

The JOURNAL
of the
AMERICAN COLLEGE
of DENTISTS

**ALTERNATIVES IN
ORAL HEALTH CARE**

**TRENDS IN
DENTAL EDUCATION**

TEACHING JURISPRUDENCE

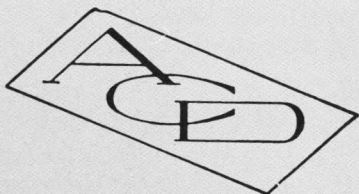
JANUARY 1975



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NEWS AND COMMENT

BOARD ACTIONS AT WASHINGTON MEETING

The Board of Regents, meeting in Washington, D.C. on November 6, 7 and 8, just prior to the annual meeting and convocation, took the following actions:

- Adopted a motion that the Bylaws be amended to eliminate the Section-at-large concept.
- Passed a resolution that would allow the SACED committee to proceed with the development and expansion of the Mini-Self-Assessment program.
- Referred to committee a motion to revise the committee system in order to improve the effectiveness of the College in its programs.
- Adopted a proposed model for Section Bylaws, which will require rechartering of all Sections.
- Adopted a prototype form for the annual report of Section activities.
- Approved the preparation of a brochure for dental students that would stress the theme of professionalism and explain the principles underlying selection to Fellowship. Such a brochure will familiarize students with the objectives and principles of the American College of Dentists.
- Adopted the 50th anniversary seal as the logo for Sections.
- Requested the Self-Assessment and Continuing Education Program committee to review the College's contract and present status with the Educational Testing Service, and to report back at the Spring meeting of the Board of Regents.
- Approved new guidelines for the selection of the William J. Gies Award, Honorary Fellowship and the Award of Merit.
- Approved a motion to hold a Journalism Conference for editors who are ACD Fellows.
- Passed resolutions of appreciation to president Louis G. Terkla and to Regent Charles McDermott, upon completion of their terms of office.

MINI-SELF-ASSESSMENT TESTS SUCCESSFUL IN NEW YORK

Nearly three hundred dentists attending the Greater New York Dental Meeting in December at the New York Hilton took part in the Mini-Self-Assessment program. Tests were given at hourly intervals over a three-day period. There were fifty multiple choice questions in the test which required about 30 to 45 minutes to complete.

Each participant was asked upon completion, to fill out an evaluation sheet, which will provide valuable feedback to the SACED committee in determining the future of American College of Dentists activities in the self-assessment and continuing education field.

All test books were destroyed upon completion of the test, and no one but the participant knew how he scored. Each dentist who took the test was presented with an identification badge which read "I did."

Comment was generally favorable, and a report to the College will be published in a future issue of the Journal, when results have been tabulated.

CHICAGO NEXT

Another Mini-Self-Assessment test will be held in February during the Chicago MidWinter Meeting. Fellows of the Illinois Section will assist in the operation of the programs, which will be held at the Conrad Hilton. The format will be the same as the New York meeting.

Plans are also under consideration to present the program at some of the other major dental meetings in 1975.

SECTION NEWS

New York Section

The Fall meeting of the New York Section was held at the New York University Club September 24th. Sixty of our section's members shared the fellowship of a social hour and dinner followed by a business meeting. The guest speaker, Michael M. Baden, M.D., the Deputy Chief Medical Examiner of the City of New York, presented a stimulating and timely lecture on "The Medical Examiners Office and the Dentist."

This was the first session for the new executive committee consisting of Dr. Michael Turoff — Chairman, Dr. Charles Hillyer — Vice-Chairman, Dr. Barry Symons — Secretary-Treasurer, Dr. Andrew M. Linz — Past-Chairman, Dr. Walter H. Mosmann — Regent, Dr. Irving J. Naidorf — Historian.

One of the highlights of the evening was the presentation of a gift and a certificate of appreciation to our past chairman, Dr. Andrew M. Linz, for his devoted service to the organization.

New Jersey Section

At a recent meeting of the New Jersey Dental Association at its headquarters building in North Burnswick, N.J., a number of Fellows of the College were in attendance as gifts of a speaker's lectern, a large projection screen and an electric pointer were presented to the Association in honor of the Fellows of the New Jersey Section who have served as officers or committee chairmen in N.J.D.A. The lectern was specifically designated in honor of Fellow L. Deckle McLean, immediate past president of the Association.

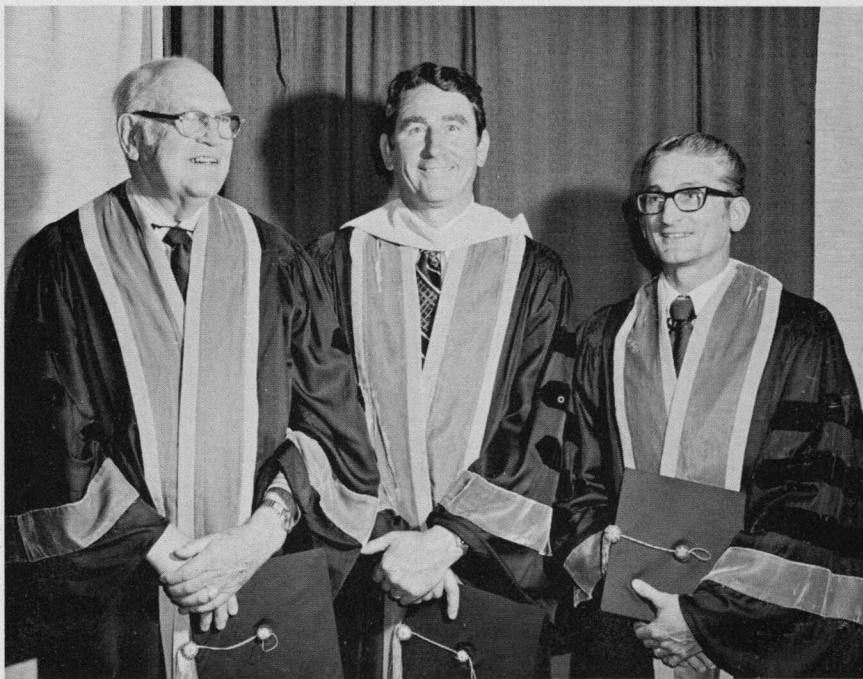


Left to right: C. Kermit Botkin, Chairman of Presentation Committee; Marvin L. Fishmann, Section chairman; and L. Deckle McLean, honor recipient.



OFFICERS OF THE COLLEGE 1974

Left to right: Editor, Robert I. Kaplan; Vice-president, James P. Vernetti; President, Louis G. Terkla; President-elect, P. Earle Williams; Treasurer, Henry J. Heim; and Executive Director, Robert J. Nelsen.



Left to right: Incoming President P. Earle Williams; Governor of Tennessee Winfield C. Dunn; and Outgoing President Louis G. Terkla.

the JOURNAL of the AMERICAN COLLEGE of DENTISTS

A QUARTERLY PRESENTING IDEAS IN DENTISTRY

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GORDON H. ROVELSTAD WILLIAM C. DRAFFIN

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P. EARLE WILLIAMS
President, 1974-1975

The President of the College

Dr. P. Earle Williams, well known oral surgeon, educator, clinician, lecturer and dental society leader is the 1974-75 president of the American College of Dentists. Born in Texas and reared in Oklahoma, he earned a B.S. degree from Southeastern College, Durant, Oklahoma; a Master of Science degree from Northwestern University, and his D.D.S. from Baylor Dental College.

He is a diplomate and past president of the American Board of Oral Surgery, a director of the American Society of Oral Surgeons, past president of the Texas Society of Oral Surgeons and the Southwestern Society of Oral Surgeons, and an honorary member of the Southwestern Society of Oral Surgeons. He is a consultant in oral surgery to the Veterans Administration Hospital's central office in Washington, D.C.

Dr. Williams practices in Dallas and is a member of the teaching faculties of Baylor Dental College and Southwestern Medical School. He has been honored twice with the Thomas P. Hinman Medallion for outstanding work in the field of dental education. In great demand as a speaker and clinician, he has travelled extensively, appearing before dental groups in forty-five states.

He is a former president of the Texas Dental Association, the Dallas County Dental Society, a member of the Board of Directors of the Dallas Heart Association, Texas Career Society, Dallas United Fund, Dallas Health Museum, Bank of Dallas, and an affiliate member of the American Medical Association. He has served on the Oklahoma Board of Dental Examiners.

Dr. Williams is a past first vice-president of the American Dental Association, past supreme Grand Master of Psi Omega fraternity, a member of Omicron Kappa Upsilon honorary dental society, and a retired colonel in the U.S. Army Dental Corps.

He is married and the father of three sons. His hobby is magic, and he is a former member of the American Society of Magicians. Long active in the American College of Dentists, the exemplary quality of his service as a regent and later as vice-president won for him the high regard of all the Fellows. Under his capable presidency, we expect that the coming year will see the College continue to flourish and grow ever stronger and more influential in its service to the profession.

Presidential Address

P. EARLE WILLIAMS, D.D.S.

As my plane took me to a recent dental meeting, I became aware that there was more to travelling by air than just buying a ticket and fastening my seat belt. I realized that first there were people who handled my ticket request and reservation. But before they could take my reservation, someone, somewhere, multiple someones and multiple somewheres, had made up a flight schedule. Someone else had purchased and someone else had serviced the aircraft after it had been built and delivered. Then a flight crew had to be hired and assigned to this plane. Arrangements had to be made with the airport from which I departed and the airport where I was to land. A stewardess served me a drink and a meal supplied by other someones. On and on, the myriad details that went into getting a plane for me to ride on were mind boggling, not to mention the manufacturing of the first plane and the improvements that had been made in subsequent planes.

It is always with a tiny bit of anticipation that I fly. I am apprehensive perhaps because from time to time I read and hear about planes that never make it, and I wonder if the next one that I am on will become another statistic.

I am reminded of the fellow who was afraid to fly because of all of the bombings and hijackings that had plagued the airlines. This fellow went to Jimmy the Greek and asked him what the odds were for him to ever ride on a plane with a man carrying a bomb, and Jimmy the Greek assured him that the odds were about a million to one. Then the fellow asked Jimmy the Greek what the odds were for him to ride on a plane where there were two men carrying bombs and Jimmy the Greek said that the odds were almost a billion to one. After that, the fellow was no longer concerned. He

Presented at the Annual Convocation of the American College of Dentists, Washington, D.C., November 9, 1974.

carried a bomb of his own every time he flew. But back to the feeling of flying. It is with some apprehension, as I said, that I feel prior to take off. When I get airborne, however, I can relax and enjoy the ride. And I am aware now of all of the preparations that had to be made prior to that flight.

I mention all of this because I see a parallel with the plane and the American College of Dentists. As I ascend to the Presidency, I have a feeling of uneasiness in the pit of my stomach. "Will my administration get off the ground?" I ask myself. Will my administration fly? Will it get airborne? Will it be a rough flight or will it be calm, uneventful?

Then I remember the crew, my predecessors, our great membership, our marvelous and efficient executive director and his able and capable staff. Officers and regents come and go, but as long as we have Dr. Robert Nelsen making our flight plans, we will have a safe and enjoyable trip. The sturdy foundation of the college was laid long before I became a Fellow, and so I feel a calm similar to the one I feel on that plane after it is airborne.

As I look out at this group before me I realize that every dentist is here because he has made a contribution to dentistry, above and beyond that which is expected of him when he first puts out his shingle. Here are individuals who have acquitted themselves with great favor and earned recognition professionally, civically, educationally, and in every way in which individuals are recognized for deeds and actions that are good. They were nominated by dentists who were already Fellows and who saw the merits of their contributions and wanted them to be honored for them by Fellowship in the American College of Dentists. It is a high honor to be a Fellow. It is a recognition of positive action on behalf of ethical dentistry. Therefore, I am humble when I realize that I who came from a small town in Texas and who practiced in a small town in Oklahoma before coming to Dallas, to lead men who are leaders, each in his own right, in our beloved profession. I know that the pattern for my flight has been set. The ground crew has been working. My course has been charted. All I have to do is to fasten my seat belt. We can get there from here.

We are privileged to be members of a profession for which there is no substitute. No one in any other area can exclusively do just what we are trained to do. We are able to relieve pain, restore appearance and function to those areas in which it has been lost, to contribute to the overall welfare, comfort and condition of the whole patient or person. What a responsibility we have! We must

strive to keep it from becoming the responsibility of others, who may have only a smattering of knowledge in those areas, or falling into the hands of the politicians, who have a cloak of comfort for any ailment, regardless of the outcome.

In Shakespeare's play, Julius Caesar, Cassius pleads for delay in action. Brutus, however, says to Cassius, "There is a tide in the affairs of men which taken at the flood, leads to fortune, omitted all the voyage of their life is bound in shallows and in miseries. On such a full sea we are now afloat and we must take the current when it serves or lose our ventures."

My friends, the tide is in, it is bringing change. When it goes out it will take with it a lot of custom and no little tradition. That is not what matters. The only thing that matters is whose hand is on the helm.

You have demonstrated that you have the abilities, the skills, the adaptabilities and the courage to change when change is in order. You have the experience, the team work, and coordination that makes it possible for you to do anything that you know ought to be done.

I challenge you to meet these changes head on. Carefully select those that are best for your community and for your patients. And then, no matter what else, keep your hand on the helm.

There are three kinds of people: Those who make things happen, those who watch things happen and those who have no idea what has happened. Our future lies with the first group. We cannot rest on our laurels, the praise and glory, which we earned in school and the position we achieved in our local communities, since we first started practicing.

