

The JOURNAL
of the
AMERICAN COLLEGE
of DENTISTS

**Symposium on
Reciprocity**

**Perspectives in
Dental Education**

**Future Role
of Government**

Hospital Dentistry

APRIL 1973

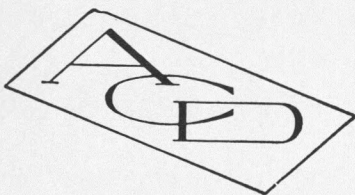


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NEWS AND COMMENT

ANNUAL CONVOCATION TO BE HELD IN HOUSTON

The 53rd annual meeting and convocation of the College will be held at the Rice Hotel, Houston, Texas on Saturday, October 27. This year's meeting will be highlighted by a panel discussion on the general topic of "Professional Conduct." A luncheon will precede the convocation and a dinner dance with entertainment will follow in the evening. The preliminary program will be found in this issue on page 77. The complete program will be mailed to each Fellow at a later date, and will appear in the July issue of the Journal.

SELF ASSESSMENT PROGRAM REGISTRATION STILL OPEN

Although the first of the four tests in the Self Assessment and Continuing Education Program will be mailed out this month, registrations are still being accepted. It was the wish of the Board of Regents of the College that as many dentists as possible be encouraged to participate in this valuable learning experience. Therefore enrollment will continue indefinitely. Those who wish to participate but have not registered may still do so by sending a check for \$40 to the Educational Testing Service, Princeton, N. J.

ACTIONS OF THE BOARD OF REGENTS

At its recent meeting in Bethesda, Maryland on March 31 and April 1, the Board of Regents took the following actions:

- Accepted the report of the Committee on Credentials and approved the list of nominees who will be invited to accept Fellowship.
- Accepted the report of the Project Library Committee and commended its chairman, Dr. Ashton E. Wick for his efforts in developing the program.
- Approved the notification of life members that after January 1, 1974, a five dollar subscription fee will be charged for the Journal.

- Expressed its regard for Dr. Harvey S. Huxtable, who has been presented with an engraved sterling silver dish in appreciation for his services as Historian of the College.
- Expressed its support for the 25th anniversary of the National Institute for Dental Research by a contribution to the American Dental Association in support of the anniversary program.
- Affirmed the assignment of Fellow Herbert C. Gustavson as representative of the College at the meeting of the American Dental Society of Europe in July 1973.
- Complimented the Michigan Section on the 25th anniversary of its founding.
- Approved the publication of a quarterly Newsletter by the Central Office as a means of improving communications with the membership.
- Approved the appointment of an Ad Hoc Coordinating Committee of the Board to review areas of College organization and function and plan future activity.
- Marked with regret the discontinuance of the annual Institute for Dental Research, because of restriction in federal training grants.
- Accepted the report of the Self Assessment and Continuing Education Program Committee, and approved another mail solicitation in order to bring as many participants as possible into the program.
- Accepted the report of the Ad Hoc Committee on Sections which is studying the organization and geographic structure of the Sections.

SECTION NEWS

New York Section

The spring meeting of the New York Section of the American College of Dentists was held March 13th at the New York University Club. Sidney I. Silverman, Professor and Chairman of the Removable Prosthesis division at N.Y.U. College of Dentistry addressed the group on "Changing Concepts in Removable Partial Denture Prosthesis."

It has been customary to honor those chapter members who have served the American College of Dentists and whose contributions have furthered the cause of dentistry in general and have exemplified the ideals of the college. This year's distinguished recipients of this recognition are: Robert L. Heinze, Jerome M. Schweitzer and Ormonde J. McCormack.

New Jersey Section

The New Jersey Section met at the Holiday Inn, Kenilworth, N. J. on January 18, 1973. Secretary Curt Hester announced that the winner of the American College of Dentists Award was Dr. John C. Hirce, a graduate of the New Jersey College of Medicine and Dentistry. The certificate and check for \$100 were presented at the graduation exercises in December 1972.

Chairman L. Deckle McLean introduced the after-dinner speaker, Mr. Edward Cohen, Director of the Office of Health Profession Education, of the New Jersey Department of Higher Education. Mr. Cohen spoke about manpower training to meet future expected demands for dental service in New Jersey. There was a lively discussion on the training of dental auxiliaries and the services which they should perform. Mr. Cohen welcomed the comments of the fellows and expressed his willingness to have the New Jersey Section set up a liaison committee to maintain further communication with his office.

NEWS OF FELLOWS

The Department of Army has announced the names of two fellows of the College among those Army Medical Department officers who were selected to the top positions in the new U.S. Army Health Services Command, which will become operational on July 1st at Fort Sam Houston, Texas. The new Command was created as a part of the overall Army Reorganization announced recently.

The U.S. Army Health Services Command will encompass the operation and management of all Army hospitals and medical facilities within the United States. In addition, all medical education and training has been consolidated into the Academy of Health Sciences under the U.S. Army Health Services Command.

The Deputy Commander will be Brigadier General Jack P. Pollock, DC, who has been with the Department of Defense as Special Assistant for Dental Affairs in the Office of the Assistant Secretary of Defense for Health and Environment. He was the dental representative on the WORSAMS (World-wide Organizational Structure for Army Medical Support) Study Group in 1970.

The Deputy Chief of Staff for Personnel will be Colonel Raffaele Suriano, DC, who has headed the Directorate of Personnel and Training at the Army Surgeon General's Office since last July.

The National Institute of Dental Research in celebrating its 25th anniversary, will hold a conference in Washington on June 28 and 29, 1973. Among the Fellows of the College who will take part in the program are Gunnar Ryge, Seymour Kreshover, Alvin L. Morris, Louis A. Saporito, Gordon Rovelstad, Michael Buonocore, Paul Goldhaber, Reginald Sullens, Samuel Pruzansky, Philip Boyne, and Honorary Fellows John S. Millis and Wilton M. Krogman.

Dr. Harold Fullmer, director of the Institute of Dental Research at the University of Alabama-Birmingham has been selected as the 1973 recipient of the Isaac Schour Memorial Award. The International Association for Dental Research gives the \$300 prize annually to individuals who have made outstanding contributions in research and teaching in the field of anatomical sciences.

Dr. James H. Shaeffer of Parker, South Dakota is the president of the world's largest conservation organization, the two and a half million member National Wildlife Federation. He holds awards from a number of organizations and travels widely to promote the conservation movement.

Frank W. Nelson has been named Director of the Norfolk, Virginia Public Health Service Hospital. His appointment marks the first time in the hospital system's 175-year history that a dental officer has become a hospital director. The Norfolk PHS Hospital is one of nine hospitals and 30 outpatient clinics administered by the Federal Health Programs Service under HEW's Health Services and Mental Health Administration.

Fellow Alonzo N. De Vanna will be honored with the Diamond Service Award given by the American Academy of Oral Medicine at its annual meeting to be held April 29–May 4, 1973 at Paradise Island, Nassau.

Colonel Simon Civjan has been appointed Director of the United States Army Institute of Dental Research, Walter Reed Army Medical Center, Washington, D.C. Formerly Chief of the Division of Dental Materials of the Institute, he received a degree of Bachelor of Chemical Engineering, with honors, from the University of Florida in 1944, a DDS degree from the University of Maryland in 1954 and a MS degree in Dental Materials from Georgetown University in 1963. A native of Lithuania, Colonel Civjan served in the U.S. Army as an enlisted man and officer from 1944 to 1949 and as a dental officer since 1954.

(Continued on Page 132)

the JOURNAL of the AMERICAN COLLEGE of DENTISTS

A QUARTERLY PRESENTING IDEAS IN DENTISTRY

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

ROBERT J. NELSEN, *Business Manager*
Journal of the American College of Dentists
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Contents for April 1973

NEWS AND COMMENT	69
THE VICE PRESIDENT OF THE COLLEGE	75
53RD ANNUAL MEETING AND CONVOCATION	77
EDITORIAL	
SELF ASSESSMENT – THE KEY TO SELF IMPROVEMENT	78
PROJECT LIBRARY	80
SYMPOSIUM ON RECIPROCITY	82
SURVEY OF ATTITUDES ON DENTAL LICENSING PROCEDURES	
<i>Viron L. Diefenbach, D.D.S.</i>	83
NATIONAL RECIPROCITY OPPOSED	
<i>Robert B. Hughlett, D.D.S.</i>	87
NATIONAL RECIPROCITY FAVORED	
<i>Robert E. Glenn, D.D.S.</i>	93
LICENSURE BY CRITERIA EVALUATION	
<i>Samuel J. Oltmans, D.D.S.</i>	97
THE IRRELEVANCE OF LICENSING EXAMINATIONS	
<i>Mark Docktor</i>	100
PERSPECTIVES IN DENTAL EDUCATION	
<i>Norman H. Olsen, D.D.S.</i>	108
THE FUTURE ROLE OF GOVERNMENT IN DENTAL	
PRACTICE AND EDUCATION	
<i>Walter A. Wilson, D.D.S.</i>	111
HOSPITAL DENTISTRY – ITS PAST, PRESENT AND FUTURE	
<i>Malvin A. Ring, D.D.S.</i>	117
COMMITTEES	129
LETTER TO THE EDITOR	131



JOSEPH B. ZIELINSKI
Vice-President

The Vice President of the College

Dr. Joseph B. Zielinski of Chicago is currently serving the American College of Dentists as its Vice President. A graduate of the University of Illinois Dental School in 1923, he has been in general practice in Chicago for the past fifty years.

Dr. Zielinski was president of the Chicago Dental Society in 1945-46 and headed the Illinois State Dental Society in 1962-63. He has been a delegate or alternate delegate to the annual meetings of the American Dental Association since 1940, and was elected to the ADA first vice presidency in 1964.

He is a member of the American Academy of Periodontology, Omicron Kappa Upsilon honorary dental society, Psi Omega dental fraternity, the Pierre Fauchard Academy and the Federation Dentaire Internationale. He was a founding board member and first president of the Illinois Dental Service, and has recently retired from practice to serve as Dental Director of this organization.

In the area of civic activity, Dr. Zielinski is a past president of the Logan Square Kiwanis Club and a founder, board mentor and past president of the Logan Square Chicago Boys Club. He has served for the past sixteen years as Illinois' State Chairman of the Advisory Committee to Selective Service. He and his wife have two daughters and six grandchildren.

Dr. Zielinski was inducted into fellowship in the College in 1956, and over the years has gone through the chairs in the Illinois Section. He is well known for his service as bearer of the Torch in the annual convocation processions. Here his commanding presence, great height and distinguished bearing set the tone for the occasion as he led the files of officers and regents, candidates and sponsors into the convocation hall for the solemn ceremony of induction into fellowship. As Vice President of the College, he carries no torch now, but continues to bring light in another way by his sincere efforts to advance the principles of the College through his wise counsel on the Board of Regents.

53rd Annual Meeting and Convocation

Rice Hotel – Houston, Texas

Saturday, October 27, 1973

PRELIMINARY PROGRAM

President Ormonde J. McCormack announces that the morning session will feature a panel discussion on the general topic of Professional Conduct. Five speakers will present brief essays on the following subjects:

The Nature of Professionalism and its Value to Society

The Professional Misconduct of Individuals

The Professional Misconduct of Organizations and Agencies

How the Law Looks at Disciplinary Procedures Available to Professional Societies

Current Challenges to the Professions in America

In an era of relaxation of morality and conduct, this symposium will offer many provocative insights into a subject which should be of concern to all professional people. Panelists will be members of other professions as well as dentistry.

A humorist will highlight the luncheon program.

The Convocation Ceremony and induction of new fellows of the College will be held in the afternoon. The Convocation address will be given by Reverend Doctor Charles Allen, pastor of the First Methodist Church of Houston, who is a well known and highly respected speaker.

The evening dinner dance will take place in the Grand Ballroom of the Rice Hotel, with entertainment by the College Singers, followed by dancing until midnight.

Make your plans now to attend!

