

the
journal
of the

**AMERICAN
COLLEGE
OF DENTISTS**

JANUARY, 1979

VOLUME 46

NUMBER 1

Not by Ambush Nor by Apathy

Factors Affecting
Professional Orientation in the
Delivery of Oral Health Care

Present and Future Problems
of the Dental Profession



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NEWS AND COMMENT

BOARD ACTIONS

At its meeting in October in Anaheim, California, in conjunction with the Annual Meeting and Convocation, the Board of Regents took the following actions:

- Appointed a committee to study a proposal to move the Executive office to another location in Bethesda, Maryland.
- Accepted reports of the Regents describing Section activities in their Regencies.
- Implemented the Oral History program by approving the employment of a historian who will begin a project on dental journalism.
- Heard a report of the Search Committee to find a new Executive Director but took no action.
- Accepted a report of the Self-Assessment and Continuing Education Committee, which program is still in progress.
- Accepted a report of the Mini-Self Assessment program which has been revised by the development of a new text and a new self-scoring mechanism.
- Accepted reports of the Commissions on Research, Education, Journalism and Delivery of Care.
- Reviewed the testimony to be presented to the Council on State Governments by president Charles F. McDermott.
- Appointed an ad hoc committee to study the Fellowship booklet.
- Referred the report of President McDermott to the Executive Committee for study, with recommendations to be presented at the Spring Board meeting.
- Sent congratulations to the International College of Dentists on its Fiftieth anniversary.
- Adopted a budget for 1979.
- Extended its appreciation to retiring president Charles F. McDermott and regents Charles A. Calder and William C. Draffin.

SECTION NEWS

Western Pennsylvania Section

On September 7, 1978, the Section held its first Annual Breakfast at the Greater Pittsburgh Meeting of the Odontological Society of Western Pennsylvania. Charles F. McDermott spoke on "Professionalism." The breakfast was well attended and we expect to make this affair an annual event at the greater Pittsburgh meeting.

On September 21, 1978, our Rechartering meeting was held at the University Club in Pittsburgh. Regent Balfour D. Mattox attended and presented the new charter to the Section. Western Pennsylvania Section Chairman Milton E. Nicholson gave a history of the Section. This event was also well attended. The enclosed photograph was taken that evening.

On December 7, 1978, the Section had its annual Spouses Night. This evening honored Charles F. McDermott and welcomed the new Fellows to the Section.



From Left to Right: Balfour D. Mattox, Regent; Charles F. McDermott, President, American College of Dentists; Milton E. Nicholson, Chairman, Western Pennsylvania Section; Ruth S. Friedman, Secretary-Treasurer, Western Pennsylvania Section; William Webb, Vice-Chairman, Western Pennsylvania Section; Marvin Sniderman, Chairman of Rechartering Committee, Western Pennsylvania Section.

Texas Section

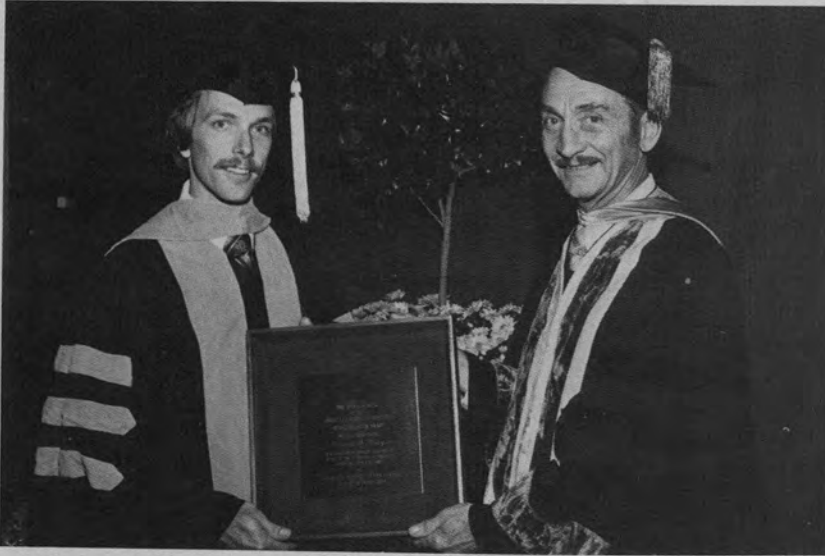
The annual business meeting of the Texas Section was held at the Fairmont Hotel in New Orleans during the Tri-State meeting, with twenty-four members present. A committee, chaired by Dr. Jim Verneti was formed to sponsor an all-day Continuing Education Program, presented by Fellows of the Texas Section, admission free to all Texas dentists, on November 18, 1978, at the University of Texas Dental School at San Antonio.

The planned program was as follows:

Implants	Kenneth L. Stewart, Roland M. Meffert
Periodontics	Walter N. Johnson
Endodontics	Russell A. Grandich
Overdentures	Robert M. Morrow
C&B Electrosurgery	George C. Kiser
Moderator	James P. Verneti

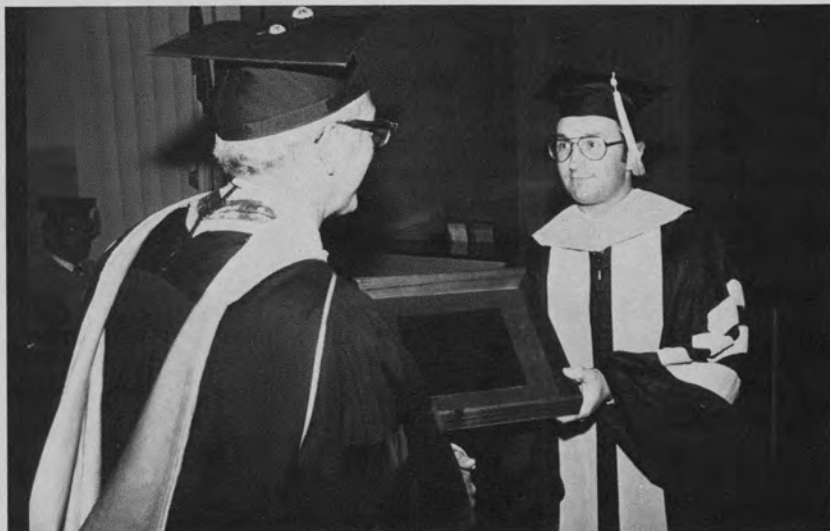
An informal breakfast meeting will be held during the Dallas Mid-Winter Clinic and the Greater Houston Dental Meeting.

The past president's plaque was presented to retiring president, Dr. John Wilson by incoming president, Dr. John Wilbanks.



The Texas Section presented its Professionalism Award to Dr. Kenneth R. Krueger in recognition of superior qualities of leadership and character evidenced during his course of study at the University of Texas at San Antonio School of Dentistry. Left to Right: Dr. Krueger and Dr. James P. Verneti, past president of the American College of Dentists.

A similar award was presented to Dr. Robert Lanham Bucy of the University of Texas at Houston Dental School.



Dr. Larry E. Stigall is shown receiving the ACD Professionalism Award from Dr. Kenneth V. Randolph, president and dean of Baylor College of Dentistry, during commencement exercises in June, 1978.

New York Section

The September meeting of the New York Section was held at the New York University Club. Fifty fellows attended.

After a brief business meeting, Dr. John K. Lattimer, was our guest speaker. His topic was "The Kennedy Assassination". Professor Lattimer gave a detailed description of the injuries sustained by the former president of the United States and illustrated how it was possible for one man to commit this crime.

The Rechartering Meeting was held in October at the Harvard Club of New York under the direction of Irving Naidorf, chairman of the N.Y. section.

The meeting was turned over to George L. O'Grady, chairman of the Rechartering Committee. Dr. O'Grady spoke briefly on the activities of the N.Y. Section and introduced George Mullen, treasurer of the American College of Dentists who brought greetings from the central office.

Our Regent Gerard E. McGuirk gave an inspiring talk on the history, aspirations and goals of the American College of Dentists.

Dr. McGuirk presented the new charter to Dr. Naidorf.

(continued on page 71)

the JOURNAL of the AMERICAN COLLEGE of DENTISTS

A QUARTERLY PRESENTING IDEAS IN DENTISTRY

ROBERT I. KAPLAN, *Editor*

One South Forge Lane

Cherry Hill, New Jersey 08002

ROBERT J. NELSEN, *Business Manager*

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LYNDEN M. KENNEDY

BALFOUR D. MATTOX

GERARD E. McGUIRK

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DALE A. HILLS
President 1978-1979

The President of the College

Dale A. Hills, a general practitioner of Minneapolis, Minnesota is president of the College for 1978-79. Born in Loyal, Wisconsin, he took his pre-dental education at Central States Teachers College, and studied dentistry at Marquette University. Upon graduation he served for three years in the United States Army Dental Corps during World War II.

After the war, he entered practice in Minneapolis and has been active on the local, state and national levels for many years. He has been president of the Minneapolis District Dental Association, having served on many of its committees. Service to the Minnesota Dental Association led to his election to the presidency in 1964. He represented his organization on the Advisory Committee on Title XIX to the Minnesota Department of Public Welfare.

His services to the American Dental Association have been particularly noteworthy. He was a member of the House of Delegates for five years, member of three Reference Committees at annual sessions, and served as a member and chairman of the Council on Dental Education. Dr. Hills has made Accreditation Site visits for this Council to 24 dental schools and 36 dental hygiene programs. He has also been a consultant to the American Association of Dental Schools, the Commission on Accreditation, the Kellogg Foundation, the Veterans Administration, the University of Kentucky and University of Texas.

He is a past president of Delta Dental Plan of Minnesota. He has lectured throughout Minnesota on various subjects and has had articles published in the Minneapolis Dental Journal and Northwest Dentistry.

Dr. Hills has also been active in community affairs, holding membership in the American Legion, Robbinsdale Lions Club and Robbinsdale Chamber of Commerce. He is an Elder in the Peace Lutheran Church, a director of the Guaranty State Bank, and is the recipient of the WCCO Good Neighbor Award. He is a member of Psi Omega dental fraternity.

He became a Fellow of the College in 1964 and served as a Regent for four years before moving up through the chairs. As he assumes the presidency, we congratulate him for his long and distinguished career, and wish him much success in his administration.

President's Inaugural Address

DALE A. HILLS, D.D.S.

Only three out of every one hundred dentists in the United States are Fellows of the American College of Dentists. You are probably thinking that you are very fortunate to be selected as a Fellow. You are correct. It is, indeed, a great honor. You may also be thinking that three individuals out of one hundred can not accomplish very much. You are not correct and I will tell you why.

In the spring of 1920, four men, John V. Conzette, H. Edmund Friesell, Otto U. King and Arthur D. Black were very concerned about the problems facing the dental profession. Dental education was attempting to reorganize its curriculum and was setting up standards for classification of dental schools; the Flexner report on medical education exerted a tremendous impact on the dental profession; dental research was just beginning and needed support and guidance; dental journalism was under the dominance of commercial enterprises. Isn't it strange that today our concerns are in the same categories?

These four dentists decided to ask twenty-five colleagues to assist them in organizing a College or honor organization in dentistry. These gentlemen decided that there was a need for an organization that would encourage dentists to continue their studies, provide incentives for students that would lead them to aspire and develop high ideals, and to recognize, through the awarding of Fellowship, the contributions to the profession made by individuals. There was doubt that an organization could be established that would be free from political pressures and friendly influences. It was agreed that the following principles must prevail if such an organization were to be successful:

1. Its aims must be of the highest order.
2. The ideals and purposes must be spelled out and fully understood.
3. These principles must be strictly adhered to. There should be no waivering to accomodate individuals.

Presented at the Annual Meeting and Convocation of the American College of Dentists, Anaheim, California, October 21, 1978.

4. The organization must be independent of all other organizations.
5. It must be free of all political influences.
6. Membership must be invitation- not by application.
7. Secrecy in considering nominations must be maintained.
8. Personnel of the committee or board reviewing the qualifications for fellowship should not be known and should be fully supported if the process is to be successful.

The officers and regents have maintained these principles through the years and they still prevail today. The College has provided leadership and guidance to the dental profession through its many studies and projects. All officers and regents are to be commended for their dedication and devotion to duty.

Recently the College has not been as active as it would like to be in the affairs of the profession because of its reorganization. In the early 1970's, the officers and regents decided that the College could be more responsive to its Fellows and provide greater leadership and service if it would establish regencies on a geographic basis. Previously, the regents were elected and served at large without any obligations, but now the regents are nominated and elected by Fellows in their regency and are accountable to the Fellows and Sections in that regency. It became necessary, because of the reorganization, to recharter all Sections.

Now that the reorganization is completed and the rechartering of all Sections is nearing completion it is again time for action.

The American College of Dentists is a sound organization. Its design and structure has survived many tests and it is anticipated that it will be tested many times in the future. The tremendous amount of knowledge, ability, dedication and leadership that the Fellows of this College possess is astronomical in scope. This energy must be released for the good of dental health service, the dental profession and our fellow-man.

Some organizations become complacent and eventually end up being dormant or mere honor societies. Many of us may have heard similar statements about the American College of Dentists, but I can assure you that this is not true and, as long as I have any responsibilities in the college, I will do everything in my power to make this an active organization. It is time for action!

Our College is needed in our profession to act as a stimulus to men and women both before and after graduation, that they may have something to look forward to beyond the acquirement of a dental degree or a license to practice. Individuals who are honored by being admitted as Fellows, should look upon their induction as the beginning of their period of service to dentistry in a new and enlarged field.

The action that I am proposing for the American College of Dentists is a means of developing a position on issues facing dentistry. Many people say we should act instead of react, but there are times when the profession must do both.

The College has an organizational structure that is designed for action, namely the commission system. This system avoids looking at a problem with limited vision, spontaneous response to crisis, complicated rituals of committee appointments, and vague programming that seems to plague many organizations. Instead, the commission system allows input from many individuals and organizations; sections can study the issues on the local level and submit their conclusions; consultants with expertise can be utilized; and Fellows of the College will be invited to present their views. After the issues are examined and studied, a value judgement will be made and the College will then state its position on important issues.

One issue before the dental profession today is the decision of the supreme court to permit the legal profession to advertise its services. This ruling is considered to be applicable to other professions, including dentistry.

Two sections, New Jersey and Upper Midwest, conducted a survey. This question was asked "Should a fellow of the American College of Dentists be allowed to advertise?". 206 out of 296 responded. This was a 70% return. Only 14 of the 206 said YES!

The Board of Regents has decided to review the code of conduct and will determine if there is a need for revision and it will also decide if specific recommendations regarding advertising is necessary.

Fragmentation of the dental profession should be of great concern to all dentists. Every group that is related to dentistry has its own organization; the specialties, general practitioners, auxiliaries, dental educational institutions, dental educators, state dental examiners and many more. Each organization should have the right to organize and govern itself through its own constitution and by-laws. Occasionally, a group will become parochial in its thoughts and actions thereby failing to consider what is best for the entire profession. Their selfishness not only hurts themselves, but all of us. Another group might decide that it should be the spokesman for the dental profession and this creates havoc. There should be only one official voice for the dental profession, and that should be the American Dental Association.

All members of the dental family should have the opportunity to present their views and debate the issues according to established guidelines. The American Dental Association should act as a collector and reviewer of all material, resolve the differences and establish policy.

The danger of the dental profession becoming divided is probably greater today, than any time in the past. We must not allow this to happen.