Rarely, has there been a time when our deliberations will be more significant than they are during these times. To say the very least, dentistry is at the crossroads and faced with so many problems and challenges, some of which are new and some of which are only receiving increased emphasis after having developed over a period of time. We are faced with the concept of health care as a right, rather than a privilege. We are faced with many additional social concepts, both stemming from that idea and contributing to it. We face proposals and possibilities of increased government control, price and wage fixing, emphasis on a nonprofit approach problems of free choice of doctors, increasing coercion and attrition on the academic and institutional environment.

I indicate problems and point out difficulties with which we must

grapple, in order to stress that this is a time, not for despair, but for a clear recognition of crises that are approaching. A time not for anger or frustration, but for unswerving determination to face our problems and solve them. A time not for philosophy alone, but for action to make our philosophy a reality.

Luke 12:44. "For unto whom so much is given, of him, shall much be expected and required. From everyone to whom much has been entrusted, the more will be demanded. Much is required of us by others, and we should demand much of ourselves, because of all that we have been given."

As I have had an opportunity to talk to many of you, I will also have an opportunity to listen. I will have, perhaps for the first time in my life, an opportunity to find out what you are thinking. And I find that many of you, as am I, are concerned about the future of dentistry. Where is it going? What can we expect? What do we fear? What do we want? What do we need? Will there be too many dentists in say, ten years, or five years? Are there too many dentists now? Are there too many dental schools? Are there too many specialists? Is it just a matter of distribution and if so, what are we going to do about it? If we do not act, what is the government going to do about it?

Obviously, I do not have all of the answers. Obviously, I haven't expressed all of the questions. There are many, many more and we have dozens that we would like answered.

We hear so often the expression, "Dentists and Doctors." I am proud to be a dentist and I am not offended by that phrase as much as I am by dentists and oral surgeons, dentists and orthodontists or dentists and periodontists. We are all dentists and we must keep that fact uppermost in our minds. We face incursions by government, social scientists, denturists, and undereducated practitioners of the healing arts. We must work faithfully and hard for our parent organization, the American Dental Association, under whose umbrella we are protected much more securely than by our specialty group.

There has been great concern in my mind for many years about the failure to recognize many worthy young men and to invite them into Fellowship in the college. Many times competence, leadership and ability seem to be related to graying hair or even to the absence thereof. This deprives the college of the leadership and the many contributions which they may provide. Any individual with much to offer can be identified within ten or fifteen years after he starts his practice and becomes associated with

organized ethical dentistry. Quality is not accidental. It is the result of honest and intelligent effort. Search out such men and nominate them for Fellowship.

My primary effort this year will be exerted along the lines of friendliness, good fellowship, good public relations and the development of brotherhood among our members. The word empathy means so much to me. It is the ability to put your feet in the other fellows shoes and to see things from his viewpoint. Empathy enables us to understand the reasons for another person's manner and attitude.

The act or capacity of entering into or sharing the feelings of another is known as sympathy; empathy, on the other hand not only is an identification of sort, but connotes an awareness of one's separateness from the observed. One of the most difficult tasks put upon man is reflective commitment to another's problems while maintaining one's own identity. The ways in which one person may react to another are infinite. The person who is able to determine his emotional boundaries, that is, to establish where he leaves off and where another begins and not indulge in the other's emotional problems, functions more usefully, happily and gracefully.

It is not only our duty but our complete obligation to observe the golden rule with every patient who enters our office to treat that person just as we would like to be treated.

We often wonder why people do not make more of the marvelous power that there is in kindness. It is the greatest lever to move the hearts of mankind that the world has ever known; greater by far than anything the mere ingenuity of man can devise or subtly suggest.

Kindness is the kingpin of success in life. It is the prime factor in overcoming friction and making human machinery run smoothly. If a man is your enemy you cannot disarm him any other way as surely as by doing him a kind act. The meanest brute that ever drew breath is not altogether insensible to the influence of kindness. It takes a strong man, the very strongest in fact, to do a kindness to a man who has wronged him, but there is no other way so certain to bring around restitution.

"We are reading the first verse of the first chapter of a book whose pages are infinite." I do not know who wrote these words, but I have always liked them as a reminder that the future can be anything we want to make it. We can take the mysterious hazy future and carve out of it anything we imagine, just as the sculptor

carves a statue from a shapeless stone, or an artist creates a beautiful picture on a piece of canvas.

We are all in the position of the farmer. If we plant good seed, we reap a good harvest. If our seed is poor, we will reap a useless crop, weeds, brambles, thorns and thistles. If we plant nothing at all, we reap nothing at all. I want the future to be better than the past. I would not have it contaminated by the mistakes and errors with which history is filled. We should all be concerned about the future, because that is where we will spend the remainder of our lives.

The past is gone and static. Nothing we do can change it. A dynamic future lies before us. Everything we do will effect it. Each day brings new frontiers, in our lives, in our profession and in our community and nation, if we will only recognize them. We are just at the beginning of progress in every field of endeavor, in spite of the great developments which have already been made.

May I say to each new Fellow of the College, God has given you a strong body and a keen mind, but your own character depends upon you. Reputation is what you fall for; character is what you stand for. This must be earned and you are the primary contributor to the ultimate outcome. You write your own transcript. Of course, you have the help and assistance of your parents, family, love ones, teachers, ministers and others, but the finished result is yours.

Your good name may be lost during an unguarded, thoughtless or careless moment, act or deed. It may be regained, but there will always be a residue or scar, and the public will look for this. One earns the name of being a splendid dentist, a fine citizen, a dependable worker, a devoted parent or a dutiful son or daughter by observing the laws of honesty, integrity and honor, which are so essential to a good life.

It is disturbing to see how so many people are careless of their good name. The making of money influences many to cut corners, take chances, compromise their position in their community and in their profession. No one has ever been honored for his money or his possessions. There never has been a King Midas street. People are honored for their services and what their name stands for.

Proverbs, 22nd chapter, 1st verse states, "A good name is rather to be chosen than great riches and loving favour rather than silver and gold." This has such tremendous meaning and significance. Your good name must be preserved, there is no substitute.

The following verse, author unknown, was written by some one

who was fully cognizant of what it means to have a name that is honored and respected.

YOUR NAME

You got it from your father, 'twas the best he had to give.
And right gladly he bestowed it, it is yours the while you live.
You may lose the watch he gave you and another you may
claim.

But remember when you're tempted, to be careful of his name.
It was fair the day you got it and a worthy name to wear.
When he took it from his father, there was no dishonor there.
Through the years he proudly wore it, to his father he was true,
And that name was clean and spotless when he passed it on
to you.

It is yours to wear forever, just as long as you shall live.
Your's perhaps, some distant morning to another boy to give.
And you'll smile as did your father, smile above that baby
there.

If a clean name and a good name, you are giving him to wear.

This poem is easy for me to use on this occasion, because I see all of you fine members of the American College of Dentists and know that you will be a credit to this great organization because you know the ingredients of a good name — honesty, faithfulness, dependability, respect for others, generosity, devotion to your God, love and kindness.

May God bless and protect you and yours. This is my most fervent wish.

WORDS OF WISDOM

Science without religion is lame, religion without science is blind.

Albert Einstein

Editorial

The Dilemma of Continuing Education

In the most recent issue of the *Journal of the American Dental Association* is a thought-provoking article which should be required reading for everyone concerned with continuing education programs. Titled "Continuing Dental Education: Reasonable Answers to Unreasonable Questions," the authors, Doctors David W. Chambers and Douglas L. Hamilton of San Francisco take the position that proponents and evaluators of continuing education programs are looking for answers to the wrong questions. They challenge the validity of the three questions commonly asked:

- How can continuing education better protect the public?
- How can continuing education be brought within the reach of more practitioners?
- How can changed behavior resulting from participation in continuing education be measured?

In referring to compulsory continuing education as a condition for relicensure or maintenance of membership in a professional society as a means of protecting the public, the authors state that compulsory attendance is an inadequate criterion for maintaining an up-to-date practice, that participation is no guarantee that learning will take place. They suggest that protection of the public is not a reasonable objective for such programs, and suggest as an alternate question — how can continuing education better serve the dental profession?

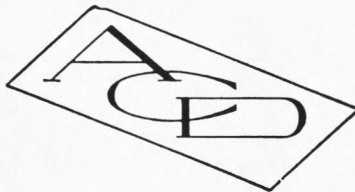
In the matter of course accessibility and content, Drs. Chambers and Hamilton state that the challenge in continuing dental education is not how to find better methods for taking the same material to more people, but how to adapt methods to meet the variety of needs that exist in the profession. What do dentists want to know or learn how to do? What are they willing to do to find out? What variety in program and format is needed to match the diversity of needs and interests of today's practitioners? These are much more relevant questions which the profession must consider.

Regarding the third question, the measurement of behavior changes, the authors believe that the important issue is not how much a dentist learns at continuing education courses, but what he knows and what he does in his practice. An alternate question they raise is — how can continuing education develop diagnostic tests to help individual practitioners and the profession as a whole identify areas of need?

As it turns out, this is the very question that the Self-Assessment and Continuing Education Committee of the American College of Dentists addressed itself to last year when it undertook to develop its test program. The College believes that the program as it presently exists answers this need. These carefully constructed tests cover every area of dental practice in considerable depth. Many questions were based on clinical material, and are designed to test the participant's diagnostic ability and knowledge of treatment methods currently in use.

Dentists who took part in the program were in agreement that the program helped them to identify the areas of their strengths and weakness. The dilemma of continuing education is not a simple one, and not easily solved. Drs. Chambers and Hamilton identify the faults in the usual approaches. The College is pleased to note that its Self-Assessment and Continuing Education Program dovetails with the new thinking which the authors recommend.

R.I.K.



SYMPOSIUM

Alternatives in Oral Health Care

The annual meeting of the American College of Dentists, in Washington on November ninth featured a Symposium on *Alternatives in Oral Health Care*. This timely topic was discussed by a distinguished panel of authorities, each in his own way directly related to the issue of dental health care and its various delivery systems. The following persons participated:

- Louis G. Terkla, D.M.D., *Moderator*, President, American College of Dentists, Portland, Oregon
- Robert B. Hughlett, D.D.S., *Organized Dentistry*, Chairman, American Dental Association Council on Dental Care Programs, Tampa, Florida
- Lincoln L. Riley, D.D.S., *Private Practice*, National Dental Consultant, Connecticut General Insurance Company, San Fernando, California
- Merrill W. Packer, D.D.S., *Federal Government*, Acting Director, Division of Dentistry, Bureau of Health Resources Development, Department of Health, Education and Welfare, Health Resources Administration, Rockville, Maryland
- Max Schoen, D.D.S., Dr. P.H., *Closed Panel/Capitation Progress*, Dean Protem, Professor of Dental Health Services, School of Dental Medicine, State University of New York at Stony Brook, Stony Brook, New York
- Stuart I. Weinstein, *Third Party Insurance Programs*, Director, Dental Services, National Association of Blue Shield Plans, Chicago, Illinois
- John E. Sparks, M/A., *United Auto Workers*, Assistant Director, Social Security Department, International Union of United Auto Workers, Detroit, Michigan
- Charles E. Parkin, D.D.S., *Delta Dental Plans*, President, Delta Dental Plan of Utah, Salt Lake City, Utah

All of the panelists were asked to provide answers to a group of significant questions. Their answers, given from each one's particular point of view, were in most instances quite diverse. However, the difference of opinion afforded a mind-stretching experience to a large and enthusiastic audience. One of the listeners was moved to offer his comment in a letter to the editor, which is appended after the questions and answers.

Unfortunately, Mr. Sparks did not have a prepared paper and spoke extemporaneously. At press time the Journal had not received a copy of his remarks. Should they be forthcoming, they will appear in a future issue.

- 1. Currently in America, is there a greater demand for oral health care than the existing workforce can provide? If your answer is no, can the existing workforce accommodate the increased demand likely to be created by national health insurance? If your answer is yes, what alternatives in oral health care would be most appropriate in meeting current and future demands?*

Hughlett: Clearly there is not a greater demand for dental care than the dentists now practicing can accommodate. We learn this from the dentists themselves, particularly those practicing in areas in which significant dental prepayment programs have been inaugurated. To be sure, the dentists in these areas have experienced a certain increase in demand, but nothing beyond their capability.

It should be made clear that I am not addressing the issue of maldistribution, the problem of underserved areas. I will comment on these problems later. Nationwide, we are capable of meeting the demand.

Now, if national health insurance is enacted and if it generates a significantly greater demand for dental care, will the practicing dentists be able to meet that demand? Obviously, the answer is speculative. I would say yes, based on two variables: one, the extent to which current productivity is unused and therefore can be expanded and, two, the degree to which national health insurance or any new initiative increases demand.

The American Dental Association, in an effort to provide answers to questions of this kind, has contracted with the Leonard Davis Institute of Health Economics at the University of

Pennsylvania to develop mechanisms through which such data can be obtained.

By the end of 1975, it is expected, these mechanisms will be operational. At that time, studies will be conducted. I can only suggest that, at present, collected information does not indicate any insufficiency in the national capability.

