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Alternatives in Oral Health Care: The Role of The Specialist

The New Wilderness

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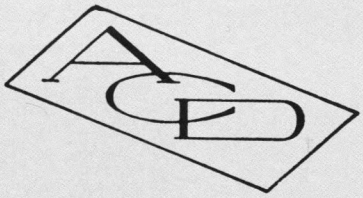


NEWS AND COMMENT

ACTIONS OF THE BOARD OF REGENTS

At its meeting in Chicago in October, the Board of Regents took a number of actions and heard reports as follows:

—Total membership at present is 4442 Fellows.

—The College will again contribute $500 to the American Association for Advancement of Science to assist Section on Dentistry in program planning.

—Two hundred sets of package libraries are presently available for purchase by Fellows for presentation to libraries. The cost is still $20. Over 200 sets have already been placed.

—The Awards Committee will make a study to determine a suitable award in memory of the late Otto W. Brandhorst.

—The Board approved the publication of the Constitution and Bylaws and other information each year with the Roster of Fellows, which would make the roster a Fellowship manual or handbook.

—The Board discussed the mini-self assessment program and its promotion by the Sections of the College.

In other actions, the Board

—Approved the budget for 1975-76.

—Approved technical changes in the nomination procedures for Regents.

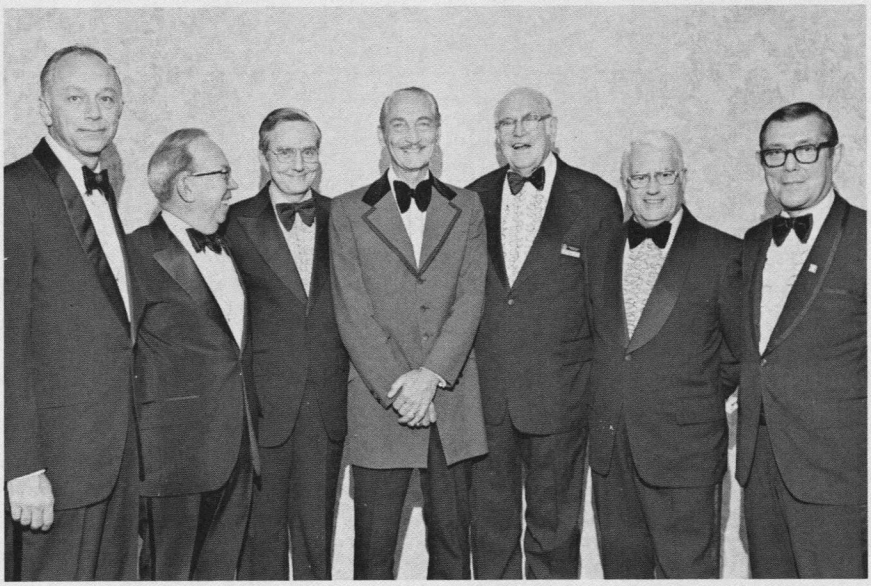
—Approved an amendment to the code of conduct which states that a Fellow "should not, by official or professional title, contribute to or participate in proprietary enterprises of journalism or commerce or, by title or copyright restrict research, education or health care."

—Adopted a motion that the editor serve as ACD liaison with the American Association of Dental Editors and the ADA Council on Dental Journalism.

—Approved recommendation to streamline operations and functions of Regency nominating committees.

—Approved the report of the Executive Director on the establishment of Commissions of the Board to examine in depth issues of importance to the dental profession.

OFFICERS OF THE COLLEGE 1976



Left to Right: Henry J. Heim, Treasurer; Charles F. McDermott, Vice President; James L. Cassidy, President-Elect; James P. Vernetti, President; P. Earle Williams, Immediate Past President; Robert J. Nelsen, Executive Director; and Robert I. Kaplan, Editor.

SECTION NEWS

New York Section

Despite the inclement weather 35 Fellows were present at the September meeting of the New York Section of the American College of Dentists.

This was the first session for our new executive committee consisting of Charles Hillyer — Chairman, Barry Symmons — Vice Chairman, Andrew Cannistraci — Secretary-Treasurer, Michael Turoff — Past Chairman, Charles A. Calder — Regent, and Irving J. Naidorf — Historian.

The meeting opened with a moment of silence in honor of two of our Fellows, David Tanchester and Joseph Obst who passed away this year. A presentation was made to our past chairman, Michael Turoff, in recognition of outstanding services.

The feature of the evening was a presentation by James C. Parkes II, MD, who is the Orthopedic Surgeon for the New York Mets. His talk on throwing arm injuries in baseball as well as orthopedic complications due to tennis and golf activities was extremely well presented and received.

Carolinas Section

In recognition of the achievements of the University of North Carolina Dental School, the Carolinas Section presented a plaque to the school on the occasion of its twenty-fifth anniversary. Section Chairman J. Harry Spillman made the presentation. In receiving it, Professor Walter T. McFall, Jr. acknowledged the tribute and the services of the Fellows of the Carolinas Section who were influential in getting the school started.

In a letter to Thomas L. Blair, section secretary-treasurer, Dean Raymond P. White expressed his further appreciation for the recognition given the school by the American College of Dentists.

Left to right: Dean Raymond P. White, Section Chairman J. Harry Spillman, and Professor Walter T. McFall, Jr.

District of Columbia Section

The Washington, D.C. Section of the American College of Dentists met on Wednesday, November 12, at the National Naval Medical Center Officer's Club in Bethesda. Dr. Thomas Louden of the Division of Dentistry, Department of Health, Education and Welfare was the speaker and gave a very interesting and informative talk entitled "Dentistry and Government Supported Public Education."

New members Morton J. Goode, Bernard Yanowitz, and Camille Lee Young were introduced. Reports were heard about the Senior Student Program, the Self-Assessment Program and Project Library. Plans are well under way for the breakfast in April to open the Spring Postgraduate Meeting. Congressman Brooks Hayes from Arkansas will be the featured speaker; the Joint Armed Forces Color Guard and the United States Air Force Ceremonial Band will entertain.

NEWS OF FELLOWS

Sidney Sorrin, professor emeritus and former chairman of Periodontia at New York University Dental College was awarded the Isadore Hirschfeld Memorial Medal by The Northeastern Society of Periodontists at its recent meeting in New York. This medal is bestowed on men of dental science who have made outstanding contributions to the advancement of periodontology through dental research, dental education, contributions to the periodontal literature and outstanding service to the society.

James R. Hayward, professor and director of the department of oral surgery at the University of Michigan School of Dentistry, has received the William J. Gies Foundation Award in Oral Surgery at the 57th annual meeting of the American Society of Oral Surgeons in Washington, D.C.

The Gies Award, one of the highest honors given by the ASOS, was presented to Dr. Hayward for his "outstanding contributions to oral surgery." At the same meeting, **Charles A. McCallum Jr.,** dean of the University of Alabama School of Dentistry, was installed as president. **Daniel M. Laskin,** professor and head of the department of oral and maxillofacial surgery at the University of

(Continued on page 72)

the JOURNAL of the AMERICAN COLLEGE of DENTISTS

A QUARTERLY PRESENTING IDEAS IN DENTISTRY

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Contents for January 1976

Photographs of the Annual Meeting and Convocation are by courtesy of Fellow Jack D. Carr of Indianapolis.

JAMES P. VERNETTI
President, 1975-1976

The President of the College

James P. Vernetti, professor of general practice at the University of Texas Dental School at San Antonio is president of the College this year. He is a lecturer and clinician of note having appeared before a large number of international, national, state and local dental and auxiliary organizations, not only in the United States but in Canada, Mexico, Puerto Rico, Germany, Italy, Japan, Singapore, Thailand and Uruguay. His presentations have included operative dentistry, practice management, rubber dam, direct gold restorations, use of auxiliary personnel, and physical fitness for dentists.

Dr. Vernetti was born in Arizona, received his early education there and studied dentistry at the University of Southern California. He spent two years in the U.S. Army as chief of the Crown and Bridge Department at the dental clinic of the Presidio of San Francisco, retiring with the rank of Lieutenant Colonel. The quality of his service was noteworthy, for he received four letters of commendation from his commanding officers.

He practiced in Coronado, California for many years before accepting the appointment to the University of Texas Dental School last year. He has held offices in a number of dental organizations. He served on the Board of Directors and is a past president of the San Diego County Dental Society. During his presidency, the San Diego Children's Health Center was begun and fluoridation of the city water supply was enacted through the effort of the Society. He was councilor and served on various committees of the Southern California Dental Association and as alternate delegate to the American Dental Association. He was chairman of the Section on Operative Dentistry of the ADA and chairman and judge of the student clinic program for three years.

Dr. Vernetti has also been active in the American Academy of Restorative Dentistry and is a past president of the American Academy of Gold Foil Operators, a founder of the J.C. Metcalf Gold Foil Study Club, and an organizer and first president of the San Diego Chapter of the Academy of General Dentistry in which organization he holds Fellowship. He also belongs to Omicron Kappa Upsilon Honorary Dental Society and the Federation Dentaire Internationale.

In the American College of Dentists he has served as chairman of Project Bookshelf, as Marshal and Regent before going through

the presidental chairs. He has served on the teaching staffs of Loma Linda University, University of Southern California, and the UCLA School of Dentistry and has been a consultant to the U.S. Naval Hospital in San Diego.

Dr. Vernetti's services to his community have been noteworthy. He is a charter member and past president of the Coronado 20-30 Club, past president of the Coronado Rotary Club, member of the Board of Directors of the Coronado Hospital as well as organizer and first chief of its dental staff, vestryman of Christ Episcopal Church and organizer and first president of its mens' club, past president of the Coronado Crown Club, the Community Chest and the Community Concerts. He was vice president of the Coronado Navy League, a member of the American Legion, Parent-Teachers Association, the YMCA and the Chamber of Commerce.

He has had a strong interest in youth activities, and organized the Little League and Pony League programs in Coronado and served as past president of each. He was Coronado District Chairman of the Boy Scouts of America and served on the San Diego County Executive Council.

He has been the recipient of a number of civic honors and awards, including the Silver Beaver Award of the Boy Scouts of America, the Chamber of Commerce Community Service Award, the Good Neighbor Award of the Fraternal Order of Eagles and the Honor Certificate Award of the Freedom Foundation at Valley Forge. Last year he received a plaque for his contributions to dentistry from the San Diego County Dental Society and was honored on "Jim Vernetti Day" by proclamation of the Mayor of Coronado who presented him with the Key to the City.

The American College of Dentists is proud to have as its leader a man who exemplifies in his daily living the principles of service which we hold so dear. By his example, others may be inspired to give of themselves to their profession and their community in the same full measure as Jim Vernetti is doing. We congratulate him and wish him well.

PRESIDENT'S INAUGURAL ADDRESS

JAMES P. VERNETTI, D.D.S.

Fellow members and guests, a warm welcome to this meeting which marks the 55th Anniversary of the founding of the American College of Dentists. The son of immigrant Italian parents stands before you today, a most humble person. Never in my wildest dream could I have ever conceived the thought that someday I would stand on this platform as your incoming president. In fact, as a boy growing up in a small mining camp in Arizona, I had no thoughts of even being a dentist. Would you believe that I had never been in a dental office prior to entering dental school. Two factors influenced my decision — first an experience-wise father who told me to be my own boss and secondly, a respected physician who said, had he to do it over again, he would be a dentist, and he gave credible reasons.

So dentistry it was! But the American College of Dentists was still an unknown factor. Why do I make this point? To accentuate the fact that even today many dentists and dental students are not yet and probably never will be aware of the American College. The point is we must make ourselves better known by our achievements and service to the profession of dentistry.

As the incoming president, it behooves me to present to you a plan of action for the coming year. At the onset, I ask that you pay particular attention to the orientation and indoctrination program presented by our newly-elected and capable president-elect, Jim Cassidy. You will see how our entire committee structure has been rearranged so that areas of action can be identified, making it possible for the College to function more efficiently in its service to the profession. We seek your input into this new concept as well as your assistance and participation.

Fellowship in the American College of Dentists is often considered as having reached the epitome of accomplishment in dentistry. Nothing could be further from the truth. Rightfully, you have been elected to Fellowship because of your valued contributions to the profession but this is only one step, granted a broad one, up the ladder of service to dentistry. Fellowship, in my humble opinion, is a pat on the back to show that one's efforts to

date are appreciated but with this honor must also come the obligation of further service.

God was kind in directing me to dentistry and one reason I am so appreciative is because I have found it to be a very unselfish profession. Never have I seen persons so willing to share techniques, ideas and knowledge, as in dentistry. Many of you sitting in this audience are the disseminators of that knowledge. Dentistry is a great profession and it is up to all of us to keep it that way. One way is to guide and direct those coming into the profession. This is so obvious to me in my new capacity as a full-time teacher. These young people are very eager for knowledge and suggestions.

One does not need to be a teacher, however, to be helpful in this way. How well I recall the story told to me by Dr. Charlie Stebner of Laramie, Wyoming. When he was a student at Creighton, Dr. Lester Myers became his "big buddy." Charlie often visited Lester in his dental office where this fine person, with patience and understanding, gave him not only technical advice but also guided him later in the workings and membership in various organizations. Today Charlie Stebner is one of the most sought-after speakers in the profession and his dissertations on the philosophy of good dentistry are classics. Both men are Fellows of this College. So I encourage each of you to be a "big brother" to a student or recent graduate.

Let me further expand on our individual and collective relationship with students and I assure you that this feeling is one of long standing and not generated because of my recent move to dental education.

These young people are for the most part completely neglected by organized dentistry. Sure, some of us are invited to schools as guest lecturers, as members of mock board examination teams, or as presenters of certain awards. As members of the American Dental Students Association, they enjoy a few privileges but in reality these are impersonal and actually this is their organization.

Other than that, little is done to make these young people feel a part of this fine profession. However, let them graduate and *then* we extend our arms, beckoning them to become members by paying dues and joining us in the many problems confronting dentistry.

How much better it would be to have personally invited them to our local dental society meetings or if no school is present in the vicinity, to have them visit our offices during their school

vacations. From personal experience let me assure you that the touching of the lives of these students can be a stimulating and gratifying experience to all parties concerned. We must awaken to a more personal relationship of people to people, and especially among those who are to follow in our footsteps.

I would like to share with you one more idea on which we can focus our attention this coming year. Rotary International in 1946 copyrighted a program known as the Four Way Test. This idea was conceived by a man named Herb Taylor. In 1932 he was given the task of trying to save a bankrupt company which was over $400,000 in debt. Since other companies had equally good products and more money with which to operate and advertise, he felt an ethical yardstick that everyone in the company could memorize and apply to what they thought, said, and did in their relations with others was a possible solution.

One morning he leaned over his desk, rested his head in his hands, asking the Lord's help, and prayed. In a few moments he reached for a white paper card and jotted down 24 words in the form of four questions.

1. Is it the truth?
2. Is it fair to all concerned?
3. Will it build goodwill and better friendships?
4. Will it be beneficial to all concerned?

He placed the card under the glass top of the desk and for two months checked everything that came over that desk by this Four Way Test. This, of course, meant eliminating all superlatives and especially from advertising copy; words such as better, best, and finest. Though difficult especially at first, he finally found it possible and practical.