I am asking the Board of Regents to determine if the American College of Dentists can act as a cohesive catalyst in the amalgamation of all dental groups and organizations for the purpose of submitting a united front to all external forces.

Today the American College of Dentists is in this position: we have the mechanism - the commission system, we have the resources - the Fellowship, with knowledge, ability and desire, the central office under the able direction of Dr. Robert Nelsen and some financial support.

All that is lacking is the push to get things started. This is where we must get involved. We must put forth our concerted efforts to place the operation in motion. If every Fellow would provide just a little cooperation and assistance, the results will be great, much greater than if all the cooperation and assistance is provided by a few. When this materializes, we then have action. Then the American College of Dentists will become a more viable and active organization.

Candidates for Fellowship, I welcome you. This afternoon you are to receive a great honor which you deserve. But you must also assume greater responsibilities and provide more contributions.

Sponsors, I commend you for recognizing the accomplishments of your candidate and for nominating him for Fellowship. It is unfortunate that there are so many individuals who deserve nomination but do not receive it. It is the duty of every Fellow to seek persons worthy of Fellowship to submit their nomination on forms provided by the central office.

I accept the obligation and responsibilities of the office of President of this great organization, the American College of Dentists. This is one of the highest honors in the dental profession and I am eternally grateful for the opportunity to serve.

3925 37th Avenue North
Minneapolis, Minnesota 55422

Honors and Awards

CITATION FOR HONORARY FELLOWSHIP TO GERALD J. COX

Presented by Regent Balfour D. Mattox

Fellows of the American College of Dentists, Honored Guests, Ladies and Gentlemen. I present as this year's recipient of Honorary Fellowship in the American College of Dentists, Gerald J. Cox. Something that many individuals strive for over a lifetime, he had accomplished by the time he was twenty. From 1913-1915, he had taught the fourth grade and had become principal of a school housing the first four grades in Bridgeport, Illinois.

This was just the beginning. The next four years were spent obtaining a B.S. in Chemical Engineering with preliminary and final honors. He worked in the Animal Nutrition Laboratories at the University of Illinois 1917-19. He took time out to marry Miss Ruth Amelia Dempsey of Yale, Oklahoma on June 22, 1919.

He went with the Special Chemicals Co. of Highland Park, Illinois 1919-1922 where he initiated among other things the manufacture of amino acids for commercial use.

In 1922 he entered the Graduate School of the University of Illinois with major studies in physiological chemistry, obtaining his M.S. in 1923. In 1925, from the same school, he obtained his Ph.D. He stayed at the Univ. of Illinois until 1929 - teaching, researching and writing.

In 1929, he bid farewell to the Univ. of Illinois and accepted the appointment of Senior Industrial Fellow in the Mellon Institute, Pittsburgh, Pennsylvania. The three lines of investigation pursued at the Mellon Institute were:

Toxicology of aluminum 1929-30.

Industrial uses for refined cane sugar, 1930-33.

Etiology of dental caries.

In the experiments running from April to August 1936, much valuable information was learned regarding the protective action of fluorides in the formation of the teeth. The dietary relationship to caries resistance and the proper formation of the teeth was studied. Caries resistance resulting from meat rations as well as pre-eruptive fluorides was

observed. Ironically, the studies on dental caries were supported by the Sugar Institute, from Nov. 1933 to October 1934 and then by the Buhl Foundation from April 1935 to April 1940.

Dr. Cox instituted the use of Keysort punch cards for analysis of data of caries in rats, a first use of this type of card in scientific work.

Having been a member of the American Chemical Society since 1919, he became Chairman of the Pittsburgh Section in 1937 and Councilor from 1937-1941.

Dr. Cox was a statistician for the War Production Board 1940-42; a reader for the National Research Council 1942-1944; Section leader for Corn Products Refining Company 1944-1948; Professor, Dental Research, University of Pittsburgh; and Professor Emeritus, University of Pittsburgh beginning in 1965.

Dr. Cox's work and findings regarding caries and the value of fluoridation have made the dental profession eternally grateful. The public should be doubly in his debt for the legacy he has bequeathed to those who have had the benefit of fluorides and the millions yet unborn who will reap the harvest of his multifaceted research.

CITATION FOR THE WILLIAM J. GIES AWARD TO HARRY LYONS

Presented by Regent William C. Draffin

Harry Lyons was born in Washington, D.C. at the turn of the century. In 1901, his family moved to Lexington, Va., which city became the site of his elementary and high school education. He was a member of the Student Army Training Corps at Washington and Lee University in 1918. He graduated with honors from the Medical College of Virginia School of Dentistry in June 1923 and was elected to Omicron Kappa Upsilon Honorary Society.

By the time of his graduation, he had determined that his contribution to the profession would be principally through Education. He was elected to a full time position on the faculty at the Medical College of Virginia in the fall of 1923. Dr. Lyons served through all the ranks from instructor to professor and Chairman of the Department of Oral Pathology, Diagnosis and Therapeutics, and Periodontology.

In 1928, he became part time professor and entered private practice. As a private practitioner in the specialized area of periodontology, he adhered to the principle of conservation of tissue, relying on curretage, occlusal harmony and scrupulous home care as a basis of sound treatment. His contributions and clinical approach were respected and admired by his colleagues to the extent that these principles form a strong foundation of periodontal treatment today.

Dr. Lyons returned to full time education as Dean of the School of Dentistry on January 1, 1951. He continued in this capacity until his retirement on June 30, 1970. At that time he was elected Dean Emeritus and his respected abilities have continued to serve the entire Medical College of Virginia.

Under his adept and tireless leadership, the Dental School built two new physical structures. Quality education, however, continued to be his prime objective and physical plant growth was not permitted to interfere but was planned so as to complement the educational objective.

As a professor and as Dean, as with his personal professional life, he sought to encourage his students to the highest possible achievement. As Dean, he retained his close contact with the student body and the Alumni exerting his magnetic influence to promote continuing education as a vehicle to maintain professional proficiency. This he did at a time before others were placing such great emphasis in this concept.

During the period 1947 to 1965, Dr. Lyons served his profession in numerous capacities from President of the Virginia Dental Association to President of the American Association of Dental Schools, American College of Dentists, American Academy of Periodontology and the American Dental Association.

President Lyons' abilities were further utilized by American dentistry on many occasions before U.S. Congressional Committees. His knowledge and sound reasoning has been utilized by many committee assignments. His professional acumen has led to duties as consultant to the Veterans Administration, U.S. Food and Drug Administration and Surgeon General of the U.S. Navy. His dedication to fairness to all was demonstrated over a five-year period as Speaker of the House of Delegates.

His accomplishments as dentist, citizen, and educator were recognized by Honorary Doctor of Science Degrees from Temple University and New York University. For the same reasons, Manitoba University presented an Honorary Doctor of Laws and the State of Israel presented to him the Maimonides Award.

By living example, Dean Lyons supported truth and justice. He spoke out fearlessly and without concern for person or position against bigotry and inaccuracy. His voice was heard on many subjects vital to the profession and his views were respected even though at times they caused a self analysis that was unpleasant. Through it all, he maintained an impersonal approach which encouraged others to emulate his high aspirations and ideals. Thereby the atmosphere in which the profession serves and functions was improved.

Educator, leader, exponent of truth without compromise, defender of principle, accomplished orator, Harry Lyons remained unaffected by success, respected by those with whom he disagreed, loved by those who knew him well. In truth, the saying

I hate that which is good.

I loathe and despise that which is bad.

I strive only for that which is perfect.

could have been written about him.

Mr. President, it is a privilege and an honor to present Dr. Harry Lyons for the William J. Gies Award.

CITATION FOR THE AWARD OF MERIT TO WILLIAM T. McCORMICK

Presented by Regent Joseph B. Zielinski

William T. McCormick holds the official title of Director of the Bureau of Convention Services of the American Dental Association.

He is a native Chicagoan, received his early education in the Chicago schools, and earned his degrees from the University of Illinois. After serving as a noncommissioned officer in the United States Army, he affiliated with the Lions International as Manager of Convention Services.

He joined the American Dental Association staff in 1969 in a similar capacity. Today, he serves as the Director of Convention Services and is responsible for putting together the many details involved in housing the annual sessions of the American Dental Association. These responsibilities start with the evaluation of the site which must be of capacity to accommodate the annual sessions. This is done six years in advance of the meeting. He maintains close relationships with the Council on Scientific Sessions and the General Committee on Local Arrangements of the American Dental Association. Besides insuring that there is enough space for all of the housing and program

needs of the American Dental Association, he is also responsible for the assignment of the hotel accommodations and meeting rooms for related dental groups who hold sessions in conjunction with the American Dental Association. This includes the allocation of space requirements for the annual meeting and convocation of the American College of Dentists.

Mr. McCormick holds membership in the Professional Convention Managers Association and the National Association of Exhibit Managers.

The American College of Dentists today wishes, with this award, to make public acknowledgement of this quiet, effective Director of Convention Services. His commitment to his very responsible position bears in large measure upon the success of Dentistry's most important meeting.

Mr. President, for these reasons and many others, I present to you Mr. William T. McCormick as the recipient of the Award of Merit of the American College of Dentists.



Officers of the College, left to right: Charles F. McDermott, immediate past president; Dale A. Hills, president; Gordon H. Rovelstad, president-elect; George E. Mullen, treasurer; and Robert I. Kaplan, editor.

Fellowships Conferred

Fellowship in the American College of Dentists was conferred upon the following persons at the Annual Convocation in Anaheim, California on October 21, 1978.

- | | |
|---|--|
| Bernard L. Abrams, Maple Heights, Ohio | Thomas J. Fitzgerald, South Hill, Va. |
| Robert W. Anderson, Aurora, Minn. | Carl A. Flecker, Jr., Pittsburgh, Pa. |
| Chris T. Armen, Newport, N.H. | Daniel Frederickson, Libby, Mont. |
| Frank C. Baker, Tupelo, Miss. | Athol L. Frew, Jr., Oklahoma City, Okla. |
| William Becker, Tucson, Ariz. | Gilbert S. Gold, Trenton, N.J. |
| William L. Bellande, Birmingham, Ala. | James E. Graham, Jr., Charlotte, N.C. |
| Herman L. Bosboom, New York, N.Y. | Richard J. Grisius, Navy |
| Clark B. Brown, Springfield, Va. | Hal E. Gronlund, Clinton, Ill. |
| Eugene M. Brown, Buena Park, Calif. | John N. Groper, Los Angeles, Calif. |
| Richard Brunmeier, Lincoln, Neb. | Abelardo Gutierrez Morelos, Guadaluajara, Mex. |
| I. Frank Brzezinski, Chicago, Ill. | Richard B. Hancock, San Diego, Calif. |
| Robert H. Charbonnet, Metairie, La. | Jack H. Harris, Houston, Tex. |
| James N. Clark, Dubuque, Iowa | Murray M. Hilton, Bayside, N.Y. |
| Morris Cohen, Washington, D.C. | Harry L. Hodges, Richmond, Va. |
| Jack F. Conley, Los Angeles, Calif. | William Hollander, Sioux City, Iowa |
| Samuel J. Coppola, Scotia, N.Y. | John E. Holt, Portland, Ore. |
| William H. Crawford, Jr., Los Angeles, Calif. | James V. Huerter, Omaha, Neb. |
| G. Barton Cross, Lebanon, Ore. | Robert E. Hunter, Norwood, Mass. |
| Harry A. Crosswell, Pottsville, Pa. | David M. Isbell, Chattanooga, Tenn. |
| Alan B. Curtis, San Diego, Calif. | Ralph C. Ivy, El Paso, Texas |
| Anthony J. Cusenza, Modesto, Calif. | Laurence E. Johns, Hagerstown, Md. |
| Bertram V. Dannheiser, Jr., Pensacola, Fla. | Edwin D. Joy, Jr., Augusta, Ga. |
| William N. Danzig, Walnut Creek, Calif. | Joseph Kanter, El Cerrito, Calif. |
| James L. Davis, Reno, Nev. | John B. Kenison, Milford, N.H. |
| Lorenz F. deJulien, Jr., Escondido, Calif. | James E. Kennedy, Richmond, Va. |
| William H. DeKock, Cedar Rapids, Iowa | George R. Koch, Sacramento, Calif. |
| Samuel B. Detweiler, Schuylkill Haven, Pa. | Joseph Kolodziejczyk, Chicago, Ill. |
| Thomas E. Devaney, Lynnfield, Mass. | Eugene M. Kouri, Fort Worth, Texas |
| David V. Diggs, Missoula, Mont. | Herbert J. Lamons, Greenville, Tenn. |
| Walter J. Dudas, Hollis, N.Y. | Frank G. Landry, Denville, N.J. |
| Robert E. Echlin, Burlington, Ont. | Harold S. Lanier, Jr., Atlanta, Ga. |
| Robert T. Edwards, Franklin, Va. | James E. Lassiter, Jr., Summit, N.J. |
| H. Ray Evans, Jr., Montgomery, Ala. | Richard F. Latimer, Claremont, Calif. |
| Robert K. Fenster, Baltimore, Md. | Ed J. Le Du, Forestville, Calif. |
| | Edward E. Levy, New Orleans, La. |
| | Henry T. Little, Greenville, S.C. |
| | Santina Rose Litturi, Park Ridge, Ill. |
| | Erwin C. Lubit, Patchogue, N.Y. |
| | Garrett B. Lyons, Wilmington, Del. |

- Ralph J. Manganelli, Brooklyn, N.Y.
 Harold B. Martin, Washington, D.C.
 J. Gary Maynard, Jr., Richmond, Va.
 Irvin L. McCaine, Sr., Mount Vernon, N.Y.
 Robert E. McDonnell, St. Paul, Minn.
 Edward C. McNulty, New York, N.Y.
 George Menken, New City, N.Y.
 Ralph R. Mezrow, Merion, Pa.
 Harvey Miller, Wappingers Falls, N.Y.
 David O. Moline, Salem, Ore.
 Joseph N. Morris, Portland, Ore.
 George P. Moylan, Jr., North East, Pa.
 Carl H. Muller, Villa Park, Ill.
 James E. Mulvihill, New Hyde Park, N.Y.
 Richard D. Mumma, Jr., New York, N.Y.
 Yoshio Nakashima, San Francisco, Calif.
 Robert A. Nathan, New York, N.Y.
 William A. Nies, Englewood, Colo.
 Warden H. Noble, San Francisco, Calif.
 Arnold M. Oosterhuis, Fort Dodge, Iowa
 Herbert R. Packard, Walnut Creek, Calif.
 Claude A. Pawelek, Houston, Texas
 Robert D. Payne, Phoenix, Ariz.
 Thomas L. Perkins, Bradford Woods, Pa.
 Robert H. Peterson, Playa del Rey, Calif.
 Robert M. Phillips, Baltimore, Md.
 Rodney M. Phillips, Beaumont, Texas
 Donald R. Poulton, Alameda, Calif.
 John W. Preece, San Antonio, Texas
 Galen W. Quinn, Durham, N.C.
 Roy L. Rasmussen, Calgary, Alberta
 D. Dean Ray, Shenandoah, Iowa
 Abraham Reiner, St. Albans, N.Y.
 Dalton W. Richey, Des Moines, Iowa
 Joseph Dean Robertson, Oklahoma City, Okla.
 George E. Rooney, Jr., Veterans Administration
 Terrell L. Root, Costa Mesa, Calif.
 Fred Rothenberg, New York, N.Y.
 Orvel T. Rozzell, Clovis, N. Mex.
 Alexander M. Samuels, Bayside, N.Y.
 Eugene A. Savoie, Tucson, Ariz.
 Eugene Schlagel, Brooklyn, N.Y.
 Robert S. Schoor, Cherry Hill, N.J.
 Jack T. Scott, Tacoma, Wash.
 Robert A. Seminara, New York, N.Y.
 George W. Sferra, New York, N.Y.
 Cherilyn G. Sheets, Inglewood, Calif.
 Sol Silverman, Jr., San Francisco, Calif.
 Theodore H. Simpson, Jr., Philadelphia, Pa.
 Harold L. Smith, Tyler, Texas
 Robert T. Smith, Roswell, N. Mex.
 Santina Marie Sparacino, Watertown, N.Y.
 Norman D. Sperber, San Diego, Calif.
 Jon P. Standlee, Santa Barbara, Calif.
 Jo Henderson Stegall, Jr., Rome, Ga.
 Frederick L. Strammer, Venice, Fla.
 Russell W. Sumnicht, Kansas City, Mo.
 Edwin S. Sved, New Brunswick, N.J.
 Melvin H. Takaki, Pueblo, Colo.
 Arthur R. Teesdale, Bakersville, Calif.
 Keith E. Thayer, Iowa City, Iowa
 Ralph W. Tjarnberg, Seattle, Wash.
 Charles C. Tracey, Detroit, Mich.
 Eugene J. Truono, Wilmington, Del.
 Thomas A. Underkofler, Marshalltown, Iowa
 Francis P. Ursoleo, Worcester, Mass.
 Billy T. Utley, Downey, Calif.
 Paul D. Walquist, Pacific Palisades, Calif.
 Fay O. Wardlaw, Little Rock, Ark.
 Jack K. Warrens, San Diego, Calif.
 Roy A. Waterhouse, San Angelo, Texas
 Thomas H. Watson, Jr., Pomona, Calif.
 Larry A. Williams, Benson, N.C.
 Quinton E. Williams, Corpus Christi, Texas
 Richard D. Wilson, Richmond, Va.
 W. Victor Wood, Springfield, Mo.
 In Absentia
 Harold C. Sternlicht, Houston, Texas

ANNUAL MEETING AND



CONVOCAATION SCENES 1978



Photos Courtesy of Jack D. Carr

Not by Ambush Nor by Apathy

PORTER L. FORTUNE, JR.