Riley: The answer to the question can be yes or no depending upon which geographical areas you choose to use as your data base. Recently there were two dental manpower studies done in California, one in the San Mateo County Dental Society located just south of San Francisco and the other in my own local society — the San Fernando Valley Dental Society — which includes much of the city of Los Angeles and contains within its boundaries conditions suggesting a high level of affluence as well as severely depressed areas. The California studies were correlated to the ADA study done in 1971 as published in the ADA Journal, Vol. 85, Sept. 1972, pages 669 to 672. It is interesting to note that both the San Mateo and San Fernando Valley study show the average dentist to be less busy in 1974 than he was in 1971 despite the increase in dental insurance and government funded programs. Response to the San Fernando Valley study indicated that 68.7% of the dentists can accept patients for routine appointments within a week or less and 99% will provide emergency care on the same day it is requested. Forty-one percent of the dentists said they were not busy a total of 1,565 hours per week. It can be estimated that there are 2,595 hours per week of unused dental manpower in the San Fernando Valley. Applied to the 761 members of the society this suggests that 310 dentists need more patients. So, if you are to base your answer to the question of the need for more dentists in major urban centers on the evidence of these statistics it no doubt would be more "no" than "yes."

There are certainly areas within both urban and rural America where shortages of dentists exists due to a variety of reasons: economic, sociological and even climatic in nature. How you are to overcome the objectionable characteristics of such areas and induce individuals to serve them through a redistribution of surplus manpower is a complex and as yet unanswered question.

The second part of the question asks, "Can the existing work force accommodate the increased demand likely to be created by National Health Insurance?" The wording of this question implies there will be a significant increase in the utilization of dental

services under a program funded by a third party, whatever the revenue source. I am not so sure this will happen based on the utilization patterns I have observed both in the Medicaid Program as well as private insurance programs. I do not think you will change the attitude of people seeking regular dental care just because they are no longer paying for it. There will be, to be sure, some increase in utilization but not to the extent that it will bring about a crisis in health care delivery in the immediate present or for that matter in the future should this country continue the trend towards zero population growth that we have seen emerging in recent years.

Packer: There are certainly segments of the U.S. population who do not receive from the existing dental work force the oral health care they want. The existing work force could, however, probably provide all the care demanded if it were redistributed and if productivity were maximized. It is our job as health planners to look at today's utilization of dental services and to predict what future demands might be. We must anticipate the events which might facilitate or inhibit the translation of need into demands for service.

For example, it is estimated that by 1980 there will be 126,000 active dental practitioners. Demand, on the other hand, will require between 118,000 to 177,000 practitioners. This estimate is based on the current utilization rate for dental services adjusted for change in population, income, education, prevention, and third-party payment including national health insurance. The lower figure assumes: (1) no current shortages; (2) a large increase in productivity and; (3) a small increase in demand as a result of national health insurance. If any of these assumptions is incorrect, it is probable that there will be a significant shortage of dentists by 1980.

We are fortunate that there are alternatives that will assist us in meeting current and future oral health care demands. Among those alternatives are increasing dentist productivity through a more extensive use of auxiliaries and the adoption of full utilization of preventive measures.

Team dentistry, which is proven to be a more effective and efficient way to provide services to the public, offers an immediate means of substantially increasing the dentist's productivity, and at the same time provides the elasticity needed to respond to the needs of the future. When I speak of team dentistry, I refer to the

utilization of one or more auxiliaries in a dental practice. For some dentists, the changeover to team dentistry may mean the addition of a single auxiliary, while others may find that they will be best served by a more complex arrangement. They may wish to employ a combination of auxiliaries drawn from chairside assistants, dental hygienists, expanded duty auxiliaries and laboratory technicians. It is the dentist himself who determines the number of auxiliaries he will employ, and the skills he will need to assist him in making the best use of his time. Not all dentists will be able to adapt to team dentistry, but it is a challenging alternative to the traditional mode of practice and a feasible way to stretch existing manpower resources.

Our Nation's dental needs could be substantially reduced by the full utilization of known preventive measures. If fluoridation were widely adopted, for example, it could so reduce tooth decay that dentists, who spend some three-fourths of their time on treatment of caries, could begin to concentrate on other aspects of care. Although fluoridation is effective, completely safe and inexpensive, only about half of the population as yet has access to fluoridated water. School fluoridation for communities lacking public water supplies, topical fluorides, fluoride tablets, fluoride mouth rinses and sealants are also valuable agents in combating dental disease.

We now know that oral hygiene has a direct relationship to periodontal disease, yet how many dentists are seeing to it that their patients know about plaque control? If we could only move people to follow a simple daily oral health regimen, fewer dental visits would have to be made for treatment of gum disease and fewer teeth would be lost. I think we have an obligation to see that these measures are adopted.

Schoen: In a global sense, I do not believe there is greater *effective* demand for oral health care than the existing workforce can provide. However, as currently organized, the dental care system cannot treat the existing need as measured by the prevalence of dental diseases and their sequellae. If national health insurance does more than just add dollars to the amount currently being spent for dental care services, stresses will be created in the system since effective demand will then exceed supply.

I believe the existing number of dentists can be adapted to the situation if auxiliary personnel are both increased in number and

retrained to perform expanded duty tasks. In addition, emphasis must be placed on a network of public or quasi-public facilities — whether federal, state or local community — either governmental or true nonprofit. Private fee-for-service practice cannot solve the problems of equity or distribution.

Enough evidence exists to surmise that without radical changes in the mode of delivery of care, maldistribution of providers and facilities as well as of services will continue to exist. One portion of the population will receive too much care while another still will receive too little.

Publicly accountable health centers should have responsibility for defined geographic areas and be permitted to deploy resources as required to meet needs. Such organizations should be allowed wide latitude in the use of ancillary personnel including independent auxiliaries patterned after the New Zealand dental nurse. They can be located both in schools and for adults in other sites. Population responsibility would encourage efforts to have demand approach need with the result that tooth loss should approach zero and edentulism gradually vanish.

Weinstein: We believe that the existing work force can accommodate the existing demand for oral health care. We question what is meant by demand, and feel that we as Third Party Carriers have been both a catalyst of demand and an obstacle of demand.

First, we must recognize that there is a difference between the need for oral health care as exists in this country and the demand by the American public to seek oral health care. Since, by our program designs and by our educational efforts (or lack of them), we can and do have the responsibility to relate need with effective demand, Third Party Carriers can have a greater effect than the responsibility they have assumed. For example, the exclusion of certain services may very well tend to negate a demand for those services thereby affecting the manpower required but may not alter the need that exists.

An additional question again relating to defining the word *demand* is the basis of this demand. The demand may be provider oriented or provider generated, yet the profession may be incapable of meeting the demand that it has generated. There is specific reference here to the whole question of preventive services and the provision of those services.

It has been shown over the last several years that as there is a

visible and economic identification of demand in a local or universal pattern, the work force has expanded to accommodate that increase. To the extent that national health insurance may further increase the economic incentives to a profession, I believe the existing work force can accommodate, in the short run, any increased demand and will accommodate over the long run the necessary increases in number to meet such demands.

In either case, the delivery of dental services will be handled through a more *pluralistic* mode of delivery. This point will be touched on in later responses.

Parkin: I would like to comment first about greater demand. Four years ago Delta of Utah signed an Ironworker contract. We surveyed about 20% of the covered families as to whether or not they had received during the previous two years: (1) an examination (2) dental treatment (3) if treated, by which dentist. When we tallied the data from the patients and their dentists we found that in the following contract period, 23% more people were treated and obtained 41% more dentistry.

With increased utilization can we provide the treatment? The work undertaken by the ADA in doing a manpower survey hopefully will take the guess work out of much of this question. Some areas of the country will be able to handle the patient load. For instance Utah has 1591 persons per dentist but Mississippi has 3446 persons per dentist. Back to the variables: (1) What is the attitude of the profession with respect to expanded duties of auxiliaries? (2) What is the availability of trained auxiliaries such as hygienists, dental assistants, laboratory technicians and business managers? (3) Of great impact: What is the dental I.Q. of the population? Will they seek dental care?

For example, we have a comprehensive welfare program for children and adults. Utilization has never exceeded 45.55% of the total covered population. Even though money is not a factor, less than half of the covered people seek care.

With proper planning and utilization of manpower, we could meet the demand.

2. How would you resolve the maldistribution of practicing dentists?

Hughlett: First, I think it is important to point out that dental care is an essential health service and that there is no question but that everyone should have this service reasonably accessible. At the same time, dental care is accessible to most of the population. For most of them, the private dental care delivery system works well. So when we speak of maldistribution we are speaking of a relatively small number of areas with no dentists serving them and, also, those areas in which the dentists practicing are overburdened, where we need additional dentists.

Now, it is relatively easy to use political boundaries, county lines, let's say, and determine which counties across the nation have no dentists. But it is quite another matter to determine that there is sufficient demand in those counties to sustain a dental practice.

Some imaginative efforts are being made to answer this very basic question. In Minnesota, a computerized matching system provides comprehensive information to dentists about areas within the state seeking dentists, as well as profile information on dentists seeking initial locations or relocation sites to leaders in these communities. It is these kinds of efforts, I believe, that will provide not stopgap measures but lasting solutions to maldistribution.

It must be recognized, however, that even the most sophisticated placement techniques cannot entirely eliminate this problem. There will always be areas which simply cannot support a dental practice. In these areas, cooperative public and private initiatives are needed. The American Dental Association continues to support such initiatives, particularly those undertaken by the National Health Services Corps to provide dentists to shortage areas.

Riley: Charles C. Edwards, M.D., Assistant Secretary for Health in the Department of HEW spoke to this question in a recent address titled, "The Future of Pluralism in Health Care," at Tufts University. He answered the question almost with another question. He said, "There may be, in fact, no way to guarantee solution to such maldistribution problems as long as physicians continue to be essentially free agents. All of us, of course, deplore the loss of freedom but on the other hand we cannot overlook the fact that there is a real conflict between the right of the physicians to

practice as they choose and the equally legitimate right of the public to obtain the services of physicians much of whose training has been paid for at public expense."

We have seen recent legislative attempts to achieve a solution to the maldistribution problem as offered by Senator Kennedy. The question is, "Would this be a solution to the problem or would it result in nothing more than a succession of doctors continually being replaced by yet another indentured colleague with no commitment except a temporary one to the patient and the community?" The real solution of course is to change the environment of the underserved areas so as to make them more desirable places in which to establish permanent ties. To achieve this would require a total national commitment of funds and energy. I am enough of a realist to know that this will not happen so the answer to the question is, "There is really no satisfactory solution to the problem."

Packer: A series of health manpower programs are being developed to solve many of the maldistribution problems. They include the National Health Service Corps with its scholarship program, Health Maintenance Organizations (HMO's), Area Health Education Centers (AHEC), Unified Health Planning, preceptorships, and such programs as the Dental Information Service Center (DISC) in Minnesota. Let me describe two of the programs.

In 1971, Congress authorized establishment of the National Health Service Corps which provides for the assignment of health professionals, including dentists, to health manpower shortage areas. Some of the National Health Service Corps dentists have agreed to serve in designated shortage areas in return for Federal scholarship assistance received while in dental school. While the time each young dentist spends in Corps service is limited to a few years, it is hoped that at least some of the Corps dentists will remain to practice in the shortage areas where they were assigned.

The Area Health Education Centers (AHEC) were authorized by the Comprehensive Health Manpower Training Act of 1971. Under the AHEC arrangements, students from participating schools and health occupations training programs receive some of their instruction in clinical settings provided by participating hospitals and other health care facilities remote from the school itself. The program thereby provides new training opportunities and added health care capability in areas while they are currently scarce or

even nonexistent. Eleven Area Health Education Centers have been established since the program in September 1972.

Schoen: Maldistribution of dentists in this country is primarily but not exclusively a product of fee-for-service private practice. However, despite changes in the dental care system, some disparities will be with us until rural life becomes as desirable as urban life and until ghettos cease to exist.

In the meantime, combinations of compulsory service is at least partial repayment for public subsidy of education; recruitment of dedicated persons into the profession; development of community group practices with outreach programs; and bussing of patients to care centers can alleviate the situation. National health insurance funded on a tax base with coverage of the entire population would be essential to success in that it would remove most of the maldistribution of dollars.

A large *public* group practice with responsibility for a remote area can staff that area on a rotational basis so no one must remain isolated permanently. Auxiliaries such as dental nurses can be on duty at all times for emergencies and routine care. The larger team, needed for more complex services, can be present at only those times sufficient to provide enough work to keep them operating efficiently.

Weinstein: The maldistribution of dentists has at its base two factors — social attitudes and economic consideration. There can be both short and long range steps taken to resolve the maldistribution problem. I believe there will always be a maldistribution issue.

In the short range, there can be government programs which supplement the regular dental force with temporary providers in a given geographic area. That area can be one where there is a scarcity of providers or one where there is a refusal by providers to service a given location. In the long run, alternative modes of delivery need be incorporated into the existing delivery systems to reach those areas where a shortage does exist. Such alternatives as group practices, increased economic incentives, etc. need come into play.

As a third party carrier, we must be flexible enough to accommodate these expansions or deliver alternatives and be responsive in our reimbursement techniques. This ties into both public and privately funded dental insurance programs.

Parkin: The possibility of extending tax credits to a dentist for practicing in certain areas and treating patients within those areas could be used. If a dentist were given tax-free income on the first \$10,000 to \$20,000 of gross income to practice in a specific area designated by a committee of professionals and citizens in each state, it would be possible to attract practitioners to that area on a free choice basis. The "money-cows" would have an incentive.

There is a possibility that the private sector of dentistry could establish a program of encouraging dentists to provide services to an underserved area on a voluntary basis. I feel that this technique would be more complex and less reliable in that it is difficult to have a sustained, voluntary program. The Utah Dental Association established a committee to work with two of the underserved areas and proposed to the city fathers a plan whereby they would provide a physical plant for an office with the equipment to be obtained with state dental association funds. Volunteer dentists would go into that area a week at a time. Ultimately, the entire project was abandoned because private dentists moved into the area and solved the problem.

