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**AMERICAN
COLLEGE
OF DENTISTS**

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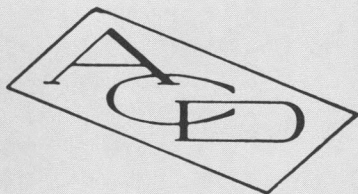
Health Legislation
The ACD and the ADA
Preparation for Lifelong Learning
Improving the Quality of Life



**MEMBER PUBLICATION
AMERICAN ASSOCIATION OF DENTAL EDITORS**

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NEWS AND COMMENT

Board Actions

The Board of Regents at its April meeting in Bethesda, Maryland took the following actions:

- Approved a motion that the Commissions of the College set up an Advisory Committee composed of representatives from each Section to develop programs in areas of common interest.
- Approved a recommendation that the Otto W. Brandhorst Award be established, to be presented to the most effective Section.
- Heard reports of the Regents describing Section activities in their Regency districts.
- Heard a report of the progress of the SACED and Mini-SACED programs.
- Adopted a motion reiterating the position of the College that professional advertising is not in the best interest of the public health, that there is no evidence of proof of quality of service and professional competence in self-attestation.
- Instructed the Committee on Conduct, in conjunction with the Publications Advisory Committee, to design a procedure for encouraging Fellows to contribute articles only to professionally controlled publications.
- Voted that the annual dues be increased to \$50, effective January 1, 1978.
- Approved a motion that, effective January 1, 1978, annual dues may be prepaid, up to the year of life membership.
- Approved the contribution of \$50 to the American Society of Association Executives Foundation to aid in the study of activities of government programs setting up new and burdensome taxes on professional associations.
- Approved the report of the Committee on Credentials.

Early Nominations Suggested

Fellows who are considering the nomination of worthy colleagues for Fellowship in the College at the 1978 Convocation are urged to begin preparation of the nominating forms as early as possible. Each year the Central office is inundated with a flood of nominations in the few days preceding the February 1 deadline, making processing difficult.

Fellows should identify individuals in the profession whose services and achievements deserve such recognition. It should be noted that it is now permissible to cross state lines in making nominations.

Nominations forms, one per Fellow, are available from the Executive Office in Bethesda. The principal nominators are expected to be present as the sponsors of the successful candidates at the Convocation ceremonies. The 1978 meeting and Convocation will take place in Anaheim, California on Saturday, October 21, 1978.

Report of the Nominating Committee

The following slate of officers for 1977-78 has been selected by the Nominating Committee. Charles F. McDermott, president; Dale A. Hills, president-elect; Gordon H. Rovelstad, vice-president; George E. Mullen, treasurer; Lynden M. Kennedy, regent (Regency 6) and Leon H. Ashjian, regent (Regency 7).

SECTION NEWS

New York Section

The Spring Meeting of the New York Section of the American College of Dentists was held in March at the New York University Club in New York City. Thirty-three members attended.

The Business meeting was devoted to the election of the executive committee. The following officers were elected: Andrew Cannistraci, chairman; Irving J. Naidorf, vice-chairman; Joseph A. Gibson, secretary-treasurer; Henry I. Nahoum, historian; and Barry Symons, past chairman.

Mr. Theodore L. Haff, Jr., vice-president of Smith, Barney, Harris Upham and Company gave an informative talk on investments.

Illinois Section

The Midwinter Luncheon Meeting was held on February 20, 1977 at the Conrad Hilton Hotel in conjunction with the Annual Session of the Chicago Dental Society. Section Chairman Herbert C. Gustavson, presided.

Awards of Merit were presented to the following Senior dental students: Timothy D. Conway, University of Illinois College of Dentistry; James M. Kane, Loyola University School of Dentistry; Herbert P. Silva, Southern Illinois University School of Dental Medicine; and Claron S. Edwards, Northwestern University Dental School. Mr. Edwards responded for the recipients expressing their appreciation.

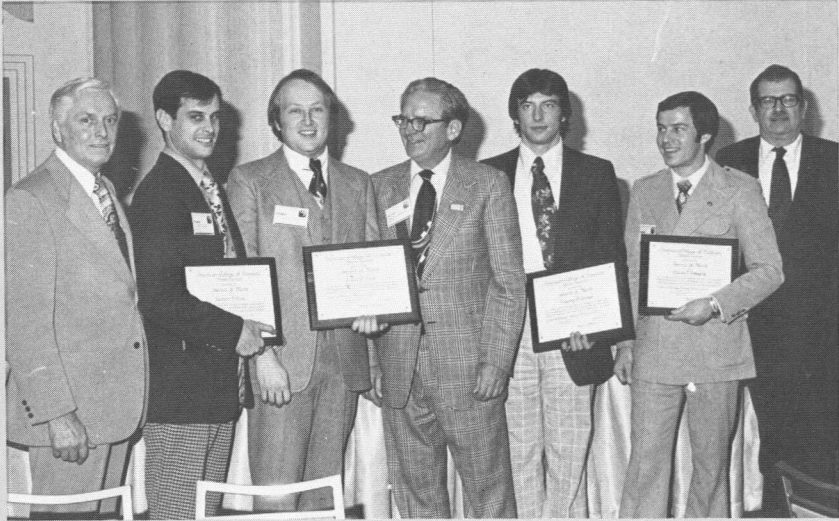
Chairman Gustavson presented a check for \$1000 to the ACD Foundation to College president James L. Cassidy, who accepted it with thanks.

C. Gordon Watson, Executive Director of the American Dental Association introduced the speaker, Frank F. Shuler, president of the ADA whose topic was "Are You Listening?" Dr. Shuler's talk is printed in this issue of the Journal.



Herbert C. Gustavson, chairman of the Illinois Section, presenting the Section's check of \$1,000 as a contribution to the American College of Dentists Foundation to James L. Cassidy, President and to Robert J. Nelsen, Executive Director.

Recipients of the Award of Merit presented annually to a senior in each of the four dental schools in Illinois by the Illinois Section of the American College of Dentists with Section officers. Each award is in the form of a plaque and a check for \$200.00.



From left to right: Syrus E. Tande, Section vice-chairman; Herbert P. Silva, Southern Illinois University School of Dental Medicine; James M. Kane, Loyola University School of Dentistry; Herbert C. Gustavson, Section chairman; Timothy D. Conway, University of Illinois College of Dentistry; Claron S. Edwards, Northwestern University Dental School; and Donald A. Washburn, Section secretary-treasurer. The presentations were made by the deans of the respective dental schools.

Louisiana Section

The annual meeting of the Louisiana Section was held at the same time as the New Orleans Dental Conference, at which time the mini self-assessment program was presented. The Section is currently assisting first-year dental students in the development of a self-assessment program which will attempt to compare the results of the test given to senior dental students and the practicing dentists.

On May 30th the Section presented a plaque and a \$50.00 check to the student considered to be most outstanding by the faculty of Louisiana State University.

(continued on page 189)

the JOURNAL of the AMERICAN COLLEGE of DENTISTS

A QUARTERLY PRESENTING IDEAS IN DENTISTRY

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Editorial Board—ARNOL R. NEELY, *Chairman*

WILLIAM C. DRAFFIN

BALFOUR D. MATTOX

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Regent Balfour D. Mattox

Balfour B. Mattox, a general practitioner of Washington, D.C. has been elected to the Board of Regents of the College, representing Regency Two. Born and brought up in Providence, Rhode Island, he studied at Washington and Lee and at George Washington Universities before entering Georgetown University Dental School. He was class president in his sophomore, junior and senior years, and was also Grand Master of the Georgetown chapter of Psi Omega dental fraternity.



After graduation, Dr. Mattox served briefly in the Veterans Administration dental clinic at Martinsburg, West Virginia, before entering private practice. This was interrupted by two years of service as a Captain in the Dental Corps of the U.S. Army, following which he resumed practice in Washington, D.C.

Active in the District of Columbia Dental Society, he has gone through the chairs as treasurer, secretary and president elect, and was president in 1966-67. He has also been general chairman of the D.C. Spring Postgraduate Meeting, and has served as an alternate delegate to the American Dental Association for many years.

Dr. Mattox was national president of Psi Omega in 1972-73, and is currently vice chairman of the Health Planning Advisory Committee of the District of Columbia, secretary of the D.C. Academy of General Dentistry and treasurer of the D.C. Dental Society Research and Education Foundation. He is a trustee of the Washington lodge of the Elks, and a member of the Knights of Pythias and the Masonic Order.

He is married and the father of a son and two daughters.

ALTERNATIVES IN THE DELIVERY

The Fourth Program in

Factors Affecting Professional

John L. Bomba, Moderator, of Philadelphia, Pa., will present the nature and background of the discussion which will consider the external and internal factors affecting dental care.

Douglas R. Franklin, of San Leandro, California, First Panelist, will discuss the influence of factors outside the profession which are leading to the loss of the profession's control of oral health care delivery.

The Convocation Speaker will be **Dr. Ewald B. Nyquist**, New York State Commissioner of Education, and President of the State University of New York.

OF ORAL HEALTH CARE IV

this Series Will Consider

Control of Dental Care

Charles D. Carter of Bowling Green, Kentucky, Second Panelist, will discuss the internal factors leading to a loss of self control and the disestablishment of dentistry as a true profession.

Louis G. Terkla of Portland, Oregon, Third Panelist, will speak on the means of contending with those factors, external and internal, which further the loss of control by the profession of oral health care delivery.

Fontainebleau Hotel
Miami Beach, Florida
October 8, 1977

Editorial

The Denturism Problem

There is hardly anything in the world that some man cannot make a little worse and sell a little cheaper, and the people who consider price only are this man's lawful prey - John Ruskin

Denturism, the illegal practice of dentistry through the fabrication of dental prosthetic appliances by dental mechanics is becoming an ever increasing problem to the profession. Illegal practitioners in sixteen states, encouraged by the success of the movement in Canada, have instituted or are about to initiate efforts in their legislatures to pass laws which will legalize their services, permitting them to work openly on the public.

Such a threat is not going unchallenged, and the American Dental Association has allocated over one million dollars to fight denturism. Funds are being disbursed in considerable amounts to various state dental associations where the mechanics are active.

Certain facts need to be recognized however. First of all, there are many people needing dentures who are not particularly concerned with the professional aspects of denture construction. They consider dentures as a product, as a commodity, and their chief concern is in the price they must pay. These are the people who have given encouragement to illegal practitioners, by seeking out their services, in their kitchens or basement workshops. These are the ones who cross the northern border into Canada or to denture mills in the United States. It is questionable if such people can ever be convinced that the fitting of dentures is a health service, or that the denturist is not competent to diagnose and treat their needs properly.

