the journal of the

AMERICAN COLLEGE OF DENTISTS

FALL 1981 VOLUME 48 NUMBER 3

1981 Meeting in Kansas City

New Directions For The College

Expanded Duty Auxiliary
—A Threat Or A Benefit

The Issues Haven't Changed Much
Since 1934

MEMBER PUBLICATION
AMERICAN ASSOCIATION OF DENTAL EDITORS

THE JOURNAL OF THE AMERICAN COLLEGE OF DENTISTS
is published quarterly at
Crescent & Mulberry Streets, Harrisburg, Pennsylvania 17104
Second class postage paid at Washington, D.C. and additional points.

Send Change of Address and Form 3579 to the American College of Dentists,
7315 Wisconsin Avenue, Bethesda, Maryland 20014.

THE JOURNAL OF THE AMERICAN COLLEGE OF DENTISTS is published quarterly—by the American College of Dentists, Inc., McFarland Co., Harrisburg, Pennsylvania • Subscription $12.50 a year; $13.50 overseas; single copies $4.00 • Second class postage paid at Harrisburg, Pa. and additional points • Copyright 1981 by the American College of Dentists, Inc.

All expressions of opinion and statements of supposed fact are published on the authority of the writer over whose signature they appear and are not to be regarded as expressing the views of the American College of Dentists, unless such statements or opinions have been adopted by the American College of Dentists, Inc.

Correspondence relating to the JOURNAL should be addressed to the Editor, 4403 Marlborough Ave., San Diego, CA 92116. Changes of address and subscription requests should be addressed to the Business Manager, JOURNAL OF THE AMERICAN COLLEGE OF DENTISTS, 7315 Wisconsin Avenue, Bethesda, Maryland 20014. Reprint requests should be directed to the author.

The JOURNAL is a publication member of the American Association of Dental Editors.

For bibliographic references the JOURNAL title is abbreviated J Am Col Dent and should be followed by the volume number, page, month, and year. The reference for this issue is J Am Col Dent 48:129-192, Fall 1981.

THE JOURNAL

AMERICAN COLLEGE OF DENTISTS

A Quarterly Publication Presenting
IDEAS IN DENTISTRY

Fall 1981

Volume 48—Number 3

KEITH P. BLAIR, DDS, *Editor*
4403 Marlborough Avenue
San Diego, CA 92116

GORDON H. ROVELSTAD, DDS, *Business Manager*
Journal of the American College of Dentists
7315 Wisconsin Avenue
Bethesda, MD 20014

Editorial Board—GERARD E. McGUIRK, DDS, Chairman
LYNDEN M. KENNEDY, DDS
ROBERT A. CUPPLES, DDS
PAUL S. BUTCHER, DDS

CONTENTS

EDITORIAL: THE DENTIST'S DILEMMA
COMMITMENT TO PROFESSIONALISM VS
PRESSURES FROM SOCIETY 131

NEWS OF FELLOWS 132

SECTION NEWS 134

1981 MEETING AT KANSAS CITY
PANEL DISCUSSION ON
DENTAL HEALTH CARE DELIVERY SYSTEMS 138

NEW DIRECTIONS FOR THE COLLEGE
President-Elect Richard J. Reynolds 142

THE HONOR OF FELLOWSHIP ALSO MEANS
COMMITMENT AND RESPONSIBILITY
John A. DiBiaggio 146

PROFESSIONALISM ENDURES THOUGH
DENTISTRY IS CHANGING
Alden N. Haffner 151

EXPANDED DUTY AUXILIARY—A THREAT OR A BENEFIT
Harry Rosen 156

PRACTICE LOCATIONS—HOW SOME STUDENTS DECIDE
William R. Posnick and Claude W. Drake 167

STUDENTS FIND DENTISTRY DIFFERENT THAN THEY
IMAGINED
Robert H. Schwartz and Bruce P. Murray 175

THE PHILOSOPHY OF DENTAL HEALTH SERVICE
—ISSUES HAVEN'T CHANGED MUCH SINCE 1934
Bissell B. Palmer 179

THE OBJECTIVES OF THE
AMERICAN COLLEGE OF DENTISTS .... Inside Back Cover

EDITORIAL

The Dentist's Dilemma

Commitment To Professionalism Vs Pressures From Society

Dentists feel their commitment to professionalism and to society, also their responsibility to their community and country, to provide the best dental care currently available. Professionalism places the needs of the patient first and assumes a personal integrity that assures high standards of treatment and high principles of conduct.

On the other hand, dentists are under strong pressures from widespread elements in society which would destroy professionalism. Present society expects dentists to be entrepreneurs and businessmen, competing commercially with each other.

In recent years, dentistry has been considered by government to be a trade, subject to trade regulations and antitrust laws. It was government action that created the present oversupply of dentists while it was doing little to increase the public demand for dental care, thus producing a *busyness* problem that has some practitioners scrambling to keep their practices going. The result is that many dentists have been forced to use business practices they deplore.

It is puzzling and frustrating for dentists to hear demands of quality assurance for dental care while federal and state agencies urge changes that would lower the standards of care to achieve their prime goal of cost-cutting.

Keith P. Blair

Under such pressures, it is difficult for practitioners of all ages to continue their high ideals and principles, especially when it appears that, in recent years, society does not appreciate professionalism.

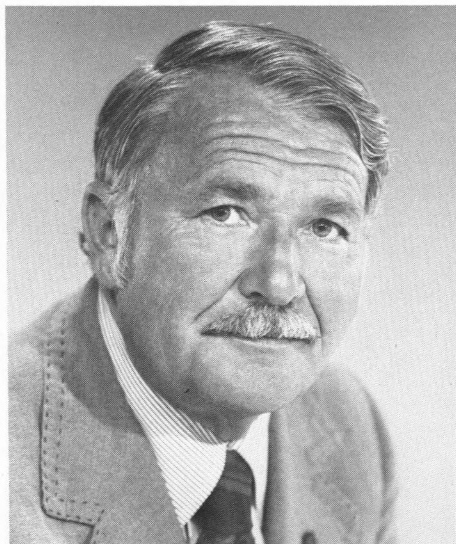
Therefore, the problem is one not only for the dental profession, but also for society as a whole. Does society want the quality of professionalism to continue in its learned professions?

Dentistry is still committed to professionalism and to quality dental care for the protection of the public. It is essential that dentists continue to uphold the highest standards, for the entire profession is judged by the behavior of individual dentists.

In the meantime, we must continue to teach and uphold all those qualities that stand for professionalism.

Keith P. Blair

News of Fellows



Albert L. Anderson

Albert L. Anderson, San Diego was named "Mr. San Diego 1981" by the local Rotary Club for his widespread community involvement. Among his many civic contributions cited were Chairman of the San Diego Stadium Commission, President of the San Diego Convention and Visitors Bureau and Chairman of Congressman William Lowery's successful campaign in 1980.

Four Fellows of the American College of Dentists were recently installed as officers of the Chicago Dental Society. They are **James H. Ridlen,** President; **Richard A. Kozal**, President-Elect; **Irwin B. Robinson**, Secretary; and **Walter F. Lamacki**, Treasurer.

Emile T. Fisher of Atlanta, Georgia, was selected as a recipient of one of the 1981 Atlanta Community Service Awards. He was honored for 24 years of volunteer service at the Massell Clinic and for his participation in an indigent denture service program for Atlanta residents.

Paul P. Hicks, Conroe, Texas, has been named Dentist of the Year by the Texas Academy of General Dentistry.

Robert S. Terkla of Seattle was installed as president of the Academy of General Dentistry, July 22, 1981 in Denver, Colorado at the AGD's annual meeting.

Robert S. Terkla

W. Arthur George, Associate Dean at the University of Pittsburgh School of Dental Medicine, was presented with the Pennsylvania Dental Association Award for this contributions to dentistry, research and the community.

W. Arthur George, left, receives Pennsylvania Award presented by Alex J. McKechnie, Jr., right.

David B. Lynn, Dallas, Texas was named Dentist of the Year by the Dallas County Dental Society.

William H. Ritchey of Bryan, Texas, has been named as Distinguished Alumnus by Baylor University. Dr. Ritchey is the Immediate Past Chairman of the Texas Section of the American College of Dentists.

Benjamin L. Lynch of Omaha, Nebraska was inducted into the Nebraska Dental Hall of Fame. Dr. Lynch is a Diplomate of the American Board of Oral Surgery.

Charles W. Jarvis, San Marcos, Texas was recently honored as a Distinguished Alumnus by the University of Texas at Houston.

Harold H. Morris of Long Beach, California was honored by the Pierre Fauchard Academy for his services as Chairman for the Southern California Section of the Pierre Fauchard Academy from 1974 to 1981.

William H. Molle, Los Angeles, has been selected for promotion to Rear Admiral in the Dental Corps of the U. S. Naval Reserve. He is also Vice Chairman of the Southern California Section of the College.

Rear Admiral
William H. Molle

Section News

Pictured, left to right, are Dr. Gordon Rovelstad, Executive Director of the American College of Dentists; Dr. John Bomba, ADA Trustee from Pennsylvania; Dr. Leigh Buzzatto, recipient of the Section award for professionalism and leadership as a senior at the University of Pittsburgh; Dean Edward Forrest of the University of Pittsburgh Dental School; and Dr. Stephen L. Kondis, Western Pennsylvania Section Chairman.

Western Pennsylvania

The Section meeting was held at the School of Dental Medicine, University of Pittsburgh, April 30, 1981. The meeting theme evolved from remarks from then ADA President I. Lawrence Kerr at last year's Section Meeting. Dr. Kerr urged the Fellows of the American College of Dentists to make dental students more aware of the ideals and principles of the College.

Chairman Stephen L. Kondis read a paper on "Professionalism" by Fellow David Ehrlich. The Dean of the Dental School, Dr. Edward J. Forrest presented the Section's award for professionalism and leadership to Leigh Buzzatto, a senior dental student at the University of Pittsburgh.

Dr. Gordon Rovelstad, Executive Director of the American College of Dentists, gave an enlightening talk on the College. Dr. John L. Bomba, Associate Dean of Temple University Dental School, ADA Trustee from Pennsylvania and Vice Chairman of the ACD Philadelphia Section, presented a paper on "The Anatomy of a Profession."

Colorado

The annual Section meeting was held in conjunction with the Denver Midwinter Meeting. Member Miles Markley was recognized for having received the American College of Dentists' most prestigious award, the William J. Gies Award, at the 1980 Convocation in New Orleans.

Ralph R. Lopez, a Colorado Section member from Santa Fe, New Mexico, and a former ADA Vice President, has been selected by the American College of Dentists Nominating Committee as the nominee to succeed Leon Ashjian of Los Angeles as the new Regent for Regency 7. Dr. Ashjian has served as Regent for six years. Section Chairman William P. Humphrey was a member of the ACD Nominating Committee which met in May, 1981 in Bethesda, Maryland.

The Colorado Section is considering a proposal to change the Section name to "Rocky Mountain Section" since we have Fellows residing in Colorado, New Mexico, Utah and Wyoming.

Section officers are William P. Humphrey, Chairman; William E. Cody, Vice-Chairman and George H. Henkel, Secretary-Treasurer.

George Henkel

Carolinas

The Carolinas Section held its annual luncheon in conjunction with the North Carolina State Dental Meeting in Pinehurst on May 17, 1981.

Dr. James G. Hardy, a member of the 1981 graduating class of the University of North Carolina, was presented with the senior Leadership Award. Dr. Hardy and his wife were special guests at the luncheon.

The principal speaker, Dr. Theodore Roberson, addressed the group on "Admissions in Dental Schools Today." Dr. Roberson is Director of Admissions for the University of North Carolina School of Dentistry and Chairman of the Department of Operative Dentistry.

Dr. Jack Shankle, Secretary-Treasurer for the Carolinas Section, congratulates Dr. James G. Hardy, right, who had just received the Section's Senior Leadership Award. He was selected from his 1981 graduating class at the University of North Carolina.

Maryland

A view of the 150 senior dental and senior dental hygiene students at the American College of Dentists Day, sponsored by the Maryland Section at the Baltimore College of Dental Surgery at the University of Maryland.

The Section is planning its Ninth Annual American College of Dentists Day, to be held in October. Over 150 senior dental and dental hygiene students attend this annual meeting. Fellows lead table discussions, in groups of ten or less students, on subjects pertinent to the practice of dentistry. The Section is aided by the faculty and administration of the Baltimore College of Dental Surgery at the University of Maryland and, especially, by Dean Errol L. Reese.

Also in October, the Section will join with the International College of Dentists in a luncheon program in conjunction with the 98th Annual Meeting of the Maryland State Dental Association. Dr. Joseph P. Cappuccio, former ADA President, will moderate a panel discussion on the topic, "Has Dentistry Lost Its Humanism and Professionalism?" Panelists will be Dr. John Houlihan, ADA President, Dr. Ashur Chavoor, ADA 4th District Trustee, Dean Errol L. Reese, Dr. Harry Dressel, a Maryland orthodontist and Dr. Gerson Freedman, ACD Section Chairman.

Oklahoma

The annual Section meeting was held at the Williams Center in Tulsa on May 1, 1981.

Among guests introduced were Dr. Robert Dixon, ADA 12th District Trustee.

Speakers were Dean William E. Brown of the Oklahoma University School of Dentistry and Dean Robert G. Hansen of Oral Roberts School of Dentistry.

New Section officers are E.W. Foster, Jr., Chairman; James Berry, Vice Chairman and Walter Dilts, Secretary-Treasurer.

Kentucky

The annual Section meeting was held April 6, 1981 at the Galt House Hotel in Louisville. Distinguished guests were Dr. Joseph Hagan, 6th District ADA Trustee; Dr. Kamal Asgar, University of Michigan; Dr. Burton Press, ADA Speaker of the House; and Dr. William Fields, President of the Kentucky Dental Association. Dr. Hagan was the main speaker.