Some thought has been given to reserving a percentage of the freshman class for students who sign contracts to serve in underserved areas for a period of two years. This scheme may solve the underserved area problem, but why should some be obligated to serve in an area not of his choosing when others in the same class do not have like obligations?

3. Is the mass implementation of public programs for the prevention of oral diseases a desirable and/or feasible alternative?

Hughlett: Certainly there are public programs of prevention which the Association supports: fluoridation, and programs being designed for the education of children in preventive techniques. But when one speaks of public programs of prevention as an alternative, I must conclude they are meant as an alternative to the private delivery system. This clearly is not desirable. The private system has served us well and it continues to serve us well. It can accommodate itself to private insurance funding mechanisms and to public ones.

The Association has long supported the principle that public funds should not be spent for dental care for those who are able to pay for it themselves, but public funds should very definitely be

spent to provide care for the poor and the medically and dentally indigent.

This is not to suggest different care for the poor. The care should be the same in any circumstance. But the limited public funds for such care — and public funds are always limited — should pay for the care which would not otherwise be received.

Riley: If we are talking about mass educational programs for the public to inform them of the advantages of prevention of oral diseases this is of course a desirable objective in our goal of reducing the need for future dental care in the mouths not already ravaged by years of neglect. But, it is equally obvious that such a program is not an alternative to the current problem which is, "How do you motivate these patients who place such a low priority on oral health?" Furthermore, it is very hard to get public acceptance of any of our suggestions as can be attributed to by the uphill fight we face everytime we suggest even proven preventive techniques like fluoridation. There seems to be a general public apathy to everything these days.

Packer: Mass communications and education programs are extremely difficult to assess. To answer your question, I would have to know what you mean by a "public program."

If we are talking about fluoridation, I have already discussed its effectiveness in preventing dental decay. We know that this public program is indeed both desirable and feasible. That knowledge was gained by more than thirty years experience and backed by more than forty years of research. If all communities with public water supplies would adopt this measure, savings in terms of dollars and manpower would be enormous. In areas where there is no public water supply, the fluoridation of school water can provide partial benefits.

Now on the other hand, if you are talking about public education programs such as "Dr. Dial," a community-wide periodontal disease prevention program, or the national periodontal disease prevention campaign, my answer would be that there is no effective measure of results. We do know that in Casper, Wyoming, for example, more the 33,000 calls were received by "Dr. Dial" in a six-week period. And we can also report that the Division of Dentistry received more than 14,000 requests for information in response to two television spots on flossing and brushing. What we don't know about public education is the end effect on patient

motivation or on the incidence of the disease itself. These are the things that need further evaluation.

In my opinion, however, any programs which attempt to reduce the incidence of dental diseases are worth trying. Any nationwide programs that could reduce the need for treatment would enable the existing work force to extend services to a greater number of people. One has only to look at the social and economic trends to grasp the need to continue and expand public programs of prevention, treatment, and education.

Schoen: Mass implementation of public programs for the prevention of oral disease is desirable, not as an alternative, but as an essential component of any program. It has not been demonstrated that oral disease can be completely eliminated for any population group through the use of existing methods. Even water fluoridation does not completely prevent caries. The long term effectiveness of plaque control on a large scale must still be proven. The prevention of malignancies is certainly questionable although early detection can prevent disability, disfigurement and death. Most malocclusions can't be prevented, and neither can clefts nor other congenital malformations.

The difficulty of implementing public programs involving behavioral change is evident from the minimal effect of efforts to reduce smoking, encourage use of seat belts and improve diet and nutrition. Major cultural changes are required for success in these areas and one must assume the same would be true for programs involving oral health.

Public programs involving environmental change, such as water fluoridation, will, as in the past, be most successful. Those involving minimal personal participation will be next, with those involving major behavioral change being least effective in the short run.

This assessment does not imply that efforts should not be made, but any program should not be conditional upon immediate success.

Weinstein: The implementation question is a two-sided one. It is the implementation of programs designed to treat and prevent oral diseases as well as the educational effort designed to reinforce ongoing programs. A public or private program can only be as successful as those that are receiving the program adapt to that program. For example, to suggest that an educational campaign

which speaks to the desirability, feasibility, or practicality of receiving improved oral health care can do more than reinforce an established pattern of care seems ludicrous. It may slightly (in the short range) generate a moderate effect, but eventually other factors will negate its singular role and the existing pattern will remain. This holds true for a treatment program as well. It may cure for the moment some of the ills, but in no way can replace a pattern of oral health care that has been accepted or practiced.

A further question is related to the type of program that merely identifies problems, jots down the numbers and does little or nothing to treat the conditions discovered. This will not appreciably reduce oral needs nor should it be viewed as a program alternative.

We as third party carriers have a dual responsibility: (1) To increase the public's awareness by acting as a reinforcer thru programs designed to identify and create an increased demand for oral health care, (2) We must be responsive to assisting those programs that do in fact deliver care, thereby becoming a preventive measure of oral diseases. This responsiveness takes the form of acceptable reimbursement.

Parkin: Mass implementation of public programs for prevention is an extremely broad statement. Certainly, it would be desirable to have fluoridation of public water supplies. This is a proven technique for the reduction of dental caries.

With respect to other techniques — such as plaque control programs and dietary control programs where the patient must be educated, and finally motivated to implement these techniques in their lives, may have questionable results.

Within two weeks we will have the data on a four-year program with 6,000 Teamsters regarding the possible reduction of disease for individuals in the same socioeconomic group having gone through plaque control programs in various offices compared to those who have not. The initial indication is that there is no essential difference between the two groups as far as disease entity or as far as cost reduction is concerned. The plaque control disease prevention programs are effective in the reduction of disease, but the real question is the motivational factors which will encourage patients to continue to use the techniques that have been taught. Usually, this is a six-week to six-month usage at which time the motivation is lost and the patient reverts back to his old habits.

We have strong indication that motivational factors are dependent on the personal contact on a one-to-one basis in order to be most effective. Mass implementation of public programs for prevention of disease may not have sufficient motivation to obtain lasting results.

4. Would the quality of oral health care have to be compromised to meet the oral health needs of the public?

Hughlett: The answer is no. No compromises are necessary and none should be tolerated. This presupposes that the private system of dental care delivery continues.

If, on the other hand, in an effort to correct some deficiencies in the private system, a new, untested, massive public system is imposed, then I would say, yes, the level of quality now being maintained would be compromised.

Riley: This question implies that somehow we are going to be overrun by the demand for more services than we can provide and afford. Since I do not think that this is the case, the question becomes for me an academic one. I do not think it is necessary or permissible to ever compromise the quality of care delivered to the individual. Assuming for the moment that demands for care might exceed supplies it would be preferable to establish priorities of care such as care for children and preventive care before providing prosthesis or care for adults, but I do not feel we should ever consider the overall reduction in quality of care delivered to the individual.

Packer: The answer is no. Quality cannot be compromised. Whatever we undertake should be done well; however, we may have to reorder our priorities. Hypothetically, if we as a profession were suddenly called upon to provide even minimum care to everyone needing it, our resources would be stretched so thin that we would have to settle for something less than a complete care regimen. At what point do we choose between delivering the ultimate in sophisticated treatment or providing for the basic needs of the patient? When do we decide that a procedure may be too expensive in both time and money to warrant its performance at the expense of caring for another patient? If it comes to a choice, we may be forced to limit the extent of the services we can

provide, but there should be no thought of sacrificing quality. The question of quantity versus total care is one which has confronted dentistry for some time. In view of the trend towards national health insurance and other broad-based public programs, the development of quality standards for dental services becomes increasingly important. It should be the clear responsibility of the profession to reach an agreement as to what these standards should be.

Schoen: Absolutely not. If quality is defined narrowly as the production of quantities of jewelery masterpieces — yes; less may be created at first. But quality in a broader sense must be linked to outcomes expressed in terms of the entire population's oral and general health. It must include the provision of services in a manner acceptable to the majority of our people.

Care, both preventive and therapeutic, which prevents tooth loss, reduces disease and eliminates discomfort for an entire population is clearly of higher quality than that which produces a few works of art, while many persons continue to suffer from severe dental disease, considerable discomfort and much tooth loss.

There is no arguing that what is done should be well done. But what the term "well done" means must be examined carefully. For example, there is no question that too many X-rays are taken in this country by supposedly fine dentists. Even if those which are not of diagnostic quality are eliminated, what on earth is the reason for frequent full mouth X-rays for persons suffering from periodontal disease? There are other methods of monitoring disease progress than continued exposure to potentially harmful radiation. Even if only one additional malignancy results from the extra exposure of 100,000 persons, I would say the care is bad, regardless of the technical excellence and appropriateness of the periodontal therapeutic procedures performed.

From another standpoint, regular routine care will eliminate the need for a large percent of the complex treatment required to rehabilitate a destroyed mouth. The elaborate procedures which give many of us so much satisfaction should not be required as frequently if oral health needs are met early.

What is needed is a perspective which I think is lacking in most of our profession today.

Weinstein: I have rewritten the question to read: "Would the

quality (whatever that means) of oral health care have to be examined to improve the oral health care needs of the public?"

We as carriers are placed in an awkward situation. On behalf of the subscriber we must reimburse to the provider an equitable fee for services that he has rendered. On behalf of the purchaser, we must identify not only what we paid but also why such payments were made. There is much question as to what quality means and how it relates to our reimbursements. Are we talking about the quality of a single service, an overall treatment episode, the equality or level of the cost for that service or treatment; or finally, the quality of the review whether that review be internal to the third party carrier or external through the profession?

Third party carriers have been given the responsibility (or have had forfeited to them the responsibility) to act on behalf of the consumer in evaluating or measuring quality in the absence of a professional commitment to develop definitions, parameters of care on both individual services, and total treatment episodes. The third party carrier is forced to be responsive to that individual patient and the consumer he represents. We as carriers actively seek — even demand — that the dental profession address itself to these parameters. We seek professional involvement to help us mutually reach our objective of quality care.

I do not believe, in responding to the original question, that quality should ever be compromised. There should never be an attempt to relate quantity with quality. Each has its own measurements.

Parkin: The quality of oral health, unfortunately, may be affected by the systems of delivery that we are building into health care at the present time. We have some rather serious problems as far as private practice is concerned in maintaining quality. However, with the closed panel capitation system, we have problems as far as motivating dentists to deliver high quality health care with a possible incentive to do as little as possible in order to conserve the premium dollar. Root canals and crowns are more costly than extractions and extractions may be used to avoid capital loss.

Unless the profession will take seriously the responsibility of providing adequate review of diagnosis and treatment, the quality certainly can degenerate. Each organization of health care delivery must have built into its system a conscientious professional review program including HMO's, commercial insurance or dental service corporations. However, the profession,

through the state associations, must have review systems functioning to encourage high quality dentistry from the profession and whose function should also be to protect the profession from unfair mercenaries who may be too cost oriented in serving their own interest.

5. Can the private practice system compete effectively with other systems in meeting society's oral health care needs?

Hughlett: The private practice system is the basic system of the American experience. It is the one which has delivered dental care to the great majority of our population. Other systems are relatively untested and relatively unfamiliar. More properly, the question should be whether these other systems can compete with private practice. They must accept the burden of proof.

If, as has been contended, facility systems, for example, can deliver comparable care at lower cost, thereby increasing the accessibility of such care, proponents of these systems must present the evidence.

Limited studies to date do not support these contentions of cost effectiveness. A study of 18 neighborhood health centers, conducted in 1973, showed the cost of medical care in these centers to be more than twice the cost of these same services in private physicians' offices. Now, I would suggest that if lower cost increases the availability of care, higher cost decreases that availability. If this HEW study is not accurate and is not representative of health facility costs, let the proponents provide the supporting evidence.

Perhaps the most significant reason these other systems must provide evidence that they are competitive is that the public, the patients, overwhelmingly support the private delivery system. A 1972 HEW study determined that 92% were satisfied with the quality of care delivered under the current system and would oppose efforts to materially alter it.

Riley: My answer is yes. Recently in California a legislative audit was conducted by Mr. H. Allen Post, the highly regarded and nonpartisan legislative analyst for the California State Assembly. He did an analysis of the administrative costs of HMO type operations in California. The findings of that audit showed that 52% of the monies expended on this type of delivery system were

taken up by administrative costs — with only 48% being expended for health care services. Since the HMO type of delivery system presently seems to be the only competitive system being suggested by government to the private practice system I would have to feel that if one is to be honest about it one would have to conclude that private practice can not only compete but also beat this government suggested solution.

Packer: Yes, indeed. Because we are here today to discuss the question, we attest to the fact that the private practice system has been effective in meeting public need or it would have collapsed many years ago. Within our political system, from almost any perspective, be it numbers of dentists, volume of production, proportion of national expenditures, and utilization rates and patterns, private practice dominates and is likely to continue to do so for many years to come.

It seems to me, however, that it is a mistake to think in terms of competition between systems; rather we should be exploring ways to mesh systems so that they complement each other and can expand their capabilities. What we need to do is to examine a variety of systems in an effort to obtain information. The Division of Dentistry has identified seventeen different dental delivery systems that presently exist in this country. The list includes both public and private dental delivery systems, profit and nonprofit, federal and nonfederal — it is by no means exhaustive. I am sure there are others in existence.

