRATION:* Each subject in the "Immediate Planning" group was given all the diagnostic aids and told to select the treatment of choice. Once this had been done, the proctor issued the corresponding objective test. Subjects were asked not to discuss the case.

The members of the "Delayed Treatment" group were also shown the simulated patient, and were allowed to study it in detail. They made no treatment decisions at this time, but were told that they would be recalled in a few days to select the best treatment for the patient. They were not warned against discussing the case—and were reminded that the patient information was available to them at any time. This simulated office conditions in which the dentist can, if he chooses, consult other practitioners, specialists, and references in deriving a treatment plan. Subjects were subsequently recalled in from three to five days and were asked to choose a treatment plan. Objective tests were administered in the same way as the other group.

*EVALUATION:* No attempt was made to assess individuals nor to compare subjects from different schools. Only group results were compared. A two tailed t-test with a significance level of 0.05 provided the appropriate statistical operation.<sup>8</sup> Group means were determined and an F-test confirmed homogeneity of variances, thus permitting a pooled variance model with increased degrees of freedom.<sup>9</sup>

Group means were used to test the hypotheses: (1) The "Delayed Planning" group would score significantly higher, (2) the "Immediate Planning" group would score significantly higher, or (3) there would be no significant difference in the two groups.



# RESULTS

| Group     | N  | Mean | s.d. | t    |
|-----------|----|------|------|------|
| Delayed   | 12 | 6.41 | 1.91 | 1.92 |
| Immediate | 12 | 8.33 | 2.72 |      |

Required t, where  $df=22$ , .05 level of significance, two tailed=2.07

Neither group was observed to score significantly higher. The first two hypotheses were rejected and the third (no difference in means) was accepted.

# DISCUSSION

There are conceivably sound reasons for separating diagnosis and treatment planning into two sessions. However, on the basis of this study, a time interval of several days between these sessions does not contribute to an improved treatment plan for the patient.

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FIFTY-FIRST ANNUAL CONVOCATION  
AMERICAN COLLEGE OF DENTISTS  
Atlantic City, N. J. — October 10, 1971

Photographs by Dr. Philip Schwartz

## Now—An Epilogue

FRANK P. BOWYER, D.D.S.\*

**A**N EPILOGUE is a dissertation at the end of a theatrical production or literary work to summarize or highlight the meaning of the story; especially, when it is so complex that the author desires to make additional emphasis to the audience in order to bring out the message. In referring to the individual who we are honoring now, this unique title becomes very significant, for truly the life of Dr. Otto Brandhorst has been most meaningful and there are great lessons to be learned from his career.

"The measure of one's life is the well spending of it and not the length of it". This tribute tonight is not merely to mark the passage of a given number of years nor to list particular events in Otto's life but rather to reflect on what one individual dedicated to the pursuit of excellence can do to enhance the image and dignity of his profession.

"Each honest calling, each walk of life has its own elite, its own aristocracy, based upon excellence of performance". Otto is certainly one of ours. I have wondered how this man could be so capable in so many different areas of importance, and have found my answer in his basic characteristics of honesty, moral and intellectual integrity, sincerity, and complete dedication to our profession.

Above and beyond this honesty in everyday dealings with his fellow man, Otto has always been absolutely honest with himself. He has never been willing to subdue his individuality and personality to conform to the crowd. We recall the advice of Polonius, "this above all, to thine own self be true, and it must follow, as the night the day, thou canst not then be false to any man". Absolute honesty, coupled with moral integrity, is essential in every relationship without regard to its effect on one's own self. Sincerity must be evident in one's every opinion, every motivation, and every action. Certainly this has been true of this man.

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\* Past president, American College of Dentists. Presented at the fifty-first annual meeting of the American College of Dentists, Atlantic City, N. J., October 10, 1971.

As a young man, Otto must have dreamed of what he wanted to do with his life and "to fulfill the dream of one's youth is the best thing that can happen to a man". We are the end product of our thoughts and dreams, for thought is the fountain of action and the thoughts and dreams within us are the fountain of our very life. "As a man thinketh in his heart, so is he".

Edwin Markham expressed this so well, when he wrote

Ah, great it is to believe the dream  
As we stand in youth by the starry stream;  
But the greater thing is to fight life through,  
And to say at the end, "The dream is true!"

Otto set his course long ago, because he is one who thinks with confidence, proceeds fearlessly and accomplishes masterfully. He learned early in life that "he who conquers doubt and fear, will conquer failure". As Franklin D. Roosevelt said in a time of national crisis, "we have nothing to fear but fear itself."

Otto dared to dream the impossible dream and for him the pursuit of excellence became his quest. He realized that men do not attract by what they want but by what they are. "Our thoughts and purpose are the makers of our character, the moulders of our life and the builders of our destiny".

To realize such a dream of excellence in so many areas as he has, required discipline, tenacity of purpose, and strong motivation. "No one has excellence thrust upon him. It is never granted to a man but as a reward for labor". Dr. Otto is truly a living example of his own famous quotation, "Good enough is not enough, you must always do your best".

There are types of excellence that involve doing something well and there are types of excellence so subjective that the world cannot even observe them much less appraise them. Montaigne wrote, "it is not only for exterior show and ostentation that our soul must play its part, but inwardly within ourselves, where no eyes shine but ours". Otto's real joy comes not from such praise which we bestow upon him tonight, but from the personal satisfaction of having done something exceedingly worthwhile for his profession and for his fellow man.

Far too many follow the philosophy of Omar Khayyam,

Ah, fill the cup, what boots it to repeat  
How time is swiftly slipping 'neath our feet,  
Unborn tomorrows and dead yesterdays—  
Why fret of them, if today be sweet?

