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of the

**AMERICAN  
COLLEGE  
OF DENTISTS**

WINTER 1981

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NUMBER 4

**Advertising in Dentistry**  
**New Fellowships Conferred**  
**Illegal Delegation of Duties**



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# *THE JOURNAL*

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## *AMERICAN COLLEGE OF DENTISTS*

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**A Quarterly Publication Presenting  
IDEAS IN DENTISTRY**

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**Winter 1981**

**Volume 48—Number 4**

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## Deaths

### George E. Mullen

Was National Treasurer for the American College of Dentists

George E. Mullen, National Treasurer for the American College of Dentists, died suddenly of a heart attack on November 22, 1981.

Dr. Mullen served dentistry in many capacities for over forty years. He was President of New York's Second District Dental Society and President of the New York State Dental Association in 1971. As a Delegate to the ADA House of Delegates for eleven years, he served on Reference Committees for seven years, three times as Chairman. He was also General Chairman of the Greater New York Dental Meeting in 1966-67.

In 1981, he received the *Distinguished Service Award* from the New York Second District Dental Society and the *Presidential Merit Award* from the Connecticut Dental Association.

He has been Treasurer for the American College of Dentists since 1978.

Dr. Mullen practiced general dentistry in New Milford, Connecticut. He was a graduate of Fordham University and Columbia University School of Dentistry (1939).

He leaves his wife, Lillian, five sons, two daughters and seventeen grandchildren. One son is a practicing dentist, another is a dental student. A daughter has a Master's Degree in Dental Hygiene.

George Mullen's service, dedication and leadership to the dental profession will be long remembered.



George E. Mullen

### Sidney R. Francis

Sidney R. Francis, former Chairman of the ADA Council on Dental Care, died August 20, 1981, after a one-year battle with cancer.

Dr. Francis was a 1954 graduate of the College of Physicians and Surgeons School of Dentistry (now University of the Pacific) at San Francisco. He practiced in San Mateo, California and was an associate clinical professor of operative dentistry at his alma mater.

It was in the field of dental care plans that Dr. Francis was considered

*Continued on Page 197*



## EDITORIAL

# A Calling

Do you have a *calling* for the dental profession or are you just in the business of dentistry?

Earlier in this century, we frequently used the term "calling" in describing something magnetic which compels people to seek a certain vocation, career or profession. We were called to the ministry, to the health profession, to teaching, to the military or to the law.

A calling meant that a person adhered to a set of principles involving high standards of personal and professional conduct, quality of workmanship and concern for others. It included the accepting of people's trust and the responsibility for being a representative of that chosen profession in the community.

Persons who received a calling were considered to be living their lives for the good of humanity, while serving the public at a level far and above the mundane process of earning a living in that field. Ministers dedicated their lives to God, physicians followed the Hippocratic oath, teachers assumed responsibility for educating the young, the military swore to defend and protect the country and the courts were mandated to uphold the law.



*Keith P. Blair*

Today, there seems to be a widespread nostalgia for previous times, expressed in many ways. Perhaps the term "calling" is a little out of vogue now, but it is staging a come-back. *Ethics* is another word from the past that is beginning to re-appear in government, military and business circles. That word "ethics" stands for honesty, trust and good behavior throughout society, not just in certain groups. Those of us in the dental profession know that it is nearly impossible to have a calling without the essential presence of ethics. Per-

haps, if we return to more ethics in society, we will have more callings again.

Over the years, we have had many dentists who never had a real calling for the profession, though they were able to attain the necessary education and to pass the examinations to become licensed dental practitioners. They were then locked-in to the field of dental treatment, a job that provided their income. Most of them remained in the business of dentistry through the years, tolerating their work and their patients, while always looking forward to the time when they could finally retire from practice and escape its responsibilities.

However, those dentists with a calling have a different attitude in life.

They are enthusiastic about their profession, participate in dental activities and serve dentistry in some capacity. They project the image of a professional person in the way they appear, act and live. They may even look forward with regret to the day they have to retire because they still enjoy their life's work.

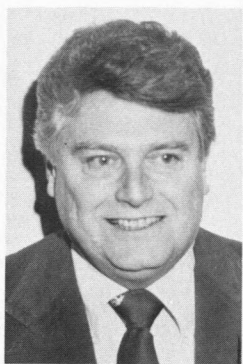
"Would you go into the dental profession if you had the opportunity to decide all over again?" The dentist who has a calling will answer that question with a very definite affirmative.

You can be your own judge. Do you have a calling or are you just in the business?

Keith P. Blair

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*Continued from Page 195*



*Sidney R. Francis*

to be one of the foremost experts in the country. He conducted seminars in 35 states and had more than 50 articles published relating to dental delivery systems, peer review and the preservation of the private practice of dentistry. He gave generously of his time and knowledge to further the advancement of dental care to the profession and to the public.

Sidney R. Francis has made a most notable contribution to the dental profession.

# News of Fellows

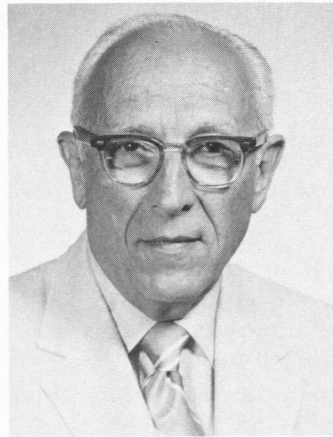
**Harry Lyons**, Dean Emeritus of the School of Dentistry at the Medical College of Virginia was installed as one of 25 new Laureates who are *Eminent Citizens* in the Commonwealth of Virginia. The award, presented by the Virginia Cultural Laureate Center, declared, "That this person's life objectives are dedicated and deeply rooted in excellence and achievement in this significant field of human endeavor."

Among others named as Laureates were TV news commentator Roger Mudd and Supreme Court Justice Lewis Powell.

Dr. Lyons, who is now 81 years old, has had an outstanding career in dentistry with many honors. The American College of Dentists named him as the recipient of the William J. Gies Award in 1978. In 1980 the ADA presented him with its Distinguished Service Award.

He was President of the ADA in 1956-57 and President of the American College of Dentists in 1964-65.

**Ralph Phillips** received three awards in 1981: the Fifth International Award by the Friends of the University of Connecticut School of Dental Medicine; Honorary Fellowship Award from the Academy of General Dentistry; and the first Mitch Nakagama Memorial Award by the Japanese Section of the Pierre Fauchard Academy. Dr. Phillips chaired the section on research at the ADA's Annual Meeting in Kansas City.



*Harry Lyons*

**Erling Johansen**, Dean of Tufts University School of Dental Medicine, was awarded an honorary doctorate degree from the University of Athens School of Dentistry at ceremonies in Greece.