Student Leadership and Professionalism Awards were presented. Dr. Thomas Brehm introduced Mr. Thomas Carroll, award winner from the University of Kentucky and Dr. Richard Miller presented Ms. Natalie Stelzer, winner from the University of Louisville.

New officers elected were Rudolph W. Keeling, Chairman; Hubert Fields, Jr., Vice Chairman and Richard L. Miller, Secretary-Treasurer, all of Louisville.

Upper Midwest

The Section met during the annual meeting of the Minnesota Dental Association.

The speaker was Fellow Richard Oliver, Dean of the School of Dentistry at the University of Minnesota. His subject was "Dentistry in the '80's", and covered the possible future of dentistry and dental education.

Dr. Odin Langsjoen of Duluth, Vice President of the American College of Dentists spoke on the activities and concerns of the College.

New officers of the Section are Ron Geistfeld, Chairman; Dan Waite, Vice Chairman; and Eric E. Stafne, Secretary-Treasurer.

Eric E. Stafne

Section Officers Recently Announced

New England

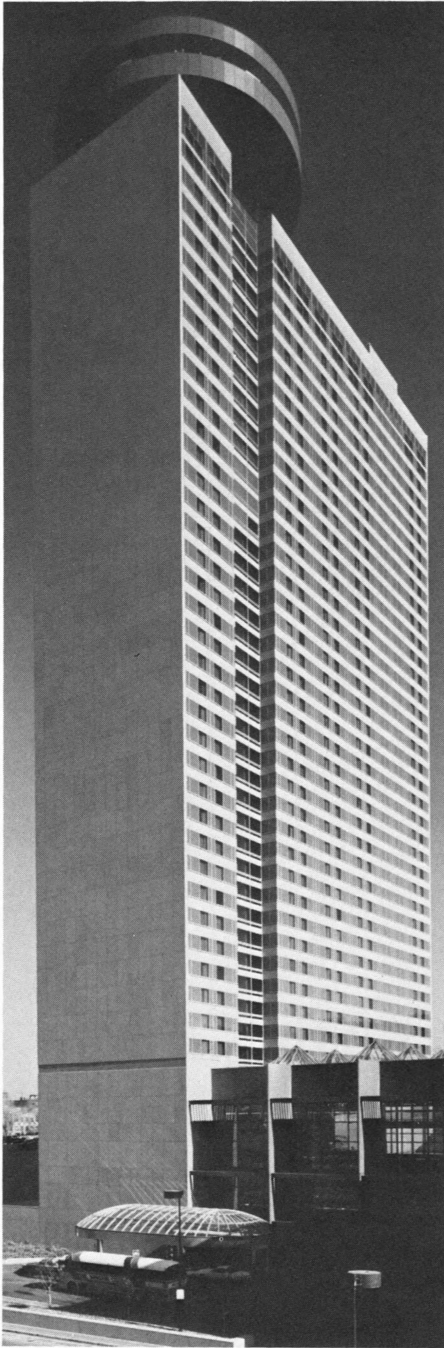
Chairman, Philip Molloy
Vice Chairman, John R. Mann, Jr.
Secretary-Treasurer, Sumner H. Willens

Northern California

Chairman, Robert John
Vice Chairman, Gaylord E. Holmes
Secretary-Treasurer, Charles E. Carara

Tri-State

Chairman, Kirby P. Walker
Chairman-Elect, R. Malcolm Oberbey
Vice-Chairman - Arkansas, J. P. Chancey
Vice-Chairman - Mississippi, Robert T. Ragan
Vice-Chairman - Tennessee, Roy O. Elam, Jr.
Secretary-Treasurer, Richard J. Reynolds



1981 Convocation At Kansas City

Friday, October 23

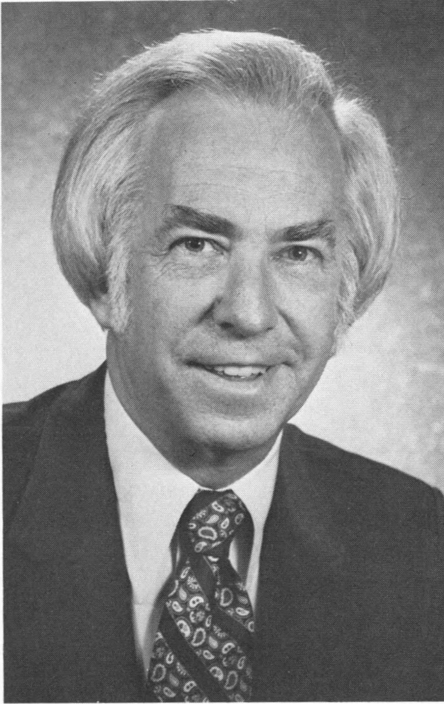
Registration of Candidates and Sponsors Regency Foyer	2-8 PM
Conference of Sections Representatives Empire Room	4-6 PM

Saturday, October 24

Empire Room Buffet Breakfast	7 AM
Chicago Ballroom Business Session	8 AM
Chicago Ballroom Orientation	8:30 AM
Chicago Ballroom Panel Discussion	9 AM
Atlanta Ballroom Luncheon	12:15 PM
Empire Room Assembly of Candidates and Sponsors	2:15 PM
Regency Ballrooms Convocation	3:00 PM
Regency Foyer Reception	7 PM
Regency Ballrooms Dinner-Dance	8 PM

The Hyatt Regency Hotel in Kansas City, site of the 1981 Annual Meeting and Convocation of the American College of Dentists.

Dr. Menninger Will Be Convocation Speaker



Roy W. Menninger, M.D.

Roy W. Menninger, M.D., is the fourth president of The Menninger Foundation. The eldest son of the late Dr. William C. Menninger, he joined the staff of the Foundation in 1961. Prior to his election as president, he was Director of the Division of School Mental Health and Director of the Department of Preventive Psychiatry. He will speak on "How to live with Executive Stress."

Dr. Menninger graduated from Swarthmore College and received his medical doctorate from Cornell University Medical College.

He is a Fellow of the American Psychiatric Association, the American College of Physicians, the American College of Psychiatrists and the American Orthopsychiatric Association, and is a member of numerous other national, regional and local professional organizations. He is now serving as Chairman of the Social Issues Committee of the Group for Advancement of Psychiatry. He recently served as a member of the Program Committee of the American Psychiatric Association and on a Task Panel on Prevention for the President's Commission on Mental Health.

His areas of professional interest are on the topics of individual responsibility for mental health promotion and dealing with stress, adolescence, human sexuality, and problems relating to measurement of quality and psychiatric treatment. He is a frequent consultant, lecturer and author in these areas.

New Fellows To Be Inducted In Kansas City

One hundred and ninety-nine dentists have been recommended by the Board of Regents for Fellowship in the American College of Dentists this year. This represents 71 per cent of the total number of nominations sent to the Credentials Committee this year.

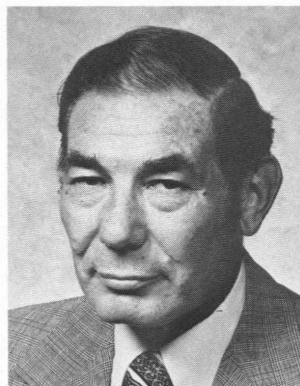
Induction will be on Saturday, October 24th at the Hyatt Regency Hotel.

HEALTH CARE DELIVERY

— Options for the '80's

Richard E. Stallard

Odin Langsjoen



I. Lawrence Kerr

The morning program at the Annual Meeting of the American College of Dentists, to be held in Kansas City on October 24th, will feature a panel discussion on Health Care Delivery—options for the '80's. Panelists will be Richard E. Stallard, D.D.S., of Edina, Minnesota and I. Lawrence Kerr of Endicott, New York. Moderator will be Oden Langsjoen, D.D.S. of Duluth, Minnesota.

The focus of this panel will be the evolution of delivery systems in dental health care and the various concerns that are now emerging. Dr. Stallard is the Dental Director for Minndent Associates who will address the subject of prepaid dental health care and capitation practice.

Dr. Kerr, an oral surgeon in private practice, and the Immediate Past President of the ADA, will speak on new dental practice settings, auxiliary usages, the busyness problem and dental advertising.

This panel of experts will consider the complex issues of changes in dental care delivery systems in a time of national economic uncertainty and predicted dental manpower surpluses. The history of experimentation with new systems of delivery of care will be reviewed as they have evolved in response to demands for payment methods acceptable to patient and health professionals alike.

Then a look will be taken at some of the complications that are accompanying departures from traditional private practice, fee-for-service dentistry.

Particular attention will be given to implications that these departures may hold for dental auxiliaries, some now seeking independent practice status.

This timely discussion on methods of delivery of dental care should spark a lively exchange of ideas.

PANELISTS

Dr. Richard E. Stallard

Dr. Stallard is internationally known as a leader in periodontology, implantology and capitation dentistry. He is presently co-owner and dental director for five dental clinics serving over 55,000 prepaid patients and was responsible for establishing the largest medical-dental HMO in the Midwest. He received his M.S. and Ph.D. degrees from the University of Minnesota and has an impressive background in dental education.

Dr. Stallard contends that prepaid/capitation systems may well be the saviour rather than the damnation of the private practice of dentistry. Capitation simply is an alternate mechanism of payment, shifting from post-payment in a fee-for-service practice to pre-payment.

Dr. I. Lawrence Kerr

Dr. Kerr is the Immediate Past President of the ADA and is an oral surgeon in private practice in Endicott, New York. He believes that the reality of professionalism is being pitted against the reality of materialism at a time when the economic downturn is grabbing the attention of the country.

At the same time that the government is backing off from health planning, the industrialists and entrepreneurs are moving into the health field. Nonetheless, in the midst of all this, he considers that there is a wide-open opportunity for the "Real" professional to serve and prosper.

Dr. Kerr is a consultant and lecturer at a number of dental and medical schools on national health issues and delivery systems.

Officers of the College, pictured at the 1980 Convocation. Left to right George E. Mullen, Treasurer; William C. Draffin, President; Richard J. Reynolds, President Elect; Gordon H. Rovelstad, Executive Director; and Odin M. Langsjoen, Vice President.

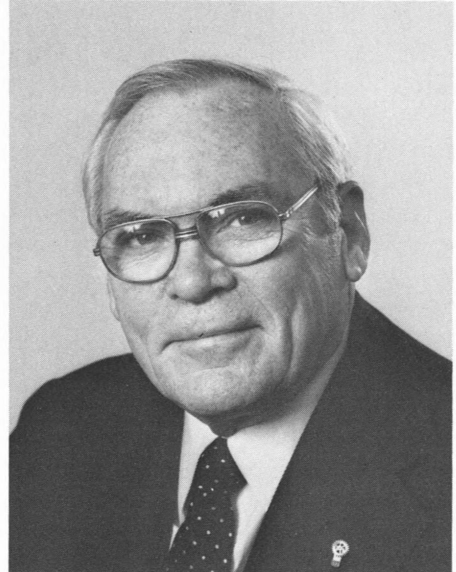
New Directions for the College

RICHARD J. REYNOLDS, PRESIDENT ELECT*

There is little doubt that, measured by conventional criteria, the practice of dentistry is undergoing a radical change. An entire litany of problems and challenges doing violence to the traditional values of professional practice can be recited. Obviously, certain of the pressures adversely influencing the nature and character of dental practice are external to our professional system and, consequently, are beyond our power and authority to control. Nevertheless, the appropriate professional response to the changes taking place, and determining the course that organized dentistry might take in planning for the future, deserves careful attention.

In this connection, it is important that the role and influence of the American College of Dentists in shaping the destiny of our profession be defined in terms of the short and long-range points of view.

At this point, and in this regard, I should like to pay tribute to our Executive-Director, Dr. Gordon Rovelstad, who succeeded Dr. Robert J. Nelsen last January, and to comment on measures he has taken to set the course of the College in a new and proper direction. Dr. Rovelstad was the 55th President of the American College of Dentists assuming office at the annual meeting of the College in Dallas, Texas, October 20, 1979. Dr. Rovelstad has had a distinguished



Richard J. Reynolds

career in many areas of the profession, having served as President of the International Association of Dental Research of the American Academy of Pedodontics. He is a Diplomate of the American Board of Pedodontics. Before his retirement from the Navy with the rank of Captain, he received both the Meritorious Service Medal, the Commendation Medal and the Legion of Merit for exemplary service. For his leadership in science, he received an Honorary Doctor of Science degree from Georgetown University. Prior to his becoming executive-director, he was Assistant Dean, Educational Pro-

*Richard J. Reynolds, D.D.S., President Elect of the American College of Dentists.

gram and Professor of Pediatric Dentistry at the University of Mississippi in Jackson. He brings to the office a broad spectrum of experience, and a distinguished record of accomplishments.

New Computer Installed

Dr. Rovelstad has recommended certain far reaching and innovative changes which have been approved unanimously by the Officers and Regents. One of these has to do with the installation of a Computer Management System. Current management of the American College of Dentists involve personnel management of a bookkeeping system with ledger cards, typewriters for direct application of all daily activities, a word processor for management of form letters and addressing programs, and a purchase of a mailing service direct from the printers, and the use of staff for sorting and distributing mail by zip code in order to meet postal regulations. These methods are augmented with the use of a postal franking machine, xerox copier, and mimeograph.

There are a number of problems besetting non-profit organizations today. These include rising costs of doing business and governmental influences (tax reporting, employment practices, postal service, and insurance). Growth is a natural development in any healthy active organization, and managing growth is also a problem in terms of space, facilities, and personnel. Several approaches to office management by data processing and word processing equipment have been under study. These would be focused in on membership accounting, publication accounting, finance accounting, event participation accounting, statistical analysis and such other activities as would relate to Sectional activities of the College. After considerable research, study and discussion of the relative merit and cost effectiveness of the various systems available, it was decided to purchase outright, one that most nearly suits our particular needs. Computerization will provide increased accuracy and speed in our accounting efforts. The increased responsiveness is particularly of interest relative to dues, donations, mailing labels, listings and correspondence. The demographic information available through the computer capability will be of great interest to the analysis of our distribution, and activities and statistical reporting on the profile of membership. In short, the computer will effect a saving of manual effort, temporary help, losses of records, supplies distribution, and postage. It will provide a degree of accuracy and immediate response that is not now available.