When my office was refurbished a few years ago, an imaginative decorator graced a table in the middle of the room with an interesting and unusual conversation piece--a crystal ball. You can imagine my delight when I discovered the crystal ball. Here was the ultimate answer to academic planning. Surely within this crystal ball could be found solutions to financial problems, a blueprint for long range planning, and the proper responses to queries from Legislators, the student newspaper, and the faculty senate. Of course, it was too good to be true. But I have often thought how perceptive the office decorator was to detect in only a brief period of association what university chancellors and presidents need in higher education today.

Speculation about the future has held special fascination for man since the beginning of recorded history. Ancient oracles read the stars or consulted bags of bones and captured for themselves positions of respectability and power. Even now we see a growing number of readers of "Your Horoscope" in the daily newspaper. Vast resources of computer-held data and development of specialized research tools, predictive formulae, and analytical techniques have given rise to a more serious interest in the future.

This interest in the future assumes the irrefutable truth stated by William Shakespeare: "There is nothing permanent except change." Although we are well aware that not all change is necessarily progress, we also realize that progress is not possible without change. Relentless and inexorable change is the dynamic of this exciting century in our history. It is this environment of change as it affects higher education and the professions that I would like to discuss with you today.

The pace of change has made its greatest impact in higher education during the past two decades. If we look back to 1958 when the Soviet Union launched Sputnik, we see the genesis of a period most critical to higher education. As we Americans gazed skyward to

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catch a glimpse of the sparkle of light reflected by Sputnik, we shared a common concern in the realization that the United States--the greatest of all nations--was not the first to enter outer space. Immediately we asked ourselves why were we not first. The inquiry ultimately led to education and--with passage of the National Defense Education Act which provided billions for support of science education, research, and technological development--resulted in far greater emphasis in the sciences. These billions of dollars proved to have been a carrot dangled before a hungry educational community that, I fear, has now become addicted to the support of federal dollars. Federal emphasis has since moved to matters of health and to social concerns, and in each instance education has paid dearly for financial support accepted at the expense of self-control and institutional autonomy.

The concern over government intervention in education by way of dependent dollars is shared now both by education and by government policy makers. HEW Secretary Joseph Califano warned recently against the undue dependence of education on federal support, noting that in 1958 the federal government spent just over \$300 million on education, a figure which grew 20-fold to more than \$6 billion in 1968. It has now grown to \$13 billion, or more than 40 times the 1958 level.

I was pleased to read that Secretary Califano expressed grave concern over the red tape and burdensome requirements which, by his own admission, have increased by 1,000 percent in a decade. I couldn't help wishing, however, that Secretary Califano were the parent of a middle class student in desperate need of financial aid and had the experience of completing the forms necessary to request a Basic Educational Opportunity Grant.

My greatest concern is that we might have sold our souls and our freedom for the federal dollars upon which we have become almost inextricably dependent. Under threat of losing the manna, we are told whom to admit to medical schools; we face incomprehensibly complex guidelines written into Title IX by HEW; and we feel frustrated in our genuine effort to meet the needs of the handicapped. It is a dilemma that leads me to comment only half facetiously that we need a Bill of Rights for institutions of higher learning.

At the same time that the Federal Government was infusing large amounts of money into education in the sixties, our nation was torn by causes of conscience and conflict. American youth, frustrated by a large-scale foreign war fought for the first time by a sharply divided America, soon turned their attention to higher education--for them, the most visible and accessible component of the establishment--and demanded greater social consciousness, relevancy in curricula, and participation in the governance of education.

With the arrival of the seventies has come the realization throughout education that the end of the baby boom is likely to mean declining enrollments and, therefore, declining revenues. Inflation has pushed the nation, with its institutions of higher learning, to the brink of insolvency, causing educators to seek lasting solutions to the problems of declining enrollments and dollars. Discovering that the relevancy movement of the sixties has led us to the extreme of offering courses so "relevant" that they are no longer really relevant to the reason institutions of higher learning exist, administrators, faculty, and students have become concerned about an erosion of academic integrity and quality. This concern is not limited to higher education. Because of a steady decline in national test scores of secondary school students and college freshmen, the public and educators alike are questioning the quality of education at all levels. Leading institutions of higher learning, including Harvard, Stanford, and The University of Mississippi, are recognizing their responsibilities and taking steps to insure that a core curriculum includes courses which will assure a mastery of basic educational skills.

This movement illustrates the increased sensitivity to responsibilities of integrity, performance, and purpose evident not only in education but also in government and in the professions. In the vernacular of the 1970's, this responsibility has come to repose under the umbrella of "accountability."

Democracy in this country is basically a concept of accountability, with the sovereign people as the watchdogs of freedom. As one of our founding fathers put it, "Eternal vigilance is the price of liberty." But as John Gardner has pointed out in his challenging book *Morale*, free people are not eternally vigilant. Dramatic achievements are interspersed with apathetic siestas during which our liberties and successes can be eroded. Even in the electoral process, which should be the basic instrument of accountability, there is a lamentable proclivity for lapses of vigilance.

Although we sometimes become impatient with the courts, Congress, the media, citizens' organizations and the like, they are "sleepless monitors of our liberties" when preoccupation and complacency distract the task of citizenship at hand.

If governmental agencies are held "accountable" for their performance, it seems only reasonable that institutions and professions should not be exempt. I do not believe that we in the professions and in institutions of higher learning wish to shirk our responsibility to our constituents and society.

However, in the good name of accountability, as even with "righteousness," sins of excess and irrelevant interpretation may be

committed. These sometimes are counterproductive as we strive to attain our legitimate goals and purposes.

Administrators have become trapped in a labyrinth of legalism that consumes an inordinate amount of time in and out of the courts that could otherwise be devoted to the quest for educational quality. The Supreme Court's decision in the Bakke Case has cast a shadow over admissions programs and policies designed to speed entrance of minorities into the mainstream of education and society. The long-awaited decision has been hailed as a landmark, but different interpretations have left education without clear direction.

I had some difficulty sorting out my feelings recently when I read in the *Wall Street Journal* that the Justice Department has entered a court case on the side of a professor who is suing a college for denying him tenure on the ground of alcoholism. The Justice Department argues that alcoholics should be considered handicapped persons and protected from job bias in federally funded programs if their work performance isn't impaired. How can one possibly measure the performance of an active alcoholic? Alcoholism is an unfortunate illness and handicap, but is it in society's best interest to place this burden on higher education, with the possible result that thousands of young people could be educationally "handicapped" by professors functioning at less than optimum levels?

There is more than a casual relationship between the environment of higher education that I have outlined and the environment in which you as professionals function. The professions have established themselves in our history in fostering the development of a nation of unparalleled good health, justice, and plenty. Today the professions, as well as higher education, are being challenged from within and without by seen and unseen groups of policy makers and planners, colleagues, students, consumers, and by a changing social consciousness.

A perusal of today's newspapers and news magazines reveals an alarming environment of conflict. The editors of *Business Week* describe the situation simply: "The professional has been the most admired individual in society because of the social status bestowed, the intellectual prowess attributed, and the excellent income earned. But today professionals are in trouble." Malpractice suits have shaken the foundations of some professions, as physicians, attorneys, dentists, accountants, engineers--and yes, educators, too--are challenged to defend their actions in the nation's courts.

Polls show the public "increasingly skeptical of professionals' claim to probity and competence." Medicine, it seems, has suffered most, with the percentage of Americans having a great deal of confidence in

medicine declining from 73 percent in 1966 to 42 percent in 1976. The Supreme Court's ruling allowing the advertising of attorney fees calls to question the legal profession's claim to self-regulation. Discount drugstores that attract customers through price advertising practices, prescription eyeglasses sold at bargain prices from sidewalk shops, and manufacturers of dentures who advocate direct sales to patients without counsel of a dentist all erode the image of the professional and the public's understanding of the role of professional services.

The professional is the creation of a structure which merges the mission of higher education with the current accepted and tested practice of professionals. The professions and education are inextricably intertwined, and there is historic significance in this marriage. Burton J. Bledstein in *The Culture of Professionalism*, has expressed this relationship as a creation of the middle class, the development of which gave rise to the growth of modern America. The university provided the matrix for growth and "held before the society the image of the modern professional person, who committed himself to an ethic of service, was trained in scientific knowledge, and moved his career relentlessly upward."

Generally, education and the professions have responded well to—and even taken leadership in—the tremendous changes that have transpired during this century. In fact, Bledstein adds, the professions have always been agents through which society has dealt with its major problems. The continuing challenge, then, to the professions and to higher education is to assume the responsibility and accept the role of leadership in guiding society in a world of inexorable change. There is no place for misoneism in our contemporary society.

It took great and courageous men to conceive and formulate the balance between individual liberty and government enunciated in the basic philosophies of our Constitution and Bill of Rights, and we may be rightfully proud of our forefathers for their vision and fortitude in making it a reality. Yet, eternal vigilance is indeed the price of liberty, and a great portion of the credit for establishing the American way of life goes to those who have stood vigilant watch since the time of our founding fathers. Our citizenship responsibility today is greater than ever before in America, for our society is more complex and our challenges more acute. If in our country any good cause is crucified, it will be because the majority of the citizens have either aggressively wanted it that way or have apathetically permitted it. The laws, government, and leadership performance we get are what the citizens of our country either demand or by indifference allow.

As professionals in education, law, the health professions, or any other discipline, we must step forward with positive answers to the

challenges of our day. In education, we must emphasize the basic knowledge and tools that will produce thinking and creative individuals who can adapt to change at any pace. As health professionals, you must become involved to the fullest extent in health planning programs which will shape the course of your practices in the years ahead. Each of us must hold steadfast to those ethics that have served to bond our commitment to excellence and human service. We must assume greater roles in determining our own destinies by speaking out, by actions of involvement, and by commitment to progress.

Robert M. Hutchins, the distinguished educational leader, poignantly philosophized that "the death of democracy is not likely to be as assassination from ambush. It will be a slow extinction from apathy, indifference and undernourishment." Let us commit ourselves in all our endeavors to the premise that those ideals which we hold dear in education and the professions will die neither by ambush from those forces which erode self-determination nor by our apathy in failing to become involved in the basic issues. This is a time for positive resolve and optimism. Nothing is impossible if only we have the vision to see, the courage to do, and the faith to believe.

GOD, GIVE US MEN!

*God, give us Men! A time like this demands
Strong minds, great hearts, true faith and ready hands;
Men whom the lust of office does not kill;
Men whom the spoils of office cannot buy;
Men who possess opinions and a will;
Men who have honor; men who will not lie;
Men who can stand before a demagogue
And damn his treacherous flatteries without winking!
Tall men, sun-crowned, who live above the fog
In public duty and in private thinking;
For while the rabble, with their thumb-worn creeds,
Their large professions and their little deeds,
Mingle in selfish strife, lo! Freedom weeps,
Wrong rules the land and Justice sleeps.*

Josiah Gilbert Holland

SYMPOSIUM

Factors Affecting Professional Orientation in the Delivery of Oral Health Care

INTRODUCTION

GORDON H. ROVELSTAD, D.D.S.

The topic for this panel discussion is "Professionalism" as it affects the dentist. The panelists have been selected because of their experiences in areas of interest affecting professionalism both in education and as well a practice. However, the definition of this topic has been left to each individual panelist. The subject is not new. Dr. Frank W. Sage published his views in the Ohio State Dental Journal in 1883 as follows: "... is not the popular idea of a professional man something like this; one who ministers to conditions of physical infirmity, or who officiates in matters of jurisprudence or who ministers in spiritual things, or who follows the vocation allied to art in contradistinction to such as connected with trade?". Dr. Sage was addressing problems of recognition. However, at that time the role of medical science in the dental curriculum was at stake. Today we have different problems. Because of the position of the College and certain areas affecting professional conduct, we have been exploring factors related to health care delivery in recent years.

Dr. Sage, in 1883, quoted one of his friend's comment as "what nonsense is all this talk about professionalism?". Today we contend this is not nonsense and we look forward to hearing from each of the separate panelists not only as to how they define "professionalism" but also as to what "professionalism" means to the pre-dental student, the dental curriculum, the dental student and the dental practitioner.

Dr. Rovelstad, president-elect of the College, acted as moderator for the symposium.

Factors Affecting Professional Orientation in the Delivery of Oral Health Care

THE PRE-DENTAL STUDENT

W. ARTHUR GEORGE, D.M.D.

When we speak of factors affecting professional orientation in the delivery of oral health care we first need to establish who is a professional person and what do we mean by professionalism. According to Webster, "A professional is a person who belongs to one of the learned professions." He defines professionalism as, "the conduct, aims, or qualities that characterize a professional person" with moral code being the basis of professionalism. What, then, is this moral code? Webster presents a number of definitions but the one that seems most appropriate for this panel states that, moral code is a "conformity to a code of right, fair, and equitable conduct." Recognizing that this might be an over-simplification of a complex definition, let us look at the moral code which we as licensed professionals must uphold. We are privileged by legislation to provide dental care for the people of this nation. How, then, do we begin to identify and instill the moral code of the professional in the high school and college student? Let us take time to look at what has happened in the lives of these students during the past thirteen years.

