The JOURNAL of the AMERICAN COLLEGE of DENTISTS

The College Today

Equitable Faculty Compensation

Dental Hygiene Education

Dental Fees, Productivity and Income

July 1974

MEMBER PUBLICATION
AMERICAN ASSOCIATION OF DENTAL EDITORS

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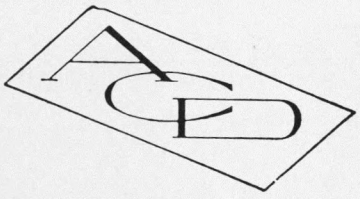

NEWS AND COMMENT

ANNUAL CONVOCATION PROGRAM

WASHINGTON HILTON HOTEL **NOVEMBER 8 & 9, 1974**

REGISTRATION

Candidates for Fellowship and their sponsors will register on Friday, November 8th between 2:00 and 8:00 p.m. at the Registration Booth in the hotel.

ORIENTATION PROGRAM

One of the requirements for Fellowship is attendance at the Orientation Program. This will be held at 8:00 a.m. on Saturday, November 9th. Sponsors and families of the candidates are welcome to attend also. A continental breakfast will be available at 7:00 a.m.

GENERAL MEETING

The annual meeting of the College will take place on Saturday at 9:00 a.m. in the International Ballroom West. When the business session is completed, a panel discussion will be presented on the topic, "Alternatives in Meeting Oral Health Care Needs".

The panelists will be:

Robert B. Hughlett – Tampa, Florida
Chairman of the Council on Dental Care, American Dental Association.

Lincoln Reilly – San Fernando, California
National Dental Consultant for the Connecticut Life Insurance Company.

Merrill Packer – Washington, D.C.
Acting Director of the Division of Dentistry, Bureau of Health Resources, Health Resources Administration.

Max H. Schoen – Stony Brook, N.Y.
Professor of Dental Health Services, State University of New York.

Stuart Weinstein – Chicago, Illinois
Director of Marketing Information, National Association of Blue Shield Plans.

John E. Sparks – Detroit, Michigan
Assistant Director, United Auto Workers, Social Security Department.

LUNCHEON

Candidates and their spouses will be guests of the College at the luncheon. A well known humorist will provide the entertainment. The officers of the Washington, D.C. Section who will act as hosts are General Edwin H. Smith, chairman; Israel Shulman, vice-chairman; and Charles B. Murto, secretary-treasurer.

CONVOCATION

Following luncheon, the 1974 convocation will be held in the Grand Ballroom. Candidates and sponsors have received information regarding the arrangements for caps and gowns and the procession. An innovation this year will be the presentation of the Certificate of Fellowship and the College lapel pin at the convocation.

DINNER – DANCE

On Saturday evening, following a reception on the Terrace, the annual dinner dance will take place in the International Ballroom. Sammy Ferro and his orchestra will provide music for dancing, and the Georgetown Chimes, a vocal group from the University will entertain.

A detailed program of the meeting will be mailed later in the summer. Hotel reservations should be made early through the American Dental Association Housing Bureau on forms printed in the ADA Journal.

SECTION NEWS

Philadelphia Section

The regular meeting of the Philadelphia Section of the American College of Dentists was held on May 30, 1974 at Williamson's Restaurant in Bala Cynwyd, Penna.

Following the invocation and dinner, Chairman D. Walter Cohen introduced Charles Santangelo, who was recently inducted to Fellowship at the Houston convocation. The chairman then spoke of the Philadelphia Section history, from its founding in 1949 to the present. The speaker of the evening, Fellow Jacoby Rothner, spoke on "Hawaii – As I Would Like to Remember It", documented by slides. The Chairman thanked the speaker for the excellent presentation and commented on the superior photography.

Officers for the coming year were installed. They are Dale Roeck, chairman, James Baker, vice chairman and Harold Lantz, secretary-treasurer.

Outgoing chairman D. Walter Cohen, dean of the University of Pennsylvania School of Dental Medicine passes the gavel of office to incoming chairman of the Philadelphia Section, Dale Roeck, associate dean of Temple University Dental School.

Kentucky Section

The Kentucky Section of the American College of Dentists held its annual meeting on April 1, 1974 at the Galt House Hotel in Louisville, Kentucky.

New officers elected were: Julian Dismukes, chairman; Thomas Schuler, vice chairman and Hubert Fields, secretary-treasurer.

The Section sponsored a student essay writing contest. The winners of the contest were: Nora M. French, John F. Cook, and Arthur C. Jee, all of the University of Louisville.

New Jersey Section

The Spring Meeting of the New Jersey Section of American College of Dentists was held at the Holiday Inn, Kenilworth, N.J. on April 18, 1974.

The Section approved purchasing a speaker's rostrum, a large projection screen and an electric pointer for the New Jersey Dental Association. These gifts are to be donated in the name of the members of the New Jersey Section who have served as officers or committee chairmen in the N.J. Dental Association.

The speaker of the evening was Mr. William R. Johnson, assistant vice president for marketing of the N.J. Dental Service Corporation. Mr. Johnson gave a frank discussion of the many aspects of the selling of dental insurance to corporations and groups.

The following officers were elected for the year 1973-74: H. Curtis Hester, chairman; Marvin L. Fishmann, vice chairman; and Jacob Oxman, secretary-treasurer.

Dr. Hester expressed the thanks of the Section to the outgoing chairman, Dr. James Hipple, for the fine programs and increased interest in the College, due to his efforts.

The next scheduled meetings of the N.J. Section of the College will be October 17, 1974, and January 16, 1975 at the Ramada Inn, Clark, N.J.

(Continued on page 211)

the JOURNAL of the AMERICAN COLLEGE of DENTISTS

A QUARTERLY PRESENTING IDEAS IN DENTISTRY

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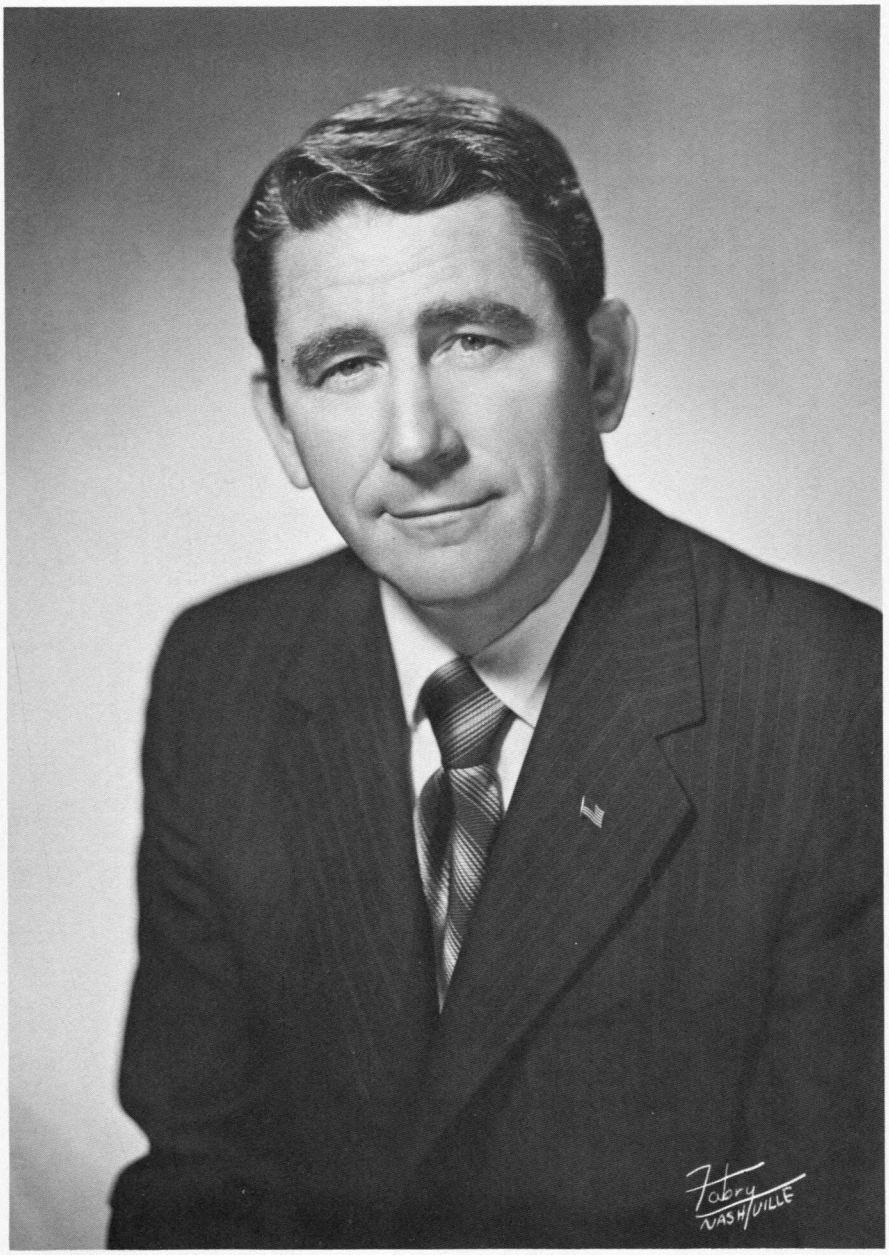

GOVERNOR WINFIELD S. DUNN
Convocation Speaker

Governor Dunn To Address Convocation

Winfield S. Dunn, dentist and governor of the State of Tennessee will be the recipient of the William J. Gies Award and will deliver the principal address at the annual convocation of the College on Saturday, November 9, 1974 at the Washington Hilton Hotel. The Gies Award is presented to persons whose contributions to the advancement of the profession or to the public have been outstanding.

Governor Dunn, a native of Meridian, Mississippi, is the son of former United States Congressman Aubert C. and the late Dorothy Dunn. After service in the U.S. Navy, he earned a degree in business administration at the University of Mississippi before studying dentistry at the University of Tennessee. He also holds the honorary doctor of laws degree from Southwestern University in Memphis, Tennessee.

He is a member of Omicron Kappa Upsilon Honorary Dental Society, The Masonic Order, Kiwanis, and a number of fraternal and veterans organizations. He practiced in Memphis for a number of years, during which time he became active on the political scene, serving for four years as chairman of the Shelby County Republican Executive Committee.

In 1970, after a vigorous campaign, Doctor Dunn was elected the first Republican governor of Tennessee in fifty years. He also is chairman of the Board of Trustees of the University of Tennessee, chairman of the Tennessee Board of Regents, chairman of the Tennessee-Tombigee Waterway Development Authority, chairman of the Republican Governors Association, and was chosen twice as Tennessee Man of the Year.

Governor Dunn is married to the former Betty Jane Prichard of Memphis. They have a son, Charles W., and two daughters, Donna Gayle and Julie Claire. The governor's hobbies are tennis, golf and flying.

Editorial

A Word to the Wise

The American College of Dentists, through a rather detailed and comprehensive selection process, makes a determined effort each year to choose for Fellowship those members of the profession who have exemplified through their own lives and actions, a true understanding of the concepts of professional conduct.

It takes individuals of character and integrity to merit the recognition that Fellowship confers, and there is no question that once they achieve it, they will never be anything other than what they have always been – persons of exemplary conduct, whose actions reflect credit upon themselves, the College and the entire profession, and whose lives might well serve as an inspiration to others.

The world is changing rapidly, however, and many of the old values that the College has endorsed are under attack from different directions. It has become necessary therefore to set down a code of conduct, not only for the guidance of present Fellows and those who are inducted each year, to help them identify deportment which is at variance with the principles of the College, but also for those who would aspire to Fellowship in the future, that they may order their lives accordingly.

The Code of Conduct is printed in this issue. It calls attention to the obligations of Fellows regarding the teaching of postgraduate courses, the question of honoraria for such services, and the need to avoid participation in proprietary journalism or commercial enterprises using one's professional title. There has been some laxity in recent years in these areas, and a few Fellows of the College have, perhaps unwittingly, lent their names and their efforts to pursuits which do not conform to the code. We mention these matters now, because they have been a cause of concern to the Officers and Board of Regents. We trust that those Fellows who may be in violation will make an effort to comply. A word to the wise is sufficient.

American College of Dentists

Code of Conduct

The Code of Conduct adopted by the Board of Regents on March 31, 1973, speaks very clearly about what is required of a Fellow of the American College of Dentists.

(a) He shall participate in courses of instruction, study clubs and seminars given only under the auspices of recognized dental societies, approved dental schools, or other non-profit professional or educational agency.