He then called in his four department heads; by faith they were a Christian Scientist, a Roman Catholic, an Orthodox Jew and a Presbyterian. All agreed that nothing in the test was contrary to anything in their faith and all agreed to try it for 30 days.

To make a long story short, this philosophy was adopted and used by all members of the company. Although a number of times sales were lost in the true application of the test, in the long run the new confidence of the dealers and customers caused business to improve and in five years the debt was paid off with interest; in the next 15, over a million dollars was distributed in dividends to the stockholders. The moral and ethical benefits from the use of the Four Way Test, however, were of greater and more lasting value than the material returns. It helped to win friends and build

confidence and goodwill with those they contacted in their business and community relations. It helped each individual to become a better person and citizen, reaching also into the family life.

Today nearly three quarter million Rotarians in 142 countries are asked to accept the high ethical standard of the Four Way Test. It is on display on billboards, on posters and in classrooms in nearly every state of the Union as well as in over 100 countries in the world. It sits on the desks of legislators and judges, has been used in the training of police officers and even trade associations such as unions have adopted the Four Way Test as a guide to ethical business relations.

Repeatedly, world statesmen have confessed that their efforts are foredoomed if people lack respect and understanding for one another. World, national, community and personal problems stem from such disregard and mistrust among people. The late Sir Angus Mitchell, President of Rotary International, in 1948-49 said, "This places a primary responsibility on the individual to see that his attitude in the course of his daily affairs will build mutual respect and understanding. If each of us were to use the Four Way Test we would begin to make progress toward the solution of world problems."

The thought occurs to me that this same idea is equally applicable to dentistry, and what better group is there to lead the way than the Fellows of the College. If each of us were to daily apply the Four Way Test of (1) Is it the truth? — signifying honesty; (2) Is it fair to all concerned? — signifying justice and fairness; (3) Will it build goodwill and better friendship? — signifying friendliness; and (4) Will it be beneficial to all concerned? — signifying helpfulness; thus, we would all be better persons in our dealings with those whose lives we touch.

So I ask you as Fellows of the American College of Dentists to accept your responsibility of leadership in our many dental organizations, in our schools, in our continuing education programs, and in the work of the College itself.

I further ask that you give serious consideration to helping younger people in the profession, students or new graduates. Finally, I challenge you to use the Four Way Test in all the things you think, say, and do because this is a worthwhile philosophy. One cannot constantly apply this test to one's relation with others, eight hours a day in our offices or schools, without getting into the habit of doing it at home, and in social and community life. Thus

one becomes a better parent, a better friend, as well as a better person morally, spiritually and professionally.

I would like to conclude with a prayer found on the front page of *Sharing Magazine,* called the Prayer of a Life-Changer.

All through this day, Oh Lord
Let me touch as many lives as possible for thee.
And every life I touch, do thou by thy holy spirit
Quicken,
Whether through the
Word I speak, the
Prayer I breathe,
The letters I write, or
The life I live. Amen.

Fellows in the College, will you join me in trying to become a "life-changer"?

President Vernetti receives the gavel from President Williams as Admiral Rault and Mrs. Williams look on.

THE NEW WILDERNESS

JOHN A. HOWARD

It is always a pleasure to take part in a ceremony which acknowledges outstanding accomplishment. I want to register my own congratulations to the new Fellows of the American College of Dentists, whose work in their profession and in public service has earned them this high honor. I also want to tell you that I was impressed with the invitation from your Executive Director who emphasized that your organization is not only concerned with sustaining the highest professional standards but also the fundamental moral values. I wish I could think of any national organization in my own field that has the same two-fold commitment. Your Dr. Robert Nelsen is a very special executive. Hold on to him.

I am told a college president is expected to introduce a little culture into his talks, so let me get that obligation out of the way early in the game by reciting two poems. The first is a progress report on the Women's Liberation Movement:

> Women it is now quite clear are very much like men
> Except, of course, for here and there and sometimes now and then.

The second has a Biblical theme:

> King Solomon and King David led merry, merry lives
> With many, many lady friends and many, many wives.
> But when their years had multiplied with many, many qualms
> King Solomon wrote the Proverbs and King David wrote the Psalms.

Even the great monarchs of Scripture had their day of reckoning. I want to offer some comments on your own day of reckoning which I believe is upon us. Let us consider a few samples of the circumstances which demand the attention of thoughtful people.

Suicide is now the second largest cause of death among the young between the ages of seventeen and twenty-four. The second largest cause of death! Last year, property destroyed by vandals amounted to about half a billion dollars. If the average vandal did

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Presented at the Annual Convocation of American College of Dentists Chicago, Illinois, October 25, 1975. Dr. Howard is president of Rockford College, Rockford, Illinois.

$50 worth of damage, that would mean ten million people, most of them young people, tearing things up and burning them down for the sheer sick pleasure of destroying. The sheer, sick pleasure of destroying! Most young people don't see much of anything wrong with smoking pot. "Maybe it isn't too good for your health, but neither is tobacco or booze, so what's new?" they say. It happens to be against the law, but even among the straightest and squarest youngsters that thought would seldom be volunteered. Well, my friends, when each person decides for himself which laws he obeys, chaos is the result. If we think we have problems with society now, just wait until a generation that is massively indifferent to the law is holding the positions of responsibility! Last year, crime increased at the rate of 18 percent. We have more crime than we can handle now. Project that kind of multiplier, 18 percent, out a few years and it is a scary sort of thing. New York City, you may have heard, is in a little financial trouble. It is, I believe, the only city in the country that provides free university education, and it is also the only one that has no standards for admission to its university. This is an extravagance that every other city has recognized it couldn't afford, and yet there are highly placed people who, in all earnestness, are proposing that the taxpayers everywhere else pitch in the funds so that New York can carry on its spendthrift ways. We should help them sustain what we know we can't afford for our own people?

And one other example: a national survey conducted by the Daniel Yankelovitch organization in 1967 found that about 70 percent of our citizens thought American business and industry were doing a fairly good job. The same organization repeated the survey this year, and discovered that only 20 percent, about one in five people, still had confidence in American business and industry. Everything that was nailed down is coming loose; crime and wanton destruction are multiplying; and young people, those who should be the most hopeful, are killing themselves in record numbers.

The title I chose for these comments is "The New Wilderness." The term "wilderness" suggests a vast area without civilization, where there are hostile forces that make living very difficult. The chances are that if any one of us should find himself in the midst of a wilderness, he would recognize it, he would know that that is what it is — a wilderness. At least, that is the supposition. However, I suggest that we are all in the midst of a wilderness, a subtle one to be sure, but a wilderness of an increasing density

that is enveloping us.

I identified a wilderness as a vast area without civilization. What does that term imply? A civilization is, I believe, a society that is organized on a commonly accepted set of principles, principles which give shape to the life of the people, which identify what is good and what is bad, what is right and what is wrong. These principles establish the basis for the laws, govern the economic system and give direction to the cultural and artistic products of the society.

In the absence of such a set of principles, the people are disorganized, each person tends to do his own thing according to his own desires; instincts and emotions take precedence over rational judgments; the laws are not generally observed; there are no standards of the good, the true and the beautiful in art and literature, and there is an every-man-for-himself atmosphere in which those who are the strongest and those who have the greatest skill in deception and subterfuge prevail.

We have, of course, had a civilization in our country. The principles upon which that civilization was founded were clear, cohesive and complementary. The government was predicated on the fundamental worth of each individual, and upon the capacity of each individual to *accept responsibility.* It assured to each citizen certain rights, and *required* of each citizen certain obligations — among them, to pay taxes, to vote, to abide by the laws and to provide military service when the government decides such service is necessary.

The mores of the society, that is the manners, the morals and the virtues, were also predicated on the worth of the individual and the obligation to respect the worth of others, so that compassion, cooperation and kindness were the cherished norms for human interaction. Children were taught to dress and groom themselves neatly to make the world a little pleasanter for others. The economic system which evolved was also oriented to the principle of the dignity of the individual and permitted the citizen to benefit from the product of his own labors, and thus gave each person encouragement to work hard and well.

The total effect was an extraordinary mix in which every man was expected to work hard to provide for himself economically, but within a framework where personal conduct was to be ruled by thoughtfulness for the other person. Although the system, like every human system, was never perfect and some individuals and groups, through no fault of their own, were victims of inequities,

nevertheless it was basically such a good system that this nation was more inventive and more effective than any other in producing and distributing goods and services, the standard of living surpassed all others, and at the same time our country outdistanced all other nations in its development of altruistic endeavor. Even the poorest people here have had a daily calorie intake that would be the envy of the middle class in many nations. It was a record of prosperity and kindness never equalled in history.

We have had a remarkable civilization, but it has fallen on evil times, as noted earlier in this commentary. The principles are in disarray, the economy is in trouble, and people are milling around proclaiming their liberation or demanding their rights or pointing the finger at the other guy, yelling, "Your end of the ship is sinking."

What happened? How did we slide from there to here? There is, I believe, one principal cause we have overlooked. The potential of every group of people is restricted or expanded according to the attitudes of the members. In a family, if everyone is pulling in a different direction and asserting his rights, it really isn't a family at all. It is a disaster. In a corporation, if each person takes pride in the product and does his best to make it a good product, that outfit is going places. If, on the other hand, the people are just putting in their time and fretting about pay and benefits and rights and privileges, that outfit is in trouble. So, too, with a nation. There are certain attitudes which are absolutely essential to a responsible free society, attitudes needed to implement the principles. When those attitudes falter, so does the responsible free society.

This country got off to a roaring good start two hundred years ago because the Founding Fathers knew this fact. The Bill of Rights which was adopted by the Virginia Assembly several weeks before the Declaration of Independence was signed asserted that "No free government or the blessings of liberty can be preserved to any people but by a firm adherence to justice, moderation, temperance, frugality and virtue." Patrick Henry wrote that the principles which guided his life were:

> To be true and just in all my dealings. To bear no malice or hatred in my heart. To keep my hands from picking and stealing. Not to covet other men's goods, but to learn and labor truly to get my own living, and to do my duty in that state of life unto which it shall please God to call me.

In his Farewell Address, George Washington stressed that compliance with the laws of the government "is a duty enjoined by

the fundamental maxims of true liberty." It was perfectly clear to that remarkable group of leaders who began our nation that self-reliance, self-discipline, respect for the law, respect for private property and a genuine concern for the public interest were essential characteristics of the citizens of a free nation.

In the absence of a respect for the law, crime flourishes and people smoke pot with no qualms. In the absence of a respect for private property, vandalism becomes a commonplace. In the absence of self-reliance, people turn to government for food, clothing, shelter, medical attention, dental care, sustenance in their old age, and so on. In the absence of self-discipline, the citizens demand more and more laws to protect them from each other, and regulatory bureaus multiply like rabbits. In the absence of a concern for the public interest, each group presses aggressively for its rights, civilized conduct wanes, standards of dress and behavior are discarded, and the people revert to savages gratifying their instincts and passions and petty interests without regard to the consequences.

One basic fact emerges from this transition back to barbarism. The codes of conduct which make it possible for people to live together in peace and friendship have to be transmitted from one generation to the next. The human being simply does not behave in a civilized fashion of his own accord. He has to be taught what is right and what is wrong. He has to be trained in the attitudes which make a given culture possible.

Unfortunately, the institutions of our society which used to carry this responsibility for training the young have largely defaulted on that activity. The schools and colleges which used to provide citizenship education and character education in most cases don't even try anymore. Indeed, many colleges and universities by some twisted sort of reasoning, proclaim it a virtue that they do not concern themselves with the students' attitudes and conduct. And so coeducational dormitories, pot smoking, gay liberation groups, radical political groups, and other phenomena totally antithetical to the foundations of our society may flourish as they will in the training centers for our youth.

Churches and synagogues once emphasized and re-emphasized the Ten Commandments, so that each little kid grew up knowing there were things he must do and things he must not do, and knowing that these same requirements applied to everyone else — his brothers and sisters, his parents, grandparents, neighbors and strangers. Now, in many cases, the Ten Commandments are soft-

pedaled by the churches or set aside altogether, and a mushy sort of ill-defined love seems to have been substituted. It has been suggested if the good Lord had supposed that permissiveness would work, He would have given Moses instead of the Ten Commandments, a tablet with The Ten Suggestions, or a thousand alternatives.

The parents who also used to teach their children the difference between right and wrong and emphasize that difference when necessary with some kind of meaningful punishment, now, in many cases, think they are doing their job if they "rap" with the kids and listen without showing too much consternation to the views which the child, in his majestic wisdom, propounds. Parents, even in the highest places, sometimes take pride in the *honesty* of a child who openly admits to being dishonest since he uses illegal drugs.

At the same time that the churches, schools and parents have largely defaulted on teaching the young how they must behave in a free and responsible civilization, our society has been overwhelmed by an avalanche of persuasive activity which encourages irresponsible, self-gratifying attitudes. Rock music has become the generational refuge of the young, the clubhouse where they may gather fairly well assured that their parents won't enter, the common bond that ties young strangers together. The mystique and power of rock music to hold and unify young people is scarcely recognized, much less understood by adults. It is, by and large, counter-cultural. Whatever the dominant culture values, the counter-culture rejects. If the culture uses booze, it uses pot. If the culture values neatness of dress and grooming, it prizes slovenliness. If the culture advocates marriages and sexual morality, it advocates "shacking up," communes and sexual liberation. If the culture believes in private enterprise, it rejects it. If the culture reveres Christianity and Judaism, the counter-culture turns to Zen Buddhism or even witchcraft and satanism. If the culture respects reason, it celebrates sensuousness.

The forthrightness of the rock music assault upon the entire fabric of our society may be observed by any citizen. Just pick up a copy of *Rolling Stone,* "the Wall Street Journal" of the rock set, at your corner grocery store. It is a radical publication, blatantly pornographic, but also regularly sprinkled with well-written articles sympathetic to various revolutionary activity. Having friendly contacts with the underground, it obtained the story of Patty Hearst as a refugee. Its circulation, I believe, is about 1,700,000, and I would suppose the readership is several times that

number. Its text will shake you up.

Let us consider one other dimension of the massive counter-education. The typical eighteen-year-old has already viewed 20,000 hours of television. The American citizen watches his set an average of more than three hours a day. It is likely that television has a greater educative impact upon the young than family, church and all of formal schooling put together, with the sole exception of the children who are brought up in the few churches that still make real demands upon their members. I ask you, how much of what is presented on television could possibly be considered as supportive of the attitudes of self-restraint, self-reliance, respect for the law and respect for private property? Precious little. Much of the programming is devoted to attractive people who in one or more respects are opposed to these attitudes. Many people have begun to register objections to the sex and violence, as well they should; but, friends, I suggest to you with all the earnestness at my command, however damaging to the individual and the society the preoccupation with sex and violence may be, of much greater damage is the absence of examples of civilized people who live by principle, who stand up to difficulties with dignity, and who sacrifice present whims and desires and short-term gains for more important long-term gains or for the public interest. This is what civilization is all about. That we do not seem to understand, and failing to understand it, we are losing our civilization.