**Stanley C. Kolodny**, a noted oral surgeon, has been promoted to the rank of Air Force Major General in ceremonies at Bolling Air Force Base, D.C.

**Stanley Sutnick** of Miami Beach, Florida has been installed as the 99th President of the Florida Dental Association. He has also been elected Vice President of the South Florida Inter-professional Council, a group representing 12,000 professionals.



**Burton H. Press**, ADA President-Elect from Walnut Creek, California, has been named Assistant Dean for Continuing Education and Community Programs at the University of the Pacific School of Dentistry at San Francisco.

The University of Southern California School of Dentistry's Hall of Fame, established in 1975, has inducted **Harold F. Eissmann**, **Floyd E. Hogeboom**, and **Charles L. Pincus** in a recent ceremony. Including these three men, there are now a total of fifteen educators, scholars and clinicians who are Hall of Fame members, each of whom is represented by a bronze bas-relief in the main entry way of the Norris Dental Science Center. Nine of the fifteen honorees are USC graduates.



*Burton H. Press*

**Joe J. Simmons, Jr.**, Dallas, Texas is the current president of the Flying Dentists Association. He holds a private, single engine, multi-engine, seaplane and instrument pilots' license and has accumulated almost 4000 hours of flight time. He flies his own twin engine Cessna 310.

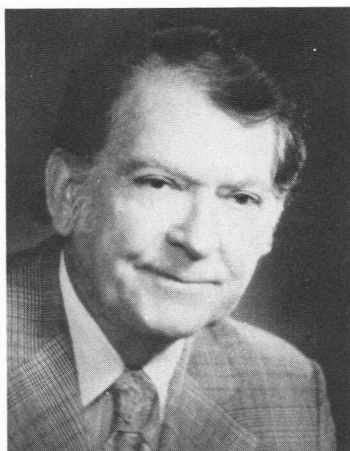
*(See picture on Next Page)*



*Morton Rosenbluth*

**Morton Rosenbluth** of North Miami Beach, Florida was installed as President of the American Inter-Fraternity Council in Kansas City during the ADA Meeting. The A.D.I.C. represents 85,000 dentists and coordinates all fraternity activities of alumni as well as those in all dental schools.

Dr. Rosenbluth is Past International President of Alpha Omega Dental Fraternity and Past President of the East Coast District Dental Society.



*Jack R. Winston*

**Jack R. Winston** of Houston Texas has been honored by having a Lectureship in Restorative Dentistry named for him at the University of Texas Health Science Center in Houston. The Lectureship will promote the interaction of undergraduate students with nationally recognized and distinguished practitioners. Among many posts held by Dr. Winston in his service to the profession, he has been President of the Texas State Board of Dental Examiners and President of the Texas Dental Association.



*Left seat—Joe J. Simmons, Dallas, President of the Flying Dentists Association. Right seat—Bill Schultz, Dallas, Vice President of District 5, FDA.*

# Section News

## Texas

The Section Meeting was held at the Holiday Inn in Corpus Christi.

Dr. Gordon H. Rovelstad, Executive Director of the American College of Dentists, presented an update of the present activities and new directions for the College.

It was decided to continue the successful annual continuing education program which is rotated each year among the three dental schools in the state of Texas. The decision was made to also continue the presentation of Professionalism Awards annually at each of the dental schools.

Section President, James P. Addison, conducted the meeting and introduced fifteen Past Section Presidents.

New Section officers are Robert Maberry, President; Ernest Besch, President-Elect; Frank Trice, Vice President; and Robert E. Lamb, Secretary-Treasurer.

The business meeting was followed by an outstanding presentation on space photography by a program from N.A.S.A. The luncheon speaker was the Honorable Waggoner Carr, former Texas Speaker of the House.

Robert E. Lamb

## New York

The New York Section of the American College of Dentistry held its first Fall Meeting at the Harvard Club. Following the introduction of officers and guests, Dr. Joseph Gibson presented the nominating Committee report with the slate for 1982, as follows:

Dr. George O'Grady, Chairman; Dr. Arthur Resnick, Vice Chairman; Dr. Howard L. Ward, Secretary-Treasurer; Dr. Robert Fisher, Historian; Drs. Joseph Fiasconaro and Louis Marino, Members of Executive Committee.

Following the business meeting, a brilliant presentation was offered by Akira Morishima, M.D., PhD. Dr. Morishima is Chief of the Division of Pediatric Endocrinology at the Columbia Presbyterian Medical Center. He is a diplomate of the American Board of Pediatrics. A lecturer, author, clinician, his area of research is in pediatric endocrinology, cytogenic diseases and the effects of marijuana on chromosomes. His topic was "Biological Effects of Marijuana."

Howard L. Ward



## New Section Chartered in New York

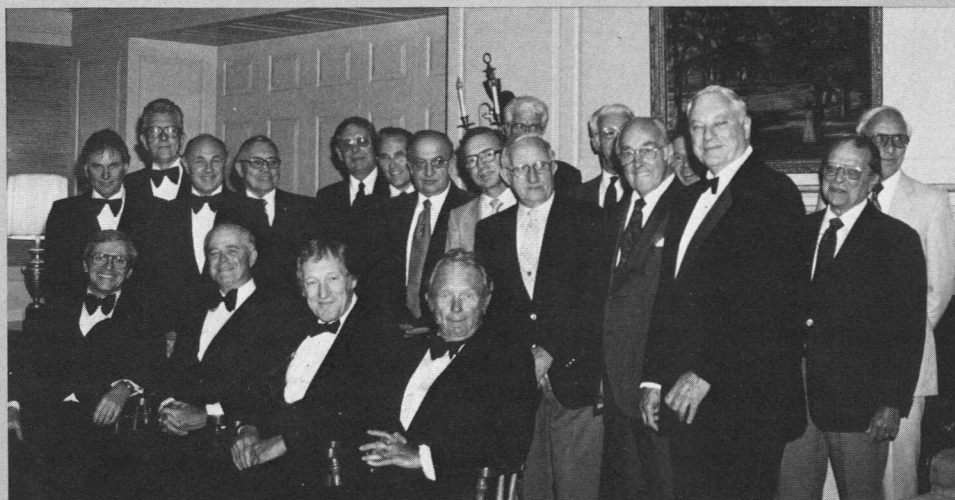
The Hudson-Mohawk Section became the newest section in the American College of Dentists when it received its Charter in Albany, New York.

Regent Gerard E. McGuirk presented the Charter and installed the first section officers: Edward J. Downes, Chairman; John W. Ehrcke, Vice Chairman; Marvin L. Kessler, Secretary-Treasurer; and William B. Smith, Historian.

Attending the event were the President of the American College of Dentists, William C. Draffin, and the ACD Treasurer, George E. Mullen.