Fortunately, however, many others like Otto believe as Winston Churchill,

“The heritage of the past is the seed that  
brings forth the harvest of the future.”

Otto's career was not guided by the philosophy that the problem of the day was the only thing important. He relied on the heritage of the past to give him the vision to project into the dynamic future while at the same time attending to the important duties of the day.

The challenge to those who have taken up the torch is to continue with equal dedication to appreciate and build on our great heritage and never permit the great and glorious deeds done by men like him to have been in vain.

Just think what could be accomplished if each of us as individuals used our full potential every day as Dr. Brandhorst has done. If each of us had the vision, dedication and wisdom of Otto, perhaps we would not be confronted with many of the problems we are today. Most of us have untapped potential that we have never used. Every person has resources of personal strength and ability that are lying dormant. Most of us have a better stouthearted self within ourselves than we realize, yet we go through life using our maximum potential only when forced by emergency or crisis. Far too many lack the desire to achieve excellence, but far more can achieve it than do now. Many more can try than are now trying and society is bettered not only by those who succeed but also by those who try.

It is historically true that the advancement of society is greatly dependent on accomplishments of dedicated individuals. Otto has demonstrated this well. He has taught us that the American College of Dentists is not an organization that seeks fame and glory for itself but considers its true value in the worth of the contributions of the individuals composing it. The Fellows of the College are individuals who have already been recognized for their service to the profession and the community above and beyond the average individual. Our continued strength and influence will be directly related to the future composite contributions of the individual Fellows working within guidelines and policies established by the College.

Isn't it strange that princes and kings  
And clowns that caper in sawdust rings  
And the common folk like you and me  
Are the builders of eternity.



To each is given a bag of tools,  
A shapeless mass and a book of rules,  
And each must fashion ere life has flown  
A stumbling block or a stepping stone.

R. L. Sharpe

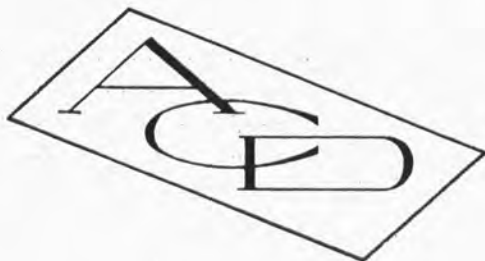
The manner in which you live each day of your professional and personal life will largely determine the destiny of dentistry.

I could not close without remembering that underlying all of Otto's personal characteristics, which are the lessons to be learned from this epilogue, has been his strong faith in God Almighty the common Father of us all.

By our very calling, we are doing the Lord's work in rendering our professional services to humanity. Whether or not we deserve His favor depends on our objectives in rendering this service. If our purpose is simply a method of acquiring material gain then that, alone, will be our only reward and this will be a very hollow trophy indeed. However, if we have in our heart the interest and love for all humanity; and service to our fellow man is our major objective, then we find ourselves truly serving God. We will then receive rich rewards and they will be "rewards of the Spirit that rust does not corrupt nor thieves break through and steal".

How true are the famous words of John F. Kennedy that are so applicable here. "With good conscience our only sure reward . . . let us go forth . . . asking His blessing and His help, but knowing that here on earth God's work must truly be our own."

On this occasion it is fitting to remember, "not armies, not nations, have advanced the race; but here and there in the course of the ages, an individual has stood up and cast his shadow over the world". Such a man we honor tonight, Dr. Otto W. Brandhorst.





## A Tribute to Otto W. Brandhorst\*

THOMAS J. HILL, D.D.S.†

THE BOARD of Regents has paid Dr. Brandhorst a very unusual but most appropriate compliment by dedicating this meeting to him. It is well deserved expression of appreciation for his long service.

I will make no attempt to recite in detail Dr. Brandhorst's activities, accomplishments and honors. This has been done and it would be redundant with the publication of the College history. Let us say that the history as published is an eloquent record of his work.

When Dr. Brandhorst became Secretary of the College, 35 years ago, he brought with him the viewpoint of a dentist, the experience of a teacher in dental education, the knowledge gained by mastering a specialty and the wisdom that is reputed to be possessed by all deans. Such a background fitted him well to cope with the many duties, the varied viewpoints and the diversity of interests and activities of the College.

The founders of the College were the architects of an institution of superior standards dedicated to the highest ideals of the dental profession. The Secretary has been the Master Builder who has labored long to bring the vision of the founders into fruition.

It is of interest to note that when Dr. Brandhorst became Secretary in 1936 there had been 557 fellowships conferred to that date. Of these 557 Fellows there are only 58 living Fellows today. This means that 99% of the present fellowships were given during Dr. Brandhorst's service. He has touched the lives of all of us and has influenced, sometimes deeply, the lives of those with whom he has worked in College activities. The growth of the College since he became Secretary is seven fold in numbers but its important growth is not measured in numbers but by the influence and prestige it has in the health professions and in the society in which we live.

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\* Presented at the fifty-first annual meeting of the American College of Dentists, Atlantic City, N. J., October 10, 1971.

† Past-president, American College of Dentists.

The evidence of this influence is in the many accomplishments of the College in support of a more adequate health service, dental journalism, dental education and dental research. These have been well chronicled in our published history. Dr. Brandhorst can look back upon these activities with satisfaction for the part he has played in them and with pleasant memories of associated events and warm friendships developed in this work.

While this is an American College, its prestige and influence has spread to other shores. At the present time there are about 200 Fellows who live in foreign lands. Essentially all of these have become Fellows during the past one-and-a-half decades.