In trying to respond to our problems, we have been putting band-aids on rashes, or in this group I should say we are simply capping the tooth with the infected root. The cosmetic effect may satisfy the person trying to attend to the problem, but the patient remains in agony. We can multiply our economic education a thousand times, but if the citizens are not deeply committed to self-reliance and a respect for private property, the support for private enterprise will in all likelihood continue to decline. We can pass more laws, quadruple the police and the regulatory bodies, and refine our judicial system, but if the citizens are not trained to respect the law, I doubt that those actions will have much impact on the crime rate. We could delete the sex from television and the theater and reimpose a ban against pornography, but if the citizens are not imbued with a faith in the family and the sacredness of marriage and a deep-rooted commitment to self-restraint, it is likely that sexual license will prevail and divorces will continue to multiply. The sickness of our society is the result of failing to understand that civilization is only possible when

supported by certain attitudes and commitments of the citizens.

We are now in the midst of a new wilderness. It isn't as readily recognizable as the original one we faced, but wilderness it is — a vast area without civilization where there are forces that make living very difficult.

Is it a hopeless mess? No, I don't think so. Let us remember that the first wilderness was not conquered by the United States Government, nor by aid from a prosperous foreign power, nor by any central plan. It was conquered by a large number of determined individuals, each of whom believed that the task was worth doing, who rolled up their sleeves, and with persistence and courage and help from their friends and neighbors labored to get the job done. Our new wilderness will, I believe, only yield to the same treatment at the hands of determined individuals, willing to make some sacrifices, willing to give up some television time and some football games to attend to these matters of the gravest importance.

It is such people as you new Fellows of the College of Dentists, who have been singled out for your contributions to your profession and to the larger society, who are accustomed to long hours and to sacrifice and who know the deep psychic rewards of sacrifice, it is you who can help get us headed back in the right direction. Our society needs leaders like you and it needs a program.

At Rockford College through the years, we have been working to develop the theory and the program. We regularly mail out essays analyzing the elements of responsible liberty and are at this time considering a new project which would expand this particular aspect of our work. If you would like to be on the mailing list for these essays, just drop me a note.

There is I believe, a great readiness in our country to reassert the principles which made this a great nation. It just takes some doing.

Let me conclude these comments on the new wilderness with a little story and an observation. My story is about the man who came to the police station to fill out a report on an automobile accident. He was rapidly moving down the sheet, filling out the blanks, until he came to a sticking point. He scratched his head and pondered a long time before he finally wrote something. The clerk who had noted this performance, scanned the report when it was finally handed in. To the question, "What could the other car

(Continued on page 32)

HONORS AND AWARDS

CITATION FOR REAR ADMIRAL CLEMENS V. RAULT UNITED STATES NAVY (RETIRED)

on presentation of the William John Gies Award
1975
by Treasurer Henry J. Heim

Mr. President, it is with great pleasure that I present Rear Admiral Clemens V. Rault, Dental Corps, United States Navy (Retired), for the William John Gies Award of the American College of Dentists.

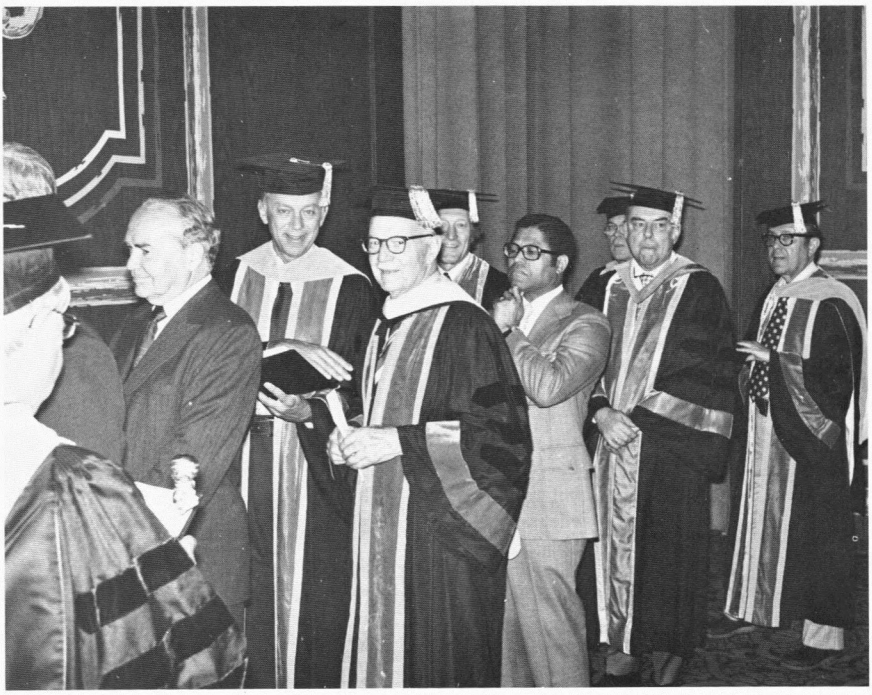
For over half a century, Dr. Rault has served his profession in an outstanding manner. This includes clinical dentistry, dental education and dental research in both the public and private sector of American dentistry. Throughout this period he has maintained the highest standards of professionalism as a clinician, counselor, teacher, leader, advisor, scientist and administrator. Dr. Rault's activities have touched the lives and provided inspiration for hundreds of professional men and women all over the world.

Clemens V. Rault was born in New Orleans on August 11, 1896, and went to dental school in his hometown at Loyola University in New Orleans. He graduated from this school in 1918 with a Degree of Doctor of Dental Surgery. He then entered the United States Navy as a Lieutenant (Junior Grade), and rose to the rank of Rear Admiral and Chief of the Dental Corps of the Medical Department of the Navy where he served with distinction. His Navy duties included clinical, educational and administrative assignments, the latter being at the highest level possible for a dental officer.

Upon the completion of his tour of duty in 1950 as Chief of the Navy Dental Corps, Dr. Rault retired from the Navy and accepted the position of Dean and Chief Administrative Officer of the School of Dentistry of Georgetown University, Washington, D.C. where he served until 1965. During this period he guided the School of Dentistry through the critical years of planning and development for new clinical facilities which the school now enjoys.

Dr. Rault has been active in many professional societies and authored numerous dental publications. He has served as President of the American Association of Dental Schools and

Vice-President of the American College of Dentists. He has received many honors including the honorary Doctor of Science Degree from Georgetown University in 1959, and the honorary Doctor of Science Degree from Loyola University in 1966. A Fellow of the College, a member of the Omicron Kappa Upsilon Society, Dr. Rault has given many years of his life to his profession. His contributions have been a credit to himself, the American College of Dentists and to American Dentistry in general. Most certainly recognition of Dr. Rault today quite appropriately honors the memory of William John Gies.



Convocation procession. Left to right: Marshal Dale A. Hills; Theodore R. Van Dellen, recipient of Honorary Fellowship; Treasurer Henry J. Heim, Clemens V. Rault, recipient of the William J. Gies Award; Regent William C. Draffin, Thomas E. Malone, recipient of the Award of Merit; Regent Richard J. Reynolds, Regent Walter H. Mosmann and Editor Robert I. Kaplan.

CITATION FOR
DR. THEODORE R. VAN DELLEN
of Chicago, Illinois
on presentation of Honorary Fellowship
1975
by Regent Charles A. Calder

Mr. President, Theodore Robert Van Dellen, MD, is known to millions throughout the world as a result of his daily newspaper column, "How to Stay Well," a feature that has reached every part of the globe in all languages. A distinguished physician, outstanding educator and medical writer, Dr. Van Dellen has made significant contributions to the dental health of the nation through his highly informative and instructive discussions of health matters including dental problems. Full recognition of dentistry and dental health in a highly professional manner has characterized Dr. Van Dellen's activities throughout his career.

Dr. Van Dellen graduated from Northwestern University Medical School in 1936. After completing his internship and residency, he returned to Northwestern University for completion of a Masters Degree in 1939. He joined the faculty of the university in 1937 in the Department of Medicine. Today he holds the rank of Associate Professor of Medicine. He was head of the Cardiac Clinic from 1944-1951 and Assistant Dean from 1949-1961. He is currently Attending Physician at Passacant Memorial Hospital in Chicago and is certified by the American Board of Internal Medicine and the subspecialty of Cardiovascular Disease.

Dr. Van Dellen has been Medical Director for the Chicago Tribune since 1945, Medical Editor for the Chicago Tribune and New York Times Syndicate since 1945, and a member of the Editorial Advisory Board, Medical World News since 1960. For the past seven years he has been presenting a weekly television program on health on station WGN in Chicago.

His professional activities have been many. He is a Life Fellow of the American College of Physicians, member of the American Heart Association and the American Federation of Television and Radio Artists. He has served as President of the American Medical Writers Association, President of the Chicago Medical Society, Vice-President of the Chicago Heart Association, Vice-President of the Northwestern University Alumni Association, and President of the William, Smith Davis Club of Northwestern University Medical School. His civic activities include serving as a member

of the Chicago Board of Health and several committees of the Illinois Department of Health.

Dr. Van Dellen has been honored for his contributions to his professions and to his community, receiving the Distinguished Service Award of the American Medical Writers Association in 1958, the Citation of Merit from the Illinois Public Aid Commission in 1960, the Merit Award of Northwestern University Alumni Association in 1960, and the Service Award of this university in 1954.

Dr. Van Dellen has had a distinguished career and with his writing has advanced the views of dentistry and dental health. He has displayed those qualities most fitting for a Fellow of the American College of Dentists. It is with particularly great pleasure that I present him for Honorary Fellowship in the College.

CITATION FOR
DR. THOMAS E. MALONE
of Bethesda, Maryland
on presentation of the Award of Merit
1975
by Regent Gordon H. Rovelstad

Mr. President, Dr. Thomas E. Malone has had an unusual career leading to a relationship to dentistry and dental research that is quite unique. A zoologist, histo-chemist and cell biologist, Dr. Malone has had a distinguished career as a scientist, author and administrator. His interest in the enzyme alkaline phosphates and expertise in histochemistry has brought him into scientific exchange with investigators at the National Institute of Dental Research and undoubtedly set the stage for his outstanding service to the dental profession. Through his activities and positions in the Grants Division of the Extramural Programs Branch of the National Institute of Dental Research, he became directly involved with dental research programs and investigators throughout the United States.

Dr. Malone, a native of Henderson, North Carolina, graduated from North Carolina College in Durham, North Carolina with a Bachelor of Science Degree in 1948 and a Master of Science Degree in 1949 with a major in Biology. He went on to Harvard University and completed a Doctor of Philosophy Degree in 1952, his dissertation being "Studies on the Tetrazoles: a Histochemical

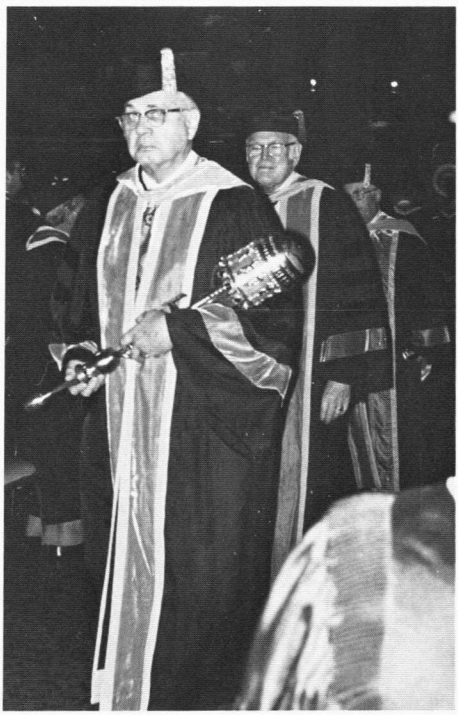
Study." Upon graduation he returned to his alma mater, North Carolina College, as Assistant Professor of Zoology where he taught for six years. In 1958, Dr. Malone was awarded a Postdoctoral Fellowship recommended by the National Academy of Science as a Resident Research Associate at the Argonne National Laboratories. From there he went to Loyola University as an Assistant Professor of Biology and to Sabin Branch Chicago Teachers College and to Illinois Institute of Technology as visiting lecturer.

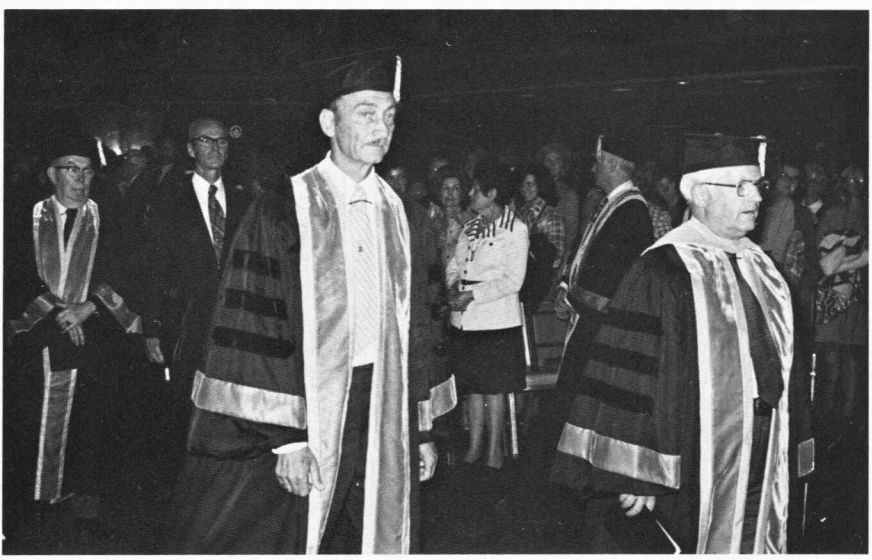
In 1962, Dr. Malone left academic life and accepted a position as Grants Associate in the Division of Research Grants, National Institutes of Health. He went on to become Assistant Chief, Research Grants Section; Deputy Chief, Extramural Programs Branch; and Chief of the Periodontal Disease and Soft Tissues Studies, Extramural Programs of the National Institute of Dental Research. He then took two years away from NIH and served as Chairman of the Department of Biology at the American University of Beirut in Beirut, Lebanon and became very active in the academic life of that university. He returned again to NIH in 1969 as Associate Director for Extramural Programs of the National Institute of Dental Research. Because of his outstanding efforts, Dr. Malone was brought into the office of the Director of the National Institutes of Health in 1972 and was appointed Associate Director for Extramural Research and Training at the National Institutes of Health, a position which he holds today.

Dr. Malone is a member of the American Association for Advancement of Science, American Society of Zoologists, the American Association for Laboratory Animal Science, the Histochemical Society, the American Society of Cell Biology, the International Association for Dental Research, and Sigma XI. He has been honored throughout his career, being a Harvard Fellow in 1950, and a National Research Council Fellow in 1958. He was awarded the Department of Health, Education and Welfare Superior Service Award in 1970 and Distinguished Service Award in 1974.

It is a privilege to recognize Dr. Malone, an individual outside of the dental profession who has contributed significantly to the advancement of dentistry, its science, and its literature.

CONVOCATION SCENES





FELLOWSHIPS CONFERRED

Fellowship in the American College of Dentists was conferred upon the following persons on October 25, 1975 in Chicago, Illinois.