*Regent Gerard McGuirk, center, presents the new Hudson-Mohawk Section Charter to first Section Chairman, Edward Downes, left, while William C. Draffin, right, President of the American College of Dentists, looks on.*



*Pictured are members of the newly formed Hudson-Mohawk Section of the American College of Dentists. Seated in the front row, left to right are Edward J. Downes, First Section Chairman; ACD Regent Gerard E. McGuirk; ACD President William C. Draffin and ACD Treasurer George E. Mullen.*

## West Virginia

The Section Meeting was held at The Greenbrier, White Sulphur Springs, W. Va.

Out of state guests were introduced, including Drs. Ashur Chavoor, Harold Gelb, Joseph Hagan, John Houlihan and I. Lawrence Kerr.

Dean W. Robert Biddington of the West Virginia University School of Dentistry, announced that the first-year enrollment has been reduced from 62 to 50 students, starting this year. Student loans through federal matching funds will no longer be available, but the Dental School has received

national recognition because nearly 100% of the student loans have been repayed over the years.

ADA President, Dr. John Houlihan addressed the Section, stating his firm convictions that our dental education system should be separated from federal government programs. The dental schools will then need considerably more support from the dental profession.

New officers for the Section are Dr. James Overberger, Chairman; Dr. Michael Joseph, Vice-Chairman and Dr. Robert Sausen, Secretary-Treasurer.

## Metropolitan Washington D.C.

The Fall meeting of the Section was held on September 30, 1981 at the National Naval Medical Center under the chairmanship of Irving M. Rothstein. After committee reports, the following new officers were installed by Balfour Mattox: Chairman Bernard Yanowitz, Vice Chairman Henry J. Heim, Secretary-Treasurer Robert J. Taylor, Members at Large Jeanne C. Sinkford and James T. Jackson.

Dr. Preston A. Littleton, Jr. spoke

on "The Implications of the Decline in Dental School Applications" and Dr. Howard L. Kelly discussed "Federal Dental Manpower Programs and their Impact on Dental Manpower Requirements." A plaque was presented to outgoing Chairman Rothstein and he was commended for his outstanding leadership and service to the Section.

Bernard Yanowitz



## Montana



*Pictured at the Montana Section meeting are, left to right, Daniel Frederickson, Section Secretary; Robert H. Griffiths, ADA President-Elect; Harold Pressman, Section Chairman and Robert A. Cupples, ACD Regent for Regency 8.*

The Montana Section met at the Fairmont Hot Springs Resort near Butte to receive its new Charter with every active Section member in attendance.

Regent Robert A. Cupples made the presentation of the Charter to Section Chairman Harold A. Pressman. At-

tending the meeting also were ADA President-Elect Robert Griffiths, Mrs. Griffiths and Dr. Geraldine T. Morrow of Alaska.

According to reports, the Montana Section was the last section to be re-chartered.

## Virginia

The Section meeting was held during the 112th annual meeting of the Virginia Dental Association at the Cavalier Hotel, Virginia Beach, Virginia.

Dr. Harry Lyons was recognized as recipient of the Edward A. Wayne Medal for Distinguished Service to the Virginia Commonwealth University-awarded 1981.

Dr. Charles R. Crews of Radford, Virginia introduced his classmate and speaker of the evening, Dr. Morton O. Alper from the District of Columbia Section. Dr. Alper presented a dynamic, inspiring talk entitled: "I Know What You Are Against, But What Are You For."

Tom R. Nicholls



# **The Profession Is Confronted By Formidable Challenges**

**The Address of President Elect Richard J. Reynolds  
Kansas City, October 24, 1981**

Fellows of the College, candidates for Fellowship, ladies and gentlemen: it has been said that "True worth is exemplified not in possessing honors, but in deserving them." This is a rather sobering thought, and I am profoundly conscious of the awesome responsibility of my attempting to follow in the footsteps of the many illustrious individuals who have preceded me in this office. Nevertheless, I am extremely honored and am determined to justify the confidence which has been placed in me by serving the College and the cause of professionalism in dentistry to the ultimate of my ability.

First, I should like to offer my congratulations to you candidates, and to welcome you warmly into the fellowship of the College. It is indeed an honor to be identified with such a select group of carefully chosen dedicated individuals representing less than 4% of our profession. It must be emphasized that with the honor of possessing fellowship, goes the responsibility of deserving it. You are charged, therefore, to demonstrate your appreciation and dedication to the College by your interest and participation in the affairs and work of the College; not only at the national level, but especially, by your attendance and

support of the activities of the particular section with which you are affiliated. Sections can be just as strong as its members are willing to make them. In order for any section to be dynamic and effective, and to have meaningful programs and worthwhile activities, the individual Fellows must attend the meetings regularly, and participate energetically. To accept the honor and distinction of Fellowship, and from that point on become indifferent, ignoring the moral responsibility of your personal involvement in the section's activities, is simply not playing the game. Before leaving the subject, I should like to add that it is incumbent on the Fellows at the section level to recognize those of his dental colleagues who exemplify the requisite leadership and professional qualities for fellowship. Obviously, the American College of Dentists is not aggressive in the recruitment of new members. It does not conduct or condone membership drives as such. Nor does it have quotas for nominations to be considered each year. It is therefore important that each Fellow take upon himself the responsibility of reviewing the roster of membership to make certain that persons of merit who are truly deserving of fellowship, are not inad-

vertently overlooked. Not to nominate an individual who is highly qualified is manifestly unfair, and defeats the purpose and objectives of the nominating procedure.

Judged by conventional criteria, the future of our profession, at least as we have known it, is in jeopardy. The emergence of alternative dental delivery systems, the burgeoning interest and involvement of non-professional elements, bureaucratic intrusion, advertising, independent denturism and dental hygiene practice, and declining busyness are having a demoralizing effect. I should like to direct your attention to instances that call into question the survival of the professional system brought about by legal, social, political and professional changes. Obviously, certain of the forces adversely influencing the nature and character of dental practice are external to our professional structure, and consequently are beyond our power and authority to control. Nevertheless, the appropriate professional response to the changes that are occurring, and determining the course that organized dentistry might take in planning for the future, deserves careful attention. 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. Let me emphasize that we should have no concerns regarding the future of dentistry from a technological point of view. There is constant progress in research and development of dental materials, new techniques, instruments, and sophisti-

cated diagnostic equipment. A few years ago, I was privileged to visit and inspect dental facilities in Hungary, Russia, Poland, and Yugoslavia. This experience gave me an overwhelming sense of pride in American dentistry. These Iron Curtain countries, under rigid political control, are dentally speaking, at least 30-40 years behind the United States. The pre-eminence we enjoy has been the result of a highly developed sense of order and organizational freedom within our profession, which has made possible the interchange of knowledge, and the enjoyment of certain rights, responsibilities,

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attest to the fact that  
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health and welfare.**

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and privileges unknown in those countries. Unfortunately, the traditional values of the dental profession which brought about our acknowledged superiority are being assailed. There are legal changes involving the constitutionality and legality of laws controlling advertising by professionals and the applicability of the anti-trust laws to dentistry and other learned professions. The rubrics of the bureaucratic lexicon underscore an overwhelming preoccupation with low cost rather than high quality care. There are



*Richard J. Reynolds  
President—1981-1982  
American College of Dentists*

social changes as patients demand that the dental profession be more sensitive and responsive to what the public's dental health needs are perceived to be. Health consumers are demanding more input into quality assurance and a more widespread accessibility to dental care.