Perhaps it is the past-presidents, the Regents, and committeemen who have worked with Dr. Brandhorst that most fully appreciate the capability and efficiency that marked his Secretaryship. He established a reputation for orderly arrangement and detailed action. The office that he maintained was highly organized and contained a wealth of information, sometimes even to minutiae. In fact the office had the capacity to record in such systematic detail that it has been said that I.B.M. got the idea of a computer from his work.

Such extreme efficiency in office procedures can result only from expert office assistance. Those who have worked with the Central office have a fond memory of Fern Crawford's great help and are indebted to her for many kindnesses.

Now, after 35 years in the service of the College, Dr. Brandhorst is about to retire and later this evening he will be awarded the past-president's emblem. May I preempt that presentation and explain that the past-president's emblem is a small replica of the College mace. As the mace is emblematic of leadership, this presentation is most deserving. We, the past-presidents, welcome him to our demoted rank. We believe that his long and distinguished career has added a new luster to the metal of the emblem and a new brilliance to the jewel which it contains.

So like men before him, who after years of service on committees, as Regents or officers, become used, drained and are retired to be past-presidents. Like no deposit non returnable bottles they, the past-presidents, become the surplus of the College. We might say the scrap heap of the College. We have a table full of past-presidents here. Because of the great emphasis that is now being placed on ecology, it has been suggested that Dr. Brandhorst be not added to this scrap heap but that he should be recycled. This was given up because if they start to recycle past-presidents, think what would happen when they got around to Jerry Timmons and Harry Lyons.

They could not be recycled and that would break up the whole ecology program.

In a more serious vein, the College appreciates the dedicated service of Dr. Brandhorst over such a long period. In an attempt to express this appreciation in a concrete form, may I be so bold as to offer this poem.

*TO OTTO W. BRANDHORST*

The College pays its whole hearted respect  
To one whose life has been earnest and real,  
One who always has striven to protect  
Our aim and our professional ideal.  
We are grateful for the years that he spent,  
As master of detail, he was supreme,  
His devoted service was vigilant  
In the promotion of the College theme.

In retrospect, we see his whole life spent  
In furthering a well laid College plan,  
A dedicated service so excellent  
That we honor this admirable man.  
Now he receives the past-president's mace  
To add to his record and to his fame,  
A symbol of the devotion and grace  
That brought honor to Otto Brandhorst's name.



# Honors and Awards

## CITATION FOR HONORARY FELLOWSHIP TO HOWARD A. RUSK

Presented by Regent Robert L. Heinze

Dr. Rusk is Professor and Chairman of the Department of Rehabilitation Medicine, New York University Medical Center; Director of the Institute of Rehabilitation Medicine, New York University Medical Center; Contributing Editor of the New York Times; and Contributing Editor of Medical World News.

From 1926 to 1942, Dr. Rusk practiced internal medicine in St. Louis, Missouri, where he was an instructor at Washington University School of Medicine and Associate Chief of Staff at St. Luke's Hospital. During World War II as a Colonel in the Medical Corps of the Army Air Force, he originated and directed the AAF Convalescent-Rehabilitation Training Program and was awarded the Distinguished Service Medal. He is a retired Brigadier General in the U. S. Air Force Reserve.

On behalf of the United Nations, World Veterans Federation, International Society for Rehabilitation of the Disabled World Rehabilitation Fund, Inc., and the American-Korean Foundation, Dr. Rusk, in recent years has observed and studied rehabilitation services in 48 nations in North and South America, Europe, the Near and Far East. He served as President of its Board.

In 1954, he was elected president of the International Society for Rehabilitation of the Disabled for a three-year term. He is currently president of the World Rehabilitation Fund, Inc. He served as president of the Eighth World Congress of the International Society held in New York in 1960.

Among the many awards he has received are: The Research Award of the American Pharmaceutical Manufacturers Association, 1951; The Lasker Award of American Public Health Association, 1952; The Albert Lasker Award in International Rehabilitation, International Society for Rehabilitation of Disabled, 1957; Bronze Plaque of the Association for the Help of Retarded Children, 1968, and a Citation by the President's Committee on Employment of the Physically Handicapped.

Dr. Rusk holds the following degrees: A.B. University of Missouri, 1921; M.D. University of Pennsylvania, 1925; LL.D. University of Missouri, 1947; D.Sc. (Hon.) Boston University, 1949; LL.D. Westminster College, 1950; LL.D. Hahnemann Medical College, 1952; D.Sc. (Hon.) Lehigh University, 1955; LL.D. Chungang University, Korea, 1956; L.H.D. (Hon.) Adelphia College, 1957; LL.D. Long Island University, 1957; D.Sc. (Hon.) Woman's Medical College, 1962; LL.D. Missouri Valley College, 1965; D.Sc. University of Portland, 1969; D.M.Sc. (Hon.) Brown University, 1969.

He is or has been in the past, consultant in rehabilitation to the United Nations, New York City Department of Hospitals, Rehabilitation Service Administration, and Veterans Administration; a member of the Expert Committee on Rehabilitation of the World Health Organization, the Board of the Medical Advisory Committee to the National Society for Crippled Children and Adults, International Society for Metabolic Diseases Council, National Institutes of Health, Public Health Council of the State of New York. He is or has been a member of the Committee for the Handicapped of the People-to-People Program, Board of Trustees of the Institute of International Education, Public Policy Committee of the Advertising Council, the Board of Directors of the International Rescue Committee, the National Council on Alcoholism and the U. S. Committee for UNICEF.