Vito Anthony Adragna, Watertown, New York
Jan Erik Ahlberg, London, England
Earl William Ah Moo, Honolulu, Hawaii
Camillo A. Alberico, Morgantown, West Virginia
Vernon L. Amundson, Duluth, Minnesota
Jimmie Lee Anderson, Harrisonville, Missouri
Robert M. Anderton, Carrollton, Texas
Leonard Andors, Brookhaven, New York
Victor Lee Andrews, Jr., Mocksville, North Carolina
Charles A. Babbush, Cleveland Heights, Ohio
Benjamin R. Baker, Kinston, North Carolina
Ronald D. Baker, Navy
George P. Barnes, Army
Harvey G. Behner, Toledo, Ohio
James H. Belding, Independence, Iowa
Joseph D. Belzile, Army
Ben H. Benson, Woodward, Oklahoma
Henry J. Bianco, Jr., Morgantown, West Virginia
Arthur John Block, Chicago, Illinois
Wilfred Rupert Bodden, Birmingham, Alabama
William Allan Booth, Sharon, Pennsylvania
Wilber C. Boren, Sr., Princeton, Indiana
John E. Boyle, Winnetka, Illinois
Billy B. Bridgford, Colorado City, Texas
Eli S. Brody, New York, New York
Herbert Lee Bronson, San Francisco, California
Weston D. Brown, Yakima, Washington
Robert W. Browne, Grand Rapids, Michigan
Frank A. Brucia, San Francisco, California
Jack Bruce Buck, Dallas, Texas
Bernard C. Byrd, Loma Linda, California
H. Vance Cartwright, Memphis, Tennessee
Dominic Joseph Catrambone, Chicago, Illinois
Ernest R. Cervis, Tampa, Florida
Richard W. Chaikin, Boston, Massachusetts
Chrys Ernest Chrys, Torrance, California
James F. Claypool, Akron, Ohio
Ralph D. Coffey, Morganton, North Carolina
Myles I. Cogan, Veterans Administration
Earl Williams Collard, Oklahoma City, Oklahoma
George J. Collings, Portland, Oregon
Dino S. Colombo, Clarksburg, West Virginia
John J. Connors, Wilton, Connecticut
Gale E. Coons, Indianapolis, Indiana
Philip W. Cooper, Savannah, Georgia
Thomas M. Cooper, Lexington, Kentucky
Robert J. Crum, Veterans Administration
W. Alan Crum, Jr., Richmond, Indiana
George I. Daugherty, II, Air Force
Walter H. Dickey, Roanoke, Virginia

Wilbur F. Dolezal, Morris, Illinois
Gordon D. Douglass, Walnut Creek, California
Raymond S. Dziejma, Maspeth, New York
Jerome S. Engel, New Brunswick, New Jersey
T. William Evans, Columbus, Ohio
Charles V. Farrell, Bellingham, Washington
David J. Farrell, Weston, Massachusetts
Jesse Harry Fischer, Akron, Ohio
Karl J. Foose, W. Palm Beach, Florida
William S. Frank, Los Angeles, California
Norman Carl Freeman, Willingboro, New Jersey
Michael Edward Fritz, Atlanta, Georgia
William J. Frome, Air Force
Henry C. Garabedian, Long Beach, California
Don Gordon Garver, Navy
Clarence E. Gerstenberger, Castro Valley, California
Howard S. Glaser, Danbury, Connecticut
Philip M. Glatstein, Miami, Florida
Richard Gliedman, New Rochelle, New York
Morton J. Goode, Washington, D.C.
Elliott J. Gordon, Ridgewood, New Jersey
Alvin J. Grayson, New York, New York
David L. Grodberg, Bayonne, New Jersey
Seymour M. Gross, Union, New Jersey
Jerry R. Hale, Smithville, Tennessee
Robert W. Hampton, Sweetwater, Texas
William L. Hand, New Bern, North Carolina
Stanley P. Hazen, Edwardsville, Illinois
Edward P. Henefer, Havertown, Pennsylvania
James O. Henry, Jr., Dallas, Texas
Francisco M. Herbosa, Rizal, Philippines
Henry J. Herpel, Detroit, Michigan
Michael A. Heuer, Chicago, Illinois
Robert W. Hewitt, Memphis, Tennessee
Saul M. Hirshberg, Boston, Massachusetts
John M. Horack, Jr., Boston, Massachusetts
Benjamin J. Horbal, Chicago, Illinois
Berne M. Howard, Portland, Oregon
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Willis B. Irons, Duluth, Minnesota
Herman Ivanhoe, Brooklyn, New York
Charles W. Jarvis, San Marcos, Texas
Paul B. Johnston, Punxsutawney, Pennsylvania
Jasper Allen Jones, Troy, Alabama
N. Buford Jones, III, Savannah, Georgia
Philip S. Kanev, Philadelphia, Pennsylvania
Joseph Francis Karpinski, Auburn, New York
Richard P. Keim, Kansas City, Kansas
Morris Kelner, Philadelphia, Pennsylvania
Marvin B. King, Valley Stream, New York
George C. Kiser, Air Force
Robert E. Krumholz, Austin, Minnesota
Ralph L. Lambert, Air Force
Donald Lewis Leake, Torrance, California
Richard H. Leggett, Menlo Park, California
Leon A. Leonard, Augusta, Georgia
Gene P. Lewis, Lexington, Kentucky
Jason Russell Lewis, Richmond, Virginia
Daniel Robert Lindborg, South Bend, Indiana
Hannelore Taschini Loevy, Chicago, Illinois
Jose´ M. Losada, Madrid, Spain
Robert H. Loving, Norfolk, Virginia

Grant A. MacLean, Glenview, Illinois
Wallace Vernon Mann, Jr., Jackson, Mississippi
William W. Manning, Madison, Tennessee
Oliver Frederick Manzini, Calumet, Michigan
Virgil H. Marshall, Charlottesville, Virginia
Howard Martin, Silver Spring, Maryland
Richard Lee McClelland, Princeton, New Jersey
Glen P. McGivney, Milwaukee, Wisconsin
Carlton J. McLeod, Navy
Kenneth A. McMurchy, Edmonton, Alberta
Clarence W.B. McPhail, Saskatoon, Saskatchewan
Andrew Emilian Michanowicz, Pittsburgh, Pennsylvania
Frank Miele, Dix Hills, New York
Harold Miller, Flushing, New York
William H. Molle, Playa Del Rey, California
Joseph R. Moran, Spokane, Washington
Paul C. Moyer, Mayfield Heights, Ohio
Rudolf K. Naujoks, Wurzburg, Germany
Jack H. Neff, Philadelphia, Pennsylvania
Harold Nemetz, Orange, California
Dwight W. Newman, Alexandria, Virginia
William A. Nichols, III, Medina, Ohio
Milton E. Nicholson, Jr., Pittsburgh, Pennsylvania
Orla Richard Nutter, Minot, North Dakota
Edward O'Brien-Moran, Wexford, Ireland
Ronald Lee Occhionero, Chesterland, Ohio
Marvin N. Okun, New York, New York
George H. Peacock, Saskatoon, Saskatchewan
Robert Hugh Peery, Pittsburgh, Pennsylvania
Max J. Perlitsh, Medford, Massachusetts
Duncan R. Perry, Bismarck, North Dakota
Zigmund C. Porter, Oakbrook, Illinois
Charles B. Price, Temple, Texas
Harry C. Priess, Brady, Texas
Eugene P. Purtell, Albuquerque, New Mexico
Claude L. Raby, Jr., Grand Rapids, Michigan
Stuart M. Ratner, West Orange, New Jersey
George T. Raust, Jr., San Francisco, California
Kenneth M. Ray, Asheville, North Carolina
Errol L. Reese, Baltimore, Maryland
Arthur M. Riley, Zephyrhills, Florida
Henry C. Rivetti, Wayne, New Jersey
Pearce Roberts, Jr., Asheville, North Carolina
Roberto E. Rodriguez, Cedar Rapids, Iowa
Everett R. Roeder, Frontenac, Missouri
Jerome A. Rogers, Riverhead, New York
Avrom A. Roobin, Macon, Georgia
John H. Ross, St. Petersburg, Florida
Martin A. Rubin, Watertown, New York
F.R. Ruliffson, Navy
Joseph L. Sajbel, Pueblo, Colorado
Allan L. Sander, La Jolla, California
Eugene S. Sandler, Lynn, Massachusetts
Clement K. Schmitt, St. Joseph, Missouri
J. Vernon Scott, Monrovia, California
David W. Seifert, Jr., Raleigh, North Carolina
Stephen M. Selby, Baton Rouge, Louisiana
Jack G. Seymour, Fresno, California
Albert Solnit, Los Angeles, California
Harvey D. Sprowl, Buffalo, New York
William J. Stern, Milwaukee, Wisconsin

Arthur Van Stewart, Louisville, Kentucky
Gideon J. Stocks, Jr., Miami, Florida
Earle W. Strickland, Zuni, Virginia
Peter H. Strife, II, New York, New York
Roland L. Stromsborg, St. Cloud, Minnesota
Gordon C. Swann, Calgary, Alberta
Joe G. Sweet, II, Oakland, California
Claude Everett Swords, Dallas, Texas
Joseph W. Tamari, Beirut, Lebanon
Newman C. Taylor, Alexandria, Virginia
Ross L. Taylor, Chicago, Illinois
Kay Francis Thompson, Carnegie, Pennsylvania
Richard W. Tighe, Omaha, Nebraska
Margaret Toalson, Clayton, Missouri
John P. Treacy, Milwaukee, Wisconsin
Edwin A. Troutt, Barrington, Illinois
Henry A. Trow, Brooklyn, New York
Robert S. Tuttle, Santa Rosa, California
Jack A. Tweedle, Oakland, New Jersey
Thomas T. Upshur, Lynchburg, Virginia
Antonio J. Venezia, Flossmoor, Illinois
Patrick N. Walker, Los Angeles, California
Richard I. Weaver, Toledo, Ohio
Don R. Webb, Jr., Jackson, Tennessee
William H. Weddington, Jr., Louisville, Kentucky
Carlisle Weese, Oak Park, Illinois
John H. Whitaker, Baltimore, Maryland
Robert M. Wilkinson, Winston-Salem, North Carolina
Benjamin H. Williams, Worthington, Ohio
Howard Marion Willis, San Pedro, California
Robert O. Wilson, Concord, New Hampshire
Curtis R. Woodford, Roanoke, Virginia
Wellesley H. Wright, Lake Oswego, Oregon
Bernard Yanowitz, Washington, D.C.
Camille Lee Young, Washington, D.C.
Edward Young, LaPorte, Indiana
John Morgan Young, Air Force
Leo E. Young, Garden Grove, California
Stephen S. Yuen, Hayward, California

THE NEW WILDERNESS

(Continued from page 22)

have done to avoid the accident?" — the man had written, "Parked elsewhere."

Wilderness, like a parked car, is simply there. It will not go away by itself. It only yields to civilizing influences by hard work and consistent effort and moral courage. Americans conquered one wilderness very successfully. We now face another. Our job is to recognize that just as there are standards in our professions which must be vigilantly maintained and transmitted to the young who follow us, so also are there standards in a responsible free society which must be vigilantly maintained and transmitted to the young. It is time to proclaim those standards anew and restore civilization to this wonderful country.

SYMPOSIUM

Alternatives in Oral Health Care - II
The Role of the Specialties

It has long been the policy of the American College of Dentists to bring to the attention of the profession matters which in the opinion of the college merit discussion. This is the second in a series on *Alternatives in Oral Health Care* titled *The Role of the Specialties.*

Following the format used last year, a series of questions have been developed and each member of the panel will respond to the same questions. The panel consists of members of seven of the A.D.A. recognized specialities and a general practitioner. They were not chosen to represent their discipline officially, but speak on their own authority as experienced, knowledgeable professionals in the different areas of dental practice.

The panelists are all fellows of the American College of Dentists, who are national and internationally known and recognized as outstanding members of our profession.

- Charles F. McDermott, Moderator, Regent, American College of Dentists, Pittsburgh, Pennsylvania
- Jacob Berke Freedland, D.D.S., Endodontics, Charlotte, North Carolina
- L.M. Kennedy, D.D.S., General Practice, Dallas, Texas
- Francis V. Howell, D.D.S., Oral Pathology, La Jolla, California
- Robert V. Walker, D.D.S., Oral Surgery, Dallas, Texas
- Harold T. Perry, D.D.S., Orthodontics, Elgin, Illinois
- Theodore C. Levitas, D.D.S., Pedodontics, Atlanta, Georgia
- Frank T. Scott, D.D.S., Periodontology, Jacksonville, Florida
- Chester K. Perry, D.D.S., M.Sc., Prosthodontics, Detroit, Michigan

1. What is the purpose of the specialties and the value of specialization in the total system of oral health care?

C. Perry: One person cannot be all things to all people. The primary purpose of a specialty practice is to benefit and protect the oral health of the public by identifying practitioners with specialists who have special competence and training to care for professional problems of an unusual or difficult nature. The title "Specialist" implies that its possessor can render with competence a service that the dentist in general practice, because of less knowledge, skill, and experience or desire, would find difficult or impossible. The growth of dental science in the past 50 years has created the need for special competencies. Also certain general practitioners have little ability or desire to perform certain dental procedures. They may have those patients with certain necessary situations completed by a specialist in that area.

Scott: No longer is it possible for any man to be an expert in more than a part of dentistry. In order to serve the patient well, problems beyond the scope of the general practitioner must be solved. Specialties have evolved because of the many problems in dentistry that are too complex to be properly executed in all phases by one person.

One man can know a great deal about one subject but a few can know all, and one can be more thorough if he concentrates in one particular field or endeavor.

Because of the ability of the specialist to concentrate on research and progress in a particular field, he can give the patient better service than if his efforts are spread over the entire scope of dentistry.

Most general practitioners have not usually gone into the postgraduate field of specialty training. The general practitioner needs to center his efforts on every improvement made in the preventive and restorative phases of dentistry and can serve his patients better by referring the problem cases that require advanced study to the specialist in that area.

Being better trained, the specialist is able to treat advanced and complex cases by virtue of his background. He makes fewer mistakes, and doing the same job every day, he works more surely. The specialist is especially trained to handle the difficult case, using diagnostic and treatment skills beyond those which can

normally be expected for the general practice of dentistry.

There is a need for the general practitioner to have someone he can call upon to perform the specific therapies he is not willing or capable to perform. Problems beyond the scope of the general practitioner must be solved. They cannot be ignored or by-passed due to someone's inability to diagnose or treat.

Levitas: The purpose and "raison d'etre" of specialties, simply put, should be to provide specialized care and treatment.

If the system works properly, the practitioner who qualifies as a specialist is supposed to be better trained, more knowledgeable and more adept at handling problems in a particular area of expertise. Of course, the mere fact that a dentist goes for two or more additional years of schooling does not automatically qualify him or her as one who will be more perceptive or who will find solutions more quickly, or who renders treatment more effectively. Granted, this advanced education will give him the opportunity to be better, but what he does with the opportunity is what actually counts.

As dental science has grown in scope, as the technical aspects of dentistry have become more sophisticated and complex, it has become obvious that most practitioners cannot be masters of everything. It is virtually impossible to read all the literature on a given area of practice, let alone be current with everything that is written on dentistry.

Left to right: Chester K. Perry, Francis V. Howell, Robert V. Walker, Lynden M. Kennedy and Harold T. Perry.