(b) He shall make professional contributions to progress as an expected obligation, and these shall be made in context with abilities and resources pertaining; such contributions may be properly acknowledged by voluntary honoraria. The prior requirement of an exorbitant fee as a prerequisite of participating shall be avoided.

(c) He shall not contribute or participate by official or professional title with proprietary enterprises of *journalism* or *commerce* or by title or copyright restrict research, education or health care.

(d) He shall be removed of Fellowship by conviction in civil or criminal court of an action which discredits the profession.

(e) He shall be removed of Fellowship upon being judged in violation of the Principles of Ethics of the American Dental Association or equivalent professional organization by the governing body of that organization.

(f) He shall be removed of Fellowship when he does not fulfill those other obligations of Fellowship as are herein or henceforth determined by the Board of Regents.

The College Today

And Some Thoughts on Dental Education
A Discussion With President Terkla

At the spring meeting of the Board of Regents of the American College of Dentists, the editor had the opportunity to tape an interview with Louis G. Terkla, President of the College. Dean Terkla, a forthright and articulate speaker, has brought his own particular brand of dynamism to the College. Here are his thoughts and ideas about a number of topics of concern to the membership.

Q. The College now appears to be passing through a period of internal reorganization. Would you mind describing for the readers of the Journal, some of the changes that are taking place.

A. Well, let me preface my reply with a few comments about the needs of the College. Having been associated with it sence 1960 in various capacities, I have had an opportunity to view it closely. It has been apparent that the Fellows of the College have had little participation in the decisions that were being made by the Board of Regents. Conversely, the Board of Regents had little understanding of exactly how the Fellows felt about the College. The Board are composed in such a manner that it was not enitrely representative of the various geographic areas of the United States, and therefore never really represented in the broadest way all of the Fellows of the College. So a very intense look was taken at reorganization for the purpose of trying to determine whether the College could be restructured in such a fashion that every Fellow would take a greater

part in the activities of the College, be more closely involved in the decision making process, and have increased participation in College projects at the Section level.

The only way that we could conceive of doing this was to divide the College into Regencies on a geographic basis, establishing as much as possible an equitable distribution of Fellows in each Regency. The Fellows in each Regency would then elect a member to the Board of Regents. In this fashion every Fellow and every Section would have its interest represented on the Board through a duly elected Regent. I think there are great benefits in this for the College because it will align the thinking and understanding of the Board of Regents with that of the Fellows of the College at large. And it will also allow the Board of Regents, because of its representation, to tap this vast and wonderful resource of the American College of Dentists for many ideas and projects and activities. If it does nothing more than provide a better base for understanding of how the College operates, and a better feeling toward the College in terms of participation by the individual Fellows, we will have accomplished a great deal. I am not totally satisfied that this reorganization alone is all that the College needs, but at least it is a first step toward some changes in traditional structure which may assist the College in gaining the support of all the Fellows within it. I am also not very confident that simple organizational changes are always effective in accomplishing what we wish to accomplish. Some people might view this as a paper change in terms of organization. We hope that it will be more than that. We hope that through the increased involvement of the individual Fellows in the Regencies we can effect future changes that will unify the College throughout the United States and Canada in terms of its major objectives.

Q. There was a time in the past when men of achievement, usually of middle age, were invited into Fellowship in the College and had thereafter no responsibilities to it other than the payment of annual dues. In recent years we have seen more and more younger men inducted. These men frequently expect to assume some responsibility in the organization. What is the College doing, or what can the College do to utilize their talent?

A. I believe it has been astute and wise of the Board of Regents over the past several years to recognize the fact that the College must be invigorated and reinvigorated with young professional people of great

potential and promise. Looking at our membership in terms of age ranges and numbers in each age range, we have found that we are heavy in the categories of older Fellows. As discreetly as we can within the nomination procedure under which we operate, we have encouraged nominators to take a serious look at young professional persons who are deserving of Fellowship. Now I do not believe that all of our middle aged or older Fellows have been unproductive for the College. There is a vast amount of talent here also. But there has been a general feeling among Regents as well as some Fellows, that often these individuals feel that they have made their mark, that the invitation to Fellowship is in recognition of past accomplishments and contributions, both public and professional. Some feel that they have thereby reached their peak, the limit of their achievement, and need do nothing more thereafter except bask in the honor.

We feel differently about invitation to Fellowship into College. We feel that such an invitation not only recognizes past and present services but it also recognizes the potential of that individual to make continued and future contributions in the same manner, especially if possible for the betterment of the College itself. We envision as time goes by that a larger number of Fellows who are initiated each year will represent the younger age groups of professional people in dentistry. We would hope that within these younger groups there will be some highly motivated individuals who will assist the College in moving forward in directions that are more important now than ever before in the history of dentistry. These young men will be our future leaders. It is important for us to help their development now.

Q. The American College of Dentists has been referred to as "Dentistry's Legion of Honor." In this day and age of skepticism and doubt regarding many of our established institutions and organizations, what do you believe is the place of an honorary organization like the College?

A. There is no other honorary organization like the College in existence in this country today. It is completely apolitical, it is independent and self-supporting, and has always been recognized by other dental organizations as a resource group, a catalytic agency which has served the dental profession well in helping to find solutions to some of its dilemmas. It is in a very important and particularly sensitive position today because it consists in the main of highly accomplished and talented people. The members of the College represent much of the cream of the profession of dentistry

and because they are its leaders and have contributed so much and have been so closely involved, they are in a unique position to observe what is happening to our profession. I think that all of us realize that there are many inroads being made into our profession today. Much of our independence and much of our self-determination are slowly being eroded and taken from our grasp. In my address at the annual meeting in Houston in October of 1973, I spoke specifically to the fact that I believe that the College and its Fellows should muster the strength and help of all the members of the profession to get this profession firmly back in the drivers seat in determining its own destiny.

Q. The Program of the last annual meeting was devoted to an exploration to the nature of professionalism and the abuses that are frequently taking place in many walks of life. What can the College do in the effort needed to combat these influences?

A. The professional ideal of "service before self" has given way in many areas to a "what's in it for me?" attitude. I would hope that the College can be instrumental by, the example of the conduct of its Fellows, in continuing to remind all the people in dentistry what professionalism is all about, what it means and how important it is to maintain on its highest level. This is going to take a great deal of effort in view of what is happening in all segments of society today.

Human beings will never be perfect. All of us do not have the same high standards of idealism, all of us do not have the same moral character. I am not so idealistic as to believe that there will never be examples of non-professionalism within any profession. I think the role that the American College of Dentists can play is to continue to remind them of their existence, to remind them that one of the most dangerous attitudes that we can assume is to ignore such laxity among us. If we become apathetic toward its existence it can only increase, and it will grow as fast as we allow it to grow. We must emphasize and continue to encourage truly professional attitudes. That is one of our major goals.

Q. Dean Terkla, as an educator and head of a prominent dental college, you have had some problems relating to government intervention in dental education. Your handling of them has won the admiration of a larger segment of the profession. Would you tell us about some of your problems at Oregon and how you went about solving them?

A. The University of Oregon Dental School has resisted and essentially refused federal aid to its undergraduate program, under the terms of the last two Health Professions Education Assistance Acts. Oregon's problem has to be explained in order for people to understand it. We don't feel exceptionally proud of what we have done. We didn't do it for the purpose of gaining admiration of the profession, or for any personal gain. We did it with full understanding that the problems at Oregon are considerably different perhaps than those that exist at any other dental school in the United States. Although there is a tendency to group all dental schools in the United States together. We do have many common problems such as keeping a dental school open and keeping it financially solvent. The manner in which each is kept solvent is uniquely different among all dental schools. None of us is exactly alike.

In Oregon we realized that we could not meet the mandatory enrollment commitment of the last two Health Professions Education Assistance Acts. The University of Oregon Dental School felt very sincerely that it would be compromising the quality of its undergraduate educational program if it accepted capitation grant funds and enrolled the number of students required by the legislation. We received support on this point of view from the Council on Dental Education, which had visited us in the fall of 1971, and agreed with our premise that we had some serious limitations in regard to expanding the enrollment. Despite the fact that the Council supported us with a written statement, the University of Oregon Dental School was unable to obtain a waiver of the mandatory enrollment requirement from the federal government. As a consequence of this, we debated the issue whether we could afford to refuse the money, and we decided that we had to refuse it or we would run the risk of compromising our educational program. There was no way in which we could squeeze a class of ninety-four students into classrooms which were built for eighty students. There was no way in which we could squeeze all these students into a clinic that had only 153 chairs, especially in a vertical curriculum, with students from the freshman to the senior year all having scheduled clinical activities. So we refused the capitation money but it was a very difficult thing to do because the state of Oregon was in a fiscal crisis at the time and we were in the throes of having to give back part of our state-appropriated operating budget in order to assist the alleviation of the fiscal problem. The decision to do this was even

more traumatic than it would have been had we not had the state fiscal crisis. We did it anyway because we knew if we enrolled 94 students, we would have to spend the majority of the capitation money on hiring new faculty and classified people to provide the teaching and support staff for these additional students. And that if this occured, we would have gained essentially nothing except to increase our output while increasing the hazard of reducing the quality of education because there was no room for the extra students. There was another long range hazard that we recognized. We felt that with a state in fiscal crisis it would not be very long before the state legislators in Oregon would realize that there would be a savings to the state of Oregon if they substituted the Federal grant money for state-appropriated operating funds. We felt that this was another risk that we were unwilling to take. We felt that if we were to grow at all, in terms of our budget, we would want to grow on state appropriated funds rather than on Federal funds. If the state legislature decided to make this kind of substitution in our operating budget, there would be no guarantee that when the Federal money was cut off or the legislation terminated or the capitation grant was not renewed, that the state legislators would pick us back up again and provide us with the state appropriated money at the previous level. Consequently we turned the money down with the full knowledge of the State Board of Higher Education, the Chancellor's office and even some of the legislators. None of these groups pressured us to take it. I give the officials in higher education and our legislators a great deal of credit for that, because they could have demanded that we take the money. As a consequence of our tight fiscal condition, we had to cut a part of our program. We did this in such a way that it did not affect detrimentally the undergraduate teaching program at the institution. We had to discharge some faculty, and some classified staff, but we let them go in areas outside of the undergraduate program.

The other thing that we did was to reduce the size of our classes. We had been admitting 85 students per class and we immediately reduced our entering class size from 85 to 80 students. I believe this option is one that institutions can consider at some time in the future when federal funds are no longer available, and that is to reduce enrollment and to cut back the staff and faculty to the point where there is a better balance between the monies available and the number of students that are being educated. This will not be possible for many schools until they have run out the ten year commitment period of increased enrollment that they had to agree to when they

either expanded their institutions or built new institutions using federal matching money. I realize that this option of cutting back enrollment to the point where income and programs are better balanced and there is less of a fiscal crisis, will not be open to them for some time. In this respect Oregon is uniquely different from some of the other institutions because we never had such a commitment. Being in that position, we felt that we had to educate state officials to our need for additional dollars, and our need to grow in other ways. In 1973, I presented a budget that requested $1,145,000 in new clinical equipment, that requested $164,000 to support the dental auxiliary utilization program which had been phased out of federal support funds and that requested $130,000 to get our hospital dental service more soundly funded. At the legislative hearings, I did not mention the fact that this institution had refused to participate in the federal capitation program. However, one of the legislators, who happened to be the chairman of the Education Subcommitee of the Joint Ways and Means Committee of the Legislature, knew about it and at the close of the hearing mentioned it to the whole committee. He and other Oregon legislators were impressed. They have made it clear that they do not appreciate any institution or agency in the state that starts programs on federal funds and then, when those funds run out, requests state funds to continue the program. Following the budget hearings the state legislature appropriated the monies needed for the programs.

A last consideration in our refusal to participate in the capitation program was the influence that the federal government was beginning to bear in determining educational philosophy and program direction at participating institutions. Oregon's faculty want full control of this process, but without excluding appropriate consideration of contemporary thought from any quarter.

Q. Would you care to predict what is going to happen next in regard to the capitation grants? Will there be federal requests for further increases in enrollment? (Note: This interview was conducted in April, 1974 before the new Health Manpower bills were introduced.)