Microfilming of Records

The executive-director also called attention to the large volume of records that are presently kept on open shelves in the Executive Office. A review of the facilities and storage space was undertaken, and a previous recommendation of the Board was to place this material in lateral files. The cost of these files was estimated to be $6000-$7000 to accommodate the current body of material and to allow for expansion. As an alternative, microfilming was suggested as a means of preserving the existing records and to utilize to the fullest the valuable space which is at such a premium. The proposal for such management called for approximately the same amount of expense as for the lateral filing system. Under the circumstances, the Board authorized the Executive Office to proceed with a contract with Washington Microfilm Corporation to microfilm the records being kept on file which have current and historic value; particularly the nominations and credentials files.

Nomination Procedures

The matter of the nomination procedure was discussed at a special meeting of the Board of Regents in February. It was reaffirmed after much discussion that the nomination procedure is valid and is designed to identify individuals by accomplishment rather than by politics or special favors. The nomination form, however, was reviewed very carefully, and several changes were recommended which will simplify, streamline, and update the nomination process.

In this connection, let us be reminded that the American College of Dentists is not aggressive in recruitment of new Fellows. It does not conduct membership drives, nor does it have quotas for nominations to be considered each year. The Committee on Credentials, in reviewing the nominations approved or disapproved. Each nomination is reviewed on its own merit. It is not compared to other nominations of other Fellows, nor do the names of the nominators bear an influence in the determination of the Credentials Committee, for the simple reason that they are unknown to the committee. Thus, personal influence of the nominators cannot affect the review. The nominee is considered only on the basis of the information presented in the nomination, and the comments made by local consultants whose names are also unknown by the Committee. The basis of evaluation is "What has the nominee done in terms of leadership and contributions to the profession or

to society that is over and above that usually expected of a person in a similar circumstance." If the information submitted on behalf of the candidate succeeds in presenting such evidence, the committee recommends the nominee for Fellowship. Unfortunately, in many instances the nomination is not completed properly, or the nominators do not bring forth the full extent of the nominee's accomplishments. For this reason, about one-third of the nominations received fail to present sufficient credentials for Fellowship. The nomination system of the American College of Dentists is as objective as such a procedure can be. It is the responsibility of individual Fellows of the College to recognize those of his peers who exemplify the requisite leadership and professional qualities for Fellowship. Not to nominate a person who may be eligible, is to defeat the purposes and objectives of the American College. It is therefore important that each Fellow review the roster of the College and reflect upon the possibility that a person of merit and deserving of Fellowship has been inadvertently overlooked.

Position Statement on Advertising

Finally, your attention is called to the Position Statements of the American College of Dentists drafted October 18, 1979, which describe the philosophical posture of the American College of Dentists. They should not be construed as a condition of membership.

Advertising by members of the health profession:

Definition. Advertising within this context is an overt effort to entice by display of fees, qualifications, and/or criteria treatment. This definition does not embrace information announcing the location and/or time of availability of professional care.

Statement. The ACD holds that the solicitation of patronage is not in keeping with the perception of professional conduct.

Commentary. The ACD recognizes that there are differences between legal perceptions and professional perceptions of the role of advertising in professional offices. The concept of advertising by health professionals is a moral issue. Dentists have been designated by society as the trustees of the oral health of the public. This trust sets a moral responsibility upon the practitioner to place the patient's welfare prior to his own, and to insure that truthful and valid evaluations are fundamental to his ministrations. Advertising, per se, is prone to distortions and overstatements, and serves to violate the moral orientations upon which professional health care is based.

The Honor of Fellowship also Means Commitment and Responsibility

An Address to the American College of Dentists, New England Section

JOHN A. DiBIAGGIO

Thank you for inviting me to address you today. As you might expect, as a university president I receive many requests to address various groups throughout the year. However, none is more flattering than being invited to address your own colleagues, particularly a gathering of members of the American College of Dentists, who represent leadership in our profession.

I have been asked to speak on how I feel the American College of Dentists can help dentistry, in what can only be described as a very challenging time. Let me begin by emphasizing the very special significance of Fellowship in the College. When one is selected for this honor, it reflects a degree of tangible evidence that he or she has reached a level of very special competence in the profession. Thus, the achievement of Fellowship should bring great self-pride to the recipient, for, in essence, it infers that a group of peers have judged a colleague to be truly exceptional.

But the achievement of fellowship has far greater significance than simple recognition of accomplishments. When an individual is identified as being extraordinary, it must also be implied that that individual appreciates that the possession of special skills also infers special responsibilities. In other words, when one becomes a Fellow of the College, he or she is not simply being recognized for past achievement, but is also identified as having the capability for significant future contribution to the profession. When Fellowship is received in that spirit, it can lift the recipient to even greater heights.

Commitment

If one were to attempt to identify a single word which would most nearly reflect the meaning of selection for the College, that word would be *commitment.* For it is commitment that separates the achievers from the non-achievers, the contributors from the non-contributors, and the happy from

*John A. DiBiaggio, D.D.S., President of the University of Connecticut

the unhappy; for only through commitment can one find the joy that comes from having given to others, from contributing to society, rather than just taking from it.

Fellows are expected to approach all of their responsibilities with fervor and with the objective of performing each and every task totally and as well as possible. In other words, committing themselves to the profession and to the total public good, thus assuring a better quality of life for those being served. Second best is simply not acceptable for Fellows, for they serve as the role models for all of their colleagues to assure that excellence is achieved throughout the profession.

Dentistry is accorded the privilege of providing services in an environment with limited peer review or quality control. Therefore, the patients being treated depend upon the practitioners' personal commitment to their well-being and upon their belief that all health professionals possess integrity far beyond that found in the average citizen. The responsibility implied in that trust has far-reaching connotations, for the profession finds itself today confronted with patient management problems of enormous complexity; and decisions made daily, often in very rapid fashion, could very well determine not only the health and well-being of patients, but even their survival. As a special group of people within the profession, it is a fellow's additional responsibility to do all that he can to assure that every patient, regardless of where they elect to receive their care, is assured of the same high standards.

Continuing Education

The educational process for dentists in this nation is clearly the finest available in the entire world, and continues to improve each year. The skills that today's dentists possess are truly extraordinary and were not equalled by predecessors of just a few decades ago. However, changes are occurring with alarming rapidity within dentistry and, therefore, it is extremely important that the learning process be continued throughout one's lifetime.

It is interesting to hear new graduates express considerable concern about the level of competency demonstrated by some of their oldest colleagues. And yet, it is difficult to convince those same students that in twenty years or so, many of their own classmates will be equally deficient, for the concepts that seem so advanced today will be altered or entirely abandoned as new knowledge comes to light. For instance, it is awe-inspiring to realize that 90% of all scientists that have ever lived are alive today, that more than 75% of the prescriptions written today are for drugs that were discovered in just the past twenty

years, and that the half-life of knowledge has now been reduced to only eight years—or, to put it another way, 50% of what we believe today will be proven to be untrue just eight years from now. Thus, any individual who does not continue his or her education must be considered incompetent eight years from the day of graduation. Unfortunately, this happens far too often. Thus, fellows must encourage, both by spoken leadership and example, participation in ongoing continuing education activities.

Equally distressing are those individuals who blithely criticize everything and everyone around them and yet refuse to get involved in efforts to effect necessary improvements in the system. Those same individuals condemn their colleagues, while being unwilling to take those steps necessary to encourage them to enhance their skills. Furthermore, those same individuals find it so terribly easy to question decisions and to seek out errors, but they very rarely offer viable alternatives.

Quality Control

Perhaps this is the area in which the American College can play its most important role. As leaders of the profession, Fellows must accept the burden of providing the profession with direction. For instance how can the profession deal with issues such as the expansion in third-party payment which, while providing opportunity for our entire citizenry to receive quality dental services, also clearly intrudes upon the long established doctor/patient relationship. And what of quality control legislation? I know of no practitioner who is opposed to assuring that all dentistry delivered in this country is of the highest quality. However, many of the so-called peer review mechanisms now being implemented by the federal government relate only to cost and really have little to do with quality. What is needed is a better alternative which assures quality, while encompassing the essential principle that the profession should control the review mechanism and not surrender this responsibility to outsiders with little or no background in dentistry.

And what about the use of expanded-duty dental auxiliaries? While many of us in academics would argue that such personnel can increase practice efficiency, it must be clearly understood that while it has been demonstrated that expanded-duty auxiliaries can perform certain functions currently performed only by the dentist, the decision as to whether they should be employed in the private practice sector must be determined through the legislative process with input from the practicing community. Again, objective leadership is needed on this issue, so that decisions of such important magnitude are not left to governmental bureaucrats alone.

Increased socio-economic and edu-

cational levels have tended to narrow the knowledge gap between practicing professionals and the population at large. Patients are now more likely to insist upon comprehensive evaluation before accepting any professional opinion. While we have achieved a great deal in the area of patient education and motivation, many of our potential patients are becoming even more confused because of the rapid fire fashion in which information about dental care has been communicated to them in the past few years. As we all know, a little knowledge can sometimes be very misleading, and, thus, the need for clear, concise explanations of dental care has become extremely important.

The individual practitioner feels far removed from the national decision-making process. Therefore, distress and feelings of insecurity are magnified by those forecasters of doom who continually predict that the dental profession will be nationalized and that all dentistry will be managed by the federal government. Accepting this premise as inevitable can only serve to precipitate modifications in the dental care delivery system that are both unnecessary and inappropriate.

Organized dentistry provides an excellent forum for the expression of concerns of the individual dentists. Therefore, College fellows must encourage every dentist to use this forum to express views on important issues. Participation in professional activities can influence future planning at the national level by insuring input from those who will be most affected, that is, practicing dentists themselves.

That dentistry will change is inevitable, peer pressures, growth of third-party payment, and more sophisticated patient expectations will force that change. Therefore, the question is not whether change will occur, but who will control the form and substance of change. An appraisal of the outcome of earlier predictions should reassure all of us that many of the current prognostications are not altogether realistic. Our colleagues must be encouraged to avoid the tendency to dwell on every extreme proposal published in the professional literature or general media, for the probability of drastic changes occurring in a short time is very low.

That dentistry will change is inevitable . . . the question is not whether change will occur, but who will control the form and substance of change

On the other hand, the profession must continue to be receptive and responsive to the changing needs of the population and must work diligently to meet those needs. This process must begin in the individual dental office, where procedures and

even social structures may have to be modified somewhat to efficiently meet demands.

Clearly in this entire process, fellows of the American College have very special responsibilities. We must provide the leadership to assure that what is clearly recognized as the finest dental care delivery system in the world continues to be enhanced in the future. We must offer ways to assure the development of better health care programs, both therapeutic and preventive, and assure that such programs are truly responsive to societal health needs. We must work to interpret the needs of the profession, in light of such emerging concepts, and we must do so in the delicate balance that exists between service for a large number of the population and the maintenance of high quality of those services.

Fellows of the American College of Dentists must provide leadership to assure the development of better dental health care programs

Thus, while we join proudly together today as members of the most prestigious of all dental associations, let us use this occasion to reassert our commitment to the ultimate goal of our profession—quality dental care for all the citizens of our great nation.

Professionalism Endures Though Dentistry Is Changing

SOCIETAL PRESSURES AFFECT TRADITIONAL CONCEPTS OF PROFESSIONALISM

Presentation at the New York Section of the American College of Dentists March 10, 1981

ALDEN N. HAFFNER*

What societal pressures are at present working in the dental community to assault traditional concepts of professionalism?

Before that question can be answered, let me offer an already presented and widely used working definition of professionalism:

> "Professionalism is a demanding code of behavior practiced by its adherents which requires their unstinting commitment to every expanding excellence in learning and knowledge and to their application to the discipline. It is an unswerving devotion to lofty ideals of the discipline's mission in terms of social purposefulness. It is an understanding that one of its fundamental tenets is devotion to service, wholehearted and genuine, even occasionally when such devotion requires personal sacrifice because that service is not divisible, and because it can be neither diminished nor deteriorated. Professionalism involves an attitudinal ambiance which differentiates, in the larger public, social and community views, callings which are entrepreneurial in their primary cast. Indeed, professionalism is commanded by enduring values which are human, social and ethical in their contexts. Professionalism provides that quality of nobility to a discipline which gives it its self esteem, its self restraint and its self realization."[1]

I have categorized some societal pressures which, in my view, are working to contravene the foundations supporting professionalism in dentistry. These have been grouped in terms that are legal, public policy, economic, manpower, peer behavior, organizational behavior and community behavior. I have listed them not necessarily either in their historic order of appearance or in the magnitude of their contribution. These societal pressures may be viewed as counter professional.

*Associate Chancellor for Health Sciences, State University of New York.

[1]A.N. Haffner, "Is Professionalism in the Professions Obsolete," *Journal of Optometric Education,* Volume 6, No. 1, page 6

Pressures from governmental entities:

The Anti-Trust Section of the Department of Justice;

The Federal Trade Commision;

The decisions of the Federal courts and State courts;

The Federal Office of Consumer Affairs;

The offices of consumer affairs in state governments;

The offices of education or educational regulatory bodies in state governments.

Pressures from the corporate business community:

Corporate entities that have had extensive histories in either denture dispensing or in the retail corporate sponsorship of dental care;

Corporate entities that have been in related fields such as pharmaceuticals and cosmetics and which now sponsor retail dental establishments;

Investment and venture capital entities, particularly foreign in origin, which encourage commercialization and corporate sponsorship of retail dental care;

Corporate establishments which encourage the merging or franchising of individual retail outlets into "chains";

Corporate sponsorship by dental manufacturers of retail dental outlets in industrialized vertical arrangements.