I spent nine years in general practice. One of the major motivating factors influencing me to limit my practice or specialize was the realization that I could no longer keep up, to my satisfaction, with all that was new in dentistry.

The purpose of the specialist should be, simply, to provide superior care in a specific area — to provide the best in diagnosis and treatment for all patients. Concentration of our efforts to a relatively confined area should make it possible to achieve this goal. It should have nothing to do with wanting to feel better or superior to others. A Hindu proverb sums it up rather well: "There is nothing noble in being superior to another man. The virtue is in being superior to your previous self."

H. Perry: Specialty by definition is a branch of knowledge, art, science or business to which one devotes himself, usually to the total exclusion of related matters. Historically, we have seen its development in the emergence of man with nomadic hunters and sedentary semi-agricultural groups. During the middle ages the crafts and guilds emerged. The Industrial Revolution introduced expanded knowledge at all levels necessitating fragmentation of interest, study and effort. Dentistry became a branch of medicine with the broadening science base related to the oral cavity. Just as medicine, law, engineering, academic responsibilities, science, and all other fields broadened their factual basis for existence, so did dentistry. The necessity for knowledge and skill in depth for one facet of the total field became apparent. Thus, men elected to pursue a particular side road, parallel to the main highway of their profession. The origin of the specialties is then historical. The augmentation of dental knowledge by research and clinical experience dictated the necessity for the specialties. The specialization in dentistry permitted a better means of patient care in that the professional could fully devote his knowledge, interest, instrumentation and skill to one specific area of the more complex dental ills or anomalies of the patient.

The value of specialization in the total system of oral health care has not changed from its original concept. It may even be more meritous. The present trends in increased overhead costs, tuition for dental education, explosive intensification of dental health needs through third party payments and the sophistication of American appreciation of dental health value underscore the profession's and laity's demand for the maximum health care at

the most minimum or modest fee. Maximum care is hopefully available and provided by the best skilled and most knowledgeable which implies specialization. The minimum or most modest fees would indicate an "open market" selection for the patient and a minimum of office procedures and instrumentation by the professional leading to superior intra-office efficiency.

Walker: A special area of dental practice is recognized on the basis of a few criteria.

One, the area shall be one for which specially trained dentists are needed to fulfill the profession's responsibility for promoting and improving the health and welfare of the public.

Two, the area shall represent a substantial field of practice which calls for special knowledge and skills requiring a study and extended clinical and laboratory experience beyond the accepted undergraduate training in order to perform services of an unusual or difficult nature.

Three, the area shall be one in which recognized educational institutions or teaching hospitals have developed a sufficient number of courses so that opportunities for advanced education and experience are available to those seeking programs of education in this special area. The area of practice need not be analogous to that of an undergraduate department in a dental school since such departments are organized to present teaching materials and not to define a division of practice.

Four, the area shall be one in which public and professional needs for such special services shall have called into existence a sizable number of practitioners whose knowledge and skills are readily available.

Five, the area shall be one in which the dentist refers patients or seeks consultation in order to provide a special health service.

Six, the area shall be one in which there is evidence that a significant number of dentists are devoting the full time of their dental practices to this special area.

Seven, the area shall be one in which a significant number of scientific papers and clinics have been presented, or in which an increasing number of high quality scientific papers or clinics is being presented.

Those criteria are not original. They were established by the

American Dental Association's House of Delegates, as requirements for national certifying boards for special areas of dental practice. They serve their purpose well in the total system of health care. I could hardly improve on our very able House of Delegates of the American Dental Association.

Howell: Before answering such a question, it is necessary to define specialties and specialization. First, we must realize that dentistry itself is a specialty since it is responsible for a specific area of the human body and certainly the dental curriculum reflects this specialization. On this basis then, we can define the "specialties of dentistry" as "subspecialties." If we look at specialization in this way, I think we can better visualize the relationship of the dental specialist and the general practitioner, particularly their roles as they influence the care of dental patients. If we look at the subspecialties in internal medicine, we realize that complex problems do not have simple answers and that special expertise is necessary for complicated and difficult problems. Specialization, therefore, is advantageous in concentrating special problems within the expertise of individuals who are specially trained to handle these problems and who are, of course, prepared to do so both by education and special equipment and armamentarium. The subspecialists in dentistry, therefore, are prepared to handle those special problems which occur in dental patients which are either beyond the scope of the general practitioner so far as experience is concerned and beyond his scope or personal preference. Specialization, therefore, has advantages to general practitioners for referring cases which do not come within his expertise or physical ability. Even more important, the patient can receive both diagnosis and therapy for complicated problems which are "routine" to the subspecialist.

Kennedy: Somehow I think the generalist feels that the purpose of dental education is to produce and provide people who can practice dentistry at the chairside level. I think the purpose of the specialties is to form a partnership, an alliance for progress with the general practitioners to achieve a common goal of promoting the health and the welfare of the public, and for no other purpose.

Originally the specialties were created to take care of those

complicated cases which required services and education beyond those which were generally available. I think no one can find fault with that purpose. As Dr. Walker said, the House of Delegates has well outlined those. But frankly I think that there is much questioning in the minds of many generalists as to whether or not there is justification for all the specialties we now recognize and in the scope we now recognize them. Perhaps it is time to have a reassessment and look at it more in the area of the complications that we are serving in the areas, rather than generalization of an area by itself being so much the criteria. I think we certainly have so much in common and so very little difference that we should be partners — that we need specialists for those unusual and complicated cases for which they were originally intended but not necessarily to take over entire areas of practice. The generalist still should be able to take care of people anywhere.

Freedland: The criteria by which special areas of dental practice achieve recognition by the American Dental Association are predicated upon a logical separation of services into those which have distinct biological, psychological, and physiological approaches to diagnosis and treatment rather than on the fragmentation of services based upon technics or procedures.

It is with this premise in mind that I would like for the singular reference in the question to read purposes rather than purpose. The purposes are: (1) to aid and assist the general dentist and other related clinical disciplines in providing the ultimate in patient care through consultation and service in their respective areas of expertise; (2) to explore, collate, and evaluate the vast body of expanding information being compiled from the basic and clinical sciences for their clinical significance and application; and (3) to provide the personnel, and the progression of information and service for the educational arena, the profession at large, and the public it serves.

The value of the specialties is the inherent strength that it generates in concentrating in one particular area of information and skill development to achieve the optimum for both dental education and oral health care for those disease states and dental conditions presented by the public. These resources should prove useful for dentistry to provide more dental care of higher quality to more people.

2. *Would the treatment of the patient be enhanced by expanding the role and competence of the general practitioner and referring to the specialist only those problem situations requiring sophisticated treatment? Discuss your reply.*

Freedland: Yes. There should be no controversy on the question of expanding the role and competence of the general dentist. Historically, dentists have been educated and trained in the "piece work" concept rather than in the concept of total patient care. In recent years, there is a change in this direction, but this transition has been slow and yet to be accomplished.

An ideal system would be a broadly based general practitioner well grounded in utilizable basic and clinical sciences and capable of providing a high level of restorative, therapeutic, and surgical care in all dental areas. The primary generalist should be competent to care for all of the ordinary and long-term needs of all age levels and basically to supervise and control the oral health care of the whole family unit. This is truly *Preventive Dentistry.* Referals would then relate to complicated differential diagnosis, specialized techniques, involved systemic conditions, and a host of other factors which require the special knowledge, skill, and experience of the limited practitioner.

It should also be understood that all dentists do not share the same enthusiasm for all areas of dental practice and prefer to limit their own services to areas in which they feel a special confidence. There are also the factors of time, convenience, and urgent patient need that may motivate a referral for such benefits that may accrue to the patient.

Kennedy: Obviously it is logical to assume that treatment of the patient would be enhanced if the general practitioner had the appropriate educational background and competence in the areas of practice which are now limited to the recognized areas of dental practice.

The real question that the Council on Dental Education had to face when it undertook the study of curriculum in dental schools was how to alter the educational process and better define the scope of general practice as well as specialty practice in a common effort to provide the patient with the best possible dental care.

Any time that we can broaden and deepen the experiences of our undergraduate students, the better will be their ability in dental practice and the greater the benefits to their patients.

Howell: Treatment of the patient would certainly be enhanced by expanding the competence of the general practitioner, but expanding the role presents the physical and intellectual impossibility of the general practitioner's being adept and knowledgeable in every area. Because of individual interests and experiences, it is possible that a general practitioner would become a "mini-specialist" by maintaining those patients who have problems he is especially interested in and referring those who are not of interest or not within his realm of capability. It would also be dangerous to say that the general practitioner should only refer to the specialist those problem situations requiring sophisticated treatment. There would be the danger that the general practitioner might ignore the simple problems which he does not wish to deal with and only refer those which are blatant or advanced. I think a general practitioner who recognizes that periodontal disease is extremely important in his practice but is not something he desires to participate in should be encouraged to refer patients with even relatively simple periodontal problems to a periodontist in order to give the patient full benefit of periodontal therapy. There is a safety factor in this in that the general practitioner who is interested in periodontics and treats simple cases in his office is also very aware of those problems which are or can become complicated and need care of the specialist. It is felt that the general practitioner who has primary responsibility for the patient's oral health should be in a position to make referral decisions based on what is best for the patient, taking into consideration the adequacy of the office to handle all problems in specialty areas and decide whether or not they need to be referred.

Walker: The general answer is "yes," but there are qualifications to it. It is perfectly clear that there is a body of knowledge to meet the needs of the practice of general dentistry. It was developed deliberately and through necessity by generalists who recognized the vital role of family relationships in maintaining the dental and oral health of their patients and accepted the comprehensive oral care of the family based upon the fundamental quality of concern. In this they were responding to the concept expressed many years

ago by Francis Peabody who said, "The secret of the care of the patient is in caring for the patient."

The general practitioner more willingly becomes emotionally involved with his patient than most specialists as one means of expressing his concern for their welfare. In order to further implement this concern, he has developed certain humanitarian values that are unique to our profession. I am not enamored by the concept of "expanding the role and competence of the general practitioner." We are all hampered by deficiencies or special interests which serve as limiting processes in this regard. What I would like for them to represent is an accurate identification of the conditions most commonly seen in a dental practice and a list of the most commonly made diagnoses, and an overall assessment of what constitutes the practice of general dentistry.

We have no critical assessment of what general practice is. Two of the best friends I have in Dallas are general practitioners of dentistry, and their scope and range is so diametrically opposed to what each does that I am confused by what right they call themselves general practitioners. The same can be said for specialists. We need to know the common vein that constitutes the practice of periodontics, oral surgery, prosthodontics, etc.

Now getting back to what might constitute the practice of general dentistry, this list might include 15, 25, 40, 60 or more common day-to-day problems seen in a general dental practice. The number is not important. The goal, however, should be teach well and thoroughly the management of those problems. There are plenty of exceptions to the usual problems that will more than take care of the specialist waiting in the wings for his place in the total scheme of the delivery of oral health care.

H. Perry: Personally, I would answer "yes" to the first part. That is in "expanding the knowledge of the general practitioner in all phases of dentistry." I recall Dean Freeman of Northwestern University greeting us as freshmen; and one phrase he used was "temporomandibular joint disease." Yet in my first year of general practice in North Dakota a female patient was referred to me by an otolaryngologist with a prescription pad which read, "temporomandibular joint problem related to occlusion." Despite my four years of dental school I did not know what to do. It may well have been I was asleep at that lecture or I was more concerned about getting my Class III foil requirements completed.

I mention this to underscore the need in the dental curriculum for enrichment of knowledge in all the so-called specialty areas. However, this immediately finds us against the perennial problem of curriculum time slots. There are only so many hours in a four-year program and perhaps less in a three-year program. Where do we find the time to give the diagnostic and treatment knowledge required to recognize, treat or refer these truly dental problems? Restorative dentistry does not wish to shorten its course; prosthetic dentistry, oral surgery, periodontics and all the others do not wish to lose time.

Certainly a better structuring of the curriculum with total coordination of effort is a constant necessity and its continuum should be to provide greater depth of information for the generalist. We are, as educators, obliged to provide the greatest spectrum of information on dentistry to our undergraduate to enhance his skill and insure the optimum care for his future patients. It can not be argued that the vast majority of his efforts will be restorative and prosthetic, both removable and fixed; and thus it is germane that these areas receive priority in education. But where do we draw the line between these and the especial patients?

In reply to the concept that the generalists refer only those problems requiring sophisticated therapy, I have mixed emotions. There is no doubt in my mind the many generalists can do better than some specialists on some of the patients whose problems indicate specialty referral. There are many factors that influence this thinking. One, of course, would be skill and knowledge. Some specialists should not be specialists just as some generalists should not be generalists. Skill and expertise are often woefully lacking. Secondly, the patient's relation with the generalist may be superb and recommendations and therapeutic endeavor will receive maximum attention by the patient. A referral to a specialist may break this intangible bond. Third and perhaps most important, the generalist must recognize his or her limitations and those of the specialist. A failure to do so and acknowledge the same to the patient can very well result in idiopathic disaster. If the generalist feels fully competent and prepared to deal with the problem, he should be able to undertake the same. However, to explain to the patient that his work will not be at the level of the specialist but will cost less, then we are dealing in a frightfully explosive commodity.

Levitas: Simply stated, my answer would have to be "no." Today, as the demand for good dental care has increased dramatically, the conscientious general practitioner is taxed to the maximum to tend to the needs of his patients. If practice really does make perfect, the specialist has the opportunity to "practice" in a given area with much greater frequency than does the general practitioner.

If an attempt is made to expand "the role and competence of the general practitioner," to quote from the question, do we mean to expand him in each of the specialty areas? Where will he find time to develop this enlarged competency and still be proficient in meeting the needs of his patients and his family? It is only human nature that many people, in all fields of endeavor, find certain aspects of their work more or less appealing. In these areas which he finds more challenging, let the general practitioner increase his ability and his technique. There is no law requiring him to refer a patient to a specialist. As a matter of fact, in most of our states, general practitioners are now permitted to participate in *all* facets of dentistry without specialized training.

I can see no way in which treatment of the patient could be enhanced by attempting to expand the role and competency of already competent, and for the most part, overworked general practitioners.

It would seem to me that no man — or, only a few — could possible be totally competent in the more complex treatment procedures of areas of specialization. But, then, who is to say what is a "complex" procedure? In the end, it is up to the individual to determine his own limitations. Flannery O'Connor said that "To know one's self is, above all, to know what one lacks." And still another proverb says that "He who knows himself is wise."

Scott: Speaking from the viewpoint of a periodontist, the answer is yes. The real problem here is, if there is a limited amount of knowledge, the general practitioner may feel incompetent and he may frequently feel reluctant to let the patient know he cannot handle a certain situation, and will not refer his patients.

As a result of this attitude, many general practitioners do not do a periodontal examination leading to recognition and diagnosis of periodontal disease. Many patients have gone to the same general practitioner for years and years, have never had a proper

diagnosis, and are totally unaware of their advanced, and possibly terminal periodontal disease.

Patients who have received such inadequate care feel resentful and bitter towards the general practitioner who has been responsible for their supervised neglect.

When patients finally do discover, either by chance or by a change to a different dentist, that they have advanced periodontal disease and are on the verge of having to undergo complicated specialized treatment, an awkward situation often develops, and everyone suffers. There have been some traumatic and costly lawsuits in situations such as this.