A. The new Health Manpower legislation appears to be heading in a totally different direction. The future of capitation grants to institutions is now being questioned. It may be only a matter of time until there are no capitation grants. Some congressmen would like to convert these into student support grants in the hope that they might indenture students because of the tremendous amount of money that

they would owe the federal government for their educations. Such legislation would require students to practice, upon graduation, in scarcity areas and help solve the problem of the maldistribution of dentists in this country. The administration would phase out the capitation program over a three year period. Dental schools in the United States are now working toward the continuance of the present legislation and they have identified a capitation figure which they are going to put forward in their arguments before the appropriate commitee in Congress. The American Association of Dental Schools, in the promotion of its philosophy, will try to maintain the capitation program without another mandatory enrollment commitment. This is an appropriate aim, because all participating schools have increased their enrollment three times now under the three Health Manpower Educationsl Assistance Acts during the past nine years. If they pledge to maintain their existing levels of enrollment by maintaining the sizes of their entering classes, then it is legitimate for them to request the same amount of capitation money that they now have, which was granted and predicated on the basis of those enrollment increases.

It is extremely doubtful, however, that Congress will pass Health Manpower legislation of this nature. It appears from the signals that have already been given, that Congress will problably want to demand another mandatory enrollment increase, or at least student commitments to serve in scarcity areas. It would be extremely difficult for schools to absorb any such increase. Many of them absorbed the last increase under great stress and they have created very difficult problems for themselves. I cannot see how any of these institutions can take any additional students, and yet most dental educators feel that there will be another effort at a mandatory enrollment increase.

My only plea would be that the private schools as well as the state supported and state-related schools ought to work diligently to try to find other means of financial support than that which comes through the Health Professions Education Assistance Acts. I would plead with them to try, if at all possible to become less vulnerable to federal assistance and its attendant insecurity. I feel that dental schools should not have allowed themselves to get this deeply involved with federal assistance. But I also understand very well that once they have passed a certain point of dependence on federal funds, it is almost impossible to turn back. It is easy to understand why many dental schools today are working very hard to get capitation grants without another mandatory enrollment commitment.

There is no feeling of security or stability when schools are supported in this fashion. Congresses change, attitudes of congressmen change, legislation changes, and it seems that every three years when the laws expire the schools are fighting for their very survival again. If the federal government really wants dental institutions to survive, now that it has them in a very vulnerable position, it is only legitimate to ask congress to pass legislation which would provide an indefinite continuing commitment, without mandatory requirements which would erode the quality of educational progress.

Q. The Self-Assessment and Continuing Education Program sponsored by the College has met with only moderate success so far. Do you believe that some form of mandatory continuing education requirement will have to be adopted eventually by all states or can the voluntary method succeed under existing conditions?

A. I think that continuing education and the problems pertaining to it are one of the major challenges that the profession of dentistry faces today. I've been fortunate enough to be rather close to it because we have a very active and productive continuing education program within our institution, including a clinical facility where about thirty local study clubs participate every day of the month. I've also been fortunate during this past year to be the chairman of the continuing education section of the American Association of Dental Schools. Recently in Atlanta, during the annual meeting, we conducted an all day program on problems related to continuing education. The issue is highly complex, and I cannot say whether mandatory continuing education is really the solution.

Mandatory continuing dental education has been legislated in a number of states already, and we are carefully monitoring what is going on in those states. I understand that some of these states are having some difficulty with it. When we ask if mandatory continuing education should be legislated in all states, a number of questions must be asked. What kind of courses are we talking about? What is their magnitude? How are they going to be administered? How are the credits going to be registered, and what are we going to do if people don't participate in the program? Are we going to be so drastic as to put a man out of the practice of dentistry by taking his license away if he does not participate? How are the results of mandatory continuing education measured in a private practice in terms of better patient service? Who qualifies the teachers?

Oregon dentists in the main are extremely continuing education conscious, and the feeling there is that practicing dentists would rather see continuing education developed on a voluntary rather than a compulsory basis. The House of Delegates of the Oregon Dental Association approved a resolution continuing education if it so chooses. It has been a year now since the Board of Examiners was given the option to make it a requirement for licensure and they have not yet done so.

There is great opposition to mandatory continuing education in some areas of the country. There are many dentists who feel that a mandatory requirement indicates to the public that certain weaknesses exist which the profession is either unable or unwilling to respond to voluntarily. In either case, whether mandatory or voluntary, we are going to find some individuals who will not participate. Those persons are going to force us to either fish or cut bait. One of the most extensive compulsory continuing education programs in dentistry now exists in the state of California. They have developed an extremely complex system of monitoring this and recording credits. I am not familiar with the total program, but I think that there are some threats to the people who do not participate. We will have to watch the California program closely. I do not think that the majority of the profession is opposed to continuing education. Most believe that it is absolutely necessary, and that all dentists must participate in it somehow.

We have not addressed what continuing education actually is and of what it should consist. We have not defined what forms of continuing education are the most meaningful. We have no structure set up to measure whether continuing education ever does any good for anybody who takes part in it. We have no way of knowing whether the individuals who participate are translating what they hear and what they see and what they learn into new knowledge and new skills to the benefit of the patients in their individual practices, and until we have answers to all of these things it is almost impossible to come out and say that we favor mandatory over voluntary continuing education.

I think that the only was we can successfully require mandatory continuing education, is to develop a satisfactory method of defining it, and to provide the right kind of study that is custom tailored to fill in the gaps or deficiencies in the individual practitioners knowledge. Continuing education can be effective for any given practitioner after he himself has identified his weaknesses. This is

why the American College of Dentists' Self Assessment Program is so important. Each individual practitioner may not know where his deficiencies are in either knowledge or skill. The SACED program helps him identify his deficiencies.

I believe that continuing education for all dentists is absolutely essential. I tell our students at the University of Oregon Dental School that all we do in four years of undergraduate education is give them a very superficial exposure to the knowledge and skills necessary to practice dentistry.All that we can do is hope that we can prepare them to begin practice at the time they graduate. I have never been a proponent of preparing students for practicing in 1980 or 2000. We have no idea what practice is going to be like then. We are preparing students and graduates of 1974 to practice 1974 dentistry. It then becomes their responsibility to keep up with contemporary dentistry throughout their entire professional lives. When we compare the total amount of education and preparation that we give them in four years against the fact that they will need to acquire much more knowledge and many more skills between the time they graduate and the time they retire from practice some forty or fifty years later, we realize that we do not provide them with very much. Their major education is gained after we have given them the basic preparation. Because of this belief, we feel very strongly about continuing education.

Q. The College has come a long way in the past 53 years and many changes have taken place in the profession in that time. Would you care to comment on the future of the American College of Dentists and its role in the world of dentistry?

A. The problem that we face today in the American College of Dentists is that many of the challenges that continually crop up within the profession of dentistry are immediately channeled to a variety of organizations, associations, societies, and academies which exist within our profession. We are a many-headed, multi-disciplined profession, and as a consequence, when a problem appears before the profession today, its not an isolated problem setting out there waiting for someone to grab and run with. I think in the early days of the American College of Dentists, there were probably many problems arising that the American Dental Association was not prepared to grapple with. But there were not a lot of other organizations around either, and the American College of Dentists could very easily accept some of these problems, respond to them,

and do something of significance toward their solution. Now with so many agencies and associations in dentistry today, these problems are very easily channeled, and its more difficult for the College to address itself to many of the major problems that organizations such as the American Dental Association, the American Association of Dental Schools and others are working with almost on a daily basis. However, I feel that there still is a role that the American College of Dentists can play. There are problems related to the philosophy and ethics of professionalism, to maintaining the high standards of the profession, that we are very capable of addressing.

A number of major issues in these areas are facing dentistry today. They need identification, study and analysis by the College to determine where our efforts can be directed most appropriately. Having recently undertaken our own reorganization and reassessment, we are now about ready to enter that process, and we hope to provide guidance to all the Fellows of the College as well as to the profession as a whole, regarding the challenges to professionalism that dentistry now confronts.

In conclusion, I should like to make mention of the outstanding service being rendered to the College by its Executive Secretary, Dr. Robert J. Nelsen. He has been the vital force behind the implementation of the many healthy changes that are taking place within the College, and his administrative expertise has been influential in advancing the interests of the Fellows in every dimension.

Fame is a vapor, popularity an accident, riches take wings. Only one thing endures, and that is character.

Horace Greeley

Toward An Equitable Faculty Compensation in Dental Colleges

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

Although the quality of dental education is determined by a large number of factors such as curriculum, educational facilities, the quality of entering freshman class, administrative leadership, and others, none of these determinants of educational excellence are more crucial than the quality of the faculty. Consequently, we cannot afford to ignore any developments which could effect the continuous availability of high quality dental faculty, and that is why, we ought to very carefully examine the current economic status of the dental faculty. Many seemingly reliable indicators suggest that the present decline of academic salaries, if continued, will have serious adverse effects on the recruitment and retention of dental faculty and therefore, produce a lowering of the quality of the dental education. This article will attempt to examine this important issue.

Need Satisfaction

From psychological point of view, the recruitment and retention of dental faculty depends on the degree of "need satisfaction"[1] derived from an affiliation with a dental school. The level of academic salaries, which will be discussed in this article, is one of the important need satisfiers. Although we live in a society which disapproves the expression of interest in money[2], income expectations are know to represent one of the important vocational incentives. According to Moore and Kohn[3], "financial earnings" and "prestige" considerations were the two leading motivating factors among students seeking admission to dentistry; some other

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motivating factors were "human service" and "autonomy." Another example and a source of direct evidence of the current concern about salaries in the academic environment is the recent study[4] covering 268 professors selected at random from the six state universities in Kansas. In that survey of faculty opinion, half of all respondents ranked "salaries" as the first priority item in any future negotiations with the state. Academic freedom was ranked second. Of course it should be recognized that the paycheck, as a rule, is perceived as more than just money, and the level of academic salary reflects also "recognition" and "status" as seen by the academic administration. Furthermore, faculty's apprehension about the declining economic security also reflects their concern about the impact of these developments upon academic freedom.

Several studies have indicated[5] that there are possibly uncorrelated differences in job satisfaction derived from intrinsic as opposed to extrinsic job factors. The intrinsic factors, such as a sense of professional autonomy, academic and professional recognition, professional growth, advancement, promotion, self-actualization work aspects and the social environment are the primary source of professional incentives and therefore, constitute the basic "need satisfiers." The extrinsic, or "hygienic" factors, which include the physical working conditions, workload, working relations with others and money, constitute those aspects of work which do not in themselves provide challenge or incentive but which are essentially supportive background factors. It has been postulated that job satisfaction resulted primarily from intrinsic job elements which allow for self-actualization while job dissatisfaction was derived from the extrinsic environmental elements which are primarily physical and monetary[6,7]. Otherwise, although ego-satisfaction or sense of professional contribution – not the level of income – may be the primary source faculty job satisfaction and professional fulfillment, it is the salary and other extrinsic "rewards" that, as a rule, underlie and cause job dissatisfaction and faculty alienation. There is a strong indication that these extrinsic factors, such as academic salaries and working conditions, become very important only when they fall below a critical psychological level. Since the fiscal conditions currently prevailing in U.S. professional colleges in fact appear to have fallen below the critical level, our attempt to review the anatomy of the present crisis in education and to assess its impact upon the continuous availability of high quality dental faculty appears to be timely.

TRANSFORMATION OF FACULTY SALARY STRUCTURE IN THE PAST TWO DECADES

The remarkable growth of the higher education industry experienced in the past few decades has been accompanied by a significant improvement and transformation of the faculty status. This progress has been achieved because of convincing demonstration of the validity of professional standards in the field of research and teaching and offering the evidence that these standards require conditions of academic freedom and economic security[8]. In 1957, the President Eisenhower's Committee on Education Beyond the High School called for doubling of faculty salaries in the next decade[9]. At just about the same time, the American Association of University Professors initiated the annual faculty salary surveys[10]. Perhaps, indirectly, as a result of these developments and the prevailing legislative "mood" in the post-Sputnik era, the rate of improvement of college professor's compensation during the 1960's was well above the cost of living escalation, as measured by the Consumer Price Index[10]. Increases in the real faculty purchasing power were enjoyed in every year from 1960-61 to 1969-70, ranging from a high of 5.9 per cent in 1964-65 to a low of less than 1 per cent in 1969-70[10]. During that period public colleges and universities not only have managed to reduce once sizable differential between salaries paid faculty in private and public institutions but also spectacularly expanded their enrollments[11]. Since then, however, partially as an expression of public resentment of campus disruptions, and partially as a result of the developing economic stresses public institutions have experienced cutbacks of academic budgets by state legislatures.

