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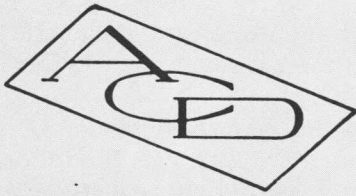
Alternatives in Oral Health Care
The Origin of Treatment Demands
The Essence of Professional Worth



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NEWS AND COMMENT

BOARD ACTIONS

The Board of Regents meeting in Las Vegas, Nevada just prior to the annual meeting and convocation of the College considered a lengthy agenda which included:

- Reports of the Officers and Regents commenting on the state of the College.
- Commendation for the Executive Director for his efforts in the publication of "News and Views."
- Considered moving the central office to another Suite in the Suburban Bank Building in Bethesda, Maryland.
- Approval of the new format for the Fellowship Handbook and Roster.
- Approval of the discontinuance of the Memorial Book program. In the future, a contribution will be made to the American College of Dentists Foundation in memory of each deceased Fellow. Sections of the College may wish to take similar action.
- A request to the Awards Advisory Committee that it establish guidelines for awards by Sections.
- Discussion of the methods and scheduling for the rechartering of the 35 Sections of the College.
- Suspension of the bylaws regulation that requires every Fellow to hold membership in a Section, for a two year period, during which rechartering of the Sections is to take place.
- Approval of a resolution of support for the Rockford College Institute by seeking membership for the College.
- Referral for study to the Financial Advisory Committee, a plan for the advance payment of dues.
- A report on the success of the MINI-SACED Program. To date 31 sections have presented the tests to a total of 1892 dentists.
- A request to the Coordinating Committee to determine the manner in which new Sections may be formed.

- Reaffirmation by the Board of Regents of its decision to remove from membership any Fellow who has been found to be in violation of the Code of Conduct.
- Approval of a recommendation of the Awards Advisory Committee for the establishment of the Otto W. Brandhorst Leadership Award, with criteria for making the award to the Section which best promotes the ideals and objectives of the American College of Dentists.
- Approval of a report on the development of a standard procedure on forfeiture of membership in the College, based on the bylaws.
- Approval of a recommendation from the Executive Committee governing the use of the seal and the logo of the College.
- Approval of a contribution of \$100 to the American Association for the Advancement of Science.
- A recommendation for an analysis of the membership so that a financial projection of dues needs can be determined.

SECTION NEWS

Carolinas Section Rechartered

The Carolinas Section, meeting in Greensboro, North Carolina, received its new charter from officers of the College. This is the first of the thirty six Sections to be rechartered according to the provisions of the current bylaws.



Left to right: President elect James L. Cassidy, Regent William C. Draffin, Section chairman Thomas L. Blair and Vice chairman Franklin Hines.

Florida Section

For the past two years, the Florida Section has supported as its special project an effort to reduce the problem of maldistribution of dentists in our State. As a part of this effort, the Section has encouraged and supported the concept of outreach programs to give dental students experience in rural practice.

The first such program will begin very soon in Mayo, Florida, where a four-operatory dental health center has been constructed to serve an area of several counties in great need of dental services. Students will be assigned there on a rotating basis beginning about February 1, 1977.

At its annual meeting, the Section voted to donate \$1000 towards the cost of student and faculty travel to Mayo.



Dr. William O. Shumpert, (left) President of the Florida Section, presenting a check for \$1000 to Dr. Quentin M. Smith, (center) chairman of the Department of Community Dentistry, with Dr. Don Allen, dean of the University of Florida College of Dentistry standing by.

New York Section

The New York Section of the American College of Dentists held its first meeting after a summer hiatus, on September 21st, 1976 under the chairmanship of Dr. Barry Symons.

Thirty-seven members attended this meeting. A Certificate of Merit and a gift were presented to past-chairman, Dr. Charles Hillyer for his devotion to and his efforts on behalf of the American College of Dentists.

Professor Jerome Leitner, L.L.B. of the Brooklyn Law School presented an interesting and provocative talk entitled, "Malpractice — Myths and Mendacities".

Our next meeting was held in conjunction with the Greater New York Dental Meeting on Sunday, November 28th at the New York Hilton Hotel. Dr. Harry Schwartz, assistant editor of the New York Times spoke on "The Future of American Foreign Policy."

District of Columbia Section

The Washington, D.C. Section of the American College of Dentists met on October 18, 1976, at the Holiday Inn in Chevy Chase, Maryland. There were reports on the self assessment program, project library, and a proposed senior students project. Dr. Israel Shulman was reelected Chairman, Dr. Joseph Salcetti Vice Chairman, and Dr. James Jackson to the Executive Committee. Dr. Balfour Mattox was appointed chairman of the Awards Committee.

It was decided to contribute \$500 to the Foundation of the American College of Dentists. Dr. Andre E. Hellegers, Director of the Kennedy Institute for the Study of Human Reproduction and Bioethics at Georgetown University, gave a very provocative and well received talk on "The Biological Origins of Bioethical Problems."

NEWS OF FELLOWS

Robert Atterbury of Chicago was the recipient of the Distinguished Alumni Award for 1976 from the University of Illinois College of Dentistry in recognition of his contributions to scientific literature, professional accomplishments and civic activities.

(Continued on page 72)

the JOURNAL of the AMERICAN COLLEGE of DENTISTS

AQUARTERLY PRESENTING IDEAS IN DENTISTRY

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WILLIAM C. DRAFFIN

BALFOUR MATTOX

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CONTENTS

NEWS AND COMMENT.....	1
THE PRESIDENT OF THE COLLEGE	7
PRESIDENTS INAUGURAL ADDRESS	10
EDITORIAL	
ARE WE PRODUCING TOO MANY DENTISTS?	15
THE ESSENCE OF PROFESSIONAL WORTH	
<i>Robert J. Nelsen, D.D.S.</i>	17
HONORS AND AWARDS	28
FELLOWSHIPS CONFERRED	33
SYMPOSIUM	
ALTERNATIVES IN ORAL HEALTH CARE III	
THE ORIGIN OF TREATMENT DEMANDS	
THE ORAL DISORDER	
<i>Richard E. Bradley, D.D.S.</i>	38
THE PATIENT	
<i>William B. Nienaber, D.D.S.</i>	56
THE INFLUENCE OF THIRD PARTIES	
<i>Lloyd J. Phillips, D.D.S.</i>	64
DECEASED FELLOWS	70



JAMES L. CASSIDY
President, 1976-1977

The President of the College

James L. Cassidy, a general practitioner of Macon, Georgia is president of the College for 1976-77. He has been active in a number of dental organizations and in community and church affairs. He was born, and received his early education in Macon. After a year at Mercer University, he spent two years in the U.S. Army, the largest part of this service in Kobe, Japan where he worked as a dental assistant. This experience impelled him toward the study of dentistry, and he enrolled at Loyola University in New Orleans, graduating in 1954.

While at Loyola, he was president of the C. Victor Vignes Honorary Fraternity, vice president of Blue Key National Honor Fraternity, president of the Junior American Dental Association and a member of Omicron Kappa Upsilon Honorary Dental Society and Delta Sigma Delta Fraternity. He also received the Louis Pillie Award as an outstanding student leader and the Alpha Omega Scholarship Award for attaining the highest four year scholastic standing in his class.

Establishing his practice in Macon, Dr. Cassidy affiliated himself with the Bibb County Dental Association, the Central District Dental Society and the Georgia Dental Association. His talents were soon recognized, and over a twenty-two year period he served these organizations in many ways. He was secretary-treasurer of the Central District Society for two terms, and held a similar position with the Georgia Dental Association for five years, later becoming the youngest president in the 116 year history of this organization. Last year he was elected the first Speaker of its House of Delegates. He has served as General Chairman of the annual meeting of the Georgia Dental Association, chairman of the Ethics Committee for the past eight years, and was named an Honorable Fellow of his state association in 1967.

Dr. Cassidy has been a member of the Georgia delegation to the American Dental Association House of Delegates for sixteen years, and has been its secretary for the past eleven years. He is a charter member of the Georgia Academy of Dental Practice, a

member of the Academy of General Dentistry, and the American Society of Dentistry for Children, and has just completed his sixth term as president of the Delta Dental Plan of Georgia.

He formerly served on the Dental Advisory Committee to the Dental Hygiene Department of Macon Junior College and was also a clinic supervisor and guest lecturer. He currently is a member of the advisory committee from the Georgia Dental Association to the Medical College of Georgia School of Dentistry, and is a guest lecturer to that institution on ethics and jurisprudence.

In his community, Dr. Cassidy has been a member of the Board of Directors of the Bibb County Unit of the American Cancer Society, The Macon Boys Club and the Family Service Agency. He holds membership in the Macon Lions Club, the Macon Chamber of Commerce and Downtown Council, and has directed the Dental Division of United Givers Fund several times.

Dr. Cassidy is a Lector and Minister of Communion at St. Joseph's Catholic Church in Macon, former vice chairman of the St. Joseph's Parish Council, former chairman of the Interparochial School Board of Macon, member of the Board of Trustees of Mt. De Sales High School and a member of the Knights of Columbus.

In the American College of Dentists, Dr. Cassidy has been chairman of the Editorial Board of the Journal, member of the Self Assessment and Continuing Education Committee, member of the Executive Committee, the Coordinating Committee and chairman of the Financial Advisory Committee. He also served as Marshall for the Convocation ceremony, and as a member of the Board of Regents.

As he assumes the office of president, the College applauds the record of service and the spirit of dedication to the advancement of his profession that Jim Cassidy has always shown, and looks forward to a successful year under his competent leadership.

President's Inaugural Address

JAMES L. CASSIDY, D.D.S.

As the time approaches for one to assume the leadership of the American College of Dentists there accompanies it a strong feeling of humility. During my six years on the Board of Regents I have watched each man, in his turn, accede to this office of honor and responsibility, not really experiencing the full import of that step until now. Although it will be a challenge, I do feel confident that I have been adequately prepared. My predecessors have been my mentors. I've had the privilege of serving under such presidents as

Frank Bowyer — Speaker of the House of Delegates of the American Dental Association and soon to be its President-Elect.

The late Otto Brandhorst — former Executive-Director of College for 35 years.

William E. Brown — Dean of the University of Oklahoma School of Dentistry.

Ormande McCormick — Eminent oral surgeon from Syracuse, New York.

Louis G. Terkla — Dean of the University of Oregon School of Dentistry.

P. Earle Williams — Leader in dentistry par excellence.

Jim Verneti — Our current President, in practice for 35 years — now sharing his experience with students as a faculty member at the University of Texas College of Dentistry.

You might say that under their guidance I have become of age, so to speak. Any successes which come during my administration shall be due in a great part to these wonderful gentlemen. Any failures shall fall upon my shoulders.

This morning I want to briefly bring you up to date on the activities of the College and where we want to go from here. I am happy to report that the internal reorganization of the College is progressing and the first rechartering of a section took place on October 3rd with the Carolinas Section serving as the pilot. As the College grew over the years, and new Sections were formed, there was a hodge-podge of by-laws with no really binding element among these Sections. As part of the reorganization, the committee on Sections developed uniform basic by-laws which

each Section will be asked to adopt, tailoring them to their own particular situation. Following the adoption of the new by-laws, the Section will be rechartered in a brief ceremony conducted by the Regent representing the Regency in which the Section is located. The prime purpose of this reorganization is improved communication and cooperation between the Fellows of the College, the Sections, the Regencies and the Board of Regents, so that the College may even more effectively assume its role as the organization within our profession which can present as over- view attitude, proposing ideas and ideals to the profession of dentistry which will enable it to better fulfill its responsibility to society.

In his final report to the Board of Regents as he completed his term as President of the College two years ago, Louis G. Terkla, a man who stands ten feet tall as a professional, issued a challenge to the Board as well as to the College and I quote, "Many of the problems we face as a profession are philosophical in nature and that arena should be the College forte. As a Board and as Fellows of the College you must stand up and be counted in terms of publicizing the College's beliefs on every critical issue that demands a statement of principle. We serve no one by being silent. We cannot assume that others think the College is important. We must make it important by wading the mainstream of events that continue to flow through our profession." In his challenge Lou was reminding us that the American College is composed of the most dedicated, conscientious leaders of our profession — but an organization composed totally of leaders (all chiefs and no Indians) must constantly guard against its members becoming complacent and being willing to just bask in the glory of their past accomplishments. No organization, or really no individual, can stand still. If they do not move forward, they fall backward. The American College has an endless wealth of knowledge and skill in its fellowship and, with the proper stimulation, there is nothing that cannot be accomplished. He is saying — wear your Fellowship with pride and become involved.

The Board of Regents accepted Dr. Terkla's challenge and established and now has operational what it calls the Commission Concept. Four commissions have been implemented with the general titles of:

- Delivery of Service
- Journalism — Communication
- Education
- Research

Each of these commissions has the responsibility to monitor the area of its prime interest and present formal reports to the Board of Regents, identifying issues and submitting a plan to justify attacking that issue. The Board will examine each proposal, establish a hierarchy of issues and ultimately select the prime issue. Each commission is composed of two Regents plus any other Fellows of the College, or indeed, anyone they feel may be essential to the proper function of the commission. Here again we are involving more and more Fellows in the vital activities of the College, giving it a broader base from which it can publicize its beliefs on critical issues which demand statements of philosophical principles.

As for other projects of the College, the self-assessment and continuing education program continues but the response still remains below our original expectations. However, an offspring of SACED, the mini-self-assessment program is proving to be most successful and interesting. This is a program designed for state and regional dental meetings which involves Fellows of the local Sections in its operation and success. I am sure many of you are familiar with it. A room is set aside in an easily accessible spot during the meeting. Fellows of the local Section man the room, distributing tests and explaining the procedure. A short test lasting about 30 minutes is taken by those wishing to participate. When the participant completes the test he scores himself and then destroys the answer sheet in a paper shredder as he leaves the test room. This makes the test completely confidential for the participant. When the mini-self-assessment was conducted at the Hinman meeting in Atlanta this past spring by the Georgia Section, I was particularly impressed and heartened by the number of younger practitioners testing themselves. This is a very rewarding project for a Section to assume. The program is subsidized by the American College of Dentists Foundation. The Foundation, by the way, deserves the support of all the Fellows of the College. A contribution to the Foundation is an excellent way to memorialize a departed friend. Beautiful, dignified acknowledgements are sent to the family of the person remembered.

Project Library continues to be successful. Due to the demand, a new library package was developed this year by the executive office in cooperation with the Library of the American Dental Association. Both public and school libraries are thrilled to receive these packages.

No report to you would be complete without a word about our Executive Office. There is really no way the officers and Regents can adequately thank our Executive Director, Bob Nelson and his most efficient staff for the function they perform. Their office is the hub of activity of the College and they lend the continuity which is demanded by an organization such as ours.