Editorials

Self Assessment

The Key to Self Improvement

Having graduated from dental school and passed a state board examination, the average dentist may be inclined to believe that he knows all there is to know about dental science. His university and his state having given him their approval, he generally considers himself to be quite knowledgable and well informed. When he enters practice, it does not take him long to discover that his education may not yet be complete. Somehow, the cases that he is called upon to treat do not look quite like the pictures in the textbooks, and his treatment does not always bring the desired result.

If he is wise, he soon makes it his business to seek some of the answers to his problems from more experienced practitioners, to attend lectures and clinics at his local or state society meetings, or to return to school for courses of postgraduate study.

Should he continue on this path, heeding the advice of G. V. Black about the need of the professional man for continuous study, there is every likelihood that with the passage of time his skills will improve to the degree that will earn for him the reputation of a competent practitioner.

If he fails to recognize his shortcomings and the gaps in his education, or recognizing them, takes no steps to correct them, his course could easily lead to mediocrity, the inability to develop a rewarding practice and the reputation of a hack or worse.

The difference between success and failure lies in his introspective ability, the quality of character which enables him to look at himself subjectively, to assess his own knowledge and skills and recognize any deficiencies. This analytic ability is the first step toward self improvement, for it suggests the measures he must take to raise his level of competence.

How useful it would be therefore if he had a simple, easily available means of making this self examination, to learn just what his level of competence is. From it, he could learn the areas of his strengths and weaknesses and plan a proper program of continuing education.

Such a measurement device is presently available in the Self Assessment and Continuing Education Program now being sponsored by the American College of Dentists in cooperation with the Educational Testing Service of Princeton, N. J. A series of four tests has been developed, each consisting of 150 multiple choice questions on all aspects of dental science and dental practice. It is being offered to the entire dental profession for the nominal fee of forty dollars for the series.

When first announced in January, it was expected that there would be an overwhelming acceptance of the program. Yet, after two months, less than two percent of the dental population has seen fit to register. Questions have arisen from individuals, expressing fear that some prejudicial use would be made of the test results, by state or federal agencies which would bring pressures for mandatory continuing education upon those obtaining low scores. It was pointed out that absolute confidentiality will be maintained, that no one will have access to the test scores, that participants will have the option of marking their own test papers, if they so choose, rather than having them machine scored by the Educational Testing Service.

Arrangements have been made with the Academy of General Dentistry which will offer credits toward membership and Fellowship for completion of the tests. The State Boards of Dentistry of Minnesota and Kentucky, which have continuing education requirements, have agreed to offer credit hours or points toward fulfilling these requirements, for participation in the program. The State Boards of Kansas and North and South Dakota are also considering granting similar credits. It must be emphasized however, that no scores will be released to those agencies. The participant alone will know his standing on the tests and his level of competence.

Here is an opportunity which the dental profession ought not to overlook. In this time of regulation, when government and the consumers are taking a hard look at the providers of health care, it is urgent that we demonstrate that we are able to keep our own house in order without outside intervention. Participation of a large segment of the profession in the Self Assessment and Continuing Education of ACD-ETS is one way of showing the public our ability to do so.

R. I. K.

Project Library

Project Library will become an active program of the College on May 1, 1973, according to Ashton E. Wick of Sheboygan, Wisconsin, Chairman of the project. At that time an assortment of textbooks, manuals, and pamphlet information on dentistry, dental health, dental research and dental education will be made available through the Executive Office of the College for placement in public and high school libraries. The complete assortment will be available at a modest fee to Fellows or to Sections of the College for presentation as a gift to their local library. The package of dental literature can be mailed directly to the library or may be delivered, preferably by the donating Fellow or Officer of the Section in person. An acknowledgment card in the package to be returned by the librarian will serve as a record to be used in future programs to keep the materials up to date. Each item will carry a small label stating that it is a gift of the American College of Dentists.

A study by the Wisconsin Section of the American College of Dentists indicated there is a critical need for more appropriate information on dental subjects in public and high school libraries. (See Wick, A. E.; Dental Information in Libraries; Journal American College of Dentists; Volume 40, #1, January 1973, pp. 24-28.)

The package will contain the following:

Text Books

1. *Dental Science Handbook*, Edited by Lon W. Morrey and Robert J. Nelsen, Superintendent of Documents, U.S. Government Printing Office, Washington, D.C.
2. *Teeth, Health and Appearance*, American Dental Association, 6th Edition, Chicago, 1966. 40 pages.
3. *Young Scientist and the Dentist*, George Barr, New York, McGraw-Hill, 1970.
4. *The Riddle of Teeth*, New York; Coward, McCann & Geoghegan, 1971, 62 pages.

Information, Catalogs, Pamphlets, Brochures

1. *Admission Requirements of American Dental Schools*, American Association of Dental Schools, 211 E. Chicago Avenue, Chicago, Illinois 60611.
2. *Dentistry — A Changing Profession*, American Dental Association, 211 E. Chicago Avenue, Chicago, Illinois 60611.
3. *Dental Admission Testing Program*, American Dental Association, 211 E. Chicago Avenue, Chicago, Illinois 60611.
- 3A. *List of Accredited Dental Schools*, American Dental Association, 211 E. Chicago Avenue, Chicago, Illinois 60611.
4. *Careers in Dental Hygiene*, American Dental Hygienists' Association, Chicago, Illinois 60611.
5. *Dental Hygiene Aptitude Testing Program and Application*, American Dental Association, Chicago, Illinois 60611.
6. *List of Accredited Dental Hygiene Programs*, American Dental Association, Chicago, Illinois 60611.
7. *List of Accredited Dental Assisting Programs*, American Dental Association, Chicago, Illinois 60611.
8. *Cleaning Your Teeth and Gums*, American Dental Association, Chicago, Illinois 60611.
9. *Fluoridation Facts — Answers to Criticisms of Fluoridation*, American Dental Association, Chicago, Illinois 60611.
10. *Your Child's Teeth*, American Dental Association, Chicago, Illinois 60611.
11. *The Care of Children's Teeth — Questions and Answers*, American Dental Association, Chicago, Illinois 60611.
12. *Orthodontics Questions and Answers*, American Dental Association, Chicago, Illinois 60611.
13. *Your Teeth and What They Do*, American Dental Association, Chicago, Illinois 60611.
14. *American Dental Association Catalog 1972*, American Dental Association, Chicago, Illinois.

It will be sent post paid upon request to the Executive Office, 7316 Wisconsin Avenue, Bethesda, Maryland 20014. The cost for each package is \$20.00. Check should be made out to American College of Dentists.

Symposium on Reciprocity

At the Conference of State Society officers of the American Dental Association, held in San Francisco on October 28, 1972 an interesting and significant symposium was held on the timely subject of Reciprocity.

Through the cooperation and courtesy of Mr. Howard I. Wells, Director of the Bureau of Dental Society Services of the ADA, we have obtained the papers presented at the Conference by Drs. Viron L. Diefenbach, Robert B. Hughlett, Robert E. Glenn, Samuel J. Oltmans and Mr. Mark Docktor. We are presenting them in this issue, without taking sides, as a service to our membership.

In the months to come, we can expect to hear a good deal more on Reciprocity as pressures mount to change existing systems. Read these papers carefully and be informed on the issues involved.

Survey of Attitudes

On Dental Licensing Procedures

VIRON L. DIEFENBACH, D.D.S.*

Dental licensing procedures by state examining boards and the matter of reciprocity between states has been a subject of lively discussion among dentists for many years. A number of states currently have reciprocal dental licensure agreements with other states. All but two states today recognize the National Board examination as fulfilling the written portion of state licensing procedures. At the same time, most states today require candidates for licensure to pass the state's own clinical examination.

Regional board clinical examinations for licensure are relatively new in dentistry, but several regions of the country—New England, the Middle Atlantic states, and the Central states—are now evaluating regional examination procedures. National or federal licensure has been opposed by the profession on the basis of intrusion in states rights to set their own standards of practice and the possible introduction of federal controls.

New publicly funded health programs, particularly those administered by the U.S. Department of Health, Education and Welfare, have created new demands for service by the health professions. Under these new programs eligible beneficiaries have sometimes not received health care because of the lack of sufficient providers in underprivileged areas. Federal and state agencies concerned with health manpower distribution and planning are now reviewing licensing procedures and the possible effects of licensure requirements on the distribution of health professionals.

Recognizing the interest and concerns of Association members about licensure, the 1971 House of Delegates adopted a resolution directing the "... Bureau of Economic Research and Statistics (to) conduct a special study of the entire American Dental Association

*Former Assistant Executive Director: Dental Health, American Dental Association, Chicago. Presented at the Conference of State Society Officers, October 28, 1972, San Francisco.

membership and related dental agencies regarding their attitudes on current licensing procedures for report to the 1972 House of Delegates."

A two-page questionnaire was developed and reviewed by staff, members of the Council on Dental Education, the Council of National Board of Dental Examiners, and officers and members of the Board of Trustees. The questionnaire then was pre-tested on 300 members.

The final questionnaire contained 17 questions pertaining to licensure and several other items about age, state, type of practice, and employment status. Of the licensure questions, about one-third were on written examination requirements; one-third on clinical examination requirements; and the remainder on reciprocity, licensure by credentials, federal licensure, internship as a prerequisite for licensure, continuing education and periodic re-examinations. The questionnaire was mailed to 114,259 active, life and student members in February, 1972. By the cut-off date in June, 76,324 questionnaires (or 67 percent) had been returned.

RESULTS OF THE SURVEY

A summary report of the survey appears in the *Supplement to Annual Reports and Resolutions*. That report is the basis for these comments on the findings. A more detailed report was published in the December issue of *The Journal of the American Dental Association*.

The responses of dentists and dental students have been tabulated separately because there are differences between the two groups in the way they answered several of the 17 questions.

WRITTEN EXAMINATION PROCEDURES

About 28 percent of the dentists but only 5 percent of the students believed "a state should require candidates for licensure to pass the state's own written examination." Nearly 90 percent of the dentists, and 97 percent of the students, believed that a state requiring a written examination "should accept National Board results as fulfilling the written portion of its requirements for licensure."

Seventy-three percent of the dentists replied that a state should accept the results of comparable written examinations of other states.

Question: "Do you believe a state should require current graduates of accredited schools to pass a written examination, either state or National Board, for licensure?" Seventy-three percent of the dentists answered yes. Only 47 percent of students said yes.

In reply to another question, dentists licensed in one state should not be required to pass another written examination for licensure in a different state, according to 58 percent of the dentists and 62 percent of the students.

CLINICAL EXAMINATION PROCEDURES

Forty-four percent of the dentists and 17 percent of the students believed "a state should require candidates for licensure to pass the state's own clinical examination." By state, the percentage of dentists answering yes to this question varied from 20 percent in Rhode Island and 23 percent in New York to 77.5 percent in Florida and 74 percent in Nevada. Other states in which more than 70 percent answered yes to this question were Arizona, California and Hawaii.

On the subject of regional boards, 77 percent of the dentists, and 93 percent of the students, indicated that states "should accept results of a regional board, if one exists in the region." In New England and the Middle Atlantic states where a regional board is functioning, 90 percent answered this question affirmatively, compared to 57 percent in the Southwest and 58 percent in the Far West.

States requiring clinical examinations should accept results of comparable clinical examinations of other states, according to 73 percent of the dentists and 88 percent of the students.

Question: "Do you believe that states should require current graduates of accredited dental schools to pass a clinical examination for licensure?" Sixty-three percent of the dentists but only 32 percent of the students answered yes.

Question: "Do you believe a state should require dentists licensed in another state . . . to pass another clinical examination for licensure?" Only 30 percent of dentists and 13 percent of students believe this to be desirable.

Question: "Do you believe a state should require dentists to show evidence of continuing education as a condition for re-registration of their license?" Sixty-three percent of dentists and 75 percent of students said yes.

Question: "Do you believe a state should require dentists to pass periodic re-examinations for license renewal?" Eighty-seven percent of dentists and 77 percent of students said no.