The patient understandably suffers complete disenchantment with dentistry, and it may be difficult for the specialist to develop the confidence and rapport that is so important to the successful handling of the problem.

Periodontitis is a so called "comfortable" disease and often occurs without any symptoms to the patient, even into the terminal stage. The more urgent nature of many problems in general practice may interfere with the important but less urgent attention required by periodontal patients. The problem with many general practitioners seems to be in diagnosis, in the timing of the referral, and failure to adequately inform the patient of the problem and its solution.

Left to right: Harold T. Perry, Frank T. Scott, Theodore C. Levitas, and Jacob B. Freedland.

C. Perry: In consideration of the area of prosthodontics by the year 1980, there will be in excess of 30,000,000 edentulous persons in the United States. The number of semi-edentulous and edentulous patients seeking prosthodontic care is increasing because: (1) the expanded educational efforts of organized dentistry are creating a greater awareness among the public of the importance of better esthetics and the preservation of health; (2) payment plans more acceptable to patients are available through dental service corporations; and (3) people who previously could not afford dentistry are now receiving subsistance under government programs.

Since there are not enough specialists to cope with the rising demands for patient services, the general practitioner must be relied upon for this area of dentistry more heavily than ever before. The general practitioner, therefore, should attempt to prepare himself to meet the demands for increased services. He can and in so many instances is up-grading his knowledge, clinical skills and judgment in postgraduate and continuing education programs and is keeping current with current periodical literature. He will be benefited in giving these services if he will become aware of the recent advances in treatment, the new materials that have been introduced, the clinical research that has resulted in a better understanding of living tissues, and the efficient use of auxiliary personnel.

3. In your opinion, what are the two most pressing problems involving the specialties which affect organized dentistry and the delivery of oral health care?

C. Perry: One of the pressing problems that involves total dentistry is the lessening of quality dental education. This situation may be said to be judged by external evaluators and not be completely valid, but the boards of examiners in many states are failing a larger percentage of today's graduates than was previously true. The Federal manpower dollars and quality dental education were not compatible, while the need for the schools to comply may have been present particularly for financial reasons. I do not believe the schools were forced to participate. Federal support did permit increased manpower, construction of new dental schools, modernization of older schools, student financial aid, and the survival of private schools of dentistry. It did

not permit an improvement of the graduates in their abilities to diagnose, plan treatment for and treat patients. They are poor performers when they come before the examining boards.

Another problem is the quality of graduate and postgraduate education in our dental schools. Not all are satisfactory in terms of preparing candidates who come before their respective specialty boards. It would help if only those schools would grant graduate programs or postgraduate programs who have a university *graduate school* of which the school of the School of Dentistry offering such courses is a part, and the Dean or the curriculum committee of the graduate school of the University would, with the cooperation of the dental school, determine the qualifications and accreditation of the teachers of graduade dental courses, the subjects of those courses and related research as well as the requirements for the advanced degree.

I should like to state a third problem: that the state boards of dentistry recognize the diplomates of the American boards of the various specialties and give recognition to them differently from those who take only the local state board and are recognized as specialists in their specialty.

Scott: First and foremost, the most pressing problem is the failure of dentists to recognize periodontal disease — many dentists simply ignore it until it reaches the advanced stage. Perhaps this is not so much the fault of the individual dentist as it is the fault of the educational system as it has existed in the past. The basic philosophy that has been followed in dental schools in the past has provided but a meager background in preventive periodontal care, if any at all. Whatever the cause, this deplorable situation does exist in our profession and it must be corrected.

Secondly, the failure to realize that there is a difference in the quality of care between the general practitioner who does an occasional gingivectomy and the periodontal specialist who handles the complexities of sophisticated periodontal surgery. Many general dentists want the same fee as the specialist for what they assume are the same procedures when there can be no comparison between the two.

Many general practitioners fail to communicate or confer with specialists. Once out of school, they may feel insecure and in many instances, may be pressed to meet financial obligations. Thus, they fail to refer patients out of their practice for specialized

care for fear the patient will be lost by the referral. Once this nonreferral pattern is established, it may be difficult to change. Therefore, many patients are not afforded the opportunity of the best treatment or a second opinion. Some third party plans and government programs have been organized with little or no provision for periodontal care.

Levitas: There are probably several problems involving the specialties of organized dentistry's efforts to deliver oral health care. The two which stand out in my mind are time and overlapping.

First, the matter of time. One of the great injustices done to dental students and new graduates is the pressing of them into specialty training immediately upon being graduated with that magical, mystical, three-letter degree. If I had my way, no student would be permitted to enter specialty training until he had spent at least two years in general practice. How can one honestly know the ramifications of the various aspects of dentistry, based upon his limited exposure to them during his school career? As I stated earlier, I spent my early dental years in general practice. What I learned from my associates, from my patients, about the practice of general dentistry has helped make me a better pedodontist. Those years gave me the opportunity to begin to understand the inter-relation of all aspects of dentistry. Rather than tunneling my vision, those nine years broadened my horizons and helped me understand why a young adult was still petrified at the thought of dental treatment and chose full dentures, rather than extensive restorative procedures.

But time seems to be of the essence — and the young student is in a rush. Would that he could be slowed down.

The second problem is the obvious overlapping of treatment between the general specialties. The A.D.A. has attempted to face this situation by approving of dual specialization. We know that overlapping exists between orthodontics and pedodontics, between periodontics and orthodontics, between oral surgery and periodontics, and possibly in other areas. I do not pretend to have the answer to such a volatile situation. But I do believe that the integrity of the individual practitioner and his ability to perform the needed services should be the ultimate factor in adjudicating these areas of conflict.

H. Perry: Fragmentation of dentistry by either fault or design. We must not forget our original common goal — improved oral health for our patients. All of us accepted this premise when we opted to study dentistry. Thus, our true link is that we are all first and most importantly dentists despite our individual interests in education, administration, or specialization. Even with total dedication as a coherent group of professionals we are a significant minority of the American population. Fragmentation of our efforts and interests or evidence either rhetorical or political of intra-profession divisiveness will thoroughly weaken our stand in securing a viable stance to vocalize our position in coming years of health insurance trends. I do not intend to be paranoid about the future as planned by other forces. I wish to be pragmatic and not prophetic, practical and not a Pollyanna. We are facing some very serious and difficult times in dealing with bureaucratic incursions which could and would alter the practice of dentistry we have all nurtured, enjoyed, and hope to perpetuate. Not a cottage-craft as one recently depicted us, but a true profession, oriented to the best for all of our patients.

Recently I saw a bumper sticker which stated, "If you like the postal service you'll love the National Health Service." I personally believe it is inevitable. But as those who know best our strengths and weaknesses, we should have the grass-root strength to make our thoughts and wishes known to those who would dictate to us. We cannot do it with intraprofessional schisms.

I therefore state my most pressing concern of the specialties as the same that faces all of us — fragmentation. Secondly, I would cite the cost of our services. Here we are on very thin ice. If as a profession we do not have a means of a true cost accounting system which fairly rewards the practitioner for his education, overhead, level of skill and proficiency, as well as a fair monetary return for his effort, we are inviting third party authoratative decisions. We must establish some fair mode for a national and regional evaluation. With our current sophistication of computerization, we should be able to establish recommended levels of fee structure for various procedures. This would not recognize the complexity of the individual operation or case but would give us some national and regional series of monetary standard of fee for service. Modifications would be acceptable in the individual offices and the survey should be a continuum to keep abreast of cost of living increases, material, salary,

education and general economic cost changes. In my own specialty I find it hard and I am certain lawmakers note it also, to understand why one case should be $850 in one part of the country and $3500 in another for similar procedures. I am not espousing a rigid fee for service scale, but a benchmark or reference for all of us to review periodically in light of our own practices and procedures. This is inflammatory dialogue and is a sacrosanct area which rarely if ever is discussed in a dental curriculum or dental meetings. Gentlemen, I would assume that Big Brother in Washington is quietly and efficiently collecting this data as are our larger unions and insurance companies. In the infantry in World War II, I learned the best defense is an offense — let us start to marshall our own facts.

Walker: The two most pressing problems involving specialties which affect organized dentistry and the delivery of oral health care are, one, communication; and second are the efforts of organized dentistry and organized specialties in keeping up the efforts of its members. This obviously requires a deeper explanation.

Communication needs improvement in quality but not in quantity. We are inundated with quality journals, newspapers, bulletins, news items, etc., but the apathy of members within organized dentistry and the specialties to read and keep up is appalling. The grass-roots level of practitioners, general or specialist, simply do not become deeply involved or spiritually committed through lack of information to the causes of dentistry.

I think a big question is how can effective programs be developed to overcome this apathy? There is information available.

I wish I had time to single out individuals in this audience and ask particular questions. What is the current consideration of health manpower in the halls of Congress? What is the PEP program and how is it faring? What is the status of dentistry's interest in hospitalization coverage, emergency dental care and dental representation on PSROs and current consideration of national health insurance by Congress?

What dentists are subject to minimum wage laws? How did dentistry fare in recent senate consideration of HEW's budget for fiscal year 1976?

What tax deduction changes recently considered by the House

Committee on Ways and Means will affect dentistry? What are the ADA's standards for dental prepayment programs and how are they being used or abused by insurance carriers in developing health plans involving the delivery of health care? I wish everyone in this audience could answer knowingly to those questions, and I doubt that very many could.

These items and many more were discussed in recent well-organized dental publications and yet I dare say one would be hard pressed to find very many in this audience or any specialty group who have a clear understanding and grasp of these issues and could contribute to their resolution by the American Dental Association.

Within my own specialty, and I think it is important in all of dentistry, having a voice at the policy making level, a seat on the board commissioners of the joint commission of accreditation of hospitals has long been considered of importance. But there continues to be rebuffs and delays in obtaining that seat. The legitimacy of dentistry having that seat is unquestioned. But the forces of other professions have thus far thwarted the thrust and efforts of dentistry.

Also within oral surgery, the frenetic activity of oral surgeons in needing guidelines for the administering of general anesthesia and the development of self-evaluation manuals, in keeping offices safe for the delivery of this pain relieving mechanism, has long outstripped the production of this by organization itself. The development of procedural terminology with glossary, and standard nomenclature with coding which is of importance to insurance carriers has long been a need in our particular specialty and has only now been produced, and the need has been there for over a decade.

I draw those examples from my specialty, not as an indictment but to point out the problem that our activities as specialists or as general dentists far outstrips our mechanisms for keeping up with them.

Howell: From the oral pathologist's standpoint, there are many problems and it is difficult to categorize and particularly to give value to those whch are most pressing. From a personal standpoint, I feel that the coordination of all activities in dentistry to keep both the general practitioner and the "specialist" informed of all phases of negotiations with providers of dental care is

probably the most important area. Oral pathology frequently is in a position of having services covered by insurance carriers while a general practitioner or the specialist referring the specimen for evaluation is not covered by insurance. At the same time, insurance carriers covering medical problems frequently reject an oral pathologist's fee simply on the basis that his degree is DDS or DHD. Certainly the evaluation of oral tissue is recognized by all medical pathologists to be most adequately handled by oral pathologists. However, those persons who manage the departments in insurance companies and make these decisions frequently decide entirely upon the man's degree. This, of course, places the patient in a situation where he may have to seek someone less qualified in order to have his insurance cover the cost. I think oral surgery has similar problems in this regard. The second most pressing problem is the area of prevention and we, of course, feel very strongly that prevention from cancer to caries depends on not only the education of the dental profession but certainly the expansion of the education of the public. It is my feeling that the latter is more important since demand for services of prevention will automatically cause dentistry to provide more and more preventive services. Certainly in the area of cancer control in the oral cavity the dentist must continue to be educated to early detection, but we realize that it is even more important for the public to understand the need for periodic oral examination for all oral disease in order for us to detect cancer in early stages.

Kennedy: The two most pressing problems that I see have been those that have arisen from specialty jurisdictional disputes and from a reassessment of the needs for the number of specialists. We must now follow medicine's mistakes and over-specialize. There has been concern expressed in recent years about the number of graduates who pursue careers in the specialties. As recently as 1966, less than 10 percent of the graduating students went into specialty programs, and yet in 1975 there were places for slightly more than 30 percent of the graduates in such specialty programs. Coupled with this are the controversies about the extent of the limits of additional functions that would be delegated to auxiliaries. The generalist suddenly finds himself in an uncomfortable position. He sees a rapid growth at the top of the educational spectrum in those areas that would limit his scope of practice, and at the bottom of that spectrum, he sees a large thrust

to delegate additional duties to auxiliaries. He logically begins to wonder just what his future position in the dental health care delivery system will be.

So when these are all integrated we find friction and dissidence. I think again that we must come to the place in dentistry where we give more than lip service to some of our beliefs. We are going to have to recognize the validity of the will of the majority and be willing to experience some minor inconvenience in our own particular areas so that we can have that one unified voice that will be heard loud and clear.

Freedland: The maldistribution of specialist limits the availability of such services to metropolitan and high economic suburban areas. In endodontics, we have ten states with no endodontist and 11 additional states with only one. Seven of the more populated states have 61 percent of all endodontists and these, too, are located in the metropolitan or high economic suburban communities.

The second most pressing problem may be the quality of education and training in the post-doctoral programs. Too frequently, graduate students move into the post-doctoral programs for specialty training without a broad based knowledge of general dentistry.

Left to right: Charles F. McDermott, Robert V. Walker, Jacob B. Freedland, President P. Earle Williams, Harold T. Perry, Chester K. Perry.

4. What are your views on the efforts of specialties and auxiliaries in dealing independently on dental matters with government, society and commerce?

Freedland: Any special area of dental practice or component of the dental profession that desires to deal independently on dental matters can only prove to be counter-productive to the profession at large.

Dissident points of view and vested interests potentiated by strong specialty organizations along with other subgroups can and may dilute the organized voice of dentistry. (We have 123,574 members in a national population of approximately 225 million.)

In an analogous sense, dentistry can be described as a wheel with a series of spokes attached to a hub which is the central position of the profession. When one of the spokes extends beyond its functional and supporting limits, it provides an imbalance and regressive force.

Kennedy: It would be difficult to find anyone who would say we should not be unified. The fact is that for two hundred years we have had for the most part a unified profession. We have achieved the finest dental health care for most people at the most reasonable cost. The American people have the finest oral health in the world.

This is a tribute to our private practice fee-for-service system. It is almost redundant to point out that we are only 125,000 strong in the dental profession and that we are in a population of 225,000,000. We simply cannot afford the fragmenting and dissidences that would divide us, because we can have impact only as long as we are together.

We must stand up and do everything we can to persuade others that our view is right because when the voice of the majority has spoken, then we have got to be willing to accept the will of the majority, abide by that and come out with a single strong voice.