Perhaps it would be helpful to view the problems we are facing today against the backdrop of the historical perspective. Prior to the establishment of educational standards and laws regulating professional practice, the public, as you can imagine, was all too often, subjected to painful abuse at the hands of ill-trained, incompetent and unscrupulous practitioners. It was only natural and inevitable under these primitive conditions for the public to rise up and demand some measure of control over the healing arts. As a result, by the beginning of the 1800's, professional licensing was well established, and a trend was set in motion for continued refinement of the regulations governing practice administered by professional associations with the legal support of the states. However, human nature being what it is, opposition began to develop. Brought into serious question was the validity of the restrictions and the unconstitutional infringement of the right of an individual to pursue a trade or profession. Beginning about 1820, state laws governing practice began to be repealed out of existence or amended to the point that they were rendered ineffective. By 1850, there were almost no regulations and predictably, a sharp decline in professional standards and image ensued.

After a time, it was realized that states had to re-enact legislation regulating the professions and to re-establish educational standards. By 1900, practically all states had licensing laws with adequate provision for professional self government and a clearly defined professional role in the licensing and regulatory process. Basically this is the framework within which present day professional licensure operates, and there has been a rather stable working relationship between state governments and professional associations. History has a way of repeating itself and there is once again increasing criticism and opposition to the concept of dental licensure. Currently, many persons, some within the dental profession, are more concerned about their individual rights than about the public welfare or the welfare of the profession. There is agitation for change in dental licensure directed specifically at State Boards by members of the dental profession and by state and federal agencies. There are those who would like to see state boards abolished, and graduates of approved educational institutions allowed to go directly into practice. Anyone with experience as a dental examiner will attest to the fact that licensing laws are necessary to the public health and welfare. Even with the present level of controls and standards, there are regrettably too many instances where patients have justifiable complaints having to do with mismanagement, faulty professional judgement in treatment planning, and poor quality service. Sunset laws are readily comprehended by dentists serv-

ing on State Boards, but it is of the utmost importance that the privately practicing dentists and the general public be cognizant of the purposes, implications, and consequences of laws critically affecting them. A typical Sunset Law has directed all regulatory agencies such as Dental and Medical

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**Historically, the common bond of all professions has been the Code of Ethics, for it is through voluntary adherence to such standards of conduct that members of a profession manifest their moral and ethical accountability.**

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Examining Boards to justify their functions and the statutory authority under which the boards carry out their activities. Colorado was the first state to issue a Sunset Law report on the State Board of Dental Examiners. The report, to say the least, was hardly a commendation. The most devastating result was the recognition of denturism as a safe and efficient method of providing prosthetic dental care. The report also emphasizes that many of the intra-oral procedures could appropriately be performed by dental auxiliaries. Oregon voters, on November 7, 1978, adopted a law that created a new health occupation called

denture technology. Oregon voters were overwhelmingly in favor of the denturists: 78% for and 22% against. They obviously were not persuaded that a substantial health risk exists when non-dentists with limited training or experience are allowed to provide denture care directly. Perceiving no real risk, perhaps they were attracted to the prospect of a more economical denture service. The issue of denturism must be viewed as but one of a series of attempts to fragment, and ultimately destroy the traditional professional system.

In Florida, the Sunset Report wrought changes to all professional boards. Basically, the Board of Dentistry was stripped of great deal of its authority. The enforcement procedures are now handled by the state bureaucracy. The nine member board formerly consisted of 7 dentists, 1 consumer, and 1 hygienist. On the new board, 1 dentist was dropped, 1 consumer was added. The board now has 6 dentists, 2 consumers, and 1 hygienist. The board no longer administers the examinations. Instead, dentists throughout the state are hired to give the examination. It is interesting to note that as costs have escalated, there has been a corresponding decrease in the amount of work accomplished. The last examination given in June, 1979, before the change, cost \$30,000, in contrast with the present year's budget which calls for \$330,000 for the two examinations and a model examination. In addition, the Florida Department of Professional Regulations was forced to limit the number of candidates taking the De-



cember 1980 examination, and will also limit the number taking the December 1981 examination.

Historically, the common bond of all professions has been the Code of Ethics, for it is through voluntary adherence to such standards of conduct that members of a profession manifest their moral and ethical accountability. Professions, like religions, have custody over the credentials and the manner in which persons are admitted and maintain their membership. The obligation to abide by common beliefs, principles, and ethics characterize professions as well as religions; because these ideals and objectives serve the common good, both are entitled to the prerogative of self-governance and the freedom from interference. Sir Thomas Browne, 17th century physician and philosopher, held that common opinion and tradition are entitled to a legitimate presumption in their favor. If a thing has been long believed or practiced, we ought not to discard it unless we obtain clear evidence that it is mistaken or outmoded.

It is painfully evident that our profession is being besieged by many challenges, and that dental care delivery is undergoing change. It has become a highly profitable market for the commercial entrepreneurs. Nevertheless, the ability of the dental profession to monitor changes and respond with progressive policies is essential to its survival, and will determine its future as a profession. We are committed to the belief that the efforts of organized dentistry and the dedication and commitment of thousands of prac-

titioners throughout the breadth of our land will ultimately prevail.

A word about alternative dental delivery systems, a term that causes panic among dentists, would be in order. Prophets of doom within our profession overlook the fact that more than 95% of dental services continue to be provided by the traditional private practitioners. Although there are some 240 HMO's operating over the country, about 3/4 of them have no provision for dental coverage. As a matter of fact, the practicing dentists associated with HMO's represent less than 1% of our profession. Most capitation plans are concentrated in a handful of states. At the present time, there are only 63 retail store dental facilities in 14 states and the District of Columbia. Relatively few dentists, all licensed and bona fide members of our profession, are employed in this kind of setting. There is concern over some of the implications of alternative dental care systems. Freedom of choice is a fundamental issue. Under many closed panel programs, beneficiaries are assigned a particular dentist, and have no choice in the selection. Blue Cross/Blue Shield now administers dual choice plans in certain states. Moreover, we have objected strenuously to the preferential treatment given HMO's under the law. Over the past few years, the government has granted over \$200 million to federally qualified HMO's. It is the contention of organized dentistry that HMO's should be required to compete on even terms and fail or succeed according to their ability to provide affordable high quality dental care. The recent budget reconciliation pack-

age, signed by President Reagan, eliminated the start-up funds for new HMO's. Many of the provisions of the final budget package will have an impact on the future delivery of dental care. One of the provisions, with which we are pleased, ends all capitation grants and mandatory enrollments for dental schools. The ADA has indicated for several years that dental manpower levels are adequate, and that these measures should be discontinued. As a result, an immedi-

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ate reduction in the size of first year dental classes can be expected.