Question: "Do you believe a state should require current graduates to serve a year of dental internship as a prerequisite for licensure?" Sixty-nine percent of dentists and 81 percent of students said no.

RECIPROCITY AND OTHER ITEMS

Members were asked "What is your reaction to reciprocity between two states?" Eighty-three percent of the dentists favored such reciprocity.

The regional variation was from about 93 percent in New England, the Middle Atlantic states and the Central region, to 63 percent in the Far West and 67 percent in the Southwest. In all states but two, Florida and Nevada, more dentists favored than opposed reciprocity between two states.

Question: "What is your reaction to nationwide reciprocity?" Nationwide reciprocity was defined as a formal agreement among all state boards under which a dentist licensed in one state may apply for and receive a license in any other state without examination and without fulfilling any other requirement except the usual state licensing fee. Sixty-eight percent of the dentists, and 86 percent of the students, favored nationwide reciprocity. A majority of dentists in 36 states and the District of Columbia voted in favor of nationwide reciprocity; a majority of dentists in 14 states voted against it.

"Licensure by credentials," was favored by 62 percent of the dentists and 74 percent of the students.

The final question was: "What is your reaction to the possibility of national or federal licensure?" Twenty-nine percent of the dentists said they favored it, compared to 49 percent of the students. The one state in which a majority of the dentists voted in favor of national or federal licensure was New York.

In conclusion, the privilege enjoyed by the dental profession to govern itself, to determine its own licensing procedures and to set its own standards of practice is based on public trust in the integrity of the profession. That trust is likely to continue as long as the profession demonstrates that its policies and practices are in tune with the times and its foremost concern is the welfare of the public. The House of Delegates is to be commended for its farsightedness in calling for this survey of licensing procedures. The results are illuminating and instructive. What, if anything, needs to be done regarding dental licensing procedures now that the opinions of the members are known is a matter for the House of Delegates to decide.

National Reciprocity Opposed

ROBERT B. HUGHLETT, D.D.S.*

The policy of the American Dental Association was very clearly restated last year by the House of Delegates when it adopted *Guidelines for Dental and Dental Hygiene Licensure in a National Health Program*. Paragraph 3 of those particular guidelines reads as follows: "It is the right and responsibility of each individual state to protect the health and welfare of its citizens. Therefore, the American Dental Association recognizes the rights of the individual states to determine the professional qualifications of those who practice in the dental health professions."

Only at one other time in the history of dentistry in the United States has it been more essential to maintain the prerogative of the states to conduct examinations of candidates to practice dentistry within their borders. As all of you know from dental history of a hundred years ago, dental education went through a wild period of proliferation with the development of many proprietary schools, most of which were of poor quality, turning out dentists who were deficient in background and technical skills. To protect the public at that time it was necessary to develop state boards and licensing examinations. The effect of this function, of a profession working in harmony with state governments to police itself and to set standards of knowledge, moral and technical skill, was the main force that made dentistry the great profession that it is today.

Today it is just as important to the preservation of the professional image of dentistry and to the preservation of excellence in dental education to maintain the prerogative of our states to examine the knowledge, moral and technical qualifications of those who wish to practice. Those who have advocated the abolition of state examinations have based their arguments on several fallacies. These misconceptions and half-truths have been effectively repeated over and over again in a very well-sustained effort and have been effective

*Immediate past president, Florida Dental Association, Tampa. Presented at the Conference of State Society Officers, October 28, 1972, San Francisco.

in changing attitudes and opinions of dentists who have not had an opportunity to view the true situation at close range. This propaganda has been based on many fallacies, among which are such statements as the following:

1. "The poorest trained dental graduate of today is more capable to practice dentistry than the best-trained graduates of a few years ago" — therefore, examinations are not necessary.
2. Another popular fallacy often repeated states that it is impossible to determine any differences in abilities of candidates for licensure by state board examination which is conducted over a period of only three or four days.
3. Another popular fallacy avers that all graduates of modern accredited dental colleges have received equal education and are all equally capable of practicing dentistry. Therefore, they should not be subjected to the indignities of demonstrating their abilities to any "local yokels."
4. Another typical fallacy has it that state board examiners are politically-appointed amateurs with little professional standing and lack the ability to design and administer examinations.
5. State board examinations have been the cause of maldistribution of dentists, making dental services unavailable to a large portion of the population in some areas.
6. State board examinations have stifled dental education, hindered innovative approaches to the improvement of dental education, and have been responsible for the deterioration of the technical abilities of recent graduates—that have been observed and reported by many examiners.
7. No state has the right to require that those licensed to practice in the state pass an examination which involves *more than minimum standards*.
8. Another fallacy repeated more often in recent months holds that the right of the individual dentist to practice on any population group, anyplace in the United States, is greater than the interest of the citizens and the right of the individual states to determine the knowledge, moral and technical qualifications of those who wish to practice in a given state.

This question has been the subject of several legal determinations in various courts over the years. In every case to date, the courts have upheld the right, given to the states by the Constitution of the United States, to exercise their police powers for the protection of the health and welfare of its citizens. Under this right the state can set standards of education, knowledge, moral character, and tech-

nical skill for any individual who wishes to gain the privilege of serving the citizens of that state.

State legislators are concerned about protecting the public from poorly-trained auto mechanics, TV repairmen, as well as many other suppliers of personal services. Therefore, the demand by certain special interest groups among health professionals to eliminate the state examination is very puzzling to many legislators who are concerned with consumer protection and the preservation of the health and welfare of their citizens.

Another fallacy has been repeated so often in so many publications, by so many bureaucrats and by so many professional educators, that it is being widely accepted as true, when just the opposite is probably closer to the truth.

How many times in recent years have you heard this statement? "That state board examinations, in limiting mobility of dentists, contribute to the maldistribution of dentists." This is, at best, nothing but wild speculation. It has no basis in fact. No scientific study has shown that reciprocity, where practiced, has in any way helped to solve the shortage of dentists in the poor rural areas or in the inner city ghettos. The record is clear. Thousands of dentists pass examinations and move across state borders each year. However, they do not go to an under-served area because of the economics and the cultural factors involved. Neither would those who failed the examination have gone to the under-served areas, had they been successful.

The president of the Florida Medical Association, in his annual address in May, had this report to make: "In recent years we have seen several steps taken to liberalize our medical licensure law. It was the death of the basic science examination and it was the relaxation of the citizenship requirement; and, finally, licensure by endorsement. These acts have lured physicians to Florida by the hundreds. Where are they going? To Dade County, Palm Beach County, and to Broward County—not to the places where they are most needed. Four counties have no doctors at all and several have only one or two . . . Anyone who believes that lowering our licensure standards is going to solve the problem is just fooling himself."

The contention that a migratory itinerant force, large numbers of dentists who could freely move across state lines—North and South, East and West—would in some magical way solve the problem of maldistribution of dental service is nothing but an unfounded dream in the minds of social planners and starry-eyed dental students. Probably the most serious effect that would be readily observed if

universal reciprocity were adopted would be the rapid depletion of dental manpower in certain areas.

It was encouraging to note that even those in HEW who have been fostering the movement toward national licensure have finally admitted, and even put into print in one of their reports, a statement indicating that they might begin to understand the problem; and I quote: "At the Department's recent working conference on health personnel licensure, some concern was expressed that a system of nationwide recognition of licenses of other states might, in fact, aggravate the growing problem of geographic maldistribution."

The most dangerous fallacy is that dental education is infallible. That once the stamp of approval—a diploma—is granted to a dentist, that he is capable and should be acceptable anyplace in the United States to practice on any and all patients. This fallacy assumes that every dental student is equally well-educated, or well enough educated to be acceptable in any circles, and that each graduate is equally capable of rendering dental health services, or at least capable enough to render them anyplace in the United States. And yet, from a practical standpoint, anyone of you who would care to visit any of our regional examinations, or any of our individual state examinations, and spend a little while on the floor, the thing that would strike you most, in a very short period of time, is not the similarity of excellence, but the vast difference of the technical abilities of individual dentists. We all know and accept the fact that individuals vary markedly. Some dental students are born artists and can learn rapidly to render excellent dental services with a minimum of training. Other dental students have a difficult time and require the opportunity to repeat the procedures time and time again to develop a relatively acceptable degree of technical skill. Others are simply inept and never develop sufficient technical skills to render dental services well enough to complete the necessary procedures in a practical period of time.

Not only is there a noticeable and significant difference between individual candidates taking the board from the same school, but there is also a significant difference between candidates taking the examination from various schools. The candidates from certain schools consistently, over a period of years, achieve the best results, turn out the best technical procedures and are consistently successful in securing a license. Whereas, other schools consistently score poorly and maintain their position at the end of the list. This fact has been well established by many state boards and particularly by the Florida board in a recent compilation of results of the examinations from

1968-1972, which involved 1,858 candidates for licensure and represented 37 dental schools with more than ten candidates—a total of 49 schools in the study. The study also debunked another contention of those who advocate national reciprocity, and that is, that state boards tend to stifle the dental educational process and limit the amount of innovative changes in curricula. Quite the contrary is true in that the more modern, more innovative schools which have made their curriculum more relevant have consistently held top places and their candidates have been almost universally successful in the examination.

In a recent paper entitled *The Dental Examiner's View of Dental Education*, Dr. Clement Alfred, who is a member of the Northeast Regional Board, made the following comment: "Experience, over the past fourteen years, has led me to the conclusion that the majority of average board applicants exhibit poor clinical skills. . . . We are well aware of the fact that the applicants have fine training in the basic sciences, and that they are well schooled in philosophies and techniques of delivery procedures, but the final phase of their training—the utilization of all this knowledge in the delivery of actual treatment to the patient—seems to be lacking and not up to acceptable standards." Dr. Alfred also indicated that in an attempt on the part of the Northeastern Regional Board to standardize the decisions of examiners to arrive at an equitable grading arrangement, a set of guidelines were set up and the requirements were nothing more than should be expected by the faculty in the school. Although these requirements represented individual technical skills, they must be mastered in order to deliver comprehensive dental care of which they are a part. Yet Dr. Alfred states, "Nevertheless, if the guidelines are followed and the decisions made in strict observance of these rules, the rate of failures would go up considerably. One combined guess of a faculty member and myself is that as many as 40% of the candidates might not pass the operative examination." In Doctor Alfred's paper he also quoted many other sources that concurred in his opinions from his experience of fourteen years as a dental examiner.

In the last year or so, in the administration of some of the recent grants, support monies for the TEAM project, and in the accelerated curricula and per capita subsidies for increased enrollment, it has become clear that federal intervention can be a real cause of deterioration of the curricula, and probably result in the graduation of dental students even more poorly trained than in some instances now. Therefore, state board examinations are going to be necessary as never before.

Also, there is another very formidable threat. The accreditation of dental education, dental schools, hygiene, assistant and technical programs, for many years has been done through the Council on Dental Education of the American Dental Association. However, now that the federal government and the Department of HEW is supplying federal funds, conflicts develop between the proper requests of the Council on Dental Education for a school to meet standards for accreditation and the regulations that might be required by HEW. Therefore, the solution is simple and apparent. HEW soon will no longer "accept" accreditation by the ADA, but will recognize a national or federal accrediting agency so that no conflict will exist between their accrediting standards and the regulations that HEW may wish to impose. All of this will naturally affect the product of the dental school. The new dentist of the future may be graduated in a much shorter time. He may have gained a great amount of knowledge by way of the new innovations in automated learning systems, but might very well have had his training further curtailed in the area of delivery of technical skills to a point where the clinical examination by the state board will be more important to the preservation of the dental profession than it was in 1870, in the heyday of the proprietary schools.

National or universal reciprocity offers no solution to the problem of delivery of a higher quality or a greater quantity of dental service. Reciprocity will not contribute to the maintenance of high standards in dental education. It will not preserve or enhance the public image or the respect for the dental profession in the eyes of the public.

Reciprocity will only serve the intents of those who wish to gain the convenience of freely moving from place to place.