Howell: I think in dealing with their dental colleagues, specialists should be able to work together to eliminate obvious mutual problems. Oral pathology and the other surgically oriented disciplines, endodontics, periodontics, and oral surgery, have often, at the local as well as at the national level, had interchange and have been able to work out many problems, thus, preventing

major disruptions. In the area of auxiliaries, we are in an entirely different situation from all other dentists since many of our auxiliaries are not dealing directly with patients. So far as dealing independently with government, society, and commerce, we feel very strongly that a unified and strong voice is necessary and that oral pathology should not independently deal with outside institutions, particularly at the national level. As an example, when it became apparent that all oral pathologists would be placed under regulations of the Social Security Act as far as directors of laboratories were concerned and so far as interstate commerce matters were concerned, instead of dealing directly with the government or going through the American Society of Clinical Pathologists, we dealt with the American Dental Association and were able to place dentistry's specialty in this area in an ideal position. This also allowed dentistry to better define the entire spectrum of oral care to our medical colleagues as well as government officials.

Walker: In approaching this question, one recalls the question that was once asked of Will Rogers. Someone asked him, "Will, what's wrong with the world today?" He thought a minute and said, "Well, I guess it's people." If someone could ask Will the question, "What's wrong with dentistry today?" his answer would probably be, "Well, I guess it's dentists." It is funny that we have to even address ourselves to the problems that we have before us because I do not think there is a soul in this room that does not feel strongly toward the vocation we follow. But there are needs that we all have, and if the satisfaction of some issues involving organized specialties or auxiliaries are not adequately addressed by the American Dental Association, the organized specialties and auxiliaries are frequently left with no other recourse but to address them themselves.

Now if it is absolutely necessary to review case histories of a problem or issues providing an intelligent objective answer, I can hardly speak of this problem or its philosophical response without a review of the case history.

One has to add the important questions. What efforts have been developed because of the straight line of communication between all specialists, all auxiliaries, and organized dentistry? In all likelihood, if this is an issue to be discussed, something probably has not been attended to that attracted the question in the first place.

H. Perry: Our foremost goal should be the consolidation of all dental specialties and ancillaries under the aegis of the American Dental Association. This must be done by persuasion, persistence, personalities and professional administration. If we fail to exhibit a united front of our own individual thoughts, hopes and desires for our patients good and for the good of dentistry, we will be diluted or subverted. If the American Dental Association seems remiss or callous to the majority in a subclass of dentistry, *i.e.,* a specialty or auxiliary group, then we must deal with the problem from within and not by separatists movements or from weakened independent endeavor.

I am enough of a skeptic, pessimist or pragmatist to believe that the people or their organizations who wish to deal with us from a power position act with full knowledge that our divided attention is to their advantage.

Persuasion is an essential ingredient to discourse and debate. The moment we permit anger or self-interest to enter our dialogue, we lose sight of our goal of patient care and strive only for our own interest. I believe each local and state dental society as well as the national specialty groups should strengthen their interprofessional and intraprofessional committees — not with lip service but with concrete action. We do not need the "mossbacks" on these committees who have many questions but no answers, but those who are perceptive and alert to the total dental needs of America and the professional interests of dentistry. Their meetings, discussions and yes, arguments would or should endeavor to ameliorate our intraprofessional differences.

Persistence is another ingredient in producing a united dental community. Failures in all of our efforts are countless regardless of our field or ken but persistence must pervade in our endeavors to overcome. If one group fails in its endeavors another should be formed and persistence pervade.

By personality I refer to those individuals at all of our professional levels who exhibit a sincere and ready interest in dentistry and who possess a strong, acceptable and representative demeanor. These are often our leaders but quite often they do not possess nor desire the political spotlight. They are content to lead at the lesser level, to deal with the difficult or sticky problem for solution sake alone. These are the persons who are the rank and file of dentistry and whom we must seek to provide us with a continual intraprofessional dialogue. At times every individual and each of our professional groups must feel that their sacred

oxen are being gored. It should be the task or appointed duty for each and every one of our elected or appointed representatives to eliminate any inter or intraprofessional rivalries or differences of opinions that this produces. As I have mentioned, this must be done by persuasion and perserverance. The minute we lose contact among ourselves as dental health professionals, we lose the potential to guide our own destiny in a fashion which is beneficial to our patients and fundamental to our profession. We do not want self-serving goals or selfish standards but a truly professional ethic which will benefit the patient, profession and practitioner.

The final ingredient that I believe is necessary is that of the professional administrator. These are the fountainhead of our committees and councils at the American Dental Association. We have all the committees and councils we need — perhaps too many. What is needed is a cleaning of the pipe lines of communications from the grass-root societies of auxiliaries, generalists and specialists to these professionals at the American Dental Asociation. I personally believe we could be blessed if there were less facing east to Washington by these people and more appreciation of the murmurs and words from the vast membership before the latter turns to a shout and clamour. These professional administrators can be the catalyst for the coalescence of our dental profession.

Levitas: This really should not take three minutes to answer. I think it is a serious error for several allied organizations to deal independently with the third parties. The truth of the matter is that our basic goals are all the same. It is for me but common sense that a single, united strong voice to represent dentistry must carry a greater impact than several single ones. The total chorus has a much more profound effect than does the individual tenor, alto or bass.

Certainly, just as do the singers, the independent dental group should give input to the central agency. But, then, we must, in a democratic way, accept certain compromises and speak with one loud, clear voice, as opposed to several solos going off in different directions. I think dentistry has erred in recent years by having several voices instead of a united chorus.

Emerson said "It is the highest form of self-respect to admit mistakes and make amends for them."

I think it is time for us to admit our mistakes, show some self-respect — and sing together.

Scott: Each phase of dentistry should be involved with protecting its own rights. We should, however, be working together to accomplish the same general goals and we should present a united front in all matters with government, society, and commerce. This can be better accomplished by good communication and understanding between all dental organizations.

The specialties should have their voice and opinions respected at all levels in the American Dental Association; and the ADA should not act independently in matters that affect the individual specialty groups. We should have all our arguments within the confines of ADA and then have the ADA speak for dentistry with one united voice.

Socialized dentistry in England has given us a portrait of what we might expect in America if the government takes control of our profession in any matter whatsoever. Private practice of dentistry as we have it today is much preferable to the socialized system, and to keep it this way we must stay abreast of all legislation with adequate and strong ADA representation in Washington. We must look progressively into the future, and as a profession, provide the American public with dentistry that cannot be equaled by any other means.

C. Perry: It is important that the needs of the populace be met. If dentistry comes under government jurisdiction, the demand for dental services will certainly increase. There would need to be much more research into treatment methods that would enable dental service to be made available to more people. Research should attempt to narrow the gap between prevention and treatment. Health comes before disease. The need is to preserve health.

The question is, when government control enters the dental health field will the quality of dental services be maintained? Dentists are clinically oriented in the treatment of dental ills. The dentist who best fills out the most complete predetermination form is often not the one who provides the best or most thorough treatment for his patient.

There are, it seems to me, many questions. Under government

jurisdiction, what control will the profession of dentistry have over its destiny? Each specialty is recognized as an area which is important to the health and welfare of the public. The specialist is one to which the general practitioner frequently refers patients in order to provide a service commensurate with advanced training, education and experience.

Under government control, traffic in dental offices will be greater. If government will provide given fees for each patient's needs, be it endodontics, orthodontics, or prosthodontics for instance, the general practitioner because of case, or patient, or procedural recompense may not refer his patient to the specialist, if quality is not demanded.

About auxiliaries — assistants and hygienists can be beautifully trained in the specific duties and responsibilities relevant to the specialty. She reduces the time for operative procedures and may become particularly adept at reducing the patient's apprehension, discomfort, and inconvenience that the patient may experience. In my specialty, she is of great help in crystallizing the esthetic decision for patients.

Technicians likewise can become most adept at carrying out the laboratory procedures pertinent to those specialties. If the profession becomes subsidized by the government, the demand for auxiliaries will be increased.

Regarding matters of government as they pertain to dentistry, more persons will be in dental offices, but will that increased proportion of the population be getting the important care the patient *deserves?*

Under government — the need for specialties will increase — will the practitioner demand their services by referring those needing special care to the specialist?

I should like to solicit the federal government's help in granting funds for research in basic science, oral disorders, and clinical dentistry, and permit the independence of dental practice governed by state, national and specialty boards who would monitor all dental service to insure the deliverance of good dental health care to the public.

5. *Should a board certification program for general dentistry be developed? Why or why not?*

Freedland: There are some who feel that our present system of

providing a DDS or DMD degree provides this base while others feel that our present system of undergraduate education cannot provide the education and clinical experiences necessary to achieve this level of competency. Medicine has already moved into this direction in establishing a post-doctoral training program for three years to improve the competency of the family physician. If dentistry desires to emulate this pattern, then it will be necessary to provide a post-doctoral training program to develop the expansion of skills and knowledge to produce such a super generalist. Competence in such a generalist may well require more knowledge and skills than that found in a specialty.

Kennedy: It has been my observation that there is more and more interest on the part of some organizations and individuals to develop a special recognition of the general dentist. Some have gone so far as to propose a specialty of general dentistry, comprehensive dentistry, or family dentistry. Such specialty recognition would in all likelihood be followed by application to the American Dental Association for board recognition in general dentistry.

In my view, there is no question that the general dentist is the backbone of professional dentistry. At the same time, there is question in my mind if there is need for a specialty of general dentistry.

Howell: From my previous comments about specialties and subspecialists, I feel that the situation of medicine does not apply to dentistry since the man who specializes in general practice or family practice does have to have extensive experience in all phases of medicine. Since the dentist is already a specialist, I feel that we are creating somewhat of a monster and therefore would be opposed to it.

Walker: We have become so busy in our lives becoming certified and registered, boarded, recognized and diplomated that these accomplishments may be losing some of their meaning. I have been very happy with a DDS degree and support the views that the backbone of the profession is general dentistry. If there is the necessity for an additional board, I fail to recognize it. I think the needs that we all have are increasing our personal knowledge of what is occurring in our profession. But if there is an explicit

need for recognition in acquiring that, then I think that the acquisition of that knowledge has been in a false manner. I applaud anyone who will take the time to participate in continuing education courses, in order to prepare himself to give lectures, write articles, and to give of himself back to his profession. But if his objective is merely another certificate to hang on the wall, I do not see how it fits into the framework that our organization's criteria established for board certification.

H. Perry: I am proud to be a dentist and I think we should all be proud of the fact that our basic vocation is dentistry. I would concur with what Dr. Howell stated — that medicine is a different beast entirely.

It started down its path a little earlier than we did and perhaps got off the ark before we did, but there is something that parallels this question that was given by Sir William Osler in an address to the New York Academy of Medicine in 1897 when he was speaking to the Internal Medicine group. He said, "It was with greatest pleasure I accept an invitation to address this section of the Academy on the importance of internal medicine as a vocation. I wish there were another term to designate the wide field of medical practice which remains after the separation of surgery, midwifery and gynecology.

"Not itself a specialty, it embraces at least half a dozen bearing without reproach that good old name physician. I have heard the fear expressed that in this country, the sphere of the physician is becoming more and more restricted and perhaps this is true. But I maintain and I hope to convince you that the opportunities are still great, the harvest truly is plenteous and the labor is scarcely sufficient to meet the demand."

I think that in this respect there is much that the general practitioner can do. Whether he needs board certification for his own edification or glorification, I do not know. I am an orthodontist but I am not board certified. I still do the best I can for my patients. I still try to be part of the society, and part of dentistry. I feel that if the general dentists would desire to have board certification, they would go through the proper channels of the ADA to act on it. If the majority approves the idea, so be it.

Scott: A board certification program for the general practitioner, if it were tied in with a well-organized continuing education program

for recertification at periodic intervals, would improve dentistry and dental care. This would encourage the general practitioner to better himself in order to receive the recognition which he would so aptly deserve.

Levitas: I really do not see a need for board certification in general dentistry. I think that a continuing education program and very likely consideration of relicensure is far more significant than hanging another certificate on the wall. I think it is in these directions that both general practitioners and specialists should aim their efforts to see to it that whether there is a specialty board or no specialty board or certification or whatnot, that men continue to be proficient in their particular area of practice, and if it takes relicensure to do this, this is what may have to be done. I think that would be far more significant than simply having another specialty board.

C. Perry: One person cannot be all things to all people. Dentistry itself is one of the great health specialties. All general practitioners in dentistry have passed their state boards enabling them to practice. Many have more than one board. If they are accomplished as general practitioners, their peers will know it. If they take additional training their patients will recognize it in terms of their better dentistry. Some hospitals offer a general practice residency which is to acquaint the young man to better understand all that dentistry entails. I know the general practitioners represent the crux of dentistry. It takes time and effort to develop a dental specialty. I think the machinery for teaching and the graduate teaching itself in a post-doctoral program of general practice would be very difficult to institute.

SUMMARIES

C. Perry: The principal objective of oral therapy is arrest of disease through the removal of the etiologic factors. If the general practitioner cannot resolve that oral problem, then it should be referred to a specialist.

In prosthodontics the management of the patient may be beyond the experience or physiological comprehension of the general practitioner. The practitioner may recognize these problems and

refer these patients to specialists who have a knowledge to cope with them.

Our topic today was the role of the specialties. The specialties do have a role in dentistry, and the need is for the colleagues of general practice to have rapport with one another. There needs to be rapport between the general practitioner and his patient and between him and the specialist as he acquaints the specialist of the patient's problem, and between the specialists of one area and those of another.

We need communications among all of the above areas of dentistry and the personnel that treat the patient. The specialist needs to minimize service to himself in terms of service to his peers, to his colleagues, to his profession. All dentists should make professionalism their goal.

Scott: As a periodontist I have to say that dentistry must do all that it can to disseminate knowledge regarding the importance of preventing mutilating periodontal disease that affects over 85 percent of the American people. Most peridontal disease is preventable. The known methods for prevention are more effective than those available for many other diseases of the human body.

With the increased emphasis on teaching periodontics in our schools, it is probable and hopeful that the generalist and his staff of well-trained auxiliaries will be able to deliver primary periodontal care to all his patients.

The specialist should find himself involved in the diagnosis and treatment of advanced cases that are beyond the scope of the general practitioner. Already the impact of third party payment is causing more demand for periodontal care. As these plans are expanding, periodontics will be faced with larger numbers of individuals who have insurance coverage. Some of these third party plans, however, provide for no periodontal care beyond scaling and curettage.

It is very important that the periodontist be included in the formation of such plans. Comprehensive periodontal care is basic to oral health and must be included if dental health insurance plans are to be effective. Increasing population and improved referral patterns will further increase the demand for care.

Periodontics must be incorporated in the private practice of dentistry. With the increased demand for better dental health care, there would not be enough periodontists even if 85 to 90 percent of

periodontal patients were treated by the general practitioner.

We know that the need for our services far outstrips our ability to deliver them. The periodontist should take the leadership in a massive public education program to help reduce the ravages of periodontal disease.

Levitas: I think if we separate the wheat from the chaff for just a moment, there is one thing we really need to understand. This comes back to the first question. "What is the purpose of a specialty program and what is the purpose of a specialist"? As far as I can see, no one has refuted the fact the specialized training in the final analysis is for the benefit of the patient not the doctor.

None of us can be all things to all people. As Dr. Kennedy said, "There is a very definite, a very profound partnership of general practitioners and all the specialists and there is certainly room for disagreement." Someone said if you have partners and they all agree, you have one partner too many, because you are not going to get anywhere; you are not going to progress if there is no disagreement.