It is extremely important that we continue to monitor congressional activity and influence the development of legislation directly or indirectly affecting our profession. The ADA president-elect, Robert Griffiths, provided testimony to Congress in

July urging that authority over state regulated professions by the F.T.C. be limited. He expressed the opinion that interference by the F.T.C. in the regulation of dental practice would fail to have the desired economic benefit to the patients, but instead would be likely to result in an erosion of the quality of care. Last year, the Association supported the McClure-Melcher Bill which would have severely restricted F.T.C. involvement in professional affairs. The bill failed by a mere 2 votes. This year, similar legislation, the Luken-Lee Bill, has been introduced in the House. It closely resembles the McClure-Melcher proposal and now has 51 other co-sponsors. It is expected that there will be a similar Senate bill introduced later this year.

The F.T.C. is not our only concern. Proposed procompetition legislation which would limit the amount employers could contribute to employee health programs could seriously curtail the dental benefits provided for in health plans. The provision of rebates to employees choosing less costly and less comprehensive health plans could encourage individuals to select plans with minimal dental health benefits.

As already stated, the federal government is not alone in its intervention, but in recent years 4 state governments have enacted legislation allowing the independent practice of denturists. Oregon is the only state permitting denturists to practice without the direct supervision of a dentist, and not one of the denturists bills, introduced in the various state legislations during 1980, passed. Strong opposition must be

continued as long as the challenge of independent denturist practice remains.

It was gratifying that the F.T.C. withdrew its request for General Accounting Office approval of a proposed denturists study. The ADA provided extensive commentary to the G.A.O. in which objections to the study as proposed were outlined. Moreover, it was equally gratifying that the F.T.C. decided to retreat on its investigation of independent hygiene practice. As in the case of denturism, violent objections were raised to the proposed study, and several state associations were quick to register their disapproval.

Even though the federal government has backed off, a core of individual hygienists are still in the vanguard of the battle in spite of the apparent disinclination of the vast majority of hygienists to support independent practice. It is acknowledged that dental hygienists have legitimate concerns about the status of the economy and employment opportunities. The number of dental hygiene educational programs has nearly doubled in the past 10 years. Dental hygienists are working more years and returning to the dental office after having families. On the other hand, many hygiene positions are part-time, do not offer fringe benefits or job security and the job market is rapidly becoming saturated.

The Board of Trustees' present position, and future options in dealing with dental hygiene are based on several potential activities included in the so-called 7 point program.

- (1) Appoint a special national committee to investigate the concerns of dental hygiene
- (2) Develop a program for dental hygienists during the ADA annual session
- (3) Conduct a study of additional employment opportunities for dental hygiene
- (4) Conduct a publicity campaign among dentists employing dental hygienists regarding the concerns and issues that should be considered
- (5) Convene a state legislative chairman meeting to discuss state legislative initiatives regarding dental hygiene and dentistry
- (6) Conduct a comprehensive study of educational standards for dental hygiene
- (7) Expand the ADA associate membership category to allow allied dental personnel to become associate members of the American Dental Association

Solutions to whatever problems and concerns exist must be found, preferably in cooperation with the ADHA.

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**Our chief hope for a  
return to order lies in a  
recognition by Congress  
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proposed, which are  
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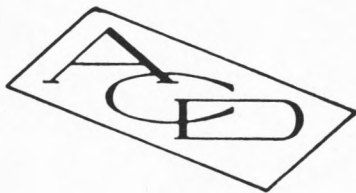
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Another major problem facing the dental profession is the decline in dental recruitment. Numerous sources have pointed up the fact that the dental applicant pool has been shrinking in size since 1975. Higher tuition and educational costs coupled with the scarcity of financial aid, are no doubt largely responsible. After graduation, the financial burden of equipping and staffing a private office, with inflation, sagging economy and high interest rates, and a lack of busyness, is having an adverse effect on career selection. Evaluation of the future financing of educational programs, which must accommodate limited resources secondary to budgetary constraints of legislature and decreasing federal funds, is an issue which must be addressed. The decreasing number of applicants of diminishing quality is a cause for concern. Development of adequate financing of student aid and loans for the under and post graduate

student would appear to be high priority.

In conclusion, may I say that the changes confronting the profession represent formidable challenges. Our chief hope for a return to order lies in a recognition by Congress that the changes proposed, which are undermining our professional structure, are not in the public interest. The improvement, or lack of improvement, of the dental health of the people of this nation will determine the propriety of the suggested changes, and in the final analysis, will be the true yardstick of our progress.

I am confident that I speak for all concerned when I say that we, the Fellows of the American College of Dentists, pledge our wholehearted support, and the weight of our collective professional energies, as we join forces with the American Dental Association, and other professional groups, in the crusade to preserve the integrity and dignity of our profession.





# Citations, Honors and Awards

Presented At The 1981 Convocation

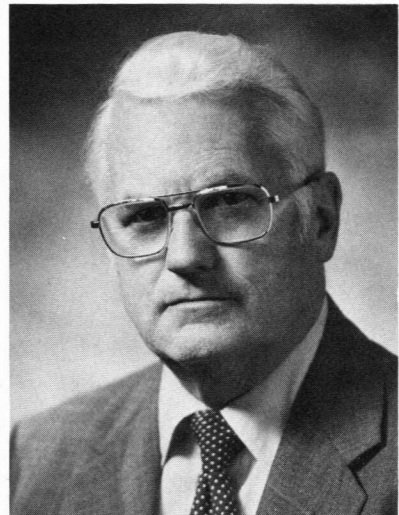
Special Recognition - Dr. Robert J. Nelsen  
William J. Gies Award - Dr. Edward V. Zegarelli  
William J. Gies Award - Dr. Ralph A. Boelsche  
Award of Merit - Mr. Karl S. Richardson

## CITATION FOR DR. ROBERT J. NELSEN

Presented by Dr. George C. Paffenbarger

I am here to honor Dr. Robert J. Nelsen on your behalf. I know him well, but I must be careful what I say as he knows me well too. Be that as it may, I speak from experience as Dr. Nelsen and I served together in World War II.

We fought at the Battle of Brooklyn. The battlefield was the Navy Medical Supply Depot. Then we lost each other until I enticed him away from the University of Washington in 1950 to become a Research Associate of the American Dental Association at the National Bureau of Standards. Why did I want him on my staff? Because he was a four *I* man. He was, and is, an innovative, inventive, initiative and industrious person; and I didn't make a mistake here, for out of his mind came, among other important developments, the turbine contra-angle handpiece, which revolutionized the surgery of the hard tooth tissues.