In addition to his numerous contributions to professional journals and books, encyclopedias and general periodicals, he is co-author with Eugene J. Taylor of "*New Hope for the Handicapped*" (1949) and "*Living with a Disability*" (1953); Co-author with Drs. Paul Dudley White, Philip R. Lee and Bryan Williams of "*Rehabilitation*" (1957) re-published in Japanese in 1962 and senior author with 34 colleagues of "*Rehabilitation Medicine*" in 1958, second edition 1964; Spanish edition, 1962; Japanese edition, 1967; Croatian edition, 1969.

Mr. President, on behalf of the Board of Regents in recognition of Dr. Rusk's many contributions to humanity and for his recognition of the need for broad cooperation in the various phases of health therapy, I present Dr. Howard A. Rusk for Honorary Fellowship in the American College of Dentists.



CITATION FOR THE WILLIAM JOHN GIES AWARD TO  
PAUL E. JONES

Presented by Regent James L. Cassidy

Dr. Jones was born near Bethel, Pitt County, North Carolina, April 9, 1890. He attended Richmond College and Medical College of Virginia and received the degree of Doctor of Dental Surgery in 1910. Dr. Jones served as a First Lieutenant in World War I from June 30, 1918 to March 15, 1919.

He served as president of the North Carolina Dental Society in 1931; and has been a member of the House of Delegates of the American Dental Association since 1931. He was president of American Association of Dental Examiners in 1943, and a director of the Bank of Farmville, from 1921 to 1937. He is a member of the Farm Bureau, a Mason, Shriner, and Knight Templar. Appointed to the North Carolina Board of Health in 1944, he served for a period of four years. He has presented several essays before the North Carolina Dental Society.

Dr. Jones served as chairman of the Advisory Committee of the North Carolina Dental Society to the Dental College committee of the Faculty of the University of North Carolina in 1951 and 1952, and was elected a member of the Board of Trustees of the University of North Carolina for eight years. He was appointed a member of the Health Committee which activated this division of the Health Affairs of the University of North Carolina School of Pharmacy, School of Nursing and the North Carolina Memorial Hospital.

Dr. Jones served as State Senator in the North Carolina General Assembly in 1949, 1953, 1955 and 1957, and was president pro tem of North Carolina State Senate Session of 1955, and chairman of Rules Committee. He authored and sponsored legislation setting up the North Carolina Dental College at the University of North Carolina. During his legislative years he was instrumental in securing appropriations for many educational programs and buildings, which marked the beginning of the dramatic growth of East Carolina University.

Dr. Jones was recognized by the Board of Trustees of the University, by naming the first large men's dormitory with a capacity of 500 students the "Paul E. Jones Dormitory". Dr. John C. Brauer, Dean of the School of Dentistry of the University of North Carolina, in his dedicatory address said:

"We are permitted to reflect upon the life and character of a man who has brought great credit to his state, this institution, his profession, family and himself. His is a life which represents a wonderful story of service above self and a dedication of Christian principles of character living and ethics. Integrity, generosity and appreciation have exemplified his character and patterned a life."

Mr. President, on behalf of the Board of Regents of the American College of Dentists, in recognition of his many contributions to his profession, his state and community, I wish to present Dr. Paul E. Jones of Farmville, North Carolina for the William John Gies Award.

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CITATION FOR THE WILLIAM JOHN GIES AWARD TO  
JOHN OPPIE MCCALL

Presented by President-elect William E. Brown

On behalf of the Board of Regents, I wish to present the name of Dr. John Oppie McCall for the William John Gies Award.

Dr. McCall was born in Geneva, New York, October 4, 1879. He received his A.B. degree from Yale University in 1901 and his D.D.S. degree from the University of Buffalo School of Dentistry in 1904. He practiced general dentistry in Binghamton, New York for one year and moved to Buffalo where he limited his practice to pyorrhea treatment. He was the organizer of the American Academy of Periodontology and coined the term "Periodontoclasia" to replace the term "Pyorrhea Alveolaris". He served as president of the Academy in 1917.

In 1907 he proposed to the Dental Society of the State of New York, the organization of a Dental Hygiene Council and served as its first chairman. This led to the association with the Committee on Community Dental Health under the auspices of the New York Tuberculosis and Health Association.

In 1912 he was asked by the School of Medicine of the University of Buffalo to organize the first year of a projected Arts and Sciences College of the university. The one year course was later expanded to the full four year school.

Dr. McCall moved to New York City in 1924 and joined the Dental School of New York University and in 1925 organized the department of periodontology.

In 1916, in Buffalo, he became associated with three physicians in a study of focal infection. He served as Director of the Murry

and Leonie Guggenheim Clinic of New York for 16 years and organized a course and school for Dental Hygienists as a part of the activities of the Clinic.

Dr. McCall organized a journal of the First District Dental Society of New York, called the *New York Journal of Dentistry* and served as its editor for 10 years. In association with the New York Institute for Graduate Dentists, he organized *Dental Concepts* as the official organ.

He was the author or co-author of 8 textbooks, including "*Periodontia*", "*Fundamentals in Medicine and Public Health*", "*Focal Infection and Eye Disease*", and others. His first published article was "*Empiricism in Dentistry*" published in *Dental Cosmos* in 1906.

On May 4, 1970, Dr. McCall was presented an award by the Alumni Association of the University of Oregon Dental School in recognition of his contributions to the art and science of Dentistry.

In June, 1970, Tufts University School of Dental Medicine, at the Berkshire Conference in Periodontology, presented Dr. McCall with an award for his leadership in periodontology.

In recognition of his many services to the profession, the Board of Regents wishes to confer the William John Gies Award upon Dr. John Oppie McCall.