Pressures from the communications media occasioned by the lifting of bans on advertising by the courts and by state regulatory agencies:

Radio and television;

Newspapers and magazines;

Billboards and other outdoor advertising.

Pressures from the organized dental community:

More commercially oriented members of organized dentistry (ADA) pressing for organization reorientation and redirection;

Non-ADA dental socieities seeking a stronger role in directing the orientation of the posture of dentistry with regard to agencies and entities of governments.

Pressures from the growth of retail fashion with regard to dentures:
The merchandising and marketing of dentures;
The advertising of dental care and dentures directly to the public.

Pressures in the generic dental community:
As a result of "competitive" advertising which tends to be more pronounced in the urban environment;
As a result of third party underwriting which tends to pit the professional against more commercially placed practitioners.

Pressures from among young practitioners:
Who seek faster growth of new practices in order to repay substantial college loans;
Who are viewing with extreme ambivalence and confusion role models which are not like what their sociological idealizations are conceived to be.

Pressures resulting from a more emphasized national laissez-faire economic posture and in which competitive forces are permitted freer reign in the market place:
Consistent with the national deregulation movement;
Trend toward business conservatism.

Pressures resulting from the questioned fragility of the economic infrastructure of dental practice:
Imbalance in skills utilization versus income produced;
Questionable viability of independent general dental practice absent the income generated from the dispensing of dentures.

Pressures from the consumer movement;
Which seeks "to price comparison shop" among professionals;
Which seeks to promote advertising as a consequence of the "consumer's right to know" endeavor.

It should be emphasized that each of the primary health disciplines are affected, to some extent, by one or more of the societal pressures presented above. However, it remains for another discussion to explore the comparative vulnerability of each of those disciplines. The overwhelming thrust of general dental practice in this century has included the dispensing of dentures as part of the array of offered services. This has directly contributed to the vulnerability of dentistry because of the relatively successful movement to commercialize that service.

There is a Developing Crisis in Dentistry of Major Consequence

The successful economic commercialization of one end of the offered services of the dentist in general practice, thereby, has "dragged-along" the rest of the services.

I intend to explore in a later paper and in another forum the issue of structural vulnerability to commercialization based upon the economic model of solo general practice dentistry. Suffice it to state, moreover, that the profession of dentistry, I contend, is potentially vulnerable to the above described societal pressures. However, it is the consequences of the toll that those pressures take upon the *decorum and substance of professionalism* in dentistry that is of issue and of moment. It is my impression that the last decade has witnessed a toll of very considerable severity. And, thereby, I allege that there is a developing crisis in dentistry of major consequence.

"Is Professionalism Changing in Dentistry?" My answer to the question is no—professionalism as an enduring social value is not changing. But, it is more than apparent that it is dentistry that is changing and in a direction that may increasingly deprive it of a professional cast and of professional decorum. To put it another way, professionalism in dentistry has declined as it has been thrust into a more commercial cast with a market place environment and with increased market place behavior. My thesis, presented in the past, is that professional behavior and performance for the health disciplines engaged in provision of human services are incompatible with the commercial environment of the market place. The former suffer in the presence of the latter.

Professionalism as an Enduring Social Value is not Changing—It is Dentistry that is Changing

> "But professional concerns for standards for meeting human service needs are properly our concerns as doctors of (any discipline). And those concerns cannot be discharged in the market place. Nor should those concerns be subject to the revisionism of the enduring values of professionalism.[2]

[2] *Ibid,* p. 7.

Finally, let me pose several serious issues and concerns that stem from this crisis of declining professionalism in dentistry that I allege is upon us:

1. There are increasing strains in the dental community resulting from more sharply defined different types of dentists. Cleavage and fragmentation may well result.

2. Called into question is whether different types of dentists may require different types of educational preparation. I do not favor this.

3. It has been said too frequently and too loudly to be ignored. Are we educating and training our new cadres of professional practitioners for a service delivery world increasingly and substantially different from the one that they actually encounter.

4. Is it possible to construct an economic model for dentistry based upon a knowledge and skills base and responsibility level to sustain professionalism in dentistry (make it less vulnerable to commercialization) and will it be consistent with human service needs and good public policy?

5. If professionalism in dentistry continues to wane, will the standing of dentistry as a profession be called into question?

In summary, what is the knowledge and responsibility level of the dentist that can be constructed better to serve the public's health needs in a cost effective and efficient manner and which can be stabilized in an economic model which enhances and stabilizes the professionalism of dentistry as a profession. Moreover, what impacts would this restructure and reorganization have upon its neighboring disciplines.

These are issues that go to the very standing of the discipline. They are simply not dental issues. I hold that they are public policy issues because dentistry has been legally recognized as a profession in the public service. The public policy issues raised and the substantial questions that stem therefrom are best studied by a public commission. That is precisely what I would propose as an appropriate forum for study, review and public resolution.

One additional point is worth noting. The subject of professionalism is but one aspect of a panoply of issues affecting dentistry. While critical in its impact, it must not be taken out of the context of the other social and institutional forces that make up the discipline.

Expanded Duty Auxiliary—A Threat or a Benefit

HARRY ROSEN, D.D.S.*

Dentistry had been good to most of us. It provided us the privilege to serve. It has offered us fulfillment as well as a reasonable lifestyle. It has provided us with an avenue for creative expression and it has brought us into contact with people who often have left permanent impressions upon us. We naturally do not want to lose our profession, nor do we want to destroy it for the next generation of dentists. That does not mean that we are insecure, or that we are paranoiac. That does not mean that we are rigid and complacent or that we are right-wing conservatives. That does not mean that we are unwilling to increase our productivity and improve the availability of dental service to the largest possible population. However, responsible professionals do not readily go from the known to the unknown.

The late Dr. Arthur Elfenbaum of Chicago taught me that a dentist is a physician of the mouth. That is true. I like that image. However, very few of the conditions that we diagnose can be treated merely by writing a proper prescription. They rarely respond to a pill or an injection. A change in diet could prevent some of those conditions, but rarely will it effect a cure once the condition exists.

Most of the conditions that I diagnose require me to render a therapeutic service with my hands. I am not ashamed that I must work with my hands. I am still flattered when a patient refers to me as a skilled craftsman. I know, and through chairside education my patients get to know, that a dentist is more than a physician of the mouth. He is also a skilled craftsman. He is also a practical engineer and materials specialist. He is also a behavioral scientist. Patients still refer to human qualities: compassion, understanding, concern, and ability to communicate as the most important factors for seeking out a specific dentist.

Most of the conditions that I diagnose require me to render a therapeutic service with my hands.

Many of my successes are derived from just listening to the patient and then educating the patient. I am sure you have had similar experiences. From that point of view we could be compared with psychiatrists. Though we do not pretend to be psychiatrists we use many sound psychiatric principles in our practices. We even offer supportive therapy where it is indicated as it relates to dentistry. The psychiatric principles are better understood because of our broad training as dentists both at the dental school and through continuing education.

*Professor and Director of Graduate Prosthodontics, McGill University, Canada

A very special blend of qualities are combined in the dentist to make him the kind of health professional that he is. We are all proud of that. The

The general high standards of dentistry in North America reflect a fine blend of qualities. Can such standards be maintained while delegating more duties to auxiliaries who are less qualified and less educated?

general high standards of dentistry in North America reflect this fine blend. Can such standards be maintained while delegating more duties to auxiliaries who are less qualified and less educated?

Before discussing the benefits or threats associated with expanded duty auxiliaries (EDA), we must first clarify what we mean by the term. We must define how the duties of the EDA differ from the conventional well-trained dental assistant, how those duties differ from those of the hygienist and also those of the dental technician.

So far as dental technicians are concerned, we in Canada have suffered considerably as a result of lax legislation as it pertains to extended duties of dental technicians. The law did not prevent technicians from making impressions for dentures when supervised by a dentist. Many of the technicians practiced illegally for years, providing dentures at cut-rate prices. They ultimately formed a corporation of their own with government sanction. They are now functioning legally as denturologists. However, they perform tasks which are beyond them by law. Some are constructing fixed partial dentures and crowns. They are competing with dentists and exploiting the public. They are guilty of every misdemeanor that they originally scorned in some charlatans in the dental profession. To my knowledge the American denturist scene is no better than the Canadian. They are a threat to our profession and I must strongly question their benefit to the public at large. However, the politician can score political points by supporting their cause before the uninformed public.

EDA's will not be of benefit to either the public or the profession unless definite restrictions are introduced limiting the parameters of their duties.

There are other professions where the overlapping of various services exists and can be cited as examples of what we should avoid in dentistry: the Ophthalmologist, the Optometrist and the Optician; the Orthopedic Surgeon, the Physical Therapist, the Chiropractor and the Osteopath.

Our subject, The Expanded Duty Auxiliary—a Threat or a Benefit, must be approached from three avenues: 1) the public, 2) the profession, and 3) the politician.

It is my feeling that in the long term EDA's will not be of benefit to either the public or the profession unless definite restrictions are introduced limiting the parameters of their duties. However, the EDA could be of benefit to the politician who would have no scruples about scoring points with his electorate at the expense of the profession. As I said before, this has already happened with denturists and with Medicare in some Canadian provinces.

COMPETITION BETWEEN DIFFERENT CATEGORIES OF DENTAL AUXILIARIES IS DEMEANING TO THE PROFESSION

The lists of auxiliaries with varying qualifications is becoming formidable. For example, there is the registered dental assistant registered by the state board of dentistry is most states. There is the class 2 dental assistant of Oregon and North Carolina. There is the EDDA of Hawaii. There is the EDH of Wyoming and there is the RDAEF of California (registered dental assistant in extended functions). There are a few others not mentioned. All are similar but not identical in training and function. Legal provisions for performing extended functions vary from state to state.

The dental hygienist was the first auxiliary permitted by law to perform intraoral procedures. The dental hygienist today is a proven beneficial auxiliary to the dental profession. More so it is felt by many that hygienists can play an even greater role if their training were broadened to include more clinical procedures. The candidates on the average are mature students of university calibre. They are trained for two years in programs which provide them a reasonable basic science background, an in-depth study of preventive dentistry and an adequate exposure to clinical procedures that they are expected to perform.

The salaries available in private practice have been commensurate with their training and the services that they render.

EDDA's any hygienists are often in direct competition with each other. The competition is unfair because EDDA's outprice hygienists. What is happening with the encouragement of EDDA programs is that a candidate with lesser qualifications receives lesser training to perform a more complex and responsible service at a lower cost to the dentist. Such practices are

A candidate with lesser qualifications receives lesser training to perform a more complex and responsible service at a lower cost to the dentist. Such practices are demeaning to the profession.

demeaning to the profession. This point is best illustrated by following the training and utilization of expanded duty auxiliaries in Puerto Rico.

Puerto Rico has 700 dentists to serve 3 million people, i.e. 1 dentist to 4500 people. Two-thirds of the total population is considered indigent and this indigent population is serviced in federally subsidized clinics by approximately 150 dentists. This alters the dentist to population ratio 1: 15,000. Some form of EDA program is no doubt justified.

The two-year University of Puerto Rico's hygienist program has been phased out and is being replaced by a one-year EDDA program. My exposure to that program leads me to cast doubts upon the consistent quality of the service that it offers. Iatrogenics is overlooked or condoned. The EDDA therefore must be considered a threat rather than a benefit to the profession and to the public.

CARIES LESS OF A MENACE IN THE 70's THAN IT WAS IN THE 60's

Fluoridation has effectively reduced the influence of caries in North America. Fifty-five per cent of the American population is now drinking fluoridated water. Many who don't receive dietary supplements of fluoride.

The lower incidence of caries is proven by the appearance of fewer clinic patients with rampant caries at our dental schools. Many children in our summer clinic present with no caries at the age of 12. This observation is more common in fluoridated areas.

Beyond the effective reduction of caries through fluoridation of water supply, fluoride appears commonly in most of the toothpastes available on the commercial market. As well as the topical fluoride that dentists have been applying for the past ten years has recently begun demonstrating its beneficial effects. In our dental clinic students are trained to apply fluoride before every rubber dam removal.

Research evidence linking plaque to both caries and gingivitis is overwhelming.[5] A further contribution to lowered incidence of caries has been made by the improved education of the North American public on oral hygiene and home care. In this area, both the American Dental Association and the Canadian Dental Association have launched excellent public relations programs on plaque control.

Fluoridation has effectively reduced the influence of caries in North America. Fifty-five per cent of the American population is now drinking fluoridated water.

Community dentistry is gradually exerting a greater influence on dental faculties and the community in general. As a result of this influence, dental students now feel a greater commitment to provide the community with guidance as well as treatment.

There is more floss sold today than ever before.

Present day emphasis on diet and fitness must also be affecting the public in the care of their teeth.

The neighborhood health center concept has made dentistry accessible to a greater segment of the American population. The U.S. National Center for Health Education was created in 1974 (Dummet). HEW programs are making preventive dentistry available to a greater segment of the American public.

Other methods of plaque control through the use of the plaque solvents in rinsing programs have been proven effective in Scandinavia. Mouthrinsing programs may have contributions to North American plaque control in the future.

MANPOWER STUDIES

Although results of the latest study by the ADA is not yet available, previous studies indicate that dentistry is becoming available to a greater segment of the population, and that the gap between supply and demand is closing. In 1976 there were 5,336 dental graduates in the U.S., more than double the number in 1950.[15] Four hundred and five (405) dentists graduated in the state of Texas alone this year.