We are also learning from the experiences of other countries how we can improve our own system. We are examining the private practice system relative to the advantages and disadvantages of other predominant nationally developed systems of dental care delivery. Particularly relevant to this point is the World Health Organization/Division of Dentistry *International Collaborative Study of Dental Manpower Systems in Relation to Oral Health Status*. Results of the study will be presented before the FDI/ADA meeting next year. At that time, we will expect to hear about those characteristics of efficiency and effectiveness within several different systems. Some cross system comparisons will also be discussed. As a result of research such as this, the United States and other nations of the world will be better prepared to answer this question.

Schoen: I believe the private practice system is quite effective in

meeting a portion of society's oral health needs. I also believe other systems are needed to meet most of society's remaining oral health care needs.

I have no illusions that under our present social system private practice will die out. It will remain a major or even the dominant component of the dental health care system.

Whether in solo or group practice, dentists receiving compensation on a fee-for-service or productivity basis will be most efficient in providing units of work. Whether this measure of efficiency is necessarily compatible with effectiveness is open to question.

I don't believe private practice can meet the needs of poor or disadvantaged Americans, or those in sparsely populated rural areas. Everything about its organization mitigates against this possibility — in fact, tends to create an inability to meet such needs.

Weinstein: The private practice system can and will not necessarily compete, but work cooperatively with other alternatives in meeting society's oral health needs. As stated in previous responses, we cannot assume that segments of our society will *magically* have available either the economics to receive adequate dental care or the providers necessary to render such dental care. There will always be desolate geographic areas, ghetto areas, etc., which will demand alternatives that the private practice system need work with. This pluralism should be viewed as a blessing and not as a negative. It is private practice which has been and will always remain as the primary method of health care delivery in the United States. But, we must be responsive to our objective which is delivering more care to more people more effectively. In a limited time frame where we wish to increase utilization, and manipulate available resources, we as third party carriers accept the responsibility to work in this pluralistic health care delivery system. We do it to strengthen private practice but more importantly, to assure care to all segments of society.

Parkin: It has been difficult to get accurate data from which we can make comparisons as to cost and disease reduction. Certainly the study done by Friedman with the Los Angeles Restaurant Workers was impressive and helpful. Using cost and quality as criteria of competition a responsible profession in a free enterprise system has been able to compete successfully in every

other industry. However, for the public to get proper dentistry at a reasonable fee, the supply of the professional services must be of sufficient magnitude to create a competitive atmosphere. When there is a lack of persons to meet the demand, frequently costs will rise and quality frequently decreases. We have seen this at work in our present economy. In the event that tax dollars are used to distort the competitive position of the systems of delivery, the tax supported system obviously will be able to produce the services at a lower fee. Most will admit that this is grossly unfair to expect the citizens of this great country to be taxed and then have his own dollars be used to create health care systems that will stand in unfair competition. If private practice is to compete, those in competition with private practice should pay for the expense of professional delivery from the consumer dollar without having a tax subsidy.

Another factor in the competitive position exists other than price of the commodity. In the selection of a professional, especially the dentist and physician, most patients will select those who can satisfy the human needs of people. These involve such things as personalized attention, treatment without pain, and a warm perception for the individual personality. The new look at health care delivery in large group impersonalization will have to be flossed and polished frequently to compete with the smaller modern personal care that small group or solo practice fee-for-service atmosphere can give.

If the private practitioner can perceive the advantages he has in delivering a personal service to people as individuals competition of other delivery systems can be met.



COMMENT FROM DR. JAMES M. DUNNING

Dear Dr. Kaplan:

In that excellent panel discussion, November 9th, in Washington, a laugh occurred when one person applauded some very pointed remarks by Dr. Max Schoen. The applause was mine, and was both spontaneous and sincere. I felt justified in applauding, after the applause which followed Dr. Parkin's statement that he was a staunch conservative.

It distressed me deeply that men like the representatives of organized dentistry and private practice felt so sure that demand for dental care was limited. Yes, rising dental fees at a time when all other costs are rising have curtailed current demand. But the economists have determined dental care to be "price elastic," and the representative of the United Auto Workers, as a consumer, showed a clear appreciation of the "overwhelming need" for dental care. Moreover, the public correctly considers availability of dental care to be an aspect of its quality, while to the Fellows of ACD, "quality" seems to mean only a beautiful restoration, preferably of gold foil.

Max Schoen is absolutely right in calling the reduction in loss of permanent teeth among New Zealand children an evidence of high quality service. The tooth loss among adults there, if indeed it is worse than that in America, is to be laid to the New Zealand dentists or to the New Zealand public, not to the dental nurses. The American dental profession should have as a clear goal the availability of good dental care at least to *all* the children of this country. They should also have faith that with proper financing, logistics, and education, our children, like the New Zealand children, will use this service. Our profession should be willing to make the changes in delivery system needed to attain this goal.

Very Sincerely Yours,

James M. Dunning, D.D.S., F.A.C.D.
Department of Dental Ecology
Harvard School of Dental Medicine

Honors and Awards

CITATION FOR THE WILLIAM J. GIES AWARD TO BRYANT WINFIELD C. DUNN

Presented by Regent Richard J. Reynolds

President Terkla, members of the Board of Regents, Fellows of the College, Ladies and Gentlemen, I am pleased to present the following citation for Dr. Bryant Winfield C. Dunn, Fellow of the American College of Dentists, first citizen, and the Governor of the great state of Tennessee.

Dr. Winfield C. Dunn, dentist, had the courage to leave the security of one of the most successful practices in Memphis, Tennessee, in order to apply his energies and talents to public service. He is to be honored with the William J. Gies Award of the American College of Dentists for his exceptional contributions in service to his fellow man.

Winfield Dunn was born July 1, 1927, in Meridian, Mississippi. He graduated from the University of Mississippi with a degree in business administration. He received his Doctorate of Dental Surgery from the University of Tennessee College of Dentistry and an honorary juris doctorate from Southwest University at Memphis.

In 1950, he married Betty Jane Prichard, daughter of the late Dr. Frank W. Prichard of Memphis, who was a Fellow of the American College of Dentists. The Dunns have three children, Charles W., Donna Gale and Julie Claire.

Dr. Dunn served overseas with the U.S. Navy in 1945-46. He is a member of Omicron Delta Kappa, Kappa Alpha Order, Omicron Kappa Upsilon, The Masonic Order, the American Legion, Veterans of Foreign Wars, and the Kiwanis Club, the Tennessee Dental Association and the American Dental Association.

Winfield Dunn was elected Governor of Tennessee November 3, 1970 and inaugurated January 16, 1971. His tenure of office has been characterized by integrity, dignity, dedication and effective administration. His leadership has been recognized beyond his state by his being elected twice to the Executive Committee, National Governors Conference in 1971 and 1972, elected Chairman of the Education Commission of the states in 1972, Chairman, Board of Trustees, University of Tennessee, Chairman

of Tennessee Board of Regents, Chairman of Tennessee-Tombigbee Waterway Development Authority. He was twice chosen Tennessee man of the year.

Important in the list of the Purposes and Objectives of the American College of Dentists is this directive "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 those responsibilities." Dr. Dunn, in meeting these responsibilities has brought great credit and high esteem to his profession of dentistry.

For his widely recognized leadership as a statesman in one of the highest offices of the nation and for his excellent example of the value of the professional man in the area of public service, we honor him today. It is with considerable pride, Mr. President, that I present Dr. Winfield C. Dunn to you for the William J. Gies Award of the American College of Dentists.

CITATION FOR HONORARY FELLOWSHIP TO MELVIN R. LAIRD

Presented by Regent Gordon M. Rovelstad

Mr. Melvin R. Laird, presently Senior Counselor for National and International Affairs, Readers Digest; former Secretary of Defense; Counselor to the President for Domestic Affairs; and Legislator; has had a most distinguished career in public service, government and national leadership. A veteran legislator, he is widely respected as an expert in matters of health, education and national security. Dental health as a function of total health has always received full attention from Mr. Laird whenever and wherever appropriate.

Mr. Laird was born on September 1, 1922 in Omaha, Nebraska, and was raised in Marshfield, Wisconsin. He received his B.A. degree from Carlton College in Northfield, Minnesota. From 1942 to 1946, he served in the United States Navy. While in the Navy, he served on the destroyer USS Maddox (DD 731) in the Pacific when it was a part of Admiral Mitscher's Task Force 58 of Admiral Halsey's Third Fleet.

His political career began at the age of 23 when he won an election to succeed his father in the Wisconsin State Senate. He

served in the State Senate from 1946 to 1952 and was Chairman of the Legislative Council.

Mr. Laird was elected to the 83rd Congress on November 4, 1952, and was re-elected to each of the next eight Congresses. He served as a member of the House Committee on Appropriations. At the time he resigned to become Secretary of Defense in 1969, Mr. Laird was the ranking minority member of the Subcommittee on Health, Education, Welfare and Labor Appropriations, and a member of the Subcommittee on Defense Appropriations.

During his career in Congress, Mr. Laird served as Chairman of the House Republican Conference and was a member of the Republican Coordinating Committee. He also was Vice-Chairman of the Republican National Platform Committee in 1960 and was Chairman in 1964.

He is the author or editor of several distinguished science books and was the recipient of the Distinguished Service Awards of the American Political Science Association and the American Public Health Association. He is a Honorary Member of the American Dental Association and has received many awards in the Health and Welfare area including the Albert Lasker Award for his contribution to health research. On January 27, 1974, he received the John E. Fogarty Foundation for the Mentally Retarded, Humanitarian Award. In March of 1974, President Nixon presented him with the "Medal of Freedom" Award.

Mr. Laird is married to the former Barbara Masters and they have three children, John Osborne, 26, married five years and teaching in Los Angeles; Mrs. Allison Kelley, 22, recently President of the Senior Class and now graduated from the University of Tennessee; and David, 19, at the University of North Carolina.

Mr. Laird was unable to be present at the convocation. His award was accepted by Dr. Murdock Head, from George Washington University.

CITATION FOR THE AWARD OF MERIT TO
JOHN GOETZ

Presented by Editor Robert I. Kaplan

Mr. President, it is a distinct pleasure for me to present to you Mr. John B. Goetz for the Award of Merit. This modest and friendly man has won renown as one of the leading graphic arts designers in the United States. He has designed books that are outstanding examples of the art of typography and is recognized by his peers in the field as one of the best.

In 1966, he brought his talents and his scholarship to the American Dental Association where, as Managing Editor, he infused new spirit and imagination to its publications, particularly its monthly Journal. Under his direction, the periodic literature of the American Dental Association has attained an excellence of design and format superior to most publications in the health field.

In addition to his outstanding contributions to the editorial department, John Goetz has always found the time to assist other departments of the Association in the design and production of their printed matter, and his artistry is clearly visible in the improved quality of such material.

He has also given freely of his counsel and talents to the American Association of Dental Editors and to the Council on Journalism of the American Dental Association. His advice and his participation in editorial workshops have significantly advanced the quality of dental journalism, and there are many outstanding publications in the United States and abroad which bear the marks of his skill.

John Goetz is also the curator of the Fine Arts Collection of the American Dental Association and the Headquarters Building in Chicago gives evidence of his cosmopolitan taste and artistry.

For significant contributions to the advancement of dentistry through his particular skills, given unstintingly, in the traditions of service that are cherished by our organization, he has been chosen by the American College of Dentists for this singular award.

Trends in Dental Education

WILLIAM K. COLLINS, D.D.S.

It is a pleasure for me to be allowed to participate in your graduation ceremony today. This is a point in the time of your lives which is marked by a singularity which will never again be duplicated. Graduation marks the climax as well as the completion of your under-graduate training in dentistry. From this time forward you become an integral part of the profession.

On an occasion such as this, it seemed proper that you might be interested in thinking along with me on a subject of particular interest to dentists who are in a transition phase from one area of professional activity, the school, to another phase of dental activity, the actual practice of the profession. There are many of your colleagues who are concerned about the relationship between the faculties of the schools of dentistry and the practitioners of the profession. Specifically they wonder whether the schools and the profession are drawing together or pulling farther apart. Recently during the 51st annual convention of the American Association of Dental Schools at Atlanta this subject held the interest of many deans and faculty in an extended panel discussion.

STATE BOARDS VS DENTAL DEANS

In discussions and in confrontations, the classic disagreement on many professional subjects is usually the purview of dental state board examiners aligned against deans and dental school administrators. And so it was during the Atlanta discussion. As usual there were certain expressions of wariness expressed by educators and by board representatives. In condensed form they were largely the following:

Doctor Collins is Secretary-Treasurer of the Northeast Regional Board of Dental Examiners. Delivered to the Graduating Class, Georgetown University School of Dentistry, May 18, 1974.

1. During the latter part of the past century, the demand for excellence in graduate dentists by state dental boards forced the elimination of incompetent schools and eliminated incompetent dentists from the profession. This was a great service by the boards.

On the contrary, the Council on Dental Education of the A.D.A. now regularly accredits all dental colleges, evaluating their physical plants and curricula, and granting or withholding accreditation as the facts found dictate. State Boards are unnecessary in face of these circumstances, one might reasonably argue.

2. The adversary position of state boards is to the effect that in spite of the conscientious efforts of the council on Education, both the National and Regional Boards constantly discover isolated areas of weakness among licensure candidates which reflect weaknesses in certain departments even in highly accredited schools.

The educator responds that actually the dental state board should constitute only a "watchdog device," seldom called upon to make a finding different from that already made by the faculty which has graduated each candidate. Certainly a significantly high finding by a board of failures among graduating dentists should immediately trigger either a long hard look at the school, or a long hard look at the examining state board. There can really be no acceptable explanation of strikingly high failure rates among the graduates of any school accredited by the Council on Education.