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CITATION FOR THE AWARD OF MERIT TO  
VICTOR A. HILL

Presented by Vice President J. Lorenz Jones

Victor A. Hill was born in Oakland, California and graduated from the University High School in 1931. He attended Merritt Business College, Golden Gate College, Sacramento State College and the University of California, majoring in business administration. His education has been supplemented by participation in symposiums, workshops and conferences on public relations, humanities, effective communications and public administration.

In 1954, Mr. Hill was appointed Executive Secretary of the Board of Dental Examiners of California. He has served the public and the profession with vigor and excellence. He is an associate member of the American Association of Dental Examiners and past executive secretary of the Western Conference of Dental Examiners and Dental School Deans. He is an honorary member of the San Francisco Dental Society and the California State Dental Association.

Long active in state government affairs, he has served on the Advisory Committee on Dental Education and Manpower Needs of the California Coordinating Council for Higher Education and, in 1957, was elected president of the Council of Executive Officers of the State of California. He has served as a consultant to many state association committees and was instrumental in developing the dental hygienist programs at community college level. His contributions to testing procedures have been significant and far reaching. The present examination in oral diagnosis and treatment planning was developed and implemented under his perceptive recommendations. This testing procedure has been adopted by the California Board and has set the pattern for many other states.

In his tenure with the State Board he has displayed a special talent for serving as liaison between the California Board of Dental Examiners, the two state organizations and the California dental and dental, hygienist school. He has made numerous appearances before the Senate and Assembly of the California Legislature in behalf of legislation concerned with the dental profession.

His special interest and training for educational measurements and testing led the California Board to revise its entire grading procedure in 1963. The question of evaluating the knowledge, skill, competence and particularly the judgment of the candidate for licensure may now be ascertained through a precise system of grading which provides uniformity of application and consistent with equity.

His extracurricular activities has been devoted to community affairs. He is past commander of the Florin Post and Pacifica Post, American Legion; member of the Governor's Cabinet District 4c5 Lions International, Boy Scouts of America and many other community activities.

Mr. President, on behalf of the Board of Regents, in recognition of Mr. Hill's many contributions to the dental profession, I have the honor of presenting Mr. Victor A. Hill for the Award of Merit of the American College of Dentists.



## Fellowships Conferred

Fellowship in the American College of Dentistry was conferred upon the following persons at the Annual Convocation in Atlantic City, New Jersey on October 10, 1971.