5420 Florida Avenue
Tampa, Florida 33604

National Reciprocity Favored

ROBERT E. GLENN, D.D.S.*

It is an uneasy position I take today, rising before all the leaders of organized dentistry to speak in opposition to one of its most sacred policies. But I believe that if the American Dental Association is going to be a meaningful Association, one that is truly representative of its members, it must continuously examine its policies to make certain that they reflect the attitudes of the members and that they are consistent with the best interests of professional growth.

We have shown by our recent changes in attitude, that we are willing to take new policy positions as our relationship to the health care system matures. Consider, for instance, the modernization in the past ten years of our thinking on such subjects as expanded function of auxiliaries and continuing education for relicensure. It is because of this kind of up-dated thinking on the part of our members and our leaders that the American Dental Association is today the strongest of all the professional associations.

Therefore, I rise to speak out against our current policy of opposition to a licensure system incorporating the principle of national reciprocity. I believe that there are sufficient advantages to a system of national reciprocity to make it mandatory that we continue to study the system and work for its eventual adoption.

Licensure systems, in one form or another, probably had their origin in the days of the early craftsmen who attempted to control the exploitation of their acquired skills. They jealously guarded their trade secrets and passed them on from father to son. When central government came on the scene, it took over the function of protection, not only of the craftsmen, but of the public as well. Herein lies the roots of our present system. It has spread and developed, as central government has become more complex, until now nearly everyone is licensed for some activity—be it no more than the operation of an automobile.

*Past president, Iowa Dental Association, Burlington. Presented at the Conference of State Society Officers, October 28, 1972, San Francisco.

Licensure systems now provide public assurance of competency. Whether it be for driving a car, wiring a house, drawing a will or restoring a tooth. Every level of government wants to get into the act. So I must have a state narcotic license as well as federal narcotic license. One state has even considered recently some new legislation making it permissible for cities to license professional people.

The question now seems to be: How shall the licensing mechanism properly serve its function—that of establishing the competency of the licensee and of protecting the public—without unduly restricting the freedoms of the licensee?

Let us examine the existing policy of the American Dental Association: Dr. Harold Hillenbrand, in his final report to the 1969 House of Delegates, had the uncanny foresight to see the need for organized dentistry to examine its attitudes and policies in order to determine its position in relation to the national health care system. The Task Force which was formed as a result of his recommendation represented the best thinking available. Its report was exhaustive and examined every facet of dentistry's relation to the total health care picture. It took nearly two years to prepare its report. Among the things that it reported on was the matter of national reciprocity. Two separate committees included recommendations on national reciprocity in their reports.

The Committee on Manpower concluded: "There should be a uniform national standard for licensure with complete reciprocity between the states, the District of Columbia, the Commonwealth of Puerto Rico and the U.S. territories."

The Committee on Delivery of Services, operating completely independently, made the following recommendation: "National reciprocity of dental licensure among all states, territories and the District of Columbia should be promoted."

I think it is significant that these two committees, which represented a wide spectrum of background, came to the identical conclusion that national reciprocity should be promoted.

These two recommendations were combined and in the final Task Force Report, they became Recommendation 55. When the Board of Trustees considered the 93 recommendations of the Report, they recommended rejection of Number 55 because it was "far too sweeping and unnecessary." This, of course, was the end of serious thought about Recommendation 55. In retrospect, as we look at the gigantic task the Board of Trustees faced in taking a position on each of the 93 recommendations, it is easy to understand how they would want to drop an obviously controversial one. And, if they had not

dropped it, we may still have been in Atlantic City on Saturday night.

But suppose the trustees and the delegates had accepted Recommendation 55, and suppose further that all the state boards of examiners had agreed to a national reciprocity system. Speculate for a moment on what would occur, if anything.

I cannot believe that all dentists would suddenly desert their practices and head for the mountains and the seashore.

I cannot believe that all new graduates would head for the sunshine states.

We don't see all the dentists who are licensed in this fine State of California all trying to locate in the most desirable place—which I happen to think is La Jolla. And someone else will think is Sausalito. And still another will think is downtown Burbank.

The plain simple logic of the situation is that the natural law of supply and demand will take precedence over the laws of man.

The laws of man, by the way, are mostly designed and written by attorneys. It is interesting to note that the legal profession has designed its own licensure system in such a way that it is possible for any attorney to practice anywhere in the United States by the simple mechanism of hiring a locally licensed lawyer to sit in with him on the case.

Last year's House of Delegates passed a resolution directing the staff to conduct a study of the ADA membership regarding their attitude on current licensing procedures. Dr. Diefenbach has reviewed the highlights of that report today.

The 67 percent response to the questionnaire makes this survey an exceptionally comprehensive study and it has produced some revealing statistics. One of the most interesting developments was the discovery that a majority of dentists in all the states and territories approve of the principle of reciprocity, by approving reciprocity between two states. National reciprocity is nothing more than an extension of that principle, and nearly 68 percent were in favor of that.

If the policies of our national Association are to accurately reflect the thinking of the majority of the members, perhaps we should reconsider Recommendation 55 of the Task Force.

Another survey being conducted by the Bureau of Economic Research and Statistics will shed more light on this subject. This survey is one involving recent dental graduates and one of its purposes is to determine the reasons why the dentist selected his particular practice location.

Much more can and will be said about licensure and reciprocity. We must continue to explore and improve the existing concept.

In closing, I would like to quote from a paper given by Dr. Diefenbach at the Fifth Regional Conference held in Omaha last summer. He said, "Probably the single most important action the dental profession must take at this time is to bolster the element of trust among dentists themselves. Trust in their organizations, trust in their institutions, trust in their leaders and trust in each other."

I believe that if we can achieve these trusts, we will have national reciprocity as a part of a strong, free and unified profession.

830 A No. Sixth Street
Burlington, Iowa 52601

Words of Wisdom

*He who knows and knows he knows, he is wise —
follow him!*

*He who knows and knows not he knows, he is asleep
— wake him!*

*He who knows not and knows he knows not, he is
simple — teach him!*

*He who knows not and knows not he knows not, he
is a fool — shun him!*

Arabic apothegm

Licensure by Criteria Evaluation

SAMUEL J. OLTMANS, D.D.S.*

In the last three or four years we have become deeply involved in our discussion of reciprocity. Most of this discussion has centered around the practitioners "right" to practice wherever he chooses. At no time have I heard anything about the "rights" of the patient.

The opening paragraph of the *Code of Ethics* of the Minneapolis District Dental Society begins with this statement, "The welfare of the patient is paramount to every other consideration . . ."¹. In revising the code a number of years ago, this statement was deleted. I am not certain but what this may be a sign of the times. As a member of the code revision committee I insisted upon the retention of this statement.

We do not usually discuss the monopoly which we enjoy which has been granted to us by the state in which we practice; nevertheless, we *do* have a monopoly. Consequently, we are governed and to some extent controlled by the jurisdiction that grants to us the *exclusive* privilege to practice dentistry. An editorial in the *Journal of the American College of Dentists*, July 1972² makes a special point of this privilege which we enjoy. It is foolhardy to believe that we can retain this privilege unless we are willing to place the public good on the top of our list of priorities.

It is time to remember that the citizens in the states in which we live also have some rights. It is in this area that I wish to direct my statements. Basically I do not favor reciprocity as most dentists think of reciprocity. I am against the free movement of practitioners when this movement entails no responsibility on the part of the dentist.

I have been chosen by my colleagues to be a representative from their profession to the State Board of Dentistry. I have been appointed to that Board by the Governor of Minnesota. But, I have not been appointed to necessarily foster the desires of the dentists. Instead, I am a citizen of Minnesota, with some dental background and information, sworn to protect the citizens of Minnesota.

It is a well documented fact that lay people are not really able to determine whether a dental procedure is in fact needed. Nor can they

*Member, Minnesota State Board of Dentistry, Minneapolis. Presented at the Conference of State Society Officers, October 28, 1972, San Francisco.

tell whether that service was performed at an acceptable level. The cry for peer review today bears out that fact.

All that we need now are unscrupulous, unethical practitioners who are free to move whenever things become too warm on the local scene. Just who will protect that patient? Certainly we do not need more malpractice suits.

If you can solve the problem of responsibility first, then you can resolve the problem of reciprocity. Just recently I replaced an eight unit anterior porcelain-metal bridge that had been placed three years previously. The bridge was placed by a dentist who was in graduate school—he needed the money I was told—but he was nowhere to be found when the bridge needed to be replaced. An isolated instance? Not so.

After spending 15 years on our District Dental Society Ethics Committee and four years on our State Board of Dentistry, I have become sympathetic to the complaints of many patients. They have good reason to complain. I honestly do not think reciprocity will solve this problem.

Generally speaking, the well established ethical practitioner is not about to move. It has taken him some time to build his practice. The plea is also often made to move because of ill health. Why should any state be forced to accept practitioners who for health reasons must deliver a compromise type of care. This is not performing a *better* service for *more* people.

The free movement of licensed dentists does not solve the problem of the unserved smaller community. Dentists may move from Chicago to Kansas City to Phoenix to Seattle. But they don't move from Chicago to Fulda, to Wheaton to Hinckly—all small Minnesota towns. And these are the places that really need dentists. Of 2200 active practicing dentists in Minnesota nearly 1200 of these are in the metropolitan Minneapolis-St. Paul area. The truth is, "You can't get them back on the farm."

Furthermore, when all of the dental schools in this country reach some reasonable, uniform level of teaching it will be easier to consider free movement. It is generally recognized by the profession that not only are there greatly differing levels of performance by students, there is also a great difference in training from school to school. We are a long way from optimum *maximum* performance by either the school or the student. And, the recent capitation program for funds doesn't do one thing to raise the standards of dentistry. It is another display of knuckling under to mediocrity for the sake of expediency.

I would like to summarize my reasons for not favoring reciprocity, and then to use a positive approach and offer what I consider to be a better alternative. We have tried it in Minnesota and know that it works.

First my reasons for not favoring reciprocity:

1. The primary concern of every dentist must first be the welfare of the patient.
2. We do in fact have a monopoly in practicing dentistry and as such we are subject to some of the same regulation as other monopolies. Consequently, each state has the right to protect its citizens.
3. Reciprocity will not alleviate the problems of dentally underserved areas as so many say it will. It is a "hope" rather than a fact.

Now then let us consider an alternative. In Minnesota we will consider for licensure and grant licenses to practitioners who are recognized by their colleagues to be ethical, qualified practitioners of good moral repute. I am well aware that these are all "arguable" judgment considerations, but this is true of most things in the world.

Minnesota's use of a criteria evaluation program has worked well. It does supply the Board with essential, pertinent information. It provides the opportunity for an interview. It protects the citizens of Minnesota in that the statements are made under oath and do make individuals open to perjury charges if the applicant does not supply accurate, truthful information.

Licensure by criteria approval does away with further examination except for a written test on the Dental Practice Act. Certainly this affords free movement to all qualified dentists. It provides protection for the citizens of our State. It does not provide a new source of patients for the irresponsible, incompetent dentist.

In all of this flurry about reciprocity let us move forward and explore new ideas, but let us at the same time fulfill our obligation to the public as well as the profession. Remember that the same legislature that gave you this exclusive right to practice dentistry can also take it away. We need to provide *better* dental care for more people.

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1015 Medical Arts Bldg.
Minneapolis, Minn. 55402

The Irrelevance of Licensing Examinations

MARK DOCKTOR*

It is our contention that State and Regional Board clinical examinations are no longer relevant to the nature and posture of the dental profession. They are the embodiment of licensing practices from an era when dentists were being trained by unqualified and unsupervised educational programs.

This is not to overlook or minimize the initial vital role that State Boards have played in the evolution and development of the dental profession, but simply to assert a firm belief that these governing bodies in retaining their original function are performing more of a disservice than a service to the profession and the community.

Today every dental school that is graduating dentists in this country is accredited at the national level by the American Dental Association Council on Dental Education. This means that these educational programs have received the individual critical review of this organization charged with the responsibility of assuring the highest standards of dental teaching and practice. The federal government recognized this agency to the extent that any graduate of an ADA-accredited school can practice as a dentist in any branch of government service; including Public Health, Veteran's Administration, the Armed Forces, and other federal dental services.