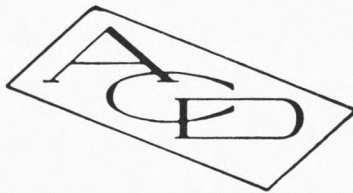
Other people, the aged and indigent particularly, may seek the services of illegal practitioners because they may be unable to afford the dentist's usual and customary fees. Recognizing its responsibility, the profession has begun to find ways of easing this burden. Dental clinics in various parts of the country are offering a low cost denture service to the elderly, and many private dentists are willing to reduce fees in some instances, or offer credit terms that would allow payment over a period of months.

At a recent ADA conference on illegal practice, Dr. Claude A. Pawelek, president of the Academy of General Dentistry commented on the contention that legal dentistry is too expensive for the aged and indigent. He said, "There is a very basic fallacy in this attitude. The poor and elderly will once again be subjected to the very worst that society has to offer. A double standard has again been created, and the poor still lose." Citing information supplied by Canadian members by AGD, he called the services provided by denturists, "dangerously substandard" and "a hoax on the consumer" stating that Canadian denturists are now charging fees close to those charged by licensed dentists, considerably above the low prices promised.

The profession is currently undertaking a greater educational effort to inform the public of the importance of denture care by qualified licensed practitioners. But the main battle will take place on the state legislative front. Political Action committees in the threatened states must inform their legislators that price alone is not the best way of determining who should serve the public.

Most state dental practice acts have specific rules outlawing the unlicensed practice of dentistry. These laws need to be enforced more strictly than at present. Unfortunately, many state boards of dentistry possess no real power, and are unable to persuade Attorneys-General to enforce the laws. Unless existing laws can be upheld and defended against further attack, there is no way that the profession can win its fight against denturism. No contest has ever carried more serious implications for the future of dentistry than this one. We must not fail.

RIK



Are You Listening?

FRANK F. SHULER, D.D.S.

Dentistry right now is faced with problems of such enormity that the practice of dentistry as we know it today may be considerably altered, to the detriment of society, by the next decade unless we do something about it now—and I mean right now; not another few years in the future.

Most of you are familiar with Lord Nelson's famous words: "England expects every man to do his duty."

Our profession—presently and in the future—should take heed of those words. Every member must do his duty. We can no longer be concerned with our own personal comforts and goals and leave the future of our profession up to others—and then not support them when they need help.

We are only 125,000 out of a total national population of well over 200 million. That is like David facing Goliath—like entering a Volkswagen in the Indy 500—like looking for a needle in a haystack. Everyone of us is needed and we can not shirk our responsibilities.

Everywhere we turn today one issue hits us right in the face. Not only as professional people, but as citizens of the United States. In case there is need for me to remind you—it is legislation.

We think of National Health Insurance, but what about OSHA regulations. We think of HMOs, PSROs, National Health Service Corps, but what about Environmental Pollution Standards, Safety Standards, Speed Limits. You see it is legislation that is really the name of the game.

What is happening is that certain people—certain groups—are saying that the solution to our problems, public or private, is based on the fact that individual initiative can no longer apply; that for the sake of controlled efficiency and planned order to guarantee the individual his inherent right to health, laws must be passed.

Presented at the Midwinter Luncheon Meeting of the Illinois Section, Chicago, February 20, 1977. Dr. Shuler is President of the American Dental Association.

In very simple words, the freedom that we have had for 200 years will be lost. What they are doing is chipping away at the private free enterprise sector; take a little bite at a time, and no one bite will be so painful as to appear disastrous. And if we let it happen, in six to eight years the government will be operating a national program and licensing illegal operators. And mind you, we will not even know what particular bite did us in. They all seemed so minor.

Are you listening?

As we enter our nation's glorious tricentennial era, you, the members of the American Dental Association, have afforded me the opportunity to serve as your President for which I am very appreciative. Then, as was done 200 years ago, let us reaffirm our belief in freedom, in the free enterprise system, in the private practice dental care delivery system that has developed the highest quality of dental care in the world. Let us remember that with this freedom goes the responsibility of doing our duty to meet the dental health needs of the public we serve.

History records that throughout all time, whenever people have decided they wanted security more than they wanted their freedom, they ended up losing both.

Neither our nation's founders, nor the church, have conceived freedom to mean freedom to do what we willy-nilly want to do. In a profound sense, both state and church understand freedom to mean that people are free to do what they ought to do.

At creation God gave people the rights of self-determination, the right and duty to choose between good and evil, between right and wrong, between obedience to God and obedience to the enemies of God. He warned that whatever a man sows, that he will also reap. God will not be mocked.

Freedom can be taken away in two ways, from the inside and from the outside. Selfishness, greed, and envy can erode it from inside. A hostile and tyrannical enemy can invade and destroy it from the outside. In the long history of humanity, it has been proven that no force from the outside can destroy it, if it has not already been destroyed on the inside.

Therefore, in order to meet the challenges of legislation our first priority must be unity within the profession. We must be disciplined and dedicated to this achievement at all levels. We must develop larger and stronger Political Action Committees—more members—more dollars.

We must enlist the aid of our wives by getting them involved in the auxiliary programs that work with and for the profession. It would double our members.

We must recognize that there is a battle before us that needs our physical and monetary resources. Let's not continue to use a sprinkling can to put out a forest fire.

We must be strong enough to look at ourselves in a mirror, and honest enough to accept the answer reflected, that we are probably our own worst enemy and are part of the problem.

Finally, we must return to the world of reality, recognize the ideals that have made our country great, and maintain a unified course of action towards a goal we know to be right.

Remember the words of Nelson?

"England expects every man to do his duty."

The forces today would probably state this statement this way:

"England anticipates that as regards to the current emergency, personnel will face up to the issues and exercise appropriately the functions allocated to their respective occupation groups."

That's not the kind of communication we need today. We need to interpret Lord Nelson's words as:

"The profession—our profession—expects every man to do his duty."

May I share this with you—

Because freedom is old, not young, yet it is born anew in the first cry of a free man's son;

It is not a living thing, yet it dies if we do not love it;

It is not weak, yet it must be defended;

It is light, yet it weighs heavy on him who is without it;

It is without price, yet it dearly costs the one who sells it;

It is not small, but great;

Yet once lost, it is never found again.

Yes, to be born free is an accident;

To live free is a responsibility;

But, to die free is an obligation.

No person achieves positions of leadership, if others do not work for and with him.

I owe you—all of you—my continuing dedication to keep our profession free. You owe your profession the time and effort of working to preserve its freedom.

Dentistry and Health Legislation

JOSEPH CABOT, D.D.S.

In the aftermath of the 1976 presidential election, the phenomenon of alternating incumbency has been widely observed and reported. One news commentator suggested that a review of our country's presidential election returns over the last three decades would lead anyone unfamiliar with our system to conclude that there is a constitutional provision calling for a change in administrations by political party every eight years.

With respect to health legislation, this same alternating phenomenon may be applied, in terms of innovation and retrenchment. The majority of political analysts are of the opinion that a new innovative cycle is beginning.

That statement sounds more alarming than intended. We are all familiar with the platform of the new administration. In the health care field, it calls for some bold steps. But the American political system, in practice, has a way of exerting a moderating influence on both conservatives and liberals. Nevertheless, I believe we can expect some new initiatives and the continuation of some significant existing programs. Recently, President Carter revealed that by early 1978 he intends to present a bill which will propose some form of phased-in National Health Insurance.

So our topic this afternoon is timely. It is, also, one of great range. In the time allotted let us consider four programs of the federal government which, at least potentially, are capable of exerting a significant influence upon the practice of dentistry: Title XIX of the Social Security Act, Medicaid; Public Law 92-603, the Professional Standards Review Organization Law; Public Law 93-641, the National Health Planning and Resources Development Act; and Public Law 94-484, the Health Professions Education Assistance Act.

Presented at the annual meeting of the American Academy of Pedodontics, Bar Harbor, Florida, May 29, 1977. Dr. Cabot is a member of the ADA Council on Dental Health.

MEDICAID

Let us begin with Medicaid. It is entering its second decade. It has affected many practicing dentists either through their participation in the program, or through their being forced to decline participation in a program whose goals they support, because of that program's structural defects and inadequate administration.

It is a poorly-administered plan which repeatedly disappoints the beneficiary and infuriates practitioners. It leaves the design, method of delivery and administration to individual states — governments which are frequently pressed to the breaking point financially. Still, we hear from the federal government that Medicaid is "The last of the open-ended programs, we will match every state dollar for dollar." I submit it is an empty boast to declare that you are willing to match bankrolls with paupers. As you well know, the history in respect to dental benefits is one of failing to meet even the minimal needs of the participants.

Medicaid is a prime example of the social planners unfortunate reliance upon regulatory decree rather than cooperative agreement — a reliance on commandment rather than commitment. There is an immense back-log of need for the medically indigent — a need which is being met in a totally inefficient and ineffective manner. Division of administrative authority creates confusion, duplication and dichotomy. As a consequence of bureaucratic mal-administration, fiscal mismanagement, and impossibly inadequate reimbursement, a major segment of private practice funds that it cannot conscientiously participate to any significant degree in the program. As a result, the Medicaid program has degenerated in some areas to the point where in inner city, high density, low income areas, there is a burgeoning movement toward the establishment of so-called "shared health facilities" or "medicaid mills" — purely entrepreneurial devices intended to take financial advantage of the Medicaid vacuum while offering a minimal and often incompetent service — indeed a sad commentary on so bright a promise for the delivery of health care to the poor. It is even more disappointing to note that President Carter's first initiative into this area, the Child Health Assistance Program, CHAP, does not include dental benefits. This is incomprehensible.

Medicaid's principal objective was one which the dental profession wholeheartedly supported: to provide a mechanism which will serve to transfer the nation's poor from the clinic to the private office; which will find for the poor a health care home; which will, finally, ensure a single level of health care for all. But after more than ten years we do

not hear much about a "dental home" for the poor. We hear of clinics, we hear of mills. We hear of abuses in the systems and we hear of fraud. Initiatives are now being undertaken to curb these practices. In an inflationary economy, health care costs, especially hospital costs, move, it seems, ever upward. The government's share of these increasing costs itself increases. Public concern for cost is heightened. Rumors abound of inadequate, incompetent and inappropriate care. The program is expensive and the care isn't sound, we hear. So professional standards review organizations were created to assess the quality of care.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

But PSRO's will not take care of the financial problem. Certainly, there is a cost control element in that review mechanism, but the resultant savings, if any, are long-term. The economic crunch in the states and the cities is now. The taxpayers concerns are immediate.

So what has been the experience in cost-containment? Primarily it has been a matter of mandating lower expenditures. Cut out programs; eliminate services; reduce the size of the eligible population through regulatory revision. Health care costs too much! Stop providing so much health care. In the case of Medicaid, this kind of cost control means that once again the poor end up paying the bill, picking up the tab for the past mistakes and present mal-administration.