- |  |   |
|--|---|
| <p>Alejandro Acevedo, APO New York, N. Y.<br/> Eugenio Alfredo Aguilar, Jr., El Paso, Texas<br/> Robert Lee Anderson, Seattle, Wash.<br/> George F. Andreasen, Iowa City, Iowa<br/> Robert A. Atterbury, Oak Park, Ill.<br/> Russell H. Augsburger, San Francisco, Calif.<br/> Donald Thomas Auten, Chattanooga, Tenn.<br/> Lillian H. Bachman, New York, N. Y.<br/> Warner J. Ball, Kenbridge, Va.<br/> Thomas Howard Baumann, San Diego, Calif.<br/> Hazle Padgett Beasley, Franklin, Tenn.<br/> Ian C. Bennett, Jersey City, N. J.<br/> Donald S. Benson, Rochester, Minn.<br/> Edward E. Beveridge, Los Angeles, Calif.<br/> Stephen Paul Bey, Perryville, Mo.<br/> James V. Bibbo, Jr., Tarrytown, N. Y.<br/> Victor E. Bird, Morgantown, W. Va.<br/> Melvin Nathan Blake, New York, N. Y.<br/> Joseph Jerome Blinderman, New York, N. Y.<br/> Gerald Borell, Brooklyn, N. Y.<br/> Robert C. Broadlick, Jr., Riverside, Calif.<br/> Howard Bruggers, New Orleans, La.<br/> Vincent Aloysius Callery, Pottsville, Pa.<br/> George W. Campbell, Rochester, Pa.<br/> Earl R. Canfield, Atlanta, Ga.<br/> Herbert Caplan, Montreal, P. Q., Canada<br/> Jesus E. Carmona, Miami, Fla.<br/> Victor S. Caronia, Montvale, N. J.<br/> Frederic M. Chacker, Philadelphia, Pa.<br/> John R. Champagne, Detroit, Mich.<br/> Robert G. Charbonneau, New York, N. Y.<br/> Frank Edmond Chowning, Indianapolis, Ind.<br/> Gordon Johnson Christensen, Denver, Colo.<br/> John R. Clark, Camp Hill, Pa.<br/> Bernard M. Cohen, Far Rockaway, N. Y.<br/> William K. Collett, Gainesville, Fla.<br/> John Alfred Crowley, Chevy Chase, Md.</p> | <p>Joseph A. Devine, Cheyenne, Wyo.<br/> Naomi A. Dunn, New Britain, Conn.<br/> Jack F. Edwards, Dallas, Texas<br/> Robert Waite Elliott, Jr., Bethesda, Md.<br/> Thomas Esmon, Indianapolis, Ind.<br/> Sol J. Ewen, Forest Hills, N. Y.<br/> Edward Harold Faget, New Orleans, La.<br/> Paul Edward Farrell, Washington, D. C.<br/> George A. Fisher, Evansville, Ind.<br/> Harry B. Fleming, Falls Church, Va.<br/> Maxwell S. Fogel, Philadelphia, Pa.<br/> Hubert Darrell Foglesong, Des Moines, Iowa<br/> Joel Bernard Freedman, Pittsburgh, Pa.<br/> Louis Paul Gangarosa, Sr., Augusta, Ga.<br/> Allen Fred Goldberg, Niles, Ill.<br/> Kenneth R. Goljan, Summit, N. J.<br/> John Edward Goodrich, Des Moines, Iowa<br/> Bernard Gordon, Baltimore, Md.<br/> Leonard Gorelick, Little Neck, N. Y.<br/> Stanley E. Graham, Morris, Ill.<br/> Larry J. Green, Buffalo, N. Y.<br/> Robert Henry Griffiths, Charleston, Ill.<br/> James Walker Guinn, Greenwood, Miss.<br/> James Guttuso, Williamsville, N. Y.<br/> Joseph H. Hagan, Crystal City, Mo.<br/> Douglas L. Hamilton, San Francisco, Calif.<br/> Lee Moncrief Harrison, Jr., Shreveport, La.<br/> Hudson David Heidorf, Rocky River, Ohio<br/> John Harleth Heiser, Overland Park, Kan.<br/> Franklin Bannon Hines, Jr., Columbia, S. C.<br/> John B. Holmes, Rockville, Md.<br/> Samuel Vernon Holroyd, Bethesda, Md.<br/> Jarrell D. Holt, Poplar Bluff, Mo.<br/> Louis K. Holzman, Chicago, Ill.<br/> Lehman D. Jackson, Fort Smith, Ark.<br/> Daniel Jacobs, Harrisburg, Pa.<br/> Wilbur Orian Jensen, Santa Ana, Calif.<br/> James Paul Jones, New York, N. Y.<br/> J. Stanley Jordan, Philadelphia, Pa.<br/> Myron Kaufman, Detroit, Mich.<br/> William James Kemp, Haskell, Texas</p> |
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Ralph Buxton King, Jr., Monroe, La.  
 Daniel J. Kleinman, Millburn, N. J.  
 Joseph M. Kline, Arlington, Va.  
 Ralph Knowles, Jr., Jefferson City, Mo.  
 Stanley Kogan, Baltimore, Md.  
 Edgar Robert Kunz, Jr., Philadelphia, Pa.  
 Maurice Dee Laine, Jr., Missoula, Mont.  
 Joseph Parker Lambert, Dallas, Texas  
 Charles F. Landis, Jr., Chattanooga, Tenn.  
 Olaf Elmer Langland, New Orleans, La.  
 James Henry Langley, Manchester, N. H.  
 Clarence T. Lee, Honolulu, Hawaii  
 Frederick M. Liebman, New York, N. Y.  
 Francis L. Lock, Honolulu, Hawaii  
 Frank Matthew Lucatorto, Northridge,  
 Calif.  
 Robert Duree Lundquist, Los Altos, Calif.  
 Harry Heathcote Luton, Grand Rapids,  
 Mich.  
 Joseph S. C. Mach, Seaford, Del.  
 Irwin D. Mandel, Cedar Grove, N. J.  
 Milton Allen Marten, Flushing, N. Y.  
 James H. Mason, Ft. Smith, Ark.  
 George Wheeler Matthews, Jr., Birming-  
 ham, Ala.  
 Marvin Carroll McGowen, Baird, Texas  
 Robert W. McMartin, Atlanta, Ga.  
 Craig R. Means, Washington, D. C.  
 Roland Matthew Meffert, APO New York,  
 N. Y.  
 Howard Barry Menell, New York, N. Y.  
 Clifford H. Miller, Chicago, Ill.  
 Harold Franklin Miller, Memphis, Tenn.  
 John Francis Moran, Springfield, Mass.  
 John Wesley Morrison, Downey, Calif.  
 Geraldine T. Morrow, Anchorage, Alaska  
 Bernard S. Moskow, Ridgewood, N. J.  
 John H. Mosteller, Mobile, Ala.  
 Martin Naimark, Southfield, Mich.  
 Donald E. Neil, Beckley, W. Va.  
 Stanbery J. Nichols, Medina, Ohio  
 Alfred L. Ogilvie, Seattle, Wash.  
 Apollon George Orphanidys, Newport  
 News, Va.  
 Rudolph W. Palermo, Albertson, N. Y.  
 LeRoy Albert Parker, Jr., Union, N. J.  
 Frederick Douglass Peagler, Washington,  
 D. C.  
 Alfred William Pearson, Fresno, Calif.  
 David Browne Pearson, Jr., Berea, Ohio

Maurice E. Petrovsky, Memphis, Tenn.  
 Clinton Williams Pickering, Lynn, Mass.  
 Anthony Picozzi, Ridgewood, N. J.  
 Anthony L. Pittari, New Orleans, La.  
 Thomas William Portway, Ridgewood, N. J.  
 Rudolph A. Posey, Philadelphia, Miss.  
 Leo J. Poxon, Redondo Beach, Calif.  
 Joseph T. Quinlivan, Buffalo, N. Y.  
 Clifford H. Rankin, Spokane, Wash.  
 J. Alfred Rapuano, Ridgewood, N. J.  
 Robert B. Raskin, Lindenhurst, N. Y.  
 Arthur Resnick, Brooklyn, N. Y.  
 Lloyd W. Richardson, Fort Worth, Texas  
 Jules Roistacher, Uniondale, N. Y.  
 Martin Rosencrans, Jackson Heights, N. Y.  
 Thurston H. Ross, Jr., Los Angeles, Calif.  
 Robert H. Roux, Jr., Savannah, Ga.  
 Curtis Elree Rutledge, Jr., De Quincy, La.  
 Homer Sneed Samuels, Oakland, Calif.  
 Leo Richard Schwartz, New York, N. Y.  
 George D. Selfridge, Rockville, Md.  
 Abbe Jonathan Selman, New York, N. Y.  
 William O. Shumpert, Fort Lauderdale, Fla.  
 Meyer M. Silverman, Washington, D. C.  
 H. William Sippel, Buffalo, N. Y.  
 Alvin L. Solomon, Roslyn, N. Y.  
 Norman T. Speck, Houston, Texas  
 James Stephen Stanback, III, Hyattsville,  
 Md.  
 Gilbert Stanton, Malverne, N. Y.  
 Frank H. Stevens, Bridgeport, W. Va.  
 Stanley Sutnick, Miami Beach, Fla.  
 Barry Symons, Brooklyn, N. Y.  
 Maurice Taylor, Flint, Mich.  
 Perry L. Taylor, Kankakee, Ill.  
 Patrick D. Toto, Maywood, Ill.  
 Frank Trundle, Chattanooga, Tenn.  
 Fumio Tsuji, Kahului, Maui, Hawaii  
 Ennio L. Uccellani, Bronxville, N. Y.  
 Anthony Valenti, Brooklyn, N. Y.  
 Edward F. Van Eepoel, Tampa, Fla.  
 Paul William Vineyard, Salisbury, Md.  
 Anthony R. Volpe, Piscataway, N. J.  
 George Wesley Wade, Washington, D. C.  
 Kirby P. Walker, Jr., Jackson, Miss.  
 Harold Clay Walraven, Jr., Atlanta, Ga.  
 John Edward Walsh, New York, N. Y.  
 Thomas Henry Walters, Tuckahoe, N. Y.  
 Jackie Gene Weatherred, Augusta, Ga.  
 William Richard Wege, Augusta, Ga.