The mid-1960's and early 70's were crisis years for our young people, many of whom had experiences which have been difficult to live down. Some became afflicted with the drug habit; some became liberal activists; whereas, others became alcoholics. Subsequently, much of this has stigmatized their lives and has even prevented some of them from achieving their goals in life. We find such examples existing on transcripts which show us that the disruption of the

Presented at the Annual Meeting and Convocation of the American College of Dentists, Anaheim, California, October 21, 1978. Dr. George is Associate Dean at the University of Pittsburgh School of Dental Medicine. From 1971 to 1976 he was Director of Admissions and Recruitment.

educational process has resulted in course repetition or failing grades which have been either impossible or, for the most part, too difficult to overcome. Such handicaps are bound to affect one's outlook on life and raise a series of questions relating to professionalism and the moral code. These students began to ask questions about who sets the moral codes, and why they should be required to follow codes not of their own making. These young people wanted to do what they thought was right and acceptable to their peers. However, they had a strong desire to do their own 'thing' and resented being told what that should be by people in authoritative positions. Each student wanted to be a specific individual who reflected an image of his or her idol in order to meet both personal needs and those of his peers. A part of this revolved around the liberation of the students, the freedom to do what they wanted to do in educational settings, an input into restructuring the curriculum, the relaxation of the moral code regarding sex, and the implementation of a strong equal rights program for women. These social changes were important, and affected the life style and the moral code of the students.

On the other side of the ledger, during this same period, many of the young people seemed to become more religious and thus were establishing higher ideals for living. While religion was not church-oriented, it did relate to living a good life. Fortunately for our country this group, by far, was representative of our young people today. More and more we see applicants who demonstrate that they want to help people and be sympathetic to their needs. They are genuinely concerned about the poor and needy and, although it may surprise you to know, a number of them make a commitment to a church or to themselves upon graduation to devote a year of their life to such endeavors. As leaders of dentistry we should be capitalizing on this trend so that it might be expanded. Within this group, however, there are those who lose such enthusiasm during their dental education years. This fact concerns those of us who are teachers because it reflects a reversal of an outstanding trait for which we may be responsible.

Faculties are always seeking answers to the questions of what turns off students who have high ideals. Are these 'downers' related to the high costs of dental education, the strict demands of the dental curriculum, or the overpowering authority of the faculty? Some schools have developed strong behavioral science programs to improve the faculty/student/patient relationships. Whatever the reasons, we should seek a solution so that professionalism in the dental profession will not be the loser.

Our young people are also placing more emphasis on personal perception. They are looking at you, the dentist, to see what kind of a

life you lead. They are not necessarily using money or the location of your home as a standard, but they want to know what kind of a person you are. It may be assumed that you are an outstanding practitioner, but what do you contribute to the community, and are you involved in those activities that make that community a better place to live? They see you as their idol and each one is searching for a personal perception which meets a set ideal. If we do not meet these standards, it is assumed that we do not share the same moral code required of a professional.

Next, let us look at the pre-dental college student from an academic point of view and see how this relates to professionalism. The social changes have been noted but little has changed in the pre-dental curriculum. A review of the requirements for admission as listed in the 1977-78 book published by the American Association of Dental Schools shows that requirements have remained almost static during this period. Most schools continue to require Inorganic and Organic Chemistry, Biology, Physics, and English. Ten-percent of the schools have dropped the English requirement, and two of the schools indicate that they have no requirements. One of these two suggests a well-rounded course of study, but students must show evidence of their ability to cope with all phases of the curriculum, including the basic sciences. The second one, has no requirements, per se, but suggests that applicants study in the areas previously noted as 'required' subjects. Nine of the schools request Mathematics. Other courses mentioned once or twice are Genetics, Literature, Psychology, Sociology, Microbiology and Biochemistry. Although the titles of the courses remain the same, the contents have changed over the years with the addition of new knowledge. While the pre-dental student today presents with a broad education, the change that has affected the area of professionalism is the competition to excel and be one of those selected for admission.

From the mid-sixties until 1975 the number of applicants to dental school skyrocketed, with the peak coming in 1975. During that period everyone was striving for grades, inadvertently bringing an increase in cheating on examinations and the use of drugs as stimulants to provide more time for study. This surely is not the way we want students to approach dental school. Yet, it has been a reality. In the past three years there has been a significant drop in the number of applications and there is a possibility that this drop may bring a decrease in these practices as the competition decreases. In his July 1978 report on this subject, Dr. James W. Graham, Director of the Division of Educational Measurements of the ADA Council on Education, studied 30 variables in the data available from the American Association of Dental Schools Application Service,

(AADSAS) and found that four of them seem to bear a significant relationship to the decline in applicants:

1. Grade point averages - Those with lower grade point averages are not applying because of information supplied to college pre dental advisors to discourage these applicants. However, the quality of the class being admitted should not be affected because there are adequate numbers of well-qualified applicants.
2. College Major - When the NASA program was terminated, a number of those who majored in the hard sciences and engineering, applied to dental and medical schools. With the reopening of employment opportunities in these fields there has been a decline in the number of applications from this group.
3. Socio-economic status - There has also been a decline in the socio-economic lower middle class which raises some questions as to who will be the dentists of tomorrow if only the affluent can afford to attend.
4. Region of parents' residence - For some unknown reason there has been a greater decrease in the number of applicants as one goes from the East to the West Coast.

The fact is significant that the drop in the number of applicants with low grade point averages may reduce the problems facing the better student. However, from my observations, competition in the Dental School seems to be greatest among those who are trying to be number one.

So much for grades and how they might affect professionalism. What other factors do Admissions Committees look for in an applicant? The criteria for Fellowship in the American College, published as an editorial in the April 1978 issue of the Journal mentions such qualifications as "What have these individuals contributed to the groups with which they are associated?"; "Is their college or community a better place to live because of their involvement?" It is evident that admissions committees are also looking for these qualifications. Added to these could be such questions as: What has the relationship of the applicant been with classmates? Have the applicants indicated an interest in the health professions by serving with health groups, and what are their personal interaction qualifications? Are they energetic persons of high moral character who are anxious to serve the public? These and many other questions are usually answered as part of the application in the student essay, recommendations, a report of work experiences, and college and community activities. From this information, committees try to select those who will be able to meet the academic and clinical standards of the profession and not lose their ideals of professionalism

in the process. Most of the time committees are successful. However, in today's complex society there are so many unpredictable variables that 100% success cannot be guaranteed. Some of those who are not meeting the challenge can be salvaged through counselling services, although others are lost. Unfortunately for the profession, some who are graduated lose their sense of observing a moral code as practitioners.

Some other factors that may be of concern to high school and college pre-dental students are:

1. The publicity given to the Federal Trade Commission decision on advertising.
2. The publication of governmental action against dentists for cheating on Medicare and Medicaid programs.
3. Malpractice suits, some of which are stimulated by members of another learned profession.
4. The increasing number of dentists who are testifying against one another in court actions.

What, then, can we as dentists do to develop a moral code for professionals which will meet the needs of our young people? Since many young persons make decisions when in high school to enter a professional field later, we need to start early to make an impression on them. Participation as leaders of groups formed in the YM, YWCA, YMHA, and scouting are a good start. Explorer Clubs have been quite successful and in some colleges the Pre-Professional Dental Science Clubs have played an important role in guiding the potential dental student.

At the University of Pittsburgh there are some 150 students in such a club who receive guidance both from members of the faculty and practicing dentists from the community and who take it upon themselves to visit the School and dental offices a number of times each year. Of course they want to know how to get accepted; but they are also interested in learning more about the profession, which, in turn, opens the door for talking about what is expected of a professional person.

Another approach can be made through local or state dental associations. About eight years ago there was a strong recruitment program, the Pennsylvania Dental Association assigned a dentist to each high school in Pennsylvania and asked him to deliver an information kit composed of material available from the American Dental Association. During this meeting the dentist had an excellent opportunity to get the message across about the profession and the type of students sought after. Counsellors do exert a lot of influence on students and this is a good place for dentists to have an input.

The Library Packet of the American College of Dentists would be another source of information to high school counsellors, in addition to the library program now in effect. Each of these programs would have a much greater impact if hand-carried to the school with enough time available to make a pitch to the librarian or the counsellors.

Last, but certainly not least, let us remember the everyday opportunities we have as we provide care for young patients. We have a great chance to get the message across as to how our offices function, our concerns for their dental and personal problems, and taking time to listen to what they have to say. To be sure, in many cases it may not be what we want to hear as they relate how they want to live their lives, but it may be the one big opportunity we do not want to miss; to have them listen to some of our ideas. Too frequently today we are too busy to take the time to listen to our young people. They have a different type of dedication from what we had and there is no way that we are going to make them accept our concepts. The vast majority of people who are applying to our professional schools have high moral codes and high ideals and want to see them implemented. That the nitty-gritties and the implementation does not agree with our ideas needs our attention. Let us take the time to make an impression on them when they are in the high schools and colleges; then let us make the time to listen, to work with them, and to incorporate some of their ideas into what they see as professionalism.

We need to do everything we can to improve our personal and public relations with the high school and college students. Perhaps this might be an appropriate time for the American College to sponsor a conference or appoint a committee which would include high school, college, and dental students to discuss such a subject with some of our leaders.

CONCLUSION

These remarks reflect some twenty years of contact with young people in pre-dental and dental fields as a recruiter, director of admissions and counsellor. Observations have been made on students who will be our leaders of tomorrow along with those who have failed. They come from one who is deeply concerned about professionalism and is searching for ways to make it work.

School of Dental Medicine,
University of Pittsburgh
Pittsburgh, Pennsylvania 15261

Factors Revealed by the Dental Curriculum Study Which Influence Professionalism in Dental Practice

DON L. ALLEN, D.D.S.

The National Dental Curriculum Study was initiated by an Indiana resolution presented to the House of Delegates of the American Dental Association in 1974. This resolution read as following:

"Resolved that the American Dental Association Council on Dental Education be directed to conduct an indepth curriculum study of all accredited dental educational programs in the United States which would include an appraisal of whether students are provided with instruction and clinical experiences in the comprehensive patient care concept of dental practice."

The reason this resolution was passed undoubtedly was due to a growing concern among many dental practitioners that dental students were not receiving the basic training, especially in the area of restorative dentistry and more especially in complete removable prosthodontics, that their predecessors may have received. The emphasis in the resolution was on comprehensive patient care. Whereas I will make some remarks about the curriculum study in general, most of my comments will be relative to findings related to professionalism and the comprehensive care aspect of the curriculum report. The specific assignment given to me was to review the final report *Dental Education in the United States - 1976*¹ and discuss components of the report which influence professionalism in dental practice. Professionalism is an elusive term with so many intrinsic, vague qualities that one is hard pressed to adequately define it. Webster defines it as "the conduct, aims, or qualities that characterize or mark a profession or a professional person." One of the definitions of a profession is, "a calling requiring specialized knowledge and often long and intensive academic preparation."

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Nelsen² referred to it as, "The term professionalism in the context of this discussion pertains to: that quality of conduct which accompanies the use of superior knowledge, skill, and judgement towards the benefit of another person or to society prior to any consideration of self-interest by the professional person or professional organization."

I believe the dentist's ability to care for the total patient is an absolute, if he/she is to practice professionalism and, therefore, also will address that aspect of the curriculum study.

As stated in the final report *Dental Education in the United States - 1976*, the general purpose for conducting the study was to gather quantitative and qualitative data which would permit objective and subjective analyses of the curriculums of U.S. dental schools. Unfortunately, "quantitative" and "qualitative" were not defined. Clearly, in the body of the report, quantitation is evident in the numbers reported for clinical procedures, number of patients treated, number of clock hours devoted to different subjects. It is more difficult to determine qualitative data in the report, that is if one defines qualitative as being related to value, worth, or rank.

Certainly, the report serves as a baseline for future studies. This is an extremely important characteristic since we really do not have a comprehensive baseline to compare changes in dental curriculums through the years. The document also provides vivid information on the current priorities and practices in dental education. It includes a great deal of data which can serve as reasons for curriculum revision since many dental schools do not have information on what national norms are. There is a great deal of information in the report relative to the degree of coordination or sequencing of various aspects of the dental curriculum.

The specific objectives of the study were stated to be:

1. Identify the institutional goals and objectives and to determine how those goals and objectives are being obtained.
2. Determine the institutional structure, organization, and scope of the curriculum material in the basic sciences, the clinical sciences, and the behavioral and social sciences related to dentistry.
3. Determine the extent to which students are given experiences in providing comprehensive patient care and to project the effect of such programs in preparing graduates to conduct a general practice.
4. Determine the effect of compressing four year teaching programs into three calendar years, especially with regard to the effect of that change on the clinical competency of the graduate of the three year programs.

5. Identify the methods by which institutions evaluate student performance in clinical and non-clinical courses.
6. Develop recommendations, based on the information derived from these determinations, for change in the dental educational process, and where indicated, for improving the teaching programs.

The curriculum study was divided into three phases. Phase I was planning; phase II involved developing, conducting and analyzing the results of an opinion survey of recent dental school graduates; phase III consisted of the actual conduct of the curriculum study. The American College Testing Program was contracted to provide technical assistance and services in the development of the survey instruments. Several committees were appointed to assist in the development of the survey instruments.

Six questionnaires were developed. These dealt with the basic sciences, clinical sciences, behavioral sciences, comprehensive patient care, general institutional policies and structure, and students. The questionnaires were field tested at four dental schools. Subsequently, each U.S. school appointed a coordinator to assist the instructors at his or her school in completing the questionnaires. Four regional conferences were held to orient the coordinators in detail as to what each component of the questionnaire meant. Hopefully, this helped provide consistency in the responses to the various items.

Schools had approximately three months to complete the questionnaires. A preliminary report was prepared for the National Curriculum Conference which was held in the spring of 1977. The conference was attended by approximately 350 participants including representatives from dental schools, constituent dental societies, state boards of dentistry, dental specialty organizations, government, offices of higher education, and members of councils and boards of the American Dental Association. The participants were organized into 12 workshop groups, each of which studied a series of questions and issues concerning dental education.

Chapters included in the final report are: Introduction, Methodology for the Curriculum Study, Demographic Overview of Dental Institutions, General Information on Institutions, Instructional Objectives, Scope and Content of Curriculums, Oral Biology, Changes in Curricular Emphasis, Learning Systems, Sequencing of Instruction, Comprehensive Patient Care, Faculty and Other Personnel, Evaluation of Student Performance, Selective Results from the Student Questionnaire, and Summary of Recommendations.

At the same time the curriculum report was submitted, the Board of Trustees submitted the following resolution which is found in the 1977 *Annual Reports and Resolutions*:

Resolved that the American Dental Association urge dental educational institutions and other appropriate agencies to implement the specific recommendations contained in the report *Dental Education in the United States - 1976*.

A great deal of discussion occurred in the reference committee which was assigned this specific report. The following resolution eventually was developed and passed by the 1977 House of Delegates:

Resolved that the American Dental Association receive the report *Dental Education in the United States - 1976* and that dental educational institutions and other appropriate agencies be encouraged to consider further study of the specific recommendations contained in the report.

Undoubtedly, this report will appear on the agenda of the 1978 House of Delegates and further deliberation will occur relative to it.

The section of the report which dealt with the Behavioral and Social Sciences includes aspects which relate to professionalism. Among other topics of instruction, this section included the following: Understanding Human Behavior, Professional Ethics, Jurisprudence, History of Dentistry, Social Issues, and Quality Assurance and Peer Review.

The total clock hours of required instruction in Behavioral and Social Sciences reported by the 59 schools ranged from 26 to 1165. Forty-six schools reported clock hours ranging from 50 to 349. There was more variation in this section than in most others. Public schools tended to offer more instruction in this area than did private or state related schools.