We are going to take the liberty of giving our administration a theme or a title, so to speak. It will be: **RENEWED PROFESSIONALISM WITHIN THE FAMILY OF DENTISTRY.**

If we can accomplish this theme I firmly believe we could go a long way toward what A.D.A. President, Fellow Robert Shira urged in his remarks to the annual meeting of the Georgia Dental Association last month. "Settle our family differences and then present a united effort toward the best oral health care for the citizens of our country." Over the years parochialism has crept into our profession just as it did years ago in medicine, each group having its own little sack of rocks to carry. If all these rocks are cemented together a beautiful effective path could be made. A return to basic professionalism, which could be the cementing factor, will do great things for us as individuals and as a profession. Many of you have heard me quote before Executive Director Bob Nelson's definition of professionalism but I feel it bears repeating.

"Professionalism is that quality of conduct which accompanies the use of superior knowledge, skill and judgment toward the benefit of another person or society prior to any consideration of self-interest by the professional person or the professional organization." That is a simple but strong definition. *Professionalism* can actually be defined by a single word — *Integrity*. The dictionary defines integrity as honesty, sincerity, uprightness, wholeness, completeness, soundness. So you see, professionalism and integrity are indeed synonymous. Recently I have been reading a book dealing with ethics in general and professional ethics in particular. It describes the history of ethics going all the way back to ancient societies. Each society had its own phrase for professionalism, but they all translated into the obligation that has been summarized for all times in the Golden Rule — "Do Unto Others As You Would Have Them Do Unto You." As an example of our game plan, we anticipate developing means whereby we can cooperate with dental teaching institutions in instilling the responsibilities of professionalism in the character of the dental student from the very beginning of his professional career.

In closing let me tell you how much I appreciate the confidence the College has placed in me and promise that, with your trust and cooperation, ours will be a most productive year. I shall do all in my power to prove your confidence well founded. I look forward to the challenges of the coming year as being one of the most rewarding experiences of my life. Several years ago, at the beginning of a new year I found in our local paper a series of resolutions. Although given as new years resolutions I feel they are appropriate at any time. They impressed me very much and I enjoy sharing them with my friends. Therefore, please allow me to leave you with this thought:

RESOLUTIONS

No one will ever get out of this world alive.

Resolve therefore in the year to come to maintain a sense of values.

Take care of yourself. Good Health is everyone's major source of wealth. Without it, happiness is almost impossible.

Resolve to be cheerful and helpful. People will repay you in kind.

Avoid angry, abrasive persons. They are generally vengeful.

Avoid zealots. They are generally humorless.

Resolve to listen more and to talk less. No one ever learns anything by talking.

Be chary of giving advice. Wise men don't need it, and fools won't heed it.

Resolve to be tender with the young, compassionate with the aged, sympathetic with the striving, and tolerant of the weak and the wrong. Sometime in life you will have been all of these.

Do not equate money with success. There are many successful moneymakers who are miserable failures as human beings.

What counts most about success is how a man achieves it.

Resolve to love this year someone you didn't love last year. Love is the most enriching ingredient of life.

360 Spring Street
Macon, Georgia 31201

Editorial

Are We Producing Too Many Dentists?

Back in the middle 60's the dental profession was warned that in order to meet the future oral health care needs of the American people, it would be necessary to produce more dentists, build more dental schools and enlarge those already in existence, correct the maldistribution of dentists, expand the functions of dental auxiliaries and find ways to serve the public at lower cost. All of these warnings were based on the assumption that there would be an increasing demand for dental care, that a national health insurance program would include dentistry, and that the population would continue to grow at the then current rate.

As with so many projections, the passage of time has shown that some were fallacious. Although the demand for dental care did increase, because of third party and government programs, and the increased public recognition of dental health as an integral part of general health, studies have shown that many dentists are still not as busy as they might be, that many could accommodate more patients than they presently treat.

Dental schools have enlarged, new ones have been built, and more dentists are graduating than ever before. But many schools, through pressures for added enrollment that accompanied government support, are overcrowded and hard put to provide high quality education to their students.

Despite all the talk of a national health program, we have yet to see the Congress of the United States pass such legislation. And if it ever does, there is little likelihood that it will include dental care at its inception. So for the time being, this element of increasing demand must be discounted.

Other factors have affected the professions as well. Economic insecurity, inflation, and the desire for smaller sized families have contributed to a declining birth rate. This has already begun to have an effect on orthodontists and pedodontists who, in some areas are treating fewer patients. The high cost of establishing a

practice has resulted in an increasing number of bankruptcies among younger dentists, which is certainly cause for reflection.

On the basis of these facts, therefore, is the profession justified in producing as many dentists each year as it does at present? Would it not be better to educate smaller classes, but concentrate on giving each student a dental education of the highest possible quality? Would it not be better for schools to reconsider the capitation grant system and try as much as possible to operate without this form of federal support? Would it not be better for states to subsidize student tuition, in return for which the student would be obligated to stay and practice in that state?

Increased production of dentists has not solved either the manpower or the maldistribution problem. It is time to look for other solutions. Perhaps the best way to begin would be to consider smaller but better educated dental school classes.

R.I.K.

OFFICERS OF THE COLLEGE



Officers of the College (left to right) president elect, Charles F. McDermott; executive director, Robert J. Nelsen; president, 1976-77 James L. Cassidy; president, 1975-76 James P. Verneti; editor, Robert I. Kaplan.

The Essence of Professional Worth

ROBERT J. NELSEN, D.D.S.

The following comments are my personal viewpoints on the subject of professionalism. They do not reflect any official concept or position of the American College of Dentists. My position with that organization of itself does not bring any endorsement of the College. I remove my hat and speak from observations made during a varied experience in dentistry. I trust my comments will merit the privilege of this podium.

Professional worth in the system of dentistry derives out of the symbiotic roles of the educator and the examiner. They share a co-relative purpose in developing and continuing competence in both the emerging profession and the practicing profession — competence being that quality of knowledge, skill and judgment necessary for a person to attain his intended purpose. If a person attains his intended purpose, then he has worth. I would like to offer the following comments on "the essence of professional worth."

The ascent of man from his beastly origins is a story of his approximation to some form of order which he has most often called his God. Essentially, man became human as he curbed self interest and selfishness and developed a concern for others. Through various systems of expressions in one way or another he acknowledged that there was something greater than himself. These became his cults and his religions. Some were quite simple, others developed into highly organized arrangements of beliefs. Historically, the magnificent variety of religions attests to this unique attribute of man which distinguishes him from other creatures. He believes. To a large extent, it is belief that makes man human.

Presented at the Western Conference of Dental Examiners and Dental School Deans, Portland, Oregon, July 29, 1976. Dr. Nelsen is Executive Director of the American College of Dentists.

When man submits to belief, he becomes "in order" with that belief and he will submit to its doctrine. Confidence in his belief is called his faith. It is in this context of belief that I wish to address the topic, "The Essence of Professional Worth." I wish to speak of professionalism as a system of beliefs. We have great need to restore our faith in that system.

For purpose of this discussion, I wish to present my definition of professionalism at this point. Professionalism, to me, is an attribute of quality in the relationships between two persons or between two groups. The nature of the professional relationship is the same whether it attends to the doctor and his patient or to the profession and the public.

In the professional relation, an individual having problems calling for superior knowledge, skill and judgment, which he does not have, seeks a solution by surrendering himself to care by a person who has knowledge, skills and judgments. Most importantly, this person professes to place the interest of the supplicant before and higher than his own interest. When such conditions prevail, we have a trinity of order, a predetermined scheme without confusion in which a first person surrenders his personal authority to a second who acts to the other's benefit prior to his own. This mixed element is the shared spiritual attitude of both which establishes the professional relationship between the doctor and *his patient*, and the patient and *his doctor*. Both are equally *in possession* of the other. In a similar context, the profession serves to advise and guide the interests of the public.

To further this desirable relationship, society by law grants esteemed position and protected privilege to those who present credentials and proclaim their dedication to another's needs before their own. Under this arrangement emerged the finest health care system in the world of which our profession is an integral part.

The effectiveness of the system depends upon the continuing respect of patient and doctor of profession and public. It requires that all parties involved believe in the system and have faith in it.

Recently, there have developed certain aberrations of confidence or faith in this fundamental concept of professionalism. The credibility of the professional and the professions is being seriously challenged. Many of these challenges have been set forth by those who would entirely dismantle the professional structure within our society. A discussion of their purpose in so doing would require a separate essay.

The professional systems in proper function are the bedrock of the American way of life which is the envy of the world. Our form of government was originally designed not by an emperor, a tyrant or a commune, but by true professionals who pledged their lives, their fortunes, and their sacred honor to the purpose of freedom for all men. This unique system of government provided an environment and an atmosphere of freedom in which true professions could develop and attain world leadership, most especially in medicine and dentistry.

Under the pluralism of our system of states united, each recognized profession by law has both the privilege and the concomitant responsibility of managing its own affairs. Could the mismanagement or the non-management of our affairs be the reason for the consumer's challenge of the professions? Could the mismanagement of our affairs be responsible for the loss of faith in our professional beliefs? If so, what are these affairs and how should they be managed.

There are four essential areas of management responsibility in which the profession maintains privileged custody of its own affairs. These areas are Research, Education, Journalism, and the Delivery of Care. Through the proper function of these four areas, the profession assures its continuing confidence in the knowledge, skill and judgment necessary to providing oral health care.

It might be well to examine these four areas separately and briefly on the premise that they are the means by which the profession attains its ends. They are not ends in themselves, for they *are of* the profession.

RESEARCH

The area of research is listed first because it is directed towards the development of new knowledge and the refinement of existing knowledge and, further, to discriminate truth from error. These are prime obligations of a profession, and they are important and they must be properly managed.

The research establishment in dentistry has grown to be a considerable enterprise. The annual subsidy through the National Institute of Dental Research alone is over fifty million dollars per year, fifty-nine million this year, some \$50,000 per year per practicing dentist. In the first 25 years of its operation, over half a billion dollars has been provided by the federal government to

develop the research establishment. It would be interesting to review the significant effects on the nation's dental health that have derived out of these five hundred million dollars. We would find that the essential means to control dental caries and alveolar bone loss are still "around the corner" and we must deal with them clinically in the traditional manner.

The American Association for Dental Research, thanks to the professional stance of its new president, Dr. Harold M. Fullmer, is now examining the manner in which the American Association for Dental Research can better attain its purpose. Hopefully, the research establishment will realize that the world is still waiting, but with growing impatience, for the answers to problems of disease. Its mission should be to seek these solutions directly. Pure research, basic research, curiosity-oriented research are being challenged now to compete within a system of finite resources with research that is directed to the solution of defined problems.

In the first lecture of a series of lectures on "The Reappraisal of the Role of the Professional in Contemporary America" at the Smithsonian Institution, Dr. Albert B. Sabin spoke on "The Role of the Research Scientist." He spoke from the professional point of view about values in basic and applied research.

Early in his lecture, he quoted the Scottish-German philosopher, Immanuel Kant who said in "Dreams of a Ghost Seer":

"To yield to every whim of curiosity and to allow our passion for inquiry to be restrained by nothing but the limits of our ability shows an eagerness of mind not unbecoming scholarship. But it is *wisdom* that has the merit of selecting from among the innumerable problems that present themselves, those whose whole solution is important to mankind."

The research establishment, to be professional, must forego self indulgence in curiosity-oriented research, in the business of redundant testing and in the accumulation of information on problems that are not really problems. Too often, the availability of funds results in an accumulation of equipment or data looking for a problem. That affluence promotes mediocrity by eliminating competition applies to the scientific community in spite of its highly touted peer review system.

For the scientist to be professional, he must forego self interest and manage his research towards some benefit. This he can do at no risk to his science or to himself. Furthermore, he must become

more attentive to society's needs and become less parochial in his orientation of interests. He must join more closely with others of the profession, the educator, the journalist, and the practitioner. In so doing, he will become more effective in attaining his purpose. The proper management of research effort is a professional responsibility. The scientist cannot consider himself to be a priest within the profession any more than the educator, the journalist, or the practitioner.

EDUCATION

Let us next consider the area of education which is most important in assuring qualities of professional competence in the delivery of care. It has the awesome responsibility of selecting and training the emerging profession and, in addition, it must provide the practicing profession with such new knowledge as it deems significant to the maintenance of quality care.

Within the educational system rests the greatest threat to professionalism as well as the unparalleled opportunity to develop and expand this concept by the professional example of the faculty. The socialization of higher education can bring mischief, disruption and harm to the distribution of knowledge. All education requires a point of view as to content, method and purpose. There is no point of view that can be taken without offending someone. Responding to federal pressures, the educator attempts to accommodate all points of view. This can result in a type of nothingness, called non-education.

The intervention of the federal government has imposed its distant will upon higher education which controls the only means of becoming certified in the profession. The Newman Report on Higher Education made in 1971 to the Secretary of Health, Education and Welfare points out that the federal government has encouraged many universities to become huge conglomerates, operating laboratories and other projects, only tangentially related to teaching and research (p. 82). This excellent report advocates reviving institutional missions and eliminating activities peripheral to education. In speaking about New Institutions for Special Missions, this report says:

"There should not be a single order of excellence in higher education. We need a variety of institutions, each excellent in its own appointed mission."

"Whose bread I eat, his song I sing" is the litany of the insidious influence of federal subsidy. True professionalism in

education is a source of resistance to pressures attending financial support, wherever its source. The unprecedented affluence of higher education has witnessed the development of great and noble edifices, but I am afraid too often we have gained a building and lost the student.

Hopefully, the current review of the dental curriculum will consider the great need to develop a true professional whose clinical competence will match his highly-developed social motivations. Education must build a professional to meet public need, not to satisfy the whims of curriculum experimentalists. For example, in this country alone, there are 24 million people without teeth. They truly are handicapped whether or not they are so recognized. Does dental education take a dim view of the importance of full denture prosthetics or do they include it in the curriculum to match the importance of a professional service targeted towards 24 million handicapped people?

The Washington Post on June 14, 1976, reported that Ralph Nader's Center for Responsive Law and Call for Action, Inc., based on interviews in 24 cities, stated that dentures were among products given the poorest rating along with grocery store items and toys. Twenty-four million people may just decide to follow Ralph Nader into the direct care of the laboratory technician.

It is incumbent upon dental education to develop and maintain a full spectrum of competence in the practicing profession. To do so effectively, it must realize that it is an integral part of the total profession and not an institution of its own. While it's sustained by the public, its constituency is not the federal apparatus nor the student. It must join with the scientist, the journalist, and the practitioner in a composite endeavor of professional care — directed to public benefit.

JOURNALISM

Too often unrecognized for its important role in developing and furthering the tenets of professional concept is the area of Journalism. The custody and the compilation of its knowledge is essential to continuing the proper function of a profession. To be professionally responsible, journalism must be under the sponsorship and the control of the profession. Commercial use of professional knowledge in throw away magazines dilutes the effectiveness of intra-professional communication.