George Arthur Weiss, Bayside, N. Y.  
 William Watkins Weiss, Jr., Philadelphia,  
 Pa.  
 William Devitt Wendle, Wilmington, Del.  
 George Jay Wrubel, Staten Island, N. Y.  
 Stanley Paul Zarembo, New Castle, Pa.  
 Michael John Zazzaro, Hartford, Conn.

*In absentia*

Robert Edward Gillis, Short Hills, N. J.  
 George Hale Green, Bethesda, Md.  
 Alexander Zane, Beverly Hills, Calif.

*Foreign*

Hector Sacchi, Montevideo, Uruguay

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## FUNCTIONAL REALIGNMENT SYSTEM

(Continued from Page 41)

4. Rosenblum, F. N.: Experimental Pedodontic Auxiliary Training Program. *Am. Dent. A. J.* 1082-1089, May, 1971.
5. Abramowitz, J.: Expanded Functions for Dental Assistants; a Preliminary Study. *Am. Dent. A. J.* 386-391, Feb., 1966.
6. Dental Nurse Training Project. Washington, Howard University, School of Dentistry, 1969. 5pp. duplicated. In Koerner, K. R.: *Dynamic Transition in Dentistry; Expanded Functions for Auxiliaries.* *Pub. Health Dent. J.* 123-140, No. 2 Spring Issue, 1971.
7. Grayland, E.: The Role of the New Zealand Dental Nurse. *CAL* 30-36, Dec., 1967.
8. Beck, D. J.: Evaluation of Dental Care for Children in New Zealand and the United States. *New Zealand Dent. J.* 201-211, July, 1967.
9. Gonzalez, J. M.: The New Zealand Dental Nurse; Forty-four Years of Service. Puerto Rico Department of Health, 55 pp. mimeo., Nov., 1967.

136 Harrison Avenue  
 Boston, Massachusetts 02111

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## NEWS OF FELLOWS

(Continued from Page 4)

The following Fellows were installed as officers of the American Dental Association at its recent meeting in Atlantic City: president, Dr. Carl A. Laughlin; president-elect, Dr. Louis A. Saporito; second vice-president, Dr. Frederick E. Hasty, Jr.; third vice-president, Dr. Marvin L. Fishman; speaker of the House of Delegates, Dr. Carlton H. Williams; eighth district trustee, Dr. Robert J. Pollock; third district trustee, Dr. George P. Boucek; fourth district trustee, Dr. Joseph P. Cappuccio, and fifth district trustee, Dr. John M. Faust.

Dr. John E. Gilster of St. Louis, Missouri was installed as president of the American Association of Dental Editors at its recent annual meeting in Atlantic City.

Dr. Harold Hillenbrand, executive director emeritus of the ADA and President of the Federation Dentaire Internationale, received honorary fellowship in the Academy of General Dentistry at its recent convocation.

## Necrology Report

The following Fellows are deceased since the 1970 Convocation:

|   |   |
|---|---|
| Harold Kane Addelston, New York, N. Y.            | Hobart F. Heston, Dayton, Ohio                |
| Spencer R. Atkinson, Pasadena, Calif.             | Francis J. Herz, San Francisco, Calif.        |
| Max K. Baklor, Baltimore, Md.                     | Thomas D. Holder, Portland, Ore.              |
| Charles Baumann, Sr., Milwaukee, Wisc.            | Frank B. Hower, Louisville, Ky.               |
| Horace R. Beachum, Dallas, Texas                  | Charles F. Hoyt, Miami, Fla.                  |
| Brooks Bell, Dallas, Texas                        | Edward H. Hubbuch, Louisville, Ky.            |
| Don H. Bellinger, Saginaw, Mich.                  | Leonard J. Huber, St. Genevieve, Mo.          |
| Robert E. Blackwell, Evanston, Ill.               | Raymond W. Huegel, Madison, Wisc.             |
| Robert L. Borland, Los Angeles, Calif.            | David Hunn, Troy, N. Y.                       |
| Morris J. Boyer, Fort Lee, N. J.                  | William H. Hyde, Cedarhurst, N. Y.            |
| Ellis D. Braud, Thibodaux, La.                    | Kenneth Jenkins, Boulder Creek, Calif.        |
| Frederick F. Brewster, Rockville Center,<br>N. Y. | James E. John, Roanoke, Va.                   |
| Virgil Brown, Laguna Hills, Calif.                | Leland Jones, San Diego, Calif.               |
| L. Franklin Bumgardner, Charlotte, N. C.          | Max R. Kadesky, Dubuque, Iowa                 |
| Allyn D. Burke, Monterey, Calif.                  | John J. Kefferstan, Lawrence, Mass.           |
| William E. Burke, Wellesley, Mass.                | W. N. Kelly, Montoursville, Pa.               |
| Carl Leon Busbee, Conway, S. C.                   | James J. Kennedy, Washington, D. C.           |
| Cecil Earl Carl, Canton, S. D.                    | Thomas H. Kennedy, Dallas, Texas              |
| Clarke E. Chamberlain, Peoria, Ill.               | Wallace N. Kirby, Downers Grove, Ill.         |
| William B. Clotworthy, Knoxville, Tenn.           | LeRoy E. Kurth, Chicago, Ill.                 |
| Robert William Conn, Tonawanda, N. Y.             | Cecil F. Lindley, Palm Springs, Calif.        |
| Fred O. Conrad, Tallahassee, Fla.                 | Franklin H. Locke, Sr., Oakland, Calif.       |
| A. J. Cormier, Moncton, N. B. Canada              | DeForest D. Lord, Santa Fe, N. Mex.           |
| Van B. Dalton, Cincinnati, Ohio                   | Robert Lush, San Diego, Calif.                |
| Gilbert H. Droegkamp, Wauwatosa, Wisc.            | William I. Macfarlane, Tomahawk, Wisc.        |
| George J. Dwire, Colorado Springs, Colo.          | Peter R. Mackinnon, Wollaston, Mass.          |
| Ralph W. Edwards, Kansas City, Mo.                | William E. Mentzer, Duluth, Minn.             |
| Semon Eisenberg, Savannah, Ga.                    | Morton H. Mortonson, Sr., Milwaukee,<br>Wisc. |
| L. Lynn Emmart, Baltimore, Md.                    | Harry Nelson, Hopkins, Minn.                  |
| B. B. Erana, Makati, Philippines                  | Robert M. Olive, Sr., Fayetteville, N. C.     |
| Hubert Eversull, Kansas City, Mo.                 | Walter E. Omundson, Washington, D. C.         |
| Caryll S. Foster, Cedar Rapids, Iowa              | Edward C. Penick, Bethesda, Md.               |
| Harry J. Fredrics, Philadelphia, Pa.              | Charles K. Philips, Denver, Colo.             |
| Harry M. Fridley, Alameda, Calif.                 | Seymour Pollock, Philadelphia, Pa.            |
| Sidney S. Friedman, Sr., Memphis, Tenn.           | Thomas T. Rider, Missoula, Mont.              |
| Edward A. Gamard, New Orleans, La.                | Joseph L. Riesner, New York, N. Y.            |
| Nathan G. Gaston, Monroe, La.                     | Elmer R. Robb, Pittsburgh, Pa.                |
| Jesse Marvin Gee, Sulphur Springs, Texas          | Henry Sandler, Sherman Oaks, Calif.           |
| Robert R. Gillis, Gainesville, Fla.               | William Bole Smith, Jr., Canton, Miss.        |
| J. Bardin Goodman, Rockville Centre, N. Y.        | Harry Saul, Atlantic City, N. J.              |
| Giles C. Grant, Portland, Me.                     | Dick Pearl Snyder, Columbus, Ohio             |
| Fred N. Harris, Pasadena, Calif.                  | Truman L. Stickney, Crookston, Minn.          |
| Maxwell A. Henkin, Jamaica, N. Y.                 | Douglas J. Sutherland, Vancouver, Canada      |

(Continued on Next Page)

## LETTERS

Dr. Robert J. Nelsen,  
American College of Dentists,  
7316 Wisconsin Avenue,  
Bethesda, Maryland 20014.

Dear Bob:

Just a belated note after my return from Atlantic City to thank you and the Officers of the College for a memorable day at Convocation.

In all my years of professional association, I have yet to be a part of anything as impressive as the solemnity and dignity of the American College and its beautiful ritual. I am mindful, too, of the great efficiency of the participants in organizing and in executing all of the wonderful meetings, meal functions and various activities. The infinite regard to detail leaves nothing to the imagination, and I must say that every inductee could not have come away from all this except with a renewed pride in being a part of it.

It is not without reason that the American College enjoys such prestigious position in the realm of organized dentistry ubiquitously. With men such as our Officers and yourself at the helm, the future of the College can only be one of strength, devotion and rededication to the exalted aims, which it sets for itself to the greater good of the profession and to our fellow humans.

In closing, I extend my sincere gratitude to all for a day that I shall cherish for its significance. If I can be of any service in any way, shape or form, please be assured of my confidence and willingness to assist.

Warmest regards,

HERBERT CAPLAN

Montreal, Quebec

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**NECROLOGY REPORT**

*(Continued from Page 63)*

Clayton A. Swanson, Minneapolis, Minn.  
Earle Thomas, Babson Park, Ill.  
Elmer A. Thomas, Hastings, Neb.  
Albert H. Trithart, Buffalo, N. Y.  
Harry A. True, Los Gatos, Calif.

Major Varnado, New Orleans, La.  
Charles B. Walton, Pittsburgh, Pa.  
Clarence D. Wofford, Plainview, Texas  
Karl Hayden Wood, Gainesville, Ga.  
Fred York, St. Petersburg, Fla.

## *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.



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