Ontario, the Canadian province whose character closely resembles that of the U.S., has had its dentist population increased annually at an approximate rate of 5%. However, the patient population has remained fairly static. The static population could be the result of a lower birthrate after the baby boom, the effects of birth control (the pill) and lower immigration—a situation analogous to many U.S. states.[6]

However, from 1975 to 1978 the number of hygienists in Ontario has more than doubled. The Royal College of Dental Surgeons of Ontario claims that Ontario may now be training more dentists and dental auxiliaries than are needed. Several younger dentists are finding it slow. Dentists seeking part-time associateships are increasing because their own practices are not keeping them fully occupied. Enquiries from dentists about the possibilities of advertising have doubled. More dentists are finding smaller, remote communities more attractive. More dental hygienists are actively seeking employment.[6]

In 1976 there were 5,336 dental graduates in the U. S., more than double the number in 1950.

Bankruptcies were unheard of in the dental community years ago. They exist now—even more in the U.S. than in Canada.

In the year 1968 there were 2,852 auxiliary graduates to 3,171 dentist graduates in the U.S. In 1974 there were 10,836 auxiliary graduates to 4,505 dentist graduates. The numbers and changing ratios are alarming.[15]

Though nationwide manpower studies are not yet complete, results from state studies as the one conducted by Helen Gift for Louisiana are rather alarming. That study concluded that an imbalance is becoming apparent where more dentists are available than are needed. The supply is surpassing the demand.[7] If we have that many dentists, why train more auxiliaries?

In the year 1968 there were 2,852 auxiliary graduates to 3,171 dentist graduates in the U.S. In 1974 there were 10,836 auxiliary graduates to 4,505 dentist. The changing ratios are alarming.

Improved technology has created a greater need for the dental assistant, but she or he is needed at the chairside, not in the mouth. Better equipment, materials and techniques, permit dentists to be more productive. For example, we use high speed instrumentation and rapid evacuation (four-handed dentistry and the washed field technique). This improved technology is of limited usefulness without a well-trained chairside assistant.

INSURANCE PROGRAMS AND PREPAYMENT PLANS

Insurance schemes and prepayment plans permit a large segment of the population to avail themselves of dental care. As a result of these schemes, lesions are eradicated in their incipiency, obviating the need for more complex restorative treatment later.

Union contracts commonly include dental care amongst their negotiating clauses. The ultimate result is a need for less dentists rather than more dentists, because patients are less neglected.

Denticare programs such as that available in the Province of Québec presently provide free treatment for all children up to the age of 14. Ultimately, a larger segment of the population will be included. The administrators of such programs are continuously searching for methods to reduce costs. On the drawing board of the government is a plan to put dentists on

salary. If EDDA's and denturists are trained and available they can readily be included in such programs to keep costs down even if standards are somewhat compromised. Already in Saskatchewan the 200 New Zealand type dental nurses are paid directly by the government. This is a threat to dentistry and to dentists.

THE HIGH COST OF DENTISTRY

The high cost of dentistry has been put forth as a reason for seeking out methods such as the use of EDDA's to reduce the costs. Yet to date there is no evidence that dentists that work with EDDA's demand lower fees. The Training in Expanded Auxiliary Management (TEAM) Grant Program was initiated by the Federal Government in 1971. From 1972-1977 thirty-nine dental schools have received federal support for TEAM programs. However, recent trends seem to indicate that the increased use of EDDA's of a few years ago is now tapering off. Certainly dentists are using EDDA's less for restorative procedures.[9]

It is possible the dentists themselves are realizing the shortcomings of EDDA's after some experience in a private practice setting.

Dentistry is receiving a smaller share of the health care pie. In 1974 Americans spent $104.2 billion on medical care (that is, all health care, including teaching and research) or $485. per capita (U.S. Government estimate).[10]

In that same year Americans spent $6.2 billion on dental care or $29. per capita. What does this mean? It means that expenditures for dental care account for only 5.95% of total expenditures for health care. This proportion is considerably smaller than that percentage spent on dental care in 1930.

In other words, dental care has received a progressively smaller portion of the health care pie. And further, at 5.95%, dentistry in America receives a smaller proportion of the health care pie than does dentistry in a number of European nations.

From 1950 to 1976 dental fees increased 2.7 times, only slightly more than the general inflation of 2.4 times.[16] Yet, the service offered is far more sophisticated.

The high cost of medical services in America has been attributed to a great extent to the inefficiencies of operating hospitals (where auxiliaries are available in great abundance). The dental office by comparison is an efficient operating unit.

The high cost of medical services in America has been attributed to a great extent to the inefficiencies of operat-

There is also concern that the delegation of intraoral procedures to auxiliaries result in anxieties amongst patients.

ing hospitals (where auxiliaries are available in great abundance). The dental office by comparison is an efficient operating unit. The dentist spends a greater proportion of working hours in productive activity than the average professional.

Several studies indicate that dentists could be more productive with the proper use of expanded duty auxiliaries. These studies were conducted in clinics. Studies with EDDA's in solo practice indicate that the employment of EDDA's can have positive results provided the dentist is committed to the concept of team dentistry and is willing to learn and apply the managerial principles of delegation.[11]

However, there is real concern by some that the proponents of the programs for expanded function auxiliaries have never really taken into consideration the non-monetary costs of mental stress and strain that these added auxiliaries would place on the practicing dentist.[12]

There is also concern that the delegation of intraoral procedures to auxiliaries result in anxieties amongst patients. Some anxieties manifest themselves in outright refusal by the patient to submit to treatment. Others submit to treatment, but with reluctance and resentment. They accept auxiliaries because they have no choice. Because patients' anxieties are unexpressed, a misconstructed conclusion of acceptance emerges.

THE PSYCHOLOGY OF THE DENTIST

Many dentists are, by nature, loners. Some of the best dentists are ardent do-it-yourselfers. No two dentists practice in the same way. The dental profession, as it is structured today, permits such individuality and the public benefits from it by receiving high quality treatment.

If, in fact, the future of dentistry lies in team practice with EDDA's providing restorative services, a whole new generation of dentists would have to be trained. Federal grants for TEAM programs have in fact been doing that since 1971. A dentist to population ratio of 1:1822 (1976 statistic) exists in the U.S. and it is predicted that this ratio will improve as more schools graduate more dentists. With this in mind, such a new training philosophy is not only unjustified, but also dangerous as the quality of restorative procedures in particular suffer.[2]

BABY BOOM GENERATION

The surge in child-bearing after the Second World War, known as the Baby Boom, created a generational bulge that has reshaped tastes and institutions in every decade as it has become older.

Now that it has hit its thirties, the generation of the Baby Boom is moving out of the soft drink stage and soft drink manufacturers like Coke and Pepsi are diversifying and jostling for new markets in the Third World.[13]

That generation no longer requires the kind of dental service that gave birth to time-motion and EDDA's in the 1960's. Patients from that generation are entering the caries immune period of their lives. The dentistry they require does not lend itself to productive use of EDDA's. Since it involves replacement of restorations that have outlived their usefulness, castings are often indicated.

EDDA's NOW—NEW ZEALAND DENTAL NURSES NEXT?

The New Zealand School dental Service was instituted in 1921 to control the problem of caries in that country. The service provides preventive and restorative care for virtually all children up to the age of thirteen. It is staffed by specially trained dental auxiliaries—the school dental nurses who work within a closely coordinated government funded program.[14]

The dental nurses are graduates of a two-year program, where heavy emphasis is on clinical experience. All primary and intermediate schools built for 450 or more pupils have small permanent field clinics to accommodate two dental nurses.

In fluoridated areas, dental nurses provide routine care at six month intervals for about 650 children; in nonfluoridated areas for 450 to 500 children.

For New Zealand this system permits a broader segment of the population to receive service at a lower cost to society. New Zealand never enjoyed a 1:1800 dentist population ratio.

In spite of this dental health care delivery system, the World Health Organization survey in the early 1970's showed that an inordinately high percentage of the adult population, age 35 to 40, in New Zealand had either full or partial dentures. The incidence of periodontal disease was low.

Also, DMF scores for 13 to 14 year olds did not measure up well with the rest of the world. The answer would have been obviously in a better preventive program and patient education

program where auxiliaries could be more effective than in a treatment program. Dr. Lois Cohen reporting in the "International Dental Care Delivery System", 1978 publication, makes similar recommendations.

The Cutress Survey of 1976 prompted by organized dentistry in New Zealand demonstrated a slightly better picture than the World Health Organization study, yet after 65 years of age the mean number of missing teeth was twenty-five and 73% of the population was edentulous. These statistics again indicated that the emphasis in New Zealand should have been more prevention and education oriented.

What could prevent HEW from subsidizing such a program in the U.S.? The Division of Dentistry, Bureau of Health Manpower, awarded the University of Connecticut $58,869.00 to analyze economic factors associated with providing incremental dental care to children.[8] Does that mean the New Zealand concept?

At what point does the auxiliary become the dentist?

Is it more difficult to prep a tooth than to restore it? Is the obturation of a root canal or the cementation of an inlay more complicated than the insertion of a direct restoration? Is the restoration of an adult's tooth more difficult than that of a child's tooth? At what point does the auxiliary become the dentist? Is the EDDA then not a threat to the dentist?

CONCLUSION

1) Manpower and demographic studies do not substantiate the need for EDDA's.
2) Some justification exists for broadening the training of dental hygienists to perform more intraoral procedures. The added versatility would result in more productivity as well as a better balance of clinical practice, consequently making the auxiliaries' work more interesting.
3) Insertion, carving, and finishing of direct restorations should remain in the hands of the dentist.
4) Not all dentists can be trained to work in teams.
5) Efficiency is desirable, however, super efficiency can dehumanize a practice with counter productive results.
6) The profession can cope with the availability of dental care. However, patient motivation remains a central problem. The dental team of the future should include behavioral scientists or dentists with training in the behavioral sciences.[14]

References

1. Baird, K.M.; Covey, G.R.; and Protheroe, D.H. Employment of auxiliary clinical personnel in the Royal Canadian Corps. J Can Dent Assoc 33:184-191 #4 1967
2. Lotzkar, Stanley and Johnson, Donald W; Thompson, Mary B. Experimental program in expanded functions for dental assistants: phase 3 experiment with dental teams. JADA 82:1067-1081, 1971
3. Waller, Robert R. Expanded duties of auxiliaries: a survey of opinions of Georgia dentists. JADA 86:1009-1091, May 1973
4. Sisty, N.L.; Henderson, W.G., and Paule, C.L. Review of training and evaluation studies in expanded functions for dental auxiliaries JADA 98:233-248, February 1979
5. Axelsson, P.; Lindhe, J. The Effect of Plaque Control Program on Gingivitis and Dental Caries in School children. J Dent Res Special Issue C: Vol 56, 1977
6. Newsletter. The Royal College of Dental Surgeons of Ontario. November 1978
7. Gift, Helen. The ADA Manpower Program. Presented at the 27th Annual Management Conference. June 1976
8. Nelson, Robert. News and Views; American College of Dentists: Vol. 6, No. 1, February 1978
9. Legal Provisions for Delegating Expanded Functions to Dental Hygienists and Dental Assistants. Council on Dental Education: ADA, October 1977
10. Worthington, N.L. National Health Expenditures, 1929-1974. Social Security Bulletin: 38(2), 1975
11. Douglas, D.W.; Moore, S.; Lindahl, R.L.; and Gillings, D.B. Expanded duty dental assistants in solo private practice. Journal of the American College of Dentists, 43,144-163, 1976
12. Igel, D.A. Must we provide the sand? Oral Health, 66, 9, 1976. Reprinted from the Journal of the Nebraska Dental Association, 52(2), 1975
13. Fraser, Graham. Montreal Gazette: January 20, 1979
14. Logan, Richard. Dental Care Delivery in New Zealand. International Dental Care Delivery System: Kellog Foundation, 1978
15. Schoem, Max, H. Dental Care Delivery in the U.S. International Dental Care Delivery System: Kellog Foundation, 1978. Edited by John Ingle and Patricia Blair
16. Current Operating Statistics. Social Security Bulletin: 40, April 1977, 91-92.

Practice Location

—How Some Students Decide

Factors Related to Dental Student Career Choices and their Educational Implications

WILLIAM R. POSNICK

CLAUDE W. DRAKE

There has been a concerted effort in the past few years to make health care a right for all people in this country. Each year, an increasingly large amount of our nation's resources are spent on health care. Funding incentives are being offered to dental schools to increase the numbers of practitioners and studies in health care delivery have been undertaken to develop innovative ways to maintain the nation's health. However, the fact remains that this ultimate goal is far from being realized. Dentistry, along with the other health professions, lacks sufficient manpower to serve the needs of all the people. After initially increasing the number of graduates to provide more manpower, the distribution of these professionals has now become a significant problem. Dental schools and dental societies are beginning to look with concern at the number of new dentists being placed into the system each year, the alleged oversaturation of dentists in some areas, and the future projections of dentist-population ratios.

In spite of all the efforts to solve the problem of maldistribution, it is apparent that we know little relative to the reasons why health professionals practice where they do. Most existing information has been gathered retrospectively and, in the case of dentistry, very little is known as to when and how this decision-making process takes place. It seems apparent that the question of when and on what basis these decisions are made, must be answered before educational programs can be developed which will help alleviate the uneven distribution of dental manpower.

This study was undertaken to examine the characteristics of a dental student population as they relate to career choices, particularly private practice. This represents the completion of the first phase of a long-term project to investigate the variables associated with practice location and determine prospectively when, why, and how students make these decisions.

Claude W. Drake, D.D.S., M.P.H., M.S., Associate Professor, Department of Dental Ecology, School of Dentistry, University of North Carolina, Chapel Hill, North Carolina 27514.
William R. Posnick, D.D.S., M.P.H., M.S., Associate Professor, Department of Pedodontics, School of Dentistry, University of Louisville, Louisville, Kentucky 40232.

Selection is a Complex Procedure

The selection of a practice location is a very complex procedure and factors involved in this decision-making process have been examined by several investigators. Beck and Gernert[1] found practicing dentists felt that the encouragement of friends, the availability of a good practice location, and the feeling that the community could provide for the needs of his family, were important factors in selecting a location. A similar student sample showed that liking the area as a place to live, the ability to establish a practice rapidly, and the needs of the community were most important.