The present licensing system is an extension of a system nearly 100 years old. State Boards were set up in the early 1900's to maintain the quality of the dental profession before accredited dental schools existed. With today's high standards of dentistry and the additional requirement of passing a series of 14 National Board written examinations, the State Boards in their present capacity are no longer needed to scrutinize the credentials of a young graduate dentist.

*Chairman, Licensure Committee, American Student Dental Association. Presented at the Conference of State Society Officers, October 28, 1972, San Francisco.

The dental schools of the country apparently train their students adequately in the didactic and clinical sciences so that with few exceptions nearly all graduates pass the written National Board exam.¹ The student is the product of a well-regulated standardized curriculum and is the graduate of a school approved by the American Dental Association. Certainly these accredited institutions can, over four years, judge the competency of their students far better than board examiners who are given only one abbreviated and artificial setting—the state board performance test—within which to evaluate candidates.²

However, these very students, trained by the schools and associated faculties who have certified these students for graduation and awarded their dental degrees indicating competency in clinical skill performance, now are often judged by state board examiners to be unqualified to practice dentistry in that state.

The clinical exam is a highly subjective skill test and as a practical examination is not a reliable determinant of a health professional's ability.

After four years of comprehensive treatment experience, the examinee must create an artificial treatment situation for this performance test. Patients must be solicited to submit to the test (often at great expense to the student), arbitrary time allotments are established to complete a unit of treatment and diagnostic judgments are qualified often not by the patient's need but by the student's need to take the test.

Furthermore, the state examiners must judge the students in one experience which is fraught with anxiety about a patient's cooperation, in a strange clinical environment, in a generally unprofessional relationship where a single service is judged usually unrelated to the overall management and care of the patient's dental health needs.

It might be hypothesized that the dental schools have less objective tests of clinical performance than the state examiners. At best, the dental school faculties do not have ideal criteria for judging skills, but they do have the opportunities for evaluating a student during a four year period in the performance of many skills. Furthermore, the bias of one or two instructors is factored out because a student's skill is judged by at least 20 or more clinical instructors, collectively by several departments, or within any one department by at least five or six instructors. The student's scholarship and clinical skill is then reviewed in sequence by department faculties, inter-departmental scholarship review committees and finally acted upon by the executive faculty of that school.³

The entire faculty and all its committees are trained and experienced over an extended period of years to teach and to judge the clinical competence of its graduates. On the other hand, the state board examiners are unquestionably very often distinguished scholars, clinicians, and many are or have been teachers. However, there are just as many other examiners who are very competent clinicians and dedicated practitioners but who have limited teaching experience and are recommended as examiners by the state society with no other qualifications than service to their dental society.⁴

Another item for consideration is the fact that the state board examiners use their licensing procedures more as a restrictive measure than as an enabling measure to allow dentists to practice in their respective states, possibly motivated by some socio-cultural or socio-economic reasons.

There is ample evidence in a survey by the American Council of Education of the less than scientific and democratic basis for judgment exercised by examiners. The study indicated that 95 percent of examiners polled said they could judge a student's theoretical knowledge; however, only 30 percent of the deans thought they could; 97 percent of the examiners were confident they could judge the clinical skill of a candidate; only 51 percent of the deans thought they could; and, finally, 41 percent of the board members admitted a candidate's chances could be impaired depending on whom he knows and a shocking 71 percent said local residents received preference at least some of the time.⁵

The major rationale for the perpetuation of State and Regional Board examinations is that they protect the public from being exposed to incompetent practitioners. As such, State Boards claim to assess the knowledge and clinical competence of dentists.

The only criterion of interest is the level of performance of the examinee, yet it is easy to demonstrate that a host of factors other than knowledge and competence are determining who passes and fails.

For example, according to the last five years of available data, *prior* graduates of dental schools are failing state board exams at twice the rate as *current* graduates.⁶ This results in the paradoxical conclusion that the public has to be protected from experienced dentists since they are judged incompetent by state board criteria.

Also, the validity of the testing procedures has been questioned by the American Dental Association. Their most recent study, comparing class rank and State Board exam performance indicates that in practically every state there is an aberrant relationship between academic standing in the senior class and passing and failing the

exam. In fact, the same number of applicants from the lower 25 percent are certified as competent as from the upper 25 percent.⁷

In other words, it appears that the state has the prerogative to decide who can practice a health profession inside the state.

In recent years, the demand for public accountability of the health professions has been increasingly fostered by government. The major aspects of health care delivery—education and practice—have received the most critical scrutiny. It has become increasingly obvious that the systems created to assure the public of quality in these two areas—accreditation and licensure—simply cannot meet the criteria for public accountability in their present forms. Reformation can best be accomplished by the professions themselves and it would be unfortunate for all involved if it were taken out of their hands due to a lack of responsiveness.⁸

Many different laws of the country and parts of the Constitution of the United States suggest that these examinations may indeed be unconstitutional.

For example, Article IV of the Constitution says "Full faith and credit shall be given in each state to the public acts, records and judicial proceedings of other states . . ." For this reason, the various states recognize births, marriages, divorces and deeds of realty, yet they refuse to recognize dental licenses, when each would seem to be a property right clothed in the public interest.⁹

The Civil Rights Act makes plain that denial of the right to practice one's occupation may violate the equal protection provisions of the 14th Amendment. It would seem obvious that, by denying a doctor who has recently moved the right to practice his profession, a state is violating the equal protection provisions of the nation's Constitution.¹⁰

Also, in the commerce clauses of the Constitution the power is given to Congress to "regulate commerce among the several states" and prohibits discrimination in interstate commerce whatever form or method such discrimination may take. A case in 1949, ruled that a state may not restrict interstate movement across its lines in order to protect local business from competition.¹¹ A ruling such as this is especially poignant when one studies the percentage of failures of out-of-state applicants vs. in-state applicants to certain states in the country.

For the years 1967-69, an average of 12 states per year passed all 100 percent of their applicants . . . 21 states per year (55 percent of the states that fail anyone) fail a higher percentage of out-of-state than in-state applicants, nine of those 21 fail 30 percent or more of

these out-of-staters. Some states are notorious in this regard; particularly Arizona, Nevada, California and Florida. Oddly enough, these states are also those with the highest percentage of population growth, and, coincidentally, rate with the highest in mean gross income.¹²

According to an American Council on Education report, the average dentist can adequately serve about 1,000 patients a year.¹³ Using this as a basis, Americans can be said to be suffering from an acute shortage of dentists, since the current national average is one dentist for every 1,683 people.

The deficiency in dental manpower is a reality that is felt by the entire country. Taking a look at the situation among the 21 states east of the Mississippi:

- Maryland has four counties with dentist-to-population ratios of greater than 1:5000.
- West Virginia has four over 1:10,000; Alabama five over 1:15,000; Mississippi has ten counties with a ratio of greater than one dentist for 10,000 people, and of the 82 counties in the state, 71 have ratios greater than 1:3,000.
- Georgia, Kentucky, North Carolina, Virginia and Tennessee have 46 counties between them with over 350,000 people and no dentists to serve them.
- And, even Florida, where so many dentists have trouble obtaining a license to practice in the state, has 38 of its 67 counties over the national average with greater than one dentist for every 3,000.
- Hawaii may be the most ludicrous of all where one cannot even apply for a license until one year's residency has been established.¹⁴

Licensure based on clinical exams in each state serves more to discourage professionals from moving than contributing to quality control. Licensure should not have an adverse effect on the mobility of health personnel, particularly in light of the seemingly unconstitutional concept of a state licensing examination of men who already have licenses.

The law has been breached in many areas—for example, the military services do not require the performance tests for dentists to treat dental problems. Federal, state and local community hospitals do not require dentists to take these tests before they treat seriously ill patients who are hospitalized. Children's hospitals and many educational institutions do not require these treatment tests before

dentists treat newborn and growing children. These institutions, including all federal dental services treating over 10,000,000 people require only the dental degree which our dental schools grant.¹⁵

The dental students of this country are not crying out alone on this issue. Recently the American Association of Dental Schools (AADS) concurred with the Carnegie Commission in stating that a system of national licensure is dictated by today's health needs¹⁶. . . The federal government via an HEW report has recommended to congress a national licensure concept¹⁷. . . A national student health manpower conference in 1972 involving students of all the various health professions drew up mandates calling for national reciprocity . . . The American Dental Association's Task Force on National Health Programs in item #55 recommended national reciprocity between all states¹⁸. . . and, perhaps the most noteworthy item of all is the general feeling of the constituent members of the ADA. In 1968, a national survey of all dentists regarding licensure reciprocity showed that 75.7 percent of all responding dentists favor complete reciprocity between all states.¹⁹ This past spring, as if the original survey were not substantial proof of sentiment of the body of the national organization, the ADA again took a nationwide Survey of Attitudes on Dental Licensing Procedures. The results once again were conclusive as about 70 percent of all responding dentists and students favored a system of national reciprocity.²⁰ One would think this would be the voice of dentistry as a mandate calling for initiation of a system to best meet the challenges of today's society in relation to the dental health needs of tomorrow.

The deficiency in dental manpower is a reality that is felt by the entire country. There are 220 counties in the United States with five million people and no dentists to serve them. As representative of the new generation of dentists and dental students, it bothers us to have inherited this legacy. There remains an estimated 3/4 billion untreated cavities among the people of our country, 12 million people who have never seen a dentist, and only 20 percent of the people ever get to see a dentist more than once a year.²¹ Ignorance of basic health principles has significantly attributed to this widespread situation of dental neglect. We are not only concerned about these problems and beginning to channel our efforts in many directions, but we look to all others for their invaluable care and assistance.

In sum then, the American Student Dental Association of the ADA offers these resolutions for your utmost consideration:

1. *Resolved*, that clinical performance testing criteria be eliminated as a basis for licensure,
2. *Resolved*, that all graduates from an accredited dental school should be eligible for initial licensure by all states and territories of the United States without further testing, and by presentation of their diploma,
3. *Resolved*, that the quality of dental health care delivered can best be assured by a system of licensure directed toward a continued evaluation of the licensee, with effective enforcement and specific criteria for periodic re-licensure, based on uniform national standards, and
4. *Resolved*, that all prior graduates of dental schools or who are licensed practitioners should be eligible for licensure by all states and territories of the United States, without further testing, and by presentation of their license.

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College of Dentistry
New York University
421 First Avenue
New York, N.Y. 10010

You can judge your age by the amount of pain you feel when you come in contact with a new idea.

Perspectives In Dental Education*

NORMAN H. OLSEN, D.D.S.†

It is my candid opinion that the future of the dental profession is in excellent hands. Not since immediately after the second World War have we had such a wealth of talent and knowledge at the threshold to our profession as we have in our student body now. Much is written and stated in the media about the young people of today, some of which is less complimentary than it should be. Unfortunately, too little attention is given by the media to the overwhelming majority of young people who do demonstrate the admirable qualities of responsibility, enthusiasm, zest for life and concern for their fellow man, as well as a commitment to their given assignments. The student of dentistry today is interested in his school and in his profession. He has concern about his responsibility in meeting the charge that is his in providing good health care for the people in the community in which he elects to practice. Unlike the times when you and I were students and we wondered why certain situations existed within our educational program, the student now asks, why? In clinical practice most of us employ a philosophy of tell-show-and-do in training our children to be good patients for the rest of their lives. Then, why should it be anything but normal to inform students when they have questions that are of importance and concern to them relative to their educational program. The students today want to participate and by participating in different areas of responsibility in their educational program they have a much keener appreciation and understanding of the problems in running an educational institution. The students now have a much greater sense of civic pride and responsibility than during the era when I was a student. At Northwestern, the students initiated a People's Clinic for indigent patients on Saturday mornings for which they volunteer their time and talents in providing dental care to people in dire need

*From an address presented at the meeting of the Illinois Section, American College of Dentists, Chicago, Illinois, February 11, 1973.