For most colleges and universities, salaries run to well over half of the total budgets[12] and perhaps for that reason, skimping on the payroll represents a frequently employed, but in opinion of many the worst possible, type of cost control measure at the time of economic downturns[13]. The austerity funding has severely curbed faculty salaries and the faculty purchasing power, that is, the relation of the growth rate of faculty compensation to the increases in the cost of living. The growth of the faculty real income has been kept at 0.5% in 1971 and 0.2% in 1972 while in 1973-74, for the first time in the history of the AAUP Salary Survey of faculty compensation, the nation's faculty actually lost ground economically[14]. This was due to the fact that the total increase in average faculty

compensation of 5.9% recorded in 1973-74 was nowhere near the consumer's price index which has taken the biggest jump in 26 years[12,14].

In 1972-73 and 1973-74 faculty increases were held to the 5.5 per cent limit set in guidelines of the Government's Cost of Living Council[12], although, early in 1974, that salary ceiling has been lifted for private institutions. Moreover, student enrollment at many professional colleges continued to grow while some institutions refused to forego putting new programs into operation despite restricted faculty hiring[4,11]. All this had a net effect of increasing faculty workload while the real faculty income has been falling behind[4].

INCOME DIFFERENTIAL BETWEEN DENTAL FACULTY AND NON-SALARIED DENTISTS

The dental faculty, or at least most of the dental faculty, is recruited from the ranks of dental profession and on account of this, the recruitment and retention of dental faculty is affected not only by the market forces and the working conditions prevailing in the academia but equally so, by the relative position of the prevailing levels of academic compensation vis a vis the income opportunities available in private practice. On the basis of data compiled by the ADA Bureau of Economic Research and Statistics[15], the Commission on the Survey of Dentistry[16] and the American Association of Dental Schools[17] it appears that the gap existing between the income of dentists employed in academic institutions and dentists working in private practice has been growing.

In 1958 the average net income of non-salaried dentists amounted to $14,311 while the average salage of full time faculty equaled $10,128. The $4,183 differential represented 41.3% of the average faculty salary. This differential is inflated by approximately 12%, that is, the average worth of faculty fringe benefits, which means that the average income of the full time dental faculty in 1958 was actually only 29.3% lower than that of private practitioners. In 1970 the average net income of non-salaried dentists amounted to $29,487 while the average salary of full time faculty of professional rank equaled to $19,348. The $10,139 differential represented 53.6 per cent, or nearly twice of that observed in 1958[15,16,17].

This deterioration of the relative competitive position of academic salaries produces highly unfavorable market pressures threatening the continuous availaibility and supply of high quality full-time dental

faculty. According to the dental deans[16], changing of the composition of dental faculties by increasing the number of full time teachers and the corresponding lowering of the part time faculty would represent a major improvement in dental education. Clearly, in light of the differential alternative professional work opportunities in private practice that are available to the dental faculty and the prospective dental faculty, these goals cannot be readily attained. What's needed is a better alignment of full time faculty salaries vis a vis the income of non-salaried dentists to reduce the impact of the existing external market averages.

The nature of market pressures that determine the "worth" and therefore, compensation of the faculty in various specialty areas cannot be demonstrated in the field of dentistry because of the unavailability of such data. However, the operation of the free market forces can be illustrated in the field of medicine where the appropriate data are annually compiled and published by the American Medical Association[18] and the American Association of Medical Schools[19]. These data reveal that the average salaries of the strict full time clinical science faculty vary from one clinical specialty to another according to the private practice income potential associated with these specialties. Thus, for example, in 1970, average income of the faculty in the departments of pediatrics amounted to $24,100 while in the same year the faculty in surgery earned on the average $30,500 and the average salary of the faculty affiliated with the radiology departments equaled to $34,000. It is noteworthy, that in the basic science disciplines where the alternative work opportunities and the external market leverages are weaker, inter-discipline salary differentials are minimal and the average salary levels are considerably lower than those prevailing in the clinical disciplines.

PROFESSIONALISM AND THE CONTROL OVER ONE'S EARNINGS

While the rank-and-file strict full time faculty may not exhibit all the attributes of a "true" professional, at least by some sociological standards, they definitely regard themselves and are regarded by the general public as professionals[20]. This has had long range implications for determining the self-imposed restrictions traditionally observed by American professionals in advancing their occupational self-interest. It should be pointed out that the remarkable progress achieved by the academic profession in the past few decades has not been attained by means of strikes or threats of

strike or disruptions of community life. Indeed, such sanctions and the very notion of unionization has been abhorrent to the faculty who viewed collective action as both demeaning and threatening their "professionalism".

The key element in professionalism is the concept of a community of practitioners to whom the society has granted the special privileges of self-government which involves responsibility for the quality of services performed. Professionalism is associated with a basic commitment toward "constant refinement of knowledge, skill and judgment to assure that professional service is appropriate to professional purpose"[21]. For that reason, when a professional puts a price upon his services, this carries an implicit commitment not only to perform his vocational activity well but to strive to improve it and to safeguard his professional mission from the lowering of the standards of quality. That is why the professional mission, as a rule, requires that it be possible to recruit the best and most promising students or scholars available to upgrade its quality and standards in the continuous pursuit of excellence[8]. And this is the reason why the organized professions strive to maintain control over earnings, working conditions, and status of the professionals[20]. Income or salaries are not just the question of money, but are also indicators of progress, worth and status[2]. They are as a rule perceived as equity measures instrumental for satisfying autonomy and independence needs[22]. This represents the fundamental premise of the economic organization of a profession[20].

Although academic "professionalism" stems from the model of self-employed professional, there is considerable confusion about faculty's professional versus employee's status. As professionals, presumably, faculty members have the training and expertise to determine the conditions under which the profession is practiced, but as employees, they don't have the power and independence possessed by the self-employed professionals. More specifically, faculty has far less control over their earnings than their self employed colleagues. However, during the past decade the nature of professionalism has been undergoing such rapid changes that even the self-employed professionals increasingly find themselves "negotiating" fee schedules with mass buyers of services, such as consumers, unions and government agencies[20,21]. Most recently, the organized dentistry actually found it necessary to initiate a ligitation against the Cost of Living Council in an effort to exempt dental fees from restrictions imposed under Phase III and Phase IV of the

Economic Stabilization Program and thus, maintain proper control over the fee schedule. According to the American Dental Association, these new fee regulations would "have a serious and perhaps lasting adverse impact upon the nature and quality of health services"[23-25].

However, the pervasiveness of these "outside controls" is much greater among employed professionals; in contrast to "laymen"-consumers who as a rule .deal with the self-employed professionals, institutional employers are likely to take a position that they are informed-consumers qualified to judge the quality of professional performance, control their compensation, determine their workload and assign their duties[20]. Generally speaking, faculty has been able to negotiate their salaries and working conditions effectively as individuals, since faculty mobility always served as a "safety valve", if one was not treated properly by a current employer. Therefore, the reduced faculty mobility resulting from the recent financial restraints placed upon the universities, various cost control measures employed by state legislatures, cuts in research funding, the emerging criticism of tenure and frequently autocratic administrative attitudes seem to convince many professors that mobility is no longer their outlet, hence, they must stand and fight where they are[4].

It is becoming quite apparent that salary belt tightening which is being experienced at education institutions is rapidly destroying the traditional collegial mechanism used for salary allocation and tends to exaggerate the inequities associated with the salary administration. Confronted with the steady erosion of their economic status and security, unable to employ the traditional individual bargaining mechanisms because of the adverse economic and highly bureaucrated conditions, and faced with the political reality of tight competition for the limited state funds among various special interest groups, some faculty members no longer seem to view collective action as demeaning. Through their professional organizations they are attempting to employ their lobbying strength and political influence to maintain their status in the society, and they seem to be willing to sacrifice their professional status and self-image for a contract that would grant them salary increments consistent with the cost of living increases[8].

Clearly, these developments, if allowed to continue, will seriously undermine the traditional academic collegiality and will result in an adversary relation between the faculty and the administration.

However, it is plausible that the prevailing trend toward confrontation and the growing alienation of the faculty could be arrested or even reversed if the outstanding issues and difficulties were frankly identified and analyzed. Let us attempt to do just that.

SHOULD FACULTY BE INVOLVED IN BUDGETARY AND SALARY MATTERS

There is a common tendency on the part of the administrators to invoke management rights and assert the privileged and confidential nature of budgetary and salary matters. These administrators, as a rule, tend to see faculty involvement in budgetary and salary matters as a zero-sum game in which faculty "powers" can be only achieved at the expense of management[8]. However, conceptually, it is entirely possible for the faculty to gain powers without any concommitant loss of power on administration's part. The total amount of "control" over budgetary events in the institution would simply increase. Frequently, deans preoccupied with their multiple responsibiliteis are not able to devote sufficient energies to faculty salaries, as a high priority issue, and therefore, faculty compensation does not get sufficient visibility either nationally or in the state legislatures. It appears that this broad area is essentially a "no man's land" where no effective control exists; the entry of another party, the faculty, into a decision process may lead to improvement by subjecting the problem of faculty compensation to greater scrutiny and giving it both the proper visibility and frank attention.

The issue of faculty rule in budgetary and salary matters has recently been reexamined by the American Association of University Professors, and the following series of recommendations prepared by Association's Committee T has been endorsed by the Association[26]:

FACULTY PARTICIPATION IN BUDGETING

> The faculty should participate in both the preparation of the total institutional budget, and (within the framework of the total budget) in decisions relevant to the further apportioning of its specific fiscal divisions (salaries, academic programs, tuition, physical plants and grounds, etc.). The soundness of resulting decisions should be enhanced if an elected representative committee of the faculty participates in deciding on the overall allocation of institutional resources and the proportion to be devoted

directly to the academic program. This committee should be given access to all information that it requires to perform its task effectively, and it should have the opportunity to confer periodically with representatives of the administration and governing board.

FACULTY PARTICIPATION IN DECISIONS RELATING TO SALARY POLICIES AND PROCEDURES

The faculty should actively participate in the determination of policies and procedures governing salary increases. Salaries, of course, are part of the total budgetary picture; and, as indicated above, the faculty should participate in the decision as to the proportion of the budget to be devoted to that purpose. However, there is also the question of the role of the faculty as a body in the determination of the individual faculty salaries.

THE NEED FOR CLEAR AND OPEN POLICY

Many imagined grievances as to salary could be alleviated, and the development of a system of accountability to reduce the number of real grievances could be facilitated, if both the criteria for salary raises and the recommendatory procedure itself were (1) designed by a representagive group of the faculty in concert with the administration, and (2) open and clearly understood.

It ought to be recognized that the above AAUP statement represents an important and timely extension of the 1940 statement of Principles on Academic Freedom and Tenure jointly developed by the Association of American Colleges (an administrative group) and the American Association of University Professors[27]. Over the years it has become apparent that the academic freedom, that is, freedom to say the unpopular, which is so necessary for the continuous growth and vitality of our educational institutions, can only exist where there is freedom from economic penalties[28]. The 1940 AAUP Statement, which has been subscribed to by most universities, protects the professor from unjustified dismissal, but not from unfair promotion-or-pay practices and perhaps, that is the reason why so many institutions have been willing to adopt the "Principles of Academic Freedom and Tenure." The fact is, that educational institutions rarely resort to outright dismissal and prefer to force the

unpopular professor to resign by using arbitrary promotion-and-pay practices[8,29,30]. In light of that, it should be obvious that the issue of economic security and freedom from economic sanctions confronting the dental faculty, similarly to the issue of freedom from external fee control confronting the dental profession, are not self-serving issues, but issues involving the preservation of standards of professional integrity and autonomy.

The recent developments at the University of Michigan[8] where a Committee on the Economic Status of the Faculty has been established as a professional consultative negotiating team responsible for formulating specific requests regarding salaries and fringe benefits for academic staff may serve as a model of faculty involvement in budgetary and salary matters and a viable alternative to unionization. That is why, it may be useful to list some of the functions of this newly established Faculty Committee:

1. Gathering salary information and formulating a specific salary proposal.
2. Negotiations with the administration on salary matters and the right of consulting directly on these matters with the Board of Regents.
3. Provision for a fact-finding or advisory arbitration in case of a disagreement.
4. A right to adopt and publicize a resolution of censure to register dissatisfaction with the administration's position in regard to salaries.
5. Provision for submitting conjointly with the administration information pertaining to salary issues to the state offices involved in making up the Governor's budget bill.
6. Continuous investigation, analysis and monitoring the economic treatment of all faculty members as individuals and upholding the right of every member of the institutional faculty to fair economic treatment in comparison with his pears.
7. Collecting comparative salary information on a regional and national basis.
8. Formulation of guidelines and procedures for assessing performance, determine salary ranges and making salary adjustments, and distribution of information about these criteria and procedures to the faculty.