I think we all have an idea of what this is leading to. When it happens, we may find that we are all paying the bill.

But before we pursue this rather unpleasant thought further, let us examine the government's primary review mechanism, the Professional Standards Review Organization, and its effect on dental practice. First, it must be said plainly: the law which established PSRO's is a discriminatory one. It calls for the review of all dental services paid for wholly or in part by federal funds and at the same time precludes dentists from membership

Over the last five years the American Dental Association has sought to correct this inequity, originally before the law's enactment and more recently through amendment to the law. In 1972, Senator Wallace Bennett, the principal congressional advocate of PSRO, stated to an association witness, who was testifying before the Senate Finance Committee hearings, that "the language of the bill as it is finally adopted...will make sure that only dentists review the work of dentists..."

When the law was enacted, this assurance was not incorporated in it, although there is permissive language, stating in part:

"...the professional standards review organization serving any area is authorized...to...make arrangements to utilize the services of persons who are practitioners or specialists in the various areas of medicine (including dentistry)..."

Nevertheless, review of dental services by dentists is not mandated. Pragmatically, dentists, through separate agreements, may be asked to perform the dental review. But dentists, the second largest group of primary care providers in the nation, and the only practitioners whose disciplines are largely unparalleled by physician specialties, are excluded in the review mechanism. This is clearly discriminatory.

We are hopeful that, with the support of the national PSRO Council and the Bureau of Quality Assurance in HEW, this inequity will be corrected soon.

Should that occur, and if PSROs are properly administered and regulated, and that is a crucial proviso, the dental profession may be in possession of an effective review mechanism, adaptable to local situations and at the same time capable of providing the structure for a reasonable degree of national uniformity.

THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT

Cost-containment was also an issue behind enactment of Public Law 93-641 — The National Health Planning and Resources Development Act. This piece of legislation was conceived as a replacement for three previous Federally-funded health planning programs: the Hill Burton health facilities construction program, the Comprehensive Health Planning Program, and the Regional Medical Program. This new authority is an attempt to build on the experience of these three programs and to combine their best features into one new health planning and resources development program. Its primary objective? To improve the accessibility, acceptability, continuity, and quality of health care services by efficient development and allocation of health resources.

First, let me say that I endorse the principle that comprehensive health care should be available to all people, regardless of geographic location, economic condition, race, color, creed or national origin; and that a mechanism be provided, where needed, for assistance and support of this concept. All health professionals, while firmly rejecting ineffective and abusive administration, should

continue to exert every possible effort to build an environment that fosters rather than impedes the delivery of high quality care to more people at affordable costs.

Yet the Federal government's methods make PL93-641 a difficult pill for the private practitioner to swallow. An almost God-like authority has been vested in the Secretary of Health, Education, and Welfare. He has the power to designate the local health service area and the agency which will represent that area; he can withhold Federal monies if the states do not cooperate in the effort to restrain the spiraling cost of health care. A state must enact certificate of need legislation by 1979 or run the risk of having its state planning agency denied full designation. Although the certificate of need applies only to institutional health services at the present time, HEW has made it clear that it intends to extend it to the ambulatory care setting in the not-too-distant-future. If that happens, we will have massive Federal regulation of our individual dental offices.

There is also discussion at HEW about offering amendments to the health planning law which would allow rate setting and rate review. The present statute permits HEW to support an experimental program of rate setting, but that authority is limited to only six states and can be applied only to hospitals and institutional providers. Now, Department officials have recommended that HEW be allowed to initiate rate setting programs in all the states, and to expand that authority to include private practitioners. For the present time, Congressional interest in this issue seems to be focused only on reimbursement procedures under Medicare and Medicaid. Any initiative to extend this program into the private, non-federal sector would require strong support from the Carter White House and would be strongly opposed by the ADA.

THE HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE ACT

The latest piece of health legislation vests still more authority in the HEW Secretary. Public Law 94-484, the health Professions Educational Assistance Act, has authorized him to designate critical health manpower shortage areas for placement of National Health Service Corps personnel. Although the new criteria for shortage area designation have not yet been issued, the ADA has proposed the incorporation of other factors with the traditional dentist to population ratio indicator. We are hopeful that the new criteria will include an evaluation of the need and demand for dental services in the health service area. Unless that approach is used, we may be faced with the placement of Corps personnel in an area which does not have a shortage of dentists.

IMPROVED ACCESSIBILITY TO CARE NEEDED

We are entering a critical time in the history of the dental profession, By even the most optimistic projections, half the people of this nation do not receive regular, comprehensive dental care. With all our advances, that is the distressing truth. Of course there is an elective aspect to dental care. Granted that a system will never exist in which everyone who needs dental care will seek it — and at the appropriate time. But we must insure that treatment is available to everyone who does seek it. Including, and especially, the twenty-six million people who live in poverty in our country. Especially these twenty-six million.

That is one in nine Americans who is categorically poor. There are several million more who are medically and dentally indigent. Ways must be found to increase the accessibility of care. If new health legislation can be instrumental in improving access and increasing utilization, fine.

But, at the same time, it will be a disservice to all of us, not simply as practitioners of today and tomorrow, but as patients, if we fail to make this improved access meaningful by making sure that it represents access to the best care we are capable of delivering and that patients, rich and poor equally, remain involved in the decision-making process which is so much a part of the traditional delivery system.

Improved access to impersonal, dehumanized dental care is of little value. Improvement of the system must mean improvement of the total quality of patient-life. I submit that we will best do that by insisting that government initiatives acknowledge the good in our system and build upon it. In the words of Past President Carlton Williams, "It isn't perfect but it's perfectible". It should be noted that there are legislators who are sensitive to the needs of the public and who share our concern for ensuring access to quality health care for all people. The ADA has proposed solutions to many of the problems we have discussed. We have projected our concern with these issues and offered alternatives in our statements on health planning, national health insurance, manpower distribution, peer review, and the children's dental health program. We have also sponsored a number of conferences on these subjects.

CONCLUSION

In short, the success of the federal government's initiatives to improve the accessibility, acceptability, and quality of health care services will depend, in large measure, upon the efforts exerted by the

(continued on page 188)

The Interrelationship Between the American College of Dentists and the American Dental Association

LLOYD J. PHILLIPS, D. D. S.

What is good dentally for the American people is good for the American dentist, for the American Dental Association and for the American College of Dentists. Now when we discuss the problems that face the profession today we talk about the three key words that surface in legislation—national and state—in the news media, the written and the spoken word. Those three words are cost, quality and accessibility of dental care. Give me any issue and all the rhetoric will involve one of or all three words.

National Health Insurance with a dental component is on the horizon. What are the reasons? Why is it being advocated? First, to reach all those who are not getting dental care, either because it is not available—accessibility, or because they cannot afford it—cost. And those enlightened and benevolent sponsors who deny any political motivation whatsoever insist that those people, indigent, medically indigent, poor, and near poor must be given dental care and the quality must be very good, the same quality of care delivered to your patients and mine who put their cash on the barrel-head.

The Declaration of Independence guaranteed Americans nothing except life, liberty and the pursuit of happiness. NOT HAPPINESS—*just the right to pursue it*. And, pursuit means hard work—the extreme of effort. I might add that I also believe health is not a right any more than happiness. I would agree that the access to, or the pursuit of, health is a right. This casts an entirely different light on the subject because I am firmly convinced that if all health care were totally free (tax dollars), utilization by the public of that source would never be 100%. In the case of dental care, in particular, that utilization would

Presented by Dr. Lloyd J. Phillips, Immediate Past Trustee, American Dental Association, Seventh District, at the Annual Meeting of the Tri-State Section of the American College of Dentists, March 5, 1977, University of Tennessee College of Dentistry, Memphis, Tennessee.

only approximate an asymptote of 80% at best. Government cannot legislate happiness, health, peace, contentment, pride, love, patriotism or any other intangible that is so dependent on personal attitudes, motivation, beliefs, philosophies and the thinking of free men and women. Some people would like to think that American freedom means automatic freedom from every worry, fear and work. No! Nothing in the Declaration of Independence, the Constitution or any recent document promises that. Freedom means only being free to work for the material things, as well as the intangibles I just mentioned, that you want in life—the quality of life you want.

Men and women of this country have fought and died fighting for freedom. It is a paradox that we must continue to fight for and preserve the very freedoms that have made this country so great.

THE COST OF DENTAL CARE

I believe that the profession has a story to tell about cost, quality and accessibility. In a recent study by the Bureau of Economic Research and Statistics of the American Dental Association, survey data revealed that between 1967 and 1975 dental fees rose 61.9% based on 1967 fees while the CPI measured by the Federal Government indicated that all goods and services in 1975 were 61.2% above the 1967 base. Now, I would say that the profession stayed very much in line. During this same period costs of operating a dental practice increased 132.5%. We have always been lumped in with our medical and hospital brethren and thus with hospital costs rising several times faster than dental fees the composite shows an increase considerably above the inflation rate. That story must be told and the leaders must tell it, the press must carry it, the media must repeat and repeat the story. But better yet you leaders—the American College of Dentists—as spokespersons for the profession must tell the story every day to every patient. Think of the communication that can be done, the advertising that can be done, the good that can be done if each dentist would spend five minutes each hour with each patient promoting the system that has produced the highest quality of dental care in the world today. There is not enough money to pay a Madison Avenue advertising company for that kind of communication to that many people.

Fifty percent of Americans visit a dentist in any one year, and a lot of these people are voters.

THE ADA PUBLIC EDUCATION PROGRAM

The public education program of the ADA began from a resolution I brought before the Board of Trustees in March of 1974. My original motion asked for a Madison Avenue Advertising Company to promote the fee for service, private practice system in the third party arena. I wanted the problems that I knew would arise to be placed where they belong. I wanted an educational program for the public so the dentist would not be blamed for problems which would develop as a result of least expensive, professionally adequate, alternate treatment clauses, usual customary and reasonable fee reimbursement profiles involving percentiles, uncovered pre-existing condition, radiographic interpretations, in-office audits, par versus non-par reimbursement levels and cost controls mechanisms imposed by fiscal agents and carriers. Any contract language developed between management and labor with no official dental association voice could be expected to be a compromise between comprehensive high quality care at no cost out of pocket to its members desired by labor and limited expenditures and cost control measures desired by management.

The public education program was broadened with several components being added in addition to the one I mentioned. The brush fires had to be put out. A spokesman training program was one of the first components added. People would be trained in the art of public speaking, utilizing all forms of the media and would be able to handle all kinds of interviewers. They would tell dentistry's story, the fee for service, private practice dental care delivery system would be espoused and with its advantages would be the heart of the message to be propagated. Over 300 dentists were trained with representatives from every state. Here in Tennessee the dentists who were trained started their own state public education program and it is a good example of what was planned for every state. The public must get the message, and one important segment of that public is the dental profession. We need a corps of dedicated leaders in every state, the circuit riders, the Paul Reveres, to arouse the dental profession so that it becomes an organization of action and not reaction. You men can be that corps. You are the leaders. You are the movers and shakers in your own state organizations. It is your star that can provide the leadership to arouse the members of the dental profession as one of the public that needs education so each will become a true spokesman for dentistry.