†Dean, Northwestern University Dental School, Chicago, Illinois.

of professional attention. You might wonder how long they will maintain this interest and dedication. I am pleased to state that this program has been functioning for over three years under student direction.

Several of our students have initiated and developed a preventive dental program for the mentally retarded patient at the Lamb's Farm in Libertyville that has brought much credit, attention and acclaim to Northwestern University Dental School. One of our students, a couple of years ago, was quite upset to think that vandals had stolen the bronze plaques on the statue of G. V. Black in Lincoln Park. He unilaterally has been raising funds to replace these plaques by selling T-shirts with the bust of G. V. Black painted on the front. When I recently volunteered alumni funds to assist him, he declined, stating that he would soon be able to realize the necessary funds required through his program of selling these shirts that he and his wife have been making.

It might shock some of you to know that it is quite probable that many of us here might not be accepted by any dental school if we were to apply to a dental school today. As of this week, we have received 3,022 applications for a class of 103 in 1973. The admissions committees of the various dental schools are simply deluged with applications. The number of pre-dental, pre-medical, and pre-law students in the colleges throughout the country is almost staggering. I have been told that on many well known campuses over half of the student body are pre-professional students. This situation is bad as well as good, since it means that many well-qualified students will not be accepted and so have an opportunity of pursuing a professional career. Competition has never been keener for acceptance.

There has never been an era in dental education in which there has been a greater air of excitement than at present. It has been aptly stated that man can move mountains if adequately motivated and when goals are clearly defined. We are currently in the midst of a chapter in the history of dental education where changes in our profession are rapidly occurring. We must be sure that these changes come about only after proper planning and deliberation with a vision for the future. The profession of dentistry is one of the noblest and most respected, and in America it enjoys a position in the eyes of the public that is unparalleled throughout the world. Dentistry in the United States has a visibility and credibility found nowhere else in the world — let's be sure that we keep it this way. It is essential that educational programs do not yield or compromise to financial and

other pressures of Federal support. As practitioners, educators and administrative leaders, it is our responsibility to determine the position of health care delivery and education. It is not the responsibility of political leaders and vested interest groups to determine the destiny of the health professions. I am sure that you share my hope that we can in the future maintain health care delivery in this country on a personal basis in fairness to the public.

Some schools have adopted an accelerated three-year program in an attempt to provide more dental manpower. This is not a new concept or philosophy of education as many schools implemented this program during the second World War, and perhaps some of you are products of such a program. It is the current feeling of the curriculum committee at Northwestern University Dental School and the administration that it is our responsibility to train our students to be as knowledgeable and capable in the delivery of health care as we possibly can. Long ago, we eliminated the summer break between the second, third and fourth years since we felt that with each succeeding year there has been a vast amount of additional material for our students to learn prior to awarding them their D.D.S. degree. For the unusually talented student, we are permitting him to advance at an accelerated rate under the close guidance and supervision of the faculty. However, it is our collective feeling that four years is not too long to properly educate our students.

The Dental School, like any other educational institution, has the responsibility of evaluating objectively different concepts and philosophies of health care delivery, and it is indeed unfortunate if some practitioners have a feeling of uneasiness about well structured, objective research activities. By the same token, the educational institution in its zest for financial support must not sell its soul to the Federal Government any more than the practitioner should to the detail man.

311 East Chicago Avenue
Chicago, Illinois 60611

The Future Role of Government in Dental Practice and Education

WALTER A. WILSON, D.D.S.*

Governments at all levels have long been involved in one way or another in the process of providing dental services to the people. From the establishment of the first Boards of Dentistry at the end of the last century, it has been government which has decided who could practice dentistry, how, and the qualifications of those permitted to do so. Likewise it has been government, directly or indirectly which has set the standards for our dental educational institutions, be they public or private, through State regulations.

To be sure, compared with today, it was not "big government" and most of the authority was placed in the hands of our own profession, our own peers. There was little thought of government domination of the profession or the practice of dentistry by the government, except in a very elementary way by the armed services, mostly emergency treatment or by school systems in clinics for children, generally quite inadequate in their services. City hospitals rendered some forms of emergency services for indigents, usually performed without compensation by volunteer dentists.

PAST GOVERNMENT PROGRAMS

In the early thirties during the so-called great depression Federal and State governments became involved in rendering dental services with two objectives: (1) to furnish needed dental services for those desiring same who found themselves suddenly without funds to purchase accustomed health services, and (2) to furnish employment for dentists whose supply of patients and income had dwindled substantially because of the great financial debacle.

*Dean Emeritus, Fairleigh Dickinson University School of Dentistry, Teaneck, N. J.

The Emergency Relief Administration, referred to as E.R.A., one of a long list of three or four lettered federal agencies which sprung up then and which have continued in format as designations for various federal commissions and agencies, managed and financed this dental service with the cooperation of the dental societies at all levels.

It cannot be said that the program was without some virtue nor can we be too proud of the emergence of the human frailties which were manifested by both political and professional participants. Abuses, both professional and political interfered with a service which could have played a significant part in enhancing dental health. With the end of the depression, however, all seemed glad to go back to the private practice of dentistry, dentists, and clients alike. Only the political bureaucrats missed their jobs.

HUMAN FRAILTIES IN MASS PROGRAMS

We mention these early examples of human frailties in the plan because in the evolution of mankind in its so called civilization, human nature does not change much and cannot be transformed by mere laws. It is this human nature which is so often forgotten or purposely ignored which will be fundamental in the planning of future national health plans. The success or failure of all mass programs, be they health, housing, education, environment, economic, transportation or whatever depends primarily on the integrity and ability of those who operate them, with the former, integrity, most important. It is this element which also contributes to the excessive cost of large government operations which need so many checks and balances ostensibly to try to assure the government that they, the taxpayers are getting honest value received. Thus the cost of these checks and balances and the large number of people required to conduct them adds enormously to the cost of the operation which the taxpayer eventually pays for the services rendered. It seems obvious that with so many unproductive people added to those rendering dental service, the cost is bound to exceed the previous cost of private practice.

Thus it is incumbent upon the leaders of our profession to take a good look at schemes, legislation and propaganda which are offered as panaceas for the idealistic furnishing of adequate dental service for all of the people. We now have the best dental care available in the world and we must keep it that way. That many are denied this service for lack of funds and facilities is certain but we cannot

sacrifice quality for quantity in a system which would threaten the very foundation of dental progress. It may well be that the answer to better distribution of dental care will be found in the overall adjustment of the economic framework of the whole society. It need not be a foregone conclusion that because foreign countries have turned to socialized health services that the United States need go hell-bent in the same direction.

This is still the U.S.A. with its own concepts of an independence of life, liberty and freedom which has a record of achievement second to none and we should continue to support that way of life. This also includes that irreplaceable element of *incentive* which leads to progress and perfection. If we drift down that path of paternalism wherein all responsibility for our health or anything else is placed in control of bureaucratic governmental agencies and the people are deprived of their ingrained American virtue of incentive, it will then not take long before the prevailing attitude of our people will be changed from one of independence to one of "let Uncle Sam do it" with a certain decline of our great country in principle and substance.

The defense of this principle has been scoffed at in recent years by those who would like to see all but their own vocation socialized or those who prefer to avoid all personal responsibility. They apparently believe that we can remain just a little socialized. This is like being just a little pregnant and is just as progressive. Once started it can only be stopped by a risky abortion.

RESPONSIBILITY FOR DENTAL SERVICE

The American Dental Association recognized the implications of the trend toward the socialization of the health professions many years ago. The Council on Dental Health was established in the early forties with a major emphasis on ways and means to guide dental health in the American way. As a member of that Council for seven years the writer was on a subcommittee which, if our memory serves us, came up with the following as one of the fundamental principles of providing health service:

"The responsibility for the health of the American people is first of the individual, the community, the State and the nation and *in that order*." Somewhere it appears that this principle has been lost or else by recent political moves we have been cornered into acceptance of a new order.

The word "inevitable" crops up in all discussions of mass health care — now usually called "National Health Insurance." We are told

it is "inevitable" so we should go along with the best we can get out of it.

Is this any truer now than 30 years ago? Is it more inevitable and do we accept the old cliché, "if it is inevitable, relax and enjoy it"? Before this is in print probably a dozen bills will be in or ready for the hopper of the 93rd Congress to socialize, by whatever other name, the health services. Whether it is the Kennedy or Nixon or A.M.A. defensive legislation, it means the same thing — government health service with all its frailties.

To be sure, much needs be done to make our dental health distribution methods more adaptable to our present needs. As in all facets of life the tremendous population growth and the greater sophistication of our professional knowledge and techniques have made it difficult to provide all of these finer services to any sizable proportion of the population, even those who want it. It is perhaps true that the proportion of those needing dental services but not getting them is about as great as thirty years ago and probably for the same reasons: financial, lack of dental health consciousness and priority for the dollar against cars, T.V.s, luxury homes and clothes and now added lottery tickets.

How can quality dentistry be made available in the future to more people and avoid the added cost of bureaucratic operation? Much groundwork has been laid by the profession itself in developing prepayment plans, dental service corporations and various types of insurance plans and benefit plans in unions and industry. Likewise the promotion of preventive programs including fluoridation of communal water supplies and topical application of fluorides has been effective. Research into the causes and prevention of dental disease by individuals and institutions, mostly supported by government funds has made much progress.

THE FUTURE ROLE OF GOVERNMENT

Herein lies the proper role for government in future dental health service. Dental disease IS preventable and every available means must be utilized to eliminate the need for widespread restorative dental services. It is a long range program but obviously the most practical one and one in which government can productively and safely use its facilities and financial resources for the greatest good for the greatest number without sacrificing the independence of the people and incentive of the profession.

Dental education with its over fifty dental schools and dental hygiene schools, needs to maintain individuality and freedom of

thought and action as well as incentive for its future advancement just as do the practitioners of the profession. It seems to us that as long as government is needed to contribute to dental education it should be done in a manner which will not perpetuate the shortage of dental practitioners with a continuing demand for more and more reparative service. Rather federal money could be channelled through the schools to be spent on dental health and education for the greatest good to mankind. It could avoid the development of a massive federal health bureaucracy by spreading the funds by State and local distribution in accordance with the need and nature of the facilities involved. Likewise the collective funds could include the contribution to sophisticated dental health education programs to promote the public acceptance and application of preventive measures. With long years of preventive dentistry information available, we have only scratched the surface in its full application for the public good. A more intensive effort with government help in this direction is not only possible but imperative if we are ever to fulfill our obligation to eliminate dental disease. Certainly this will never be accomplished by any system of supplying dental repairs by government subsidies. Much of this effort could be directed to the early preventive care of *all* children in the elementary schools or other children's dental health centers, including the elimination of all tooth defects and irregularities. If carried out to its practical end, the need for massive public treatment of adults would be unnecessary and all talk of need for greater and greater numbers of dentists to be educated could be brought into proper perspective.

BETTER USE OF AUXILIARY AIDES

The more efficient use of all of our dental personnel could be better organized without depriving the people of the services of qualified professionals. Dental educational institutions can be depended upon to provide the kind of training which our personnel will need to meet the future demands for this kind of service. Restorative service will be needed for some time in this long-range program and will be paid for by those who wish to give their dollars priority for dental service over less valuable items whether by cash or the other insurance and benefit programs aforementioned.

It would not require the injection of federal government supervision or control of our institutions and it would place a premium on the individual's contribution to his personal welfare, where the major responsibility belongs in a free country.

IS GOVERNMENT TAKE-OVER INEVITABLE?

Is government take-over of dental health service inevitable? Not if we follow the aforementioned vigorous program of prevention, research and early treatment of all children and if government is restricted to the expenditure of its vast funds through the States and communities to the educational institutions and hospitals. If the American people can be fully informed of the wisdom of such a program they will work to save their own treasured incentive, independence and freedom.