It must be clear that one of the basic prerequisites for an effective functioning of a faculty committee, as the one established in Michigan, is a free access to salary data. Since this would require a

radical departure from the traditional secrecy surrounding the budgetary and salary matters, let us review the issue of confidentiality of the salary information.

SHOULD SALARY DATA BE KEPT CONFIDENTIAL

Most managers and administrators are acutely conscious of the paycheck and, as a rule, use their budget control as a mechanism of power and influence[2]. They claim that the "management prerogatives" give them the right to make salary decisions without divulging budgetary information to the faculty[4] and further contend that if the "privileged" budgetary information were to be made public, substantial damage to the universities could result[31]. However, it is becoming evident that the "religion of secrecy" is neither morally nor constitutionally defensible and in fact has become "an all-purpose means by which administration conceals its purposes, buries its mistakes, manipulates its [faculty] and maximizes its power."[32]. Recent decisions of the National Labor Relations Board in a case involving Boston University[31] and current activities of various consumer protection organizations in the field of post-secondary education[33] indicate a discernible trend toward disclosure of budgetary information and the "truth-in-education" legislation. Moreover, in a large number of states the confidentiality of salary data cannot be enforced because the current "public information" laws in these states require full disclosure and publication of the salaries of all state employees. All this puts in question the frequent assertions that budgetary information must remain "privileged" and therefore, accessible only to administrators.

In light of all this controversy, it is highly noteworthy that in December 1973 the Executive Council of the American Association of Medical Colleges announced a new policy for the release of data collected by that organization which has reclassified the previously confidential annual salary information to a new category of "unrestricted"[34]. Under the new policy, "the descriptive statistics developed from the AAMC's annual salary survey" may be made available not only to the faculty but to the general public[34]. It appears, however, that the obsession with secrecy is more heavily entrenched in the organizational structure of the American Association of Dental Schools[35], which in 1972, has reaffirmed the policy that "confidentiality of the full salary survey should be maintained with the dental deans, who, at their discretion could release detailed information to others."[36]. Subsequently, in 1973, in

response to a request from the Council on Dental Education for "date from the Annual Salary Survey on both a national and individual school basis, for use in accreditation site visits," the Executive Committee of the American Association of Dental Schools recommended that "no such information be released without permission from each dean."[37].

So far, only the moral and constitutional aspects of the confidentiality of salary data have been discussed. Let us now consider the economic implications of non-disclosure of salary information.

The National Commission on the Financing of Post-graduate Education in its Report to Congress submitted in December 1973, noted that education is "one of the few major industries without formal price and cost-index information – specifically tailored to institutional and consumer needs."[12]. The Commission recommended the establishment of indexes of relevant price trends including academic salaries because, the Committee stated, "there exist at present no reliable measures for post-secondary education inflation"[12]. Undoubtedly this condition prevailing in the educational industry is to a large degree responsible for the generally regarded adjustment of faculty salaries to the rapidly escalating cost of living which erodes the real income of the faculty[38].

In the absence of a formal price-and-cost index for education industry, the readjustment of the level of academic salaries to the rate of inflation can be effectively accelerated by well publicized salary surveys data which tend to mitigate the distortion in academic salary structures resulting from uneven and incomplete impact of competition[38]. According to the economists, public knowledge of prices, wages and salaries paid is one of the essential prerequisites for the functioning of a free competitive market[38]. In other words, the access to salary information would enable the informed faculty to capitalize on its market position[10], thus forcing the educational institution to make an effort to maintain a competitive salary level at all times in order to maintain their share of "labor market". In the context of a free competitive national education market, in the course of inevitable competition for manpower, the institutions that pay unduly low salaries are unable to recruit and retain their share of qualified professional manpower and therefore, are forced to reassess their compensation policies.

This simple fact could very well represent one of the reasons why most deans are reluctant to release the salary data to the faculty.

They recognize that any condition which enhances or facilitates faculty mobility raises the level of faculty salaries and improves faculty's bargaining power. They are able to maintain salaries at a comparatively low level as long as they operate within conditions of imperfect competition. This gives them, as oligopoly without significant competition, the power to control salary levels[9].

Well publicized salary surveys also constitute an effective mechanism for bringing pressure on individual institutions to seek higher rankings in these annual reports by upgrading their scales[38]. This effect of publicized salary information, however, one should presume, the deans generally welcome. Although no scholarly study has been conducted to confirm direct relationship between publicized salary surveys and the improvement in academic salaries during the 1960's, many faculty members and administrators have testified to the existence of such a relationship at their institutions. For example, it has been frequently reported that a disappointing standing in the AAUP surveys strengthens the administrator's argument with his Board of Regents that the rate of improvement in faculty compensation must be substantially increased[10].

Finally, disclosure of faculty salary data constitutes an effective device to re-establish an adequate spread between ranks which is necessary to maintain the attractiveness of the academic career to larger numbers of qualified persons. Faced with fiscal problems, the administrators are likely to distribute salary increases without reference to merit by giving the greatest amounts to newcomers in order to keep the institution competitive in seeking and attracting the best of the prospective young faculty. At the same time they are inclined to give smaller salary increases or withdraw the raises entirely from the less mobile members of the staff who, generally speaking, represent older faculty "rooted" in the community in many ways, but particularly by the retirement system, and for whom there is a lessened demand in the academic labor market. Policies of this nature produce a "levelling" effect which, once identified, can be overcome by establishing higher minimum salaries for professors and associate professors[8,38].

On the basis of the above presented considerations it would appear that faculty salary data should not be viewed as a confidential and purely internal administrative matter; nor should the salaries be considered an issue reflecting self-serving, political interests of the faculty. There is ample evidence that non-competitive faculty salaries affect faculty retention, impair faculty recruitment and produce a decline in the quality and an eventual shortage of the full time

faculty. In the final analysis, these events reduce the amount of time available to the faculty for teaching preparation, research and self-development, affect the quality of education[39] and the quality of our educational end-product, the practicing dentist. Therefore, it seems that as long as the freely accessible information about the comparative levels of faculty salaries tends to improve the external competitiveness and the internal consistency of the institutional salaries and the individuals are not identified in a survey, there is no legitimate justification for keeping the faculty salary data confidential. One might also point out that unrestricted distribution of dental faculty salary data would tend to "sharpen" and improve the data by subjecting them to public inquiry and scrutiny.

INTERNAL CONSISTENCY OF PAY DIFFERENTIALS

Equal in its importance to the external competitiveness of academic salaries, both vis a vis other institutions as well as vis a vis the non-salaried dentists, is the internal consistency of academic pay. In fact, the basic rules and principles of salary administration are designed to maintain both a competitive position of the institution and equitable relations within the organization. The degree of acceptability of the particular pay system and the level of understandability of the concepts of distributive justice underlying the differential pay decisions have a critical impact on the institutional climate. Therefore, a model of salary budget should be clearly delineated and the criteria and procedures employed in the process of allocation of pay differentials frankly communicated to the faculty.

The annual salary budget should take into account the following broad considerations:

A. Budgeting salaries for a new faculty.

In contrast to industry which employs various methods of job "positioning"[40] based upon job evaluation, maturity curves or time span of discretion, the determination of the initial pay of the new faculty depends primarily upon the market conditions, academic maturity, and therefore, the rank of the new entrants into the academic profession and, naturally, the fiscal conditions of the institution[41]. Only few dental institutions have established salary range, that is, the spread between the minimum and maximum for a given rank. As a rule, this spread should not exceed 35 per cent and should be narrower in the lower ranks and wider in the higher academic ranks.

B. Budgeting salary increases for continuing faculty.
   1. Adjustment increases:
      a. Across the board increase – to overcome the cost of living escalation.
      b. Special adjustments – to overcome inequities existing in particular cases.
   2. Promotion increases – for those faculty members who have been advanced to a higher academic rank.
   3. Regular in-service increases based upon:
      a. Seniority, that is, number of years in rank, or
      b. Merit, that is, demonstrated quality of individual performance.
   4. Productivity increases – as indicated by the real rate of increase in the output per worker.

Let us now briefly discuss some features and the rationale underlying these differential salary increases:

Across the board cost of living adjustment vs. the merit increase. As we have indicated before, the education industry is one of the few major industries which does not have a formal index of the rate of inflation to provide a reliable measure of cost of living increases specifically tailored to the institutional needs. Somehow related to this is the fact that many educational institutions do not budget the cost of living adjustments. These institutions usually contend that in the presence of tenure, the academic vitality can be preserved only if the differential salary reward system is based on individual merit and therefore, they refute the notion of the cost of living adjustment. However, frequently, the so-called "merit increases" granted in those institutions fall below the cost of living inflation (10.8% last year) which, in terms of faculty real income, makes them de facto "merit decreases"[42]. As a rule, these institutions also insist that the determination of individual merit be left with the administration and assert that the management prerogative gives them the authority to make free distribution of merit increments in the context of so-called "star" system which does not make any attempt to measure the "quality" of the faculty but rather emphasizes the prestige distinctions among the faculty[8,29].

Many faculty members feel that making all raises merit increases, and letting the deans make the decisions about who is meritorious places "a weapon into the hands of administration that will humble the faculty and set back collegiality and faculty participation in university governance"[29]. They complain that such system is based

on administrative paternalism under which pay boosts are granted as "personal favors." Therefore they try to reduce or eliminate the power of "management" to differentially reward the "star" faculty with merit salary increments. They feel that the myth of the "confidentiality" of salaries needs to be exploded together with the prevailing "star system" which allows playing off one employee against another[29].

Some administrations, not many, set up college-wide personnel committees, or peer review committees, usually composed of senior, "elite" faculty charged with the preliminary assessment of "merit" of their younger colleagues. The administrators like to utilize these advisory committees for making unpopular and difficult decision for which they are reluctant to take the responsibility[8]. The risks involved in such exercise of "faculty power" are minimal because if the faculty committee makes a managerial decision which is unacceptable to the administration, the decision can be vetoed under the so called "shared authority" system. Clearly, there is some need to convert the shared authority system into a "guaranteed authority" system under which faculty recommendations could be overridden by the administration only for most compelling reasons.

As a rule, faculty personnel or peer review committees' functions are cloaked with confidentiality; discussions are privileged, at least within the university community, if not in law, and they vote by secret ballot. In a way, the "peer evaluation" or "merit determination" functions performed by these committees resemble a form of "ritual cannibalism" pursuant to which the establishment senior group of the faculty evaluate the junior non-establishment group[8]. There are many dangers and pitfalls associated with these committees because of their generally limited experience with the due process safeguards, and the usual absence of clear guidelines or procedures for assessing the "merit". Furthermore, most faculty members consider their committee assignment as unduly energy-consuming and economically as well as professionally unrewarding. In light of all that, the rank-and-file faculty may need protection against their "peer review" colleagues as much as they seek protection against the administration[8].

Seniority salary increase. In contrast to the merit increase which is based upon subjective judgment, the seniority can be measured by the objective standards, that is, the years in rank. For a faculty member to advance through the ranks from an average instructor's salary to an average full professor's salary in 20 years, a moderate

rate of progress, his annual in-service increase would have to average 3.5 per cent. The same climb achieved in 15 years, which is more applicable to the conditions prevailing in professional schools, would require an in-service component averaging 4.7 per cent per year. These calculations are based upon data which suggest that the average salary of full professor is twice as high as the salary of the average instructor[14].

Promotion increase. The magnitude of this salary increment is to significant degree determined by (1) the width of the within-rank salary spread; that is, the range between the minimum and maximum for a given rank; and (2) the presence and the number of within-rank salary "steps".

Production increase. This represents an allowance for the general increase in wealth, as indicated by the real rate of increase in the output per worker and is needed to keep abreast with the rest of the country[14]. For example, real output per worker was 2.5 per cent greater in 1973 than in 1972 and this rate of improvement is quite steady from year to year.

On the basis of the above presented salary increment formula, naturally assuming that the economic trends remain unchanged, the following projection of an equitable average, in-rank salary increase could be made for the 1974-75 academic year beginning on July 1, 1974:

cost of living adjustment	10.8%
In-service increase	4.7%
General productivity increase	2.5%
TOTAL EQUITABLE ANNUAL SALARY INCREMENT	18.0%

On the basis of the above formula, the magnitude of salary increments of those faculty members who are being advanced to higher academic rank ought to be larger than 18 per cent.

CONCLUSION

Whether the dental faculty is able to reverse the recent decline in its real income and achieve equitable salary increases without resorting to some form of collective action will be determined, in principle, by the fundamental power relationship underlying the salary negotiations. If the faculty and frequently the administration continue negotiating salaries and making salary decisions on the basis of fragmentary facts and unsubstantiated perceptions about the academic market conditions, the external competitiveness and the internal consistency of faculty compensation will not be achieved.