*Robert J. Nelsen*

I came here not to praise Dr. Nelsen but to present to him a remembrance that would signify your appreciation of his service as the Chief Executive Officer of this College for twelve years.

*Continued on Page 226*

**CITATION FOR  
DR. EDWARD V. ZEGARELLI**  
**Presented by Regent Dr. Gerard E. McGuirk**



*Edward V. Zegarelli*

Educator, clinician, researcher, writer, editor, examiner, administrator: all of these titles are those which describe Edward V. Zegarelli, Dean Emeritus, Columbia University School of Dental and Oral Surgery, New York City.

Dr. Edward V. Zegarelli has had a distinguished professional career, having served the public through Columbia University, the state of New York, and the Federal Government for over 40 years in many significant ways. Beginning in 1937 as an assistant on the faculty of Columbia University, he progressed through all ranks to the high position of Edward S. Robinson Professor of Dentistry in 1958 where he still serves. He was appointed Dean of the School of Dental and Oral Surgery in 1974. His contributions in oral

medicine, oral diagnosis, and roentgenology are known world wide.

As Attending Surgeon, Columbia-Presbyterian Medical Center, New York, he served as Director of the Dental Service, Presbyterian Hospital. He also served as consultant to the Veterans Administration Hospitals at East Orange, Kingsbridge and Montrose, as well as the Public Health Service Hospital at Staten Island and the private hospitals, Phelps Memorial and Vassar Brothers. His special areas of interest are in oral medicine and oral therapeutics. He has published over 175 scientific papers in professional journals, authored four textbooks and contributed to four other textbooks as well as served as Chairman of the Editorial Board of the *Journal of Oral Therapeutics*.

Dr. Zegarelli has been an Examiner for dental competence for over 18 years. He was Vice President of the New York Board in 1969-70 and President 1970-71 and he is now Chairman of the Examining Committee of the North East Regional Board. The concept and development of simulated clinical testing for state licensure was developed and produced first for the State of New York by Dr. Zegarelli. This examination is used by the North East Regional Board and is now widely accepted by other states.

As Head of Diagnosis and Roentgenology, Director of the Division of Stomatology, and finally, Dean, Dr.

Zegarelli provided leadership to Columbia University School of Dental and Oral Surgery during critical periods in its growth and development. His firm hand and steady guidance were major factors influencing the attainments of the faculty and progress of the school.

All who have attended Columbia University School of Dental and Oral Surgery since 1937 have been touched by Dr. Zegarelli's mind. All who have been examined for licensure in New York State since 1963 and later in the North East Region since 1969 have been touched by Dr. Zegarelli's hand. He has directly affected thousands of young men and women in their preparation for the practice of dentistry. Thus, the many titles given to Dr. Zegarelli describe more than nominal positions.

There have been many ways in which Dr. Zegarelli has contributed his talents outside the university environment. He served as a member of the Governor's Task Force on Dental Health Policy in New York State; as a Central Office Consultant, Veterans Administration, Washington, DC; as Chairman, Council on Scientific Research, New York State Dental Society; as Chairman, Panel on Drugs in Dentistry, National Academy of Sciences—National Research Council—Federal Foods and Drug Administration; Washington, DC; as a member of the Board of Directors of the American Cancer Society of the New York City Division; as a member of the Council on Dental Therapeutics of the American Dental Association; as a

member of the Committee on Physical and Biological Research of the American Dental Association Health Foundation; and as a member of the New York State Health Research Council. He belongs to numerous professional organizations and is a diplomate of the American Board of Oral Medicine.

For his efforts and activities, Dr. Zegarelli has received many honors. These honors include most recently the Samuel Charles Miller Medal, American Academy of Oral Medicine in 1976, and the American Association of Dental Examiners Award of Merit in 1972. The American Association of Dental Examiners recently awarded Dr. Zegarelli the position of the title of Dentist Citizen of the Year, and the First District Dental Society of the State of New York recently awarded him the Henry Spenadel Award.

He is a member of Omicron Kappa Upsilon and Sigma XI Societies and is listed in *Who's Who in American Education*, *Who's Who in the East*, and *American Men of Science*. Dr. Zegarelli resides with his family in North Tarrytown, New York.

It is significant that Dr. Zegarelli should receive the William John Gies Award today. The many years of Dr. Gies' contributions to dental education and science while a faculty member at Columbia University have carried over into Dr. Zegarelli's life and career.

Mr. President, it is a privilege and honor for me to present Edward V. Zegarelli for the William John Gies Award.

**CITATION FOR  
DR. RALPH A. BOELSCHE**  
**Presented by Regent Dr. L. M. Kennedy**

In 1939, the Board of Regents established the William John Gies Award. The purpose of the Award is to encourage and recognize Fellows of the College for outstanding and unusual services in dentistry and allied fields—in education, research, literature, and community service. This Award is made in honor of Dr. Gies but it also serves as a testimonial of the appreciation and esteem for those Fellows of the College whose contributions have warranted this exceptional recognition.

Since 1939 there have been fifty-five distinguished Fellows who have received this Award. A list of the recipients could well serve as the roll of the most noble and dedicated Fellows who have personified professionalism in its finest form.

The areas of service of these men have varied. Some in one area, some in another, some in several areas. The gentleman I present for this Award today is truly a man for all Seasons. He has faithfully served his Maker, his Country, his profession, his community and his fellow-man. He has been a teacher, a researcher, a writer, a practitioner, a civic worker and a stalwart in his church.

Ralph A. Boelsche was born December 22, 1904 in Industry, Texas. He received his pre-dental education at Blinn College and at Texas A & M University. While at Texas A & M he



*Ralph A. Boelsche*

was selected as the Band Leader of the Freshman Unit of the famous Texas Aggie Band.

Dr. Boelsche received his dental education at the Texas Dental College in Houston in 1927. He was the valedictorian of his class. On May 12 of the following year, Dr. Boelsche won the hand and married Ida B. Fordtran. Her love, companionship and support have been enriching and enabling factors in the magnificent career of our Awardee.

Upon graduation, Dr. Boelsche entered a residency program at Jefferson Davis Hospital. At the same time he was a clinical instructor in operative dentistry at the dental school. From



this beginning evolved a long and successful private practice. Throughout the years of his practice, Dr. Boelsche has had unlimited energy and unsurpassed dedication and love for his profession. He always found time to be deeply involved in those pursuits designed to increase knowledge and to improve the quality of the profession. He has been a continuous student with an unquenchable thirst for knowledge and a burning desire to share that knowledge with his colleagues. He has motivated and stimulated others to join with him in forming and participating in study clubs and he has inspired others, through his example, to provide superior services in a most professional way.