Dental schools and dental societies are beginning to look with concern at the number of new dentists being placed into the system each year.

One of the most frequently mentioned factors which bears on practice location is the individual's place of rearing. Glass and Baldwin[2] found a significant tendency for dentists, especially generalists, to practice in their hometown or communities known to them. The same authors made the observtion that little objective information was involved in one of the most important professional decisions of a lifetime, but rather the selection was a "complex phenomenon that involves many personal judgments."

Although income does not appear as the most frequently mentioned factor in the decision of where to locate, there is evidence that it is important. Dentists tend to settle in high socio-economic areas, and areas with high median income and per capita sales.[3,4] Williams[5] found that within the Greater Boston Standard Metropolitan Statistical Area there was great variation in the number of dentists available, with high poverty areas having the fewest dentists relative to the population.

In the American Dental Association Survey of Recent Dental Graduates, factors such as economic level of community and financial interests, though not ranked as high as some other factors, were ranked frequently as factors influencing selection of practice location.[6]

Although the role of a dentist's spouse or family in deciding practice location has not been extensively examined, a study by Meskin et al.[7] found that wives who were rated as having a "considerable effect" on their husband's choice of practice location came from smaller communities than wives who had little or no effect.

We know little relative to the reasons why health professionals practice where they do. It is a complex phenomenon that involves many personal judgments.

It must be kept in mind that choosing a practice location may be a process rather than a "decision", and that this is an intricate, involved process working on several levels of

consciousness with many questions remaining unanswered.

As the first phase of a longitudinal study, a cross-sectional survey was made of the undergraduate dental students at the University of North Carolina, Chapel Hill. The data were gathered by means of a questionnaire. The validity and reliability of which was established according to the methods suggested by Hagood and Price.[8] These included "judgment of experts" and "evaluation of the internal consistency" of the survey instrument. The students' identification numbers were requested for follow up of non-respondents to assure a high overall response rate, and for longitudinal matching in subsequent years. Confidentiality was assured to all students completing the survey.

Student Characteristics

The response rate to the questionnaire was as follows: Freshman 100%, Sophomores 95%, Juniors 99.5% and Seniors 98.7%. The mean age of each of the four classes was 23, 24, 25 and 26 respectively. Females comprised 16% of the first year class, 13% of the sophomores, 15.6% of the juniors and 5.5% of the seniors. While 30% of the first year class was married, this increased over the four year period to 65.4% in the fourth year. Over 70% of all students had an undergraduate major in the basic sciences. Students with an undergraduate major in the behavioral sciences comprised 16.2% of the first year class, 12.2% of the second, 14.7% of the third, and 15.1% of the fourth year class. Most students decided on dentistry during college and for more than 85%, dentistry was their first choice. (Table I)

The distribution of students and their spouses by hometown size is shown in Table 2. The largest percentage of both students and spouses came from towns in the 10,000-50,000 population range.

Findings

Sixty-five percent of the entire sample indicated they intended to enter private practice immediately or within five years after graduation. For those indicating a preference for private practice immediately, seniors (60.3%) had a higher level of commitment to their decision than freshmen (30%). There was little difference among the classes for private practice preference. Of those who planned on entering private practice, 50.2% preferred solo and 49.8% group practice. The freshman class had the highest

TABLE 1

STUDENT PROFILES BY YEAR OF ENROLLMENT

	First Year	Second Year	Third Year	Fourth Year
Mean Age In Years	23	24	25	26
Male	84% (68)	87% (67)	84.4% (65)	93.5% (72)
Female	16% (13)	13% (10)	15.6% (12)	5.5% (5)
Married	30% (24)	44% (33)	50.6% (39)	65.4% (51)
Single	70% (56)	56% (42)	49.4% (38)	34.6% (27)
Undergraduate Major				
Pre-Dental (3 yrs.)	2.5% (2)	16.2% (12)	22.7% (17)	19.2% (14)
Basic Science	81.3% (65)	71.6% (53)	62.7% (47)	65.8% (48)
Behavioral Science	16.2% (13)	12.2% (9)	14.7% (11)	15.1% (11)
When Decided on Dentistry				
Pre-High School	15.0% (12)	16.9% (13)	5.2% (4)	10.3% (8)
High School	27.5% (22)	16.9% (13)	14.3% (11)	25.6% (20)
Early College	26.2% (21)	26.0% (20)	33.8% (26)	20.5% (16)
Late College	21.2% (17)	31.2% (24)	31.2% (24)	32.1% (25)
Post College	10.0% (8)	9.1% (7)	15.6% (12)	11.5% (9)
Dentistry As A Preference				
First Choice	86.4% (70)	89.5% (68)	88.2% (67)	84.4% (65)
Second Choice	13.6% (11)	10.5% (8)	11.8% (9)	14.3% (11)
Third Choice				1.3% (1)

TABLE 2

HOMETOWN SIZE OF STUDENTS AND SPOUSE BY CLASS

	First Year		Second Year		Third Year		Fourth Year	
	Student	Spouse	Student	Spouse	Student	Spouse	Student	Spouse
Less than 2,500	8.6%(7)	4.5%(1)	13.5%(10)	18.2%(6)	14.3%(11)	20.5%(8)	12.8%(10)	13.7%(7)
2,500 - 10,000	13.6%(11)	22.7%(5)	12.2%(9)	12.2%(4)	14.3%(11)	20.5%(8)	14.1%(11)	21.6%(11)
10,000 - 50,000	38.3%(31)	18.2%(4)	37.8%(28)	42.4%(14)	31.5%(24)	20.5%(8)	37.2%(29)	25.5%(13)
50,000 - 100,000	17.3%(14)	13.6%(3)	18.9%(14)	15.2%(5)	19.5%(15)	15.4%(6)	16.7%(13)	13.7%(7)
More than 100,000	22.2%(18)	40.9%(9)	17.6%(13)	12.1%(4)	20.8%(16)	23.1%(9)	19.2%(15)	25.5%(13)

rate of solo practice preference, 56.4%. For all classes there is a greater preference for private practice by males. Seventy-seven percent of the males indicated plans to enter private practice while only 50% of the females had such plans.

Of those students who indicated a preference for private practice, 46.1% planned a rural practice and 53.9% urban. Freshmen, sophomores and juniors had a greater preference than seniors for rural practice, as 61.4% of the fourth year class indicated they planned to practice in an urban setting. There was a strong relationship between hometown size and practice preference. For all classes, 76.7% of the students whose hometown size was less than 2500 planned on rural practices. The size of the spouse's hometown also appears to be related to rural-urban preference. Of the respondents with spouses from communities of less than 2500, 69.2% expressed a preference for rural practice. Students from out-of-state generally expressed a preference for urban practice. However, in the fourth year class, 70% of those students from out-of-state desired to enter a rural practice. All students desiring to specialize planned an urban practice. Students who planned to practice in an urban setting generally preferred group practice, this included 58.6% of the freshmen, 55.2% of the sophomores, 64.1% of the juniors and 52.9% of the seniors. (Table 3)

The mere training of more dentists will not solve the problem of manpower shortages in underserved areas.

Discussion

The majority of the students in this cross-sectional study plan to enter private practice after graduation. A higher percentage of senior student expect to be practicing in an urban setting than do freshman students. If the longitudinal data confirm that students actually shift plans toward urban practice during their education, it might suggest that there are significant factors effecting this change. If students are unable to identify the "ideal" rural practice, a determination of suitable rural sites may need to be undertaken. However, they may be swayed by other factors to choose an urban location. It would appear that some of the variables which need further investigation are the subtle influences which dental students are subjected to during the education process. Quite possibly the role model displayed most vividly to students is that of an urban practitioner. Dental schools are in urban areas and the dental faculty are likely to be urban dwellers.

The dental curriculum may be

TABLE 3

PRIVATE PRACTICE: GROUP VS. SOLO PREFERENCE
URBAN VS. RURAL PREFERENCE

Practice	All Classes	First Year	Second Year	Third Year	Fourth Year
Solo	50.2% (109)	58.0% (29)	50.0% (27)	42.1% (24)	51.8% (29)
Group	49.8% (108)	42.0% (21)	50.0% (27)	57.9% (33)	48.2% (27)
Rural	46.1% (90)	41.2% (21)	45.5% (25)	58.6% (32)	38.6% (22)
Urban	53.9% (118)	58.2% (30)	54.5% (29)	41.4% (25)	61.4% (34)

Choosing location may be a "process" rather than a decision.

structured in a manner which does not permit students to learn about rural practice potentials. Community based externships generally tend to be placed in the last two years of the curriculum and many students may have already decided on a practice location before being exposed to a broad range of practice sites. The longitudinal data being collected will help to determine when career decisions are made.

The effect of urban dentists discouraging new graduates from urban practice sites may be positive or negative. In North Carolina, the dental supply houses have traditionally played a role in site selection and it might be speculated that an urban practice and easy access to the dentist might be their preference.

There are obviously many factors which play a role in the decisions which students make relative to their career plans. Some of these can likely be manipulated or enhanced by dental school environment; others are personal and individual. It is important to develop an understanding of the manner in which schools can help to guide students in making a clear, rational, scientifically researched examination of one of the most important decisions in their lives.

References

1. Beck, J. D., and E. B. Gernert, Attitudes and Background Values as Predictors of Urban-Rural Practice Location. *J. Dent. Educ.,* 35(9):46-53, 1971.
2. Glass, R. L., and D. C. Baldwin, Factors Influencing the Selection of Dental Office Location. *Am. Dent. A. J.,* 81(6):1337-41, 1970.
3. Boudreau, G. E., An Analysis of the Dental Practice Location in Connecticut. *Conn. S. Dent. A. J.,* 47(3):155-57, 1973.
4. Tryon, A. T., Determinants of Variations in the Supply and Distribution of Dental Manpower among Metropolitan Areas. *J. Dent. Res.,* 52(4):774-78, 1973.
5. Williams, A. F., H. Wechler, and F. Garfield, Dental Manpower in an Urban Area. *Med. Care* 7(4):288-94, 1969.
6. Bureau of Economic Research and Statistics. "Survey of Recent Dental Graduates: II. Factors Related to Selection of a Practice Location." *Am. Dent. A. J.,* 87(4):904-06, 1973.
7. Meskin, L. H., G. N. Bjella, J. B. Kenny, and J. G. Geier, Factors in Choice of Dental Practice Location: A Survey of University of Minnesota Graduates, 1950-1962. *North-west Dent.* 47:102-06, 1968.
8. Haygood, M. J., and D. O. Price, *Statistics for Sociologists.* New York: Henry Holt and Company, 1953, p. 140.

Students Find Dentistry Different than they Imagined

Realistic Expectations as they Relate to Career Satisfaction in Dentistry

ROBERT H. SCHWARTZ* AND BRUCE P. MURRAY**

Recent studies of career satisfaction among both dentists and dental students suggest that less than 75 percent of the individuals studied would choose to become dentists if they could choose again.[1–4] In contrast, among eleven other groups of professionals the positive responses to this same measure of work satisfaction ranged from a low of 75 percent for solo practicing lawyers to a high of 93 percent for urban university professors.[5] This data suggest that career satisfaction among dentists and dental students is relatively low.

According to work satisfaction research one of the causes of low work satisfaction is the presence of discrepancies between expected and realized work rewards.[6,7] This is relevant to dentistry because a majority of dental students are reported to find dentistry different than they had imagined it.[2]

Support for this idea that unmet expectations are related to low career satisfaction can be inferred from a study of academic distress among dental students.[8] In this study, ten individuals who voluntarily took leaves of absence from dental school (usually because they were not certain they wanted to be dentists) were compared with a control group of sixty-seven dental students. It was found that none of the leave-of-absence group had worked in a dental office or dental laboratory, and seven of the comparison group had. It was also found that two (20%) of the leave-of-absence group had been influenced by a dentist in their decision to choose dentistry, and twenty-seven (40%) of the control group had been influenced by a dentist. Our interpretation of these data is that dental students who had prior work experience in dentistry or who had previously been influenced by a dentist in their decision to choose dentistry were less likely to find discrepancies between expected and realized work rewards.

Career Satisfaction among Dentists and Dental Students is Relatively Low

Finally, in the authors' analysis of

*Robert H. Schwartz, Graduate School of Business Administration, The University of Michigan, Ann Arbor, Michigan 48109.
**Bruce P. Murray, College of Dentistry, University of Kentucky, Lexington, Kentucky 40536.
The authors wish to acknowledge editorial comments made by Dr. James Bader.

TABLE 1:

RELATIONSHIP OF DENTISTS' WORK SATISFACTION AND CONCEPTION OF THE DENTIST'S ROLE PRIOR TO ENTRY IN THE PROFESSION

Work Satisfaction Score	Responses to the statement: "I had an accurate conception of the role of a dentist prior to entering the profession"										
	Strongly Disagree f	%	Disagree f	%	Undecided f	%	Agree f	%	Strongly Agree f	%	Total N
Low (17 or less)	4	(5.3)	11	(14.5)	22	(28.8)	35	(46.1)	4	(5.3)	76 (100.0)
Medium (18)	4	(5.2)	5	(7.8)	11	(20.6)	28	(44.0)	7	(12.7)	55 (100.0)
High (18 or more)	6	(7.3)	9	(9.1)	24	(20.0)	51	(50.9)	26	(22.4)	116 (100.0)

Note: Kruskal-Wallis test, $p < .0033$; Median test, $p < .0314$. Total N = 247.

data from a study of work satisfaction among dentists in Utah,[9] it was found that dentists whose satisfaction scores were low were significantly more likely than dentists whose satisfaction scores were high to disagree with the statement, "I had an accurate conception of the role of a dentist prior to entering the profession" (see Table 1).

