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**AMERICAN
COLLEGE
OF DENTISTS**

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Union Goals

Dentist-Patient Relationship

Third-Party Payment System

Dental School Admissions

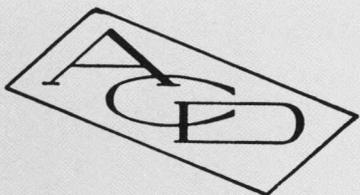
Continuing Education



**MEMBER PUBLICATION
AMERICAN ASSOCIATION OF DENTAL EDITORS**

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NEWS AND COMMENT

SECTION NEWS

Hawaii Section

We now have 23 fellows in our group and will continue to grow as our dental population increases. On Saturday, December 13th, we had our 12th annual luncheon meeting at the Pagoda Restaurant in Honolulu. Walter S. Strode, M.D., a local urologist spoke on the future of health care.

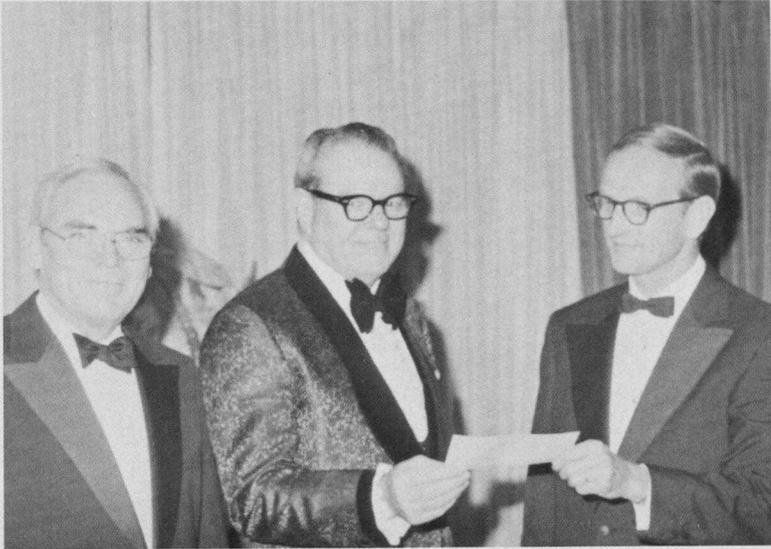
Our project in the past has been operation Book Shelf sending literature to the Phillipines, Vietnam, Indonesia and Japan. We now plan to provide new textbooks to the various hospital libraries here in Hawaii.



Hawaii Section meeting in Honolulu.

Tri-State Section

The Tri-State Section of the College has made a contribution of \$1000 to the American College of Dentists Foundation. This generous gift by the Tennessee, Arkansas, and Mississippi Fellows will aid the Foundation in its support of the Mini-Self-Assessment program, which has been presented successfully by six sections and is scheduled for 15 more in the near future.



Left to right: Regent Richard J. Reynolds, vice-president of the ACD Foundation's Board of Directors, and secretary-treasurer of the Tri-State Section; Marshall M. Fortenberry, chairman of the Tri-State Section, presenting the \$1000 contribution to Regent Gordon H. Rovelstad, president of the ACD Foundation Board of Directors.

Texas Section

Texas is again honored in having the president of the American College of Dentists residing within our borders, even though we had to import James P. Verneti. Jim is now a professor in the general practice department of the University of Texas Dental School in San Antonio. We all extend a hearty welcome to President Jim.

Last year, at the business meeting of the Texas Section, the membership voted to move the annual meeting to the annual session of the Texas Dental Association. A luncheon will open the meeting this year, with a program and business meeting following. The date is Thursday, April 29, 1976, in Galveston. A very outstanding program is planned. Our luncheon speaker is a well-known humorist and one of our newest members, Dr. Charles Jarvis. The program will include Dr. William J. Frome, dentist for the astronauts; Dr. Duane L. Larson of Shriners Burn Institute, Galveston; and Mr. Eric Bishop, Assistant Executive Director of the American Dental Association, who will update us on Third Party Programs. This program is designed to have widespread appeal, and Fellows are encouraged to bring their wives to the luncheon and to the program.

There will be no meeting of the Section at the Dallas Mid-Winter Clinic. However, the American College of Dentists Mini-Self-Assessment Program will be offered. Come by and take this interesting and educational test. There is no charge, as this is supported by the American College of Dentists Foundation.

Carolinas Section

The Carolinas Section met early in February at the Mid-Pines Club, Southern Pines, North Carolina, and heard an address by Fellow James B. Edwards, Governor of South Carolina, who spoke on the need for involvement in all levels of government.

Raymond P. White, dean of the University of North Carolina School of Dentistry spoke on mandibular growth and syndrome, and orthognatic procedures in the maxilla.

Regent William C. Draffin reported on the new changes in the constitution and bylaws; changes necessary to bring the sections into cooperation with the College. Executive Director Robert J. Nelsen reported on the results of the Mini-Self-Assessment program, and the progress of Project Library and the Section Awards program.

New Section officers are Thomas L. Blair, chairman; Frank B. Hines, vice-chairman; and T. Edgar Sikes, Jr., secretary-treasurer.



Louis A. Saporito, D.D.S., National Chairman, AFDH Dentists Campaign, at his Alma Mater, Columbia University School of Dental and Oral Surgery

“Did someone help you when you were in dental school?”

“I remember the times when people helped me. There were discouraging moments when others gave me guidance that enabled me to make it through. And there was financial help when I really needed it.

“I've never forgotten that assistance. That's why I'm involved with the AFDH campaign! It's a way of repaying some of the help I enjoyed when I needed it.

“If you feel the way I do, you can help too. Simply make a contribution to the American Fund for Dental Health! Your check will help provide scholarships for some of the country's 20,000 dental students, and it will help support the many research projects that ultimately help you practice better dentistry.

“I hope you'll send your check right now. There's really no better way of remembering the help you got when you were in dental school!”

American Fund for Dental Health

211 East Chicago Avenue, Suite 1630, Chicago, Illinois 60611

the JOURNAL of the AMERICAN COLLEGE of DENTISTS

A QUARTERLY PRESENTING IDEAS IN DENTISTRY

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WILLIAM C. DRAFFIN ARNOL R. NEELY

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Editorial

ADVERTISING IN DENTISTRY

In a strange and unprecedented action, the Federal Trade Commission has charged that the codes of ethics which prohibit advertising by members of various professions, including dentists, are in violation of antitrust laws. The FTC supports unrestricted advertising of services and fees. This challenge is about to be debated in the courts, and the outcome has some serious implications for dentistry.

In its belief that health care is a commodity, to be bought and sold according to the accepted practices of commerce and the marketplace, the FTC shows a total lack of understanding of the meaning of professionalism, and what is much worse, a complete disregard for the health needs of the public. There is an apparent desire to introduce the element of competition into the health field, with the object of driving down fees for services by setting professionals against each other, through advertising of their qualifications as a means of soliciting patients. This is out-and-out hucksterism of a particularly repugnant kind and needs to be fought vigorously.

How does one advertise professional competence? Does a listing of his degrees, diplomas and honors tell anyone of the doctor's sense of compassion for his patients? Will a roster of postgraduate courses attended indicate his respect for his patient's psyche? Will a published fee schedule give any information about his ethical character, integrity and honesty? No possible advertising can provide this information. It can be obtained only through personal contact — only through the time-honored patient-doctor relationship.

The profession of dentistry, which started as a craft, evolved over many years into one of the great learned scientific disciplines. It was once plagued with its advertisers, and its literature was rife with commercialism. Having undergone a self-induced cleansing process, it cast off these disreputable aspects and accepted voluntarily a set of ethical principles which outlawed advertising as being inconsistent with true professionalism. The Federal Trade Commission would now like to turn back the clock by reducing dental treatment to the level of Madison Avenue.

Principles of ethics or the scramble of the marketplace — which shall it be? Need we ask?

R.I.K.

Regent Joseph B. Zielinski



Joseph B. Zielinski of Chicago, Illinois, former vice-president of the College has been named to the Board of Regents at the last annual session. The son of an early Illinois dentist, Dr. Zielinski received his dental degree at the University of Illinois. He practiced in Chicago for over 50 years and has rendered long service to organized dentistry.

He is a past-president of the Chicago Dental Society and the Illinois State Dental Society, and served the American Dental Association as first vice-president. He has been a dele-

gate or alternate delegate to the ADA annual sessions since 1940, and was chairman of reference committees on three occasions.

Dr. Zielinski is a member of the American Academy of Periodontology, Omicron Kappa Upsilon honorary dental society, and Psi Omega dental fraternity. He is a founding board member and first president of the Illinois Dental Service. Last year he received the Distinguished Alumnus Award of the University of Illinois. He was honored with a citation from the President of the United States for 16 years of service as Illinois State Chairman of the Advisory Committee to Selective Service.

He is a past-president of the Kiwanis Club of Logan Square, and a founding board member and past-president of Logan Square Chicago Boys Club.

Dr. Zielinski is married to the former Wanda Ostricki and has three daughters and nine grandchildren.

Regent Leon H. Ashjian

At the 1975 annual session of the College, Leon H. Ashjian, a general practitioner of Los Angeles, California, was named to the Board of Regents. The son of a Congregational minister serving as a missionary in the Near East, Dr. Ashjian received his early education in Beirut, Lebanon. His dental degree was earned at the University of Southern California.

He is a past-president of the Los Angeles Dental Society, and served as chairman of many of its committees. In the Southern California Dental Association, he chaired a number of councils, serving also as alternate delegate and then delegate to the American Dental Association. Currently, he is a trustee of the California Dental Association. He was also chairman and a member of the board of directors of the California Dental Service Corporation. On the national level, he was a member of the ADA Council on Dental Laboratories for six years, the last two as its chairman.

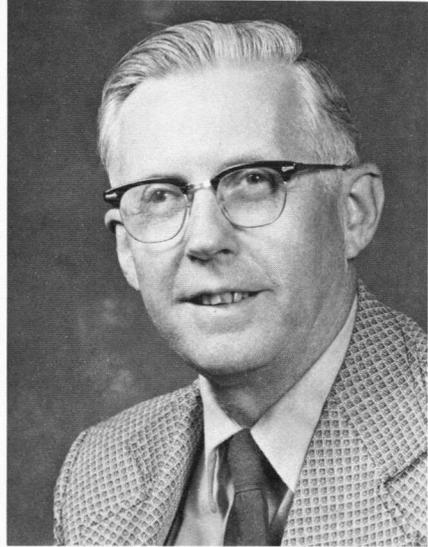
During World War II, Dr. Ashjian served for five years in the U.S. Army Dental Corps, and was Executive Officer and chief of dental and maxillo-facial surgery of the 187th General Hospital in the European Theatre of Operations. At present he holds the reserve commission as Colonel in the Air Force Dental Corps.

Dr. Ashjian is a past-president of the La Brea-Wilshire Optimist Club, past-president of the Executive Toastmasters Club, an active member of the Wilshire United Methodist Church, and a guest lecturer on ethics and professionalism at the dental schools of the University of California at Los Angeles and Loma Linda University. He is also past grand master of the Los Angeles graduate chapter of the Delta Sigma Delta fraternity.



Regent Arnol R. Neely

Arnol R. Neely of Portland, Oregon, professor of dentistry at the University of Oregon Dental School, was installed as a member of the Board of Regents at the annual meeting of the College recently in Chicago. Born in Willamina, Oregon, he studied at Linfield College, McMinnville, Oregon, before taking his dental degree at the University of Oregon Dental School. During World War II he served overseas in the Southwest Pacific Theatre of Operations with the U.S. Army Dental Corp.



Following military service he returned to private practice but an interest in dental radiology led to advanced education, specialty practice, and the teaching of radiology and oral diagnosis at his alma mater. Currently, he teaches full time.

He has been a consultant in dental radiology and oral diagnosis to the Barnes Veterans Hospital, Vancouver, Washington, and the Sam Jackson Veterans Hospital, Portland, Oregon, for the past 16 years.

Dr. Neely is a Fellow of the American Academy of Dental Radiology, a Fellow of the Academy of General Dentistry, and a member of Omicron Kappa Upsilon Honorary Dental Society. He is a past-president of the Alumni Association of the University of Oregon Dental School having served in this office for five years. He is also a member of Psi chapter of Delta Sigma Delta fraternity. He has been a Fellow of the American College of Dentists for the past 15 years, and also holds membership in the American Dental Association and the Oregon State Dental Association.