State board men will usually hold certain concepts as to what should be the capacities of their professional colleagues; and how well they should demonstrate their talents in the performance of certain techniques. They invariably insist that the examination of dental graduates who are candidates for licensure shall be the board's singular and paramount duty, and that under no circumstances should this be left to the discretion of dental school faculties. The breadth and nature of testing in the various disciplines by state boards can possibly force a certain standardization of curricula in dental schools, however unpleasant this may be to school administrations and faculties.

The charge is made that the dental profession at large attempts to control the dental schools. It does appear, indeed, that this can be demonstrated in their insistence upon certain arbitrary routines

of questionable significance required in certain board formats of procedures.

Insistence upon certain classic procedures by candidates during examinations are strongly endorsed by boards; and the schools must produce graduates who can satisfy the board's arbitrary requirements. Resistance to change in these areas of requirements are nearly fanatical within some state societies and dental boards.

Unhappy in these circumstances are the dental schools who find certain board restrictions intolerable. And yet however laudable may be the intent of the dental schools to invariably graduate only fully competent dentists, certain strongly influential factors are at play, in both their creation and in their continuing existence which are worth our serious study.

ECONOMIC INSTABILITY

Every dental school throughout its entire period of operation must be aware of its economic instability. By far, the major source of its funding must be found other than in the tuition of its students and the income from its clinics. The success with which this funding is found, determines the capability of the school to attract competent faculty and to maintain the continuing adequacy of the physical plant. Most schools are engaged in a faculty game of musical chairs, with the schools which are offering the better inducements gaining, and the unfortunate schools, unable to meet demands, losing their best faculty. The latter less affluent schools replace them with non-school oriented faculty — and at worse even with incompetent faculty. Graduates of these poorer schools find greater difficulty at the state board level; and state board examiners who see consistently poor performances from these poorly trained graduates will defy any attempt by their critics who may be seeking to eliminate state boards, with their last ounce of energy.

INCREASED RELIANCE ON FEDERAL FUNDING

Increasingly greater reliance upon federal grants and federal funding, it has been stated, is slowly converting the majority of our American Dental Schools into federal schools. Such circumstances must produce for these schools a relationship of dependence upon the government. This circumstance could possibly lead to forced acquiescence to unwise federal government demands upon these schools. This capitulation may

take the form of curriculum compression or foreshortening, experimental programs of a bizarre nature and the unwise overpopulation of classes. The profession fears that the continuing imposition of such programs by the government upon the schools will eventually force acquiescence to misdirected bureaucrats by otherwise conservative dental administrations and faculties; that it will force a deterioration in the quality of the graduates of these "captured schools." It is feared that the Council on Dental Education of the A.D.A., should their findings of incompetence of these schools become a source of annoyance to the government, will be superseded as the accrediting body by the federally controlled Office of Education. Finally it is feared that should state and regional boards show an increasingly larger percentage of failing students each year as the schools decline in quality, there will emerge a system of federally controlled national licensure which will waive graduates of poor quality into the practice of dentistry, past the traditional checks on licensure candidates which have for long prevented academic compromise.

TRAINING OF EXPANDED DUTY AUXILIARIES

Perhaps the most highly charged area of concern in the dental profession is the matter of the training of expanded duty hygienists and assistants within the dental schools today. Many practicing dentists feel strongly that there is marked indifference exhibited by the schools to the subsequent impact upon the profession of this type of training. The practicing dentists are heard to state that people are being taught to perform certain procedures, in a two-year program, which were once restricted to dentists who had been trained during a minimum of six years (after high school). Proposals to designate private offices as extensions of teaching institutions, in which use may be made of expanded duty hygienists in spite of dental practice acts to the contrary, have not endeared the schools to the profession. Even today the dental boards are girding for battle with the schools over this issue. One board member described these schools which advocate the training of expanded duty hygienists in a recent public statement as exponents of a "monkey see, monkey do" philosophy of education.

It seems that this evolutionary program in the training of hygienists and other types of assistants is the chief source of friction between the dental profession and the dental schools at this point in time. The present series of expanded duties which are

being taught in many of our dental schools are strongly opposed by significantly large segments of the profession. The dental boards are expected to function as the first line of resistance to this change in the concept of how the dental practice of the future is to be conducted. There is no little confusion in the mind of the established, classically trained, dentist — a general practitioner — who learns of the newer concepts in the training of expanded duty hygienists; and he is disquieted at the prospect of being caught between the upper and nether millstones of specialists above, and expanded duty assistants below.

This issue involves the very economic survival of tens of thousands of practicing dentists. The matter is emotion charged. A battle over this problem between the schools and the dental profession cannot fail to produce scars which will not heal quickly.

These matters which have in the past, and now in the future, promise to disrupt the tranquility are really the fruits of an unfortunate decision made over a century ago to create the separate profession of dentistry, distinct and apart from the profession of medicine. Whatever may have been the benefits of that separation; they have been short-lived; and dentistry today, now more than ever, is a branch or specialty of the medical profession. The oft repeated statement that medicine willingly draws into its ranks a dozen auxiliaries, many with highly skilled contact with patients, while dentistry shudders at the sacrifice of a single one of its privileges to a trained assistant is essentially true.

DENTISTRY AS A SPECIALTY OF MEDICINE

But dentistry is the prodigal, and now after more than a century of independent experimentation and change, should return to the home of its father, medicine. As a respected specialty of medicine, there could be a gradual conversion to the use of trained dental auxiliaries who quite conceivably under proper supervision would perform many of the services now restricted to dentists.

This will necessitate a complete change in the attitudes and programs of the *schools*, and no less a change in the attitude of the practicing dental profession. Assuming that the demand for dental care will continue to increase, and that no dramatic breakthrough will occur in the treatment of periodontal disease or dental caries in the near future, both the schools and the profession should be preparing newer approaches to the delivery of health care.

GROUP PRACTICE

Emerging as perhaps the best system for delivering health care — including dental care — is group practice. Group practices are certainly not new, nor are their effectiveness as an instrument for care delivery seriously in doubt. What is in question is the optimum form or forms of group practice for the future. Closely related to the organization of the delivery system is the role of auxiliary personnel in the delivery service. While it has been shown through a number of experiments that dental auxiliary personnel, both chairside assistants and expanded duty auxiliaries can increase the productivity of the dentist, it is far from clear what the optimum situation is for delivering dental care, considering all personnel, equipment, facilities and support systems.

THE TEAM APPROACH

The immediate plan which should now begin to hold the attention of the profession and the schools and to draw them closer together is the team approach in delivery of health care. The team of the future shall be headed by a dentist. His primary functions shall be diagnosis and treatment planning; and he shall be the supervisor of all the work of the members of the team. In the early stages of the team approach, the supervising dentists will be the presently licensed dentists and those dentists who in the near future will graduate from our conventional dental schools. But as time goes on, the conventional dentist team leader will be replaced by a graduate of a medical school with a specialty in stomatology. He shall not have completed the traditional "lock-step" curriculum of the past in which every physician has been required to learn every course prescribed during a four-year training program. Instead he will have taken advantage of the newer curriculum concepts of medical schools wherein the medical student completes a rather rigidly ordered course of training in the biomedical sciences for two years or a little better; and then throughout the remainder of his training elects to study certain specific courses, along with the regularly prescribed courses, which will carry him into a given specialty. For the dentist of the future this new curriculum will prepare him for direction of a dental health team; and instead of spending previous years in learning mechanical techniques in preclinical laboratories, he will have been trained in a curriculum in which greater emphasis is placed upon the study of the medical aspects of oral diseases and

the most intelligent approaches to their alleviation. He will know all of the technical procedures — cavity preparations, impression techniques, the restoration of tooth anatomy, and he will be able to evaluate, supervise and correct these procedures which are done by ancillary personnel. Thus relieved of the burden of responsibility for performing all of the technical procedures by trained assistants, he can then direct his energies to diagnosis, treatment planning and supervision of the work done by those persons employed in his office.

THE DENTIST AS A PHYSICIAN

He will be a physician, and shall have been graduated with a doctor of medicine degree. His specialty will be stomatology.

Schools of medicine today have already begun to train students in specialties, through the selection of electives while still in their predoctoral education, rather than holding all students in an identical training program until graduation. This will be the method of educating our new dentist.

He will confer with his team on their various responsibilities with each patient after completion of the diagnosis and treatment plan. The restoration of carious teeth demands much of today's dentist's time and effort. This will become the responsibility of a skilled auxiliary who has been carefully trained in the cutting and filling of teeth. Quite logically this will be the role to which the hygienist will rise when the dentist changes his status.

If and when such major changes could be effectuated, the pulling apart of schools and profession would fade into non-existence. For both the typical practicing dentist and the typical dental school would be phased out of their present day performances. Benefits would be innumerable for the cost of dentistry could be measurably decreased, and the costly expansion of our dental colleges which now produce an obsolete overtrained dentist and an underemployed stomatologist (in deference to our existing dental practice acts) will be eliminated.

You who now constitute the student body of Georgetown University School of Dentistry will shortly become a welcome and significant part of the dental profession of America. If this concept appeals to you, I would recommend your dedication to such a realignment of the Medical profession as has been suggested here this afternoon.

4645 Deane Ave., N.E.
Washington, D.C. 20019

Teaching Jurisprudence to Dental Students

ELOF O. PETTERSON, L.D.S., M.S.S., M.P.H.

The National Association of Dental Faculties recommended in 1899 that approximately 14 hours of the dental curriculum be devoted to jurisprudence.³ The Council of Dental Education also expects to find the subject as an integral part of today's dental education. However, because jurisprudence is neither a basic science nor a clinical subject, it has been relegated to a position somewhere within the "intercellular fluid" of dental schools. Not until the sixties, with the advent of separate administrative units in preventive and community dentistry, did the subject receive a departmental base from which it could be organized.

Considering this change, or rather trend, (all schools did not start such units, and all schools with such units did not terminate the organizational orphanage of jurisprudence) it was decided to take a look at the subject in a 1969 survey of dental school departments of preventive and community dentistry. Specifically, answers were sought to the following questions all pertaining to the instruction in jurisprudence: How many hours were devoted to the subject? Which students were brought in contact with it? How was the subject taught and integrated with other subjects? And how was it looked upon by dental students? The purpose of this report is to present the answers which were found to these questions.

DATA COLLECTION

Data on the teaching of jurisprudence were collected in the spring of 1969 from 20 schools of dentistry in the United States. The schools were selected to include only schools with separate administrative units, mainly departments of preventive and community dentistry.

Information concerning the teaching of jurisprudence was obtained from (1) documents (official course catalogues, curriculum reports, and course handouts), (2) the chairmen of the

"departments" of preventive and community dentistry, and (3) dental students. Dental students at 17 schools also described their perceptions of instruction in the subject. (Due to pretesting procedures students at three schools were not asked the specific questions about instruction in jurisprudence.) The chairmen provided their information in personal interviews, the students on a questionnaire.

A class-stratified random sample of 40 students from each of the 17 schools was selected. This sample included 68 classes with 10 students in each. Data from four classes could not be used, however, because they had ongoing jurisprudence instruction at the time data collection began. Accordingly, 640 students remained in the study. Of these, 34 did not answer the questionnaire, and 109 gave answers which were incomplete. Data from 497 students (73 percent of 680 and 78 percent of 640) were used in the analysis.

Students who answered "yes" to the question: "Have you had a course in Dental *Jurisprudence* yet?" were asked to evaluate that course. Those who answered "no" were asked to indicate their expectations in regard to receiving a course in the subject. The evaluation was made by checking seven bipolar adjectival scales below the concept "Course in Jurisprudence." The scales, each divided into seven steps, were important-unimportant, appropriate-inappropriate, useful-useless, valuable-worthless, meaningful-meaningless, effective-ineffective, and exciting-boring.

THE TEACHING OF JURISPRUDENCE

All 20 schools were teaching jurisprudence. A median number of 10 hours was devoted to the subject, but the school range was large: minimum 4, maximum 30 hours. (These figures exclude ethics and other topics taught in conjunction with jurisprudence.)

Eight schools had singled out jurisprudence to constitute a separate course. Those remaining taught the subject together with ethics, together with practice management, or in combination with several other subjects.

No school introduced the subject to freshman students although one offered it to sophomores. Three schools taught jurisprudence to juniors, but the subject was generally a course for last year students (at 16 schools).

Jurisprudence had become a responsibility for the new "departments" of preventive and community dentistry at 15

schools. However, many of these departments were continuing previously conducted courses either because they were considered adequate or because of an insufficiency of time for revisions. Lecturing was the teaching method applied in all courses except one. This exceptive course used programmed self-instruction material. One lecture course stressed the inclusion of case studies.

STUDENT EXPECTATIONS

An overwhelming majority of the students who had not yet received instruction in jurisprudence rated the subject as most relevant to their dental education (90 percent of 355 students).^{*} Only two students rated the subject as irrelevant; 10 percent expressed neutrality (indifference) to prospective instruction in jurisprudence.

The 48 class means representing all 17 schools, ranged from slightly relevant (4.4) to very relevant (7.0), but these class differences were not significant statistically.

No significant differences were observed among the schools except on the freshman level. This latter observation suggested differences in entering populations at the individual schools, but no difference was observed between private and public schools at the same level. A statistically significant difference between private and public schools was only observed at the junior class level. An interactional effect was thereby suggested between type of school and class level, but this interaction was not significant statistically.[†]

A prospective course in jurisprudence was expected to be more relevant than prospective courses in public health, epidemiology, statistics, and dental history ($p < .01$; t-tests; sum of difference scores on the five "relevance" scales). A prospective course in jurisprudence was also expected to be more relevant than prospective courses in ethics and human behavior, but these differences were not significant statistically. These observations pertained irrespective of class level (first three years).