Practical perspectives on what action might be taken to deal with the relationship between unmet expectations and low career satisfaction may be inferred from realistic job preview research.[10] The realistic job preview emphasizes both desirable and undesirable facts about an organization. In contrast, the traditional job preview emphasizes only the favorable characteristics about an organization. A number of studies have shown that giving people realistic expectations about a job has a postive impact on their work satisfaction.[11-13] Gruneberg suggests that this may be due to the fact that realistic job previews redirect the attention of people from values that are not likely to be fulfilled on the job, to values that can be fulfilled.[6] He also suggests that realistic previews help to clarify roles people are expected to assume in organizational life.

Some Students do not have Realistic Expectations or Practical Perspectives for their Future Role as a Dentist

Dental Schools Admission Policies have been Concerned Primarily with the Individual's Academic and Professional Potential

Traditionally, dental school admissions policies have sought to determine the academic and professional potential of each applicant. These policies do not usually consider the applicants' expectations of a career in dentistry in an effort to minimize dissatisfaction and career terminations. Considering the relationships discussed in this paper, this lack of concern for realistic expectations may be a shortcoming of the admissions process that, if remedied, would tend to improve the career satisfaction of both dental students and dentists.

References

1. Howard, J. H., Cunningham, D. A., Rechnitzer, P. A. & Goode, R. C.: Some patterns of stress in the job and career of a dentist. *Ont. Dent.* 1975:52(2):14-25.
2. Dean, H. D.: How stressed is the dental student? *Dent. Stud.* Nov. 1978:30-31.
3. Green, D.: How well are they winging it? *Dent. Mgmt.* Dec. 1977:23-29.
4. Lipman, M. & Summer, J.: Is dental school harmful to your health? *Dent. Stud.* Dec 1978:38-40.
5. Pascal, A. H., Bell, D., Dougharty, L. A., Dunn, W. L. & Thompson, L. M.: *An evaluation of policy related research on programs for mid-life career redirections: vol. II—major findings.* Rand Corporation, Santa Monica, CA 1975, pg. 25.

Continued on Page 192

"The More Things Change, the More They Remain the Same."

Departing from its usual custom, the Journal is reprinting in this issue an article originally published in another dental journal. The article titled, "The Philosophy of Dental Health Service: Its Relation to the Changing Social Order" was first presented as a paper before the annual meeting of the New Jersey State Dental Society in 1934 by the late Bissell B. Palmer, a Fellow of the College, an acknowledged leader in the profession and one of the founders of the American Association of Dental Editors.

It is important to remember the time in which it was written. The country was then in a serious economic depression and health care was not the major issue that it was to become later. The Federal Government, under President Roosevelt, was struggling to improve conditions, but the Civil Rights movement was yet to come, as were the great changes produced by World War II.

In reading Dr. Palmer's historic writings, it is interesting to note how far we have progressed in the past forty-six years. And yet, as we consider the essentials that he prescribes for an acceptable health insurance plan, we realize that these principles remain very much the same today as they were in 1934. Read this paper and remember his advice.

Robert I. Kaplan
Past Editor
American College of Dentists

The Philosophy of Dental Health Service: Its Relation To The Changing Social Order

BISSELL B. PALMER, D.D.S., F.A.C.D.

Advice from 1934

Seldom, if ever, in the history of our profession has there been such bewilderment over a major problem as now exists in relation to the discussion of social changes in dental health service.

Consideration of other important general questions has been temporarily abandoned so as to focus full attention on a problem that is so important, and so extremely complex, that decisions in relation to it will directly affect the economic, social and cultural status of every dentist in the United States. The decisions to be made will also affect the 123,000,000 of our country's population, for the extremely vital question of public health is directly involved.

As is the case with so many other problems, it is frequently found that early solution is expedited by the consideration of the fundamental principles involved. In studying the relationship of our Profession to the conditions arising from current social trends, we might effectively resort to such a method of approach.

THE PHILOSOPHY OF DENTAL HEALTH SERVICE

In any discussion of the future of Dentistry, we must not lose sight of the reasons for our existence as a health service profession. Primarily, we are a public health agency. We assumed this privilege and obligation when we asked of our state legislatures statutory regulation to prevent others than licensees from practicing dentistry. State licenses to practice are granted only on the conditions formulated and imposed by our profession. In so limiting the practice of dentistry to those who meet our specified requirements, we become the only body in the state capable of, and legally qualified to, protect the public health in its dental aspect. There being no other group to which the public or the state government can turn for a progressive program of health service, we find ourselves in a position of tremendous responsibility. We cannot become static in our concepts of our public

Reprinted by permission from the Journal of the New Jersey State Dental Association, July 1934.

service functions. We must be constantly attuned to the wave-lengths of public needs, and alert to the audible expressions of those needs as broadcast from progressive legislators.

Another fundamental to consider is the fact that Dentistry is a Profession and not a trade. It has been well said that: "Trade is occupation for livelihood; profession is occupation for the service of the world. Trade is occupation for joy of the result; profession is occupation for joy in the process. Trade is occupation where anybody may enter; profession is occupation where only those who are prepared may enter. Trade is occupation taken up temporarily until something better offers; profession is occupation with which one is identified for life. Trade makes one the rival of every other trader; profession makes one the co-operator with all his colleagues. Trade knows only the ethics of success; profession is bound by lasting ties of sacred honor."

In keeping with the doctrine set forth in the foregoing, it becomes obvious that we must adopt and practice a high-minded philosophy for the dental profession. Contrary to the teachings of the itinerant, commercial vendors of courses in dental economics, we are not engaging in a *business*; nor is it our primary purpose to exact from the public all the "traffic will bear" in remuneration for our services. We are members of a profession that has accepted the sole responsibility for the dental health and comfort of a whole population. To emphasize our professional concept, it might be brought out that all dentists would be delighted beyond measure, if through our researches we could end all dental diseases, so that there would be no further need of a dental profession. Under such a development would we not all be joyfully willing to make such personal adjustments as might be necessary, and enter other fields of endeavor, happy that we had been part of a profession that had contributed so much for the benefit of mankind? If a similar accomplishment were possible in medicine, would not medical practitions be supremely happy that all disease had been eliminated? Would not the consciousness of participation in such an accomplishment be sufficient compensation for any personal inconveniences for physicians that might result from such a development? If as groups we did not harbor such reactions and sentiments, then we would be unworthy of the appellation—profession.

It being established that we would gratefully welcome any development that would be productive of widespread dental health for the masses of our population—does it not seem logical that we should be the initiators of, and participants in any movement that will tend to deliver the population from the present scourge of dental disease with all its destructive sequelae? With these purposes in mind, surely it will be

agreed that as a profession we would wish every man, woman and child in the United States to know the importance of dental health; to be educated to the doctrine of prevention, and to have made available to them the skill, ingenuity, and scientific capabilities of a profession acknowledged the world over to be without a peer in dental functional therapy. Believing this point to be established and indisputable, let us turn to another phase of the situation.

THE SOCIOLOGICAL TREND IN HEALTH SERVICE

Beginning in the middle ages, the consciousness of the desirability of contributing to mutual funds in time of health, for the care of members of the contributing groups in time of illness, has gradually attained broad development. Through a long process of evolutionary social changes, health insurance in one form or another has spread so widely that today but few of the important nations of the world have not adopted it. Countries that have either voluntary or compulsory health insurance today are: Argentina, Australia, Austria, Belgium, Bulgaria, Canada, Chile, Czecho-Slovakia, Denmark, Esthonia, Finland, France, Germany, Great Britain, Greece, Hungary, Irish Free State, Italy, Japan, Latvia, Lithuania, Luxemburg, Netherlands, New Zealand, Northern Ireland, Norway, Palestine, Poland, Portugal, Roumania, Russia, Spain, Sweden, Switzerland, Union of South Africa, Uruguay, and Yugoslavia.

The days of the stage-coach, the pony express and the trans-oceanic sailing vessels are gone forever. Today we have the high-speed ocean liners; the airplane, and the radio. A message can now be projected from Washington, and in a few minutes be read in the farthest corners of the world. International communication today is almost instantaneous. Political, social and industrial changes develop more rapidly in these days for just this reason. Evolution in all these fields has been geared up. The changes that formerly were slowly developed in the course of a generation, are now accomplished in a few years. In addition to changes in methods of communication, our advances in universal education and the general adoption of the doctrine of freedom of thought and speech have contributed no little to this speeding up program. Lecturers, imbued with the enthusiasm born of inspiration for causes, are enabled to travel the world over, and spread their teachings. Frequently their utopian concepts of sociological and political problems find willing ears and impressionable minds. The seeds sown bear ample fruit and are soon replanted in thousands of fertile fields. Our newspapers and magazines publish translations of works of authors from nations spread over the entire earth. Our current

events clubs, speakers' societies, motion picture news reels, and radio programs are a constant source of miscellaneous information on innumerable questions of national and international consequence. The achievements and inadequacies of the socio-political doctrines being currently promulgated, particularly in the United States, Russia, Italy and Germany, are recorded and studied by interested groups the world over. Consequently no nation can consider itself as being insulated against the changes produced by the trends of the day. Science, industry, religion and art become involved in these changes, and if logical, we cannot expect the health service professions to be uninfluenced by the developments.

TRENDS

When we use the term "trend" in discussions of socio-economics we do so to indicate the tendency of a number of related or unrelated sequential events to forecast an ascertainable ultimate. For instance, during a prolonged period in history there was a trend toward democracy in national governments. In recent years there have been indications of the development of a trend toward dictatorships. The tendency of physicians and dentists to enter the practice of specialties might properly be referred to as a "trend." In the United States for the past twenty-five years there has been an unmistakable trend toward social legislation. When we speak of "social legislation" we refer to that legislation that has for its purposes the bettering and safeguarding of living and working conditions for great masses of the population. One favoring such progressive legislation need not embrace socialism as a political doctrine, nor need he be known as a "Socialist." To emphasize this point it is only necessary to point out that the major political parties in recent years have sponsored legislation that twenty-five years ago would have gratified the most radical Socialist. Let us review briefly some examples of social legislation that are already a part of the law of the land. Of course the abolition of slavery was one of the first examples of social legislation, enacted in this country. Compulsory education provided by the state is another. Other examples of social legislation of particular interest will be found in our public health services. In this category may be listed compulsory vaccination, and state sanitation laws covering such items as food inspection, sewerage disposal and smoke nuisance. Also we have state provision of asylums for the insane, and clinics and hospitals for the health service of the indigent. In reviewing the social legislation already enacted we must not forget the maximum rent laws of a decade or more ago, or the present submission of the Federal constitutional amendment prohibiting the employment of children in industry. Passing for the moment

any reference to the social implications in the NRA rulings, let us consider some other examples of social legislation that seem certain of early enactment. First, old age pensions. President Roosevelt has endorsed this proposal and important individuals are currently making public addresses to arouse interest in, and support for such legislation. Another development we may soon expect is State or Federal unemployment insurance. The legislation in New York State has such a law now under consideration. Secretary of Labor Perkins has recently held a number of conferences with the state governors regarding this issue, and in view of the support of the present administration for the measure an unemployment insurance law seems certain of adoption in the not distant future. Surely the foregoing will serve to convince the most skeptical as well as the most conservative that there is an unmistakable trend in this country toward social legislation. If this statement is accepted then it must be agreed that the same forces that are producing these social changes will not stop short of making health service available in all its branches, including dentistry, for our 123 million population. The validity of this opinion is emphasized by the fact that today the United States is the only leading nation in the world without health insurance. Included among the thirty-seven countries that have provided this form of health service for their masses of population are the most powerful and highly respected nations of the world. Will the United States resist this trend? Trained legislators, sociologists and economists are emphatic in their opinions to the contrary. One other indication that social legislation affecting the health service professions is imminent, and not just a possibility for some remote future date, is that the enactment of unemployment insurance legislation which has been advocated by President Roosevelt as a part of his social program, will make early health insurance inevitable. It is companion piece of legislation. One is not workable without the other. When a man becomes ill, he loses his job, and under unemployment insurance he begins to collect money benefits. The agencies making such cash payments want that man to get well, and to return to work as soon as possible, in order to terminate the benefit payments at the earliest moment. To attain this end it is necessary that such a man have medical or dental attention. If the man is receiving only enough in unemployment benefit payments to keep a roof over his head, and sustenance for his body, how can he pay for his medical or dental care? What if he must go to a hospital, or if he requires nursing care? How can the insurance agency ascertain whether the man is really ill enough to justify benefit payments, and how can they ascertain when it is safe for the man to return to work? These and many other interrelationships, as well as observations on

social legislation in other countries, indicate the health insurance in some form is an inevitable companion of unemployment insurance legislation.

Since the presentation of this paper, President Roosevelt has publicly declared that health insurance for industrial workers is to be a part of his social program.

EUROPEAN EXPERIENCES WITH HEALTH INSURANCE

Now that it has been definitely established that there is a probability of near term social legislation that will vitally affect every dentist in the United States, the question arises regarding what we are to do about it. The answer can be found in the experiences of the medical and dental professions in the other thirty-seven countries where such legislation has been enacted. In every nation in which the professional leadership has been unseeing, insensitive to current trends, stupid, obstinate, or belligerently opposed to such legislation, the laws have been enacted despite that indifference or opposition. The unsympathetic attitude of the professions in such instances has always resulted in most unhappy aftermaths, for the antagonized public and legislators subsequently denied the professions any part in drawing up the insurance legislation. In consequence, the interests of physicians and dentists received but scant consideration in the legislation, which in some instances was so poorly drawn up as to become a menace to public health. Years of effort, large assessments on members of the professions for funds for a legislative lobby, and a complete rebuilding of public esteem, became necessary to modify the undesirable legislation. Among collateral evils resulting from a combative attitude on the part of the professions have been: (a) inadequate compensation for physicians and dentists; (b) lowering of the status of, and respect for, the professions; (c) depreciation of the quality of service to the public; (d) injection of commercial or political control of the health services, with a subsequent dropping of the bars allowing non-graduates to practice, with resultant fee wars between that group and the graduate practitioners. This debacle must not be permitted to occur in the United States.