Union Goals in Prepaid Dental Programs

KENNETH L. WORLEY

I am very pleased to have the opportunity to talk with you today about the goals and principles which the UAW and other unions have sought to have embodied in our negotiated prepaid dental plans. And in participating in this conference, I also look forward to drawing upon this group of knowledgeable professionals to increase my own understanding of the problems and issues of providing dental care services. Although the UAW occasionally has had areas of disagreement with organized dentistry, we strongly believe that the only adequate way to run a dental insurance program is in close cooperation with the associations representing the dental profession. My own experience as a member of the Board of the Missouri Dental Service has certainly borne this out.

It is important to understand that the UAW views the development of its collectively bargained health benefits in the context of the health care delivery system as a whole. First we determine what the health needs of our members and their families are. Then we design and negotiate for benefits which attempt to meet these needs, taking into account the problems and potentialities of the health care system.

Before this informed audience, there is no need for me to review exhaustively the critical problems in health services in this nation. Runaway costs are threatening our pocketbooks. Millions do not have adequate health insurance coverage. Obstacles to access to necessary care confront those of all income levels. There are unacceptably wide variations in the quality of care rendered. Services are fragmented and disorganized. Maldistribution of

Presented at the Amarillo Summer Seminar of the Potter-Randal Dental Society, Amarillo, Texas, July 31, 1975. Mr. Worley is Regional Director, International Union, United Automobile, Aerospace and Agricultural Implement Workers of America.

manpower and resources leads to overabundance and unnecessary duplication in some areas, while others are left high and dry.

Labor unions have had a long and discouraging experience in attempting to use the voluntary health system to gain access for their members to high quality health care at a price they can afford. Inflation erodes past gains. And although over \$1 billion a year is involved in UAW negotiated health programs, we have been frustrated by our limited power as consumers to influence the health care system.

CHARACTERISTICS OF DENTAL CARE DELIVERY AND FINANCING

In many ways the situation in dental care mirrors the problems of the overall health system, and in some ways it is unique. Problems of inequitable access to dental services, uneven quality of treatment, and maldistribution of dental resources are recognized by all of us.

In addition, dental disease differs from other health problems in a number of ways which must be considered in designing programs to control and reduce its prevalence. In the first place, I don't have to tell you that incidence is universal. Virtually everyone requires some professional dental care on at least a periodic basis. On the other hand, it is relatively easy for a patient to ignore for a period of time the consequences of failure to obtain treatment. Further, examination of consumer beliefs and attitudes has shown considerable fear and ignorance surrounding treatment procedures — although perhaps not as much as in the past. Such characteristics explain, but only in part, our appalling record of dental disease and neglect.

According to the National Center for Health Statistics over 20 million persons — almost 10 percent of the population — are without any natural teeth. Of these, almost two million have an incomplete or no replacement. Another two million who have replacements never use them. A 1967 survey showed that at every age level the percentage of decayed or missing teeth exceeded the percentage of filled teeth. Another report showed that over 25 percent of adults had levels of oral hygiene which ranged from barely adequate to injuriously poor.

Study after study has demonstrated the existence of very severe socio-economic barriers to obtaining dental services. There is a

direct relationship between the level of dental care received and an individual's educational and economic status. For example, in a recent study of a sample of predominantly low income families in Nashville, Tennessee, 95 percent of the persons examined by the dentist in the survey had unmet needs for dental services and 90 percent of diagnosed conditions were not under care. In a society which values health care as a right, our performance in the dental arena is falling far short of our ideals.

Removal of economic deterrents to regular dental care through prepayment mechanisms is an essential element to help solve the problem of accessibility for the consumer. This is especially relevant for the low income or working consumer who may be forced to give optimum dental health a relatively low priority in relation to his other health problems and other economic needs.

How far have we progressed in providing prepaid coverage for dental care? That depends upon your perspective. According to the U.S. Government, in 1973 only 10.4 percent of the population had any kind of insurance coverage for dental care. That compares to 75 percent who enjoyed hospital care protection. In fiscal 1974, 86 percent of all dental expenses were paid out-of-pocket by consumers, compared to about 10 percent for hospital care. As a society we spent only \$29 per person on dental care in fiscal 1974, representing only about six percent of our total national health expenditures. So it is clear that we have a long way to go.

But we have also come a long way in recent years. In 1962 only one-half of one percent of the population had dental coverage. By 1970 six percent of the population was covered. And the 10.4 percent figure for 1973 — the most recent year for which we have data — undoubtedly has been surpassed by this time, especially with the extension of coverage to auto workers. Some forecasters are predicting that 50 to 80 million persons will be covered by dental insurance by 1980.

In terms of trends, therefore, it is clear that dental care prepayment is here to stay and is, in fact, the fastest growing component of health insurance coverage. We must make sure that the dental insurance movement serves the needs of the public and does not become a runaway, counter-productive, dollar-eating monstrosity.

For example, a major expansion of dental prepayment must not be allowed to inflate fees unjustifiably or to emphasize "highly remunerative dentistry." Nor should it represent an area of

windfall profits to insurance carriers to the neglect of its effects on the organization and quality of dental services.

If we wish to avoid such distasteful scenarios, we must take great care in how we design new prepayment programs right now before the wrong kinds of patterns are rigidly formed. This is why the UAW has sought through the collective bargaining process to have certain principles embodied in the dental plans for our members.

THE UAW DENTAL PROGRAM

Before getting into a discussion of those principles, however, let me briefly describe the design of the dental benefit program which we won in 1973 for our members working at the big three. This should represent something specific and concrete to relate to in considering the broader principles.

First, in terms of benefits covered, we have attempted to put the major weight of our prepayment dollars behind prevention and early intervention. The plan pays 100 percent of customary and reasonable charges for preventive and emergency palliative services. It pays 85 percent of customary and reasonable fees for all categories of restorative services and 50 percent for prosthodontics and for orthodontics for children under 19 years old.

There is a \$750 annual maximum benefit per eligible person payable by the carrier, and a lifetime maximum of \$500 for orthodontics. Payments made for orthodontics are not included in the \$750 maximum.

Excluded from the list of payable expenses are items such as purely cosmetic services, charges for personalized dentures and charges for replacing lost or missing prosthetic devices and for duplicate devices.

Where the charge for a course of treatment can reasonably be expected to exceed \$100, the dentist is asked to submit the treatment plan to the insurance carrier for predetermination of benefits prior to beginning the course of treatment. In determining the amount of benefits payable, consideration is given to procedures or services that are customarily provided by the dental profession for the condition concerned, consistent with sound professional standards of dental practice. We recognize that the dental consultant for the carrier *must* discuss the particular case and treatment plan with the attending dentist before making any decisions in this regard. This is an important element of carrier

administration in order to avoid arbitrary decisions by lay staff of the carriers and to assure that such claims policies are carried out at a high level of professional consultation.

Wherever possible, we build in the feature of "participating dentists" who agree on their fees in advance with the plan, based on their customary and reasonable charge. In such cases the dentists agree to accept the plan payment directly, as full payment for their dental services — except for any patient copayments or charges over the plan maximum.

Finally, in most areas, we are developing in partnership with the profession, significant quality and cost controls including pre-treatment and post-treatment professional review of dental procedures in order to ensure economical and effective use of the program.

SOME UAW PRINCIPLES AND OBJECTIVES

In developing the auto program, we took into account the problems of the health care system and the specific characteristics of dental care which I have already mentioned. We were aware of our pattern-setting influence, and we wanted to design the right kind of program from the beginning.

There are several major principles or features which we at the UAW believe are essential to the development of an acceptable prepaid dental program. I want to discuss these features and how we have attempted to implement them in our dental plan with the major auto employers.

1. A dental program should provide as broad a range and depth of diagnostic, preventive, surgical and restorative services as are consistent with the principles of good dental practice and the continued maintenance of good oral health. We are not interested in buying a limited program and then perhaps adding on separate riders in an attempt to achieve comprehensive coverage. Such an approach is unacceptable to large group providers for it ignores the totality of dentistry and the widely varying needs of patients.

2. Benefit specifications should keep limitations and exclusions to a bare minimum. This might offend the traditionalists of the insurance world. However, we would include only those limitations and exclusions which are necessary to maintain premium costs within the funds available for financing the program, to control abuse of services, and to place restrictions on services which cannot be justified on the basis of good professional standards of care.

3. We seek the highest level of economic protection in our dental programs. This means that methods of payments for covered services should provide "paid-in-full" benefits up to the level of the insurance carrier's liability.

4. Dental benefits should be provided, wherever possible, by dentists who are under either written or implied contracts of service with the insurance carrier by which they agree to accept payment by the agency as payment in full, *directly* from the agency.

If insurance is to be *certain* for the patient, he should be "held harmless" in any fee dispute unless he has reached firm agreement with his dentist, prior to service, to meet charges beyond his coverage. This implies, of course, that an acceptable system of arbitration is available to both the dentist and the carrier.

5. Prepayment programs should offer some alternatives for the patient in terms of mode of delivery of service. Payment on a capitation basis to dental groups should be permitted, and insured members should be free to enroll in group dental practice programs. Such constructive competition would serve to maximize consumer preferences and should add to the health and vitality of the dental industry.

6. In our auto dental program, we placed great emphasis on choice of carrier. Why? Because we want to assure real program performance in relation to the huge premium expenses involved. The areas of performance which we consider most critical are the following:

- A. Payment policies to be administered with a recognition of high professional standards of practice;
- B. Built in fee controls and utilization controls to stay within premium limits while encouraging the highest possible benefit utilization; and
- C. Prevention, regular care and early treatment to be promoted through claims payment policies.

Whether such principles are translated into actual performance depends greatly on the insurance carrier. For the carrier to be successful its involvement must go beyond traditional insurance practices and it must enlist the involvement of the dental profession.

Because of the importance of carrier performance we made the choice of carrier a matter of collective bargaining with the Big Three. Wherever possible, we attempted to obtain dental service

corporations, that is, "Delta Dental" type plans. Since these are sponsored by the various state professional dental associations, we believed they would more likely have the professional involvement and service orientation which is needed. We have such arrangements for all of our workers at the Big Three in Michigan and for GM workers in St. Louis and California. Compromise settlements with the employers left us with Aetna as a carrier for Ford and Chrysler outside of Michigan. At other GM locations, Connecticut General is the carrier, except in Ohio where we were able to get Ohio Medical Indemnity, a Blue Shield Plan, as the carrier.

7. Because of the unique types of cost controls and quality standards we are seeking to achieve, we believe that the collective bargaining process must go beyond negotiating benefit specifications and include more detailed requirements for claims processing policies. Prior to 1973 we had initiated dental benefits plans on a much smaller scale for many of our members in the agricultural implement and aerospace industries. Our experience there taught us that success at achieving our program objectives was heavily dependent upon issues related to administration of claims — upon such things as interpretations, limitations, and the application of sound treatment procedures. We have concluded that it is necessary to make such claims policies and issues matters for collective bargaining.

As a result, our agreements with the Big Three auto companies call for a single Administrative Manual developed by the union and the employers along with the dental insurance carriers. The Manual specifies the obligation of all the carriers for quality and cost control by spelling out requirements for:

- A. Predetermination;
- B. Case review and disputed claims procedure;
- C. Post-treatment clinical evaluations;
- D. Overall program assessment in terms of utilization;
- E. Peer review relating to quality of care;
- F. Administration of a system of usual, customary and reasonable fees.

Let me expand on a couple of these elements. As I mentioned before, predetermination would be required for all courses of treatment which can reasonably be expected to exceed \$100. The purpose of this review is to confirm that the procedures to be performed meet professionally recognized standards of quality, to

validate the dentist's charges against established fee screens, and to define the patient's responsibility for payment, where applicable.

Secondly, the Administrative Manual provisions for routine case review and for peer review of selected cases are aimed at achieving consistency in the interpretation of benefits and evaluating the quality of treatment to assure best application of the premium dollar. This obviously requires organized relationships between the carrier and the dental profession and is one of the reasons why we favor the delta-type plans, which have such relationships.

Thirdly, utilization review should be designed to assess overall program performance in delivering care. This must be done with the full involvement of representatives of the dental profession — particularly to evaluate patterns of treatment under the program and to improve quality and cost control mechanisms. What we are getting at here is something which goes far beyond individual claims adjudication. The carriers must enlist the necessary input from the profession to assess the total delivery of the program.

Fourthly, carriers should perform post-treatment clinical evaluation of services on a random or selective case basis. Patients representing completed cases would be asked to voluntarily submit to a post-treatment evaluation and be examined by a consulting dentist to assure the treatment reported has been provided and has been performed up to reasonable standards of adequacy.

All of this, of course, cannot be implemented overnight. Even in the plans serving our members in the Big Three much of this is still in the developmental stages. But the UAW is determined that with the magnitude of the dollars involved in this program, we must seek ways to assure ourselves and our members that they are receiving appropriate treatment rendered in accord with sound professional standards of care.