^{*}/Relevance: Average score on the five scales of important, appropriate, useful, valuable, and meaningful; alpha coefficient .92.

[†]/The statistical analyses were carried out by means of two-way analyses of variance, fixed factors, unbalanced designs, least-squares solution.⁴ Class level was tested against (1) school, (2) school type: (a) public, private, (b) public, private denominational, private nondenominational, and (3) region: east, south, central, and west. No significant variance ratios were obtained.

COURSE EVALUATIONS

Twelve percent of the 147 students who had experienced courses in jurisprudence expressed a less than favorable** view of these courses. However, none of the 16 classes (15 senior classes and one junior class), which were represented by these students, had mean ratings expressing an overall unfavorableness or even neutrality to the same instruction (min. 4.6, max. 6.7). Nevertheless, the favorableness differed significantly among the 16 classes. ($F = 3.23$; $df = 15, 126$; $p < .005$.)

The most positive class ratings were found on the two scales of important and appropriate, and the low degree of variability on these scales brought the class differences within the interval of chance occurrence. The greatest class differences were found on the four scales of exciting, meaningful, effective and valuable ($p < .005$), while the usefulness scale was intermediate in its ability to differentiate the classes ($p < .05$). All 16 classes (representing 15 schools) rated their courses in jurisprudence as important and appropriate, but six of them did not describe their courses as effective and exciting (neutral ratings).

No associations were found between course ratings and (1) the class level at which the instruction was given, (2) the number of hours of instruction, (3) integration with or separation from other topics, and (4) school type (private vs public).

The instruction received in jurisprudence was considered more important and appropriate than the instruction received in human behavior, ethics, epidemiology, public health, dental history, and statistics (largest difference). The same was true of the two scales of exciting and effective except in comparison with human behavior (t-tests of summed difference scores).

RELATIONS BETWEEN EXPECTATIONS AND EXPERIENCES

The instruction in jurisprudence appeared to be as relevant and interesting as the students expected it would be. A "patch-up" comparison between juniors rating a prospective course in jurisprudence and junior-seniors rating experienced courses in the subject coincided quite well. (No expectation scores were available from senior students.) This condition was exceptional for jurisprudence in comparison with the six other subjects analyzed in a corresponding way: The evaluations of experienced courses

**/Overall favorableness: Sum of all seven scales, alpha coefficient .92.

in ethics, human behavior, public health, epidemiology, statistics, and dental history, were consistently less favorable than the evaluations of anticipated courses in the same subjects. The instruction in jurisprudence seemed to fulfill the students' expectations in a way not evident in the other subjects.

DISCUSSION

Giddon has observed "very positive reactions to law and legislation, practice management and any other courses designed to keep the student out of trouble."² Findings from this study appear to support this observation: The students were most favorable to the subject and looked upon it as most relevant. A similar observation was recently made by Dworkin, Picozzi and Simon.¹

Consequently, there seems to be little left for discussions from the point of view of student goals. However, it might be worthwhile to ponder about the observation that some schools were better able than others to stimulate the students' interest. Another issue which is left for discussion is the condition that some schools devoted four or five times as many curriculum hours to the subject as others. The educational objectives must have differed, if not explicitly so at least implicitly. The students must have left their schools with quite different sets of knowledge in dental and general jurisprudence.

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Lund University School of Dentistry
Carl Gustavs vag 34
S-214 21 Malmo, Sweden

FELLOWSHIPS CONFERRED

Fellowship in the American College of Dentists was conferred upon the following persons on November 9, 1974 in Washington, D.C.

William Zev Abrams, Princeton, N.J.
 William H. Adelberger, Cleveland, Ohio
 Fae T. Ahlstrom, Las Vegas, Nev.
 Manuel M. Album, Jenkintown, Pa.
 Richard G. Alexander, Arlington, Texas
 Albert V. Allen, Oakland, Calif.
 George Russell App, Columbus, Ohio
 Norris H. Atkins, Washington, D.C.
 Edward D. Atwood, Benton Harbor, Mich.
 Mike J. Baba, Wichita, Kans.
 Russell S. Barnett, Galveston, Texas
 Andrejs Baumhammers, Pittsburgh, Pa.
 John A. Bell, Arlington, Va.
 Leslie B. Bell, West Palm Beach, Fla.
 Sheldon D. Benjamin, Los Angeles, Calif.
 Kenneth C. Bentley, Montreal, Quebec
 Charles L. Berman, Hackensack, N.J.
 Robert V. Blackmore, Edmonton, Alberta
 James D. Blankenbeckler, Winston Salem, N.C.
 William D. Bleser, Coral Gables, Fla.
 Juliann Stephanie Bluitt, Chicago, Ill.
 William Blumenfeld, West Orange, N.J.
 Maurice H. Bonemeyer, Fargo, N. Dak.
 William K. Bottomley, Potomac, Md.
 Milton M. Bradley, Little Rock, Ark.
 Raymond M. Bro, Chicago, Ill.
 R. Henri Brouillet, Montreal, Quebec
 Edward C. Brown, Atlanta, Ga.
 Walter B. Brown, Fairmont, W. Va.
 George G. Burger, South Orange, N.J.
 Wesley R. Burt, New York, N.Y.
 Richard C. Caesar, San Francisco, Calif.

Donald B. Carlsen, Midland, Mich.
 Dwight J. Castleberry, Birmingham, Ala.
 Alex Chertoff, Bayonne, N.J.
 James M. Childers, San Antonio, Texas
 Noah Chivian, W. Orange N.J.
 Max M. Chubin, Chicago, Ill.
 Durward R. Collier, Nashville, Tenn.
 Ralph B. Congleton, Lexington, Ky.
 Silas M. Crase, Fort Bragg, N.C.
 Richard C. Curry, West Monroe, La.
 William E. Dahlberg, Glendale, Calif.
 Clark D. Danner, Manhattan, Kans.
 Grover M. Davis, Ft. Lauderdale, Fla.
 Henry H. Davis, Jr., Monroe, La.
 John Dupree Davis, Dothan, Ala.
 John A. DiBiaggio, Richmond, Va.
 Walter E. Dilts, Oklahoma City, Okla.
 Randolph J. Drahota, Omaha, Nebr.
 James H. Edwards, Raleigh, N.C.
 Robert J. Everhart, Presidio of San Francisco, Calif.
 Alan Douglas Fee, Edmonton, Alberta
 Moses J. Finder, Pittsburgh, Pa.
 William R. Firth, Melrose Park, Pa.
 Yves J. Fissore, Monte-Carlo, Monaco
 Wilbert C. Fletke, Lansing, Mich.
 Chet Anthony Frank, Chicago, Ill.
 Eugene Friedman, Massapequa Park, N.Y.
 Ruth S. Friedman, Pittsburgh, Pa.
 J. David Gaynor, Beverly Hills, Calif.
 Philip P. George, Manchester, N.H.
 Stanley L. Gibbs, New York, N.Y.
 John J. Gibson, Long Beach, Calif.
 William L. Graham, Morgantown, W. Va.
 Walter Granruth, Jr., Baltimore, Md.
 Edward J. Green, Shaker Heights, Ohio
 Russell P. Greer, Lexington, Ky.
 Om Prakash Gupta, Potomac, Md.

- John W. Hart, Texas City, Texas
 Daniel F. Haselnus, Portland, Ore.
 John F. Hasler, Lutherville, Md.
 Gerald D. Hastain, Clovis, N. Mex.
 Harry H. Hatasaka, Palo Alto, Calif.
 Edward J. Hempstead, St. Louis, Mo.
 Leon Herschfus, Detroit, Mich.
 Eugene Hickey, San Antonio, Texas
 Robert C. Hinkle, Columbus, Ohio
 James A. Holt, Los Angeles, Calif.
 Matthias J. Hourigan, Laurel, Md.
 Richard L. Hover, Visalia, Calif.
 Walter F. Hrin, Johnstown, Pa.
 John H. Huey, Warren, Pa.
 George L. Humphrey, Moorhead, Minn.
 Joseph W. Janda, Van Nuys, Calif.
 Byron M. John, Roanoke, Va.
 Robert John, Belmont, Calif.
 Joseph M. Johnson, Laurinburg, N.C.
 Peter Kapsimalis, Summit, N.J.
 August G. Kegler, Independence, Iowa
 Robert B. Kelly, Bay City, Texas
 Nhak Hee Kim, Muscatine, Iowa
 Sanford E. Klein, Roslyn, N.Y.
 Steve Kolas, Augusta, Ga.
 Stanley C. Kolodny, Lackland AFB, Texas
 Arthur R. Krause, Erie, Pa.
 George Kuttas, Oxon Hill, Md.
 Robert L. Lasater, Evanston, Ill.
 Rocco John Latronica, Hines, Ill.
 John R. Law, Washington, D.C.
 Benjamin J. Legett, New Orleans, La.
 Robert J. Leupold, Bethesda, Md.
 Charles G. Lewis, Muleshoe, Texas
 Leon E. Lewis, Dallas, Texas
 Maxwell J. Lipkind, Calgary, Alberta
 David J. Lloyd, Dallas, Texas
 Myers W. Lockard, Jr., Oklahoma City, Okla.
 Richard E. Lombardi, Seattle, Wash.
 George V. Lyons, New York, N.Y.
 William D. McHugh, Rochester, N.Y.
 Edward J. McKenna, Red Bank, N.J.
 William H. McKenna, Wellesley Hills, Mass.
 Sewell R. McKinney, Memphis, Tenn.
 James H. McLeran, Iowa City, Iowa
 Ronald O. McWilliams, San Angelo, Texas
 Belman C. Maddox, McLean, Va.
 Vernon R. Manny, Portland, Ore.
 Manuel H. Marks, Levittown, Pa.
 Harold L. Martin, Flora, Ill.
 Joseph S. Meadows, Atlanta, Ga.
 William W. Merow, Morgantown, W. Va.
 Mahlon S. Miller, Jr., Boulder, Colo.
 Kenneth S. Minato, Honolulu, Hawaii
 French H. Moore, Jr., Abingdon, Va.
 Carl A. Moss, Richmond, Va.
 Peter A. Neff, Vienna, Va.
 George V. Newman, West Orange, N.J.
 Ronald W. Niklaus, Shiremanstown, Pa.
 Masao Nishi, Honolulu, Hawaii
 Arthur W. Nolen, Lansing, Mich.
 Milton Panzer, Flint, Mich.
 Francis X. Pelka, Chicago, Ill.
 Howard C. Peterson, Sioux Falls, S.D.
 Robert H. Peterson, Milwaukee, Wis.
 Shelley H. Phillips, Greenwood, Miss.
 Richard N. Pipia, Chicago, Ill.
 Donald J. Pipko, Pittsburgh, Pa.
 David N. Plessett, York, Pa.
 Alfred Pollack, East Rockaway, N.Y.
 Irving H. Posnick, Minneapolis, Minn.
 Donald E. Priewe, Walnut Creek, Calif.
 Irwin Quinn, Freehold, N.J.
 James D. Quinn, St. Joseph, Mo.
 Harold M. Rappaport, Haddonfield, N.J.
 Frederick Raucher, New York, N.Y.
 Roy H. Reger, Denver, Colo.
 Antonio Reyes-Guerra, Eastchester, N.Y.
 Elisha Roscoe Richardson, Nashville, Tenn.
 John M. Robertson, Oklahoma City, Okla.
 Ronald H. Roth, San Mateo, Calif.
 Irving M. Rothstein, Washington, D.C.
 Herman Rubin, Bronx, N.Y.
 Robert F. Rudisill, Latham, N.Y.
 Khodabakhsh Salamat, Kensington, Md.
 Joseph R. Salcetti, Washington, D.C.
 Henry J. Sazima, Washington, D.C.
 Sanford S. Scheingold, Cincinnati, Ohio
 Frank J. Schiesser, Philadelphia, Pa.
 Frank A. Schroeder, Arlington Heights, Ill.
 Leon Seligman, Owings Mills, Md.
 Clarence E. Sheets, Jr., San Francisco, Calif.

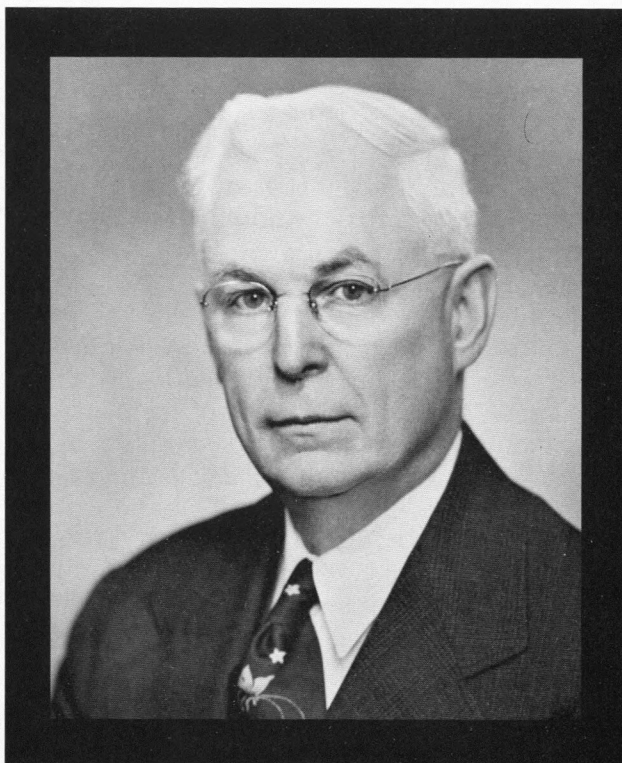
Robert J. Sheridan, Portland, Ore.
Frank L. Shuford, Jr., Washington,
D.C.
Joseph M. Sim, Edwardsville, Ill.
Rodney E. Sippy, LaGrange, Ill.
Ivar Edward Siqveld, Jr., St. Paul,
Minn.
Robert Edgar Smith, Jr., Washington,
D.C.
David E. Snyder, San Diego, Calif.
H. Richard Sonis, Newton Highlands,
Mass.
Adna L. Spencer, Washington, D.C.
Murray Stein, Rome, Ga.
Arthur I. Steinberg, Phoenixville, Pa.
Martin Stern, E. Norwich, N.Y.
Ewell L. Stevens, Lake Charles, La.
Marilyn E. Stone, Atlanta, Ga.
Carl Stoner, New London, Conn.
Earl L. Stover, Souderton, Pa.
William T. Strahan, Silver Spring,
Md.
Edward F. Sugarman, Atlanta, Ga.