SOCIO-ECONOMIC TERMINOLOGY

Before proceeding further in this presentation, it would seem appropriate to first define some elementary terms used in discussing socio-economic health service questions.

By *production* we mean the process of providing health services by a practitioner.

By *consumption* we mean the utilization of the health services of practitioners by the public.

By *distribution* we mean the system or agency through which the *consumer* receives the *production*.

When we speak of *state medicine* we mean that the government, *the distributor,* takes full charge of providing health services to *the consumer*, the public, and employs for the purpose the practitioners, who are the *producers*.

By *insurance medicine* we mean the establishment of a fund through premium payments so that the insured may receive health service paid for by the funds so set-up. Insurance medicine may be either *voluntary* or *compulsory*. In the latter system, legislation is enacted making it necessary for all employees receiving less than a specified annual income to become insured.

Panel medicine is really not a separate system of medicine. Instead it describes but one method of distribution of patients, generally under an insurance system. Primarily it consists of a list of practitioners who have expressed a willingness to participate in the plan of providing health services under the socialized system. The term has also been used in referring to the list of patients allotted to such a practitioner.

Fee Scale is a term that refers to the schedule of remunerations agreed upon for health practitioners who serve masses of population under a socialized system of medicine; whether it be *emergency* (temporary) or *statutory* (permanent).

The Clinic System is the antithesis of the *private practice system* of health service. The clinic system is practiced in some of the socialized European countries, especially in Soviet Russia, and consists of groups of practitioners working under supervision, in a public clinic. The philosophy underlying such a system is mass production, with reduced overhead expenses, and a consequent lowered cost for the patients, principally at the expense of the practitioners.

Pattern is the term used to indicate the establishment of a preliminary plan or method for providing socialized health service. Patterns may be set up to indicate, (a) the kind of system, whether state or insurance, (b) under the latter system, whether the private or clinic type of practice; (c) forms of remuneration, whether by salaries, fees, or per capita; (d) wage groups eligible for the service; (e) extent of services to be rendered, etc.

PATTERNS

European experience has taught the health service professions in America many useful lessons, but none more important than the

significance of patterns. In this connection it might be useful to call attention to the fact that legislation to socialize the health services generally appears at a time when there is general unrest and dissatisfaction in a populace due to economic and social conditions. During this period the health service practitioners suffer no less than the masses. Consequently a large proportion of the members of the professions at such a time recognize the need of (1) providing *services* for those groups of the population unable to pay standard fees, and (2) providing *patients* for that group of practitioners unable to subsist on the meagre income derived from their deleted private practices.

With this double acting incentive pulling the professions toward a change, and with the legislative demands of large masses of voters pushing in the same direction, the end result has generally been some form of socialized health service. Prior to the enactment of such legislation, however, the professions in an attempt to temporize or compromize the situation, often establish certain *emergency devices* to alleviate conditions for both the public and the profession. Here is where the great danger lies, for this is the establishment of a *pattern*.

Initial plans may later be greatly elaborated or extended, but they follow the original outline. For instance: European experience indicates that if the first step consists in setting up a low fee clinic for a certain of the low income groups of workers, the clinic system invariably develops as the national system of health service. Such systems always expand. If the original beneficiaries under the system are limited to the group earning but six hundred dollars per annum, in a few years the legislature, under pressure, raises the limit to include income groups of nine hundred to a thousand dollars. In a few more years the group entitled to health service includes not only those employees within the specified wage groups, but also their immediate families. Thus the system expands steadily, and generally on the pattern originally laid down. It is unnecessary to go over to Europe or back through the years to find an example of the importance of a pattern in socialized health service. In 1932, New York State voted an appropriation of $15,000.00 for dental relief. It was decided to spread the work over a period of ten weeks, and to limit the sum paid any one dentist to $150.00. Thus each dentist, over the period, received the equivalent of $15.00 per week. Thus we had a *remuneration pattern* established during an emergency. This arrangement was made under the supervision of the New York State Emergency Relief Committee. In May 1933, a plan was presented to the Dental Society of the State of New York providing free universal dental service for children, with remuneration for part time dentists again fixed at $15.00 per week.

Later in 1933, in New York City, an emergency dental relief program was inaugurated under the auspices of the city health department and once again $15.00 per week was the remuneration paid dentists for part time services.

How did the authorities arrive at this figure of $15.00 per week? The answer is that a pattern, or a precedent, had been set-up previously in what had seemed to be an innocent emergency arrangement. It is thus obvious that we must exercise the utmost caution in establishing these primary patterns, even when the occasion may seem quite devoid of the possibility of providing future repercussions. Original patterns developed in a moment of panic, or as a result of weak or misguided leadership, may establish the basis for a future system of health service that will demoralize the professions, and deteriorate the quality of their services to the public.

ESSENTIAL PROVISIONS IN A HEALTH SERVICE PLAN

It seems certain that the social trend is toward the development of a system of medicine and dentistry for the large masses of population economically unable to avail themselves of health services under our present system. As a profession, we are obligated not only to provide such services, but also to co-operate in producing such a system. How are we to do it? First, we must study. We must familiarize ourselves with all that has gone on before. We must examine carefully the experiences of the professions in Europe, and profit by their mistakes. It is suggested that practitioners read and re-read "The Way of Health Insurance" by Simons and Sinai, published by the University of Chicago Press. This book was written by two scientific investigators who went abroad to study the experiences of Europe in health insurance. The survey was sponsored by the American College of Dentists and is generally acknowledged to be the most valuable work ever done in the field. Only with such a background as this book provides can we approach our problem with the knowledge and understanding necessary for its effective solution.

A careful study of previous experiences in socialization of medical and dental services indicates that in order for such a system to be made workable in this country certain fundamental principles must be taken into consideration. Here in the United States, despite all rumors to the contrary, we still have a democratic form of government. Also, we have a system of economy in which profits are permissible, and at least theoretically, are directly related to the degree of intelligence, technical skill, and profoundness of application of an individual to his chosen work. Under such a combination of political,

economic and individualistic factors it would be obviously impracticable to transplant to the United States, a European system of health service designed to work primarily under a Communistic system of government, and a Marxian or Stalinistic doctrine of economics. This statement is made without attempting to evaluate the comparative values of either system.

When we speak of an *effective* health service system, we mean one that provides both *quantity* and *quality* of such a service sufficient to meet the requirements of the population; and provides compensation for the ministration of such services, (1) commensurate with the amount of time and money expended by practitioners in educating and preparing themselves to adequately perform health services, and (2) sufficient to secure the cultural activities and happy living conditions so essential for practitioners of a health service, if they are to be humane, ambitious and effective in their calling. An acceptable plan must also retain the attractiveness of the health service professions, so that they will continue to draw to their ranks, practitioners with the essential characteristics necessary for the rendering of a high quality of service, and who can be depended upon to continue to advance the science and art of the professions. Any health service system that fails to meet these fundamental requirements is foredoomed to failure, and will create chaos.

There are only two ways in which health service can be provided for the population in the lower brackets of income: (1) by taxation of citizens or, (2) by some form of health insurance. With the present almost intolerable burden of taxes, it would seem practically impossible to increase them to the extent required to finance a socialized health service. If this statement may be accepted as sound, then we may turn to a consideration of health insurance.

HEALTH INSURANCE

The advantages of a health insurance system are primarily two-fold: first, it provides health service for the masses of population who have heretofore received practically none, rendering this service at a cost the lower income group can pay. Second, health insurance provides a back-log of patients, and consequently tends to provide a professional income that should be a reassuring anchor to windward during periods of national economic storms.

Health Insurance despite its advantages as a system, may, under certain conditions, also carry serious liabilities. These hazards are found mostly in the provisions of the inequitable plans conceived and

promulgated by lay bodies. Such movements gain headway only because of a lack of interest on the part of the professions when insurance plans are being discussed. To avoid these liabilities, it is imperative that the professions unite in demanding that certain provisions and safe-guards be included in any system of health insurance advocated for adoption in the United States. The following are among the most important essentials of an acceptable health insurance plan:

1. *Free Choice of Practitioners and Patients must be assured.* If we are to preserve the professional aspects of our calling, and retain our self-respect, we must have the privilege of declining to accept any patients whom we do not wish to include, or to continue to retain in our practices. This provision works both ways, and patients must not only have the privilege of free selection of practitioners, but also of terminating the relationship should it prove to be an unhappy or unsatisfactory one. Only under such a mutually protective arrangement can a system of health service succeed in the United States.

2. *The Private Practice System of Health Service must be continued.* The clinic system of health service, with its regimentized personnel, is not an acceptable substitute for the present private practice system in the United States. The establishment of a clinic system creates a mechanism by which a distributing agency can force groups of practitioners to compete economically with each other, and thereby reduce professional remuneration and living conditions to an intolerable degree. A clinic system, in its ultimate development, means a foreman and workman relationship between practitioners and supervisors, and a chain-store philosophy of health service. It means an overemphasis on reducing costs of service, including remuneration to practitioners which constitutes the principal cost. It eliminates the freedom of professional activity and individuality, two of the features that attract individuals into health service professions. A clinic system tends to destroy that traditional personal relationship between practitioner and patient which, in the minds of the public, has become an inseparable part of our American system of health service. No logical reason can be advanced for discontinuance of the private practice system of health service in the United states unless the professions are unwilling to adjust their private practice systems to meet current requirements and changes.

3. *Professional Remuneration must be Adequate.* Any scale of remuneration that tends to impoverish the professions, makes practitioners dissatisfied and unhappy, and reflects itself

directly in an involuntary lowering of the quality of services rendered. We must devise a system that will assure appropriate compensation for health service practitioners, but which will at the same time provide services at a cost that may be borne by the low income group.

4. *Quality of Service must be maintained.*

The scope of health service provided under any insurance system must be sufficiently limited so that practitioners may equitably devote sufficient time to the proper performance of each service, and not be forced to sacrifice quality for expediency.

5. *Commercial Control of Health Service must be prohibited.*

Profit seeking agencies, acting as distributors, cannot be tolerated in health service. Their entrance into the field invariably inaugurates a three cornered war, in which their main objective is to reduce costs to the distributing agency, at the expense of the practitioners. As the primary motive of the commercial insurance corporation is to make money, it becomes obvious that consideration of other important factors will be considered secondary to profits.

6. *Political Control or Interference with Health Service is Intolerable.*

When politicians come in the door of health service, efficiency in organization, quality of service, happiness of practitioners, and too often honesty, go out of the window. In some of the present dictator systems of government in Europe, political grafters are stood up against a wall and shot. In our easy going system of government, too often these rogues are retired and given pensions. Until an outraged public opinion rises in wrath to terminate this plague, dishonest politicians will always be with us, and they must be allowed no place in health service.

7. *The Dole System Menace must be avoided.*

One of the most outstanding lessons for the professions in the United States to learn from European experience is that the provision for health service under an insurance system must be kept absolutely apart from any question of cash benefits for the patient. In some of the European countries where such a combination of health service and cash benefits is provided for by law, the practitioner is caught between two terrific forces: (1) the power of the distributing agency which demands that the practitioner, under penalty of incurring the suspicion and displeasure of the agency, take the patient off the cash benefit list even before the practitioner is willing to agree that the patient is well enough to return to work; and (2) the pressure that

is brought to bear on the practitioner by the patient, who insists upon being kept on cash benefits even after the practitioner believes him fit to return to work. If the practitioner incurs the displeasure or dissatisfaction of his patients in this respect, he is quickly listed as too hard-hearted and he loses as large part of his insurance practice. American practitioners of health service must not be subjected to this cross-fire which is intensely demoralizing to the professions. The only way to prevent it is to eliminate cash payments to patients as a part of health insurance.

While there are numerous other pitfalls in health insurance which must be guarded against by the professions, almost all of them are more or less related to those just described.

THE RESPONSIBILITY OF PROFESSIONAL ORGANIZATIONS

It is the duty of every health service profession to see to it that its membership is educated along socio-economic lines so that the commercial corporations, the opportunist politicians, both lay and professional, and even well meaning but sometimes over-zealous philanthropic agencies, may not impose their respective wills upon uninformed professions to the detriment of practitioners and the public health.

The health service professions in the United States must avoid the costly mistakes made in Europe where in too many instances, reactionary professional leaders stuck their heads in the sand and thereby convinced themselves that no changes were occurring in the world around them. Stupidity or indifference on the part of the professions will lead only to disaster.

Continued from Page 177

6. Gruneberg, M. M.: *Understanding job satisfaction.* John Wiley and Sons, New York 1979, pp. 18-24.
7. Forrest, W. R.: Stress and self-destructive behavior of dentists. *Dental Clinics of North Am.* 1978:22(3):361-371.
8. Horton, T. S.: Can academic distress be predicted prior to dental school? *J. Am. Coll. Den.* 1978:45(2):111-119.
9. Schwartz, R. H. & Murray, B. P.: Factors affecting work satisfaction among dentists in Utah. *J. Am. Coll. Den.* Spring 1981:48:47-58.
10. Wanous, J. P.: Organizational Entry: the individual's viewpoint. In: Hackman, J. R., Lawler, E. E. & Porter, L. W. (eds.): *Perspectives on behavior in organizations.* McGraw-Hill Book Co., New York 1977, pp. 126-135.
11. Scott, R. D.: Job expectancy—an important factor in labour turnover. *Personnel J.* May 1972:360-363.
12. Wanous, M. P.: Effects of a realistic job preview on job acceptance, job attitudes and job survival. *J. Appl. Psych.* 1973:58:327-332.
13. Youngberg, C. F.: "An experimental study of job satisfaction and turnover in relation to job expectations and self-expectations." Ph.D. dissertation. New York University Graduate School of Arts and Sciences, 1963.

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.

Revision adopted November 9, 1970.

American College of Dentists
7315 Wisconsin Avenue
Bethesda, Maryland 20014

Return Postage Guaranteed

Second Class Postage
PAID
Washington, D.C.
and Additional Mailing Points