Because of such requirements it should be obvious to you that a dental carrier must be far more than a "fiscal intermediary" for the patient or "bill collector" for the dentist. And in order for a carrier to adequately fulfill such requirements, it must achieve wide acceptance among individual practicing dentists and the active support and participation of organized dentistry.

Whether the carrier is a "Delta" dental service corporation, a Blue Shield Plan or a commercial carrier, the essential criterion for its success is to obtain and build upon the cooperation of the

organized dental profession.

Likewise, we call upon the dental profession to participate positively and constructively to help make these programs reach their potential. The goals of organized dentistry certainly are not inconsistent with those of us who represent consumers. We both want to reduce dental disease by promoting preventive care and regular and early treatment. We both would like to see benefits paid only for treatment rendered according to high professional standards. We both want to avoid excessive inflation of costs which only frustrate consumers and hurt the image of the profession.

It would appear, therefore, that enlightened leaders of organized dentistry would see it in the best interests of their profession to encourage their colleagues to cooperate in our programs of predetermination, case review, post-treatment evaluations and peer review. We need your assistance to develop and successfully implement systems of usual, customary and reasonable fees which give the patient and the plan adequate financial protection while guaranteeing the dentist adequate and equitable reimbursement for his services. We would also like to enlist your professional expertise in assessing the overall effectiveness of our prepaid dental programs. And we think that you can go a long way toward accomplishing such objectives by developing and supporting professionally sponsored plans of the Delta service type.

DENTAL RESEARCH STUDY

Another important area which testifies to the possibility for successful cooperation between the dental profession and the UAW in matters of mutual concern, is the development of a nationwide research project designed to measure the impact of the UAW-Auto Dental Program on the dental health care system. While many of you may be familiar with this research project, I would like to briefly summarize its purpose and scope. The UAW-Auto Dental Program was the first national prepaid dental care program designed for blue collar workers and their families. In light of the pattern-setting influence of this program, a rather large scale research project was developed and is currently being conducted by the UAW-affiliated Michigan Health and Social Security Research Institute and the Division of Dentistry, U.S. Public Health Service. The American Dental Association as well as a number of state and local societies and individual practitioners have provided immeasurable assistance in the development of the

project. Currently, the first phase of the study is complete. Interviews have been conducted with over 1500 UAW households and 3300 non-UAW households in eleven areas, nationwide. About 600 dentists have also been involved to date. The survey will be repeated next year and at a third subsequent point.

When completed, the study will provide information about the effects of the UAW-Auto Dental Program on dental practice patterns and consumer utilization patterns. With the expected continued growth in dental prepayment or insurance, the data from this study should be invaluable to the dental profession, as well as all those involved in planning for the improved dental health of all Americans.

NATIONAL HEALTH INSURANCE

While we are working very hard to get our own negotiated dental plans off the ground, we are painfully aware of the fact that the collective bargaining process will never be able to bring comprehensive dental benefits to the entire public. Even in more traditional areas of health insurance coverage, an estimated 41 million Americans under 65 have no hospital insurance and even larger numbers of individuals are without surgical, medical, nursing home and other benefits. Furthermore, privately financed dental and other health benefit plans — no matter how sophisticated in design — cannot adequately attack the problems of disorganization and fragmentation of services.

As you know, the UAW, all of organized labor and a broad coalition of progressive organizations are supporting a universal Social Security financed Health Security Program for the nation. The Kennedy-Corman Bill (S.3 and H.R.21) represents the only proposal which from the beginning has included the provision of comprehensive dental benefits — without deductibles or copayment features. It also includes great emphasis on quality care and review and the encouragement of more effective delivery systems.

The Health Security Program clearly recognizes that the volume of dental care required under a comprehensive, universal system of national health insurance cannot be made available within the existing manpower supply, or under current systems of dental practice. Consequently, covered dental services, comprehensive in scope, are proposed first for coverage of children under 15 years, with the covered age group increasing by two years each year after passage until all those under age 25 are covered. This

benefit is limited initially because, even with full use of dental auxiliaries, there is insufficient manpower to provide dental benefits for the entire population. But persons once covered for dental services would remain covered throughout their lives. And it is the Bill's declared intention to extend dental benefits to the entire population, on a phased-in basis, beginning seven years from the initial implementation date.

It is important to understand the proposed phasing in of comprehensive dental care benefits, over time, is designed to view dental care as an individual priority among a range of health care services, and not as a service to be ignored or given a lower priority. In the dental area, this in itself distinguishes the Health Security Bill from the many health proposals now under public and congressional debate.

Incidentally, the original Nixon bill for national health insurance demonstrated a lack of concern for dental care by totally ignoring it. After considerable pressure from the A.D.A. and others, the second version of the bill, supported last year by the Ford Administration, contained some very limited and inadequate provisions for dental services for small children. I believe that dental care has a far more central and integral position in our overall health system.

Labor is convinced that only through a combination of national financing and administration and the private provision of service within an organized, evolutionary system can this nation achieve high quality health care for all Americans at a cost which they can afford.

Until such a goal becomes reality, labor will continue to press for negotiated health and dental care programs to provide for better access to care for our members and their families. And we intend to help lay the groundwork for national health insurance by developing programs which deliver reliable economic protection to our membership while controlling costs, improving quality and reducing the prevalence of dental disease.

In order to help us attain such goals, we invite the dental profession to play an important, meaningful and constructive role. And we truly believe that our new dental programs will assist you in achieving the professional goals which you value.

130 South Bemiston Street
St. Louis, Missouri 63105

Preservation of the Dentist-Patient Relationship

The Indiana Plan in Action

DAVID B. McCLURE, D.D.S.

It is indeed a pleasure to speak before this most interesting and well-planned seminar. The dental leadership in Indiana is proud of the many friends we have in Texas and of the excellent working relationship our two states have at the A.D.A. level.

Many of you are familiar with the "Indiana Plan," because the guidelines adopted by the Texas Dental Association regarding dental prepayment plans are quite similar. Basically, the "Indiana Plan" is philosophical in nature. It is nothing more than the preservation of the dentist-patient relationship, under the fee-for-service, free enterprise system. When Charlie Wilson was Secretary of Defense, under President Eisenhower, he made a statement that caused him to get a great deal of criticism. It was as follows: "What is good for General Motors is good for the Country." By the same token I believe you will agree, that what is good for dentistry is also good for our patients. The "Indiana Plan" encourages the dentist to be the patient's advocate. We want our patients to receive the full benefits due them, so we will cooperate by giving them a pretreatment estimate that they might submit it to their insurance carrier. Our members are asked to treat all patients the same. Because a patient has dental insurance, the dentist-patient relationship should be no different. The "Indiana Plan" emphasizes that all aspects of treatment and fees be a matter between the patient and dentist.

As for myself, I do not want to be tempted by the insurance company's check. Let the patient receive payment from the carrier. Many carriers will say to us, "You are making a mistake because the patient will spend the money and beat you out of the fee." Even labor leaders tell us the same thing trying to get us hooked on the

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third party check. Our answer is, "We have always had to deal with payment problems in our practice, and we will continue to work out payment arrangements with our patients." Examples of the dangers in accepting assignment of patient's benefits are:

1. Financial failure of the third party (*i.e.*, failure of New York Dental Service Corporation in the mid-sixties)
2. Withholding payments until you agree to their condition, *e.g.*, accepting their payment in full, submit treatment plans and x-rays to lay people, modify treatment plans, reduction of payments so third party won't lose money, and delaying processing of claims so third party can invest money in short term securities.

Ninety-five percent of my practice is prepayment; and if I accepted assignment, I would truly be working for "the man." He would control my destiny if he so wanted. It is not easy to take this type of stand. President Ford said a few weeks ago that "freedom is never free." To be free, we must be strong in our convictions.

I am a little bit of a history buff, and my childhood hero was Patrick Henry. As a child I often visited the church where he made his great speech. I do not mean to be melodramatic, but is not professional liberty as important as civil liberty?

Ten years ago in Indiana we made an in depth study of the service corporation concept. While we were making that study, our house of delegates established an Indiana Dental Service Corporation so we could activate a service corporation if our study showed us it was in the best interest of Indiana dentists and the patients they serve. We considered many factors in this study such as these:

A. The risk in marketing plans appeared to ride with the participating dentist, and the five percent withhold was not appealing to our members.

B. The concept of dental insurance, as related to the service corporation, violates the three basic principles of the insurance industry. It would be well worthwhile to look at the three principles and how they conflict with any group that tries to underwrite and administer dental insurance.

1. *The loss insured against should be of infrequent occurrence.* In a dental insurance plan the potential utilization when compared to other types of insurance is much higher. Ninety-five percent or more of the population has some form of dental disease. Since the utilization cannot be controlled, it only leaves actuaries one other area where they can exert pressure

in order to control costs — the dentist, his fees, and the treatment delivered. For this reason, insurance companies and others were quick to develop the “least expensive adequate procedure” concept, now known as the alternate method of treatment. By this method, in determining their liability, they assume the right to determine what type of treatment is necessary and appropriate. It makes no difference whether it is a profit or not-for-profit group; the claims cannot be higher than the premiums. If they are, it means economic disaster.

2. *The loss must, for practical purposes, be beyond the control of the insured.* One of the most obvious facts about dental utilization is that it *is not* beyond the control of the insured. With other types of insurance, there is a risk factor involved — this is not the case with dental insurance. For an example, just stop and think about your car, life, or homeowners policies.
3. *The loss must be of an amount which is definite.* In dentistry there may well be a choice regarding treatment of a particular patient; therefore, dental insurance violates the third basic principle of insurance. Again, third parties have attempted to solve this problem by using the “least expensive adequate treatment” or “optional course of treatment” concept which in all cases they reserve the right to make such a determination. Gentlemen, Indiana dentists believed then and now that the right of diagnostic judgment belongs entirely to the attending dentist.

After this study, our conclusion was not to go the service corporate route. We felt it was not in the best interest of Indiana dentists and the patients they serve. We have continued with our philosophy of doing what we were educated to do which is to practice dentistry to the best of our ability. We have no “bone to pick” with the states that have adopted the service corporation concept. I am certain this concept has a place if administered properly and if a line is drawn on how far the service corporation will go before saying, “No! We will go no further if it interferes with the doctor-patient relationship.”

Because of our stand, we have received a bad press. Articles have been written that claim the leadership in Indiana is irresponsible because we do not go along with the crowd. We have often asked ourselves, “Are we wrong and truly out of step with what is best for our profession and the patients we serve?” The answer keeps coming back loud and clear. “No! Right is right and the preservation of this concept must be fought for.”

The name of the game is "money" and "control." Management, government, labor and the insurance industry are determined to reduce the cost of the dental health dollar at the expense of the dentist. You and I know there is no way a dental service can be rendered cheaper with the insurance company getting its cut and our overhead going up because of the bureaucratic paper work.

Let us look at some of the union rhetoric that reached the press while the auto negotiations were going on. Irving Bluestone, U.A.W. Vice President in charge of bargaining at G.M. said, "We will have a new benefit program that will control fees charged by dentists. Under the dental program the dentists would be required to get authorization of their charges before proceeding with more than routine dental work. The union would also request that completed dental work be checked on a random basis to see that dentists are doing the job properly. The system would give us better control over costs and quality."

Melvin Glasser, Director of U.A.W. Social Security Department stated in the Detroit press, "Estimates will go to a dental committee which reads x-rays and compares fees. The committee can approve the estimate, reject it or suggest an alternate procedure. This gives a control on costs and quality. If a need for correction is shown, the dentist must do the work at no charge. The dentist cannot charge the patient more than the deductibles."

Mr. Glasser and Mr. Bluestone made no bones about why they wanted the Delta system to have the contracts. Delta, they said, would service the contracts for eight cents an hour while the private carriers would cost 10 cents. Furthermore, they said and strongly let it be known, Delta would have more *control* over the dentist than the private carriers. Gentlemen, who do you think will make up that two cents an hour, if it isn't the wet finger dentists servicing the Delta Dental Plans?

ADJUSTING TO THE ABNORMAL

Coleman McCarthy, in an editorial a few weeks ago, talked about adjusting to the abnormal. I think this is an easy trap to fall into. Take the radiograph issue. We all know that it is not good dentistry to attempt to diagnose from radiographs alone, yet our profession has adjusted to the abnormal by telling ourselves that a consultant sitting in some distant claims office is making a benefit determination when he uses radiographs to determine an alternate mode of treatment. Today, most carriers will even admit that they are diagnosing from radiographs. At an A.D.A. reference

committee meeting in Washington, D.C., an official of the Utah Dental Service Corporation got up and admitted they were diagnosing and getting dentists to change treatments.