Professional Ethics, Jurisprudence, History of Dentistry, Social Issues, and Quality Assurance and Peer Review fell under the rubric of Community Dentistry in the report. Fifty-five schools reported required instruction in Community Dentistry. The range in clock hours was 4 to 322, the median being 65. Twenty-two schools offer electives in this area. Forty-nine schools provide specific instruction in, "Psychology of the Doctor-Patient Relationship."

I will comment later on the recommendations in the report, but at this time will go into some detail on the comprehensive patient care component of the curriculum report. As you will recall, this was the specific reason for having the study in the first place.

For purpose of the curriculum study, comprehensive patient care was defined as follows, . . .the ability to:

1. Examine and evaluate patients;
2. Identify and list the dental problems presented by patients;
3. Prescribe a treatment plan and be able to perform a majority of the care required by the patients, including care related to the several disciplines of dentistry;

4. Recognize and accept the need to refer patients to recognize dental specialists if the scope of the required treatment is beyond the capability of the general practitioner.

The results from the survey instrument indicated that 30 of the 59 schools reported specific systems for teaching comprehensive patient care. Forty-four schools have written objectives, but only 26 typically distribute them to faculty for planning and evaluation purposes. Thirty-one schools distribute instructional objectives to students. The other 13 schools state that students receive the objectives through documents or meetings of one type or another.

Twenty-one schools reported having some type of group practice or consortium format for student practice in CPC. The average senior at these schools participated in the treatment of 20 patients. Apparently, most of the patients were only partially treated by any one student.

Forty-six schools used the solo practice or individual practice format. The average number of patients treated by each student in these schools was 29 and this figure probably reflects only the patients treated during the students' senior year.

The schools reported that their most important criteria for selecting the faculty to teach in comprehensive patient care were the years of practice experience of the teacher and the amount of advanced educational experience. The majority of schools reported no in-service program for teachers of comprehensive patient care.

Thirty-six schools reported evaluation of attitudinal or affective characteristics. These included observations, role playing, recordings, and videotaping of critical instances.

Fifty-four schools had DAU Programs, 29 had TEAM programs with 4 other schools stating they had programs comparable to TEAM. Sixteen had EFDA programs.

A partial listing of procedures accomplished by a typical student indicates to some extent the amount of clinical experience students received. The following is not intended to be all inclusive of the procedures reported in the curriculum study:

1. Complete examination and treatment plan - 35.2
2. Diagnosis and treatment of emergencies - 33.0
3. Endodontically treated teeth - 9.8
4. Fixed prosthodontic bridges - 5.7 posterior and 2.3 anterior
5. Single full crowns - 15.1
6. Amalgam restorations - 33.3 Class II, 12.0 Class V, 6.0 pin retained
7. Composites - 26.9
8. Direct gold foil - 9.8
9. Castings - 17.3

10. Extractions - 60.3 (includes 4.9 impactions)
11. Orthodontic appliances - 3.6
12. Children treated - 12.4
13. Periodontal patients treated - 6.3
14. Periodontal surgeries - 5.6
15. Arches of complete removable dentures - 8.6
16. Removable partial dentures - 4.9
17. Denture relines and repairs - 3.6

There were 51 recommendations made in the report. Forty-one are from the survey data itself and 10 from general observations.

Thirty-four of the recommendations were administrative in nature and were concerned with such items as school policies, cost accounting systems, dissemination of instructional objectives, faculty orientation and systems of evaluation. Ten recommendations indicated that at least some dental curriculums need more pharmacology, hospital dentistry, oral surgery, emergency care instruction, nutrition, dental auxiliary utilization, endodontics, periodontics, removable prosthodontics, practice administration, expanded clinical skills, and more knowledge in delivery systems.

The other 7 recommendations stated that schools and/or agencies should make studies relative to the dental specialties and general practice residencies as to determine the educational need of future practitioners; determine optimal sequencing for pre-professional, dental, and advanced educational programs; admission requirements; relationships between education and practice; evaluation of recent graduates; the need for a required general practice residency; and future studies using this one as baseline data.

Two recommendations relate to professionalism.

23. The behavioral and social sciences should be integrated more effectively into the clinical setting, and existing clinical faculty should serve as transmitters and evaluators of behavioral and social sciences curricular content.
47. Professionalism entails values and ethical behavior, and, therefore, the dental schools should carefully select students and faculty members with high ethical values and maintain an educational environment which reinforces ethical behavior among its graduates.

The 3 specific recommendations which dealt with comprehensive patient care are as follows:

31. The primary focus in dental education should be to prepare students to provide comprehensive patient care to all population age groups including the handicapped and medically compromised patient.

32. The background knowledge, technical skills and clinical experience of the pre-doctoral student should be expanded in scope so that the graduate will be prepared to provide a broader range of services as a general practitioner.
33. All predoctoral students should be provided with learning experiences in the various health care delivery systems so that the graduate can make sound judgements on selecting a type of practice setting.

In closing, I believe that the reliability of this study is high if one will consider the entire study in context. Obviously, much of the isolated data is not valid when used out of context. The greatest value of the study is that it does provide a comprehensive baseline on which future studies can be made and compared. Probably its greatest value will be if each individual school will study it objectively and make changes internally that are in keeping with the overall institutional goals and purposes of that particular institution.

The current status is that the report is in the hands of the Board of Trustees and House of Delegates of the ADA, the AADS, the AADE, the Council on Dental Education, and of course, the Deans and faculties of the dental schools. During the next few years all of these groups will no doubt develop further recommendations and policies relative to it. I sincerely hope that all these groups will keep in mind the various individual strengths of the dental schools and will not attempt to develop policies that would tend to limit innovation or individualization of the various curriculums in the schools, but rather would provide the incentive for optimal growth and development of each institution.

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J. Hillis Miller Health Center
College of Dentistry
University of Florida
Gainesville, Florida 32610

Factors Affecting Professional Orientation in the Delivery of Oral Health Care

THE DENTAL STUDENT

WILLIAM F. VANN, Jr., D.D.S.

The topic of professionalism receives little or no attention in most dental curricula. I did not peruse the recent ADA Curriculum Survey to ferret out clock hours or time allotments, but suspect that little time is spent in acquainting students with the subject. In dental school we discussed the ADA Code of Ethics, but my recollection is that this code was concerned more with etiquette and custom than ethics.

It has been proposed that a course in ethics for professional students be included in the dental curriculum, and several such suggestions have emanated from symposia and sessions of the American College of Dentists. You may also be interested to learn that a recent conference on dental ethics, sponsored by Washington and Lee University, explored several methods of teaching professionalism in dental schools. It is likely that future dental curricula will include such important information.

Without apology, it must be stated that this paper is probably addressed to the wrong group. The American College has shown a lot of attention to this subject. Indeed, if one looks to the literature, the ACD Journal is the prime reference on the subject of dental professionalism.

At the outset, it is necessary to define one's terminology. In the abstract, professionalism has many meanings. Your Executive Director, Dr. Robert J. Nelsen has given a good operational definition as "the quality of conduct which accompanies the use of superior

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knowledge, skill, and judgement towards the benefit of another person or to society prior to any consideration of self-interest by the professional person or professional organization."¹

A similar definition of a profession was given by Judge Louis D. Brandeis at a 1912 Brown University commencement.² This definition has three characteristics and captures my perception of a profession and what professionalism means:

1. A profession is an occupation for which the necessary preliminary training is intellectual in character, involving knowledge and to some extent experience, as distinguished from mere skill.
2. It is an occupation which is pursued largely for others and not merely for one's self.
3. It is an occupation in which the amount of financial return is not the accepted measure of success.

This paper will also refer to ethics, which is defined as the science of morality. "Morality" concerns our efforts to answer the question "what ought I do in the situation I now face", and "ethics" relates to the logically prior question "what should I consider, how should I proceed, and by what process should I arrive at a decision about what I ought to do?"³

We can classify pressures affecting dental students into three primary categories: (1) personal pressures (2) institutional pressures, or pressures brought on by the "system" and (3) non-institutional pressures, or pressures brought on from outside the institution, some of which may also operate on the "system".

PERSONAL PRESSURES

What personal pressures do dental students face? It may surprise you, but their pressures are probably no greater than those faced by previous generations of dental students. It is true that during the past decade, the cost of a dental education has soared and this pressure is a source of concern to many students. However, the extent to which these accumulated debts might affect developing professionalism is most conjectural. For example, we do not have very good data on the number of dental students who default on loans accumulated during dental school, but the number is not considered to be high. We have reasonably accurate information on state loans accumulated, and this payback percentage is near 100%.

Other than financial pressures, marriage and family are atop the list of personal pressures for dental students; however, these are rarely implicated in affecting professional orientation. We know that over the past decade the profile of the dental student has changed. In general, students are older, have more education, are more likely to be married,

are more likely to have children, and are more likely to have had working experience or military experience. So, one might cautiously infer that today's dental student is more mature, more stable and perhaps more responsible than those in past years. With respect to suicide and divorce rates, it is likely that the recent study reported in the ADA Journal applies to dental students as it does to dentists.

INSTITUTIONAL PRESSURES

Now let us consider pressures from within the institution, or, if you will, those pressures that seem to be part of the "system". We can start with dental admissions.

We know that there are students who resort to questionable acts in an effort to improve their chances of admission and these acts may have a lasting, detrimental effect upon the developing professionalism. Pre-medical students have been quoted as saying "We cheat. We try to give the wrong information to our colleagues. We take books from the medical library and destroy part of them. We sabotage other students' chemistry experiments."⁴ In addition, once accepted into professional schools, the students may exhibit increased cynicism toward the selection process when it is clear that "if you have enough money, you can buy your way into medical school."⁵ It can be argued that admission to dental school has not yet entailed these extremes; however, the process is infinitely more competitive than it once was. Today, approximately 15,000 young men and women compete for 5,000 places.⁶ An example of the competitiveness engendered by this situation was contained in a letter regarding a particular applicant in which the preprofessional advisor reported on the student's aggressive behavior toward faculty members and physical threats to undergraduate teaching assistants, all in an effort to change grades.⁶

It is clear that the admissions process itself has potential impact upon professionalism among presumptive dental students. Superimposed on this admissions dilemma, researchers have generated in recent years a plethora of research relative to dental admissions; and a lot of questions are unanswered. We know more or less how to produce scholars of dentistry, but we do not know so much about producing competent providers of patient care. This leads one to ask the question "Should students be chosen because they are good students or because they hold high promise of being good providers of health care, and, to what extent are these compatible?"³

In regard to this issue, I believe that we should shift to a lottery system of selection once a body of acceptable candidates for

admission has been identified. This suggestion is not original, it is being used by some medical schools and has been suggested by some dental educators. You may be interested to know that research has shown that we could drop our minimal standards dramatically and affect our quality of product very little.⁷

So much for admissions. What about other pressures on students from within the system. In pedodontics, we teach our students that they can modify child behavior by modeling, expectations, and reinforcement. We might look at the educational system using those parameters. To what extent are these tools being used to shape developing professionalism?

With respect to modeling, we have a problem in the system. Dental education provides minimal opportunity for students to be taught or influenced by a "role model."³ Medicine, in contrast, has a period of residency training which allows for more direct influence by physicians who can function as a role model. The medical educator also has an opportunity to aid the student in dealing with value questions which may or may not modify his or her current value system; this opportunity rarely exists in dentistry.

What about expectations? It is fair to say that dental educators do not maximize the use of expectations with regard to their teaching practices. Our expectations of our students is a powerful educational psychological tool. In preparing this address, I spoke with a friend who is a freshman dental student, asking her what she felt to be the greatest impact on her developing professionalism. She replied, "We are not treated as professionals, we are not allowed to make any decisions. We are made to feel incompetent and to feel that we just don't have it totally together." Obviously, this woman's behavior has not been favorably shaped by faculty expectations. If we do not treat our students like professionals and have high expectations of them, we cannot expect them to develop professional attitudes.

We have spoken about modeling and expectations; what about reinforcement. To my knowledge, very few clinical systems in dental institutions provide reinforcement for the students who practice professionalism in their dental training. Our reinforcement system in dental school is primarily oriented around academic and clinical skill achievement. Obviously these are critical. However, the conscientious management of patients can be taught and reinforced in dental school. The professionalism of managing the patient as a person, has to a great extent, been left to chance.

This leads to a discussion of another institutional pressure which affects developing professionalism, that being the system of clinical teaching employed by the dental institution. For this topic, let me

share with you the thinking of the Council of Students of the American Association of Dental Schools. This national organization of dental students has addressed itself to this aspect of professionalism for approximately the past four years. At the 1977 Annual Session of the AADS, the Council presented the following resolution (25-77-H):⁸

"Resolved, that the Council of Students urge the American Association of Dental Schools to express to the American Dental Association's Commission on accreditation, concern that student clinical requirements appear to be considered more strongly than patient needs."

This resolution was referred back to the Council of Students for study and clarification with a report to the 1978 House of Delegates.

Prior to the 1978 AADS Annual Session, the Council developed a comprehensive background statement regarding the issue of clinical requirements and ethics. Briefly, it stated that the placing of importance on clinical requirements over that of patient needs, fosters unethical behavior. This unethical behavior was felt to carry over into the student's professional practice. At the 1978 Annual Session, the Council presented this resolution (42-78-H):⁹

"Resolved, that the American Association of Dental Schools urge its member institutions to re-evaluate their patient care systems to determine whether procurement of clinical requirements fosters unethical behavior among the student body."

This resolution was discussed, debated, amended and finally tabled definitely until the 1979 Annual Session. As you can see, this issue is a hot potato. Besides a general discomfort with the word "unethical" two arguments have been made against the resolution. One argument is that clinical requirements are a necessity for a well rounded clinical experience and are not incompatible with good patient care. This may or may not be true, depending on circumstances.

A second argument is that students are the major factor in good or bad behavior, and unethical behavior is an individual, personal flaw uninfluenced by the system of its management. This is not necessarily so!

While students may be the ultimate instrument of behavior, ethical or otherwise, they are most certainly influenced and, in fact, bound by the system they operate within. They are also influenced and bound by the management of this system. The situation might be entirely different if students had a choice within the system; however, this is not the case. Once in dental school the student must conform to the system or else withdraw from it. There are no options.

This does not mean that clinical requirements are incompatible with either good patient care or ethical behavior. It does mean however,

that there is a very real chance of mismanagement of a clinical requirement system which can lead to poor patient care and unethical behavior of the student. More importantly, the attitudes are likely to continue into professional practice.

Much of what has been said to this point implicates dental educators and the educational system. Educators have not always been resourceful in devising systems that educate students to treat people; although they have done well at devising systems to treat disease.

NON-INSTITUTIONAL PRESSURES

Let us now consider outside pressures affecting students in dental school. To some extent the practicing dental profession, and to a great extent State Boards of Dentistry, are seriously implicated in the educational "system" as we know it today. In other words, they must share the responsibility for the "system".

State boards, armed with the often quoted legal charge of "protecting the public," put tremendous indirect pressures on the educational system. Few dental schools will admit to "teaching for state boards", but you can be sure that a lot of this goes on. Many dental curricula are more concerned with training a person to be technically competent than conscientious about patients. Obviously the two are not mutually exclusive, but there is not much premium on the latter, especially from the State Board point of view.