To be productive and meaningful the process of salary "negotiations" – whether between faculty and the dean, the dean and the president or the central administration and the board of regents and the state legislature – all these "negotiations", to be productive, must be based upon mutually accessible, accurate, adequate and comparable information. Only then will the salary negotiations involve the process of rational demand formation followed by a rational revision of this "demand" by the other party which fundamentally, represents the basic mechanism whereby the parties converge toward an equitable agreement[43,44].

Some "tough" administrators are know to employ a "take it or leave it" tactic in "salary negotiations" with their staff and frequently, are able to impose unilateral concessions upon their "timid" faculty. Their institutions tend to applaude this capacity to "stretch" the salary package, usually unaware that concessions beyond the point of acceptable yield[43] impose heavy costs in terms of academic climate, cooperation, faculty motivation and morale which give rise to faculty alienation. Such insensitivity toward the meaning of "pay" which, generally, is perceived as a shorthand of the "worth" of faculty member's job, as seen by the administration, invariably leads to institutional dissonance which, as a rule, impairs the attainment of organizational goals. Furthermore, in the context of rapidly escalating cost of living, the power to impose unilateral salary concessions upon uninformed faculty amounts to having power to virtually dismiss the faculty without due process. Clearly this must be viewed as contrary to the accepted standards of academic freedom and tenure and inconsistent with the best interests of dental education.

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This is the first of a series of articles dealing with the current issues in dental education and examining their impact on the quality of dental education and the continuous availability of high quality dental faculty. The future articles will be devoted to such matters as the professional autonomy and academic promotions.

"Love is wise, hatred foolish. In this world getting more and more closely interconnected, we have to tolerate each other. . . to put up with the fact that some people say things we don't like. We can only live together in that way and if we are to live and not die together we must learn a kind of charity and tolerance that is absolutely vital to the continuance of life, all life on this planet.

Bertrand Russell

Is Dental Hygiene Education of Today Preparing Students for the Challenges of Tomorrow?*

SHIRLEY R. PYKE, R.D.H., M.P.H.**

The topic was chosen for the occasion of your Capping Ceremony because you are preparing for entry into a profession which is undergoing dynamic transition and facing many challenges. It is hoped that you will consider what will be said so that you can form your own opinions and come to some conclusions regarding the question posed in the title.

There is no need to remind you that the dental hygiene profession came into being in 1913 as a result of Dr. Fones' interest in preparing young ladies to provide prophylactic services for the school children of Boston. If a comparison between the progress that has been made in the profession in 61 years with the progress that has been made in other health professions over the same period of time, it appears that the dental hygiene profession does not compare too favorably.

The focus of dental hygiene education today is not much different from what it was 28 years ago when I was graduated as a dental hygienist. Then as now, proficiency in clinical technics and preparation for private practice was emphasized. This emphasis was and is justified probably because at least 85% of all graduating hygienists do go into private practice. Another justification might be that state statutes and dental practice acts have been specific and restrictive when defining the duties of the dental hygienist.

But let's face it, and be honest with ourselves, does it really take two years to develop proficiency in "scaling teeth"? Until recently, that has been the major duty of the hygienist in private practice. To what extent was or is she or he permitted to put to use the basic

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*This paper was presented at the Fifth Annual Capping Ceremony of the Dental Hygiene Class at Camden County College, Blackwood, New Jersey, May 26, 1974.

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sciences which were included in the curriculum? Frankly, most dental hygienists are over prepared for what they are permitted by law, to do.

Yet, because of the influence and authority which the Council on Dental Education of the American Dental Assocaition exerts in determining which schools and programs shall receive accreditation, the criteria for dental hygiene education which they have established must be followed, if the graduates are to be eligible for licensure in any state. When we recognize that the majority of the professionals on this Council represent the private practice of dentistry, is it any wonder why the emphasis is on preparation which will meet the needs of the private dental practitioners? And what percentage of the population benefits from the services of a dental hygienist in private practice? The Survey of Dentistry published in 1961 showed that only 40% of the total population sought dental care during any year and only 20% of the population sought it regularly. Today 13 years later, despite the increase in dental school graduates and the growth of dental hygiene programs, we have not managed to increase the percentage of the population which receives dental care. The problem must lie with us, the members of the profession, and not the public. How can we rectify the situation and abide by the section in the A.D.A. Code of Ethics which states that ". . . we have the obligation of providing freely skills, knowledge and experience to society . . ."? As members of the dental profession you will be facing challenges and have to cope with a transitional state new to the profession. What are some of the ways the profession is being challenged? – and what transitions are taking place in the profession?

One of the overwhelming transitions is that the consumer is now demanding a "little piece of the action". By that is meant they have banded together as a coalition and have verbalized their concerns about the delivery of health care in this country. Briefly, they are concerned with and demand that something be done about; the cost, the quality, and the availability of health care, as well as consumer involvement in the planning and delivery of health care. All of which has resulted in the recognition on the part of the health professionals and government that there is a need for some form of National Health Care Legislation. I won't bore you with the details of the many proposals under consideration to assure the availability of health care as a right rather than a privilege because until some form of legislation becomes law it is difficult to predict what form it will take, but rest assured, dental care will be included.

Another transition, particularly in the provision of dental care is the increased concern with and emphasis on third-party payment mechanisms. In addition to the pre-and post-payment plans for dental care, organized labor is now including the provision of dental care for their membership and their families in contract negotiations.

To you, perhaps the most overwhelming transition taking place in the dental profession is the appearance of the expanded duty auxiliary. This auxiliary is trained, frequently in less time than you, to perform duties which many states still deny the dental hygienist the right to perform. You should not be blamed if you question the justice in such action.

So what is your role in the future, and to what extent are you being prepared and educated to meet these challenges and transitions?

In the first place, becuase the dental hygienist has the responsibility for patient education, she or he should be well versed in the behavioral sciences, and educational methods. When one compares the amount of time allotted to these areas in the dental hygiene curriculum with the time allotted to clinical and technical areas, how well prepared is the hygienist to meet the responsibility of being a competent patient educator? And how much time is allotted to community experiences which might help the student to develop a degree of social awareness which might enable her to understand better the needs and demands of consumers? And outside of a lecture or two on social and legislative issues, how much time is spent helping the student to understand these to the point that he or she can converse intelligently with a patient who does not quite understand all of the ramifications of a piece of legislation? How much time is spent in helping the student to understand third-party payment plans, especially as they relate to private practice?

As for the expanded duty auxiliary, why should the dental hygienist feel threatened by an auxiliary who is simply a trained technician? It is understandable, if the hygienists are not much more than clinicians or highly trained technicians themselves. But if the hygienist has the expertise to meet the challenges which have been outlined, then she or he is secure in the fact that they are professionals and educators with more than clinical proficiency and technical competency.

I ask you to give serious thought to what has been said, and form your own conclusions about whether dental hygiene education of today is preparing students for the challenges of tomorrow.

Dental Fees, Productivity and Income

MAX H. SCHOEN, D.D.S., Dr. P.H.*
and NEVILLE DOHERTY, M.S., Ph.D.**

Introduction

The current crisis in health care includes a number of problems such as inadequate manpower, maldistribution and lack of accessibility. But, probably the most dramatic problem is that of increased cost of service. Between 1952 and 1970 the price index for all medical care rose by 103 percent, while the overall consumer price index, including medical care as a component, rose 46 percent (Table 1).[1] Inflation, in any form, may create problems, but that for health services has been out of hand, at least until the wage-price freeze. As a percentage of the gross national product, health expenditures have risen steadily over time and in 1971 they reached and passed 7 percent which was double the rate of 1929, the first year for which statistics are available.[2] While it is too early to evaluate conclusively the long range effect of the 1971-72 wage-price freeze on the cost of care, the medical care component of the CPI rose at a faster rate than the index in 1972.[3] This continued rise was a major reason why, in 1973, the administration continued mandatory price controls on the health industry while lifting them from most other industries.

Hospital care, the single largest health care component, is also the area of greatest inflation in health costs. The rise in expenditures from $4.7 billion in 1952 to $28 billion in 1970 represented an increase from $29 per capita to $134 per capita. While expenditures have increased each year, the rate of increase has picked up dramatically since 1965 – 13 percent per year compared with 7 percent in the previous 13 years.[4] In terms of the Consumer Price Index, the hospital component rose 309 percent from 1952 to 1970![1]

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The rising cost of hospital care is atrributable to a greater use of hospitals and to an increasing cost per unit of hospital services. More utilization, however, has accounted for only an eighth of the increase. The remaining seven-eighths are attributable to inflationary forces in general, but more specifically to particular forces affecting hospitals. Substantial increases in hospital wages, more personnel per patient day of care and increases in the value of hospital plant and equipment are the most significant components.[5]

What can be said of dental care costs? It is the purpose of this article to explore the changes that have taken place in fees, dollar value of production and dental incomes over the eighteen-year period from 1952 to 1970. The sources of data are triennial surveys on dental practices performed by the Bureau of Economic Research and Statistics of the American Dental Association,[6-12] Internal Revenue Service Reports[13] and material issued by the Bureau of Census.[14,15] Since the ADA surveys contain the greatest amount of information about dental practice, the study period was selected to coincide with the period during which they have contained income data.

DENTAL FEES

Dental fees rose 76 percent over the eighteen year period, 1952-1970, during which the CPI rose 46 percent. The annual rates of change, using 1952 as a base, were 4.2 percent for dental fees and 2.6 percent for prices in general (Table 1).

While all prices or fees are ultimately regulated by the laws of supply and demand, many forces are at work in the market for any particular commodity or service which can effect its price at any given time. Among the possible causes of increased dental fees are the following:

1. increased costs of production – a supply factor
2. increased consumer demand for dental care – a demand factor.
3. relative lags in supply in adjusting to increases in demand.

Each of these can operate independently or together. Each one affects the demand for dental care, the supply of dental services or both.

Hann,[16] in a study of relationships between costs and fees, suggested that rises in dental fees were only indirectly related to supply and demand factors. Because supply and demand caused higher wages in "other" industries, dentists were forced to obtain income parity by raising fees. The possible implication that dentists ignore the market for their services when they set fees is implausible.

If there is any doubt on this point, we suggest that the doubter double his fees and then observe the demand for his services. What might be more plausible is that dentists have benefited economically from a relatively slow adjustment of supply to increasing consumer demand for dental care. Whether normal or contrived, this lag has insulated dentistry from the harsher vicissitudes of a competitive market. Consequently, dentists have been able to exert a degree of control, comparable to that in other professions, over the prices at which they provide their services.

In another vein the American Dental Association has issued a pamphlet, intended for distribution to patients, explaining dental fees.[17] It points out that although fees have risen more than the cost of living, wages have increased at a greater rate. The pamphlet contains a chart describing the distribution of dental office expenses, but does not include the dentist's income. The clear implication is that fees have risen because of the increased cost of production.

TABLE 1

Selected Price Indices
1952 - 1970[1]

Year	Consumer Price Index	All Medical Care	Physician's Fees	Dentists' Fees
1952	100	100	100	100
1955[2]	102	110	109	108
1958	109	123	122	116
1961[2]	113	137	132	123
1964	117	147	143	132
1967	126	169	167	148
1970	146	203	203	176

Source: Table 4 Bureau of Economic Research and Statistics. Expenditures and prices for dental and other health care JADA 83:1334-1337 December 1971.

1. In all tables and charts in this article where constant values are used, 1952 = 100.
2. The figures for these years are derived by interpolation between two even numbered years.

What is not clear, however, is whether the remuneration of the dentist is regarded as a wage item, a return on investment, a profit, or something else.

Thus, while there is general agreement that dental fees have increased, the cause of the increase is not altogether clear. Costs have definitely increased, but there is a lack of agreement about what constitutes different aspects of costs. In particular, in looking at the reasons behind the changing cost of producing dental services, it is important to differentiate between resources over whose price the dentist has little control – as is the case for most of the tiems he purchases – from those over which he has considerable control.

DOLLAR VALUE OF PRODUCTION

Tables 2 and 3 show that the mean gross income of independent dentists has risen from nineteen to fifty-nine thousand dollars (216 percent) in the period under study. If we adjust these figures for the 76 percent increase in dental fees, we find that this more than two fold increase in dollar value represents an 80 percent rise in constant dollars. The various ADA surveys of dental practice report practically no change in work hours or work weeks over these eighteen years, so the 80 percent increase represents a true rise in the monetary value of the output of services per dentist work hour. The data suggest that the productivity changes this rise represents are largely attributable to the use of more auxiliaries, more skilled auxiliaries, more equipment and more advanced technology.