The fact that we are operating in Indiana without submitting radiographs did not just happen. The road has been long and rough, and the battle is still being fought. In the past few years, the officials of the Indiana Dental Association have traveled many miles and spent many hours at discussion tables with top officials of labor, management, government and the insurance industry. As a result of keeping our ears to the ground, we have learned a great deal about the big picture.

In the mid-sixties the 13 states Teamsters' contract was our first big challenge. We stuck with our standard claim form and sent no x-rays. It was rumored that the teamsters had a million dollars to break the dentists in Indiana. We survived that one, and now have very few problems with the Teamsters' plan. Before the farm implement workers contract in 1970, we contacted management and labor to inform them of the I.D.A. Principles of Acceptability and the ground rules under which we "played the third party game." After the Harvester contract was let, Aetna came to us with the attitude — here it is, you service it the way we say. Fort Wayne, Indiana, has the largest Harvester plant in the country, and the men stuck together and won that one. It was not easy as Aetna does not give up easily.

ALTERNATE MODES OF TREATMENT

As a result of the Harvester contract, I authored the resolution that was passed by the ADA against the least expensive adequate type of treatment in contract language. Recently, they just outfoxed us in the auto contracts by changing the wording to "alternate modes of treatment." I would, at this point, like to voice disappointment at the Delta Dental Plan's leadership for not objecting to this language; and in fact Delta should have refused to bid on a contract that had such wording. I will speak more later about the role of Delta regarding their input into dental contracts.

As most of you know, Connecticut General got the G.M. business in Indiana. It just so happened that Connecticut General contacted us about six months before the contracts were let. They had no insurance in Indiana at the time, but they wanted to set up a line of communication with our state association. They approached us with a good philosophy. You are the dentists and the only ones that can deliver the services, and we will learn to work with you.

At least a year and a half before the contracts, we started to alert and reeducate our membership in the areas that might get auto contracts.

In my town, Anderson, Indiana, we held our first meeting in a church. The purpose being to keep the dentists away from the cocktails that might affect their judgment. You can be sure this was, and is yet today, serious business to those of us in leadership positions. We implemented a state pledge project, whereby all of the dentists in the state were contacted in an eyeball to eyeball situation and asked to sign a pledge of their continued support of our plan. The results were over 85 percent for holding the line and standing firm. Locally, in Anderson, we have one of the largest G.M. plants in the country where they employ approximately 20,000 people. The president of the local dental society and I went to the personnel director of this plant and explained that we could see some real problems if G.M. accepted a contract like the Harvester-U.A.W. plan. This man was most interested and told us that he had enough problems with labor without getting the dentists on his back. He asked us to get a copy of the Harvester contract, go over it line by line, and bring it back to him with the objectionable points outlined. He then took this to Detroit to top G.M. management. In about two weeks we received a call from one of the top negotiators for G.M. He asked if he could come to Anderson and talk with the president and me. This was a real experience for us. Here was a man who had spent all of his professional life in the negotiating arena with labor. Believe me he was as tough as nails. He bluntly told us that management did not want prepayment, but labor was boxing them in; and if it came about, they would prefer a table of allowances. We agreed with him that a table of allowance or an indemnity program was the best way for a prepayment program as it did not fool around with cost controls by tampering with treatment plans which they would have to do in the least expensive adequate type of contract. He did tell us quite bluntly that G.M. was in business to make a buck, and if it came to G.M. losing a buck and the dentist gaining one, G.M. would come out on top every time. He did raise some strong objections to the Delta Dental Plans system, and how they had bedded down with labor. He said labor was now trying to force Delta down their throats. I believe, as a result of this Delta activity, we have lost whatever friendship we might have had with management. It is alleged that Mr. John Sparks, U.A.W. Assistant Director of Social Security Benefits is on the Board of Michigan

Dental Service Corporation. This is a true conflict of interest, and I believe organized dentistry should have raised hell about this. It is unbelievable that we could stand by and bed down with the union in this manner and have Mr. Sparks be one of the top inputers into the contracts at the table.

Mr. Leonard Woodcock sent Mr. Sparks to Indiana to talk with us after the contracts were let. In the meantime, we got a copy of the contracts and we could not believe what we read. We asked Mr. Sparks who gave the dental input; and he proudly said the name of an official of the Delta Dental Plans. We hastened to assure him that this individual did not speak for the dentists of Indiana. It is difficult for us to believe that our profession would be party to a contract that would have the "hold harmless" clause in it and would cop out for a cost control that would center around alternate modes of treatment that depend upon a long distance radiograph diagnosis by a consultant. At this point, Delta should have stood tall and said, "No! We might go broke, but we want no part of this contract because it is not what is best for dentistry and the patients they serve."

I wish each of you could have been in the room when we met with Mr. Sparks. Remember he is one of the top U.A.W. policy makers and plans for a national health insurance program. This man implied that he did not give a damn what we thought as dentists. His implications were loud and clear, that he had the power to control our fees, our ethics, and our futures. I still have an uneasy feeling when I think of this confrontation. I told the State Director of U.A.W. that my patients would be knocking on his union door because I was going to tell them they had a bad contract. He assured me they had ways of dealing with people like me. It was not very long after this that I heard from a patient that the union had passed the word around that I was not for the working man and was against prepayment. After this, all of the dentists in our area received a questionnaire from the local U.A.W. union. We immediately called an emergency meeting of the dental society and had the largest turn out in our history. We answered the union as a society. We found out later that the questionnaire had been drafted in Solidarity House in Detroit and the purpose of it was to picket the dental offices of those who would not cooperate. We were told that out of 50 dentists only two responded and said they would do what the union wanted.

The union respected this kind of unity. It was only a few days later that we got a call from an attorney who represented the local

credit union. He wanted us to meet with the credit union and work out a plan whereby the credit union could lend the patients the money to pay their bills while waiting for their insurance check. About this time, we did receive some good newspaper coverage on our stand; and the union members were beginning to give the local leaders some static about why they got such a contract. Well, we met with the credit union and helped them work out a beautiful plan. They would lend people money in various drafts; and as the treatment was performed, they would pay us with the drafts. Patients would not pay interest on the drafts until they were returned to the credit union — after we had cashed them. It is alleged that the local union took this plan to Detroit and it was turned down. So, this bubble burst.

We have had many meetings with the Health Insurance Council of America, and time after time we will raise a little hell about the contracts and the carriers will get angry and say, "Don't get mad at us about the language in those contracts, get mad at Delta because they are the ones who had all of the input."

As most of you know, it is said our nation's clothes style and social mores start in California and spread to the rest of the country. Please watch closely what is happening in California. There is much unrest with the California Dental Service Corporation as they want to get into capitation. It seems that in order to renew some contracts and get new ones that the C.D.S. may have to offer capitation. This type of closed panel concept of practice has always been opposed, and in fact this is why the service corporation was established in the first place — to keep the longshoremens from going to a closed panel type of operation. In the June issue of the *Journal of the California Dental Association*, Dr. Arthur Harris said, "Unfortunately California Dental Service has (in effect) control of California Dentists and the California Dental Association."

The A.D.A. is spending a million dollars this year to promote the fee for service private practice of dentistry and Dr. Bill Schiefer, president of the California Dental Association is saying, "In truth, we must admit that both the capitation system and the fee for service system have potential for both good and abuse." I could spend hours on telling you what is wrong with the capitation system.

I would also encourage you to read the article in the June 1975 issue of the *California Journal* by Dr. Sanford Plainfield entitled "Why I Resigned from California Dental Service Corporation." The

California Dental Association has just adopted standards for program design to assure quality of dental care. I have read this, and it scares me because I know some of the people who were on the task force and I know their interests were not those of the wet finger dentists. As I see this, just to satisfy California Dental Service, they have sold the wet finger dentists down the river. If this goes nationwide, the quality of care will be in the hands of third parties and not the profession! I would plead with California to please not try to force their mistakes on us at the A.D.A. level.

How is our nonradiograph program working in my town? Real well. Too, it is my understanding that only a few dentists in my area are accepting assignment. The rest of us are dealing with our patients as we always have. The insurance program has helped many people obtain dental care that they might not have been able to afford. We have given Connecticut General good dental consultants; and if they want to have more information on a treatment plan, we will be glad to talk with them. If they want to look at the radiographs, they can come to the office; and we will go over all of the diagnostic aids with the qualified consultant. As many of you know, Anderson was a pilot project for the A.D.A. Public Relation Program (PEP); Flint, Michigan, was the other city in this study.

I would like to quote from the Anderson Summary that was prepared by the public relations firm doing the research. "The Anderson dentists are experiencing a smooth transition to insurance coverage. They have had no apparent problems with payment and pre-authorization. They do have somewhat more paperwork, but believe this is inevitable. They attributed this relatively smooth transition to insistence that dental insurance is between the patient and the insurance company."

The General Motors program in Flint is handled by the Michigan Dental Service corporation and the Michigan Blues. Let us see what the research report has to say about how things are going there; "The Flint dentists are having a difficult time relative to their Anderson colleagues. In all three phases of the research, they expressed displeasure with the amount of paperwork, the slowness with which they receive payment and the long waiting times to receive insurance company authorization for certain procedures."

We in Indiana are like the rest of you, fallible men, searching and often grasping in the darkness for answers. The profession needs

(Continued on page 111)

The Effect of the Third-Party Payment System on the Profession

ROBERT J. NELSEN, D.D.S.

Two is company — three is a crowd. The eternal triangle has long been a source of trouble in two-party systems originally designed to function in peace and harmony. The intervention of third-party involvement in the delivery of health care has not been all peace and tranquility.

To challenge the third-party role in health care would be quite involved. A consideration of the effect of third-party interests upon the profession would have to be qualified by a consideration of its effect, good or bad, upon the public, patient, the doctor or the third party. In an analysis of the system of third-party involvement, the significant denominator is — what benefit accrues to the patient? Does his participation in a program further his well-being in a manner that would not occur without the plan? Will the availability of health care without a direct affront to the individual's pocketbook further his well-being significantly above that which would derive without the plan? Perhaps he will have better health by having better access to care.

If it can be proved that the overall health of persons involved in third-party systems is significantly improved (remember, significantly), then the profession is mandated to the growth and implementation of this kind of care system. If this is not so, then the profession, as the custodian of oral health care systems, has need to review the cost/benefit effectiveness of the third-party system and so advise the public. I don't know if this is being done in an objective unbiased manner. The profession, by the very nature of it being a profession, is obliged to endorse or challenge any program affecting the availability, cost and delivery of that care to the public. Should the system bring advantage and benefit, the profession must become an advocate of the system, as long as the relationship of the patient and doctor remains in balance.

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Should the system favor the patient at the expense of the doctor, he must defend himself — for a program that cheats him is as wrong as a program that cheats the patient. While the profession is obliged to look to the benefit of the public first before its own interests, it has no obligation whatsoever to do so to its own disadvantage.

The advent of third-party participation in the symbiotic relationship of patient and doctor introduces a disparate factor into the system. Negotiation and consensus of the personal elements involved in seeking care and delivery care in the past were carried out on an individual person-to-person basis in a one-to-one relationship. In third-party programs, this became a wholesale negotiation by stand-in substitutes of those actually involved in the professional relationship. Previously, where cost accommodations and concessions to the financially disadvantaged were balanced by admitted surcharges to the affluent, the professional exercised value judgments by which his services were available to those who sought them. In the past, this was an important prerogative of the professional. There are remnants of this system still in existence, but the advent of the scheduled collection of the fee by a third party purportedly to assure availability of funds when needed has brought on accommodations and concessions that present a whole new ball game and, most significantly, a change of umpires and as of now, some fuzzy rules.

The advent of the third-party payment system has altered the relationships of patient and doctor and has made the exchange less personal as each became subject to the negotiated schedule which others have sold and bought in a sort of commodity market atmosphere.

The gross effect of negotiation is ultimately a refined itemization of the details of care which mandates treatment into standard concepts of performance. While it may be an effective and efficient means to manage paper work and to translate itemized treatment procedures into a bill, this system reduces the professional's care performance to a table of allowances which is identifiable with craft and trade. In general surgery, an operation could be measured by hernia equivalents. The gross effect of such standardization upon the profession is to further codify the professional's realm of treatment and thereby identify him collectively as a performer of sterile, craft-like actions devoid of those important value judgments attendant to even the simplest of

treatment. Many of those who establish criteria of treatment and its schedules are not themselves involved in treatment under the specifications they themselves establish. As previously mentioned, the advent of the third party imposes significant changes in the ball game — one more base to touch, additional players, and allowing and even inviting the folks in the stands to play in the game (consumerism), a change to different umpires, new rules and, not to be discounted, a business approach to the game which has profit as its hard-core objective.