Perhaps we have done a little flag-waving about a system which has brought us so far, but God knows that if we stop waving that flag someone else will tear it down. Call it what you will, socializing of our health institutions is one sure way to take us down that path of no return.

67 Hornblower Dr.,
R.R. 1, Box 175 A.
Waretown, N. J. 08758

If you do not want to bear the light burden of education, you will have to bear the heavy burden of ignorance.

Moses Ibn Ezra

Hospital Dentistry

Its Past, Present, and Future*

MALVIN E. RING, D.D.S., M.L.S.†

Dentistry, after a long upward struggle, has earned for itself recognition as a full-fledged and equal member of the important health professions. The duties of dentistry include the maintenance of health not only of the oral cavity, but of much of the face as well. Dentistry undertakes to treat these areas when they are affected by disease or abnormality, and as a result dental care has a direct bearing on speech, mastication, digestion, expression and appearance. It is not difficult to see how in helping to maintain these functions dentistry contributes immeasurably to human health and welfare.¹

The Constitution of the World Health Organization defines health as a state of optimum physical, mental and social well-being. The connection between dentistry and health is readily apparent.

The Council on Medical Education defines a hospital as an institution organized to "... supply all, or any recognized part, of the complex requirements for the prevention, diagnosis and treatment of physical, mental and medical aspects of social ills." Note that nowhere in this definition does it say that this treatment must stop at the level of the chin and resume at the level of the eyes.

Therefore, it would seem elementary that care of the *whole person* would be the goal of the hospital, with an eagerness to have care rendered by whoever is most qualified to perform it. Unfortunately, this is not the case with many hospitals, as shown by the current status of hospital dentistry and a review of the struggle on the part of the dental profession to secure for itself its rightful place in the hospital environment.

*Presented at the dedication of the Dr. Morris J. Kowal Library, Wasył Pluta Center for Oral Health, The Genesee Hospital, Rochester, New York, November 12, 1972.

†Assistant Professor of Clinical Dentistry, School of Dentistry, State University of New York at Buffalo, Editor, *The Bulletin of the History of Dentistry*.

MEDICAL ATTITUDES

Since hospitals have been generally under the control of the medical profession, there has existed a misunderstanding of the nature of the service rendered by dentistry, as well as a snobbishness on the part of the holders of the M.D. degree which has caused them to look down on the dental specialist, seeking a place on the hospital staff, as an upstart who did not know his place, or an interloper intruding where he did not belong. He must be seen but not heard in urgent dental situations which might arise in the hospital, problems with which the physician could not cope. Physicians felt it beneath their dignity to accept an "outsider" except when toothache compelled fraternization. "They thought of him as a repair man who handled teeth as if they had been of the prosthetic variety in the first place."²

The dentist, for many years beset by this attitude, reacted by developing an inferiority complex, a humility which caused him to accept this second-class status, this position of inferiority, vis-a-vis his medical confreres.

HISTORICAL CONTRADICTION

But the lessons of history teach us that this attitude is a wrong one. We go to history not only for a guide to future action but in order either to support or counter current attitudes. And history shows us that it is high time that dentistry repudiate this unfair second class status and demand its full rights. Dentistry has been charged by law with responsibility for the maintenance of oro-facial health; it is now time that this responsibility be fully implemented in every modus of service, including the hospital.

The picture is not uniformly bleak in the many hospital dental programs across the nation, such as the excellent new Wasył Pluta Center for Oral Health of the Genesee Hospital in Rochester, New York. These hospital programs were established either willingly by far-seeing administrators or else instituted by the pressure of organized dental groups after years of prodding reluctant hospital staffs. However, after establishment and operation of a dental service, the hospital administration is readily convinced of its value. In some institutions, dental staff members have been elevated to positions of leadership. Several years ago it was in the Montefiore Hospital in New York where the dental department was so successful that the chief of the service was elected to the presidency of the staff.³

HOSPITAL DENTISTRY SINCE ANCIENT DAYS

The exclusion, or neglect, of the treatment of dental and oral ills from the hospital routine is relatively recent. In ancient days dental care was not separated from general medical care. In ancient Greece the Temples of Aesculapius were, in effect, early hospitals. To these hospitals came sufferers of a variety of illnesses and afflictions in order to consult with the priests of Aesculapius, the god of healing. After listening to a description of the symptoms, the priest gave the sufferer a sleep-inducing potion, after which the patient slept in the Temple. During his sleep the god appeared to him in a dream and told him what steps to take to cure his illness. After he was cured, he often returned to the Temple with a votive offering to the god, thanking him for his recovery. These offerings, many of which have been recovered in archaeological excavations, were stone plaques on which were carved pictures of the affected part: a foot, a hand, a liver, and in many cases a jaw, a tooth or even whole sets of teeth.

Other than these temples, no true hospitals existed in the ancient world. In ancient Rome, for example, the wealthy patrician consulted his physician in his home; the poor man had no medical care.

ORIGINS OF THE MODERN HOSPITAL

To find the beginnings of modern hospitals we must go back to the late middle ages. At that time the institution of the "hospice" was established, and it is from this word "hospice" that the word "hospital" derives. The hospice was a shelter for pilgrims and wayfarers, generally being attached to monasteries. In time these became lodging places for the aged and infirm. And because these groups were frequently suffering from illnesses the hospice became, although only incidentally, a place where they received the meagerest of medical treatment. And yet, in the face of even this limited patient care, dental procedures have positively been placed in these early historical hospitals. This is borne out by the finding in the surgical armamentarium of the 12th century Pantocrator Monastery of several odontagra, instruments used exclusively in dental surgery.⁴

Later still the bishoprics established hospitals, as they had come to be called, with the famous St. Bartholomew's in England being founded in 1123 and St. Thomas' in 1200. However, the emphasis was still primarily on caring for the traveller and ministering to all varieties of the unfortunate. In France their function was even more clearly related to their name, "Hotel" (hostel), with the first one, the Hotel Dieu being founded by St. Landry, Bishop of Paris about 600 A.D.

Abominably poor public hygiene in medieval Europe contributed widely to the spread of disease, and the fear with which leprosy was viewed stimulated the establishment of special hospitals for lepers, more places of isolation than of treatment. Because of poor diagnostic measures, persons suffering from a wide variety of other skin afflictions were classed as lepers and these unfortunates were shut away in lazarettos as they came to be known after the order of St. Lazarus, whose principal duty was the care of the leper. Since such a large part of the population suffered from skin diseases, more and more of these hospitals were built, until they numbered in the thousands in Europe alone. And the significance of these institutions in a historical context is that they established the tradition for the building of special hospitals in order to treat special problems and special diseases.

With the disestablishment of the Church in England, all religious institutions were seized and confiscated by Henry VIII, and among these were the monastic hospitals. St. Bartholomew's and St. Thomas' were reopened sporadically and maintained by private contribution; in the reign of Edward VI these institutions became, in a sense, municipal hospitals.⁵ From this time forward, hospitals in England were built and supported by public funds. A wave of hospital building got under way in the 1700's with Westminster Hospital, Guy's, St. George's and the London Hospital being built in the years between 1720 and 1740. Quite pertinent to our study is the fact that in England in the early 1800's dental care was considered as among the proper functions of a hospital when Joseph Fox received the appointment of dental surgeon to Guy's Hospital and Thomas Bell, a member of the Royal College of Surgeons, was named as Lecturer on Anatomy and Diseases of the Teeth at the same hospital.

HOSPITAL DEVELOPMENT IN AMERICA

In the American colonies hospital service was far inferior to that of the mother country. For more than the first 130 years no true hospital existed in the thirteen colonies. The closest thing to a hospital was the pest-house, whose principal object was to protect the populace at large by shutting away sufferers of communicable diseases. These pest-houses were commonly located on islands, with Boston opening one in 1717, followed by Philadelphia, Charleston and New York.

At about the same time another institution came into being; the almshouse, workhouse or poorhouse as it was variously called. In 1731 the city of Philadelphia founded an “Almshouse and House of Employment” for the aged and infirm poor of that city. That care of the sick was only incidental is indicated by the fact that the first physician was not appointed until 1769, and then only on a part-time basis. There existed a general tendency to lump together the physically handicapped, the sick, the socially unwanted and the poor. Thus in Charleston, South Carolina, St. Phillip’s parish church obtained permission to raise funds to build and support a “hospital workhouse and house of correction” and this was built in 1738.

The first general hospital as we know it today was established in Philadelphia in 1754, but as late as 1770 New York City was without a hospital. In 1769 at the graduation exercises of the first medical class of Kings College (later Columbia University) Dr. Samuel Bard made a plea for the establishment of a hospital in New York City where the sick could be cared for and medical students instructed. Two years later, in 1771, the Society of the New York Hospital was organized and built a hospital which burned down when it was almost completed. Undaunted, the Society started again and in 1776 another building was erected, but no sooner was it completed than it was immediately seized by the British and used as a barracks and military hospital. After the Revolution, in 1791, The New York Dispensary opened its doors.

ORIGINS OF HOSPITAL DENTISTRY IN THE UNITED STATES

A few years before this, in 1788, a young dentist Richard Cortland Skinner had immigrated from England to Philadelphia. He was very well trained for his day, having studied in London under Bartolomeo Ruspini, one of the most noted dentists of the time. In 1791, the year the New York Dispensary was established, Skinner moved his practice to New York and almost immediately offered his services to that institution as dental surgeon, proposing to treat the dental ills of indigent patients. His offer was gladly accepted and the following letter signals the establishment of the first hospital dental clinic in the United States:⁶

New York, Sept. 2, 1972

Sir:

The Board of Managers of the Dispensary received yours addressed to them; — they directed me to acquaint you of the acceptance of your offers, in such cases as may be of avail to the Dispensary. It gives pleasure, Sir, to find that an institution founded upon such motives, will meet with your benevolent attention.

I am, Sir, with respect
Your obed't. Servant
Wm. Cock, Secr'y.

Mr. Skinner
Surgeon-Dentist

It appears that Dr. Skinner, as a result of his early connection with the Dispensary, developed close associations with faculty members of other institutions of higher learning, and it is probable that he also consulted with them in the course of his professional activity. That they were also patients of his is evident in an advertisement he placed in the *New York City Directory* for 1802 in which he thanks for their patronage the "... Chemical and Medical professors of Columbia College, and many of the Physicians and Surgeons of this City."⁷

We have in the career of the eminent Richard Skinner evidence that dentistry in America has been closely associated with hospital service from almost the time the first hospital in New York was founded.

LIMITED PROGRESS

After this auspicious beginning little further progress was made in putting dentistry in the hospital. However this is not surprising in view of the fact that early hospitals, as noted earlier, were considered primarily as refuges, as places for the homeless sick, and this is attested time and again by the early charters and records of these hospitals. This attitude hung on for many years; as late as 1908 the Massachusetts General Hospital would admit only poor, non-paying patients.

The idea that better care could be given patients in hospitals is a relatively recent one, and did not evolve until after the Civil War. Added to this was the fact that the death rate in hospitals was shockingly high, ranging from 15 to 20 per cent of admissions. No wonder then that hospitals tried desperately to keep people from being admitted, excluding from admission, for a wide variety of reasons as many sick as they could. In fact, the Hotel Dieu of Montreal in 1817 would not accept as a patient anyone suffering from any type of fever!⁸

GROWTH OF PRIVATE HOSPITALS

As a result of these exclusion policies hospitals owned by private practitioners began to spring up and one of the earliest was a dental hospital. The *Porcupine Gazette* of Philadelphia for December 15, 1797 carried a notice by a Doctor Duvivier, a surgeon formerly from Paris, advertising that he "... performs all the different operations appertaining to the dentist's and the surgeon's art..." further advising that he had in his house "commodious apartments" for the lodging and boarding of any patient who wished it.