It was recognized long ago that publications whose purpose is profit compromise their content to attract the reader and thus lead his interest to the advertising. Profit, being the single purpose of the proprietary commercial journals, allows no space for controversy or challenge so essential to the establishment of truth. New ideas need peer review — which only professionally owned journals can give. Ideas must be published widely — and the professional must read as well as listen.

The professional publication provides the dentist with the source of ideas and ideals. Articles published in the professional journals are subject to challenge and review by the writer's peers. Falsehood and error are taken to task as the profession by possession of its own literature maintains truth and accuracy in matters of oral health care.

The virtues of the professional concept should be extolled more often in our journals. Too frequently, so-called editorials speak of pedestrian issues which have little bearing upon the mission of the profession and do even less to encourage professional ideas or to defend them when they are set upon by those who discredit the concept.

Editors of journals should invite others to write guest editorials, especially asking leaders in various areas of the profession to comment. The voice of the clinician should be heard in the *Journal of Dental Research* — the views of the educators should be sought by the state journals. The orthodontist and the pedodontist, the oral surgeon and the endodontist, and especially the examiner, should exchange editorial comment in their specialty journals.

By such exchange, the various areas of the profession will better realize that they have a common purpose in the delivery of oral health care.

There is a great need to modify the parochialism and isolation which has occurred within the professions and there is no better way than in the pages of the professionally responsible and professionally sponsored dental publications.

THE DELIVERY OF CARE

The profession's response to the demand for care is through the practicing dentist. The public's image of the profession is largely that of the dentist at the chair. He is there because he has survived the systems of selecting, credentialing and licensing. He functions primarily in the manner largely determined by his apti-

tudes and his attitudes. Within these two dimensions, he applies knowledge, skill and judgment to effect the care requested. He likely has learned very early that he can neither know everything nor develop adequate skills for every problem. He attains success as a practitioner by learning the art of compromise which modifies the ideal to the attainable.

The extent to which he departs from the ideal is a dimension of professional judgment. This is a value judgment because it is based upon his individual, internal scale of preferences between the alternatives presented in each circumstance. This value judgment takes on a further dimension because it is made for another person — the patient who has surrendered his own prerogatives of judging to the professional. Because it involves another person, it becomes a moral value judgment. It is the acceptance of the responsibility for making this moral value judgment in behalf of another that distinguishes the professional from the craftsman and the tradesman. This judgment is the core of the doctor-patient relationship and it is this that the professional is so justifiably defensive against intrusions and tamperings by third parties. While the patient's benefit must always be considered first, there is a righteous self interest allowed the professional as long as it remains secondary. There is no reason for him not to prosper in this system. However, if he turns opportunist and sets self interest first, he immediately becomes Robert Louis Stevenson's Mr. Hyde. He turns into a tradesman-provider, and his patient unwittingly becomes a customer-consumer.

The exercise of judgment in clinical practice is subject to many hazards, not the least of which are the intrusions of third parties. Also, the professional must guard against those who would garner certain aspects of care to their own advantage. Some, like the denturist, would completely remove the patient from the doctor — while the others, such as the auxiliaries, are becoming more aggressive in demands for sharing in treatment. So far, they wish to operate independently but within the physical shelter of the professional office and under the professional's liability and financial protection. Because of the moral issues pertaining to treatment, auxiliary utilization should remain a prerogative of allowable delegation by the doctor and not a right of the auxiliary.

The practicing profession must be ever mindful of financial influences pressuring for a modification of the chartered responsibility of the doctor for his patient. If he succumbs to the tempta-

tion to relinquish greater and greater treatment responsibilities to auxiliaries, they will in time demand equivalent and independent authority. Much of oral health care has within it craftlike actions of treatment which may be delegated. However, the nature of treatment must first be determined by a professional who considering alternatives makes a value judgment to the best interests of the patient. If third parties continue to insist, treatment may become an arbitrary decision based upon matching needs with allowances, then treatment becomes craft. The doctor becomes a provider-entrepreneur, the patient a customer, and soon the odor of caveat emptor pervades in an arrangement of services rather than of professional care.

Should the professions relax their inner direction and self control by surrendering to other directions and succumbing to codes, specifications, allowances, preauthorizations, they shall lose their professional worth.

The alternative of course is to maintain professional prerogatives, to resist intrusions and appropriations of treatment by those on the periphery of health care. The first order of need is to strengthen the concept of professionalism from within. Then the patient and the public must be told that the best of the alternatives in health care is not in socialization, not in industrialization, and not in fragmentation, but in the system of professionalism.

The essence of professional worth rests in the belief that true professionalism is intrinsically moral and that it is an outgrowth of man's spiritual evolution. I have complete faith in that belief.

7316 Wisconsin Ave.
Bethesda, Maryland 20014

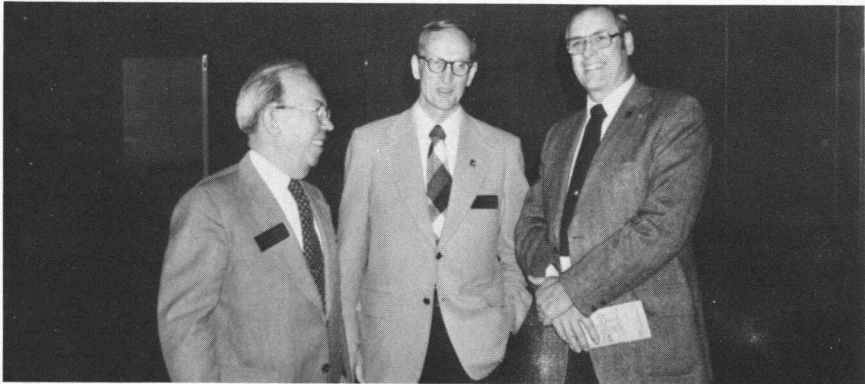
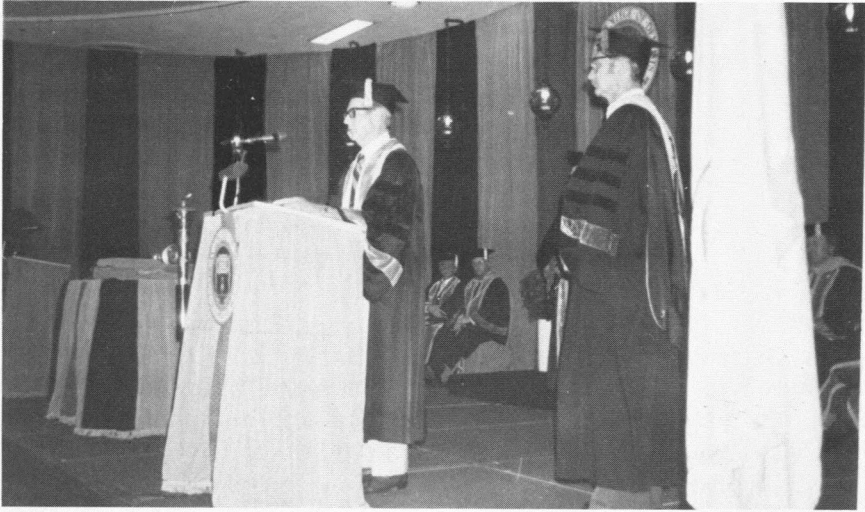
Somewhere in the world there is defeat for everyone. Some are destroyed by defeat, and some made small and mean by victory. Greatness lives in one who triumphs equally over defeat and victory.

John Steinbeck

Annual Meeting and



Convocation Scenes 1976



Photos courtesy of Dr. Jack. D. Carr

Honors and Awards

CITATION FOR DR. ALBERT B. SABIN
of Charleston, S.C.
on presentation of Honorary Fellowship 1976
by Regent William C. Draffin

Mr. President, it is a particular privilege for me to read the following citation of Dr. Albert B. Sabin, physician, scientist extraordinary. From out of the remarkable successes of his research, he has provided health science with the means to annul the wickedness of many of the morbid diseases.

Dr. Sabin was born in Poland and came to the United States at an early age. After graduating from high school in Paterson, New Jersey, he attained the Bachelor of Science and the M.D. degrees from New York University. Dr. Sabin started his professional career by enrolling in the New York University College of Dentistry.

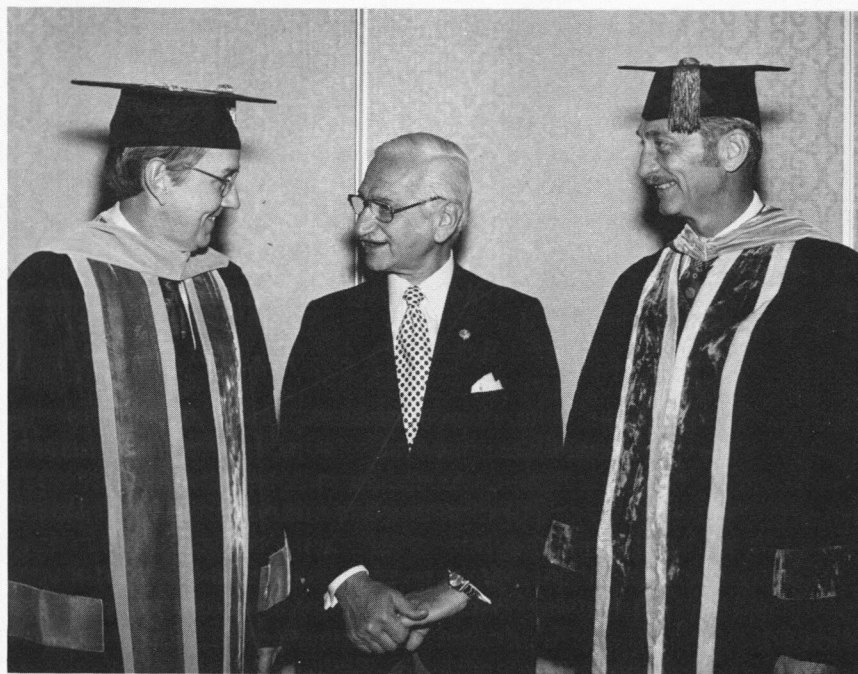
On graduation from medical school, his career in biomedicine went from one important position to another over the fifty years of teaching, research, consulting, and advising here in America and in every area of the world. Among the more than thirty of these were appointments to the Lister Institute in London, the Rockefeller Institute in New York. He was Associate Professor of Pediatrics at the University of Cincinnati College of Medicine and the Children's Hospital Research Foundation; Consultant to the U.S. Army Commission on Virus and Rickettsial Diseases, sent on special missions to Panama, Japan, Korea, China and Germany.

He has served, or is still serving, on the Armed Forces Epidemiological Board; as a Consultant to the National Institutes of Health; as a Consultant to the Select Committee on Government Research of the United States House of Representatives; as a member of the Board of Governors, the Hebrew University of Jerusalem; as a member of WHO (World Health Organization) Advisory Panel on Virus Diseases; member of the Board of Governors, University of Tel Aviv Israel; member, Advisory Committee on Medical Research, Pan American Health Organization, and to many other important posts, including his present position as the Distinguished Research Professor of Biomedicine, Medical University of South Carolina in Charleston.

His fellow scientists, his profession of medicine, his government and many other governments of the world, as well as universities, institutions, organizations and religious bodies have recognized the remarkable worth of Albert Sabin. They have honored him with Doctorates, Achievement Awards, Citations, Orders of Merit, Gold Medals and Professorships. Because of his contributions, he has received over 80 important recognitions, among which are the International Antonio Feltrinelli Prize (\$40,000) in Medical and Surgical Science from the Accademia Nazionale dei Lincei, Rome, Italy; the Albert Lasker Clinical Medicine Research Award; the Distinguished Civilian Service Medal of the United States Army, and the United States National Medal of Science.

In spite of all these honors, Albert Sabin continues today most active and productive as he applies his talents and energies in full measure to his life-long pursuit of new knowledge.

Today, after over 300 papers on pneumococcus infection, poliomyelitis, encephalitis, toxoplasmosis, viruses and cancer and



Left to right: Incoming president James L. Cassidy; convocation speaker, Albert B. Sabin; outgoing president, James P. Verneti.

other topics, about his discovery of B virus, his work on attenuated orally administered polio-virus vaccine, after receiving over 80 significant honors and awards, even after deciding not to become a dentist, we of the American College of Dentists realize we could not embellish these mighty honors already accorded Dr. Sabin. Parenthetically then, to all these prior tributes, we wish to add that the true greatness in the man is in his dedication to purpose and the constant evidence of the true professional, both as a man of science and a man of medicine. And yet, in spite of these exceptional successes and the overwhelming recognitions of the world, he has remained the modest, genial, friendly person, a first-rate human being, much to be admired and long to be remembered.

Mr. President, it is with particular and great pleasure that I present to you, Albert B. Sabin, for Honorary Fellowship in the American College of Dentists.

CITATION FOR
RALPH WILBUR PHILLIPS

of Indianapolis, Indiana
on presentation of the William John Gies Award
1976
by Regent Gordon H. Rovelstad

Mr. President, it is with great pleasure that I present Dr. Ralph W. Phillips, Research Professor of Dentistry and Associate Dean for Research of the Indiana University School of Dentistry, for the William John Gies Award of the American College of Dentists.

For over a quarter of a century he has been a member of the faculty and during this time has earned the reputation of an internationally renowned teacher and investigator in the field of dental materials. Recognizing that scientific information becomes useful only through application, he has lectured to over 1,000 scientific and professional meetings throughout all of the 50 states and about a dozen foreign countries. He is the author of more than one hundred scientific publications and textbooks on dental materials that have been translated into several languages and has served as consultant to government and to the industry. His graduate students are scattered all over the world.

Ralph W. Phillips is respected in all areas of dental research and education as an acknowledged leader in both areas. He is a past president of the International Association for Dental Research and holds the distinguished professor rank of Research Professor at Indiana University. Not a dentist, he is an honorary member of the American Dental Association. He is a recipient of the Wilmer Souder Award, the highest honor in the field of dental materials research of the International Association for Dental Research. He is the Chairman of the Biomaterials Research Advisory Committee of the National Institute of Dental Research and a Consultant to the Director of that Institute. He is a visiting faculty member and consultant to research programs at six universities. He is the principal author, editor or contributor to twelve textbooks. He has appeared on over 1,000 different dental programs in 48 states and over 15 foreign countries. Just to keep busy, he served as organizer and chairman of over 40 symposiums and conferences on materials research.

Perhaps the most significant contributions Dr. Phillips has made are in bridging the gap between dental materials science and clinical dentistry, so that practicing dentists can discriminate between fact and propaganda and thus select and apply materials and technics intelligently. He has brought honor to his profession and distinction to his university.

He continues to apply himself in a full measure of service to dentistry. For these and many additional reasons, he has been a credit to himself, the American College of Dentists, and to dentistry.