COMMERCIAL AND POLITICAL INTRUSIONS INTO HEALTH CARE

The health professions have had to come to grips with their environment which is essentially a commercial and political environment. The professions have been too polite in their accommodations to the intrusions of commerce and politics into health care for profit — financial and political. In spite of the perfume of altruism, the selfish profit motive comes through — and it stinks.

What attracted government and industry to involvement in health care? The life insurance market and the social security system have become saturated. Total health care has been declared a right by government and characterized as a fringe benefit by labor and the insurance industry.

The focus of the insurance industry is on money. The dimensions of its interest vary from the individual fee to the Gross National Product. The intensity of this focus is generated simply by the profit motive and there is nothing wrong with that as long as it remains a standard of commercial enterprise and does not supersede the professional moral value judgments involved in health care. However, in the materialism of this age, most values are expressed too often only in dollar amounts. This is what creates the turbulence at the interface of professional health care philosophy and commercial or political health care practice. The sad fact is that it is the patient himself who is immediately at that interface when he brings his health needs to the doctor. The professional's judgment now must be subjected to an absent umpire who calls the play after hearing the details and consulting a mimeographed schedule of allowances. Some ball game!

A recent issue of the *British Dental Journal* carried an

announcement inviting dentists to attend a meeting which will consider means for private programming of dental care. Looks like they are going back to the old rules. Can we learn anything from this? I doubt it, for we of the profession already know. We should tell our patients about the British experience. Perhaps the PEP program of the ADA will include a comprehensive review of the cost effectiveness of the British experience. As a diversion, let us pick a point in time when third-party commercially-funded dental care amounted to ten percent of the gross national dental care of five billion dollars. This would be before the recent large contracts were signed, of course. Ten percent of five billion dollars is 500 million dollars. These 500 million dollars are dollars collected, held — transferred and again held for a time and then paid to the dentist *after* he has sent his bill. Note the dimension of time. In matters of contracts for money, always — “Time is of the essence.”

As an example, to cover overhead, the carrier removes eight percent of the money collected, and to that is added a two percent profit. Total — ten percent of the money collected — or 50 million dollars, consisting of 40 million dollars as expenses of the middlemen paper shufflers and 10 million dollars as profit for the commission merchants. Since the patient is a consumer and the doctor is a provider and health care is an industry, it is only *polite* to refer to the carrier as middleman and commission merchant — a wholesale peddler of dental care.

What is the effect of third-party involvement in dental care? There is more to it than meets the eye. The figures used in the example are not too far out of line according to conversations with an expert in the field. The recent growth of third-party programs will raise the percentages and dollar amounts considerably. But to stick with the example for purpose of discussion, the 50 million dollars comes from somewhere. It must be a line item in the total national budget, for it certainly will show up in any audit of the cost of dental care. The question is — is it added on somewhere or is it taken off, or out of some other budget item? This ten percent must have an effect upon the total dentistry purchased or the total dentistry delivered or, perish the thought, on its quality.

If agreements are made by the wholesalers of dental care to sell and purchase at usual and customary unit costs established before the sale and the commission merchant receives ten percent, eight percent plus two percent for his role, where is the ten percent applied?

EFFECT OF THIRD PARTY

What is the effect of third party on the profession? Somewhere, ten percent of something is shaved off. The third-party system does not remove or lessen overhead or other costs to the dentist significantly. The advantage of being paid without having to collect is soon wiped out by the additional burdens of expanded paper work and the vicissitudes of prior approval, nonapproval or variable allowances. The 50 million dollars paid to the wholesaler does not fill teeth. Dental fees of all dentists must increase one percent across the board or the fees of those participating dentists must increase ten percent to equal the costs of the commission merchants. If usual and customary fees are mandatory base lines of fee schedules, what happens? Something changes. What is reasonable? Either the dentist loses ten percent, his fees increase ten percent, or his production per dollar increases — or cheaper fillings. Enter the quality control monkey on the professional's back.

The dentist is really the adjuster of cost and quality and adjudicator in this arrangement with the wholesale mark-up system. What effects does it have on the profession? The loose democratic, inefficient, not too well-funded system of organized dentistry has difficulty coping with the tight, efficient, goal-oriented, well-funded wholesaler (or bureaucrat) who manages the collection and dispersal of money. The wholesaler has only two dimensions — time and money. He makes contractual arrangements which require that performance be according to the contract terms and any deviation is subject to nonapproval or disapproval. The burden of proof is upon the dentist. So tight and well-structured are these protocols of participation that the professional is now fending off what apparently is a part of the auto industry UAW dental benefits contract, *random and periodic audits of individual dental office records* to determine whether charges are consistent for insured and noninsured patients. "Such reasoning seems to the Association," says Robert B. Hughlett, D.D.S., former chairman of the Council on Dental Care Programs of the ADA, "to fall far short of justifying a procedure that is intrinsically so objectionable and so unlikely to serve a useful purpose."

How aggressive are the carriers? What effect does third-party pay have on the profession? Who will ever know? It's a new ball game with rubber rules and we are forced to use a rubber bat. Who

signs these contracts? Who reviews the contracts? Who represents the participating dentist? I may be wrong, but usually the promoters and advocators of grand programs are not involved in consequences, but have a string on the benefits.

Time is of the essence when money is involved. It is not uncommon for a participating dentist to wait one month and longer before receiving payment for bills rendered to a carrier. The flow of money, time-wise and in amounts, should be published each month in a public statement indicating to the worker, the employer, to the patient and to the dentist participant, the fund balance and its position in the cash flow pattern. And why not a peer review of carriers?

Should the dentist maintain a costly shelter for his and his auxiliary's services at his own expense? Should he underwrite both the fixed and variable costs of treatment during the treatment period, pay them when billed, then submit his bill and wait an additional month or more before reimbursement with that money which has already been removed from the patient, directly or indirectly does not matter?

There must be equity in any system. If the dentist must agree to accept protocols of fee schedules, preauthorization, allowances and proof of service, the carrier should be required to present a full statement of his custody, management and use of funds involved. Is only the dentist to be subject to open records and quality control, while the commission merchant manages as he desires?

Such talk may sound paranoiac, filled with delusions of persecution and hallucinations about third-party effects on the profession; it has a point.

CONSTANT SURVEILLANCE NEEDED

The third-party system should be under constant strong surveillance by the profession. The profession should not allow itself to become defensive about the role of the professional in the health care system. It is an obligation of the profession to resist the take-over of health care by commercial or political systems. The professions must cooperate with and help extend those features of good and responsible private enterprise and good and responsible government which can be applied in the furtherance of better health care. However, the appetite for profit and the lust for political power by third-party systems must be held in check. If we become submissive, or, in satisfying our own self-interest, join

with third parties and forget the interest of the patient and public, we lose our professionalism and freedom and become the beleaguered vassals of the lords of industry or the submissive serfs of the bureaucrats of government.

The effect of third-party programs, while a hazard to the profession, can be a much more serious hazard to the patient and the public as commerce and politics supplant the profession as the custodian of health care.

In all our approaches to the public, we should stand tall in support of the professional concept in our society. We should describe it well and insist that its value to persons and to people be recognized.

Professionalism is a consortium of moral elements, each equally essential to the proper function of the total system. While the concept of professionalism can be described, it cannot be explained. It must be experienced, and once experienced, no explanation is necessary.

ELEMENTS OF A TRUE PROFESSIONAL RELATIONSHIP

What are the three elements necessary to a true professional relationship? They are the two involved persons (or the public and a profession), plus the attitude between them. Consider the following characteristics and attributes of a professional.

The first element of the system is a person in a situation of serious personal need whose knowledge, skills and judgments are inadequate to the resolution of that need. Notice, I said personal need — not material need.

The second element is another person — one who has superior knowledge, skill and judgment, and who professes to make these available to another's benefit prior to his own self-interest. Such a person is a professional. He is granted particular privilege and position in the social order on this basis of having superior knowledge, skill and judgment which he declares — or professes — to make available to others prior to his own interests. Remember that definition. *It is the only reason that professionals are granted special privileges* and can justify their existence within the social order.

The third and equally important element in this unique relationship between these two persons is the spiritual dimensions of confidence, trust, honor, responsibility, accord and reciprocal esteem. The intervention of self-interest by the

professional or the seeking of special advantage by the patient destroys the relationship. Should the privilege of his position be used for personal advantage, the professional reverts to the status of a trade or a craft and he subjects himself to the restrictions thereof. Such misconduct becomes subject to codes, to specifications, to allowance tables, to preauthorizations and directions and to management by others on the basis of piece work and quality review. Freedom to apply his knowledge, skill and judgment to another's benefit as a true professional is lost; he has abandoned his trust to self-interest, and society defends against him by limiting his freedom.

The upcoming Bicentennial of our American society attests to the great value of the role of professionals to all of us. The founding fathers were true professionals. They had no personal advantage in mind as they pledged their lives, their fortunes, and their sacred honor to the creation of a system of government which has proved to be the best yet designed by man. This system provides for a freedom of responsible enterprise which has made our way of life the envy of the world. Few people fight to leave this country. Many thousands contend for a chance to come to America and share in its open opportunity. The problems we have today can be traced to the malfunction of our professionals who have used their privileged positions for self-interest. *If our society is to correct its ways and restore itself to good order, it will do so only by developing within itself a corps of valid professionals who, by training and commitment, apply superior knowledge, skill and judgment to the benefit of others prior to their own self-interest.* Unless we as a nation provide for the emergence of such a cadre of superior persons, we shall deteriorate as the aggressive self-interest of commercial enterprise becomes locked in a death struggle with the socialistically oriented greedy government bureaucracy. Only a vital functional system of professionals can keep these adversaries in check.

What is the Effect of Third-Party Pay on the Profession?

I believe it has had some good effect. It has brought us to a realization that proper functioning professions are a magnificent asset to our pluralistic society. Third-party intervention has certainly been an irritant if not a stimulus to dentistry, to re-recognize itself as a profession, to restate its commitments to patients and the public, to present its convictions about professionalism in loud, strong voice. Third-party involvement has pointed out that dentistry must take issue with those within its

ranks who abuse its freedoms and fault its obligations by opportunism and self-interest. Should these delinquents not concede to requirements of the profession, they must be removed from the profession. Dentistry must take a strong professional stance before an informed public, and from that position, direct the great energies of our pluralistic society, our free enterprise system, and our representative government to the optimum of professional health care.

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DENTIST-PATIENT RELATIONSHIP

(Continued from page 102)

a renewal of faith in the private practice, fee-for-service system. We can no longer close our eyes to systems that would destroy the doctor-patient relationship.

1907 W. 10th St.
Anderson, Indiana 46011

Not armies, not nations, have advanced the race; but here and there, in the course of ages, an individual has stood up and cast his shadow over the world.

E. H. CHAPIN

Private Practice and Other Systems of Dental Care: Must They Compete?

JAMES OGRODNIK

The private practice of the dentistry system does not need to compete with other delivery systems in meeting society's oral health needs. The emphasis should be on cooperation and coordination, rather than on competition. As the projected dentist to population ratio of 1:1800 in 1980 and 1:1700 in 1985 indicates,¹ there will be a need for all dentists to work effectively to meet the oral health needs of the people. Although the number of active dentists is now increasing proportionately faster than the population,¹ comprehensive dental treatment of the entire population will utilize all available manpower. This is true because at the present time the existing delivery systems do not reach the entire society. Cooperative efforts, properly coordinated, between the private practice of dentistry and other delivery systems will be necessary in order to achieve the goal of modern dentistry.

During the past two decades, there has been increasing criticism of the health care delivery systems in the United States. Inequities in care delivery and of service utilization have been specific targets. Most of the current literature supports the thought that the system we have today is inadequate and discriminatory. This means there must be changes, and cooperative efforts are necessary. Modern dentistry has committed itself to the goal of providing first rate dental care to all people. Access to general health care including oral health services is now regarded as both a universal human right and a goal of the American society. The objectives of dental delivery systems must be to permit all people equal access and relatively easy entry into the changing dental health care delivery system and to provide high quality dental care to all people once they are in the system. The goal of effecting such a system is to improve the level of dental health in the

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population. The acceptance of the concept of the public's right to quality dental care is bringing with it a shift in emphasis from the treatment of acutely ill patients to prevention and health maintenance.²

This changing goal will necessitate leadership by the dental profession. If the dental profession does not provide quality dental services for all people, the government will step in. The great pressure for change in the dental delivery system is now causing activity at all levels of government in supporting and legislating the expansion of health services. This governmental activity is taking the form of the advent of such agencies as Regional Medical Programs services, proposals for a National Health Insurance program, and the development of health services research.