We have an example of how such a program worked in the iron range country of Minnesota. This is steel country, one industry and the union people were given an option to elect for a "capitation" program with an established medical HMO with a dental component and several groups of dental contract providers. The public education committee, on which I served, voted up to \$25,000 if matching funds became available and they did from the Duluth district in an effort to preserve the private practice system. This election was proposed last August but did not take place until January 16, 1977. The education program went to work. Strategy was planned, newspaper ads, personal letters from the family dentist to the patient, team captain, dentists calling each dentist to urge his participation, direct contacts with people and the message was told. The result was almost a total repudiation of the closed panel in that area. Unofficial but reliable results estimate between five and six percent of the union people voting for HMO. The first battle in this section has been won and to me it represents the viability of the program.

QUALITY ASSURANCE

Quality is another term we hear tossed around. Everybody wants quality—good or high quality—yet no one, to my knowledge, has ever defined the word. Webster defines the word as proper or essential being, nature and thus an attribute, characteristic, class, kind or grade, distinctive trait, power, capacity and applies to that which is predictable. This definition, in itself, is somewhat general and lacks real specificity. Quality assurance has crept into contract language. The UAW-Automotive contract calls for a post clinical random sampling of covered beneficiaries. Each carrier by contract is obligated to conduct such a program. A system of analysis of quality which divides the evaluation into satisfactory and unsatisfactory and then further divides each of these groups into two more. The evaluation will result in a score or coded grading based on such things as polish, contour, occlusion, esthetics, color, fit, extension of denture borders, etc. which readily makes one recall the check off lists on the punch card used in undergraduate days in the dental school. Even a random sampling of two percent of the treated cases creates a cost problem for such a program.

We used to believe that the system we have evolved is a quality system and as such will produce a quality product, a dental graduate who will deliver quality care. Good educational institutions, excellently trained and talented professors, with school accreditation

by the Commission on Accreditation of the American Dental Association which in itself is recognized by the Office of Education of HEW have to be strong building blocks in this quality system. Then State Boards of Dentistry recognized and given authority by legislative decree provide a check and balance on the output of our educational institutions by examining and testing that product academically and clinically. Then National Boards took over most of the academic testing and Regional Boards are partial answers to the clinic testing and the reciprocity dilemma. All of these are checks and balances. And still further, peer review mechanisms in each component and constituent society provide a check and balance when patient, third party or even dentist have problems which they cannot mutually solve.

Alas, the public, the consumer advocates, labor, management and government are now saying that the system I have just outlined is too subjective. They are not accepting the rationale of what I just stated as producing quality assurance. Post clinical treatment review of all patients would be a prohibitively costly system especially if the dental school undergraduate step by step checkoff list was used. What is the middle road and what system should be used to insure quality? As President of the American Fund for Dental Health I announced in November 1976 in Las Vegas that the W. K. Kellogg Foundation had committed \$2.5 million over four years to a national program for dental quality assurance. The fund will administer this program, develop guidelines for proposals to be submitted and select seven or eight research studies to be funded. Hopefully some answers will be forthcoming. One of the first things to be done is to define the term quality. These grants will be made to dental societies, individuals, dental schools and any responsible entity that submits a proposal that will be judged in competition with others so that the best seven or eight can be chosen.

AFDH PREVENTIVE DENTISTRY DEMONSTRATION PROGRAM

Another project of the American Fund for Dental Health which is exciting and to me has great potential is the \$5.5 million preventive dentistry demonstration program. Twenty thousand school children in first, second and fifth grades in ten sites throughout the country will be chosen to participate in this project. There will be two sites in the east, two in the mid-west and two in the west. Half will be in fluoridated and half will be in non-fluoridated areas—one each in each area. There will be several regimens of treatment involving professional fluoride application, self-fluoride application and brush-ins, home care

instruction, sealants and dietary involvement. There will be a cost analysis so that the cost effectiveness of each program and combinations can be determined. I am personally convinced that we can essentially eliminate dental caries in the test groups. The Rand Corporation of California will take all the data and do the analysis from a statistical viewpoint. I see great possibilities emanating from the project. If there is to be a dental component in any National Health Insurance program it makes sense to use the available dollars in a children's preventive program that is cost effective. Secondly, the private prepayment market should have the answer to what is a preventive program and thus have one that could be included in the package of benefits and thus be reimbursable.

The Robert Wood Johnson Foundation has given through the American Fund for Dental Health approximately \$15 million since 1971 to dentistry. The Fund and the profession are most grateful. As you might know the American Fund for Dental Health is a national non-governmental, non-profit, independent agency that raises funds and allocates grants to support dental education research and the dental health delivery system. Founded in 1955 as the American Fund for Dental Education, the Fund expanded its scope in 1974 to include support of research and dental health programs. In 1976 the American Fund for Dental Health raised more than \$1.3 million to support its objectives from dentists, the dental industry, foundations and corporations. The Board of Directors consists of 15 members, five from dental education, five from the dental trade industry and five from the profession. The Fund supports teacher training fellowships, scholarships, dental student loan programs, grants to national dental organizations, a \$4.7 million program to train undergraduate students to care for handicapped patients and the two programs I just mentioned, one in preventive dentistry and one in quality assurance. The American College of Dentists has been a strong supporter of the Fund in the past and I hope it will be in the future. In addition, each one of you should support the Fund and its activities for we are not dependent on government money for our activities.

ACCESSIBILITY OF CARE

The third topic is accessibility. A project was completed in February 1976 after a two-year study by the Leonard Davis Institute connected with the Wharton School of Business at the University of Pennsylvania in Philadelphia. The purpose of the study was to develop productivity and demand indices and develop the soft ware, the survey instrument

needed to gather data in a uniform and comparable manner. This data would be fed into a computer and then with a good instrument, uniform method of data collecting, accurate data, we would have the information that would permit us to make intelligent predictions on manpower needs as related to demand. This would enable us to discard the dentist-to-population ratio as an outdated, unrealistic and inaccurate method for measuring manpower needs.

Surveys were taken in Massachusetts and North Carolina as test states and then Indiana, Pennsylvania and Louisiana were added. An additional ten states are in the process of having data gathered. The use of soft questions in the surveys reveals startling information, not to the dentists, but to the bureaucratic planners. Ninety percent of the dentists in Massachusetts said they could take more patients, 75% in North Carolina and in Ohio 50% of the dentists said they could take up to 18 more patient visits per week. The Ohio situation is interesting because a bill was introduced into the state legislature to create a new dental school in Toledo. A legislative study committee was appointed by the Governor with broad representation and two young graduate students working on their doctorate in economics, staffed the committee. One of the facts discovered was that Ohio with the largest dental school in the country—Ohio State University—together with Case Western Reserve was producing dental graduates for export. Forty-three percent of the graduates of these two schools remained in Ohio to practice and the rest of the graduates left the state. That coupled with the 50% of the dentists who could take up to 18 more patient visits per week indicated an over-supply or insufficient demand for the available supply. The bill for the third dental school in Ohio never got out of committee.

The unused elastic productivity of the dental manpower is considerable. Thirty-three million people are covered by dental prepayment in this country today and they have been absorbed into the delivery system without problems on the dental manpower side of the question. It is estimated that 50% of those people were already in the system and 50% are new to the system. It is estimated that 65-70% of the dentist's bill under the UAW-Automotive contract is covered by insurance. I also know that in Anderson, Indiana where 95% of the people going to see a dentist are covered under that UAW contract, I have had three of the 50 dentists in Madison County tell me they are only working two and one-half to three days per week since the first of the year because of insufficient demand.

We may have some distribution problems but it appears to me from the facts that certainly no manpower shortage exists and very possibly

due to the unused elastic productivity potential an oversupply of dental manpower is real.

It is true that anyone without money has a difficult time buying a loaf of bread, let alone seeking dental care, but the people in that category are truly the government's responsibility and fortunately small in number, unbeknown to the government. The problem that is always paramount is the motivation of the individual and his or her sense of priority. There are many who drive Cadillacs with model "T" dentistry in their mouths. That is by choice and not by chance nor because of cost. The social planners always talk of need, never of demand. The accessibility of dental care is indeed of concern. Yet only 1.1% of all Americans live in counties in the United States that have no dentists practicing within their boundaries. The unavailability of dental care in rural, thinly populated sections of our country is not a fault of the system or the profession, but merely a matter of economics and geography. Only government can operate a dental practice in such areas because only government can continue to operate a business without a profit and with deficit financing. How long government can continue to do that may be a moot question because when we find the answer, it will be too late to do anything about it. The ability to operate a dental practice in ghetto areas of our cities has similar problems of economics plus the problem of crime which our government is unable or unwilling to cope with.

THE FREE ENTERPRISE SYSTEM

It is my sincere belief that the American public will get what they want. I believe also that the legislative community will pass laws that, from a socio-economic-welfare benefit aspect, will give the people what the legislative community thinks they want. I believe that most will support that position as a political expediency that will produce votes to bring them back to Washington. They take or have taken for their use surveys to test public opinion and desires. Surveys taken by Seasonwein and Associates for the public education program indicated that approximately 75% of the people wanted National Health Insurance while 75 to 80% believe in the present fee for service, private practice system. There is a message here. We have something to sell. We have something the people want. Tell them the story through every available means of communication, personal—doctor to patient, the written word, newspaper and magazines, Readers Digest, Time and Newsweek, the TV media, a documentary if you please that can be shown as a public service message to millions of

people, or if not the latter, buy the time, but repeat and repeat and repeat. Sell the system that has made our country great. It is readily apparent to any of us who operate in the free enterprise system that profit is not a dirty word, but it is a wonderful and magic word that has made this country of ours great—in fact, the greatest in the world. Profit has provided the incentives for innovation, for inventions, increased productivity, hard work and development of plain old American know-how for the solutions of difficult problems. What is it that is said of us? "We solve the difficult immediately and then take a little longer to solve the impossible." Any system that destroys the profit motive eliminates all that I have described and reduces what we have to mediocrity, limited productivity, limited improvements in techniques, in equipment, in methodology and results in minimum standards for the care delivered. Let all who make decisions either in the private or government areas take heed!

The challenge is clear and the American College of Dentists represents the elite, the leaders, the movers and shakers in the profession. There are members in every state. You can be, you should be the heart of the communication effort. Organize with your state organization, be the driving force, create cells in every component society, be the spokespersons, and wherever you can find one or a hundred to listen, spread the word. Get the facts, facts for spokesmen—and preach the truth—what the greatest health care system in the world can do, has done and will do to deliver the highest level of dental care to the American people. Answer the questions related to cost, quality and accessibility. Answer with the truth, for the truth shall keep you free.