It is most appropriate that today we can honor the memory of William J. Gies who, although not a dentist, was in his time a significant leader and prolific contributor to the profession. I am privileged to present to you, Mr. President, Ralph W. Phillips for the William John Gies Award.

CITATION FOR
MR. RAY COBAUGH
of Harrisburg, Pennsylvania
on presentation of the Award of Merit
1976
by Dr. Charles F. McDermott

Ray Cobaugh was educated in the public schools of Harrisburg, Pennsylvania, and received the A.B. degree with a major in English from Elizabethtown College.

During World War II, he served with the U.S. Navy as a gunnery officer in all theaters and presently holds the rank of Commander. After the war, he became the Executive Secretary of the Pennsylvania Dental Association and Business Manager of the Pennsylvania Dental Journal. It was in this position that for three decades he was the effective spokesman for the dental profession throughout the state and particularly in the Capitol at Harrisburg. He is known and admired throughout the dental world as a superb executive director. He holds the qualification of the American Society of Association Executives as a Certified Association Executive.

He is much respected for his considerable ability in the perceiving and solving of difficult problems. This has been evidenced by the important role he has taken in advancing the professional status of the state association.

A true professional, he has often used his good offices to guide students to a career in dentistry.

His affiliations and offices reflect the range of his interests and influence. They include: past president of the Harrisburg Trade Association Executives, certified associate executive of the American Society of Association Executives, associate member of the American Dental Association, and past president of the Elizabethtown College Alumni Association. He holds membership in the Carpenters Union, the Tuesday Club, the American Legion, and the U.S. Naval Reserve.

Under the administration of Ray Cobaugh, the Pennsylvania Dental Association has become the model for other health and civic agencies. He has recently received an award from his Alma Mater, Elizabethtown College — "Educate for Service Through Professional Achievement."

For his exceptional service to Dentistry, not only in his own state but nationally, it is my privilege to present Mr. Ray Cobaugh for the American College of Dentists' Merit Award.

Fellowships Conferred

Fellowship in the American College of Dentists was conferred upon the following persons on November 13, 1976 in Las Vegas, Nevada.

Charles L. Abernathy, West Memphis, Arkansas

Joseph Abramowitz, Glendale, Wisconsin

William E. Alexander, Eugene, Oregon

Robert L. Anderson, Portland, Oregon

Ralph H. Baahlmann, Alton, Illinois

Lionel R. Ballesteros, Pico Rivera, California

C. Larry Barrett, Davenport, Iowa

Marvin L. Barron, Rainsville, Alabama

Thomas H. Beavers, Indianapolis, Indiana

William W. Beazley, Encino, California

Michael M. Belenky, Army

Ernest H. Besch, San Antonio, Texas

Mark W. Blackburn, Jackson, Mississippi

David D. Blaha, Marshalltown, Iowa

Keith P. Blair, San Diego, California

George G. Blozis, Columbus, Ohio

Howard P. Boller, Encino, California

Charles R. Breckenridge, Lodi, California

Allen K. Brown, Seattle, Washington

I. Stephen Brown, Philadelphia, Pennsylvania

Robert S. Buchman, Stockton, California

Ronald E. Buell, Santa Ana, California

Edmund C. Butler, Lebanon, Tennessee

Herbert C. Butts, Chicago, Illinois

James A. Campbell, Jr., Hayward, California

Jean E. Campbell, Placentia, California

Anthony A. Caputi, Newport, Rhode Island

Charles B. Cartwright, Ann Arbor, Michigan

Dale J. Cartwright, Cabool, Missouri

Osamu Chiono, Gardena, California

Myron Chubin, Highland Park, Illinois

Lawrence L. Clark, Air Force

Kenneth M. Clemens, Lima, Ohio

Stephen Cohen, San Francisco, California

Perry P. Cohn, Milwaukee, Wisconsin

Robert C. Coker, New Orleans, Louisiana

Russell L. Corio, Navy

Fred E. Cory, Quincy, Illinois

William M. Creason, Grand Haven, Michigan

Joseph M. Croley, Orange, Texas

William R. Dannahower, Fort Pierce, Florida

John D. Davies, Newburgh, New York

Charles G. Defever, Anchorville, Michigan

Donald H. Devlin, San Leandro, California

Homer J. Dyer, Seattle, Washington

Lewis R. Eidson, Dallas, Texas

Jacob M. Eisenson, Lakewood, Colorado

Harold F. Eissmann, Reno, Nevada

Charles M. Enright, Holyoke, Massachusetts

- David S. Faigel, Burlington, Vermont
Jorge J. Fernandez-Pabon, Rio Piedras, Puerto Rico
Philip Finell, Bay Shore, New York
John G. Finnegan, Rye, New York
Emile T. Fisher, Atlanta, Georgia
Knud G. Flygenring, Northridge, California
Clifford W. Fox, Jr., Akron, Ohio
Ralph F. Frogley, Boise, Idaho
Sanford B. Gelb, Passaic, New Jersey
S. Gordon Geldart, Edmonton, Alberta
Peter T. George, Honolulu, Hawaii
Clarence E. Gerstenberger, Castro Valley, California
Bert W. Gilbert, Springfield, Illinois
Louis Goldberg, Closter, New Jersey
Jay Phillip Goldsmith, New York, New York
Burton H. Goodman, Tacoma, Washington
Jack W. Gottschalk, Cincinnati, Ohio
Daniel B. Green, Arlington, Virginia
George G. Groom, Canonsburg, Pennsylvania
Stanley A. Grzybinski, Danvers, Massachusetts
Girard A. Gugino, Buffalo, New York
Abraham W. Haddad, Worcester, Massachusetts
Richard J. Haffner, St. Louis, Missouri
Bertin D. Hall, Oceanside, California
Chuachote Hansasuta, Bangkok, Thailand
James D. Happle, Dearborn, Michigan
Ernest Hardway, II, Washington, D.C.
Frederick Harvey, Ridgewood, New Jersey
Frederick G. Hasty, Fayetteville, North Carolina
George H. Henkel, Denver, Colorado
William R. Hiatt, Kansas City, Missouri
Thomas J. Hicks, Jr., Atlanta, Georgia
Samuel S. Hirson, West Newton, Massachusetts
Stanley A. Hoch, Brooklyn, New York
John H. Hogeland II, Iowa City, Iowa
Kenneth G. Holcombe, Lafayette, California
Harold R. Horn, New York, New York
Charles W. Horton, High Point, North Carolina
James R. Hugg, Burlington, Iowa
Donald A. Igel, Omaha, Nebraska
Larry A. Jones, St. Joseph, Missouri
Jon A. Jourdonnais, Great Falls, Montana
Joseph E. Kafer, Bayside, New York
Duane E. Kalar, Palo Alto, California
Rudolph W. Keeling, Louisville, Kentucky
John N. Kent, New Orleans, Louisiana
Duncan A. King, Louisville, Kentucky
Russell T. Kittleson, Milwaukee, Wisconsin
Seymour Koster, Port Chester, New York
Richard A. Kozal, Summit, Illinois
Daniel P. Kozie, Chicago, Illinois
Robert K. Kuribayashi, Honolulu, Hawaii
Phillip A. Lainson, Iowa City, Iowa
Walter F. Lamacki, Burbank, Illinois
Travis L. Lanham, Fort Worth, Texas
Reed P. Larson, Salt Lake City, Utah
Carl C. Lau, Los Angeles, California
Joseph J. Lawrence, New Orleans, Louisiana

Miles D. Lazerwitz, Paterson, New Jersey
Theodore Kuonjam Lee, Oakland, California
John M. Leitch, Farmington Hills, Michigan
A. Lewis Leo, Gainesville, Florida
Farrell F. Le Vasseur, Bay City, Michigan
Hal E. Leyland, Nassau, Bahamas
Helyn A. Leuchauer, Hollywood, California
Jack A. Lyons, Hearne, Texas
Emanuel H. Malamed, Philadelphia, Pennsylvania
John R. Mann, Jr., Brattleboro, Vermont
Frank T. Manning, Thermopolis, Wyoming
Roy S. Mar, Seattle, Washington
Vincent A. Mazzeo, New York, New York
Billy Westmoreland McCann, Memphis, Tennessee
Paul J. McKenna, Springfield, Massachusetts
William D. Mellert, Hawthorne, California
Hubert W. Merchant, Augusta, Georgia
Donald B. Merker, Zanesville, Ohio
Ray M. Miles, Monterey, California
Stanley A. Milobsky, Washington, D.C.
Charles R. Mitchell, Downers Grove, Illinois
John C. Montgomery, Iowa City, Iowa
Harry H. Morikawa, Honolulu, Hawaii
Patricia S. Moulton, Atlanta, Georgia
James K. Muller, Spokane, Washington
C. Renton Newbury, Melbourne, Australia
James E. Nicolette, Mt. Pleasant, Pennsylvania
Thomas G. Nisbet, Charlotte, North Carolina

Donald P. Noel, Klamath Falls, Oregon
Monica A. Novitski, Albuquerque, New Mexico
Sherwood R. O'Kuhn, Passaic, New Jersey
Theodore R. Oldenburg, Chapel Hill, North Carolina
Franklin L. Oliverio, Clarksboro, West Virginia
M. Darril Opdahl, Stockton, California
Jack M. Osburne, Pueblo, Colorado
Francis V. Panno, Mamaroneck, New York
Charles E. Parkin, Salt Lake City, Utah
William R. Patteson, Baltimore, Maryland
Michael L. Perich, Sacramento, California
Charles Perlman, Houston, Texas
Robert G. Pickard, Veterans Administration
William L. Podesta, Mattoon, Illinois
Scott H. Polizotto, Valparaiso, Indiana
Henry Pollard, Portland, Maine
Prem Prakash, Bombay, India
Louis T. Pratt, San Antonio, Texas
William R. Priest, Saginaw, Michigan
Donald B. Proctor, Winnipeg, Canada
Robert Rapp, Pittsburgh, Pennsylvania
Marvin W. Reed, Germantown, Tennessee
Robert S. Reid, Castro Valley, California
Nancy J. Reynolds, Columbus, Ohio
Malvin E. Ring, Batavia, New York
Barbara B. Rocco, Allendale, New Jersey
Sam W. Rogers, Jr., Houston, Texas
Mildred Romans, Washington, D.C.
Wendell M. Rovelstad, Elgin, Illinois

- Joseph E. Rowan, New York, New York
David L. Russell, Birmingham, Alabama
Nicholas D. Saccone, Scranton, Pennsylvania
Jeremiah Sachs, Kingston, New York
Baxter B. Sapp, Jr., Durham, North Carolina
Francis M. Schmitt, Garden City, Michigan
Orval H. Schroebel, Stockton, California
Albert W. G. Schubert, Great Bend, Kansas
David J. Seitlin, Miami, Florida
Frank F. Shuler, Jr., Clinton, Wisconsin
William F. Slagle, Memphis, Tennessee
Leon Slavin, Winchester, Virginia
Irwin A. Small, Birmingham, Michigan
Robert A. Smith, Johnstown, New York
Robert Lee Smith, Jr., Little Rock, Arkansas
Thomas E. Sommerdyke, Grand Rapids, Michigan
Robert E. Sprott, Napa, California
Paul A. Stephens, Gary, Indiana
Michael Timko, Pittsburgh, Pennsylvania
Leonard J. Tocci, West Newton, Massachusetts
Jimie A. Vance, Miami, Florida
Robert E. Vonada, Altoona, Pennsylvania
Paul D. Wachter, Omaha, Nebraska
Leo C. Ward, Los Angeles, California
Claude P. Warden, Walnut Creek, California
Douglas H. Warren, Vancouver, British Columbia
R. Winston Warren, Crawfordsville, Indiana
William H. Watson, Nashville, Tennessee
Otis L. Wedum, Denver, Colorado
John T. Welch, Morgantown, West Virginia
Scott M. Welch, Lovell, Wyoming
Donald A. Welk, Oklahoma City, Oklahoma
Raymond P. White, Jr., Chapel Hill, North Carolina
Ralph C. Wilkins, Fresno, California
Charles E. Williams, Jr., Chicago, Illinois
Edward C. Williams, Midland, Michigan
James H. Williams, Dallas, Texas
Robert J. Wilson, Gaithersburg, Maryland
Charles R. Wold, Salem, Oregon
Merwin Wolf, Bronx, New York
Cullen C. Woods, Oklahoma City, Oklahoma

SYMPOSIUM

Alternatives in Oral Health Care III The Origins of Treatment Demands

This is the third in a series of annual programs that are considering *Alternatives in Oral Health Care*. The first program in Washington in 1974 examined *The Kinds of Delivery Systems*. The second, in 1975 in Chicago was a panel discussion on *The Role of the Specialist in the Delivery of Care*. This year's program considered *The Origin of Treatment Demands* from three different standpoints.

The influence of the Oral Disorder in Initiating Treatment Demands was presented by Richard E. Bradley, a periodontist and dean of the University of Nebraska College of Dentistry.

The Role of the Dental Patient in generating demands for care was discussed by William B. Nienaber, a general practitioner of Minneapolis, Minnesota.

The Effect of the Third Party in developing treatment demands was reviewed by Lloyd J. Philips, a general practitioner of Indianapolis, Indiana and currently president of the American Fund for Dental Health.

The College has the unique capability of drawing from a wide range of competent authorities within its Fellowship to discuss these aspects of our profession and its responsibility to society. Whether they are educators, researchers or practitioners, they bring their particular expertise to this Symposium. When they speak, it is not only as experts in their various fields, but also as Fellows of the American College of Dentists, who are interested in promoting the purposes and objectives of the College, thereby enhancing its efforts to serve the profession and the public.

The Origins of Treatment Demands

The Oral Disorder

RICHARD E. BRADLEY, D.D.S., M.S.

There is a tendency for professions to sometimes become so preoccupied with themselves that they become insensitive or unmindful of the forces that brought them into being. Obvious, but sometimes obscured by this inward focus on ourselves, is the fact that our organizational structure, our mission and our future are based on the disorders and diseases that we are asked to treat. We must constantly remind ourselves when planning for the future that the genesis of our profession came from the needs and demands of human beings with oral disorders and diseases.

Caries, periodontal disease, malocclusion, oral facial defects, oral cancer and a wide variety of inflammatory lesions of the oral mucous membranes are the same diseases that brought us into being and with little exception are where our attention still centers.

There is no question that our knowledge and understanding of these diseases has increased significantly through the years, but it is interesting to observe that two of them, caries and periodontal disease, are still considered the most prevalent diseases known to mankind. The universal and progressive nature of oral disease has few counterparts among human ailments. Thus, the distinctive difference between medicine and dentistry emerges. Many of the diseases treated by physicians are self-limiting and undergo remission regardless of treatment. Others respond to advice and prescription. Not so with most of the disorders faced by dentists. The carious lesion does not heal itself. Alveolar resorption from periodontitis does not undergo spontaneous remission. These differences, then, place demands on dentists unlike those that confront physicians. The resulting accumulation or backlog of oral

Presented at the annual meeting of the American College of Dentists at Las Vegas, Nevada, November 13, 1976. Doctor Bradley is Dean of the University of Nebraska College of Dentistry, Lincoln, Nebraska.

disease requires health services that are technically demanding, time consuming and, many times, costly. While these differences are well known to us, they are not fully understood by many who would project our future role in the same context as medicine. The recurring nature of oral disease, the time needed for treatment per patient, the unique type of physical facilities and equipment needed by dentists and the very nature of dental treatment itself are all factors that mandate knowledgeable differential planning.