CLOSED PANEL VS OPEN PANEL

In discussing the private practice of dentistry system and other major delivery systems now in operation, one must look at the concept of closed panel and open panel systems. An open panel system gives the patient the freedom of choice to go to any licensed practitioner in the area. It also gives the dentist a similar freedom in that he can provide dental care to those of his choice. On the other hand, a closed panel system limits both the patients and the dentists in their choices. A dentist may be under contract to provide dental services to a particular group of people, such as the employees of a company. The dentist then closes his practice to those outside the stated group; the people must confine their choice of dentist to the one or more provided by the company. Each type of delivery system has its own advantages and disadvantages, and one must analyze the entire situation when setting up a dental program. The open panel system, however, has the added advantage of reducing the possibility that a third party will exercise restrictive control over the ethics and professional standards of the dentists involved.³

The private practice of dentistry system includes solo, group, and team practices. Clifton Dummett comments on the solo practitioner thusly: "... the autonomous practice of dentistry in the United States has generally tended to produce a conservative practitioner, satisfied with his lot, and disinclined to disturb the status quo."⁴ The demands of the public and the goal of modern dentistry are affecting the private practice delivery system, and it must initiate change. New concepts in private practices are

emerging, but they are not as yet widespread. The dental team, with the dentist as the head, can make use of support professionals and dental operating technicians as permitted by state dental practice acts. Functioning efficiently, the team delivery system of dentistry shows the potential of increasing the availability of dental care. This type of private practice should be organized to make optimal use and availability of professional, support professional, technological, and administrative dental personnel. The effective use of all auxiliaries would increase the dentist's productivity; thus, it would contribute to the goal of providing quality dental treatment to all people. Another suggestion would be a group practice rather than a solo private practice. The traditional concept of a group practice is several dentists of different specialities forming a group in order to share the costs of managing a dental office. In order to provide the community with a more readily accessible dental delivery system, group practices composed of general practitioners may become common in the future. This way the office can continue to run with someone missing with much less dislocation than in a solo private practice.

The most common example of a closed panel dental delivery system is the dentistry provided as a fringe benefit in employment. Industrial dentistry of this kind provides two benefits: reduction in industrial absenteeism and better dental health for the employee. It is becoming more prevalent, and it involved possibly ten million people in 1970.⁴ According to James Dunning, 1000 workers are probably the best lower limit for a successful full time service.³ Generally the union sponsored programs include prepaid dental care of a broad scope rendered through group practices, clinics, or occasionally even open panels. Industry sponsored programs are more apt to provide only limited prepaid dental benefits. This type of dental delivery system increases the understanding and knowledge of dental health in a segment of the population that may not have been receiving a significant degree of dental care from the private practice system.

THE DENTAL SERVICE CORPORATION

There is a growing trend for prepaid delivery systems, and the dental service corporation helps project the voice of the dental profession into this growing market place. On a national level the Delta Dental Plan system is comprised of independent, autonomous corporations in nearly every state. Under the

guidance of the Delta Dental Plan system, the state dental societies organize these prepaid, group dental care delivery systems. The state dental societies provide this service on a nonprofit basis so the dental profession will have a voice in shaping these systems. The dental service corporation of each state offers prepaid, group benefits to the purchasers of health care services in both the private and publicly funded markets. The dental societies still consider private practice and the fee-for-service concept as superior, but they recognize the need for the profession to provide leadership in organizing a delivery system that is becoming popular. California alone has over 900 groups covered in the dental delivery system set up by the dental service corporation.⁵

GOVERNMENT PARTICIPATION

The participation of the government at all levels — national, state, county, and community — in the overall dental delivery system has been increasing steadily. This participation has resulted in welfare clinics, school clinics, traveling mobile dental clinics, and the availability of such governmental funded programs as Medicaid. It is difficult to separate existing programs by the level of government responsible for its development because many are funded by the federal government and administered by state or local governments. The concept and development of the neighborhood health center has now expanded to include comprehensive dental treatment. Dentistry is viewed as having six facets in the current neighborhood health center: 1) the provision of direct dental services, 2) health education, 3) providing jobs for the community, 4) recruiting auxiliaries and dental students, 5) relating dental to total health, and 6) training and sensitization of dental students.⁶ There has been a shift in emphasis from treating only the acutely ill to providing comprehensive dental care including prevention and dental education. An example of a successful neighborhood health center is the Bunker Hill Health Center in Boston, Massachusetts which opened in January, 1969 in Charlestown, an inner city area. It was established as a community health service of the Massachusetts General Hospital in order to bring the hospital closer to the people in this inner city. Dental care is of high quality at a reasonable cost and greatly facilitates the dental delivery system for the area. The delivery system is tailored to meet the community's dental needs; thus, it is experiencing success.

In assuming increased responsibility in the planning of health care, the United States federal government has a variety of programs and delivery systems as well as grants for dental research. Most federally assisted dental care programs are under Title XIX of the Social Security Act which is commonly known as Medicaid. Each state must enact its own programs in order to utilize Title XIX funds. In a study done in Massachusetts, it was concluded that dentists generally viewed the program with dissatisfaction.⁷ The dentists are unhappy with the lack of professional input into the development of the program; the prolonged delay in reimbursement, and the fee structure. Most of the practicing dentists realized the need for some kind of governmental support of dental care for low income people, but they were not happy with the Medicaid program. Obviously the dental profession needs to exert more leadership during this critical time when governmental programs are being developed.

FOREIGN SYSTEMS

In order to discuss the major dental delivery systems in existence, one must comment on foreign systems. New Zealand utilizes the services of a dental nurse who is a high school graduate with an additional two years of training in dentistry. She works in the public schools and provides regular dental care, including cavity preparation and placing of amalgam restorations, to almost 100 percent of all school children through age 13. Documentation shows that this system is effective in New Zealand, but one must question if it is appropriate for this country. In the United Kingdom most of the dentists work in a private office on a contract basis with the State. The fees are manipulated by the State, and 90 percent of the funding is provided by the State. Although this delivery system handicaps the dentist by tiresome chores, such as the presentation of treatment plans and estimates for complicated forms of treatment, 95 percent of the dentists participate in this program. Germany has a health service system based on the sick funds which is compulsory for practically the whole population. The dentist has freedom regarding the treatment he wishes to provide. With the dentist-to-population ratio of 1:2000, the dentists cannot meet all the needs of the people yet. An interesting facet of this system is that the dentist is not in direct contact with the sick funds. Remuneration is calculated by a separate association using an approved scale of fees. In 1970 the

government of Sweden adopted a full National Dental Service. This system utilizes the sick fund concept, but the patient is also expected to pay 50 percent of the bill. Sweden is one of the few countries with a surplus of dentists.⁸

COST CONSIDERATIONS

A discussion of dental delivery systems cannot avoid the sobering question of who is to finance the cost of providing quality dental care to all people. Currently there is the fee-for-service method, insurance, prepayment, and budget postpayment. The fee-for-service system alone clearly does not alleviate the high cost of dental care, the maldistribution of dentists, fragmentation of services, and the lack of quality control. Prepayment has shown itself to be a stimulus to regular care, and it permits contributions from an outside source, such as an employer. Insurance is actually a prepaid program, but many of the programs do not provide comprehensive treatment. Postpayment is taking the fee-for-service cost and spreading the payment over a period of time. Many such plans are sponsored by dental societies and help the patient receive the dental care he needs at the time. Each type of plan for financing the dental delivery system has inadequacies and could not serve as a national model. Nationalized dental health insurance appears inevitable in one form or another, so it is up to organized dentistry to work through existing channels in Washington for a program that would be successful in meeting the modern goal of dentistry. This nationalized dental health insurance should cover all treatment procedures and expedite the patient's entry into the dental delivery systems.

There is a strong indication that the pressures for change are dynamic and will remain constant until there has been a clear increase in the availability of health care to all citizens, that the care will be within the financial reach of all citizens and that the care will be of an acceptable standard of quality for all. Ways must be found to make dental services available in places where they are inadequate or totally lacking. The primary concern when developing a dental delivery system is to meet the needs of the particular community. The community's needs must determine what types or combinations of dental delivery systems would be most effective. Dentists must develop a social sensitivity in identifying a community's major health problems, and then they must work with others in the community to help solve them. There is no need for the private practice system to compete with other

delivery systems; cooperation and coordination of efforts are the keys to providing quality dental care to all people. There is no single solution to dealing with dental disease on a community basis. The delivery systems are inseparable from dental education, prevention, and research.

ROLE OF THE DENTAL PROFESSION

As we all witness the inevitable changes in the dental delivery systems, there are some concrete actions the dental profession can take. It is imperative that the profession take a *leadership* role in formulating new delivery systems and their financing. Bureaucrats are attempting to pass judgment on treatment they do not understand. More input by the dental profession is necessary in order to develop viable, working programs without compromising the ethics of the profession. At the present time manpower hours could be saved by utilizing sound business principles in the practice of dentistry. Such concepts as cost effectiveness should be applied to present dental delivery systems. Also at the present time there is a need for more effective use of auxiliaries. "According to data from the National Institutes of Health, the efficient use of one chair-side assistant can increase a dentist's productivity by 50 percent, use of two can increase productivity by 75 percent, and full utilization of the skills of other members of the dental health team can further increase the dentist's productivity."² Commitment to the goal of providing quality dental care to all people is foremost. Awareness of the existing problems and professional input into solving these problems will help create dental delivery systems to meet society's oral health needs.

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The Dilemma of Dental School Admissions:

A Possible Solution

ROBERT F. BARKLEY, D.D.S.

The following is a report on recent research conducted under the auspices of The Dental Health Committee of The American Academy of Dental Practice Administration. Several United States dental schools, along with hundreds of dentists and patients, have participated. The selection firm is a private enterprise service organization and has no financial connection with the author or any of the participants in the studies that have been completed. Several dental schools are currently testing the selection process.

In his book *Crisis in the Classroom*, Silberman says that until people sense some possibility for improvement, they will make no effort to rebel from their circumstances. Admissions committees of dental schools are beginning to rebel against traditional selection methods, but they are often stymied in their efforts to develop more accurate systems. A major breakthrough may be approaching. A handful of innovative U.S. dental schools are currently evaluating a revolutionary new selection process that may not only help solve the admissions dilemma, but may actually take a major step toward remaking the dental profession.

Due to the lack of any better means of ranking applicants, many schools still rely far too heavily upon predental grade point averages and Dental Admissions Test scores. With today's inflated college grading systems, grades do not always mean very much. They may be honest grades, but are often the results of unscrupulous activities by students desperate to be accepted into dental school. Even if honest, the top grades may belong to an individual who has concentrated upon intellectual development at the expense of the rest of his personality. Such a person may be

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excellent at memorizing information, but may not be very effective as a total personality. One dental educator told this author at the 1974 Annual ADA Meeting that his school's freshman class had the highest aggregate grade point averages and DAT scores of the nation's dental schools, and should have been the "cream of the crop." "Yet," he sadly exclaimed, "We've got some real donkeys."

After only a few weeks of the freshman year many schools are painfully aware of one or more selection mistakes and drop them from school. This is bad for both the rejected students and the schools involved. Perhaps even worse, for both the public and the profession, is the significant percentage of students that the faculty wishes had never been accepted, yet who eventually graduate and join the profession. Early indications from testing senior dental students from several schools with the new selection vehicle reveal that a sizeable percentage is below average and probably should never have been selected to study dentistry, regardless of how high their GPA was.

At the time of this writing those schools exploring the possibility of using the new selection process include Loma Linda (where some of the original research was completed), Colorado, Tufts, Indiana, Michigan, and Maryland. Three-day workshop sessions have introduced the new instrument to these schools. During this initial orientation and training, admissions personnel have scored prerecorded interviews of some of their respective school's senior students. The results have been interesting. Correlation of agreement between selection process ratings during the training sessions and the schools' prior appraisal of the students involved has been remarkably high. There has been one notable exception. During training one admissions director evaluated two recently admitted students. Since the faculty was not yet familiar enough to rate the freshman, their scores were compared to their rankings by the school's existing admissions criteria. Surprisingly, the students switched ranking by a wide margin! The very high GPA student scored only mediocre with the new process and the much lower GPA student scored quite high.