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Our grand business in life is not to see what lies dimly at a distance, but to do what clearly lies at hand.

Thomas Carlyle

Preparation for Lifelong Learning

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Lifelong learning in the health professions is no longer an optional activity but rather it is an essential part of professional responsibility. The rising level of public expectation in health care, the rapid expansion in new knowledge, and the changes in both technology and delivery systems require an adaptive, changing model of the health care provider. Various agencies concerned with the Nation's health are becoming increasingly aware of the need to improve the system whereby professional competence is continually maintained.¹

While the current strategies are designed to encourage the professionals already in practice to become involved in continuing education, there is a growing concern that the educational institutions involved in training health manpower may eventually share the responsibility for the continued maintenance of learning in both the knowledge and practice of their graduates.

The current philosophy in the health professions assumes that the educational institution's responsibility for learning ends at the point of graduation. The maintenance of learning is assumed to be the responsibility of the individual practitioners. Although the ethical code of most professions requires continuous learning, there is a growing indication that while "participation" in continuing education activities is quite general, the professional often does not have the skills to learn independently.² His education has taught him *what* he needed to know but has largely ignored teaching the process of how to learn and *how* to insure lifelong maintenance of professional competence.

It should be clear that because a student has learned, it does not necessarily follow that he has learned *how* to learn.³ Nor does it follow that because a student has learned in a structured or formal setting, under a system of extrinsic motivation, he will necessarily learn in the independent, unstructured environment of professional practice.

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How then is a faculty to teach and a student to learn the skills of independent learning? The question has been at the core of educational philosophy for decades, but to date, a strategy for lifelong learning has not been included in many professional curriculums. In the following discussion, the author proposes to share some basic concepts of the learning process and provide an alternative strategy for curriculum design. In addition, an improved insight into the conditions of learning independence may demonstrate ways in which education systems can be made more effective.

A DEFINITION OF LEARNING

What do educators mean by "learning?" Learning occurs when an experience produces a change in behavior. A person learns from the day of birth. Some behaviorists insist that conditioning may even occur before birth. In essence, the process of learning is necessary for survival, for without learning the human being exists only as a totally dependent and helpless organism.

To learn is to acquire the skills to cope with one's environment. Thus, learning may be defined simply as problem solving. The learning process begins when an organism interacts with its environment. For example, when conditions disrupt the satisfactory equilibrium or steady state of the interaction, then a problem becomes evident and a state of disequilibrium or stress is presented in which effort is usually expended to return the interaction process to a state of equilibrium or optimum satisfaction.⁴

The reader will easily recognize that learning may occur as the result of inquiry or purposeful experimentation and thus may be the result of an aggressive attitude rather than a defensive or coping interaction with one's environment. However, the consequences of either process are stress and the individual's motivation to expend effort to resolve a problem and maintain a personal level of satisfactory equilibrium.⁵

Behaviorists call this "homeostasis."⁶ The "homeostatic" process is the continuous attempt on the part of every living organism to optimize the conditions of its environment. The human body possesses a variety of complex homeostatic processes by which it maintains physiological equilibrium with its internal and external environment. A simplified definition of learning, then is a conditioning process between the organism and its environment so that a constant state of satisfactory equilibrium is maintained. Thus, all learning involves stress. Without some form of stress no learning occurs or at best is random.

In some instances the stress is external to the learner as in the form of grades, a license to practice, or simply conforming to social pressures. However, stress may also be of the internal or intrinsic type. Intrinsic stress is caused when an organism senses a difference between the conditions which exist and those conditions which are desired, (i.e., satisfaction). All stress consists of two components: the amount or strength (quantitative) and direction (qualitative). The amount and direction of the discrepancy between "is" and "ought to be" (or desired) determines the strength and type of reaction to the stress.⁷

The quantitative (strength) component of the stress situation can have a profound effect on the learner's reaction and the learning process. While small amounts of stress may encourage effort to change the conditions, large increments of stress may result in frustration and/or withdrawal. Thus, the size of the increment of change required must be individualized in order to sustain and encourage learning but not frustrate the learner.

When the response to stress is such that the organism has altered its environment, or more often has acted to prevent or control the condition of dissatisfaction or stress, then the organism has "learned" or acquired a new coping skill to deal effectively with a specific problem of its environment.

EDUCATION AND LEARNING

Education may be of several types. Informal education occurs largely as the result of ad hoc or random experience. It is very limited as the result of the chance occurrence of a single or random stress-producing incident. Informal education is limited further by the time and place of the incident and may not always be typical of such experiences for society or other people generally. However, the greater the frequency and variety or scope of experience of a particular type, the more likely the incidents will produce the experience or learning that represents the wisdom necessary to cope effectively with one's environment. Thus, increased frequency and scope of problem solving experiences generally lead to increased probability of the appropriate (qualitative) learning and thus, a functional education. It should come as no surprise, therefore, that wisdom appears often to correlate positively with experience. Likewise, the more problems or stress situations one has resolved, the greater the probability of practical wisdom or a "common sense" education.

It should be apparent, at this point, that informal or random experience is very often inefficient since each individual is limited by time and place for the quantity and quality (frequency and scope) of his education. In order to overcome these constraints, civilized societies long ago invented a formal or structured education system. Within this system the essence of human problem solving experiences is pooled to form an aggregate or corporate summary of similar experiences so that it represents the accumulated knowledge (wisdom) of mankind.^{8,9} Thus, the conveying of knowledge of experience (vicarious though it may be) through the process of formal education has been able to overcome the time and place constraints of individual learning. Formal education is obviously more efficient, though not necessarily more effective than informal learning.

Although the discussion thus far has shed some light on the "why" of learning and formal education, it has not examined directly the "how" of learning. However, it was noted that learning is largely the consequence of experience in coping with the stress or dissonance in one's environment. This process might have been described as an "environmental dissonance" theory of learning. The concept is equally applicable to the psychological or cognitive "environment." When an individual becomes aware or senses a difference, dissonance, or disequilibrium between his current state of knowledge and that which he senses he needs to know to accomplish a particular goal or problem, then a condition of "cognitive dissonance"^{10,11} exists. Frequently this situation produces the internal stress or motivation for some type of action or problem resolution. That process which the individual uses and which consistently leads to satisfactory resolution of stress (whether cognitive or environmental) is the "how" of learning. Thus, learning how to learn is ultimately a systematic and often individualized process of problem solving.^{7,12}

It should be clear at this point that formal education, if it is to lead to independence in learning, should be designed essentially as a curriculum for "problem solving." A problem-oriented educational strategy involves the fabrication or simulation of situations and case studies in which the learner recognizes a significant disparity or dissonance between what he currently knows or is able to do and that which he needs to resolve the posed problems and reach his ultimate educational goals. A curriculum should be designed to lead progressively to independence, not only in identifying and analyzing problems, but also in the selection and testing of the means to resolving them.^{4,13}

Current educational strategy in the professions is largely a process

of learning the solutions to problems which have been identified by the faculty.¹³ The course director decides which problems are the most powerful and generalizable as well as what method will be used to resolve the problems. In addition, he selects the standards for determining whether the student is able to recall and defend the faculty member's selection of a correct solution. The process of learning too often requires simply a matching of solution to problem. However, good teaching involves the fabrication of questions or problems to be solved, not simply to test the recall of content but to teach the process of acquisition through the application of knowledge and the evaluation of the consequences of application. Thus, knowledge becomes the vehicle rather than the destination of learning.¹⁴

CONSTRAINTS IN LEARNING

The experienced teacher has observed that some students learn more easily than others. Some individuals, it appears, do not learn except under the most severe conditions. From the preceding discussion of the learning process, it may now be possible to identify some of the more significant blocks to learning.

There is probably no more powerful block to learning than prejudice or personal bias; that is, to persist in the retention of a belief, "knowledge" or "truth" despite compelling evidence to the contrary. The resistance to change may be principally a lack of trust in the source of new or conflicting information. Where the individual has had strong opinion leaders, either as a parent, religious leader or other peer group figure, then the credibility of the new source must be established before any significant learning can occur.

A second powerful block to learning is previous learning. Children tend to learn more easily than adults, not only because of the trust in the source, but also because there is so little conflict with prior learning. For many adults, new learning requires much unlearning.¹⁵ One's personal experience, though often random and limited, tends to appear more valid than the experience of others. An effective strategy for teaching adults requires certain curriculum alternatives in order to overcome the constraints of prior learning.

An additional block to learning is an immature or poorly organized psychological structure that either prevents or limits the acquisition of new or more inclusive information. In order to absorb and retain new information there must be, as Ausubel¹⁶ describes it, a "cognitive structure of sufficient maturity to subsume and retain the new

knowledge." Thus, the learner must have achieved a certain level of prerequisite knowledge in order to retain and use increasingly complex information, especially along the concrete-abstract process of intellectual growth. Surely the most serious constraint to learning is the absence of adequate motivations. Too often, the student fails to recognize or appreciate the significance of a particular learning objective. Motivation is the result of stress, created either externally or internally, which produces reaction and change. Orientation to a subject area should prepare the learner by establishing the relevance of the material as well as the degree of disparity between that which the student already knows or is able to do and that which is required.³

IMPLICATIONS FOR TEACHING

Teaching students *how* to learn as well as *what* to learn are not simple tasks. Simply because a faculty member is a content expert does not automatically confer teaching or continuous learning skill. The ability to teach effectively and to encourage the capacity for lifelong learning requires the understanding of certain principles and the mastery of certain skills. Fortunately, the conditions which help students learn how to learn are surprisingly similar to those which aid in the acquisition and retention of knowledge.³ The importance of those conditions which encourage independent learning include the following:

1. Learning how to learn requires experience in problem-based learning. The design of a course of study should include an opportunity to identify real problems worthy of the students effort to find solutions. The process may include inductive, deductive, and rationale thinking in order to sense the difficulty of the problem and proceed by successive steps to search for alternatives and select the most feasible and optimum solution.

2. Learning how to learn requires active participation. The learning experience should be designed to stimulate a reaction and encourage the student to become involved in his own education.^{4,18} The popular practice of providing pre-packaged, self-instruction materials can be an effective aid to learning. However, many of these independent learning programs leave little to the speculation or decision of the learner. The program may benefit the developer more than the student. The program developer may make the decisions concerning the necessary and sufficient content, select the best process to be used in reaching a solution, and may even offer the solution. As a consequence, the program developer learns and the student is given

the by-product of his learning.¹⁴ I believe it was Dewey who wrote: "Too often we are giving students cut flowers when we should be teaching them how to grow their own plants." Only when students learn the "how" of flower growing are they reasonably assured of a continuous supply of fresh flowers.