The average increase in real output has been 4.4 percent per year in relation to 1952 dollar production. Over the same period the real value of the gross national product (the final value of all goods and services produced and sold in the economy deflated by the CPI) rose approximately 4 percent per capita per year.[18] Thus dentistry's growth rate has been slightly better than that of the overall economy.

In this 18-year period, however, reported patients per dentist have only increased by 47 percent (2.6 percent per year).[6,12] These rather small changes indicate that the number of patients seeing any dentist in a given year has increased very little. Also the 47 percent increase per dentist contains considerable overlapping, since specialization has increased and more patients have been seeing more than one dentist. The National Health Survey data and data on the utilization of dental prepayment plans seem to verify this finding of a small

TABLE 2

Annual Income of Independent Dentists 1952 - 1970

Year	Mean Net Income	Median Net Income	Mean Gross Income	Mean Net as Percent of Gross
1952	10,873	9,961	18,797	57.8
1955	12,480	11,533	22,093	56.5
1958	14,311	13,366	26.030	55.0
1961	16,020	14,747	29,435	54.4
1964	19,835	18,020	36,352	54.6
1967	24,740	22,850	46,391	53.3
1970	30,770	28,100	59,325	51.9

Source: Triennial surveys of dental practice conducted by American Dental Association Bureau of Economic Research and Statistics.

TABLE 3

Indices of Change in Income of Independent Dentists 1952 - 1970[1,2]

Year	Mean Net Income	Median Net Income	Mean Gross Income
1952	100	100	100
1955	115	116	118
1958	132	134	138
1961	147	148	157
1964	182	181	193
1967	228	229	247
1970	283	282	316

1. See Table 1, Note No. 1.
2. Derived from Table 2.

increase in use. NHS studies for 1957-68, 1962-63 and 1969 report annual use rates of 36.7%, 42.0%, and 44.9% respectively.[19,20] The rate of increase over the 11½ year span is only 19.6 percent, or 1.7 percent per year. Data on utilization of prepaid plans, collected by an ADA task force committee[21] and by Schoen,[22] show a clustering of rates around the 50 percent level; a few exceptions rising above 60 percent are balanced by some falling below 40 percent.

Since the real value of production has risen at a greater rate (4.4% per year) than the rise in the number of people seeing a dentist (2.6% per year), the most logical deduction is that dental patients are receiving more care than previously. Some verification of this deduction is obtained by comparing the distribution of visits as reported in the NHS studies for 1957-58 and 1963-64.[19]

While total visits were the same (1.6 per person per year in each period), in the latter period the percent of visits for "cleaning" had risen from 10.4 to 13.6 of the total. "Straightening" had risen from 3.4 percent to 5.8 percent, and "gum treatment" from 1.5 to 3.6 percent. Extractions had decreased from 17.0 percent to 15.0 percent. Other classifications were changed during the interval so that differences in distributions might be due to interview variables rather than service variables. Additional verification of the changes in

TABLE 4

Indices of Change in Mean Gross Income of Dentists in Constant Dollars[1] 1952 - 1970

Year	ADA Data	IRS Data
1952	100	100
1955	109	120
1958	119	131
1961	128	138
1964	146	159
1967	167	187
1970	180	186

1. The constant dollar index is determined by dividing the annual gross income index (Tables 3 and 6) by the index for the increase in fees.

content of dental care is obtained from Moen and Poetsch's study of changes in dental practice occurring between 1950 and 1969.[2 3] Examinations, prophylaxes and topical fluoride treatments, crowns and specialty treatment increased considerably while extractions decreased.

Another set of figures on dollar value of production is obtained from the Internal Revenue Service. The annual gross income reported is about 25 percent less than that contained in the ADA survey (Table 5). Undoubtedly the sample used and method of reporting accounts for the difference. The IRS data show an increase of 228 percent. This is remarkably similar to the ADA's 216 percent (Table 6). The rise in constant dollars is 86 percent or 4.8 percent per year (Table 4).

TABLE 5

Annual Income of Solo Proprietorship Dentists – IRS Statistics 1952 - 1970

Year	Mean Net Income	Mean Gross Income	Net as Percent of Gross
1952[1]	7,254	14,020	51.7
1055	0.616	19.239	52;7
1958	10,672	21,294	50.1
1961	12,154	23,892	50.9
1964	14,947	29,422	50.8
1967	19,805	38,877	50.9
1970[2]	22,668	45,957	49.3

Source: Internal Revenue Service statistics on income – Personal Communication Zachary Dyckman, Division of Health Insurance Studies U.S. Dept. of H.E.W.

1. The 1952 figure was not available from IRS. Gross receipts were calculated by interpolation from 1951 and 1953. Net income was calculated by interpolation from 1951 and 1953 of those dentists with net profit and adjusted downward by the percent difference reported in 1953.
2. The 1970 figure was not available. Therefore, it was calculated by extrapolation. The rate of increase of 1969 over 1968 was applied.

INCOMES

Dentist net incomes did not rise quite as rapidly as gross incomes, reflecting a slightly disproportionate increase in expenses. Nevertheless, the Surveys of Dental Practice show a 183 percent increase in mean net income (10.2% per year) and 182 percent in median net income (10.1% per year) Table 3). The IRS data increase of mean income is 212 percent (11.8% per year) (Table 5).*

The dentist, however, is only one component of the dental team and the change in incomes of the other members should be compared with his. To begin with, his income is considerably larger than that of any of the auxiliary employees (Table 7). The most numerous auxiliary is the dental assistant, who also has the smallest mean and median salary – $4,764 in 1970. Increases over the 18-year period have been 123 percent for the mean and 134 percent for the median (Table 8). The annual rates are 6.8 percent and 7.4 percent respectively.

The only member of the team whose income has gained at approximately the same rate as that of the dentist has been the hygienist. There are still relatively few hygienists available and, at

TABLE 6

Indices of Change in Income of Solo Proprietorship Dentists
IRS Statistics
1952 - 1970

Year	Mean Net Income	Mean Gross Income
1952	100	100
1955	133	130
1958	147	152
1961	168	170
1964	206	210
1967	273	277
1970	312	328

1. See Footnote No. 1, Table 1.
2. Derived from Table 5.

*The use of mean or median in this article is determined by the availability of these figures in the original source material.

TABLE 7

Annual Salaries Paid to Full Time Dental Auxiliary Personnel 1952 - 1970

Year	Hygienists		Laboratory Technicians		Assistants		Secretary - Receptionists	
	Mean	Median	Mean	Median	Mean	Median	Mean	Median
1952	3,065	2,973	3,429	3,225	2,136	2,036	2,185	2,030
1955	3,651	3,500	3,807	3,738	2,421	2,333	2,509	2,404
1958	4,396	4,100	4,652	4,125	2,703	2,583	2,931	2,579
1961	4,784	4,600	4,853	4,817	3,096	2,960	3,542	2,994
1964[1]	5,448	5,220	5,532	5,460	3,384	3,324	3,696	3,612
1967	6,552	6,048	6,660	6,120	3,984	3,924	4,380	4,238
1970	8,424	8,340	8,436	7,260	4,764	4,764	5,172	4,860

Source: Triennial surveys of dental practice by American Dental Association Bureau of Economic Research and Statistics.

1. Since 1964 salaries have been reported as monthly, rather than annual incomes. The annual amount recorded in this table is twelve times the monthly amount and assumes no decrease for vacation or other time off periods.

TABLE 8

Indices of Change in Salaries of Full Time Dental Auxiliaries 1952 - 1970[1,2]

Year	Hygienists		Laboratory Technicians		Assistants		Secretary - Receptionists	
	Mean	Median	Mean	Median	Mean	Median	Mean	Median
1952	100	100	100	100	100	100	100	100
1955	119	118	111	116	113	115	115	118
1958	143	138	136	128	127	127	134	127
1961	156	155	142	149	145	145	162	147
1964	178	178	161	169	158	163	169	178
1967	214	203	194	190	187	193	200	209
1970	275	281	246	225	223	234	237	239

1. See Footnote No. 1, Table 1.
2. Derived from Table 7.

least until recently, in most states demand for hygienist's services has been increasing at a greater rate than the supply. As a result their wage rates have risen significantly.

COMPARISON WITH OTHER SECTORS OF THE POPULATION

The IRS data provide a means of comparing dental incomes with those of other sectors of the population. Table 9 compares dollar amounts and Table 10 compares rates of change. In 1952 the median dentist's income was $6,674, slightly over twice the median ($3,220) income of all employed males. By 1970 the comparative figures had reached $20,628 and $8,036 respectively. Thus not only had dentist's incomes increased absolutely, $14,000 compared with $5,000, but also relatively, 11.6 percent per year compared with 8.3 percent per year. In other words, dentists had approximately double the income of employed males at the beginning of the period, but the difference increased during the period, so that at the end it was approximately two-and-a-half times as great.

The median annual income of all full-time employed women rose 108 percent over the 18-year period, from $2,565 to $5,343 (Table 11). This 6 percent per year increase is less than that for dental assistants (7.4 percent) or for other full-time female auxiliaries. However, the level is about $500 per year more than for secretary-receptionists and assistants, although hygienists incomes are about $3,000 per year higher.

DISCUSSION

The methodology used in this paper to determine changes in dental fees and value of production has combined changes in the Consumer Price Index with changes in the average gross income per dentist. Another method for measuring fee changes involves the use of the "composite fee" used by the ADA's Bureau of Economic Research and Statistics.[24] This composite fee includes five dental procedures (prophylaxis, amalgam filling, extraction, acrylic jacket crown, and full upper denture) in varying proportions to approximately the actual distribution of services, as opposed to the CPI's use of only two procedures, one surface amalgam and extraction on permanent teeth, (more recently three with full upper denture added). From 1956 to 1970 the composite fee increased 6.3 percent per year,[24,25] considerably more than the dental change in the CPI (4.6 percent). However, the rate of change for each item varied from

4.8 percent per year (prophylaxis) to 7.5 percent per year (simple extraction). The 4.8 percent item is one of those not included in the CPI. The other four procedures vary from 5.5 percent (one surface amalgam – more recently changed to two surface) to 7.5 percent. Apparently the difference in the two types of measurement stems from the differences in each item of service rather than from the use of different proportions. Furthermore, the ADA surveys are of a

TABLE 9

Comparison of Annual Income of Dentists To All Males (14 Years Old and Over) 1952 - 1970[1]

Year	Median Income of Males[2,3] Including Unemployment	Employed Only	Median Dentist Income[4]	Dollar Difference Between Dentist Income and All Employed Males
1952	$3,105	3,220	6,674	3,454
1955	3,354	3,797	8,847	5,050
1958	3,742	4,344	9,925	5,581
1961	4,189	5,035	11,182	6,147
1964	4,647	5,587	13,602	8,015
1967	5,571	6,610	18,221	11,611
1970	6,670	8,036	20,628	12,592

1. The data for all males includes part-time as well as full-time workers and a number of teenagers. There was no data available to compare the exact levels of part-time functioning as dentists, or the relative effects of dentsits with no income. It is assumed that if all differences in sample selection were eliminated, the relative amounts would remain about the same.
2. US Department of Commerce, Bureau of the Census. Current Population Reports: Consumer Income. Series P-60, No. 69, April 6, 1970.
3. Current Population Reports: Consumer Income. Series P-60, No. 80, October 4, 1971.
4. Median income has been calcualted from mean income in Table 5 by taking the same proportion of median-mean as exists in Table 2, since this data was not directly available to the authors. The resultant approximation is sufficient for the broad generalizations used in the article.

TABLE 10

Indices of Change in Median Annual Income for Dentists and All Males [1,2]

Year	Median Income of Males Including Unemployed	Median Income of Males Employed Only	Median Dentist Income	Ratio of Dental Income to All Males	Ratio of Dental Income to Employed Only	Dollar Difference in Income
1952	100	100	100	215	207	100
1955	108	118	133	264	233	146
1958	121	135	149	265	222	162
1961	135	156	168	267	222	178
1964	150	174	204	293	243	232
1967	179	205	273	327	276	336
1970	215	250	309	309	257	365

1. See Footnote No. 1, Table 1.
2. Derived from Table 9.

different sample, and since the distribution of services in dental practice is not known accurately, the construction of the composite fee must also involve problematical estimating procedures. As an additional complication, the relative proportions of each item have changed over the years, so the Bureau correctly cautions against comparing different periods.[24]

Similarly, the ADA studies show much greater gross and net incomes for dentists than do the IRS data. However, because the rate of change was about the same, the discrepancy in amounts does not create any difficulties in this analysis.