We all believe that dentists should be technically competent, and that the board should protect the public. However, the philosophy of the "initial examination" with no relicensure or recertification, is a paradox. This philosophy gives no incentive to those dental schools which would like to design systems that might produce more "people-oriented" dentists. You see, there is no pay-off for this type of product, the pay-off is in the product who can perform the best cavity preparation or partial denture design. Thus, the system perpetuates itself and the student is the direct victim. However, it may be that developing professionalism is the ultimate victim.

Practicing dental professionals must be considered as a non-institution factor affecting professional development. As we know, in 1974 the American Dental Association modified its Principles of Ethics in such a way that now "The dentist has an obligation to report to the appropriate agency of his component or constituent dental society instances of gross and continual faulty treatment by another dentist."¹⁰ This change must be applauded by advocates of professionalism.

Unfortunately however, early experience has revealed that dental practioners are reluctant to participate in professional society

programs of peer review. A recent study revealed that during a six month period in a large Northeastern state, not a single report was made to an appropriate component or constituent society. Dentists have not totally resisted involvement in peer review, but clearly the profession has been slow to take responsibility to police itself. We complain about litigation, and ever-increasing malpractice confrontations, but much of the problem lies with the professionalism of the practicing profession.

It is not certain to what extent these changes affect developing professionalism in students. It is difficult to know whether students develop a dislike for peer review before graduation or after, or both. Whatever the case, some practitioners do not appear to be setting an example for the young dentists who are entering the profession.

SUMMARY

In summary, this paper has been an attempt to focus on pressures that may affect developing professionalism in dental students. Pressures have been categorized as personal, those from within the institution, and those from outside the institution. It is surmised that developing professionalism is impacted little by personal pressures, but greatly by pressures of the "system", the system being shaped by input from educators, state board examiners, and practitioners.

I have shared a lot of personal feeling and subjective observations; and in doing so, have expressed serious concern over developing professionalism in our students.

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Factors Affecting Professional Orientation in the Delivery of Oral Health Care

THE DENTAL PRACTICE

CARLTON H. WILLIAMS, D.D.S.

The three previous speakers have eloquently and forcefully outlined the factors affecting professional orientation as it affects those preparing themselves for the ultimate goal of the practice of Dentistry. It is my privilege and assignment to discuss the position of the dental practitioner himself.

There has been an evolution in dental practice, and historically one could go as far back in our history as the 1830's, and relate some of the more painful evolutions such as the Amalgam War which had devastating effects, and from which the profession never has completely recovered. Or perhaps we could recall the battles in those early years over patented nostrums and secret remedies which stifled progress and delayed recognition of dentistry as a profession. However, I see my role in today's discussion as much more contemporary, and at the same time more practical. I wish to talk to you of what has transpired in the last forty years to cause a fundamental change in the practice as we know it today.

Dr. James Verneti, past president of the American College of Dentists, has said "professionalism in the true sense involves a concept of unselfish service to others and requires adherence to a code of ethical conduct of the highest order. A professional is a person who not only possesses a superior knowledge and skill, but also applies this expertise for the welfare of the individual who needs his services. A true professional is committed primarily to his patients well being and will not exploit the patients need for personal gain."

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The concern for this attitudinal change toward professionalism is not confined to our country alone. It is of world wide concern. Recently Dr. C. Renton Newbury, president of the Australian Dental Association, made it the topic of his address opening an annual national conference. Dr. Newbury stated that the change in professionalism was of deep concern in Australia, and also in the Capitals of Europe, and gave convincing supporting evidence. We, in the United States would do well to recognize the significance of this world wide concern, and to give leadership to the movement to improve our posture as we have so often given leadership in the past.

I believe the total approach was delineated a few years back when Dr. Alvin Morris, Executive Director of the Association of Academic Health Centers, formerly Chancellor of the University of Kentucky, speaking to a workshop of the college in 1965, made this statement. "If a dentist is to have a good image of his profession, he must have a good image of himself as a dentist. The first step in achieving respect for his professional role is a recommitment to dentistry and his practice. A fundamental challenge in life is for a man to choose the ground on which he shall stand, the profession with which he shall assume identity, and the activity by which he shall be judged a success or failure. When men shun a true commitment to their life's work, the potential of their human resources is never realized. Our nation is in need of more committed men. The dental profession is in need of more committed dentists."

If that statement were true in 1965, and I believe it was, it is infinitely more true today. Unfortunately I see many, too many young practitioners who seem committed to economics, to opportunism, greed and monetary gain, than are truly committed to dentistry as a profession.

Dentistry was elevated to the level of a profession by selfless men who believed in their ordination as ministers of health, who believed that their calling was to alleviate suffering and pain caused by dentally oriented disorders and to serve mankind in this exceptional manner.

The image of the dental professional man has become tarnished by a great number of happenings in recent years. Most of these have been made in the name of social progress, but each has left its effect upon the total picture of today's dental practice. Some of the factors affecting ethical attitudes can be evaluated, but there are far too many to make this an all inclusive survey, so I will cover but a few.

One of the first, and perhaps the most insidious, occurred sometime after 1945 when government decided to pay for dental treatment rendered to the indigent and impoverished. Before that time every professional person contributed some of his time and talents to

serving those who could not pay for their dental services. It was part of his professional obligation. He did it gladly and knowingly, and it worked quite well. However, in the late 1940's Federal and State Governments began paying dentists to perform these services. This did two things. First, it removed the cloak of professional respectability, and professional pride for participating in these very human activities, and secondly, it created intense resentment because, although government agreed to pay for these services, they only agreed to pay a portion of the dentists' necessary fee. In essence the dentist, in addition to being taxed like everyone else, was further taxed for being a dentist. The respectability of giving an eleemosynary service was gone; instead he was accepting alms for his efforts.

About this same time the returning veterans from World War II were beginning to have their effect upon the profession. These young people had seen life and death in their ugliest forms. They had suffered physical, economic, and emotional pain. They were much less idealistic and much more pragmatic than the pre-war students. Ethical standards appeared more flexible - to them.

It is not fair to separate the dental student from the rest of society and make it appear as though he, or she, was the only one affected adversely. This is certainly not true. Ethical and moral conduct had begun a slide into oblivion. Today we see it expressed in higher crime rates, more vicious types of crime, more murders, more embezzlement, social acceptance of cohabitation, nude shows, nude beaches, homosexuality, etc. These changes in attitudes were aggravated by the war in Korea, and later the war in Viet Nam. Young people found themselves involved in wars about which they knew nothing, and unlike any previous period of history, wars in which there seemed to be no desire to win. This attitude of fighting and sacrificing young lives with no intention of winning had a most deleterious effect on the outlook of Young America.

From the beginning of modern history men have fought and sacrificed for two fundamental principles, for God and Country. The events of these recent wars have taken their toll in the attitudes of young people toward their country. Patriotism has suffered and when a people loses sight of the highest moral objective, and certainly patriotism is one, then they have lost the foundation for living and decadence will be their reward.

Patriotism, moral and ethical values all are part and parcel of the general attitudes which guide our daily lives. We need to re-establish the value of each or we will cease to exist as a profession, yes and even as a nation.

The American Association of Dental Examiners, feeling the need to examine the quality of the ethical standards of applicants for licensure in the various states created a program called the "Character Reference Program". This program had a short and stormy life, and although it was ill conceived, and poorly structured, it does point up the fact that the examiners were aware of a change in ethical standards and were trying to do something constructive about it.

This raises a question regarding the activities of dentists which leads one to picture the profession declining in its ethical and moral posture. Why do I, along with a great many others, feel that the profession has been less attentive to its standards in recent years? Some of the actions leading to that feeling are to be found intimately connected with the new, or relatively new, area of the pre-paid dental programs. These have done much to create ethical problems or to nurture those which were lying dormant.

These pre-paid programs have brought great sums of money into dentistry, and the opulence the money has brought has been accompanied by many opportunists in the profession attempting to secure an advantageous position in these lucrative programs over the other dentists in the area.

Some of the methods to gain the economic advantages are: Outright advertising. With the Supreme Court opening the way, some dentists have embraced this approach which historically has been held to be unethical.

Closed panel clinics, wherein a principal dentist or a group of dentists sign a contract to care for a large number of patients supplied by a union management pre-paid dental health program. These types of preferential contracts have always been considered as being on the fringe of professional acceptability, if acceptable at all, for they do take established patients from established practices and force them into a clinical environment if they are to receive the care to which they are entitled.

There are also franchise type practices where a dental entrepreneur will agree to give comprehensive dental care to a group of patients, usually a union, for a given amount per person per month, in other words a capitation program. These are also less than professional and their track record for high professional performance has left a great deal to be desired.

These are the same type of opportunists who try to create their own empires by operating an H.M.O. or Government sponsored and government funded capitation program. In these programs, as repeated investigations have revealed, the principal operator can

manipulate the rate of delivery of care, the type of delivery of care, and the amount of care delivered, to his own advantage.

Many of these pre-paid health plans, based upon a capitation method of payment have failed, but not until the operator has lined his pockets with gold, because it takes a long time before the patients covered under these programs realize that they are not getting the required care, and then report this to the union agent, who in turn investigates the charges, and eventually acts to rectify the wrongs.

All of these types of practices, and others you may know of, lead to a lowering of the respect in which the public holds the profession on the one hand, and the respect and self esteem the dental practitioner participant, has for himself and his profession.

All of these problems have led to the present changes which have been created to offset some of the abuse of the professional posture. These include the development of peer review mechanisms, quality control measures, compulsory continuing education and others, all designed to limit those who would degrade the profession by poor performance and retrogressive measures.

The profession is having to police itself, or it will have a policing mechanism forced upon it. These policing measures must be handled by men of great integrity and fortitude, and they must be forthright and resolute if they are to forestall some type of government body being initiated to do the police work the public is beginning to demand. This indeed is no place for the timid. I salute the men who are working diligently to make these self-imposed policing mechanisms work.

In view of all these things it appears time for the profession to reassess its position. This year the A.D.A. House of Delegates will try to make the principles of ethics more meaningful by rewriting Section 18. One can only hope the House finds a means of accomplishing this, as it is desperately needed.

Time is running out and although the profession is being attacked from many outside sources such as consumer groups and well intentioned legislators, I fear that the greatest danger and most possible source of destruction is coming from within.

It is time therefore to call upon the dental professional to rededicate himself to his profession, to join the efforts to strengthen its posture and to support the men who have taken the mantle of leadership. If they do not agree with policy, let them work within the framework of the Associations to change the policy. There is nothing wrong with disagreement as long as it is honest, sincere, and constructive.

It is time too to ask again "what is a Professional Gentleman?" Dr. Harry Lyons a distinguished dental educator and past president of the

American Dental Association has said it best, so I repeat a statement of his, although not quoted verbatim.

The Professional Gentleman is, first of all, a gentle man with all of the personal qualities that the word "gentle" connotes: amiable, kind, considerate, helpful, empathetic, sympathetic, understanding.

The Professional Gentleman is, then a gentle person who professes certain things. He professes that he is educated beyond the general level of his community.

He professes that he possesses special knowledge and unique skills limited to only a relatively few persons in his community.

He professes that he uses his superior knowledge and unique skills more for the benefit of his fellowman than for himself.

He professes that he gives more than he receives.

He confesses that he inherited a vast body of knowledge from his predecessors,

But

He professes that as he labors in the vineyard of his profession he will enrich that body of knowledge by his own contributions.

The general public believes his professions and rewards him generously. Through legislative channels the public awards the professional gentleman a monopoly. In the instance of the dental profession, only a dentist may practice dentistry. However, this special status carries with it certain responsibilities of equal magnitude. That responsibility (the main one) may be stated in simple terms: our profession must strive to achieve for the public access to dental health care for everyone within the ability of the individual to pay. That is our great challenge which we ignore at the risk of losing our privileged status.

The risk we incur is based on our governmental principle that what the people give they may take away.

Dental practitioners are well aware of the threats which exist to the established, acceptable way of conducting a daily practice, today, that were not confronting the profession a few short years ago.

In order to have a strong, informed, and forceful voice in the legislative halls of our country, where important decisions affecting dentistry are being made, it is imperative that we have a unified voice. In order to have a unified voice it is imperative that we embrace the actions taken by our parent body.

However, there has been a trend toward discrediting the actions of the American Dental Association lately and some groups, such as the American Association of Dentists have organized themselves to take actions different from that of the A.D.A.

No one can be totally satisfied with every action of the House of Delegates, but it is a very democratic body, and everyone has the opportunity of appearing before its committees to register his or her thoughts regarding pending resolutions. To those who would be divisive, to those who would be disruptive, to those who would discredit, I can only urge that they look deeply at the problems facing dentistry today and if they feel errors are being made, get in and work within the system to see that their views, and their ideas are factors to be considered in making a final decision.

This has not been the method of choice by some, and so we have the law suit brought in Arizona which challenges the right of the American Dental Association to require that membership in a local society be contingent upon membership at the State and National level. If this lawsuit is successful it will have weakened the posture of dentistry to a devastating degree.

The Federal Trade Commission is also attacking the foundation of our profession. Its lawsuit is costing vast sums of money, and I feel is nothing but a fishing expedition. To those of us in the profession, the charge that the A.D.A. has restrained trade by setting fees seems ridiculous, but stranger things have happened in courts before, and it is imperative that the A.D.A. use whatever resources it has at its command to win a just decision for the profession.

The added impact of the Supreme Court decision upholding the right of professionals (lawyers) to advertise, and the impact of the court decision making it illegal to set minimum fees have contributed to the attack on the "Establishment". Add to these problems the move by speciality groups and the Academy of General Practice to establish special lobbyists for their own particular interests, as well as the growing interest in the formation of dental unions, and it is apparent that we need to come back to the beginning and reaffirm that we desperately need a strong viable American Dental Association to protect the interests of all practitioners, generalists, specialists, educators, and researchers alike. After all the American Dental Association is not a group in Chicago, it is a small bit of each one of you. You all are the American Dental Association--you all, collectively, must make it work. You all, collectively, have too much at stake.

All of these attacks on the establishment have eroded, to some extent, the attitude of the dental practitioner toward his profession. Is there anything then that can be said about the good news side of this dissertation--yes there is. First we must not overlook the fact that, the foregoing notwithstanding, the majority of dentists still do view their profession with respect and devotion. Not all practitioners, by any

means, young or old, are falling into the patterns here discussed, and because of this fact dentistry continues to rise in the esteem of the American public.

The most recent surveys have placed dentistry second only to medicine in the areas of respect and trust as far as professions and occupations are concerned. Therefore, I will close with some positive thoughts aimed at trying to stimulate a resurgence of the pride and professionalism that made us Dentists first and Fellows of the college second. In my view we must:

1. Give support and encouragement to the schools to give a sound ethical foundation to the dental student. To inculcate a deep sense of professionalism and professional integrity into each graduate.
2. To recommit ourselves, each and everyone, as Dr. Morris urged, to being more of a professional than ever before. To convince the public by precept and example that we are professionals, that we are concerned with the public welfare. That our goals are, in fact, Dental Health for all people.

Such commitments, starting with the dental student, but strongly supported by practicing professionals can, and will, cause a change in the direction of our great profession.

No one person can turn this world around overnight, and there is no way to legislate morality, but as James Vernetti has pointed out, there are 100,000 dentists in the United States seeing conservatively one million patients per working day. The impact on this number of patients of the attitudes of true professionals can have a tremendous impact on the future of our profession.

I repeat, we need more committed men, we need more committed dentists.

2654 Fourth Avenue
San Diego, California 92103

Not by physical force, not by bodily swiftness and agility, are great things accomplished, but by deliberation, authority, and judgement; qualities with which old age is abundantly provided.