At this point it seems proper to discuss why this research is first being reported in this Journal rather than in one primarily directed toward educators or researchers. The reason is simple. Much of the inspiration and direction for this current research came from the September 1962 issue of this Journal. A 1958-1962 study underwritten by The American College of Dentists was reported in a lengthy article entitled "The Dental Student Approaching

Graduation — 1962.”¹ The reader is encouraged to seek out a copy of this report for it is extremely relevant today when many dentists worry that third party intervention will seriously damage dentist-patient relationships and, thereby, reduce the dental profession's effectiveness. If the above study was reliable, perhaps we are quite vulnerable.

Dr. Douglas More, the researcher, and his employer Dr. Nathan Kohn, Jr., were appalled by their findings that less than one percent of the 1962 seniors were concerned about improving their ability to establish good dentist-patient relationships. More and Kohn felt that the potential future success of these students as professionals was almost certain to be stunted. More and Kohn were also very pessimistic about the dental profession's future since they saw it as being highly dependent upon the relationship building competence of dentists. The 1962 report clearly stated, “The basic problem in the establishment of dentistry in the long run then centers on the fundamental doctor-patient relationship. It is within this particular face to face relationship that the idea of the dentist as an authority is established and carried forward. It follows, obviously, that only the highest principles of professional activity in this face to face relationship will be effective in establishing and maintaining the position of dentistry in our occupational structure in the future.” It was ironic that only one percent of the students were concerned about this critical area. Their enthusiasm was reserved for other courses.

More deplored the strong interest in the so-called “how to do it” courses compared to the students' lack of concern for courses that would contribute to their general understanding of the field of dentistry in its ethical, professional, and communal relationships. He concluded that most students want to become “practicers” rather than “professional practitioners.” Dr. Kohn concurred because his studies with practicing dentists revealed that their attitudes were not much different.

In 1962, Dr. Kohn told this author that it was believed that an inadequate dental curriculum was to blame, or at least, poor patient management during the clinical experience. Recent evidence would suggest that this may be partly the case, but at this point, selection seems largely to blame. We may be recruiting the wrong people! On the other hand, we have had no reliable scoreable means for doing any better.

In 1972, this author was introduced to a rapidly growing selection research firm² that had developed a remarkably accurate method

of sorting out the most effective teachers from all the applicants received by school boards. They have found that effective teachers differ sharply from ineffective teachers in several respects, but a major difference is in their level of appreciation and desire for mutually favorable relationships with their students. What is more, the type of relationship the outstanding teachers desire is remarkably similar to the type of doctor-patient relationship espoused several years ago by More and Kohn. On the other hand, less effective teachers place a relatively low value upon such relationships.

Perhaps most intriguing is the evidence that one's attitudes toward other people, especially learners, seems to be established prior to early college age and remains basically unchanged thereafter. With all of the people they have tested, four years of teachers college has never yet made an effective teacher from a freshman whose "profile" was that of an ineffective teacher. This would seem to clearly indicate that regardless of its quality, training cannot overcome faulty selection. If doctor literally means teacher, and if the desire to develop good working relationships with other persons dates back to childhood and adolescent personality development, then, perhaps dentistry could do well to locate relationship valuing people and train them to become dentists. This might be far better than to recruit top quality science students and then try to make them effective at working well with patients and staff.

This author asked the selection firm if they might, by studying outstanding practitioners, learn if dentists might have enough identifiable traits that a selection process similar to the highly accurate teacher selector, might be developed. The firm indicated interest and agreed to conduct such a study if the research cost of it would be shared between the participating dentists and themselves.

Subsequently leading dentists throughout the United States and Canada voluntarily participated, each paying his own way and receiving, in return, a three or four page written "developmental appraisal" of himself. Mostly what each received, however, was the satisfaction of helping dentistry develop a better method of selecting students. These dentists were optimistic. The new method would not duplicate a major weakness of the other selection processes and only identify those who might simply be good dental students, but, rather, would pick people likely to be outstanding dentists, aware of and concerned with relationships

with people.

The first ten dentists studied were carefully chosen as being successful technically, economically, and interpersonally. Most were nationally known with outstanding practices. Both generalists and specialists from large and small cities were included. The selection firm was highly impressed. They declared that these dentists understood learning better than most educational psychologists with whom the selection firm had dealt. The dentists could not speak with the terminology of educational psychologists, but their understanding was superior. Apparently dentists quickly see the results of their patients' learning, or failure to learn. These dentists understood and valued relationships with patients and with dental office personnel.

As additional dentists were studied definite patterns began to develop, patterns that were readily identifiable. Some were identical with effective teachers, but there were some specific to dentistry. Fourteen separate strength areas called "life themes" were defined. These included mission, health, ethics,* activator, individualized perception, relator, delegator, conceptualization, ego drive, self-actualization, technology, and sophistication. By tape recording highly structured interviews, the researchers were able to discriminate between the more effective dentist and his less effective colleagues by interpreting their respective responses to the same interview questions.

By early 1973 the selection firm felt that they had a workable "profile" of the successful dentist. The question of whether this profile would correlate to student performance was ready to be answered. To evaluate the vehicle, it was tested on approximately one-third of the senior class at Loma Linda University where the faculty and students know one another intimately. The faculty carefully evaluated the seniors by criteria provided by the selection firm. Nearly 60 separate judgments were made of each student in the areas of the fourteen life themes. In the meantime, the selection firm interviewed each student for approximately one and one-half hours. These interviews were analyzed and scored theme by theme.

The scores ranked the students into three well-separated categories — above average, average, and below average. For selection, these would translate into highly recommended,

*Means of readily measuring ethical and moral standards have not previously been available, but correlations with faculty evaluations of senior dental students and the ethics section of the new instrument have been extremely high.

recommended, and not recommended. The evaluations of the faculty and the selection firm were then compared. The correlation between the selection process and faculty appraisal was nearly 90 percent! With almost unerring accuracy, the new process told the school who their outstanding students were and, perhaps more important insofar as selection is concerned, identified those who were far below average and probably should never have been accepted. The latter is perhaps the most important to schools who currently must graduate some of their poorer selection choices.

With reasonable certainty that the profile would work, considerable additional work has been accomplished. A program already developed for training "teacher perceivers" for local school boards has been adapted to introduce admissions personnel to the new process and, if they like what they see, train and certify "dentist perceivers" for admissions departments. At less cost than the tuition loss from one selection mistake, a school can have two of its own people trained and certified to interview and score applicants for ranking. Furthermore, these "perceivers" can train others within their own school to help.

Also a method of screening large numbers of applicants with an abbreviated scorable interview has been developed. This 30 minute screening promises to be capable of eliminating the below average applicants, thus reducing the number who must be evaluated with the complete perceiver interview to, perhaps, two applicants per position. From this smaller group the most outstanding can be selected. Of course, GPA and DAT scores will continue to be used. They are not without merit, and they can reduce the applicants to a number that can logistically be screened and profiled. Perhaps the top three or four applicants per position will be screened.

Much more work remains to be done before the new process will gain universal acceptance. For one thing, while early results are very promising, very little dental school data exists to "prove" the selection process. At this time we must rely upon extensive data the process has generated with other professions and the excellent early data from the dental studies. This is why only the more innovative schools are exploring it. These schools will generate their own data to convince themselves of the instrument's accuracy before actually selecting new classes with it. In so doing the schools are making a remarkable contribution to dentistry, since their data will also be of use to other schools.

Data can be generated a number of ways with existing students.

Before their graduation senior students can be interviewed with the perceiver profile. This can serve two purposes. One is for training the school's "dentist perceivers," the other is to rank the students for comparison with faculty appraisal of the same students. Close correlation of perceiver scores and faculty appraisal will give reason for confidence, especially if both ratings routinely identify the below average students.

Freshmen can be evaluated and then tested again as seniors to see if any significant changes in ranking occur. While the selection firm has not seen this happen with any other profession, such dental data must be obtained to support the contention that selection is more important than training insofar as attitudes toward patients and staff are concerned.

In the teaching profession the selection process has proven to be nondiscriminatory to women or disadvantaged minority groups. With a significant increase in dentistry's recruitment of women and minorities, it will be necessary to prove that the dental perceiver also is nondiscriminatory.

Another important data-getting contribution the early participating schools can make is to evaluate students with both the screener and perceiver interviews. If the scores of below average students correlate highly between the two interviews, a school could be confident that the screener would, in fact, help them avoid taking the below average students, regardless of their GPA and DAT scores.

Proving the reliability of the screener instrument is important because, due to fairly low budget and manpower allocation for admissions, in the beginning some schools may only use the screener to avoid serious selection mistakes. Data to support such a decision would be a major step forward. Later, as the admissions process becomes highly valued and gets adequate funding and personnel, the perceiver interview can be added to further upgrade the overall quality of those selected through identifying the highest scoring applicants from those who pass the screener interview.

Interestingly enough, practicing dentists can also benefit from this new selection process. The same selection interview can be used with a practicing dentist to give him a written developmental portrait that reveals strengths as well as those areas where support may be needed from auxiliaries and associates. It can also be used to match dentists for more compatible group practice. It can even be used to alert prospective group practitioners to the

likelihood of their being incompatible, thus avoiding the formation of ill-fated partnerships and groups that seems so prevalent today.

Another spinoff is the development of a similar profile for auxiliaries that can be used as a selection device as well as a developmental tool. Staff development, where the auxiliaries' strengths supplement the dentists', can be enhanced with the awareness of the strengths of each auxiliary. Such sophisticated staff development can go a long way toward helping solo practitioners become more productive to compete effectively in these changing times.

The American College of Dentists should be proud of its contribution through the 1958-1962 study of the attitudes of dental students. During the past decade, considerable attention has been paid to it in curriculum changes and clinic reform. Unfortunately, no major changes are detectable with current graduates. Now the selection process, inspired in part by the 1962 study, may go a long way toward solving the dentist-patient relationship problem thus insuring the future effectiveness of the dental profession. Properly selected and trained dentists will have little worry about third party intervention reducing dentistry's effectiveness.

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Banish the future. Live only for the hour and its allotted work. Think not of the amount to be accomplished, the difficulties to be overcome, or the end to be attained, but set earnestly at the little task at your elbow, letting that be sufficient for the day.

WILLIAM OSLER

Continuing Education: The Challenge and the Opportunity

MICHAEL C. WOLF, D.D.S., M.P.H.
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Continuing education has recently become the focal point of controversy and considerable attention. The American College of Dentists has been especially active in promoting continuing education through its self-assessment program, and the proposed Dental Practice Acts in New Jersey and other states may soon contain provisions requiring continuing education for renewal of a license to practice dentistry. Six states now require continuing education credits for relicensure and 28 states are actively considering this.¹

If these proposals become law, State sections of the American College of Dentists will be in a good position to lend expertise and influence in implementing this requirement. Dental schools throughout the country will be called upon to use their experience and resources in helping to provide continuing education courses, and in maintaining their quality and value.

The American College of Dentists, in introducing its self-assessment program in 1973, stated that "continuing education and the self-assessment it implies are inherent in the practice of every profession." The A.D.A. Principles of Ethics mention "the need for continuing education and training to maintain and improve professional knowledge and skills" as one of our professional obligations and a characteristic of the profession.

The rapid development of new techniques and materials has created an obvious need for continuing education courses. For example, a large percentage of the drugs prescribed today did not exist ten years ago.

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REVIEW AND ACCOUNTABILITY OF HEALTH SERVICES

The development of public and private review of the dental profession places increased importance on continuing education. Federal and state governments, insurance companies and public interest groups have all increased their insistence on review and accountability of health services. Effective continuing education programs must be developed before they are imposed on the profession by others. Neither the public nor the profession is served when legislators devise laws and programs without necessary facts and adequate consultation with the profession they are attempting to regulate.

Since the introduction of the College's self-assessment program, more than 5,000 dentists, representing about five percent of the dentists in the country, have used it. At the same time, continuing education programs have increased in number and in scope. The pages of the A.D.A. Journal consistently list more and more continuing education courses offered throughout the country. Fairleigh Dickinson's Department of Continuing Education is offering 23 courses this year including programs in orthodontics, oral pathology, radiology, medical emergencies, occlusion, oral diagnosis, pain control, practice management, dental auxiliary utilization and high blood pressure detection. These are exclusive of courses cosponsored with the New Jersey Dental Association, the Bergen County Dental Society, the Passaic County Dental Society and hospitals in the area with which the school cooperates. In 1974-75, 432 dentists and auxiliaries enrolled in 13 courses at Fairleigh Dickinson. The numbers who enrolled in these courses, plus the numbers using self-assessment, indicate that there is a great demand for continuing education, and the dental schools will have a monumental task in meeting this need.