This early private dental hospital was followed by others, the most notable being that founded in Wheeling, West Virginia in 1850 by Simon P. Hullihen, the Father of Oral Surgery. Hullihen, after successful home study, was awarded an honorary M.D. degree by Washington Medical College of Baltimore. In 1835 he moved to Wheeling where he practiced dental, oral and general surgery. By his exceptional competence in both medicine and dentistry he achieved high public respect and esteem, and he was able to bring to fruition his life-long dream of a hospital for oral surgical procedures. This began as a private infirmary in East Wheeling, but soon thereafter with the aid of a Catholic religious order he succeeded in founding the Wheeling Hospital. His surgical accomplishments during his short twenty years of practice before his death were most impressive: over 100 harelip operations; 50 for cleft-palate; 200 antrum cases; 200 cataract removals; 25 "new noses"; 50 "new lips"; and 10 rebuilt mandibles; these in addition to over 400 other types of general surgery.⁹

THE FIRST HOSPITAL EXCLUSIVELY FOR ORAL SURGERY

This tradition of hospital dentistry was carried forward by James E. Garretson who was graduated from the Philadelphia College of Dental Surgery in 1856 and received his M.D. degree in 1859. In 1869 he was appointed Oral Surgeon to the hospital of the University of Pennsylvania, thus achieving for oral surgery the first official recognition of its status as a distinct specialty of dentistry. Six years later he was appointed to the faculty of the Philadelphia Dental College, and in order to improve the facilities for teaching oral surgery he erected a Hospital of Oral Surgery. This first hospital devoted exclusively to oral surgery had "... but two cots, a few sheets and a place to keep dressings; the food was obtained from a nearby restaurant and the students served in the capacity of

nurses.”¹⁰ Because of the constantly increasing demand for oral surgical services this hospital was merged with the Medico-Chirurgical Hospital of that city, and in his honor the name of the hospital was changed in 1897 to the Garretson Hospital, a name it retained until 1907 when that hospital was absorbed by Temple University. Thus Garretson was instrumental in firmly establishing oral surgery as a full-fledged department of a modern hospital.

SPREAD OF HOSPITAL DENTAL SERVICES

By this time it was apparent that a hospital which proposed to treat the sick properly must include a dental department, and to this end the Massachusetts General Hospital, in a pioneering move, established an out-patient dental department in its own building as early as 1867.

In 1900 Dr. Robert H. Nones, dean of the dental department of the Medico-Chirurgical College in Philadelphia established a dental service in the Philadelphia General Hospital. The new service consisted of one appointee from each of three dental schools in the city: University of Pennsylvania School of Dentistry, Pennsylvania College of Dental Surgery and the Philadelphia Dental College (now Temple University School of Dentistry.) The first dental interns in the United States were appointed at the Philadelphia General Hospital in 1901. Oral surgery clinics, which were held regularly and were attended by medical students as well as the students of the dental colleges of the city, continued until World War I.¹¹

In this early undertaking almost three-quarters of a century ago was set the pattern for hospital orientation for dental students and hospital practice of dentistry which is still followed today.

A NATIONAL RESPONSIBILITY

Finally, all of this activity in the several hospitals which provided dental services came to a head in 1922 when a special committee of the American Dental Association recommended action to encourage the establishment of hospital dental services universally. But action languished, and it was not until 1944 that the A.D.A. Committee on Dental Education established a Special Committee on Hospital Dental Service headed by the eminent oral surgeon and dental historian W. Harry Archer, charging the Committee with the creation of a set of standards. These “Basic Standards of Hospital Dental Service Required of Approved Hospitals” were published in 1946,

and the new constitution of the American Dental Association adopted in 1948 provided for a Council on Hospital Dental Service, which was to be given the responsibility of directing all hospital dental programs.¹²

SLOW RESPONSE BY THE NATION'S HOSPITALS

Did hospitals lacking dental services rush to establish them? Sad to say, few did. Primarily responsible for this neglect was the earlier mentioned unenlightened attitudes on the part of the medical staffs toward dentistry. But coupled with this was the timidity of the dental profession which hesitated to insist on the rights due it. This timidity was a result of dentists not being aware of the long historical connection of dentistry and hospital service; in spite of the fact that dentistry had had close association with hospitals for many more years than many of the other medical specialties such as ophthalmology, psychiatry and physical medicine.

In addition dentists have traditionally practiced solo-fashion—one man, one office. Many of the dentists in practice today are accustomed to working alone and it is foreign to their experience to practice in a co-operative environment; too, they failed to receive instruction in hospital procedures. However, dental students today are being trained in hospital methods and it will be as natural for them to practice in a group as it is for the older practitioners to work alone. Moreover, an increasing stress is placed in the literature and in education today on consultation with one's colleagues as being the key to rendering better service. As it was admirably expressed at a Canadian seminar on hospital dentistry: "The minor advantage of a hospital to us is its equipment and facilities. The major advantage is consultation and mutual assistance. This is the keystone in the total health concept."¹³

HOSPITAL DENTISTRY AND ITS PROBLEMS IN ENGLAND

In England things were moving slowly in a similar fashion. Because of the exigencies of World War II, dental surgery had developed as a highly complex branch of jaw and facial surgery, and won recognition as a medical as well as a dental specialty. It became the common practice at that time to have dental surgeons attached to the general hospitals in England. But the old reluctance on the part of the medical profession to grant equal status to their dental colleagues showed itself here too; but this the dental profession fought. The old division between medicine and dentistry seemed no

longer applicable to hospital dentistry, and the small body of hospital and consultant dental surgeons wanted due recognition of their expertise.¹⁴ And where they were not receiving it, they tended not to affiliate. Since the medical staff could not fill the need the shortage was quickly apparent, and it led at least one progressive physician to exhort his colleagues: "We need more dental doctors . . . We cannot expect to get them unless we give this medical specialty the honour which is its due and the partnership which, on theoretical and practical grounds, it deserves."¹⁵ And as though to support this position the Royal College of Surgeons in the early 1950's established a section of dental surgery, on a par with all the other branches.

HOSPITAL DENTISTRY TODAY

In America today dentistry is being practiced in hospitals more widely than ever before. Long-term hospital patients, at least in the major population centers, are at last receiving total health care which includes dentistry. In most general hospitals this care is limited to oral surgery and exodontia.

Increasingly, however, hospital dentistry has come to cover a multitude of procedures. Mentally handicapped children, or those incapacitated by crippling diseases are receiving comprehensive care in hospitals. The growing science of implantology is expanding the role of the hospital in dental treatment. The periodontal health of the patient is increasingly being recognized as of the most intimate importance concerning generalized infections, and periodontists are finding themselves called upon more and more frequently by the physicians to help in the general care of the hospitalized patient. A recently reported case¹⁶ where a 56 year old man, apprehensive about dentistry to begin with, and with a history of glaucoma, diabetes, osteoarthritis, hypertension and tuberculosis was able to have very extensive, and very much needed, dental care rendered in the hospital by a periodontist and prosthodontist working together, points up the fact that there are a myriad number of possibilities for better, and fuller, treatment of the population, treatment which is presently neglected.

To arrive at a state where complicated treatment such as that described could be performed was not easy. The experience of dentists in a Minneapolis hospital, for example, is typical of the stumbling blocks put in the way of hospital dentists across the nation. In 1950 a dental staff was set up in this hospital as a

sub-section of the surgery staff. This complicated matters as no independent decisions could be made without the "assistance" of the hospital surgeons. It was found that the elective dental cases did not have the same priority as the elective surgery cases. But after years of mounting pressures from the Dental Staff, it was finally granted independent staff status, no longer under the supervision of the Surgical Staff. For the first time "equal rights" were given in essence to the Dental Staff, in that it was able to make its own decisions, elect its own officers, hold its own meetings and establish its own priorities on elective cases to be done under general anesthesia.¹⁷

With the advent of insurance and pre-payment plans dentistry has increasingly been performed in hospitals by practitioners who seldom before utilized hospital services. In fact, overutilization by dentists who lack adequate training in hospital procedures and the management of surgical patients has caused some hospitals to curtail and restrict their activities, a possibly necessary but unfortunately regressive step.¹⁸

Nevertheless, better preparation of dental students in hospital procedures is fast doing away with this problem. Coupled with this is the self-policing being done by the hospital dentists themselves. This began in 1939 with the founding of the Metropolitan Conference of Hospital Dental Chiefs of New York City. Headed by Dr. John Oppie McCall this organization blazed the trail for the recognition of the vital role hospital dentistry plays in the total health care of patients. It took years of work and patient determination to elicit recognition for this old, but seemingly new, and significant area of health care from the dental as well as the medical profession. Because of constantly growing interest, the Metropolitan Conference expanded to national scope and in 1961 held the first meeting in Philadelphia, at which the American Association of Hospital Dental Chiefs was founded. Literature followed soon after organization, and in 1967 the official organ, the *Journal of Hospital Dental Practice* was launched.¹⁹

It has become increasingly apparent today that dentistry can no longer be held back from assuming its full role in the hospital. More important, however, is the fact that dentists are now beginning to see themselves as an essential and integral part of organized efforts to provide service through the pooling of many kinds of human and material resources. But coupled with this is a determination to be self-directing, to decide not so much *what* they will do as on deciding *how* they will do the tasks within their area of responsibility, and on having leeway to expand that area. "They want to gain satisfaction

and recognition, including advancement, from working close to the highest level of their competence; they believe that the other professions and hospital administration know too little about the scope of their training and experience to pass effective judgment on what the boundaries of their areas of responsibility should be."²⁰

Dentistry is a profession with a long and noble tradition of service to mankind. It has been in hospitals since almost the days of their founding in this country, and now once again is finding its future expanding in that environment which offers such dynamic possibilities for more and still greater service. And in these endeavors dentistry will not take a back-seat to medicine or any other profession.

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Letter to the Editor

Not only justice, but the interests of the profession and the good of the public, demand that the dentist should receive a liberal compensation for his services. Every person is justly entitled to such a reward for his labor as shall enable him, by prudent management, to obtain a comfortable support, and lay up something besides.

The men who would make the best dentists cannot be induced to enter the profession, unless there is some encouragement of their receiving a fair remuneration for the time, labor and money it may cost them to prepare for practice. No man can afford to spend the time and money necessary to obtain a thorough dental education, and avail himself of every facility to enable him to practice dentistry to the best advantage, unless he can receive for his operations what may seem to those who consider only the time spent in performing them, a high price.

No dentist, however high his reputation, has any right to demand exorbitant prices; but every one who desires to see the interest of the profession advanced, should feel bound to take a firm stand for reasonable remuneration.

Experience has convinced me that unless a dentist is well paid he cannot do justice to his patients without doing injustice to himself. There are cases in which it is our duty to operate at reduced rates, or even gratuitously, and no man of generosity would refuse to do so. But let me urge every young dentist, as one of their number, never to operate, except under peculiar circumstances, for any thing less than will enable him to do the best in his power for his patient, while, at the same time, it secures to himself a just compensation.

A. M. Hooker

As you may suspect, this letter was not directed to the Journal of the American College of Dentists, but was sent to the editor of "The Dental News Letter" and is dated May 1852. It was called to our attention by Fellow C. Douglas Hoyt of Fair Haven, N.J. We print it herewith for we believe that the opinions expressed over 120 years ago are still valid.

NEWS OF FELLOWS

(Continued from Page 72)

Dr. Albert Wasserman of San Mateo, California has received Mastership in the Academy of General Dentistry at its annual convocation in San Francisco in October 1972.

An annual student award has been established by the School of Dentistry, in honor of Dr. Walter J. Pelton, who has retired as assistant dean for auxiliary programs and chairman of the Department of Community Dentistry. Dean Charles A. McCallum announced that the Walter J. Pelton Community Dentistry Award will be presented each year at graduation to the senior student who has best demonstrated potential for leadership in efforts to improve the oral health of the public.

Dr. Harold Sherman has been appointed professor and chairman of the department of Operative Dentistry, of the College of Dentistry, Brookdale Dental Center of New York University. Dr. Sherman was previously on the staff of Columbia University School of Dental and Oral Surgery.

Fellow Reuben L. Blake of San Francisco, orthodontist, teacher, editor and artist has been named Alumnus of the Year by the Alumni Association of the School of Dentistry of the University of the Pacific.

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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