In order to gain a better perspective of the oral disorder and its relationship to the demands confronting the dental profession, it can be reviewed from the following aspects:

1. Incidence
2. Cost impact
3. The disease process
4. Relation to general health
5. Prevention
6. Manpower considerations
7. Societal consideration

CARIES

Health examination surveys conducted by the Division of Health Examination Statistics reported figures in the late sixties and early seventies that depicted the prevalence of caries in adults aged 18 to 79 and youths aged 12 to 17. Of those who still had teeth, "More than one-half had more than 18 decayed, missing and filled teeth."¹ Less than one percent of the adults who had all 32 teeth were without caries or restoration. The average number of DMF teeth per person was estimated at 17.9 (1.4 decayed, 9.4 missing, 7.0 filled). In the younger population, the studies showed a DMF ranging from 4 in 12-year-olds to 8.7 in 17-year-olds. Differences in the prevalence of tooth decay measured in this manner were small among various demographic factors. But the association between filled teeth and increasing family income and between decayed and extracted teeth and decreasing income is significant and serves to emphasize one of the chief delineators in the level of dental care.

It is estimated that there are around 700 million unfilled carious lesions in the United States population and that caries afflicts 98% of all Americans at some time in their lives. Caries is responsible for most of the loss of teeth in children and young adults and is probably the most common cause of pain in children.

Tooth loss caused by dental caries accounts for impaired speech, malocclusion, faulty mastication, undesired esthetics and even emotional distress. Even the process of extracting such teeth poses certain problems. Persons with heart conditions may be endangered by the introduction of harmful bacteria as the result of tooth extractions, not to mention the fear sometimes arising from childhood extractions that may have lasting effects on adults which discourage them from seeking periodic dental care.

PERIODONTAL DISEASE

Periodontal disease in the United States is the greatest cause of loss of teeth in persons over 35. Fifty percent of our population has chronic destructive periodontal disease at the age of 50, and nearly everyone is afflicted by the age of 65. Projections based on the latest population figures indicate that of the 127 million adults in the United States who retain some of their teeth, 94 million have periodontal disease, and of that number, 32 million have it in the advanced form. Periodontal disease is not confined to adults. Gingivitis which may be the precursor to an advanced form of periodontal disease is observed in four out of five individuals before the age of fifteen. Six percent of children have frank periodontitis. It is estimated that of the more than 94 million persons affected by periodontal disease, at least 25 million receive no care and others only partial care.²

While not a disease entity in itself, edentulism is a serious handicapping type of disorder arising from the neglect of periodontal disease and caries. In 1971, there were an estimated 22.6 million edentulous persons in the United States. Expectedly, 86.3% of those persons were 45 years or older. In the 13-year period ending in 1971, there was a marked decrease in edentulous persons over 45. This could be interpreted as an improvement of dental health in the United States. However, these people are as surely handicapped as persons who lose other appendages and pose very special problems.

MALOCCLUSION

It is difficult to ascertain accurately the number of people in the United States who obtain orthodontic care. Estimates out of Canada reveal that about one percent of the Canadian population receive orthodontic care in any given year. If this holds true for the United States, it is, indeed, unfortunate because Moller estimates

that 20 to 30 million children in America have malocclusion. Further studies indicate that 24.4% of Americans have normal occlusion, 39% have minor malocclusion, 22.4% have definite malocclusion where orthodontic treatment is elective, 8.7% have malocclusion where treatment is needed and 5.5% have malocclusion where treatment is mandatory. As can readily be seen, therefore, the incidence of malocclusion vastly exceeds treatment capability — a characteristic of oral disease. Further, malocclusion has been related to tooth loss, periodontal disease and eating difficulties. Unfortunately, treatment for malocclusion seems restricted to the white, upper middle class, adolescent child and more than any other oral disorder, its treatment is related to the size of family income.

CRANIOFACIAL DEFECTS

Each year, it is estimated that between 5000 and 6000 infants are born with cleft of the lip and palate. The frequency is highest in the Mongoloid races (1.7 per 1000 births), intermediate among Caucasians (0.6 to 1.3 per 1000 births) and least among Blacks (approximately 1 per 2,500 births). These deformities constitute about 13% of all reported birth defects. Such deformities, if not treated properly, make it difficult to speak, breath and swallow. They also increase susceptibility to upper respiratory conditions and deafness. The team approach to the management of these disorders has proved to be the most successful, the orthodontist, the prosthodontist, the oral surgeon, the plastic surgeon, the pedodontist or general dentist, the psychologist and the social worker all serving as prime members of such a unit.

ORAL CANCER

Oral cancer kills about 800 Americans annually. It is most frequently found in men over the age of 40. Oral cancer constitutes approximately 3 to 4% of all cancer. Lip cancer accounts for 25 to 35% of all oral cancer, while the tongue and the floor of the mouth are the next most common sites. Because of early absence of pain, many oral cancers go unnoticed and undetected. If oral cancer is detected early and proper therapy instituted, many of the patients are alive after five years. Lip cancer is 85% curable.

However, as stated by Kegeles, in the United States in those areas in which the best dental care is available, the cure rate of cancer of the oral cavity does not exceed 30%. This seems to be

due principally to the fact that most oral cancers are detected and brought to treatment at a relatively late state. A series of epidemiological studies from around the world indicate approximately the same findings.

Cahn's comments are most appropriate:

"It is a paradoxical fact that although squamous carcinoma is more prevalent in the uterus than on the tongue, the cure rate is much higher for uterine cancer than for lingual cancer. This would seem strange since the upper vaginal vault is certainly less accessible than the oral cavity. Uterine cancer has a higher cure rate because it is discovered earlier mainly through routine cytological examination."³

COST IMPACT

It is well known that oral disorders are responsible for substantial loss of time from work and other normal activities. It is estimated that in the United States' noninstitutional population, 6.7 million work days are lost each year due to acute and chronic dental disease. Oral problems cause 29.6 million days of restricted activities and 10.8 million bed days are due to oral disease. It is further estimated that the annual dental bill of the American public is in the neighborhood of 7.5 billion dollars. An excess of two billion dollars a year is spent on tooth decay. This does not include the construction of the prosthetic devices that follow tooth loss. Further, it is estimated that 1.5 billion dollars are expended each year for the treatment of periodontal disease. The cost of habilitating a cleft patient through the 18th year is approximately \$30,000. Totally, it is estimated that 190 million dollars are spent annually for the treatment of this disorder.

The source of funding such large outlays for dental service comes primarily from the private sector of our population. In fact, only 5.3% is funded from public monies. In contrast, physicians' services are funded at the level of 24.7% from public sources, and, as economic studies confirm, increase in demand for health services is directly related to the increase in public support. This is something dentistry might consider in projecting future provider levels if larger amounts of public monies are expended for dental care.

It is evident, then, from the foregoing information that oral disorders continue to be a major health problem in our society. This is an interesting paradox when less than half of our population is seeking or is able to seek dental care.

CARIES

Once the carious process has started, unless treated, it will progressively destroy the calcified structure of the tooth and cause death of the pulpal tissue. The etiology of caries is complex but basically one that is a refined version of the chemoparasitic theory of Miller's published in 1890.⁴

The initial caries attack is a process of localized acidic demineralization.

There are three essential criteria for the initiation of the caries process:

1. A dietary carbohydrate substrate
2. Bacteria capable of anaerobic fermentation of CHO to lactic acid
3. Susceptible tooth structure upon which fermentive acid by-products act to produce demineralization.

It should be recognized that there are other significant variables important enough to alter the process by predisposing to either rampant progression or marked inhibition. Further, the essential factors contain a broad range of variability which may determine whether or not a person is caries prone or caries resistant. The combination of the essential factors with secondary factors of influence, such as saliva, plaque constituents and oral hygiene actually determine the presence or absence of caries.

It has been long recongized that the ingestion of certain nutrients, namely carbohydrates, play an important part in the progress of caries. It is now widely accepted that carbohydrates are an essential ingredient for all types of carious activity and also serve as a substrate for ATP synthesis which is necessary for bacterial survival and proliferation. It is also known that dietary carbohydrates to be active in the carious process must be in readily useful monosaccharide form or be broken down to that form by bacterial activity. Glucose, for example, once liberated from sucrose readily enters the cell of most bacteria. It is then metabolized by anaerobic glycolysis to a variety of by-products, including lactic acid. Simple monosaccharides provide the primary energy source of bacteria common to the tooth surface. In the presence of excessive carbohydrates, a surplus becomes available which may be directed toward alternative metabolic pathways, namely, the synthesis of various polysaccharides which become essential ingredients of the villainous plaque.

The literature is replete with papers dealing with bacteriology of caries. Fitzgerald and Keyes in 1960 demonstrated that inoculation of microorganisms isolated from carious rodent teeth would initiate caries in germ-free rats and albino hamsters providing the diet was rich in sucrose. While they did not specifically identify the bacteria involved, they were generally grouped as "cariogenic streptococci." One of the characteristics of such colonies was that when they were incubated with sucrose they produce copious amounts of a sticky material identified as extracellular glucans. More specific identification of their nature revealed that they were a streptococci similar to a strain described by Clarke in 1924. They were given the name *Streptococci mutans*. In spite of the vast numbers of bacterial species associated with dental caries, *S. mutans* remain the prime culprit. Because of a peculiar property of *S. mutans*, these bacteria do not adhere to soft tissues but readily colonize on trauma-free tooth surfaces in the presence of dietary sucrose. It is clinically significant that because colonization does occur easily or at random, minor physical abrasion is sufficient to prevent colonization on tooth structure. The relationship of plaque to *S. mutans* is easy to understand because of the bacteria's propensity to form abundant viscous plaque itself. With such characteristics, it assumes the No. 1 ranking in initial early phase of smooth surface caries.⁵

As stated earlier, there are many other bacteria, particularly strains of streptococci, that play a secondary role in caries formation. It has been reported that lactobacilli are related to smooth surface caries only after prior demineralization and cavitation have taken place. Lactobacilli may, however, play a great role in pit and fissure caries. Such anatomical locations provide for the establishment of different bacteria without prior plaque buildup.

Whether or not caries is an infectious disease is still questioned. There is, however, investigation at the present time into the possibility of developing a vaccine that could control human caries. It is interesting, however, to note that some authors feel caries is not truly infectious and that the research directed toward that concept may be fruitless. Their reasons are based on the fact that injury to the enamel does not involve a cellular reaction between the offending microbiological agent and the host tissue. Hence, the lack of host response would not initiate immune mechanisms except in the advanced stages of tooth destruction.

It is apparent that much is known about the process of caries. The ultimate value of this knowledge will be how it can be put to use in the prevention and/or control of the disease.

PERIODONTAL DISEASE

Our understanding of periodontal disease, while it has improved considerably over the last twenty years, is still far from complete. It is a complex disease process and like caries has a number of complicated etiological factors. Our general understanding of the inflammatory process has contributed significantly to a better understanding of periodontal disease. Extensive epidemiologic studies consistently show that age and plaque are the key variables that affect the severity and rate of the disease. The response of the host varies considerably to the virulence of the plaque organisms — all the way from a mild gingivitis to a fulminating terminal periodontitis. As with caries, prevention of plaque does more to combat periodontal disease than any other single factor. The destructive nature of the disease makes treatment a time consuming, often expensive, episode for the patient.

I will not go into a detailed description of plaque — suffice to say, it is a complex mixture of dense microbial elements enmeshed in a gel-like matrix of salivary products and bacterial polysaccharides. The role of plaque in the initiation of caries is well documented and easy to understand in that it brings into close approximation to the tooth the bacterial products responsible for demineralization.

Likewise, in periodontal disease, microbial plaques and pocket flora are the initiating factors in gingivitis, periodontitis and periodontosis. The complex immunological host responses play the major role in the maintenance of periodontal inflammation. Simply stated, bacteria in the gingival sulcus seem to cause an increase in the permeability of cellular epithelium and dental plaque antigens pass through this epithelium to produce an immune response to the underlying tissue.

Research by NIDR has emphasized:

1. Understanding of periodontal tissue structure and metabolism.
2. Periodontal microbiology.
3. The process of inflammation and immune response to periodontal disease.
4. Prevention and diagnosis of periodontal disease.⁶

The important role of microbiology in the understanding of periodontal disease cannot be overemphasized. However, even in the last decade, there has been surprising little attention paid to the nature of microorganisms associated with diseased and

healthy periodontal tissues. Admittedly, the task assumes formidable proportions when we realize that as many as 100 to 150 species of microorganisms can colonize in periodontal tissue. The nature of the organisms make it very difficult for culture and the variability from patient to patient and site to site on the tooth further complicates the problem.

There has been progress made, however, in this area. Culture studies show a striking increase in early gingivitis of an organism known as *Actinomyces israelii*. As gingivitis intensifies and later plaques develop, a second organism, *Actinomyces viscosus*, shows a significant increase. Plaque associated with periodontitis seems to harbor a filamentous bacterial organism. Between the plaque and the epithelial lining of the pocket, there is a group of unattached microorganisms which consist almost exclusively of spirochetes and rods with cell walls characteristic of gram negative organisms. In the examination of teeth involved with periodontosis, there is very little bacterial plaque present but large numbers of gram negative organisms are observed in the depths of the pocket.

The groups of gram negative rods thus identified in periodontosis were quite different from the species of gram negative rods predominant in rapidly advancing periodontitis. This could be a very significant finding and while the investigations are recent and their full significance is not fully developed, it could lead to new modes of control and treatment. While we are gaining more and more information about the fundamental periodontal disease process, there are other factors, both local and systemic, which are known to influence the progression of the disease. Unfortunately, many of these factors are iatrogenic. The overhanging margin, the improperly contoured and overextended crown, the primary and secondary trauma induced by improperly constructed fixed and removable prosthetic appliances are all examples of built-in irritants.

The diagnosis of periodontal disease seems to be much more difficult than the diagnosis of caries. For this reason, many of our patients are not treated early enough and suffer unnecessarily the discomfort of the disease and loss of teeth. Good eyesight, a sharp explorer and good contrasting xray films make the detection of caries a fairly simple task; however, the subtleties of early periodontal disease tend to be passed over by many practitioners. While there is new research into better ways to diagnose periodontal disease, the best available tools that we now have are

the periodontal pocket probe and the xray film. This coupled to an operator with a good understanding of tissue morphology and inflammation can do more to detect periodontal disease than anything yet devised. The elaborate instruments that measure tooth mobility and sulcular fluid, while interesting experimental tools, are too time consuming and impractical to be of general use.