EVALUATION OF CONTINUING EDUCATION COURSES

The professional literature is filled with controversy over the wisdom of mandatory continuing education laws. The August 1975 issue of the ADA Journal contained an editorial by Dr. Herbert C. Butts on the subject, in which he commented that the continuing education courses available today range from very good to practically worthless.² Dr. Butts may be right in his judgment. An important question facing the profession is: How can we evaluate these courses and measure their effectiveness? Have we tried to do this? If we are going to require dentists to attend these courses,

we had better be sure they are getting their money's worth.

One way to evaluate the success of a course is to set out detailed written educational objectives for the course participants and to administer pre-tests and post-tests based on these objectives. The self-assessment program of the American College of Dentists is one step in the right direction. A dentist can and should assess his own knowledge before *and* after he has attended continuing education courses, and it would be interesting to see statistics on this. Could we detect a significant increase in test scores as a result of these courses? This could be a very useful study and should be instituted by all agencies which provide continuing education programs.

Commenting on Dr. Butts' editorial, the president of the Tennessee Dental Association, Dr. Faustin Weber, pointed out that a dentist may choose courses that "emphasize areas of practice that have no relation to his technical needs and deficiencies."³ The truth of Dr. Weber's comment is perhaps borne out by the popularity of courses on personal investment strategy and achieving a six-figure income. These have merit, but not at the expense of basic courses on subjects that were not taught when most dentists were in school. Examples are mucogingival periodontal surgery, premedication and sedation, and new restorative materials and techniques.

THE VALUE OF SELF-ASSESSMENT

There is a fertile area for cooperation and correlation between the American College of Dentists' program and existing and future continuing education courses. Dental societies and dental schools offering continuing education courses should encourage self-assessment by dentists who take their courses — and of course, also by those who do not. If this were done, dentists would benefit from better guidance in course selection and the tests could be used by the dentist in evaluating the courses he has taken. However, no law and no threat of denial of license renewal can compel a dentist to participate attentively and conscientiously in the courses he really needs and to incorporate new knowledge and procedures in his practice. The "true professionalism" that Dr. Butts referred to will be put to a severe test.

The *Journal of the American Medical Association* in its August 18th issue published an article titled "Help Stamp Out Mandatory Continuing Education."⁴ The authors pointed out that continuing

education should mean continuing self-education, not merely continuing instruction. They deplored the use of external threats and legal requirements to promote continuing education. It is our feeling that it is more important to insure that dentists practice properly than merely to compel their continuing education. Our students are taught that optimum learning does not occur in a threatening environment, and that self-initiated and self-motivated learning is the most effective and lasting kind. It is our experience that threatening a patient with the loss of teeth will not necessarily motivate him to change his behavior and adopt effective home-care procedures. The threat of not renewing a license will not necessarily facilitate learning by a dentist. It may lead him to the fountain of knowledge, but it certainly would not make him think. It is important to seek internally-generated motivation to maintain and improve knowledge and avoid externally-imposed threats. There are several ways to accomplish this.

A nonthreatening environment should be provided. Testing should be done with as much privacy and anonymity as possible. The College's self-assessment program is doing this now, and the confidential aspect of the program must be emphasized. The College now manages the program itself, having concluded its contract with Educational Testing Service. Tests are now scored by the participant which eliminates the remotest possibility of embarrassment or disclosure of results.

EMPHASIS ON CLINICAL PARTICIPATION

Continuing education courses should emphasize clinical participation. Obviously, a certain amount of didactic instruction is required, but the ultimate goal is to improve the quality of dental *practice*. This does not have to be done exclusively in a dental school but can be accomplished through a recognized study club or participation course with one's peers, using private offices. Several local dental societies are doing this utilizing members with specialized or advanced training, instructing their colleagues in a friendly, comfortable, and relaxed atmosphere that facilitates learning for its own sake and makes learning an enjoyable and rewarding experience. Continuing education should become part of the dentist's regular life-style.

Fairleigh Dickinson University is presently associated with the Bergen County Dental Society's Continuing Education Program which promotes this type of participation course. It would be helpful to offer clinical self-assessment pre- and post-tests to the

individuals in these study clubs. Educational institutions can help provide these services.

The use of visual aids such as videotape should be considered. Excellent intraoral visibility can be attained on videotape. There is a great deal to be gained by seeing a clinical procedure performed and narrated by someone you know, and then discussing it with him as he shows the tape to your study club. Tapes are relatively inexpensive to make, and can be made at almost any dental school in the country. Participants in courses could make pre- and post-videotapes, using patients or models, and then the tapes could be discussed and analyzed when the group meets. If the members of the club prefer anonymity, close-up pre- and post-tapes could be analyzed by an expert at an educational institution who is unaware of the clinician's identity. The results and comments might then be coded and forwarded to the dentist by a local independent agency, such as, the State Section of the American College of Dentists. Of course, such a program would require the close cooperation of educational institutions, dental societies and organizations and private practitioners.

MANDATORY RE-EXAMINATION

If Dental Practice Acts require attendance at continuing education courses, is it a logical next step to expect a law requiring re-examination in addition to continuing education? The current prognosis indicates more third-party payment for health services and increased review of services, and this could easily include laws requiring re-examination. Any consumer advocate or legislator can maintain that the knowledge explosion we are experiencing requires these laws. This is not as fanciful as it may sound; national mandatory relicensure examinations are being considered by the Congress, and several State Boards of Dentistry do not seem satisfied with requiring attendance at continuing education courses for relicensure but are attempting to require practicing dentists to pass re-examinations. It is our understanding that the American College of Dentists has received several requests to use its copyrighted self-assessment tests for this purpose.⁵ The State, and possibly Federal, laws requiring continuing education courses are being passed by well-intentioned legislators responding to a perceived public need. Whether they have chosen the correct response remains to be seen. Many thoughtful people in our profession fear they have not.

It was stated earlier that neither the public nor the profession is

served when legislators devise laws and programs without the necessary facts and appropriate suggestions from the profession they are attempting to regulate. If the profession is to avoid ineffective and burdensome regulation and interference, however well-meaning, it must rise to the occasion. The current situation in continuing education should be considered a challenge rather than a threat, and an opportunity rather than a crisis. Whether or not the profession is responding adequately is questionable. Frankly, time is rapidly running out. The American College of Dentists and the educational institutions and dental societies can and must continue to provide original thinking, leadership, and especially cooperation in helping the dental profession to meet this challenge and this opportunity.

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SYSTEMS OF DENTAL CARE

(Continued from page 118)

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LETTER TO THE EDITOR

Dear Doctor Kaplan:

The August issue contains a stimulating editorial ("The New Slavery") which cites several reasons why passage of the Health Manpower Act of 1975 would be discriminating and ill-advised.

My initial response was affirmative — total agreement; but, after reflecting on the issue, I have some mixed feelings now.

I, too, suspect that distribution rather than number of dentists represents the stimulus for this type of legislation. In addition, it is distressing to observe an apparent conspiracy to flood our professional field with an ever-increasing number of debt-ridden competitors.

The "numbers game" referred to in dental education is little different than the numbers game at any church bingo bazaar; it favors heavily the dealer, not the players. Where true tithing exists, there is rarely, if ever, the need for devious means of providing for the needy. If dentistry were to tithe in a meaningful way, there would be no call for a "payback or serve" plan.

Admittedly, the Health Manpower Act is a thinly veiled arm-twist to force dentistry to provide care in areas traditionally shunned. Where lies the fault? Part must lie at the feet of a diseased profession suffering from social semi-consciousness.

Why this apparent deficit? It has been suggested, and quite correctly I believe, that dental schools perpetrate admission requirements that place no value on the humanities. Instead, faculty go on screening future dentists on the basis of "science" requirements. Of course, dentistry can claim to have produced some practitioners and educators who exemplify the highest level of social awareness, despite having made no purposeful provisions either in the curriculum or administrative policy to account for such a favorable outcome.

In the past ten years there has been a shift in the sociopolitical climate of student bodies of dental schools. In some areas of the country faculties are beginning to reflect the demands of an enlightened few who have catalyzed a trend toward a holistic approach to dentistry.

I sense that many of these students look back at our traditional educational program (science and mechanics) as the very real and "incredible system of indentured servitude"; that they support the

concept of serving a "Fellowship" in an "underserved" community and would consider it a reasonable exchange for an education and potential for wealth they would not have received otherwise.

I would concur with the statement "Dentistry, as a health profession, is best practiced as a one-to-one profession" — if the word *disease* is substituted for *health*. For dentistry to qualify as a health profession, I see the dentist as a coordinator of a team approach designed to create incentives and the acquisition of knowledge leading to a preventively oriented life style (*ie*, a desire and ability to achieve homeostasis). It need not necessarily be a one-to-one relationship.

Organized dentistry could support inner city and rural dental health a lot more effectively than the federal government. The funds could come from "tithing" in form of ADA dues with matching federal subsidies. If graduating students and dentists in practice were given the option of serving a one-year Fellowship or paying ten dollars per month while gainfully employed in dentistry for the privilege of avoiding this service, approximately ten million dollars a year would accrue to the Fellowship Fund. Any dentist serving a Fellowship would not be assessed thereafter. A dentist's assessment over a 25 year period would total about \$3,000, a reasonable payoff for avoiding a less rewarding Fellowship.

Is organized dentistry ready to put its money where its social consciousness isn't?

I question our wisdom in bad-mouthing the Fellowship concept by calling it "indentured servitude" without offering some very positive alternatives as they relate to meeting the dental health needs of inner cities and rural areas.

Very sincerely,

Richard M. Adams, DMD, MSD

EDITOR'S NOTE: The Editorial which stimulated Dr. Adam's letter appeared, not in the Journal, but in the Autumn 1975 issue of NEWS AND VIEWS.

NEWS OF FELLOWS

Brigadier General **Jack Pollock**, Deputy Commanding General of the U.S. Army Health Services Command at Ft. Sam Houston, Texas, has been awarded the Silver Beaver Award, highest adult recognition presented by the Alamo Area Council of the Boy Scouts of America.

Major McKinley Ash, Jr., professor and chairman of the department of occlusion at the University of Michigan School of Dentistry, recently was awarded an honorary doctor of medicine degree by the Faculty of Medicine of the University of Berne, Switzerland, for his contributions to dentistry as an author, scientist, and teacher.

Clifton O. Dummett, University of Southern California professor of dentistry was the keynote speaker at the recent meeting of the Academy of Operative Dentistry. The title of his address was "Community Dentistry's Contributions to Quality Health Care."

Elliot Feinberg of Scarsdale, New York, has received the D. Austin Sniffen Ninth District Dental Society Medal of Honor for the year 1976. Dr. Feinberg is an international lecturer and clinician, and author of the textbook, "Full Mouth Restoration in Daily Practice."

Louis Simon, professor emeritus of preventive dentistry and community health received the Harry Stusser Award for contributions to public health. Dr. Simon devoted much of his career to care for children and the handicapped, pioneering for fluoridation and establishing the NYU department of preventive dentistry and community health.

Thomas J. DeMarco, professor of pharmacology and periodontics, has been named acting dean of the School of Dentistry at Case Western Reserve University.

Dr. James K. Avery, acting director of the University of Michigan Dental Research Institute, recently became director of the institute.

John A. Crowley of Bethesda, Maryland, has been promoted to clinical professor of orthodontics of the Georgetown University School of Dentistry. Dr. Crowley has served on the School of Dentistry's faculty for the past 21 years and was chairman of the department of orthodontics 1959-62.

Louis Atkins of Blountstown, Florida, was honored recently by Governor Reubin Askew with a citation commending him for his "imaginative leadership" in civic and professional service.

Manuel H. Marks of Levittown, Pennsylvania, is president of the Philadelphia Society of Periodontology and also heads the Pennsylvania Society of Periodontists.

Victor L. Steffel, professor emeritus of prosthodontics at the Ohio State University College of Dentistry has been honored by the establishment of an annual seminar entitled "The Victor L. Steffel Lectures in Dentistry," founded and endowed by a gift from the American Prosthodontic Society in appreciation of his more than 20 years as Executive Director of the Society.

Harold R. Fenton of Austin, Minnesota, was honored at a party recently to celebrate his retirement after 61 years of practice. About 250 patients as well as many of his professional friends were in attendance.

Marvin Sniderman of Pittsburgh, Pennsylvania, editor of the *Pennsylvania State Dental Journal* and **Bernard P. Tillis** of Brooklyn, New York, editor of the *New York State Dental Journal* received honorable mention in the William J. Gies Editorial Award competition.

Henry Green of Detroit was the 1975 recipient of the Award for Meritorious Service presented by Alpha Omega fraternity. This award recognizes outstanding efforts in furthering the progress and achievement of the fraternity.

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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