In addition to his Fellowship in the American College, which he dearly cherishes, and where he has served as Regent, Dr. Boelsche has been and is a member of numerous dental organizations. To mention a few: He is a charter member and past president of the American Academy of Gold Foil Operators. He is also the first recipient of the Distinguished Member Award of that organization. He is a member and past president of the American Academy of Restorative Dentistry, a member of the American Academy of Endodontists, American Academy of International Medicine and Dentistry, the Woodbury Gold Foil Study Club and is one of the founders of the Southwestern Society of Oral Medicine. He had made many contributions in other dental organizations.

Dr. Boelsche's goodness and greatness aren't limited to the profession of

dentistry. He is a faithful and loyal member of the Methodist Church of Industry. He has served on the Board of Stewards and as a lay delegate to the Annual Conference. He is an active participant in the total church program. He was quite active in the promotion of a recently constructed church building in Industry, seeing it as a meeting place for the community's young people. He has given substantial support to the Texas Methodist Foundation and other institutions of the United Methodist Church.

Dr. Boelsche is an astute business man. He has an excellent sense of values. He has demonstrated good judgment, wise investments, self-discipline, fair play and faith in the free enterprise system. He is the Chairman of the Board of the Industry State Bank.

Innate modesty and humility are responsible for a general lack of knowledge of the generous philanthropies of Dr. and Mrs. Boelsche. One recently came to light when a sizable trust for Baylor College of Dentistry was provided in memory of the late Dr. Bernhard Gottlieb, a former faculty member with whom Dr. Boelsche had studied for some ten years.

Time allows only a scratching of the surface of the many many contributions of this great man. After fifty-two years of providing beautiful dentistry and compassionate care for his patients, Dr. Boelsche retired from active practice. He is sorely missed by his patients. Although his active practice is terminated, his influence for the betterment of our profession and so-

*Continued on Page 226*

**CITATION FOR  
MR. KARL S. RICHARDSON**  
**Presented by Regent Dr. Norman H. Olsen**

The Award of Merit of the American College of Dentists was established by the Board of Regents on February 8, 1959. Since that date, there have been 24 recipients. The purpose of the Award of Merit is to recognize unusual contributions made toward the advancement of the profession of dentistry and its service to humanity by persons other than Fellows of the College. This Award is made annually at the Convocation to an individual who has made a unique contribution or has given devoted service to dentistry. It is interesting in every walk of life there are a few individuals who distinguish themselves above their peers. It is such a man that we honor today. As James Bryant Conant said, "Each honest calling, each walk of life, has its own aristocracy based on excellence of performance."

Karl Richardson is a man of many interests and talents. During a tribute to Karl Richardson's tenure as the Executive Director of the Chicago Dental Society, past president Richard Fischl stated that the Board of Directors of the Chicago Dental Society was conferring Honorary Membership to Karl "as a testimonial of their love and affection and in appreciation of his years of tireless and dedicated service to the Dental Society." Mr. "R" as he is known affectionately by his staff has served under 39 different presidents and boards, not to mention serving the



*Karl S. Richardson*

needs of literally thousands of different committees during his tenure. To be held in the highest esteem by all of those he has worked with over the years is a testimonial to Karl Richardson.

Karl was born in Ottawa, Illinois, a small town about 125 miles southwest of Chicago. He was the son of an architect; his interest in buildings of all types has been a lifelong one, and he is virtually an authority on historical landmarks in and around the City of Chicago.

Karl attended the University of Michigan from 1927-31 where he obtained his degree in the College of

Arts and Sciences. While at the University of Michigan, he was a member of Kappa Sigman Fraternity, and he also earned his "M" for his exploits on the gridiron.

With the country being immersed in the great depression, the question confronting Karl and many others at that time—"What should I do?"

After graduation from the University of Michigan, Karl and two of his fraternity brothers drove to Florida in a Model "A" Ford and found work in a bean market near the Everglades. Later they sold the Model "A" and bought a boat which they used to sail around the Bahamas. They lived on fish, grits, and other foods that they exchanged for work in the cane fields and on fishing boats.

When conditions improved, he returned to his hometown of Ottawa, Illinois, where he developed a real estate and insurance business.

Following a tour of duty in the Pacific in the Navy during World War II, he moved to Chicago where he became the Program Director of the American Committee on Maternal Welfare (now known as the American College of Obstetricians and Gynecologists). He remained in this position of responsibility until 1950 when he became the Executive Director of the Chicago Dental Society. He served the Chicago Dental Society in this

capacity for 29 years, retiring in 1979—only to continue as a "Senior Consultant for Special Programs," a position he holds to this date. Karl has a unique ability to interact and get along with people. Having served so many different presidents of the Chicago Dental Society and their respective Boards of Directors, and being respected by each and every one of the members is a singular testimonial. During the 50's and 60's and 70's the Chicago Dental Society grew both in scope and stature, so that today this dental society is recognized as one of the most active and effective in the United States. Much of this excellence that the Chicago Dental Society enjoys today in the dental profession can be attributed to the era in which Karl Richardson served so capably.

Dr. Harold Hillenbrand in paying tribute to Karl Richardson stated, "Under his professional direction, the Chicago Dental Society membership has become socially aware and responsive to the needs of the patient, the public and the community."

Mr. Karl Richardson in his capacity as the Executive Director of the Chicago Dental Society has indeed made a most significant contribution to the advancement of the dental profession.

Mr. President, it is a singular honor for me to present Mr. Karl S. Richardson to you for the Award of Merit.

# Fellowships Conferred

Fellowships in the American College of Dentists were conferred upon the following persons at the Annual Convocation in Kansas City on October 24, 1981.

Thorsten Aggeryd, Stockholm, Sweden  
Leo G. Alexander, Duncanville, TX  
Boyd Allen, Jr., Plainfield, NJ  
Richard A. Amstadt, Akron, OH  
Stanley B. Anderson, Jr., Pasadena, CA  
William J. Ashendorf, Jr., Atlanta, GA  
Stephen J. Atsaves, Skokie, IL  
Michael P. Balbo, Monmouth Beach, NJ  
Sheldon R. Baldinger, Washington, DC  
George S. Beagrie, Vancouver, BC  
William C. Bean, Charlotte, NC  
Ralph Bellizzi, U.S. Army  
C. Richard Bennett, Pittsburgh, PA  
Graham Bennett, Greenville, SC  
William E. Bernier, U.S. Army  
Robert L. Bernstein, New York, NY  
Robert F. Birtcil, Jr., Kensington, CA  
Donald W. Bongard, Alexandria, MN  
Eugene L. Bonofiglo, Grand Rapids, MI  
James C. Brandes, Cedar Rapids, IA  
Darwin L. Brendlinger, U.S. Air Force  
A. Allen Brotman, South Orange, NJ  
D. Michael Brown, Landover Hills, MD  
Rudolph H. Bruni, Jr., Richmond, VA  
Robert E. Bryant, Western Springs, IL  
Jesse T. Bullard, Dallas, TX  
Ernest R. Burriss, Jr., Savannah, GA  
Albert E. Caffey, Jr., Shelbyville, TN  
John D. Callahan, Manlius, NY  
Richard H. Carnahan, Jr., San Antonio, TX  
Robert L. Carter, Baytown, TX