While periodontal disease may more closely resemble an infection than caries, there is still a marked difference between the true infections and the nature of the periodontal lesion. Again, it is more of a host type immune reaction similar to the arthritic diseases than it is a classical infectious process. I am sure there will be some fruitful research into the possibility of developing vaccines that could be effective against some of the bacteria that are associated with the periodontal lesion. As you know, however, such a vaccine has not been developed. We, therefore, must concentrate on preventive measures that will have widespread convenience and effectiveness.

MALOCCLUSION

For the most part, current investigations in orthodontics deal with therapeutic considerations and studies of growth and development. There is little information regarding the prevention of malocclusion in our population. Genetic studies are being undertaken that will yield valuable information. Also, a better understanding of the factors which affect growth and development of the oral structures will give us basic information with which to better understand the etiology of malocclusion. A great deal of information about the behavior of periodontal tissues has come about through research directed at the effect of various forces induced on the periodontium during orthodontic treatment.

Unfortunately, the scarcity of information makes it difficult to ascertain the effect of prevention on malocclusion. This, of course, is a result of the lack of complete understanding of the determinants of facial growth and dental development. Early interceptive orthodontics is a method widely used to prevent the development of malocclusion. The results are variable but often successful. Another preventive method that is highly successful is the retention of the primary dentition. It is a fact that premature loss of the primary dentition is directly related to unsatisfactory alignment of the permanent teeth.

CRANIOFACIAL DEFECTS

As with malocclusion, more research is needed into the genesis of some of the severe cranial-facial defects. The cleft lip and/or palate are some of the most common of all birth defects and, yet, little, if anything, is known about their etiology. Research in this area is centered around the process of gene activation, translational mechanisms of proteins, cell surface specificities, cell migratory patterns, mechanisms of intercellular adhesions, integration of various organ systems within the developing embryo and hormonal control of developmental morphogenetic processes. Further, important information in this type of birth defect may be forthcoming from epidemiologic studies of disease prevalence and the surveillance of populations for possible teratogenic effect of new drugs, environmental pollutants and epidemic-type infections.

ORAL CANCER

We are all familiar with the intensive research programs investigating the nature and cause of cancer. Millions of dollars are being spent annually by the Federal Government and by private foundations to seek out the cause and to provide better methods of control and treatment of all forms of cancer. It is becoming increasingly apparent that cancer has multiple etiologies and that the host response, as in periodontal disease, may be one of the keys that will unlock its mystery. Certainly, the early diagnosis of oral cancer has to rank high as one of the prime responsibilities of the dentist. The dentist is one of the first health professionals to be consulted by a patient who has a suspected oral lesion. Even more important, however, is his ability to detect the lesion without symptoms.

Early detection must be emphasized over and over again as our only effective weapon in curing this disease. The use of Papanicolaou cytology and the surgical biopsy are the methods of choice in examination of suspected lesions, but even more important is the emphasis that should be placed on a thorough examination of all soft and hard tissues by the dentist. It is interesting that the floor of the mouth is the area most neglected in the examination process and the one where a high incidence of mouth cancer occurs.

Oral cancer is unquestionably related to smoking tobacco, betel chewing and the use of alcohol, and the actual site of the lesion

can be traced to the location of the irritant. It would seem that, because of the close association between smoking and oral cancer, it would be relatively easy to effect a reduction in incidence by anti-smoking campaigns. However, as in lung cancer education, the reduction of smoking is short lived.

ORAL DISEASE IN RELATION TO GENERAL HEALTH

In 1910, William Hunter, a distinguished English physician read a paper before the medical faculty of McGill University in which he severely indicted the dental profession. He said, "No one has had more reason than I have had to admire the sheer ingenuity and mechanical skill constantly displayed by the dental surgeon and no one has had more reason to appreciate the ghastly tragedies of oral sepsis which his misplaced ingenuity so often carried in its train. Gold fillings, gold caps, gold bridges, gold crowns, fixed dentures, built in, on and around diseased teeth, form a veritable mausoleum of gold over a mass of sepsis to which there is no parallel in the whole realm of medicine or surgery."⁷

Even though Hunter's knowledge of oral disease was limited and he was confusing simultaneous occurrence with etiology, his impact on the practice of medicine and dentistry was significant. Nonvital teeth were routinely condemned even if they had been properly treated. Virtually every disease was blamed on infected teeth, particularly those the physician could not readily diagnose. Indiscriminate extractions were the order of the day and only after hundreds of thousands of sound teeth had been sacrificed in vain would the fad begin to wane. Easlick, in 1951, after a three-year study published an 84 page report to the Council on Dental Health of the American Dental Association.⁸ He drew three conclusions which are worth noting:

- "1. Dentists must remain concerned about a demonstrated infection in the mouth or any part of the body because of the possibility of local extension of such an infection, or the invasion of the bloodstream of such an infection, or the invasion of the bloodstream to the extent that the host's numerous defensive mechanisms are overwhelmed.
- "2. Dentists appear to have sufficient information to warrant particular concern about oral surgical intervention or the presence of oral foci in the mouths of patients with valvular heart disease. *Streptococcus viridans*, common residents of the oral cavity and pulpless teeth most frequently are associated with subacute bacterial endocarditis and adequate

evidence has been presented over a period of years of the occurrence of transient bacteremias after surgery of the mouth.

- "3. The evidence is extremely poor in support of an etiologic relationship between oral foci and joint disease, heart disease (other than in those patients with valvular damage or congenital heart lesions), renal disease, ocular disease and skin diseases. Dentists should continue to eradicate oral foci, then, as a therapeutic measure, not as a curative measure."

There is direct evidence that oral disease can have an impact on the general health of an individual both physically and psychologically. Certainly, the complete dysfunction of the oral apparatus or the extension of infection into adjacent structures, or the metastasis of the oral cancer to other parts of the body can have devastating effects on the body. Of interest also is the effect that systemic disease can have on inflammatory diseases of the mouth. It is well known that the uncontrolled diabetic patient who has severe periodontal disease requires more than local treatment. The underlying disease can modify the course of infection and inflammation so as to render oral therapy useless. The wide variety of systemic diseases that are manifested in the oral cavity further substantiates such interrelationships.

PREVENTION

Our ability to effectively deal with the oral disorders is related to many factors but possibly none so important as prevention. While it is true that we have little enough control over the absolute dental needs of our population, we are obligated to recognize that it is from these needs that the demands for care arise. If we concern ourselves with only what is demanded of us as a profession, society will continue to search for more control of our actions and destiny. One of the areas that holds great promise for the profession is the increasing awareness of prevention. In the broadest sense of the term, effective preventives are those that reach the largest number of people with the least amount of expense and effort and produce the optimum results. Using this definition, nothing used so far has surpassed the effectiveness of fluoridation of public water supplies and, yet, during the last decade, there has been a slowing down of efforts to increase the exposure to fluoridated water. It is estimated that about half the

population the population of the United States is now drinking fluorinated water but only one-fourth of community water supplies are treated. Most epidemiological studies reported 50 to 60 percent reduction in caries. Yet, the anti-fluoridationists, through scare tactics, irrational and unfounded medical claims have been able to defeat attempts to fluoridate water in community after community.

Knowing full well the effective potential of fluoridation, the dental profession should resume a vigorous approach in its promotion. While not 100% effective, fluoridation, used in combination with other preventive methods, produces a dramatic decrease in the incidence of carious lesions. Other agents, such as pit and fissure sealants, dietary additives which reduce the effect of bacteria, antimicrobial agents which reduce plaque formation and the possibility of vaccines, are all under considerable investigation. Of the preventive methods for home use, nothing yet has surpassed the toothbrush. It is the single, most widely used adjunct for oral cleansing and, if used properly, toothbrushing still remains the most practical method of plaque disruption and removal except in the interproximal spaces.

The use of other aids, such as dental floss, toothpicks, water spray devices and a variety of especially constructed interproximal brushes are effective but only to the degree that the patient can be motivated to use them. This very fact severely limits their exposure to large segments of our population.

Public oral health education is a very important facet of prevention. The oral health programs of the ADA and the many educational programs offered to the public by the AAP, PHS, ASPD, and local professional dental societies are serving well in this regard and need to be continued with increasing vigor.

Oral health education goes on, not only in the dental office but in schools, hospitals, nursing homes and many other institutions where there are captive audiences in need of such instruction. Many industries have health education programs for their employees. Hospitals are involving themselves in outreach programs that deal with all types of health education. This is also the type of activity that is likely to increase the awareness of the public to the benefits of oral health and thereby increase the demand for more dental services.

The impact of prevention on oral disease is difficult to measure. In communities that are fluoridated, there are scattered reports that some pedodontists are returning to general practice or pre-

paring themselves for other specialties. Many dental schools are also reporting less pedodontic activity than is desired. If this is, indeed, a valid trend, then adjustments in our profession are forthcoming and, after all, we have to expect that if prevention is effective, it will change practice patterns.

MANPOWER CONSIDERATIONS

There are a number of factors which could have a dramatic effect on the ability of dental manpower to provide demanded services. Such factors as we have discussed under prevention — the possibility of an ever increasing amount of third-party payment systems, the eventuality of national health insurance, population factors, increased life span and public awareness of oral disease — are a few of the variables that will affect our capability to keep pace with the demand. Fortunately, the profession has increasing ability to accommodate such variables. There is no doubt that the dentist of today is capable of seeing more patients and performing more tasks than he was fifteen years ago. His productivity has increased considerably. Improved materials, equipment, techniques and more effective use of auxiliaries are largely responsible. While the auxiliary issue is still being debated, I feel that it has to be resolved in order to continue to provide dentistry with better trained paraprofessionals.

In the special report from the Council on Dental Education concerning dental auxiliary utilization and education comes some wise advice:

"It is the Council's observation that the growth and vitality that dentistry has exhibited over the past century is the result of its acknowledgment of the need for research, experimentation and orderly change. To maintain this vitality, the profession must continue to be sensitive to society's needs. In recent years, the greatest challenge to health professions has been the charge that they are not responding to demands for health care. Regardless of the accuracy of the charge, it has persisted and the profession must continually demonstrate its commitment to providing quality care to the American people."⁹

All of the current avenues available to us with which to deliver oral care need to be continually studied and improved. I see the private sector as remaining the prime source of such care, but also recognize the important role of the tax supported Public Health dental clinics, especially in the large cities where they continue to

play the role of provider to thousands of indigent children. New York has one million pupils from kindergarten through ninth grade. In 1975-76, 259,229 children were cared for by the private sector; 60,000 by health department clinics; and 62,844 more wanting care in such clinics.¹⁰ Unfortunately, over one-half million children in New York received no care in any given fiscal year.

Consistently demographic findings indicate that the number of dental visits per person per year is directly related to family income and probably to level of education. Between 1950 and 1965, family incomes more than doubled and the demand expressed in dental visits rose 56% (1.13 to 1.76 visits per year). If family income continues to rise, it is reasonable to expect more demand of dental service.

I do not anticipate further significant increases in the numbers of dental graduates, at least over the next decade. The new school boom is over and I think by now most dental administrators are completely fed up with having to increase their class sizes to qualify for capitation funding. The numbers game is a dangerous one and can have serious consequences in the quality of education offered our students. I can think of no greater disservice to the public than turning loose upon them dentists who were subjected to compromised educational programs.

Herman Somers recently commented on manpower policies for the future with regard to medicine. What he said has meaning for dentistry:

"... The mortality data show a preponderant incidence of preventable causes, but generally not of the kind that lend themselves to medical 'cure'. They reflect primarily the consequences of life style and personal behavior and portray circumstances wherein medical intervention is usually too late. . . . It now seems that the greatest potential for improving the health of the American people is probably not to be found in increasing the number of physicians or hospital beds, but rather in what people can be taught and motivated to do for themselves, in influencing personal behavior and attitudes."¹¹

One overriding question must be answered in manpower analysis and planning and that is, "Are the public's demands being met?" This, of course, is a difficult question but the answer must take into consideration the latent factors that translate into unmet needs in the patients we treat. For example, it has been

shown that general practitioners spend between 95 and 98 percent of their time diagnosing and treating the ravages of caries while only 2 to 5 percent of their time is devoted to periodontal disease. Epidemiological studies clearly indicate that in the adult population, periodontal disease is virtually universal. This discrepancy can not be compensated for by referral to specialists and has to imply that many patients who have periodontal disease are not receiving treatment and yet expect complete care.

Bailit,¹² using preliminary data, suggests that services rendered patients may be in a large part a "function" of the style of practice developed by the dentist and not just the patient's socioeconomic class or education. This "provider effect", he suggests, may be as inherent in dentistry as it is known to be in medicine. In other words, the needs of the patient are seen by the dentist to be met by what he understands and enjoys doing the most. Third party payers and peer review groups are most certainly apt to take a hard look at this phenomenon.

It is interesting to speculate what changes would have to occur in our delivery system if the dentist would routinely treat incipient periodontal disease, much less get involved with the more advanced forms of the disorder.

SOCIETAL CONSIDERATIONS

If, as Eli Ginsberg says, "Professional society exists for the benefit of its members", and that, "There is a basic struggle between the aims and goals of the members versus the needs and desires of the public",¹³ then it is no wonder that consumer interest in regulating us is at a high pitch.

The recent activities of the F.T.C. in investigating advertising regulations, price fixing in health professions and, more recently, the denturism issue, clearly indicates the power being exerted on the health professions by the public through the government. The familiar questions, "How do I gain access to dental care?" and "Why does it cost so much?" are being converted into government probing and legislative rulings that may eventually negate our "self-regulating" tradition. Yet, this is the situation and we must be prepared to offer alternatives that will be acceptable to the public and to the profession — a formidable task!

SUMMARY

In my opinion, the demand for the treatment of oral disorders will continue to increase. Increasing improvement of our under-

standing of disease etiology and treatment will foster such demands. In spite of the progress made in preventive dentistry, we have a long way to go before oral disease is conquered. In fact, saving more teeth by fluoridation may actually increase the magnitude of periodontal disease, an area already badly neglected. There are forces at work in society that will surely bring about more demand for the treatment of the ailments so universal as to affect virtually every person in the United States.

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The Origins of Treatment Demands

The Patient

WILLIAM B. NIENABER, D.D.S.

This morning as a panel we are discussing third party dentistry, the oral diseases, and the patient. Certainly the greatest variable in this trio is the patient. In discussing the patient it soon becomes evident that of necessity one's thoughts are mostly subjective because there is very little hard data that describes the patient. We can count them — or can we? A person does not become a patient until he actively seeks dental care. What more do we know of this potential or actual dental patient? What does he really want from dentistry's health care? It is indeed interesting that we as a group, to my knowledge and the knowledge of others I've questioned, have never formally asked this question of patients. Independent researchers and some health planners have made some attempts but not dentists themselves. This might be a most enlightening project, a project that might be well undertaken by the College at some future time. To better know this patient, let us try this morning to sit down in the dental chair, looking up for a change. I have to do this frequently and I always learn something.