3. The ability to develop skill in continuous learning is dependent on the relevance or meaningfulness of the problem-solving experiences.³ Problems must be realistic and practical. The process of arriving at decisions or solutions must simulate the environment and constraints of professional experience. And finally, the process of evaluating competence in independent learning should contribute to the students internal stress and motivation for self improvement.¹⁸

4. The ability to learn independently is dependent on the students ability to conceptualize. The rote learning of facts cannot provide the cognitive organization with which to analyze information, formulate relationships, and deal with complex problems.^{3,4} Concepts provide the higher order of organization for the acquisition, retention and management of information.

5. Attitudes and values determine how one feels about the content, learning method and evaluation of learning. The affective dimensions of the learning process can influence retention and have a stabilizing effect on the associations that give meaning and coherence to information.³ Thus, attitudes and values influence the ability as well as the desire to learn.

IMPLICATIONS FOR A CURRICULUM

The evidence to date tends to indicate that learning is a very individual process; that is, the process is conditioned by a host of variables that are unique to the individual.³ Thus, a curriculum that is designed to accommodate a heterogeneous student population should be flexible enough both in learning pace and learning method to optimize the individual conditions for effective change. It has also been shown that when "independence in learning" is an objective of a curriculum then certain conditions or contingencies of design and strategy are indicated.^{7,14,19} Preparation for lifelong learning requires a curriculum that progresses along a process from an extrinsically motivated and dependent learning environment to one of intrinsically motivated independence. If courses and experience in the early part of the curriculum are highly structured, selected, directed and supervised, the later part of the curriculum should be less structured,

directed and supervised. In the final stages students would be expected to identify their own learning and performance problems, and using a variety of available resources, they would progress to a satisfactory problem resolution and learning change. Ultimately the responsibility for evaluation of the quality and adequacy of learning should be transferred to the learner.^{18,19,20}

In building a learning experience or curriculum, it is essential not only to create an awareness of the need for learning (stress) or the relevance of the problem for the learner, but there must also be some initial guidance in selecting the direction or method for problem resolution.¹⁷ Too often an instructor will attempt to teach solutions before his students recognize the problem or its relevance to their needs. For example, much of the early work in preventive dentistry and patient education was directed at changing patient behavior before the patient understood or appreciated the extent and consequences of their dental health problems. The rapid advances in preventive therapy were made possible only after dentists recognized the need to help each patient appreciate his problem before offering the solution.

Courses in resource management traditionally teach solutions to management problems before the student is aware of the need. As a result, both interest and retention may be low. Many other courses offered in professional curriculum also violate the need to create internal stress (motivation) as a prerequisite condition for effective learning. As an alternative, where students are provided extramural experience in a preceptorship environment, these settings should be used as a resource to identify problems in management *prior to* the terminal undergraduate course in resource management.

An effective evaluation process is critical to the successful implementation of any curriculum. However, the simple testing of selected cognitive or performance objectives is no longer adequate. Evaluation systems must be designed to identify the constraints to effective and efficient learning.¹³ Where blocks to learning exist with the learner, the subject matter, or the learning-teaching environment, they must be identified and overcome or reduced. Systems must also be developed to evaluate progressive maturity in intrinsic motivation to learn and to provide remedial guidance where necessary in order that self-directed learning is achieved and maintained.^{18,19}

NEED FOR RESEARCH

It was previously noted that formal education is simply an invention for conveying the corporate wisdom of a culture or society to the

individual. Such wisdom is believed to be essential in order for the individual to cope with the conditions of his or her environment. Formal education is designed to make the process of learning and coping more efficient and it is hoped, no less effective. The complexity of contemporary society makes it mandatory that some system be employed to improve the otherwise random, limited and inefficient process of coping, predicting, and controlling one's environment.

The corporate wisdom of a profession or the conclusions of its corporate experience are assumed to be the special domain of the professional faculty. It is essential not only to design an effective and efficient process for conveying the wisdom of a profession to its future practitioners, but it is also imperative that a faculty assume the responsibility to determine continuously *what is* the corporate or aggregate wisdom and what parts of that wisdom are both necessary and sufficient for safe, successful and responsible professional education. Thus, research, both clinical and educational, is a necessary correlate to responsible teaching in any formal education system.

A faculty has as one of its basic responsibilities to conduct such research so as to make a judgement concerning the truth or quality of the corporate professional experience. The knowledge and the discipline of research methodology, as well as the strategy for problem solving that is inherent in such methodology, are essential prerequisites for continuous learning for faculty as well as students.

CONCLUSION

Quite clearly, the health professions have not yet developed an effective system for assuring the continuous competence of its practitioners. Alternatives need to be explored in order to increase the probability of self-initiated change and lifelong learning. There appears to be growing support in favor of improvements in educational strategy that are designed to produce both the skills and the motivation for self-directed change.

Certain constraints of the curriculum and teaching process have been identified and explored. The future projects no lessening of the pressures for change and no reduction in the necessity for improvement in the coping skills and self-directed learning required of the health practitioner. The educational institutions can and must adapt their programs to increase both the capacity and the will to adjust and change if lifelong learning and continued competence is to become a reality for the health professions.

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(continued on page 188)

Toward an Improvement in the Quality of Life

JEANNE C. SINKFORD, D. D. S., Ph. D.

We have reached a moment in history where the health problems in developing countries show vast similarities to those of developed countries. Therefore, the health planners and health care deliverers must continue to be concerned about strategies that affect the overall quality of health and effective systems of health care delivery.

Our purpose and dedication must include the concept that health care is a right for all people and not only for a privileged few who may be able to afford it. Also, concern for patient access to health services, health education, attitudes toward health and life, today complicate what used to be the primary mission of the health professional: to alleviate pain, eliminate disease and to prolong life.

Dentistry has evolved as a crisis oriented profession and most dental care systems have been designed to relieve pain; that is, to extract or to drill and fill. We have just begun to focus on preventive concepts that would reduce the magnitude of oral disease to a level where health care "may" become possible and accessible to all.

While this is our mission and our present dream, we must look at the current facts. In the United States, we are a far cry from solutions for the oral health problems that beset our nation as we review such statistics as: half the children between ages 4 and 14 in the United States have never seen a dentist for treatment; there are over 1 billion unfilled dental cavities and half of the school age children have some form of malocclusion and gingival disease;¹ oral cancer strikes some 14,000 persons annually and causes 1 in every 40 deaths from cancer;² twenty-five million adults have lost all their teeth by middle age and another 25 million have lost half of theirs;³ 6,000 babies are born annually with cleft lips or cleft palates.⁴ In addition, dental bills of American families exceed 5 billion dollars annually despite the fact that less than half the population visits a dentist's office each year.⁵ And—American industry loses over 100 million man hours of production time annually because of problems related to dental

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health.⁶ Our overall dentist to population ratio is 1:2,500 whereas in the black community, the ratio is 1:12,500. This does not approach the magnitude of the dental manpower problem in the Commonwealth Caribbean in which the dentist per population ratio is approximately 1:20,000!⁷ However, our maldistribution problems are similar to yours in that United States dentists are concentrated in urban areas which leaves large segments of the population in underserved, rural and other shortage areas.

The current system of health in the U. S. is large and costly. It utilizes about 4.5 million people—double the number it employed 25 years ago—making it one of the largest industries in the country. Spending for health care in the U. S. now totals in excess of \$100 billion annually or about 8% of the gross national product!⁸

In the U. S. our current health status has been complicated by the response to increased social pressures and federal support of the concept of access to health care as a right for all people. The U. S. has attempted to make health care available to all through support of some form of a health insurance program (we do not have a national health insurance), Health Maintenance Organizations, Neighborhood Health Centers, Third Party Payment Plans, etc. Although these efforts are being made to improve health care delivery when and where it is needed, we still operate without a clear cut national health policy since our most effective planning has been on a local or regional basis. The Health Planning and Resources Development Act of 1974⁹ provided federal funding for regional health planning and development. Also, the new Health Manpower Bill¹⁰ passed in 1976 will give support to health educational training and will attempt to correct maldistribution of dentists and physicians in remote areas of the United States.

As we look at the progress dentistry has made through the years, we can be proud that as a health profession, dentistry has undergone steady growth since the founding of the first dental school in 1840. In removing the proprietary and apprentice nature from dental education and patient treatment, the profession assumed the responsibility for setting standards for dental health, for diagnosis and treatment of oral diseases and disorders, and for assuring steady progress toward the elimination of disease through research and clinical patient care. Advances in technology (high speed, finger touch drills) and the use of local anesthetics have done much to reduce the anxiety and fear related to a visit to the dentist. We have gone from a drill-fill and denture-oriented profession to a prevention oriented profession during the past twenty years. Still, the overall health status of the people in my country has not changed significantly nor accordingly

except in fluoridated communities where dental caries have been significantly reduced. I do not think that this should surprise us when we learn that only one third of the nation's children receive proper vaccination against diphtheria, pertussis, tetanus and polio even though these vaccines are available and free at public health clinics throughout the nation! This apathy is similar to that found in England.

If we consider that half of the nation does not visit a dentist annually—for even a screening examination—then we have nearly a 50% needy nation! Not that they will all require treatment, but they do need an oral health evaluation. In an effort to meet the dental health needs of a needy nation and anticipated demands for dental health services, our efforts have focused in the following areas during the past ten years:

1. *Modifications in dental education with the objective of increased dental health manpower.*

Through Capitation awards to dental schools, we have been able to more than double the dental student enrollment within the past ten years. Schools responded to the Carnegie Commission's Challenge to increase enrollment to offset the anticipated increased demand for dental treatment. We are now graduating 5,000 dentists per year.

2. *Experimentation with expanded function auxiliaries.*

This concept envisioned the utilization of highly skilled dental assistants and hygienists trained in dental procedures traditionally performed by the dentist that could be delegated without a reduction in the quality of service received by the patient. Some 25 dental schools now receive TEAM grant funds from HEW to implement these programs. Also, it was envisioned that the expanded function auxiliary could be assigned along with dentists to rural and other underserved areas. The resolution passed by the American Dental Association in October, 1975* opposed the preparation of teeth and injection of local anesthetics by dental auxiliaries. However, TEAM grants continue to be funded in dental schools where the function of the auxiliary is not in conflict with the state dental practice act.

3. *Other experimentation involving private practitioners, in the form of group and corporate practices, neighborhood health centers, HMO's, four-handed concepts, improved management techniques and increased utilization of auxiliary*

*Resolution 861, American Dental Association, House of Delegates, October, 1975.

personnel, has taken place. All of these changes have helped improve the system of delivery but have in no way reduced the cost of dental services. In fact, during the nine years since the 1967 base line of 100.0 was established for Consumer Price Index, the costs of operating a dental practice have increased more than 133% while dental fees have increased 66.5%. Our technology advances and our system of delivery to date have not demonstrated that we can reduce operating costs or that a saving can be realized by the consumer—the patient.