Cicero

The Contributions to Dental Science of Robert J. Nelsen

GEORGE C. PAFFENBARGER, D.D.S.

The introduction of a distinguished former colleague such as Dr. Robert J. Nelsen, today's recipient of the Callahan Memorial Award, is always a pleasant assignment. This assignment is more than an enjoyable occasion; it is a gratifying one for me and also for you. Why do I say it is a gratifying occasion for you? Because you subsidized Dr. Nelsen from 1950 - 1955, when he was a Research Associate for the American Dental Association at the National Bureau of Standards. Now that you paid his salary for those five years with your ADA dues, you can ask yourself a pertinent question -- What have I, as an ADA dues paying member, received from this gentleman's research? It would also be well for you to ask another relevant question -- How has the recipient's research benefited the public? Let us look at the record. Every one of you who operates with a turbine contra-angle handpiece uses the invention of Dr. Nelsen.

In 1967 the late ADA Research Associate, Mr. Harold J. Caul, calculated the cost/benefit ratio to the public.¹ He did this using the number of patient's visits per dentist per year, the number of self-employed dentists, the number of restorations made, the time saved in cavity preparation, and the gross income per hour at the chair for the years 1958 through 1966.⁽²⁻⁴⁾ His calculations for those years showed a \$1.4 billion dollar benefit. As the estimated cost in developing the handpiece was \$55,000, the benefit/cost ratio was estimated at 27,000. In other words, for every dollar that the American Dental Association expended in this research of Dr. Nelsen's, \$27,000 was realized. Of course, if these calculations were projected to the present time you realize what a tremendous investment it was for the American Dental Association and, for you, its members, and for the public you serve.

If you will look on page 324 of the September 1953 issue of the Journal of the American Dental Association you will find the original

This paper was presented by Dr. Paffenbarger former Director of Dental Research, National Bureau of Standards as introduction to Dr. Robert J. Nelsen who was the recipient of the Callahan Memorial Award of the Ohio Dental Association, Columbus, Ohio, September 23, 1978.

article, hydraulic turbine contra-angle handpiece, by Nelsen and associates.⁽⁵⁾ In 1962 the American Dental Trade Association reported a survey showing that between 94 - 96 percent of all dentists in the USA were using contra-angle handpieces⁽⁶⁾ within nine years after their first introduction on the market.

No patent was taken out on the handpiece. Instead, the manufacturers of handpieces in the USA were invited to the Dental Research Section of the National Bureau of Standards to see the shop model of the turbine contra-angle handpiece in action. The manufacturers made almost no statements about any proposed developments. That was indeed disturbing not only to Dr. Nelson, but to the whole dental research staff at the National Bureau of Standards. So what did Nelsen do? He demonstrated the shop model to several dentists in the Washington, D.C. area. These dentists put up \$500 each to have a handpiece made for them by a mechanic, a Mr. Kern of Arlington, Virginia. From this demonstration the enthusiasm spread not only nationally but internationally.

Let us now explore another aspect of the effect of the development of the turbine contra-angle handpiece. Let us attempt to calculate how its savings of chair time for the dentist really replaces dentists.

In 1966 about 234 million restorations of single teeth were made by dentists using turbine contra-angle handpieces.⁽⁴⁾ By the use of this handpiece at least a savings of 3 minutes per cavity preparation is attained,⁽¹⁾ thus 11.1 million hours were saved in 1966. As the average productive work time for dentists is roughly 47.1 weeks per year and as the average weekly office hours at the chair was 33.6 hours in 1975, each dentist worked on an annual average of 1591 hours at the chair. Now if one projects Mr. Caul's 1966 statistics to 1978, assuming a 2 percent increase annually in the number of fillings per year, the time saved by the use of the turbine contra-angle handpiece would amount to 14.8 million hours in 1978.

If a dentist works about 1600 hours at the chair each year and if about 14.8 million hours are saved annually by the use of the turbine contra-angle handpiece, that is equivalent to a savings of 9,062 dentists. It must cost in the neighborhood of \$100,000 to educate a dentist beyond high school and to set one up in practice. So that would amount to a savings of approximately 1 billion dollars. I cite these estimates to give a gross idea of the enormous impact that this invention of Dr. Nelsen's has had and is having upon dental health practice.

Now I would like to be a little more personal. I first met Dr. Nelsen during World War II as we served together at the Naval Medical Supply Depot in Brooklyn, N.Y. I immediately realized that he was an unusually exceptional and innovative person.

After he left the service at the end of the war he went into private practice at Faribault, Minnesota. In 1947 he became Executive Officer

of the Department of Dental Materials at the University of Washington. There he immediately began some research on the panoramic dental x-ray machine and the front surface mirror. In 1950 I persuaded him to become a Research Associate of the American Dental Association at the National Bureau of Standards. During the five years he was with us he was a most productive researcher. His main publications were a demonstration of percolation of fluids at the tooth-restoration margin and the handpiece.

He wrote and produced in 1954 a sound-color motion picture on the Hazards of Dental Radiography that won second prize at the International Venice Film Festival.

After leaving the ADA Research Staff at the National Bureau of Standards in 1955 he again established a private practice in Potomac, Maryland and taught at Georgetown University.

A person with Dr. Nelsen's ability, industriousness and drive is never content, so he became Chief Collaborator in Research and Chief of Material Science and Clinical Studies at the National Institute of Dental Research in 1965. Here, as elsewhere, it was a pioneering effort.

After several years at the National Institute of Dental Research he became the Executive Officer of the American College of Dentists. Now he tells me that he is retiring in a year or two and plans an episode of house building, boating and fishing. I have already invited myself down to visit him.

Ladies and Gentlemen, I present to you Dr. Robert J. Nelsen, who was your employee for five years in the American Dental Association Research Unit at the National Bureau of Standards, and Dr. Nelsen, I present you this medal in recognition of your many achievements in significantly advancing dental health service. As was said of Abou Ben Adhem--May your tribe increase.

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Some Reflections on Present and Future Problems of the Dental Profession

ROBERT J. NELSEN, D.D.S.

Any viable organism from the date of its conception must contend with external and internal factors of mischief which mitigate against its survival. Like all organisms, associations and professions must contend with internal and external influences which promulgate disorder. I wish to comment about some of the disorders I see within and about dentistry. Indeed, the first essential of order is the recognition of disorder. What do we find in dentistry and its environment which has potential for altering professional orientation of dentistry and the professional delivery mode of oral health care?

Today, the patient is considered a customer, the doctor a provider and the profession an industry now subject to fringe benefit negotiations between labor and business with the concentration of large sums in the hands of the carrier. It follows, naturally, that the entire system of dental care delivery has become an attractive market in the eyes of conglomerate commercial entrepreneurs. This is more of an immediate hazard in my view than the specter of National Health Insurance.

The recent court and FTC declarations, which served hemlock to the ethics of professionalism, leave but an interval until it may be necessary to write the epitaph of professional dentistry. Recent announcements of programs and studies about dentistry bring one to wonder; could these be the handwriting on the wall?

Consider the purposes and objectives behind a number of present studies which relate to delivery and cost of dental care.

This paper was presented by Robert J. Nelsen in acknowledgement of the Callahan Memorial Award from the Ohio Dental Association, Columbus, Ohio, September 23, 1978.

The Division of Dentistry, Bureau of Health Manpower, gave a total of \$305,000 in contracts: (1) To Stanford University, \$99,899, for an economic analysis of the characteristics of the dental services market; (2) to Research Resources Corporation of Texas, \$99,036, to study the effect of labor substitution on the economics of dental delivery. This means expanded duty (piece work) auxiliaries. (3) To The American Dental Association, Chicago, \$58,869, to study the economic relationship between dentists' income and time worked; and (4) to The University of Connecticut, \$58,869, to analyze economic factors associated with providing incremental dental care to children. This is called the New Zealand concept.

The Council of State Governments has launched a comprehensive study of state dental practice laws. It has recently released a background paper, DENTAL EDUCATION AND THE STATE DENTAL PRACTICE ACTS, prepared for the National Task Force on State Dental Policies. This report should be required reading for anyone interested in "What's going on?" in respect to professional control of dental care. More on this later. . . .

The Kellogg Foundation has funded The Dental Foundation of North Carolina, \$91,000, to study factors influencing the public's utilization of prepaid dental insurance programs. This project, conducted in collaboration with the Michigan Health and Social Security Institute of Detroit, is an extension of a comprehensive study of dental disease patterns and of dental manpower and care delivery. It is designed to demonstrate methods and provide data which make possible a more rational approach to planning for the delivery of dental health care.

Significantly, the R. J. Reynolds Tobacco Company also in North Carolina is building a forty-chair dental clinic and is advertising in the Journal of the American Dental Association for dentists to operate it for its employees. In this system, the tobacco company will have complete control of the delivery of the fringe benefit of dental care to its employees by hiring dentists, thus eliminating the third-party carrier and allowing bulk purchase of clinic materials, equipment and supplies. In an informal discussion which I had with one of the Reynolds people, I proposed that the company should consider health motivational and educational programs of prevention as this would be less costly to the company in the long run when compared to the costs of treating disease. He agreed that good management would find this out in time. Industry should be told that preventive maintenance of its employee's health is less costly than repair after it breaks down. Industry has already learned the value of preventive maintenance of its buildings and machinery.

The Federal Trade Commission's Bureau of Competition will investigate fee review activities and HMO administration in the competitive health care delivery marketplace. State laws inhibiting HMO's will be reported to HEW.

According to the Council on Dental Care Programs of ADA, forty-eight million persons are now covered by dental insurance; sixty million will be by 1980. The money management of dental care is big business - a study should be made to learn how big and how profitable.

The National Association of Dental Laboratories, in a letter to all dental deans, recently asked if dental technicians can audit dental school courses; if evening courses are available to technicians. Would the school change its policy to allow technicians to take dental school courses?

IMS, the world's largest health care market research firm, has asked 400 dentists to allow it to microfilm their 1976 purchase invoices - the information to be used by dental manufacturers and dealers in developing products, they say. More likely, these will become usage rate tables which will provide specific figures on the actual per hour income of the dentist when they are combined with the information the ADA is gathering on the relationship between dentist's income and his time at work.

Sears Roebuck has opened dental offices in the California dental market area.

And last - but not least, the thinking members of the profession might dwell on the implications for possible harm to the public, inherent in the provisions of an act drafted by the Council of State Governments' National Task Force on State Dental Policies to be recommended to state legislatures. Quote. . . .

"Section 505 (Construction)

(a) Nothing in this act shall be construed as permitting by rule or otherwise:

- (1) Limitation of ownership of dental practice to holders of dental licenses.
- (2) Limitation on the number of auxiliaries a dentist may supervise.
- (3) Limitation on the number of offices or sites at which a dentist or auxiliary may practice.
- (4) Limitation on the right of specialists and nonspecialists to practice together in an association, partnership, corporation or other lawful entity."

Provisions such as those above would allow commercial-industrial enterprises, unions, dental laboratories or "other lawful entity" to own assorted franchised dental parlors employing multitudes of auxiliaries under few dentists to provide dental service a' la assembly line

generosities. If these recommendations become the state dental code or law, then anyone may hold ownership of a dental practice, any one dentist may supervise any number of auxiliaries, persons who "work on people" may move from one dental parlor to another, any number of persons may practice anywhere in any number of offices under "other lawful entity."

From an examination of these studies, programs and events, one might conclude that dentistry, often described as "the last of the cottage industries," may become the first commercially franchised health service system. Ponder the relationships of the above events: the concerted advocacy of expanded function auxiliaries - piece work persons or labor substitution; the dental technicians' sudden interest in "auditing" dental school courses; the ADA study of dentists' work time and income relationships, the court and FTC murder of professional ethics and meretricious dentists already advertising their merchandise: the explosive growth of prepaid dentistry; foundation funded studies to revise state dental practice acts seem bent to weaken the acts' purpose of protecting the public while opening doors for commercially franchised dentistry. The intensive monetary analysis of the profession entices the rapacious eyeing of the dental market by third and fourth parties. Does this not all seem to fit together? Does it not look like writing on the wall?

Are the professional control of dental care and the exercise of moral value judgment for the patient's benefit to be lost to the cost accountant's report? The market analysis and monetary value judgments of the fourth party entrepreneur of franchised dentistry give us the message on the wall, if we will but read.

Student enrollment in dental schools is dwindling. Perhaps those who are to direct dentistry in the future are now in schools of business administration preparing for a career in health industries.

GOVERNMENTAL INTERVENTION

Concomittantly with this seemingly programmed pattern of industrial assault upon the professions, there occurs governmental actions which appear to function synergistically with third and fourth party ambitions.

The recent intrusion of governmental agencies into the affairs of professions gives additional cause for alarm. Society has designed within itself several systems of management, two of which are government and the professions. Government is intended to provide, by common agreement, those services which are not attainable by private effort.

The professions are designed to provide solutions to private and public problems which are beyond solving by the individual or society.

They do this through the profession's use of its superior knowledge, skill and judgment.

Government operates by laws which are essentially guides intended to enhance the common good. Some laws are restrictive of personal freedom while others protect and guarantee that very same freedom. Frequently, agencies of government charged with implementing a category of law arbitrarily extend their jurisdiction beyond the intent of the original act. This has happened in the Federal Trade Commission's recent challenge of Codes of Ethics accusing them of being a restraint of trade. Such a view is nonsense, for the obvious purpose of all Codes of Ethics under which professions function is to curtail harm to the public by mercenary actions of venal practitioners. Codes of Ethics, like laws, are brought about by common agreement and bring censorship only to those who refuse to hold to these guidelines for professional conduct.

ADVERTISING

The practitioner who advertises cancels his professional standing for the reason that advertising is the hallmark of trade and commerce. The nature of a profession does not include such commercial trappings.

Those who so wander away from the guidelines of professional ethics are properly regarded as engaging in commerce. They should be removed from the profession and then, like industry and commerce, be monitored very closely by an appropriate governmental agency such as the FTC for the protection of the public by restrictive law, code, specification, allowance and legal sanction.

Professionals who conform to ethical guides are of great and unique value to the public and must not be subjected to exploratory challenges and admonishments of governmental agencies. Codes of Ethics are more stringent than laws in defining appropriate professional conduct. Because they are self imposed, they are more effective than any legal system. It is because of the very moral principles of these codes that our professions are singularly allowed a privileged independence in making value judgments for others. Such judgments cannot be compacted into a code, a law or a statute. Without our system of ethical, morally-oriented professions, order in society would cease and the first disintegration would be government itself.

Within the assembly of organizations in our society, our professions must have independence and precedence over government - for without them, there would be no government. It is an obligation of the professions to make public declaration that the purpose for which professions function can be smothered by pervasive governmental intrusions and regulations to the great detriment of the public.

HEALTH RESPONSIBILITY

Now you may ask, who is responsible for health?

The condition of one's health is a subjective state in which the individual considers that he can function to attain his perceived purpose. Its origin is in intra-personal qualifications. The person alone determines how he feels about the state of his health. Disease, on the other hand, is an objective state identifiable by scientific methods. It is expressed as an impairment of the normal state and as affecting the vital functions. It has inter-personal qualifications. Persons other than the victim can qualify disease. Thus, the notion of being adequately healthy is a personal judgment of the individual. Health management then is primarily a personal responsibility.