Now the reason I'm here as a patient is because I want to have a pleasant appearance, I want my mouth to feel comfortable, and I would like to be able to chew. These three basic desires can run the gamut from the gold central to the shade 59 showman's smile, from a few teeth that occlude to the full mouth rehabilitation with a cuspid rise. What is comfortable to one patient, will keep another awake half the night. This patient with these three basic desires is already a complex entity. These differences are brought about by varied ethnic, geographic, socio-economic and philosophical backgrounds. Systems that must deal with these differences must of necessity be individualized and flexible. The

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more centralized third party systems are, the more difficult it is going to be to escape bureaucratic rigidity. Decentralized systems have a much better chance of being sensitive to these variables.

At this A.D.A. meeting I am sure we are once again going to lock horns on expanded duty delegatable tasks. The A.D.A., after hundreds of hours of hearings, workshops, and a truck load of paper cannot yet come up with a single formula that is suitable to even a majority of states. The reason? Vastly different needs in different areas. There should be a lesson here.

Sometimes we in dentistry have had a tendency to overlook individual needs that differ from our own. Some years ago, I had just finished rebuilding the dentition of a fifty-eight year old man with a cleft palate and severe speech handicap. I informed him that now I could proceed to make him an appliance to improve his speech. "Young man", he said — and I was young then, "I have talked this way for 55 years. I'm a successful small town physician, own three farms, have served as mayor, councilman, and president of the school board. If I change my sound now people will think I'm putting on airs". I've often thought that it was too bad that he didn't let me help make him a "success".

Third party dentistry must be sensitive to patients' individual desires. Centralist systems, run by well meaning health planners hundreds of miles away from the problem are going to have a difficult time both defining the problem and solving it. Individual dental offices or local health care units will be more efficient. Dental health care, however provided, is not the whole answer to the problem. Patient responsibility is a great factor. One of the conclusions of a national health study brought before Congress was: "Health care has little to do with health" — about 10% by some estimates. The great recent increases in life expectancy have come largely from reduced infant mortality. Life expectancy for people who reach the age of 55 has only increased two years since 1900. If health care cannot greatly influence the nation's health, individual living habits can. Any consideration of national health insurance should therefore seek ways to encourage people to take better care of themselves.

THIRD PARTY SYSTEMS

Patients are, in a very important way, responsible for their own state of health. Third party systems that will encourage patient responsibility by co-insurance, economic incentives for utilization

of preventive measures, and patient education will be a great help in improving dental health. It is disturbing that 69% of dental insurance plans today work on a deductible basis with the first \$25 usually deductible. The first \$25 is usually the buck that has the biggest bang in prevention. Delta Dental Plans and other carriers that have recognized this need should be commended.

A complex question to ask ourselves is, "Should a patient that takes good care of himself have to suffer the burden of higher premiums or higher taxes to cover his less responsible neighbor?" Education of the consumer is going to have to stress the point over and over again. Careless health habits and living patterns are expensive! Although third party dentistry seems free to many, it all costs in salaries that might have been raised in lieu of the fringe benefit increases and in taxes that could be lowered with less health care expense. People must be made aware that increasing health care costs to governmental systems means that those dollars spent are millions of dollars that cannot be spent on education, food and shelter. Federal dollars are not even free to the non-producer. Federal dollars are indeed the most expensive dollars that can be utilized for health care. The reason of course is the concomitant increase in administrative expense. The more centralist the health care system, the smaller that part of the dollar used in direct patient care. In Great Britain from 1965-75 hospital staffs grew 28%, but non-medical administrative and clerical staffs had increased by 51%.

QUALITY CARE

In at least one area, patients' needs and patients' desires are identical. As a patient sitting in the dentist's chair, I need and I want quality care. Is the profession delivering it? Uniformly? The best in the world! That is a pretty small yard stick if you've seen much of world's dentistry. Most of the clinical dentistry we see is, I'm sure, competent. It is that other percent which is not, that should give us reason to worry. How many restorations do we see in patient examinations that wouldn't pass a state board examination? Is the board wrong or are we guilty of a double standard? How many cases of undiagnosed untreated periodontal diseases have we seen in patients that have had reasonably periodic dental examinations? This, by the way, is now one of the most frequent causes of malpractice litigation, and the most difficult to defend. Until we can be proud of all of our dentistry as well as the

dentistry we see coming in to our offices, our profession is indeed vulnerable to those who would despoil it. As a patient, one of the greatest steps forward I can see is the advent of peer review brought about by third party dentistry. Patients are becoming more knowledgeable consumers every day. They want quality care and assurances that they are receiving it. Quality care must start with students who have been adequately trained to be clinically competent.

QUALITY EDUCATION

Past years have brought an abundance of new curricula to our dental schools. In many instances this new material was placed into educational programs at the expense of clinical teaching time. I think we are now seeing renewed emphasis on the excellence of clinical performance in many schools. The federal government and hungry dental schools have in many instances, collaborated in expanded enrollments that have made it almost impossible to competently teach clinical dentistry. There are dental students today laboring in physical clinical surroundings that are more crowded and antiquated than the schools many of us attended 20-30 years ago. It is most disturbing that when an unbiased, outside and somewhat knowledgeable accreditation commission asks a dental school to cut back its enrollment to a level that is compatible with facilities and staff, they are unable to because of binding federal grants. In effect, federal authorities are saying, "You made the commitment and you will have to stick by it, even at the expense of quality education." In the past three years the Commission on Accreditation has had to tell eight institutions that they must cut back enrollments to assure quality programs and accreditation approval. We expect to find even more cases of this nature in succeeding years. Of these eight, four have made adjustments and four have to this time not been successful. Extremely bright and talented students are, in some instances, not being given the opportunity to reach their full clinical potential. As a patient this would be of grave concern to me. It should also be of concern to third party carriers, and most of all to our health planners.

AVAILABILITY OF CARE

Availability of dental care is another desire that concerns patients. Not having dental care available in the immediate vicinity

is of concern to most patients but it should have more direct effect on the poor because they are less mobile. I said "should"; it doesn't always follow. In our community, we are seeing some unexpected things in certain areas. A well qualified young black physician moves into a less-than-affluent center city community and is "broke" in less than two years. An excellent, experienced, group of women physicians in the same community are less busy than they were before. The reason? Funded patients in some instances are going into more affluent areas to receive treatment, and what is really intriguing is that government funds are being used to pay for the cab that takes them there. New guidelines for accessibility proposed by H.E.W. state that a source of dental care should be available within 30 minutes time, except under unusual circumstances, and that dental appointments should be available within two weeks time except for emergencies which should receive immediate care. In most areas this has been taken care of by supply and demand. Some years ago it would have been most unusual for a young dentist to set up practice in a town with less than 1000 population. In our state, in the last year, two young dentists have set up in towns of 650 population that are only seven miles apart. It was the best opportunity that they could find. Rural areas that were calling for dental practices in our state are now saying "Thanks a lot; we appreciate it, but don't send us any more." I am sure some patients would like to have us on every corner with open hours on Sunday.

There can be no doubt that the advent of third party dentistry has increased accessibility simply because more dentistry is being done. More dentists have been educated because of the emergence of funded dentistry. The question that many young unestablished dentists are asking is "Where does availability begin and where does full employment of dentists end"? There are more partially employed dentists in this country than we realize. Availability is a two way street. The dentist must be available, but since he cannot start before the patient gets there, the patient's failure to keep appointments breaks the whole system down. It has been the experience of many practicing dentists that funded patients, particularly fully-funded patients, have a higher incidence of broken appointments than do self-funded patients. Strong incentives are going to have to be made in third party plans addressing the problem of both patients and dentists in keeping their appointment commitments.

ECONOMIC ASPECTS

The economic impact to patients of third party dentistry is a most important consideration. In fact that is what its all about. It is really basic economics that brings us here today. If we look closely at most third party plans, their basic rational is an economic one. To overstate it only slightly, most proposed integrated national health programs, especially those referred to as national health insurance, are programs to cope with financial problems, not programs to cope with medical (or dental) problems. This is most evident in Great Britain where the economic problem of dental care has been "solved" (if for a moment we can forget the tax levy). However, the total effect on the nation's dental health is most unimpressive. It has been estimated that by age 45, fifty percent of the people in Great Britain are edentulous. In the words of Arthur Seldon, a London economist, "This is the fatal flaw of all state systems. They spend too little on actual dental and medical care, and the more that health services are financed by taxes the more debilitating becomes the weakness."

The economic advantage of third party payment to the patient seems self evident in our private practices. This may not be true in H.M.O. settings or to average income patients under national health plans. As an average-income or above-average-income patient you may be paying out more than you are getting in return. In our offices we can see that more patients are having regular preventive care, crowns instead of six surface amalgams, and edentulous areas restored. But how about the non-covered patient? Will the non-covered patient pay more for dentistry because of increasing third party coverage? Looking at a parallel example in hospital care costs, one must believe the danger is more than probable. If all hospital bills were paid "out of pocket" they could never, in God's world, have raised hospital costs to what they are today. The empire building of some enterprising hospital administrators has been legion. Their competitiveness is to be the best and the brightest at any cost, including technological duplication, is a fright and can be documented by most anyone who has served on a State Board of Health. Since most hospital fees are on a cost plus basis there is little incentive to keep costs down. Once we have lost the "pay out of pocket" consumer we have lost the greatest incentive to keep costs down. This I believe is a truism in all health services.

INTERPERSONAL RELATIONSHIPS

Finally, speaking as a patient looking up to you, I want you to take the time and have the patience to treat me like an important human being. Discussing this paper with a psychiatrist friend, I mentioned that worth of questioning patients about their needs in health care. His reply was, "I can tell you what they want, they want someone to set down with them and listen to their problems. Someone who will take the time and direct them. You know, we have now done over 800 kidney transplants at the University Hospital. Technically they're getting pretty good, especially in children — about 85% successful, but after the operation the surgeon goes on to the next one and the problem begins. These children have to take up to 40 pills a day. Mom is the dispenser. The kid gets mad at mom who then falls apart, and the biggest unsolved problem begins in the inter-personal family relationships. You know dentists have really got it made here. When you spend an hour and a half in two appointments making a crown for me, we have more communication than I would have had with a physician in open heart surgery. This is what patients want. I hope you dentists don't lose it.

In some instances, third party dentistry can facilitate this interpersonal relationship by partially diminishing the economic barriers. It is much easier to establish a warm, friendly doctor-patient relationship when the fee is of little concern. One of the strongest deterrents to a good personal-professional relationship is lack of choice for either party. Closed panels that deny patients free choice of dentists create forced relationships that have slimmer chances of creating and maintaining good personal-professional relationships. This is probably the reason that in dual choice options where union members have been given the option of closed panel care or contracted private practice therapy, they predominantly chose the private practice.

Third party systems whose goals are more economically focused are going to push for more and more delegation of duties in dentistry. This is one of the stated objectives in the basic H.M.O. concept. More prevention — more delegation — decreased costs. To my knowledge, at this point, more delegation has helped the dentist but has had precious little effect on the patient's pocket book. In our metropolitan and surrounding rural communities a prophylaxis is about \$14 no matter who does it.

Working on excessive volumes of people with super-delegation is going to give us less and less personal contact with that patient. We could lose one of the things that our profession is doing better than any of the other professions. That is spending time with the patient and creating strong relationships. It is expensive and sometimes tedious, but I would venture to predict that this could be the deciding factor in many people's choice to remain private practice patients. We really enjoy a unique position in service to people. If a patient spends two or three hours a year in a one-to-one relationship with his clergyman, physician, or attorney, one could assume that he has severe marital problems, spiritual problems, litigation problems, or a chronic disease. We have an opportunity to enjoy this one-to-one relationship with people who are for the most part healthy and want our personal attention. They are not getting it from many other sources. As my friend said, "I hope you dentists never lose it"!

We have, this morning, discussed the patients' concerns with third party dentistry in the areas of being sensitive to individual needs, meeting accessibility and economic requirements, addressing concerns about quality treatment, and maintaining interpersonal relationships.

Third party dentistry is here to stay in some form or another. The patients, by their votes are going to be the final arbitrators as to what forms of third party dentistry will exist. While it is most valuable to discuss these topics in groups such as this, and equally important to tell our story in public relations programs, our case will finally be won or lost in the dental chair.

So be nice to me when I look up to you as a dentist. You'll enjoy it! There are only 125,000 of you, there are about 60 million of me and that's enough to win any election.

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The Origins of Treatment Demands

The Influence of Third Parties

LLOYD J. PHILLIPS, D.D.S.

Obviously, one of the first things for me to do is define third parties. Broadly, I could define them as any entity that has a direct or indirect bearing on the relationship of a doctor and his patient in the delivery of dental care. That involvement could include partial or total reimbursement or direct payment to the dentist or the patient for the cost of that care. The third party could be an administrative agency such as a commercial insurance company or a union trust fund or a not-for-profit service corporation. It could be government — state and/or federal utilizing fiscal intermediaries to handle the administrative chores. There are still others; nevertheless, whatever the character of the third party there definitely is an influence. That influence varies in kind, extent and significance depending on the nature of contracts under which the third party functions and also the character of the third party. Regardless of whether the contracts are negotiated in the private arena or implemented under statutory provisions, or administrative rulings under those statutory provisions, the influence exists and is real, not imagined.

Several facts must be kept in mind because they are important and directly related to that influence.

In the private arena, contracts for dental care benefits have been written with varying degree of input from the dental community. Some contracts have had little input. In a labor-management bargaining situation, cost is obviously a prime consideration of one of the parties involved. The comprehensiveness of a dental benefit program will depend on the dollars available and may be curtailed, and usually is, when dollars are limited.

When contracts are signed, the provisions or stipulations and many times the specific details of administration are outlined. A third party in the free enterprise system will usually bid on the

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administration of that contract, and in the competitive marketplace and under the contract, management has the right to select the carrier or third party for that administrative task.

The flexibility of the third party's administration of the contract is limited. Concerns for costs and quality of care to be delivered may be in contract language and will be of concern to the third party during the life of the contract and, in particular, as the contract renewal time approaches. The stewardship of management's money will be examined and comparative costs of several third party companies will be competitively considered prior to selection of the carrier for the next contract period.

Now to be specific — when the third party attempts to decide on the extent of its liability and the determination of benefits, it will enforce contract language. And remember, it may have had little to say in what is in the contract. As an example, the alternate treatment concept of the least expensive, professionally adequate treatment being the extent of the contract's liability will be enforced by the third party. A full cast gold crown will be reimbursed at the level of an amalgam restoration if the third party, utilizing a dental consultant, decides that it is an adequate treatment. Now, I believe that is a definite influence on a patient's decision concerning the acceptance of a treatment plan proposed by the attending dentist. The wedge is driven between the patient and the doctor. Other cost control mechanisms such as limits on specific benefits, exclusions, non-covered, pre-existing conditions will also, by economic coercion, have an influence on the patient's decision concerning a treatment plan proposed by the attending dentist.