4. *Targeted research objectives.*

At the present time and because of limited research funding, federally directed research dollars have been directed toward studies that are of major incidence and concern. For dentistry, NIDR has provided substantial support for caries prevention studies, pain and anxiety control, for periodontal disease research, for behavioral research and for growth and development studies.

5. *Preventive dentistry* has become an accepted philosophy and ideal not just a movement. Every dental teaching institution now includes prevention in its curriculum. Studies on prevention indicate that reinforcement is essential and the most effective programs (outside of the military services) have been those that included the homemaker or "mother figure" as the propelling stimulus. We have not done nearly enough in our preventive public education and media utilization. Material and Child Care Benefits include an Early Diagnosis, Prevention and Screening Program which provides for a dental component that is now being implemented to the extent that the federal funding authorization allows.

6. *General practice and total patient care concepts:*

General practice residencies have increased and general dentistry clinical experiences are being added to dental curricula across the country. The dental graduate of these programs is expected to be a highly skilled community oriented, general dentist and an expert diagnostician. He is expected to be the primary care provider for dentistry, to reduce the need for increased specialists (who come at a higher cost and perform limited services) and to be concerned with the general health and well being of the patient—including screening examinations for diseases such as hypertension, sickle cell disease, oral and pharyngeal cancer, diabetes, etc.

All of these efforts to provide health care, where, when and for whom health services are needed have been less than adequate for we have not made the consumer an active participant in health—he has remained the health critic, the recipient and demander of health treatment. We have failed to properly educate the American public in self-assessment and health orientation. We have essentially left the consumer out in the diagnosis of health. The World Health Organization (WHO) has defined: "Health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity".¹¹ This is a holistic view of health but the WHO definition seems to imply that the patient has a role in the diagnosis of health in that his or her feeling of "well being" is the crucial criterion. This obviously cannot be the basis for a judgment of health—consider the "healthy" individual with oral cancer—undiagnosed. Does the patient become unhealthy only when he or she feels bad or when the cancer is detected following an oral examination and biopsy? The patient's feeling of well being is not a satisfactory guide to oral health status, but is a very good indicator of how he (she) priority-ranks health and what he will be willing to give up or to do to maintain a level of health that is acceptable. I would like to expand this concept further since our prevention studies clearly indicate the very significant role that the homemaker (mother or mother substitute) has in setting the level of quality for family health and nutrition. Can we afford to leave this type of responsibility to hostile, uninformed teenage parents with low levels of self-image and with unstable family structures?

The working mother and head of a family who must work eight hours a day, return home and cook and clean for her family with nothing better to look forward to than a repeat of this, day after day and year after year, must receive substantial support and motivation if that family is to grow and reap the benefits of our affluent society. In my experiences in two inner city hospital clinics and in the dental school clinic, I have found that all of the needy mothers, regardless of race, want more out of life for their children than they have received. All of them are willing to bring their children in for treatment when they themselves are truly dentally indigent but they want their children to be secure and to have the things that other children have and things that they themselves were denied as children. They want a better quality of life for their children.

As we assess our present ability or lack of ability to provide adequate dental health services for all people and look to the future, we must take serious cognizance of plaguing questions such as what will be a

more effective system of delivery than that which we now have? Who will be the dental health care providers and who will pay for dental care for people that cannot afford to pay? Can we realistically afford equitable health care for all? To this, I would answer a qualified "no"—under our present system of delivery and with our present attitudes toward health and nutrition. I predict, however, that once we have distilled the biases against federally funded health programs, such as Medicare, eliminated the abuses of such programs and instituted proper checks and balances, the Medicare type program can be written into a national health insurance system, partially subsidized by the federal government but controlled and managed by the private sector at state and local levels. This does mean that the federal funding must be distributed differently with more dollars going directly to health care with a base-option health program available to all Americans of all ages and various socio-economic strata.

As we anticipate and plan for the future, I believe the following strategies should be fully utilized in the U. S. and should be considered by developing countries as rational approaches to an improvement in the quality of life and in health care delivery:

1. *Health Planning and Resources Development*

In my country this would mean full implementation of the act passed in 1974 which provides for networks of Health Systems Agencies across the United States for planning and development for regionally identified population groups known as Health Service Areas (204). The HSA's have been designated to serve population areas of 500,000 to 3 million people. The HSA, if properly implemented, will allow for proper utilization of health resources on a regional basis.

2. *Health Manpower Training.*

Federal support for health manpower training must continue, to assure that the quality of medical and dental education is maintained. Also, funding for incentives to practice in underserved areas may prove to be an effective mechanism for solving the manpower distribution problem. Scholarships and loans to students are essential if children of poor and moderate income parents are to be recruited to careers in dentistry and medicine.

3. *Significant Behavioral Modification*

This is needed, especially as it relates to personal attitudes toward health and nutrition. This goal will not be easy in the U.S. where alcoholism and drug abuse are still on the rise. In spite of the broad exposure given the Surgeon General's warn-

ing on cigarette smoking, there has been a rapid rise in smoking among women and teenagers. We have become flabby, comfortable "adults" with our carbohydrate-rich snacks, soft diets and lack of meaningful exercise. Air pollution continues to be a menace and viruses continue to be a major health problem. Still, we must begin somewhere and for impact and effect, I suggest that health education be included in all levels in the public school curricula. Churches and other religious and civic organizations should include health education and counseling programs. A broader utilization of television and other communications media is needed that will allow prime time for health and nutritionally related subjects and sponsored at times where families can participate. Preventive dentistry and plaque control instruction are special areas that should be taken to pre-school instructional level.

4. *Fluoridation*

Where fluoridation is not available in the drinking water, special dental health programs are needed to assure that individuals receive the proper counseling and guidance regarding resources for fluoride, plaque control and diet. I had nearly forgotten what children's teeth looked like prior to mass fluoridation until I visited the state of Florida recently. The teeth of children from middle and upper income families looked far worse than the teeth from poverty stricken children in Washington, D. C. which has been a fluoridated community since the early 1950's.

5. *Auxiliary Utilization and Systems of Delivery*

Systems of delivery and utilization of auxiliary personnel must be changed to meet anticipated needs and demands for dental treatment. The availability and logistics of dental services do present problems for inner city parents who both work. Practices in centers and shopping malls that are well lighted and where parking and protection are already available could provide for evening dental services. Also, neighborhood dental clinics should extend full services on weekends. Dental screening examinations could take place in the schools, churches and in mobile units that could be stationed in various parts of the country on an announced-date basis. Auxiliary personnel such as neighborhood health advisors, expanded function auxiliaries, nutritional advisors, etc. could be utilized in group practice settings and in health clinics to improve the

quality of services rendered, to expand patient education and to increase the patient load.

6. *Distribution of Health Manpower*

A careful assessment of the maldistribution problem must be made and evaluated in terms of anticipated systems of delivery and need assessment. Experimental programs such as the Shortage Area Projects (SAS) that are currently being funded under the Special Projects Grants Program in the U.S. have exciting possibilities. The students in these programs spend time in remote sites (in a practicing dentist's office). Students are allowed to select their training site and the practitioner is considered off-campus faculty. The practitioner is sensitized to his responsibility as a teacher and recruiter through seminars sponsored by the school for off-campus faculty. Recruiting dental students from designated shortage areas who plan to return home to practice is another possible mechanism, but that will not provide immediate results. Still, it should be explored in the long range planning for manpower and manpower distribution in needy areas.

7. *Special Patient Care*

The dental student during his undergraduate dental training experience must be sensitized to the needs and peculiarities of special patients and on how to treat these patients. Dental school clinic patients, in general, are moderate income paying patients. They are sensitized to oral health to the point that they come to seek treatment and they make visits on a regular basis because they know if they do not, they will be dropped or the student's progress will be affected. Our graduates need to know how to treat the fearful patient, the chronically ill patient, the developmentally disabled patient, the drug addicted patient. Therefore, we must make use of off-campus training sites such as neighborhood clinics, neighborhood health centers, hospitals, nursing homes and private offices to provide the clinical experiences that cannot be gained in a dental school clinic environment.

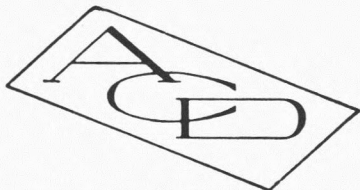
8. *Dental Research*

Research efforts should be directed toward the elimination of major disease categories such as: dental caries, periodontal disease, pain and anxiety control. Also, educational research and research regarding systems of delivery and behavioral aspects of dental care are needed for efficiency and quality assessment purposes.

In summary, behavioral and attitudinal changes toward health must accompany our health planning strategies for the future. If we are to improve the status of health and the quality of life, we must reduce crime, poverty, pollution, social restrictions and debilitating diseases that cripple the minds and bodies of our people. It is not enough for us to prolong life and eradicate disease. We must improve the quality of life for all people. In order to achieve this goal, health professionals must be motivated and unified in their ideals and purposes. Our effectiveness in the achievement of this mission will be measured by the quality and status of health in our children and in the future generations to come.

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READER COMMENT

In this new feature the Journal will print brief thoughtful opinions from Fellows of the College. All contributions are welcome.

COMMUNITY DENTISTRY—ANOTHER VIEW

Dr. H. Barry Waldman's article "Departments of Community Dentistry—Are They a Threat To The Profession"¹ does not answer the question. Interesting evidence is presented. Presumptive conclusions are stated (presumptive because they are not based on the evidence). But most importantly a number of questions were raised.

After pages of evidence showing the limited ability (or the inability) of departments of community dentistry to "turn students around" (his term) he asks what is the threat of these departments to the profession. He answers, "No doubt it is the insidious long term effects that the members of these departments may have upon the profession".² In the following paragraph the same conclusion is clearly restated without qualification. I must ask where is the scientific method and how is such an answer justifiable in contradiction to the evidence. Is this logic or "going on faith"?

Dr. Waldman argues for change....gradual modification, and that the profession must not be "static". Certainly the profession, or almost anything, must change to live. To remain "static" is to die....agreed. Clinical dentistry has been and is changing much. Delivery systems have changed but little and here, I believe, is the point of concern.

Dr. Waldman infers that "custom" is the control on dentistry, and that it is out of date. The use of this sentiment at the end of his "conclusions" would suggest that it is the cardinal thought....the parting shot intended to produce the latent image. I read the article again to see what it was about dentistry that was out of date—being controlled by "custom". I could not find answers—only inferences. I was caused to wonder what exactly is wanted. What *are* the goals of

the teachers of Community dentistry? I must ask some specific questions.