Ruth Riley Swords, Fort Worth, Texas
Tally J. Tacelosky, Mahanoy City, Pa.
William J. Takacs, Oxon Hill, Md.
Leonard F. Temple, Oakland, Calif.
Stewart L. Thompson, Syracuse, N.Y.
Pasquale Tigani, Washington, D.C.
Kenneth C. Troutman, Richmond, Va.
Robert A. Uchin, Ft. Lauderdale, Fla.
Edwin C. Van Valey, New York, N.Y.
Gerald L. Vander Wall, Grand Rapids,
Mich.
John W. Wakely, Pittsburgh, Pa.
D. Bruce Ward, Montreal, Quebec
David R. Weise, Columbus, Ga.
Albert Weiser, Abington, Pa.
Donald D. Weissman, Los Angeles,
Calif.
Noel D. Wilkie, Rockville, Md.
Edward D. Woolridge, Jr., Governors
Island, N.Y.
Irving Yudkoff, New York, N.Y.
Derek Freeman, Sydney, N.S.W., Aus-
tralia — In Absentia

Thank God every morning when you get up that you have something to do that day which must be done, whether you like it or not. Being forced to work, and forced to do your best, will breed in you temperance and self-control, diligence and strength of will, cheerfulness and content, and a hundred virtues which the idle never know.

Charles Kingsley

IN MEMORIAM



DR. OTTO W. BRANDHORST

Dr. Otto W. Brandhorst, Secretary Emeritus and former President of the American College of Dentists died on November 15, 1974 in St. Louis after a long illness. His accomplishments over the past sixty years of his professional life were outstanding, and he earned renown as an educator, practitioner, clinician, editor, writer, administrator and dental organizational leader.

Dr. Brandhorst was born and brought up in Nashville, Illinois, and graduated in 1915 from Washington University School of Dentistry. He lived and practiced ever since in Webster Groves, specializing in orthodontics. Joining the faculty of his alma mater as an instructor, he rose to professorship and served as dean from 1945 to 1953 before retiring.

He held office in many dental organizations including the presidency of the St. Louis Dental Society, the Missouri State Dental Association and the American Dental Association, and was a member of numerous others including the American Association of Orthodontists, International Association for Dental Research, American Association of Dental Schools, American Public Health Association, Omicron Kappa Upsilon Honorary Dental Society and Delta Sigma Delta Fraternity.

Dr. Brandhorst lectured widely and published over fifty papers and articles in various publications and was the recipient of a great many honors. He held honorary degrees of Doctor of Science from the Medical College of Virginia and Temple University, and was the recipient of the William J. Gies Award and Scroll of Honor of the American College of Dentists, the Distinguished Service Award of the American Association of Dental Editors and the Achievement Award Medal of the Thomas P. Hinman Clinic.

Among his most noteworthy achievements was his service to the American College of Dentists. As secretary for thirty-five years he left an indelible impression on the policies, procedures and philosophy of the College. At the end of his tenure, when Dr. Brandhorst was elevated to the presidency, the annual meeting was dedicated to him. Some beautiful tributes were presented at that time by Dr. Thomas J. Hill and Dr. Frank P. Bowyer. Dr. Bowyer, in his eloquent address, said, "Each honest calling, each walk of life has its own elite, its own aristocracy, based upon excellence of performance. Otto is certainly one of ours. I have wondered how this man could be so capable in so many different areas of importance, and found my answer in his basic characteristics of honesty, moral and intellectual integrity, sincerity and complete dedication to our profession."

Otto W. Brandhorst is gone, but his legacy of a strong, respected and influential organization lives on. The American College of Dentists, to which he devoted so much of his energies, is not likely to forget the lesson he taught of the true meaning of professionalism.

Deceased Fellows

Since the 1973 Convocation, the following Fellows are deceased.

*Leslie T. Allen, Lethridge, Alberta, Canada
 Axel Anderson, Hinsdale, Ill.
 Paul A. Barker, Denver, Colo.
 A. Raymond Baralt, Jr., Detroit, Mich.
 A. L. Barry, Lakewood, N.J.
 William T. Barto, Hartford, Conn.
 Herbert J. Bartelstone, New York, N.Y.
 *Emanuel E. Blumenthal, Brooklyn, N.Y.
 *William J. Brennan, Omaha, Nebr.
 *J. Menzies Campbell, Scotland
 *Ralph L. Clark, Arvada, Calif.
 Alfred I. Coleman, Los Angeles, Calif.
 William Diamond, New York, N.Y.
 Alan Docking, Victoria, Australia
 Elmer T. Duncan, Summerville, S.C.
 Wayne R. Dunnom, Elmwood Park, Ill.
 *George S. Easton, Laguna Hills, Calif.
 *H. T. J. Edwards, South Australia
 *Walter H. Ellis, Vero Beach, Fla.
 Carl J. Ericsson, Westlake, Ohio
 Everett M. Finger, Oakland, Calif.
 Daniel J. Formosa, Teaneck, N.J.
 *A. Elmer Frame, La Canada, Calif.
 *William L. Glenn, Sr., Galveston, Texas
 *J. Orton Goodsell, Saginaw, Mich.
 Ernest R. Granger, Mt. Vernon, N.Y.
 Joshua Grant, Spokane, Wash.
 *Donald W. Gullet, Ontario, Canada
 *Clarence W. Hagan, Pittsburgh, Pa.
 *Archibald B. Henderson, Bronxville, N.Y.
 *Paul H. Hoeffel, Green Bay, Wis.
 *George M. Hollenback, Encino, Calif.
 A. N. Humiston, Cedar Rapids, Iowa
 *Niels B. Jorgensen, Los Angeles, Calif.
 *Varaztad H. Kazanjian, Belmont, Mass.
 *Arthur G. Kelly, Denver, Colo.
 Norman A. Korn, Minnetonka, Ma.
 **Edward H. Kraus, Ann Arbor, Mich.
 *Joe R. Kuebler, Port Arthur, Texas

*Burt L. Lageson, Medford, Ore.
 *Edmund J. Leach, Carmel, Calif.
 *Victor H. Levitz, Palo Alto, Calif.
 *Theodore E. Lilly, Dayton, Ohio
 Duane B. Madison, Herkimer, N.Y.
 Colen A. McHardy, Baton Rouge, La.
 *Malcolm J. McKinnon, Tequesta, Fla.
 Emory W. Morris, Scottsdale, Ariz.
 Norborne F. Muir, Roanoke, Va.
 *Arthur L. Nygard, Pompano Beach, Fla.
 Sumner Pallardy, Lee's Summit, Mo.
 *David T. Parkinson, La Jolla, Calif.
 *Frederick F. Peel, Des Moines, Iowa
 *John R. Pharr, Charlotte, N.C.
 *Hobart H. Proctor, Denver, Colo.
 *William B. Prophet, John Day, Ore.
 Bernard Z. Rabinowitch, Los Angeles, Calif.
 Gustave Ratte, Quebec, Canada
 George W. Rock, Austin, Texas
 Loren Dana Sayre, Chicago, Ill.
 William H. Scherp, Birmingham, Ala.
 *Arthur G. Schultz, Seattle, Wash.
 *Clarence J. Schweikhardt, Maplewood, N.J.
 *Rupert C. Seibert, Sr., Webster Groves, Mo.
 Roland E. Silverman, Tiffin, Ohio
 *Oscar G. Skelton, Washington, D.C.
 Donald E. Smith, Grants Pass, Ore.
 *Guy W. Smith, Denver, Colo.
 *Roy S. Sommers, Des Moines, Iowa
 **Wilmer T. Souder, Landisville, Pa.
 Walter W. Stevens, Poughkeepsie, N.Y.
 *C. Ray Sturm, Fairmont, W. Va.
 Harold R. Superko, Coronado, Calif.
 *Harry G. Sutherland, Bellingham, Wash.
 L. Wood Swaggart, Denver, Colo.
 Nicholas E. Tapp, Sheboygan, Wis.
 Gustav C. Tassman, Philadelphia, Pa.
 Richard Troxell, Bethesda, Md.
 Sunder J. Vazirani, Silver Springs, Md.

(Continued on page 63)

Book Review

Orthodontics in Daily Practice, J. A. Salzmann, D.D.S., F.A.P.H.A. Lippincott, Philadelphia and Toronto, 1974.

The author of this text is a particularly versatile individual. Since the 1930's, Professor Salzmann has published articles in various fields of dentistry and public health besides orthodontics. Many orthodontic organizations and other dental groups have benefited from his participation and leadership. The extensive curriculum vitae of this giant of dentistry attests to his years of effort and achievement.

This publication follows the trend of his two previous books. Each chapter is documented with an extensive bibliography so that one can delve deeper if so desired. The material is concise and condensed but so well explained that both the novice and sophisticated practitioner may profit from it.

One marvels at the amount and organization of the material as evidenced by the chapter headings, which cover the complete fields of facial growth, dental development, occlusion, orthodontic diagnosis and treatment. The many illustrations lend clarity and are very well done.

The book is further enhanced by chapters covering additional subjects by a variety of contributors. Dr. Salzmann has strengthened his book with material by experts in various fields of orthodontics. Melvin Moss contributed a chapter on the Functional Matrix and Clinical Orthodontics. Interceptive-Preventive Orthodontics is well covered in the chapter by Faustin N. Weber. R. William McNeill, shows the Edgewise Appliance, its construction and uses. The Direct Bracket Attachment to Enamel Without Banding Teeth is described in a basic manner by Fujio Miura. Raleigh Williams adequately covers the Begg Technique. Donald Woodside explains the Activator, its possibilities, limitations and uses in the management of different malocclusions. The Twin Wire Appliance is covered by Earl E. Shepard. H. K. Terry writes his chapter on Labiolingual Technique. The Crozat Appliance in Theory and Practice is examined in depth by W. Marshall Parker. Midpalatal Suture Opening, its indications and contraindications is discussed at great length by Robert A. Wertz. Tissue Changes in Orthodontic Tooth Movement is well done by Kaare Reitan.

The last chapter deals with Public Health, Prepayment Programs and an explanation of the Salzmänn System of Indexing of Handicapping Malocclusions. The Index assigns point values to maloccluded, missing and malpositioned permanent teeth, a necessity in dealing with payments by a third party.

This book by Dr. J. A. Salzmänn would be a great asset to those just beginning to understand orthodontics and occlusion. The one who is already considered an expert would also find a great deal that would be useful.

John A. Crowley

Deceased Fellows (continued from page 61)

John Versnel, Clayton, Mo.

*Victorino Villa, Philippines

*Arthur L. Walsh, Montreal, Canada

Edward C. Weinz, Camillus, N.Y.

*Gunnar N. Wennerburg, Balsam Lake, Wis.

Roberto Eduardo Woodworth, Mexico City, D.F.

Alexander Zane, Los Angeles, Calif.

*Life Members.

**Honorary Fellows.



Dr. Henry J. Heim presents a check for \$1,000 from the American College of Dentists to Dr. Everett Jackson of the Smithsonian Institution for publication of booklet, "The Dentist and His Tools." Dr. Robert J. Nelsen looks on. (Dr. Angle's office)

NEWS OF FELLOWS

Admiral Alfred W. Chandler, USN, Ret., former Chief of the Navy Dental Corps., was honored with the presentation of the Hayden-Harris Award of the American Academy of the History of Dentistry at its annual meeting held at the Smithsonian Institution on November 8, 1974. The Award is named in honor of Drs. Horace Hayden and Chapin A. Harris, cofounders of the Baltimore College of Dental Surgery, who were instrumental in organizing the first national dental society and publishing the first dental journal in the world.

S. Elmer Bear, chairman of the department of oral surgery at the Virginia Commonwealth University of Dentistry at the Medical College of Virginia in Richmond, received the distinguished service award of the American Society of Oral Surgeons at its 56th annual meeting in Las Vegas recently.

John M. Frankel, a pioneer in the neighborhood health center movement and in delivery of direct medical care to the nation's poor, was honored at a dinner sponsored by the Dental Health and Medical Care Sections and Black and Chicano-Latino Caucuses of the American Public Health Association during APHS's 102nd Annual Meeting in New Orleans, in October.

Sanford Kirsch of White Plains, New York was installed as president of the Northeastern Society of Periodontists recently. Dr. Kirsch is also the current president of the Ninth District Dental Society of the State of New York.

Norman H. Olsen, dean of Northwestern University Dental School and immediate past president of the American Academy of Pedodontics, was the recipient of the Award of Merit of the American Society of Dentistry for Children.

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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