When the management of health gets beyond the individual - because of disease - the person may elect to become a patient by assignment of the disorder to another who has been credentialed as having knowledge, skill and judgments in the management of such disorders. Most importantly, this person also professes to place the interest of the patient always before his own interest. He is a professional. This is the nature of professionalism; it has great worth.

When the patient sets the responsibility for treatment of the disorder upon the professional, he cannot annul personal accountability for his own health. He cannot disregard good health practice, then hold the professional responsible for correcting all consequences of his own neglect. There is great need for the practicing profession to defend itself against those who accuse it of being irresponsible.

There is an order of responsibility which places the individual first in accountability for his state of health. Next, the primary educator is the agent of society delegated to bring health care knowledge to the youngster and advise him that he has the principal responsibility for his health during his lifetime. The sector of primary education is not doing its job. Next, the public health system is charged with bringing effective means of personal health care procedures to the elementary school teacher and to foster public awareness of continuing self-care. The public health establishment must implement, not only advocate, accepted public health preventive measures; e.g., fluoridation and avoidance of over-indulgence in food, drink, tobacco and drugs.

Finally, the practicing profession must maintain itself fully capable of treatment of disorders of those persons who wish to be patients. It must refute accusations by opportunistic operators of political and economic machinery that it is derelict. The practicing professions can never attend to all the conditions which accrue through the conscious neglect by the individual, the non-effective primary education system and the disoriented public health establishment. The profession must

state publicly and emphatically that the individual is responsible for his health; the profession is responsible for disease. Nevertheless, the profession constantly must monitor the public health system and the educational system to assure that people are educated and motivated to care for their own health. It must hold itself constantly available and fully competent to assume the management of disease when asked.

THE IMAGE OF DENTISTRY

In the minds of those having power to determine support of or even the inclusion of the profession in public health care programs, the image of dentistry apparently does not compare favorably with the image of other health services. Much of this is dentistry's fault. In the past, many of our national programs have presented a simplistic concept of dental health "A Smile is to Keep" or "Swish and Swallow." We may have made so much of the ease and success of water fluoridation that many may believe dental disease has already been curtailed. Dentistry must do more than advocate such simple statements if it is to be taken seriously. The decisiveness of a heart attack, the tragedy of a stroke, or the sorrowful disaster of cancer, relegate to a low order the significance of oral diseases when we declare "A Smile is to Keep" or "Swish and Swallow" as our motto.

We should continually and emphatically point out that the 23 million Americans without any natural teeth are truly handicapped persons; that decayed and sensitive teeth do seriously interfere with the selection of adequate diet; that the important beginnings of digestion occur in the mouth and that digestion, as well as self-image, is impaired by cruddy teeth; that smoking is dangerous and is an aberrant oral compulsion; that neuromuscular dysfunction of the mouth system can cause headache and debilitating referred pain; that the orofacial complex is a most important factor in the total health of the person and has a considerable influence on one's self-image. We must proclaim that poor oral health is a real threat to the person and that 23 million toothless people are truly handicapped and are a national concern; that these unfortunates require scientific professional care. We must believe this ourselves first if we expect others to believe it. We must effectively concern ourselves with projecting the seriousness of dental disease if we wish others to take dental disease seriously. We must assign to auxiliaries the "show-and-tell" of tooth brushing and plaque control. Patient orientation and motivation in oral hygiene procedures are the province of the auxiliary and do not require the professional time of the dentist. Educational and public health agencies should be directed by the profession to

send auxiliaries into the community and into the schools where preventive "show-and-tell" and elementary hygiene instruction can be programmed most effectively. To relegate instruction in simple care procedures of brush and flush to the dental office is a costly retail procedure. The image of the profession will be enhanced as the public becomes aware of the seriousness and the magnitude of dental disease, and of the unique knowledge, skill and judgment which proper treatment requires.

How does this simplistic projection of dental care affect concepts of dental care delivery? The mouth's importance as an integral organ system seems to get lost in the monetary charm attached to traditional piecemeal management of plaque, fillings, gums, extractions and prostheses. Too often do teacher, practitioner, third party and patient consider a laundry list of seemingly workshop procedures as the only measure of professional care. Dentistry itself has not fully accepted responsibility for management of the total mouth. The profession must concern itself with the mouth as the primary organ of nutrition, and the authoritative organ of speech and expression. Being the pristine organ of aggression and defense, the mouth still harbors a residuum of this ancient purpose. Out of the complexities of the complete "mouth" are born the great oral-centered mischiefs of overeating, excessive drinking and compulsive smoking. Dentistry pays little heed to these dilemmas of oral health. Yet, if we publicly proclaim our responsible custody of the mouth, dentistry should expand its programs in research and education to embrace the total mouth and all its functional aberrations as well as its structural faults.

The important role of the mouth as an integral part of the person and the personality certainly needs to be more fully recognized by the profession and the public if dentistry is to be believed an important health service.

It was that great philosopher POGO who said, "We have met the enemy and they is us."

AN ACTION PROGRAM

There is need for immediate action. There is opportunity for that action now. The following might be considered.

1. Bring the profession to a more comprehensive responsibility for the total mouth system. Remove the tradition that dental care consists of a laundry list of procedures and fabrications.
2. Re-establish within dentistry a respect and accord with the philosophy and doctrines of professionalism.
3. Be hard nosed about discipline of those who abuse professional privilege.

4. Quit being intimidated by legal opinion and bureaucratic dictum on every issue which comes before the profession. We still have charge of the final delivery of oral health care. If legal opinion, the law or government regulation is contrary to what we believe is to the best interest of the public, then determine how the law should be changed and set about to get it changed. If agencies of government intrude into professional prerogatives, elect officials who will curtail aberrant aggressive bureaucrats.

5. Become less amenable, less cooperative, less acquiescent to those whose objective is the industrialization or socialization of the profession. Make stronger alignments with other professions such as medicine and engineering which have principles, purpose and problems parallel to ours.

6. Present a scholarly statement to the public explaining that a pluralistic society benefits considerably when it provides for and protects systems of professions which it can trust: That this trust is predicated on the exercise of moral value judgments by the professional for the primary benefit of individuals and society. Bring into being an ongoing program that will educate the public on the role of professions within our society.

The opportunity before us is that of action; the opportunity is ours not theirs. The action must be ours, not theirs. If we do not act, the future of dentistry as a profession may well end up on the trash pile of lost opportunities.

I don't think that the profession of dentistry is going to end up on a trash pile. I am convinced that it has the inherent vitality and necessary strengths to resist encroachments upon its prerogatives and thus assure each dentist that he can continue to provide unfettered professional service to his patients. Let us not allow this writing on the wall to become the epitaph of dentistry as a profession.

7316 Wisconsin Avenue
Bethesda, Maryland 20014

The marvel of all history is the patience with which men and women submit to burdens unnecessarily laid upon them by their governments.

William E. Borah

Deceased Fellows

The deaths of the following Fellows have been reported to the central office between October 1977 and October 1978.

- *Anderson, Percy, Toronto, Canada
- *Applegate, Oliver C., Ann Arbor, Mich.
- Barnes, Francis P., Waterbury, Conn.
- Bentley, Christopher F., Livermore, Calif.
- Berlove, Ira J., Boca Raton, Fla.
- Bimestefer, Lawrence, Baltimore, Md.
- Blackwell, Richard T., Mission Hills, Kansas
- *Booth, Allan, Sharon, Pa.
- Brown, Weston D., Yakima, Wash.
- *Burkhart, Richard H., Falls Village, Conn.
- *Burr, Leroy E., Yonkers, N.Y.
- *Calkins, Earl D., Racine, Wis.
- *Carnes, Harold A., Boston, Mass.
- *Cartee, Horace L., Coral Gables, Fla.
- Carr, Wesley A., Augusta, Ga.
- *Chandler, A. W., Chevy Chase, Md.
- *Cheney, Howard A., New York, N.Y.
- *Chevalier, Paul L., Richmond, Va.
- *Cleveland, Charles, Jacksonville, Fla.
- *Cody, Glen L., Denver, Colo.
- *Cook, J. Russell, Cumberland, Md.
- *Cooper, H. K., Lancaster, Pa.
- *Dempsey, Peter A., Hingham, Mass.
- DeVanna, Alonzo, Scarsdale, N.Y.
- *Dillon, C. F. Stinson, Los Angeles, Calif.
- *Dixon, Maxwell M., Los Angeles, Calif.
- *Dunn, Arlo M., Omaha, Neb.
- Draper, Donal L., Indianapolis, Ind.
- *Elder, Donald J., Miles City, Mont.
- *Ennis, LeRoy M., Broomall, Pa.
- *Everhard, Will D., Middletown, Pa.
- Faigel, David S., Burlington, Vt.
- Fisher, Gordon, St. Louis, Mo.
- *Foerster, Frank H., St. Louis, Mo.
- *Garrett, William A., Atlanta, Ga.
- *Gill, J. Raymond, San Juan, P.R.
- *Gillespie, Rupert H., W. Palm Beach, Fla.
- *Gray, Charles N., Glosgow, Mont.
- Greek, William J., Springfield, Ill.
- *Hair, P. Belton, Spartansburg, S.C.
- Hart, Max, Flint, Mich.
- Heard, J. Milton, Jr., Macon, Ga.
- *Hess, Lawrence E., Jenkintown, Pa.
- *Hicks, Hugh T., Baltimore, Md.
- Hicks, Thomas J., Jr., Atlanta, Ga.
- Highfield, John F., Princeton, Ill.
- *Hookway, Harold, Belmont, Mass.
- *Johnson, Earle E., Woodstock, Vt.
- *Johnston, John F., Indianapolis, Ind.
- *Jones, Paul E., Farmville, N.C.
- *Kletzky, Benjamin, Denver, Colo.
- Kirby, Joseph V., Clayton, Mo.
- Korkhaus, Gustav, Bonn, Germany
- *Leavell, Fred W., New Castle, Ind.
- Leckie, Archibald, Canada
- *McCall, John O., Portland, Ore.
- *McClelland, William D., Pittsburgh, Pa.

- McGuirl, Hubert A., Providence, R.I.
 McHugh, Francis X., Bronx, N.Y.
 MacIntosh, William D., Providence, R.I.
 *Madda, Carl J., Chicago, Ill.
 *Maguire, John F., Wilmington, Del.
 *Martin, Joseph, Rochester, N.Y.
 *Matthews, George W., Birmingham, Ala.
 Melarkey, David, Reno, Nev.
 Morinville, William A., Pawtucket, R.I.
 *Myers, Lester E., Sun City, Ariz.
 Ortolani, Francis C., Plymouth, Mass.
 *Paquin, Ozias, St. Louis, Mo.
 *Pattishall, Harold B., Sr., Jacksonville, Fla.
 *Peck, Merritt E., Jeffersonville, Ind.
 *Pierson, F. A., Sr., Lincoln, Neb.
 *Pritchard, Griffith C., St. Petersburg, Fla.
 *Rosenthal, Albert E., Miami, Fla.
 *Rushing, Shade P., Lake Village, Ariz.
 *Sager, Aubrey, Lakeland, Fla.
 Saturen, Bernard, Philadelphia, Pa.
 Schuler, Thomas, Covington, Ky.
 *Sippel, Harold E., Buffalo, N.Y.
 Spangenburg, Harry, Columbus, Ohio
 *Steffel, Victor L., Columbus, Ohio
 *Steninger, George E., San Francisco, Calif.
 *Sherwood, Paul P., Cleveland Heights, Ohio
 *Sturdevant, Roger E., Chapel Hill, N.C.
 Tancelosky, Tally J., Mahanoy City, Pa.
 *Teal, Douglas M., Yale, Mich.
 *Timmons, G. D., Scottsdale, Ariz.
 *Walker, Chester K., Huron, S.D.
 *Warner, L. Edward, Baltimore, Md.
 *Wherry, O. T., Portland, Ore.
 *Wilson, Walter A., Jr., Waretown, N.J.

*Life Fellow

THE DENTAL STUDENT

(continued from page 48)

7. Yancey, J. M. and Van Stewart, A.: Effect of selection ratio on correlations between admissions criteria and measures of dental student success (AADA abstracts) J. Dent. Educ. 42:37, 1978.
8. Proceedings of the 55th Annual Sessions of the American Association of Dental Schools. J. Dent. Educ. 42, 1978.
9. Proceedings of the 54th Annual Sessions of the American Association of Dental Schools, J. Dent. Educ. 41, 1977.
10. American Dental Association Principles of Ethics with official advisory opinions as revised, Section 8, justifiable criticism and expert testimony. J. Am. Dent. Assoc. 90:184-191, 1975.
11. Waldman, H. B.: Dentistry and peer review: Sham, Smoke screen, or Reality? J. Am. Coll. Dent. 43:164-175, 1976.

SECTION NEWS (continued from page 4)

The Metropolitan Washington Section

Under Bill Bottomley's able direction, the largest number ever, 117 individuals, took the Mini Self Assessment Examination during the D.C. meeting.

58 seniors and their guests attended the Senior Breakfast which was co-sponsored with the D.C. Dental Society. Dr. Herman Tow did a fine job coordinating this activity.

Hank Heim, with his usual dedication, chaired the Project Library Committee and 34 packages were purchased and mailed this year; a record for this Section, and perhaps any section.

Regent Bal Mattox has been working on the Junior Student Award, and it is anticipated that a \$250.00 check and a plaque certificate will be presented to a junior student from Howard and Georgetown University Dental Schools who typify the essence of professionalism in their respective classes.

The nomination committee headed by Will Dudley presented the names of the present officers to the Fellows for consideration to serve another year; all were unanimously re-elected.

In the months ahead we will consider the possibility of a joint meeting with the Maryland Section, and of a workshop on proprietary journalism. We look forward to another year of progress in the Metropolitan Washington Section.

Statement of Ownership, Management and Circulation

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Free distribution	227	112
Total distribution	4,301	4368
Copies not distributed	47	47
Total	4,415	4415

I certify that the statements made by me above are correct and complete.

Robert J. Nelsen
Business Manager

NEWS OF FELLOWS

Regent **Charles W. Fain, Jr.** of Daytona Beach, Florida was the recipient of the Award of Excellence of the American Society of Dentistry for Children at its recent meeting in Anaheim, California.

Robert W. Elliott, Jr., associate professor of prosthodontics at Georgetown University School of Dentistry has been appointed editor of the Newsletter of the American College of Prosthodontists. Dr. Elliott relieves J. D. Larkin of San Antonio, Texas who held the post for six years.

Erling Johansen, an internationally known researcher in the field of dental medicine, has been named dean of the Tufts University School of Dental Medicine. Johansen, chairman of the dental research department at the University of Rochester will succeed dean Robert B. Shira, who is retiring after eight years of service. Dr. Shira will move into a central administration role, assisting in the development of Tufts' expanding health sciences programs.

S. Elmer Bear, chairman of the department of oral and maxillofacial surgery at the Medical College of Virginia's School of Dentistry, has received the William J. Gies Foundation Award from the American Association of Oral and Maxillofacial Surgeons.

Daniel M. Laskin of Chicago, received the 1978 American Association of Oral and Maxillofacial Surgeons' Research Recognition Award for his research contributions in the area of temporomandibular joint disorders.

Howard L. Ward, professor and chairperson, of the Department of Preventive Dentistry, was appointed assistant dean for clinical affairs at New York University Dental Center.

Patrick Walker of Rancho Palos Verdes, California, was elected a director of the American Association of Dental Schools at the group's annual meeting in Atlanta.

Maurice J. Saklad of New York City, has been named to serve on the New York University board of trustees. He recently received the College of Dentistry's annual Alumni Association Achievement Award.

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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