This article has calculated average annual rate of change using the initial year (1952) as a base. Another method is to use each year as a base. During a period of constant increase the resultant percentages consequently would be less. However, the key source used in this paper[1] uses a single base year. In addition, even if the annual aver-

TABLE 11

Annual Income of Women (14 Years and Over) Employed Full Time and Indices of Change[1,2] 1952 - 1970

Year	Median Income	Change
1952[3]	2,565	100
1955	2,778	108
1958	3,133	122
1961	3,371	131
1964	3,740	146
1967	4,329	169
1970	5,323	208

1. See Footnotes 2 and 3, Table 9.
2. See Footnote No. 1, Table 1.
3. Figures were not available for women employed full time in 1952. The percentage difference between full-time and all incomes (including part time) for all the other years were averaged and applied to 1952 to construct the figure used in the table. (The range of difference for the other years was 137-144 percent greater for full-time overall workers.

ages were different the relationships between fees, productivity and income would remain the same.

It is quite common for production to be measured by number of patient visits per dentist.[21,26] As indicated earlier, this approach produces a smaller change over the 18 years than the use of differences in constant dollars. The possibility that the change in content of a visit creates greater error than miscalculations of fee rise has led to the rejection of this approach by the authors. It would have been desirable to measure changes in productivity of dentists in the technical sense of units of output per unit of input, but such information is unavailable and indirect indicators must be used instead. The following discussion assumes that the increased value of production, in constant dollars, reported here is approximately equal to the real change in productivity of dental practices over the past 18 years. This hypothesis is based on the assumption that the change in the mix of services previously reported would not materially affect dollar value.

Despite the increase in production, dental fees have increased by more than enough to compensate for increases in costs. Even if fees had risen at the same rate as costs, dentists could have redistributed some of the benefits of their increased productivity to their most numerous employees, in the form of higher wages, or to their patients, in the form of lower fees without grossly disturbing their relatively faborable economic status. The fact that neither of these courses of action has been adopted is understandable in an economic sense, and conforms with our earlier statements about the control dentists have over their market environment.

The demand for care has been such that the increases in fees have been paid for primarily by that minority of the population who use the dentist regularly and who have also received more service. As a result, dentistry may have become even more inaccessible to lower income groups who do not use its services regularly. Hypothetically, less inflation, regardless of other factors, might have allowed more demand for care by more persons on a fee-for-service basis and more third party purchase of dental care. But, whether or not this increase in the quantity of services demanded would have motivated more dentists to use more auxiliaries and to increase, thereby, productivity and the availability of care must also remain a hypothetical issue.

A major question raised by the data concerns the effect of expanded duties of auxiliaries. The thesis has been advanced that fee and production increases have been used primarily for the dentist's

economic advantage. If this is correct, is it not logical to expect that future productivity increases also will accrue to the dentist? As long as a shortage of dental service exists, and the dentist represents the scarcest resource as well as the entrepreneur, it should not be assumed that incorporating higher level auxiliaries into private dental practice will automatically result in lowered or even stabilized fees.

Under normal market conditions, such a change might cause the supply of services to increase sufficiently to offset the effects of the growth in demand on fees. However, to describe the market for dental services as normal, in the sense of competition and predictable demand, is misleading. Furthermore, the dentist is a determinant of demand in that he usually can find more work to do on those persons seeking dental care. Might not, therefore, another 80 percent increase in output still be applied to only a small percentage of the population?

Obviously, if the ability to produce dental care expanded sufficiently to create a surplus of providers, the interaction of supply and demand and the effects of competition might start to drive fees down. Economic theory, however, amply verified in the American industrial experience, tells us that as long as producers maintain some measure of control over their economic environment, it pays them to limit production; to stop short of letting prices fall to the point where they are equal to the value of production.[27] In the final analysis, one must ask what objective reason can be found for supposing that dentists, either individually or collectively, should behave differently with regard to economics.

The purpose of this article, however, has been to examine facts and to ask questions, not to propose solutions. Nonetheless, some additional forms of control, no matter how onerous, might be imposed on the profession. It is imperative, therefore, that the profession becomes completely involved in working out reasonable solutions to the problems of shortages and high prices.

Dentistry, after all, operates within the total health care scene which now consumes over 7 percent of our Gross National Product. The wealth of the country may allow some further increase in this amount, but pressures are mounting to institute controls. Every system has its limits and the present one is threatened at its seams.

SUMMARY AND CONCLUSIONS

Data have been presented which show that dental fees have increased by 76 percent over an 18-year span. At the same time,

average value of production in constant dollars has increased 80 percent while dentists' incomes have increased by 183 percent.

Dental assistants and secretary-receptionists' incomes increased at a slower rate (123 percent and 137 percent respectively). While the increase has been greater than that for all women employed full-time, the median income is well below the average for all full-time employed women.

The rate of increase in dentists' incomes was greater than that for all males. Since dentists' incomes are in the top 5 percent bracket, the absolute difference in dollars increased even faster.

A disequilibrium exists between supply and demand in the market for dental care. The demand for dental care has increased relative to the supply of services, and inflation has counteracted the economic effects of the supply increases that have occurred. These factors have been associated with large increases in dental fees and incomes. However, as long as the market for dental care services departs substantially from the competitive norm, dentists cannot realistically be expected to pass on a greater share of the economic advantage of productivity gains to the consumer. Since greater competition is not to be expected in the strict economic sense, control functions, largely the prerogative of the profession prior to the recent freezes, are likely to be shared more and more with consumers and government. If the situation is to be changed, it would seem that a combination of private and public policies should be designed to improve the efficiency with which market prices reflect both underlying human wants and the true value of production.

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Book Review

Community Dentistry: Dummett, Clifton O. and ten contributors. Springfield, Illinois, Charles C. Thomas, 208 pp.

The objectives of this book, as the author states in his introduction, are "to present a contemporary overview of community dentistry and its parameters; to define its relationships and involvements with other specialties of dentistry; to point out who, what and where are advantaged and disadvantaged Americans; to look at and understand their concepts of health and health care; to appreciate the priorities they ascribe to medical and dental care; and to emphasize the necessity for interprofessional empathy and coordination in order to furnish comprehensive health care." To accomplish these aims, the author, professor of community dentistry at the University of Southern California has drawn on his own experiences and the expertise of other authorities in the dental medical, sociological and psychological fields. In their chapters they have discussed community dental programs, examined the development of group practice, delineated the scope of dental care and emphasized the influence of the social and behavioral sciences on community dentistry.

Dr. Dummett is to be commended for the excellence of this text and the choice of his contributors – authorities such as Rudolph Friedrich, Max Schoen, Jay Friedman, Myron Allukian and C. Edward Rutledge. Together they have produced a book, one of the first of its kind, which all dentists interested in the subject can read to their advantage.

"We judge others by their actions, we judge ourselves by our motives."

Dwight Morrow

Letters to the Editor

The editorial, "Third Party Programs: Implications for the Future", which appeared in the January 1974 issue of the Journal, was reprinted in the May issue of the Journal of the American Dental Association. Two letters of comment by non-Fellow dentists are printed here.

Dear Dr. Kaplan:

I wanted you to know that I agreed with you on your observation on how our economy was going and the trend in America of "gathering gloom". I feel that if we successfully solve our present problems we will be in a stronger position to tackle the problems around the corner which the eighties will bring.

It appears from your article that you feel third party payment of dental care is the answer for survival during hard times. Look at our physician brothers! They have accepted third party payments, and gone astray with that decision.

Dr. Kaplan, look into P.S.R.O. Physicians are fighting for their very survival, as a profession, through various organizations attempting to repeal this act of our congress. A pediatrician friend of mine and I were discussing third party payments the other night and both agreed on peer review, but he realizes that if trends continue he may get rich but lose his freedom to diagnose and treat diseases as he feels is best for his patient. P.S.R.O. (Professional standards review organization) Blue Cross, Blue Shield, Delta Dental, and other interested third party organizations have and will continue to tell us how to treat their patients, how long hospitalization is needed for each disease, yes and even what is a fair fee without knowing the doctor or patient. I think we in dentistry are making a grave mistake if we believe for a second that insurance companies, federal government, etc. care more for our patients than we do. We could be slipping into the old trap of accepting responsibility without authority.

I disagree entirely with the fact that our profession should be committed to "bringing dental care to everyone that wants it". Please send me any quotes where our leaders have stated this.

There are many things I want personally, but they all have there price. I do not know of anything that doesn't have a price. My

children want many things that they cannot have due to the price and also it would hurt them to have everything they wanted. We will never get everything we want. If there is no price, I want it all. Don't you? Fortunately in the real world everything has a price, even dental care.

If the American public wants dental care at the price of losing free enterprise and prostituting a fantastic profession, the price is too high and it is past time to tell them no.

Yours for better dentistry,

Bill Adams,
Austell, Georgia

Dear Dr. Kaplan:

This morning I received the May issue of the Journal of the American Dental Association and read, with great interest, your editorial, entitled, "Third Party Programs: Implications for the Future". You have certainly stated things very well and placed them in perspective. You delivered a message to our fellow practitioners which cannot be repeated too often.

It is certainly true that we do, indeed, have a buffer against the extreme hard times that were experienced by many dentists in the great depression and that is, as you have pointed out so well, by the presence of third party programs. It is our view that these are not only good for the profession, because of the economic stability they provide, but also as you have said, by making dental treatment available to the people. Both elements are quite necessary if our profession is to retain the prestige it enjoys and the good will of the people it serves.

Congratulations on an excellent editorial and thank you for your support of Delta Dental Plans.

Kindest regards.

Yours very truly,

Burton H. Goodman, D.D.S., President
Delta Dental Plans Association
Tacoma, Washington

New England Section

The annual Spring Meeting of the New England Section of the American College of Dentists was held Monday evening May 6, 1974 at the 57 Restaurant in Boston, in conjunction with the annual meeting of the Massachusetts Dental Society.

The speaker was Regent Gordon H. Rovelstad who gave a very interesting and informative talk about the College. Among other things, he brought us up-to-date on recent changes which have taken place. Following his presentation he responded to numerous questions.

Spencer Frankl, who is Regency One's representative on the Nominating Committee, talked briefly about that committee's activities.

The following members were elected to office for the year 1974-75: Chairman – Ira S. Colby, Pittsfield, Mass.; Vice-Chairman – A. James Kershaw, Jr. of West Warwick, R.I.; and Secretary-Treasurer – Orrin Greenberg of Chestnut Hill, Mass.

NEWS OF FELLOWS

The Alumni Association of the School of Dentistry of the University of Alabama-Birmingham has named Edwin M. Speed, assistant dean, the recipient of the H. Moran Fuller Award.

The award is given annually in recognition of outstanding service and accomplishment in the dental profession. It is named in honor of the late Dr. H. Moran Fuller of Centreville, who was instrumental in the establishment of the School of Dentistry.

Harold M. Fullmer, director of the University of Alabama-Birmingham Institute of Dental Research, has been elected vice president of the International Association for Dental Research, and vice president of the American Association for Dental Research.

Herbert V. Muchnic, Beverly Hills, California, was installed as president of the American Association of Orthodontists at its annual session in Houston, Texas recently.

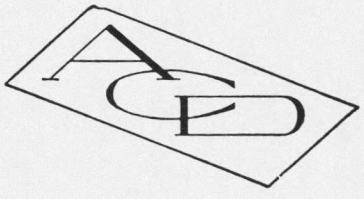
John Erdmann Aldrich of Columbus, Ohio, was installed as president-elect of the American Association of Orthodontists at the same time.

James J. Ficca of Wilmington, Delaware was the recipient of the Certificate of Honor awarded to an alumnus of the School of Dentistry presented recently at the Temple University Founder's Day Dinner.

John Salley, dean of the school of Dentistry of the University of Maryland at Baltimore, has resigned to accept a new administrative position at Virginia Commonwealth University, the associate vice presidency for research and graduate affairs.

Lincoln L. Riley of San Fernando, California, has been named the national dental consultant of Connecticut General Life Insurance Company.

Frank J. Orland of Chicago is the author of a history of the first fifty years of the International Association for Dental Research. Dr. Orland is a past president of the IADR.



The Objectives of the American College of Dentists

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

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

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

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

(d) To encourage, stimulate and promote research;

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

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

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

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

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

Revision adopted November 9, 1970.

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