We in pedodontics recognize that the majority of dentistry for children is performed by general practitioners. And this is exactly as it should be. The American Society of Dentistry for Children has as its motto, "Little can be done for grown up people, the intelligent man begins with the child." We urge all of you to begin with the child. Nothing that you do will entice parents and families to come to your office more than your ability to take care of children, to tend to their needs, to offer them succor and help when they are in trouble.

So we urge you, the general practitioners, to participate in dentistry for children, and give them the very best care that you can. But we also must understand that sometimes some of us do not choose to do certain things. I think however, as a physician once said, that a lot of patients are rejected to psychiatrists rather than being referred. I think this happens in dentistry.

I think we have a responsibility to refer, to make a recommendation, and do it in the kindest, most honest way and give our reasons for saying, "I think it is necessary at this particular time for you to seek the services of such and such a specialist." I think this enhances patient confidence in the practitioner and in the profession in general. It has been said that some men succeed by what they do, some succeed by who they

are, and a few succeed by what they are. You and I are rendering unique services for the well being of the general public. What we do for them really and truly does make a difference.

If we are to succeed, we must be concerned about our patients, but not just about their dental problems. Rather, we must see them as individuals, as human beings and treat their egos and their psyches with the same tender loving care that we treat their oral tissues.

H. Perry: We have gathered here by invitation and mutual interest to review some very important questions, concepts and directions that face our profession. The panel, in presenting their views, have purposively not stated those of their specialty but rather their own as specialists. These questions were lyrics composed by Bob Nelsen and I am certain many others. Our conductor of this orchestration has been Dr. McDermott. You of the audience and we of the panel have noted discordant notes in our presentation but just as any orchestra we must practice our parts for better symphony and perfection. Hopefully we did not present an opus from Babel but struck some symphonic counterpoint rhythm. If I may use the simile that we are all individual instruments in this orchestra of dentistry, we all have our own tone, timbre, resonance and contribution to the total symphony of dentistry. If one of us is out of tune with the rest we must improve for the total quality of the piece. In this instance that piece should be likened to Dvorak's happy "New World Symphony" and not to the depressing notes of Wagner's "Gotterdammerung" or "Ring Cycle." We as the members of the orchestra should be able to choose, to some degree, the excellence, quality and metre of our effort. Our lyricists have been dentists, our conductor a dentist, our instrumentalists have been dentists and our audience dentists. We as dentists should be able to produce harmony and cohesions at all levels of our profession. We must not accept the redundance of a Ravel's "Bolero" or cacophonous sound of a disorganized orchestra. We can, we should, and we must have some say in our orchestrations. I am certain, and it should be apparent to all of us that there are, waiting in the wings, many who would love to write our lyrics and music and even more numerous nondentists who would love to conduct us.

Our individual presentations have also pointed to a concern for greater generalist involvement in total patient care. Personally, I

would like to consider that our generalists could be educated parallel to the lines of the medical internist. These individuals represent acute diagnosticians who examine, review, and summarize the patients' problems. Then they either treat the ills, or dependent upon their background, refer those who they wish or elect not to treat to the specialist they believe has experience capable of dealing with the problem. I for one, by experience, believe this would require a far more significant undergraduate academic effort in diagnosis. In this respect this quote from "The University in Transition" by James A: Perkins is most apropos:

> Knowledge acquired most be transmitted or it dies. Knowledge acquired and transmitted must be used or it becomes sterile and innert. Even more, the chemistry of knowledge is such that the very process of transmission, together with the discipline of application, *stimulates* and *guides* those who work at the frontiers of knowledge. Knowledge is, therefore, in many respects a living thing — it grows, it changes, and various of its parts are replaced as they become obsolete.

There is no reason for the specialties not to impart their "special" knowledge to the generalists in academia, meetings, literature and postgraduate educational programs. Not to do so is a violation of professional ethics. There is, however, an obverse to the coin and that is the situation wherein a man may feel he can deal with any problem after a short course from craniotomy to hemorrhoidectomy. Now I say this in jest, but I have seen the results of such foolish undertakings and they are most tragic. To me the knowledge of when not to treat is just as important as how to treat. Certainly a broadened base of diagnostic information and peer review (by dentists) will hopefully curb such professional adventures.

In my teaching and living I find that humor is the succor for survival in a hectic world and with that in mind I would like to end with a couple of quotes which must alert all of us to our future.

The first is by A.V. Hill from "The Ethical Dilemma of Science." As a member of parliament (1940-45) he developed an attitude about "pure politicians" which he defined as one who has no idea in his head but politics. "Inquiry is mere inquisition and knowledge creates inhibition. The worst ignorance can still become famous enrolled as a pure politician."

All of us, as American dentists, must constantly struggle as a population minority, to demand the very best possible dental

health care we can provide for all Americans at a fair and equitable fee. Our strength lies in our common background — dentistry and not in fractional alignment of special interest groups or individuals.

The second and final quote is a parody by Clark Kerr of Don K. Prices limerick which Kerr had in his book, "The Uses of the University" in 1963.

"There was a young lady from Kent
Who said she knew what it meant
When men took her to dine,
Gave her cocktails and wine,
She knew what it meant, but she went."

Before we go much further, let us review what is meant.

McDermott: In summary, it would seem there is evidence that the dental profession is gradually being fragmented and that we may be moving towards departmentalization of care. The discussion this morning clearly indicated that the topic is complex and should not be over simplified by generalization. It is apparent that the parameters of each discipline is governed by the individual's education, training and capabilities. Forces outside the profession are exerting pressure to change or limit these parameters. The federal governments influence on the dental schools to graduate more students in a shorter period of time and the variation of third party fees for the same procedure are but two examples. If it is found desirable to change the role of the specialist for the welfare of the patient or for economical reasons, the adjustment must begin in the dental schools, which must be free to educate their students to deliver quality care at a reasonable cost to the patient. Whatever path our profession may choose to follow in the future, it is important that we use all resources at our command to study and evaluate the alternatives.

For this reason, I intend to request the board of regents of the American College of Dentists to submit this discussion to one of its newly formed commissions for further study.

Howell: The only criticism that I might have of the panel is that we chose questions that probably kept us away from some controversial areas. We did come down to the point of unanimity and we all feel very strongly that we are all a part of dentistry and

must act together on the problems affecting our future.

I do feel a little uncomfortable that we do not have better coordination, that we do not have better coordination between the various specialties. We do have good interchange between general practitioners and the individual specialty groups, but we do not have a good interchange with each other. We do not have a chance to sit down and talk about our inter-related problems. My suggestion would be for the ADA to push toward better coordination of the specialties and a better interchange of their recent problems.

Kennedy: I am impressed with how many things we find in agreement and how few disagreements we have. First of all there is general agreement that we are all dentists and that dentistry itself is a specialty. I did not hear any disagreements with the concept that all dentists, generalists and specialists alike should have the greatest possible competence in all their areas. All dentists have the moral obligation to recognize their limitations and stay within the confines of their competence. If one feels deficient or uncomfortable in any area of practice, then he should refer to someone in whom he has confidence in that area.

I think there is general agreement that there is definitely a need for specialists who have the advanced education to help solve the problems that occur in the most complicated and unusual

A large audience attended the Symposium.

situations. There is total agreement that we must be unified and that we must be responsive to the will of the majority.

Its been my observation that most everyone believes in majority rule, as long as they are on the side of the majority. After we have used all of our persuasive powers to see that our philosophical beliefs prevail, in such instances when we do not prevail, our duty is to bite the bullet, to accept the will of the majority, and not try to be obstructionists to that will.

Friedland: In substance, the goals of the specialist and the general practitioner are identical. I think too, the specialist's self-interest has served a vital role in providing education, care and delivery of care that can only accrue to the public.

If the anthropologists are accurate in their observations, they have very strong evidence that man need not lose his natural dentition throughout his normal life span. If we accept this premise then we must in turn also admit that organized dentistry is far indeed from achieving its goals.

I might also say that problems easily seen are not easily solved. I think we have a problem, and I think the voice of dentistry can be a strong one. I think it will take our concerted cooperative efforts to move in this direction.

Walker: I know there are some differences in opinion among us. In my opinion the general practitioner, by vitrue of an ever changing dental curriculum, will assume more and more responsibility than he ever has in the past within the scope of specialty practice. That holds true in oral surgery and I think that is the way it should be. There has been refinement of instrumentation, and techniques that make removal of third molars far simpler than was taught me in dental school and I feel strongly that most of these problems can be handled well by the general practitioner. I am happy to become more proficient in other areas of oral health care by the interest that the general practitioner has in my specialty.

I believe that the general practitioner will be more willing to turn over certain functions to the auxiliary as he develops expertise in some of these specialty areas of dentistry and in that context expand his capabilities.

COMMENTS ON THE SYMPOSIUM

The impact made by a conference of this type is not always easy to measure. In an effort to obtain some idea of the reaction of the audience, those present were asked to write brief opinions of the symposium. These were collected, and will be useful to the planning committee for next year's meeting in Las Vegas.

Representative comments, pro and con, are presented here.

—I approve the program! Please continue with this type presentation in the future.

—Good format and presentation.

—Panel mechanism an excellent approach!

—This is an interesting and practicable program approach covering material of considerable present day concern.

—To my mind, this type of program totally eliminates long-winded and kilometric dissections of the various ramifications of total oral health care. It further challenges the panelists to get to the point and not "beat around the bush," so to speak. Congratulations to the committee in charge!

—The balance of panelists' answers would be better changed to increase the number of questions answered at the request of the audience and decrease the number of questions automatically responded to.

—These questions should be offered to the College prior to the program. It is difficult to study the questions and listen to the panelists.

—By having specialist-oriented individuals all respond to the same questions, the answers must become redundant — they all look at general questions from the same viewpoint.

—Medicine through overspecialization reduced the general practitioners latitude and effectiveness of treatment. Consequently, medicine has found it necessary to establish a "Family Practitioner" specialty. Is dentistry going down the same road? Are general practitioners going to be managers of expanded duty auxiliaries and merely refer patients to specialists? This appears to be the trend in the philosophy of future dental delivery.

—Run an open forum from the floor, held in control by the moderator.

DECEASED FELLOWS

Since the 1974 Convocation, the following Fellows are deceased:

*Harold F. Anderson, Clovis, California
Howard A. Arden, Scarsdale, New York
*Alwyn J. Arnott, Sydney, Australia
*Carlisle C. Bastian, New York, New York
*Richard C. Beatty, Palm Desert, California
James W. Benfield, Wilton, Connecticut
Wallace H. Black, El Paso, Texas
*Samual B. Bleadon, San Francisco, California
*Samual Bogdonoff, Washington, D.C.
*Carl O. Boucher, Columbus, Ohio
*Louis Brach, Jersey City, New Jersey
O.W. Brandhorst, St. Louis, Missouri
Eugene L. Brown, Fort Worth, Texas
Harry K. Brown, Ottawa, Canada
*T. Mitchell Bundrant, Monroe, New York
Ralph H. Campbell, Detroit, Michigan
*K. Paul Carson, Edina, Minnesota
*Walter C. Cole, Orinda, California
*George A. Coleman, Wynnewood, Pennsylvania
*Thomas Conner, Atlanta, California
Edward J. Cooksey, Houston, Texas
*William G. Delp, Rural Retreat, Virginia
*William D. Diessner, Waconia, Minnesota
*Earl M. Eaton, Thatcher, Arizona
*Robert H. Fladeland, Sun City, Arizona
Lyman E. Francis, Montreal, Canada
William T. Goss, San Antonio, Texas
W. Alan Grainger, Australia
*Sebastian John Greco, San Mateo, California
*J. Alexander Haller, Pulaski, Virginia
*Walter C. Hava, Waveland, Mississippi
*Ralph W. Helms, Toledo, Ohio
*Clarence J. Hudson, St. Petersburg, Florida
*John M. Hughes, Richmond, Virginia
Walter Hyde, Minneapolis, Minnesota
*Philip Jay, Ann Arbor, Michigan
*George A.C. Jennings, Richmond, Virginia
Howard R. Lady, Washington, D.C.
Clarence T. Lee, Hawaii
*Maxwell J. Lentz, Passaic, New Jersey
Daniel S. Lockwood, Colorado Springs, Colorado
Clifford K. Lossman, Park Ridge, Illinois
*Ralph W. Ludwick, Lincoln, Nebraska
Lee B. Malone, Atlanta, Georgia
*Carlos Maristany, Puerto Rico
*Bernard A. Martin, Sarasota, Florida
William D. McCarthy, Denver, Colorado
*Roy E. McCasland, Tulia, Texas
*L. Halliday Meisburger, Buffalo, New York
*John Phelps Murphy, Dallas, Texas
*Paul K. Musselman, Ocala, Florida
*Ivor P. Muzzy, Athol, Massachusetts
*Edwin P. Nestler, Hinesville, California
*Joseph J. Obst, Brooklyn, New York
*Norman E. Page, Seal Beach, California
*Lowell N. Peterson, San Francisco, California
*Charles C. Poindexter, Greensboro, North Carolina

*J.B. Poindexter, Huntington, West Virginia
*George L. Powers, Paris, Tennessee
*Sherman A. Pyfrin, Melborne Beach, Florida
*John L. Preston, Wichita Falls, Texas
*Francis J. Reichmann, Oklahoma City, Oklahoma
G.A. Roelke, Tulsa, Oklahoma
Arne Foster Romnes, Chicago, Illinois
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Patrick R. Savino, Milwaukee, Wisconsin
*Andy Wilson Sears, Jacksonville, Florida
*Harry M. Seldin, New York, New York
*Jules B. Seldin, New York, New York
*Jacob Shapiro, New York, New York
*E. David Shooshan, Pasadena, California
George H. Siersma, Denver, Colorado
Viggo B. Sorensen, Chicago, Illinois
Walter G. Spengeman, Yonkers, New York
*George A. Staples, Nashua, New Hampshire
Carl J. Stark, Lakewood, Ohio
*M.H. Thornton, St. Paul, Minnesota
B.M. Tylicki, Long Beach, California
Robert Vason, Mt. Dora, Florida
*W. Lew Warburton, Salt Lake City, Utah
*Abraham W. Ward, San Francisco, California
*H.O.W. Warrick, Enid, Oklahoma
*Paul M. Weber, Matawan, New Jersey
*Albert P. Westfall, Houston, Texas
*Roy B. Wright, Wellton, Arizona
Marion A. Flesher, Oklahoma City, Oklahoma

**Life Members.*

NEWS OF FELLOWS

(Continued from page 4)

Illinois College of Dentistry, Chicago, was installed as president-elect. **Terry W. Slaughter** of Salinas, California, was elected vice-president. **Lawrence Kerr** of Endicott, N.Y., received the "Committeeman of the Year" award.

The "Committeeman of the Year" award is presented annually by the ASOS board of trustees in recognition of a committeeman whose services and contributions to the Society have been "exemplary."

Sidney I. Kohn, professor and chairman of the Department of Pediatric Dentistry at the Fairleigh Dickinson University School of Dentistry has been elected secretary-treasurer of the American Society of Dentistry for Children.

Marie U. Nylen, chief of the Laboratory of Biologic Structure of the National Institute of Dental Research recently received the Federal Woman's Award. She is one of the world's foremost experts on the morphology of tooth enamel.

The Objectives of the American College of Dentists

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

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

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

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

(d) To encourage, stimulate and promote research;

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

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

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

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

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

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American College of Dentists
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