Without question prepayment for dental benefits has made more dentistry available to more people. This is good. Over 31 million people are covered under some form of dental prepayment in the private sector today with an estimate of 60 - 80 million by 1980. The influence of third parties grows simply by the number of people covered.

If we calculate simply the magnitude of the business by dollar volume, the significance is apparent. Available dollars for benefits can be calculated by using 750,000 U.A.W. workers at ten cents per hour, 2000 hours per year, and the figure is \$150,000,000. If you calculate eight per cent administrative cost and two per cent profit for purposes of illustration the figure is \$15 million for the administrators or third parties; their costs and profit. If you project the figures for 31 million people using three dependents for each worker and assuming the U.A.W. contract to be a prototype you

arrive at \$1500 million in premiums and \$150 million for costs of administration and profit. Now, the U.A.W. contract is one of the best, benefit wise, while most of the other dental contracts provide less benefits. Nevertheless, we are talking about a lot of dollars and in the marketplace, third parties, carriers, and insurance companies must demonstrate stewardship with other people's money if they expect to continue to get the contracts. That stewardship will center around cost containment and quality assurance. It is estimated that \$2 billion out of the total national dental bill of \$7.5 billion is directly involved in third party programs, private and government.

A significant influence is in the area of quality assurance. Contract language in most contracts stipulates some form of quality control. One plan proposes a two per cent random selection of treated patients covered under that plan in four treatment areas. This involves a post treatment professional review.

Government involvement in quality control will be implemented through PSRO legislation first at the institutional level and later in the ambulatory sector. Utilization review which I said, first in institutions and later in the ambulatory arena, will be both a quality assurance program as well as a cost containment mechanism.

Influence of all third parties, both by contract and by statutory regulation, will center around quality, cost containment and accessibility of the provider.

As federal laws are passed or as contracts are written with a given benefit package and as these become total payment contracts, carriers (third parties) will seek, through participating agreements, dentists, groups of dentists, corporate structures such as service corporations and HMOs to deliver that care. Reimbursement may involve a fixed fee per service, a fixed payment per capita, or a fixed sum of dollars to be disbursed on a usual, customary and reasonable schedule of fees with a maximum per service or a maximum for total services per provider. Management and labor today are seeking contracts that will cover total costs of dental care with the patient having no direct financial responsibility. As we approach this situation where the patient has no direct costs for the care, and the per capita allotment or cost per service is limited or fixed, we approach the situation when the dentist is fast becoming a salaries servant or employee. His office wherever that physical plant is located will become a satellite of the union-management contract and the insurance industry. Within that insurance industry, I include in a

broad sense, the commercial companies, the not-for-profit organizations, the dental service corporation, the Blues and government. The competitiveness among dental providers, as the unit of the provider becomes a larger multi-member corporate structure, will eliminate the need for the advertisement of fees because the service will be on a capitation basis.

While the dental service corporation may have a five to eight per cent marketing advantage because of three to five per cent withholding of the fees paid to the participating dentist and the absence of two to three per cent state premium tax on insurance, they must continue to do battle in the marketplace if they are to get a share of the business. Of the 31 million people covered today in the private arena, 14 million are covered under dental service corporation contracts with approximately 4.6 million in California.

The 31 million people, who include approximately one-half who were already in the health care delivery system and one-half who represent new participants, have been supplied with care with no problems relative to dental manpower or maybe I should say personpower. The influence of prepaid programs in providing more care for more people is a good one. The cost barrier has been reduced. The elastic productivity potential of the dental manpower resources has absorbed the increased demand. The early results of the ADA dental planning informational system which has been gathering data through a survey instrument indicates considerable elastic productivity potential. Other surveys taken in Ohio indicate fifty per cent of the dentists can absorb up to 18 more patient visits per week. The utilization of auxiliaries, strongly supported by ADA policy, which includes dental assistants both conventional and expanded function, hygienists and laboratory technicians all enhance that productivity function of the dental team. As survey data is collected for the entire country, I believe the dental planning informational system of the ADA Bureau of Economic Research and Statistics will be able to supply data that will allow us to predict the capabilities of the dental care delivery system to meet future demands.

Third party programs in themselves have had little effect on the distribution problems of dental manpower. The solution to placement of dental manpower in shortage areas such as inner city ghettos and thinly populated rural areas is not one involving prepaid dental programs. The locating of a dental office in a ghetto area involves such factors as safety, crime rate, social and cultural opportunities and educational opportunities for children.

It is not the responsibility of the profession to solve the problems of shortage of manpower in ghetto areas. The elimination of the ghetto areas will solve that problem as well as all the others I mentioned above. The rural area is a similar problem. It is impossible to operate a dental office in a county of 400 square miles with 4000 people when the largest single community has 500 people. No dentist in an area like this can earn an adequate living income unless he is subsidized by government. And, transportation would be a barrier to all those people in that area if they were to utilize the service of the dentist in that community. Only government can operate a dental office without a profit. Only government can spend more than it receives, and how long government can do that is probably a moot question for when we know the answer to that question it may be too late.

Third parties via the contracts they administer, and provided the contracts contain the language, could be a strong influence in preventive dentistry. Most contracts are sickness or repair ones and not preventive oriented. We all know the answer to dental disease, carious lesions and periodontal pathology, is prevention. Incentive programs, reimbursement differentials for successful preventive maintenance control, higher maximums for these patients all could enhance and promote prevention and in the long run solve the problem of dental disease and be the best cost containment program that exists.

Administrative costs must be public knowledge because those costs represent dollars that do not provide dental care for people. We are all aware of the tax money we send to Washington, D.C. and the amount that comes back. The more hands our dollars go through the more "administrative costs" there are and less is left for service benefits for those who gave. When administrative costs average fifty two percent as reported in the survey of prepaid health plans in California, then that third party has questionable value as a part of the dental health care delivery system.

Prepayment and third parties are here to stay. The profession has accepted them and really initiated them in many areas. They have been a strong influence to date and will continue to grow in significance with time. More people are receiving dental care as a result of prepayment and the reduction of the cost barrier has made it possible. This is commendable. The influence has varied — some good, some bad — but in all fairness the goodness or badness is related to the language of the contracts and how they are being administered and in many cases the profession has had little influence on the benefit package in those contracts. There

has been a lack of emphasis on prevention. Demand has been satisfied to date. Elastic productivity potential exists in the delivery system. Utilization of auxiliaries is the key to further immediate or short term increases in that productivity. I foresee some problems ahead particularly in the interference in the doctor-patient relationship, the economic coercive influence on treatment planning and acceptance of that plan by patients and the destruction of the heart of the fee-for-service, private practice free enterprise dental care delivery system which is the increased productivity and profit relationship. The direction of total care reimbursement programs at controlled maximums with no direct patient financial responsibility and ultimately the unilaterally determined fixed fee schedule will destroy the present delivery system and, of course, its advantages.

It is apparent that quality assurance and cost containment are high priorities in the prepayment field. Both will influence the practice of dentistry. Quality assurance, once it is defined, and incidentally I have never read or heard a definition of quality — can only mean in the broad sense better dentistry for more people. Cost containment implies to me the least expensive but not necessarily the best treatment. The enforcement of a cost containment program in the treatment of dental disease will interfere with the treatment planning by dentists. The best cost containment program is a preventive one and I see no signs of one in the private or the government areas. If the ultimate third party is the government and all dentists become salaried employees of that government directly or via a unilaterally determined fee schedule under the guise of cost containment, then I believe we will have the quality program Great Britain has today. Twenty-seven years of National Health Insurance as reported in a London newspaper in March 1976 has resulted in thirty seven per cent of all people over 16 years of age in England and Wales edentulous and forty-four per cent in Scotland.

Let us not destroy the system that has produced the highest quality of dental care in the world. Let us perfect it, extend it to more people but never eliminate the incentives in the free enterprise, private practice fee-for-service system — the system that is responsible for that high quality.

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Deceased Fellows

The deaths of the following Fellows have been reported to the central office between October 1975 and October 1976.

*Cecil H. Collins, Laguna Hills, California
 Frank G. Everett, Portland, Oregon
 Lyle H. Pitt, Pittsburg, Texas
 DeWitt T. Lewis, Jackson, Mississippi
 *Willard C. Camalier, Washington, D.C.
 Alex M. Dinin, New York, New York
 *Bruce R. Tidwell, Denver, Colorado
 *Ralph E. Raker, Shamokin, Pennsylvania
 Clyde G. Barthelemy, New Orleans, Louisiana
 *Andrew J. Donnelly, Muskegon, Michigan
 Oscar Ginder, New York, New York
 *James P. Hollers, San Antonio, Texas
 *Oscar J. Chase, New York, New York
 *Reuben R. Rhoades, Jefferson City, Missouri
 *John I. Sloan, Cleveland, Ohio
 *Connie N. Williams, Memphis, Tennessee
 *Edward T. Fischer, Fairfield, Connecticut
 Charles F. Bartels, New Orleans, Louisiana
 *Joseph A. Tartre, San Diego, California
 *James H. Samuel, Lake Worth, Florida
 Norman H.C. Griffiths, Washington, D.C.
 *Robert S. Davis, Coronado, California
 *J. Stafford Allen, Providence, Rhode Island
 *Herbert O. Hoppe, Green Valley, Arizona

Clare T. Budge, San Antonio, Texas
 *John J. Clarke, Artesia, New Mexico
 *Kenneth T. Adamson, Melbourne, Australia
 *Adam C. Bock, Baltimore, Maryland
 *Ernest L. Johnson, San Francisco, California
 *Leo Schoeny, New Orleans, Louisiana
 *Russell C. Wheeler, St. Louis, Missouri
 Theodore S. Grant, Millbrae, California
 Stanley R. Korf, Chicago, Illinois
 *John Steen, San Diego, California
 *William J. Armstrong, Thousand Oaks, California
 *Fred Wertheimer, East Jordan, Michigan
 Dollie Mae Woodul, Dallas, Texas
 Walter C. Stout, Ennis, Texas
 *Clarence A. Dunn, Sarasota, Florida
 Frederick W. Ebinger, Vista, California
 *Vivian Z. Brown, Sierra Vista, Arizona
 *Paul M. Weber, Matawan, New Jersey
 *M. H. Thornton, St. Paul, Minnesota
 *William G. Delp, Rural Retreat, Virginia
 *Robert H. Fladeland, Sun City, Arizona
 *Ralph W. Ludwick, Sr., Lincoln, Nebraska
 Marian A. Flesher, Oklahoma City, Oklahoma

G. Thaddeus Gregory, Indiana, Indiana

*Earle M. Crysler, Watertown, New York

*Sherman, Granville Collierville, Tennessee

*Edward R. Hilden, Eugene, Oregon

**Ernest C. Colwell, Deland, Florida

Charles E. Hebert, New Roads, Louisiana

Arthur I. Bell, Ft. Lauderdale, Florida

*Charles M. Silk, San Francisco, California

*William T. Ralph, Belhaven, North Carolina

Arthur L. Milbourn, Dallas, Texas

*Henry C. Petray, Oakland, California

Joseph G. Stewart, Montgomery, Alabama

William M. Tweed, Tucson, Arizona

Robert F. Rudisill, Latham, New York

S. L. Drummond-Jackson, London, England

**Lloyd E. Blauch, Washington, D.C.

George E. Carbonelli, Utica, New York

William J. Takacs, San Antonio, Texas

Robert L. Twible, Toronto, Ontario

*Russell A. Dixon, Silver Spring, Maryland

Wilvor C. Waller, Pittsburgh, Pennsylvania

David L. Ford, Columbus, Ohio

*Roscoe M. Justice, Ashland, Kentucky

Raymond F. Paul, St. Louis, Missouri

Walter H. Swartz, Ann Arbor, Michigan

Albert L. Knab, Elmhurst, Illinois

*Floyd H. Binkley, Hennessey, Oklahoma

*Anthony S. Gugino, Buffalo, New York

*Max E. Ernst, St. Paul, Minnesota

Ralph H. Stern, Los Angeles, California

*C. A. Hopper, Ridgewood, New Jersey

*Ruth Martin, Santa Barbara, California

John W. Sabo, Pueblo, Colorado

Leo B. Lundergran, Clayton, Missouri

*Harold W. Oppice, Omaha, Nebraska

Lewis I. Townsend, Atlanta, Georgia

*Dwight R. Kinsley, Bay Village, Ohio

Herbert W. Grinnell, New York, New York

Otto J. Dick, St. Louis, Missouri

*Leroy P. Hartley, Dallas, Texas

*Erroll W. Willett, Largo, Florida

John E. Pleasants, Houston, Texas

*Angus M. Sellers, Birmingham, Alabama

*Blanchard K. Braum, Minneapolis, Minnesota

*Louis T. Austin, St. Paul, Minnesota

*Life Fellows

**Honorary Fellows

NEWS OF FELLOWS

Executive Director, **Robert J. Nelsen**, a 1940 DDS graduate of the University of Minnesota School of Dentistry has received recently the Outstanding Achievement Award from the University of Minnesota. This award was established to recognize outstanding graduates of the University who have "attained unusual distinction in their chosen fields, professions, or in public service and secondarily have demonstrated outstanding achievement in community services on town, city, state or national levels.

Dudley H. Glick of Los Angeles was honored recently by the State of Israel which accorded him the David Ben-Gurion Award for his "concerned involvement on behalf of the land, the faith and the people".

Alfred E. Seyler of Detroit, Michigan, writer, teacher and former editor of the Journal of the American College of Dentists, has been named "ASDC Great" for 1976 by the American Society of Dentistry for Children ASDC Foundation. The award was presented to Dr. Seyler at a luncheon recently in Las Vegas, Nevada.

Clifton O. Dummett, professor of dentistry at the University of Southern California, Los Angeles, was awarded the Distinguished Service Award of the American Association of Dental Editors at the annual meeting of the Association in Las Vegas, Nevada recently.

At its 58th Annual Meeting held recently in New York, the following Fellows were elected to office in the American Society of Oral Surgeons. President, **Daniel M. Laskin** of Chicago; President elect, **Terry W. Slaughter** of Salinas, California; Vice President, **William R. Wallace** of Columbus, Ohio; Board of Directors, **Philip J. Boyne** of San Antonio, Texas and **John G. Whinery** of Amarillo, Texas. **Robert V. Walker** of Dallas, Texas received the William J. Gies Foundation Award in Oral Surgery at the same meeting.

Erik D. Olsen of San Mateo, California has been named Executive Vice President of California Dental Service. He replaces **F. Gene Dixon** of San Francisco who will become Senior Vice President and Consultant to the CDS Board.

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;

(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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