Does "community dentistry" wish to deny the reward incentive which has proved to be the greatest stimulus to production and distribution? If so, what would replace it....do goodism? Humanity's experience is that such does not well serve society. Perhaps other motivations exist such as serving society (the State) not the patient. Enlightened self interest (ethical private practice) remains the proven best way for production and distribution of dental services.

Indeed, in America ethical private practice is the custom. If, as Dr. Waldman infers, custom has "become the tyrant", what customs or aspects of them should be discarded to meet the changing times...."in an altered arena"?³

If the custom be private practice, shall we replace it with group or clinic practice?

If the custom be operative or prosthetic dentistry done by dentists, shall we stop and be supervisors?

If the custom be the highest professional standard of service, shall we do "alternative treatment plans" (cheap)?

If the custom be insisting on patients being responsible for their own dental health, shall we now assume that responsibility for these individuals or assign it to mother Government?

If the custom be ADA ethics, with what shall they be replaced?

To allay suspicion, and correct error, and enhance education it would be of service to the entire profession....students, teachers, and practitioners, for the "Community Dentistry" professors to precisely identify the changes and the goals they seek. To do otherwise isn't "leveling".

Dr. Waldman reassures the reader by arguing that surely professors of community dentistry, being dentists, would not destroy the profession. Such a conclusion is not necessarily a safe or reasonable one. A number of dentists have been revolutionaries of world renown. Being a dentist is no assurance that one would not strive to injure the ethical, academic, or economic bases of the profession.

1. J. Am. Coll. Dent., Vol. 44, p. 80-92, April, 1977.
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Book Review

THE HEALTH ROBBERS,
Edited by Stephen Barrett,
M.D. and Gilda Knight. Phila-
delphia, George F. Stickley
Co. 1976, 340 pages \$10.50.

Health science has never had more to offer than it does today. Yet trust in doctors has fallen — and quackery is at an all time high. By unmasking the frauds, the crooked promoters, and those who prey upon the ignorance of the public, the authors and editors have rendered a valuable public service in presenting this information.

Subtitled "How to Protect Your Money and Your Life", this excellent book attacks diet and health food quackery, fake cancer cures, and false claims of the pill and nostrum peddlers, faith healers, questionable sex therapies, and medical fads and gadgets of every imaginable kind.

Two chapters of particular interest to dentists concern the "poison-mongers" (anti-

fluoridationists) and the practitioners of dubious dentistry, including the promoters of the concept of balancing body chemistry for better dental health. The activities of the National Health Federation, its leaders, and their unscientific health theories and products are described in some detail, and the reasons for failure of many fluoridation referenda are discussed.

Written in an eminently readable style, this book is a real eye opener. Aimed primarily at the lay public, even the most sophisticated professional will benefit from the penetrating observations made by the authors. If it has one fault, that would be the failure to include a chapter on denturism, the illegal and unqualified practice of dentistry. In this reviewer's opinion, illegal dentistry constitutes a major threat to the health of the public. Perhaps the editors will consider such a chapter in the next edition.

Wisdom is knowing what to do next, skill is knowing how to do it, and virtue is doing it.

David Starr Jordan

Preparation for Lifelong Learning*(continued from page 175)*

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Dentistry and Health Legislation*(continued from page 156)*

medical and dental professions; for a system built without the cooperation of its health care providers cannot succeed. We believe that we, the dental profession, can play an important role in this endeavor. It is critical that our concerns be acknowledged and incorporated into any health care delivery system if dentistry is to remain a viable force in ensuring the dental health of the public in the years to come.

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NEWS OF FELLOWS

Francis X. Pelka, president of Chicago Dental Society recently received the Alumnus of the Year Award from the Loyola University School of Dentistry.

Thaddeus Weclaw of Chicago received the Order of the Palmes Academiques of the French Government earlier this year for his contribution to French continuing dental education.

New Jersey Section

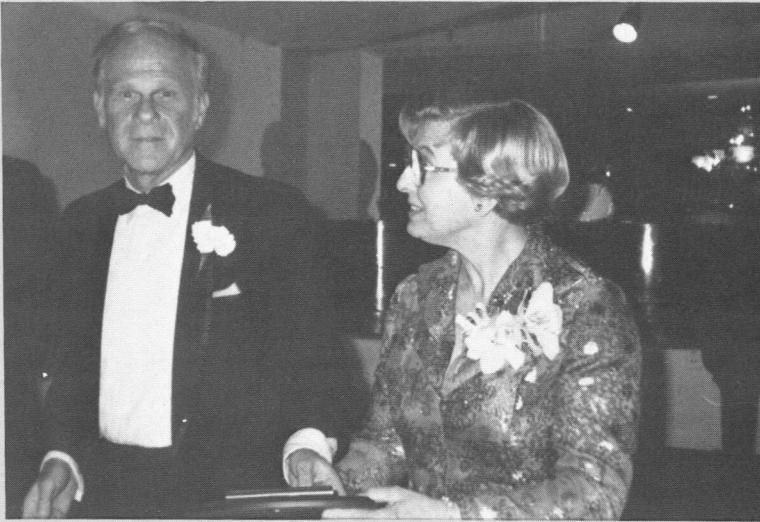
The New Jersey Section met in April at the Ramada Inn, Clark, New Jersey. Chairman Jacob Oxman presided.

The following officers were elected for the 1977-78 year: David Alterman, chairman; Ralph Terrace, vice-chairman and Philip Schwartz, secretary-treasurer.

Dr. Alterman appointed William Joule to serve as chairman of the committee on rechartering of the Section. Serving on the committee also are Deckle McLean and Thomas DeStefano.

Joseph Pollack introduced the speaker of the evening, Dr. James R. Cowan, Senior Vice President for Health Affairs of Blue Cross and Blue Shield of Greater New York, who gave an informative talk on National Health Insurance. Dr. Cowan feels that it will become a reality in the near future. He believes the best way to approach health care would be by insurance from both the private sector and the federal government, not the federal government alone. The program ended with a question and answer period.

NEWS OF FELLOWS



Fellows **Irving W. Eichenbaum** and his wife, **Naomi A. Dunn**, who practice pedodontics together in New Britain, Connecticut, were honored recently by the presentation of the 29th Annual Award of the Dental Society of Greater Waterbury.

Within recent months a number of Fellows of the College have received honors and awards from dental organizations and academic institutions. The College extends its sincere congratulations.

Robert L. Heinze, former Regent and Vice-president of the College received the Distinguished Service Award of the Second District Dental Society of New York in Brooklyn recently.

Henry M. Sorrells has been named Dentist of the Year by the Texas Section of the College, and also Outstanding Alumnus of the University of Texas Dental Branch at Houston.

O. V. Cartwright has been named Dentist of the Year by the Dallas County Dental Society.

Louis J. Boucher of the New Jersey College of Dentistry has received the Merit Award of the Marquette University Alumni Association.

John H. Mosteller of Mobile, editor of the Journal of the Alabama Dental Association since 1956, has received the University of Alabama School of Dentistry Alumni Association's Moren H. Fuller Award. The Award was presented at the Association's annual luncheon meeting, held in Mobile in conjunction with the 108th annual session of the Alabama Dental Association.

Morris S. Minton, McKinney, Texas received the Distinguished Alumni Award of the Baylor Dental Alumni Association at the annual luncheon of the association in El Paso, Texas recently. The award was presented in recognition of constant devotion and outstanding contributions to the art and science of dentistry—1977.

Thomas H. Swift of Bronxville, New York was awarded the Ninth District Dental Society's Medal of Honor. A presentation was made at a meeting in Tarrytown a few months ago.

The society's highest honor, the medal is awarded to the member who has given of his time, energy and ability for the benefit of the society and who has made notable contributions to the dental profession. Dr. Swift is a past-president of the society.

Kenneth Bentley, professor of Oral Surgery, became dean of the Faculty of Dentistry of McGill University in June succeeding Ernest Ambrose who recently resigned, to take up a new post as dean of Dentistry in the University of Saskatchewan at Saskatoon.

Spencer N. Frankl has been named dean of Boston University School of Graduate Dentistry and took office on July 1, 1977 upon the retirement of the school's first dean, **Henry M. Goldman**, who received an honorary Doctor of Science degree at the recent commencement exercises.

Clifton O. Dummett, professor of dentistry at the University of Southern California and president-elect of the Los Angeles Dental Society, has been appointed to the Advisory Committee on National Health Insurance by Secretary Califano of the U. S. Department of Health, Education and Welfare.

Seven leaders in dental health were honored at the First Annual Founders Awards Dinner of the American Fund for Dental Health in Chicago in February for their roles in establishing the Fund twenty years ago. They are **Harold Hillenbrand**, executive director emeritus of the American Dental Association; **Maynard K. Hine**, special consultant to the president of Indiana University; **Andrew M. Howe**, former director of special projects for the William Wrigley Jr. Co.; **Harry Lyons**, past president of the American College of Dentists and special assistant for development of Virginia Commonwealth University; **Raymond J. Nagle**, dean emeritus of New York University College of Dentistry; **Henry M. Thornton**, chairman of the board and chief executive officer of Dentsply International; and **Gerald D. Timmons**, former dean of Temple University.

The following Fellows were recently elected as officers of the American College of Prosthodontists at its annual meeting in San Francisco. **Robert W. Elliot, Jr.**, president; **Daniel F. Gordon**, president-elect; **Kenneth D. Rudd**, vice-president; **Dean L. Johnson**, secretary; and **Noel D. Wilkie**, treasurer.

Nathaniel H. Rowe, University of Michigan professor of dentistry and pathology, has been named president of the American Academy of Oral Pathology during its annual meeting recently in Seattle.

Charles F. McDermott, ACD president-elect, and **George P. Boucek** received Distinguished Alumni Awards at the recent graduation ceremonies of the University of Pittsburgh School of Dental Medicine.



The American College of Dentists was well represented at the dedication of new "satellite" dental clinic in the country town of Mayo, Florida. Standing in front of the clinic building are, left to right: Quentin Smith, professor and former chairman of the Department of Community Dentistry, University of Florida College of Dentistry; William Collett, associate dean of the UF College of Dentistry; John F. Bowman, chairman of the Department of Removable Prosthodontics; Parker Mahan, chairman of the Department of Basic Dental Sciences; Stanley Lotzkar, chairman, Department of Community Dentistry; Gene Lewis, director of the Division of Health Resources, HEW Region IV; Don Allen, dean of the UF College of Dentistry; and Charles Fain, past president of the Florida Dental Association.

Samuel Pruzansky, director of the Center for Craniofacial Anomalies, University of Illinois Medical Center, Chicago, has been appointed chairman of the Executive Board of the Health Education Committee and member of the Study Group on Medical Education of the Metropolitan Chicago Chapter of the National Foundation—March of Dimes.

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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