Samuel J. Cascio, Chicago, IL  
John S. Casco, Iowa City, IA  
Mario T. Catalano, Catskill, NY  
Richard Chace, Jr., Winter Park, FL  
William R. Chapman, Greenville, SC  
J. Thomas Chess, Los Angeles, CA  
James N. Clark, East Orange, NJ  
Thomas A. Clary, Sr., Auburn, NY  
Stuart H. Coleton, White Plains, NY  
Paul F. Colletti, Port Arthur, TX  
Harvey L. Colman, Minneapolis, MN  
Arthur E. Comolli, Nashua, NH  
Harry H. Cook, III, Topeka, KS  
William R. Cotton, U.S. Navy  
Runo Cronstrom, Ronneby, Sweden  
J. Richard Crouse, Frederick, MD  
Joseph A. Cuminale, New Orleans, LA  
E. James Cundiff, II, Dallas, TX  
William J. Deighan, Jr., Bangor, ME  
Nyle L. Diefenbacher, Kitchener, Ontario  
Thomas R. Dirksen, Augusta, GA  
Theodore A. DiSantis, Cleveland, OH  
David W. Downey, Kalispell, MT  
Francis D. Dunne, Garden City, NY  
Bernt Ekvall, St. Clair Shores, MI  
Thomas E. Emmering, Wheaton, IL  
Donald R. Erickson, Billings, MT  
Harold A. Eskew, Silver Spring, MD  
Michael W. Fallon, Camillus, NY  
Robert T. Ferris, Altamonte Springs, FL  
John F. Field, Mill Valley, CA  
Fred C. Fielder, Nashville, TN  
Carl W. Franklin, Madison, TN



## Fellowships Conferred

- Joseph J. Franzetti, Brooklyn, NY  
Paul S. Freeman, Jersey City, NJ  
Herbert H. Frommer, New York, NY  
Tommy Wilton Gage, Dallas, TX  
Thomas V. Gardner, Jr., Iowa City, IA  
Laurence A. Garfin, Golden Valley, MN  
Ralph S. Gattozzi, Lyndhurst, OH  
Steven M. Goldman, Pleasant Hill, CA  
Joseph F. Goodsell, Glendale, CA  
Edward M. Grosse, Prospect Park, PA  
Frank B. Guthrie, Seattle, WA  
William E. Hall, Pittsburgh, PA  
Nicholas T. Hallick, Corpus Christi, TX  
Wade B. Hammer, Augusta, GA  
Stanley L. Handelman, Rochester, NY  
Lawrence S. Harte, Sparta, NJ  
Edgar C. Hatcher, Jr., Bristol, TN  
Bert Y. Hayashi, Honolulu, HI  
Terrence W. Hayes, Santa Rosa, CA  
Arnold J. Hill, Jr., Rochester, MN  
Lloyd G. Hill, Casper, WY  
Robert Himmelfarb, Hempstead, NY  
Edward H. Hirsch, U.S. Army  
Edward H. Hodges, Jr., Fort Worth, TX  
James L. Jensen, Flossmoor, IL  
Vernon L. Jensen, Lufkin, TX  
Myron J. Kastle, Indianapolis, IN  
Willis V. Kittleman, Boulder, CO  
Stuart N. Kline, Miami, FL  
Robert S. Knight, Takoma Park, MD  
Dean D. Koffler, Lewistown, MT  
Michael H. Kontos, Montgomery, IL  
Benjamin S. Koplik, New York, NY  
William H. Kopperud, Naperville, IL  
Sigurds Otto Krolls, Madison, MS  
Donald A. Krzyzak, Chicago, IL  
Frederic R. Kunken, Rockville Centre, NY  
L. Leo Lancaster, Jr., Meridian, MS  
John O. Lane, Jr., Ridgefield, CT  
Eugene P. LaSota, New York, NY  
William E. LaVelle, Iowa City, IA  
William P. Lavori, Staten Island, NY  
William I. Lawrance, Indianapolis, IN  
Robert M. Liebers, Schenectady, NY  
Walter S. Linville, Wilson, NC  
Henry B. Lorentz, Great Falls, MT  
Lawrence R. Ludwigsen, Jr., San Francisco, CA  
Jerome A. Mahalick, Milwaukee, WI  
John A. Maloney, Tyler, TX  
Stanley Markovits, White Plains, NY  
Clifford Marks, Miami, FL  
Richard J. Mathewson, Oklahoma City, OK  
Lawrence L. Mautone, Kingston, NY  
Timothy A. Mayer, Pharr, TX  
Donald S. McLeod, Pensacola, FL  
Malcolm E. Meistrell, Jr., Port Washington, NY  
Randolph D. Minatra, Houston, TX  
Joseph C. Morganelli, Chicago, IL  
Robert L. Moseley, Detroit, MI  
Robert P. Murphy, Severna Park, MD  
Lawrence E. Nash, New Lexington, OH  
John F. Nelson, Iowa City, IA  
Myron Nevins, Swampscott, MA  
Albert L. Ousborne, Jr., Baltimore, MD

## Fellowships Conferred

Hugh E. Parminter, Whittier, CA  
 Martin J. Peskin, Richmond, VA  
 George P. Petznick, Birmingham, AL  
 Jerome M. Piekos, Chicago, IL  
 Joseph F. Pinto, Garden City, MI  
 James L. Pittman, Benton Harbor, MI  
 William J. Polson, Tucson, AZ  
 Neil G. Powell, Orlando, FL  
 Jack D. Preston, Los Angeles, CA  
 Thomas C. Pyron, Memphis, TN  
 Edward H. Radcliffe, Richmond, VA  
 Sidney Rafal, Hartford, CT  
 Bernard L. Rainey, Memphis, TN  
 R. Chester Redhead, New York, NY  
 John J. Reuthe, South Bend, IN  
 Marjorie Snyder Reuthe, South Bend, IN  
 Paul B. Risk, Muncie, IN  
 James R. Roche, Indianapolis, IN  
 Richard S. Rogers, Eugene, OR  
 Louis F. Rose, Philadelphia, PA  
 Robert Z. Rosenthal, Flushing, NY  
 Louis I. Rubins, New York, NY  
 Robert L. Sachs, San Francisco, CA  
 Steven J. Salman, New York, NY  
 Richard W. Samuel, Circleville, OH  
 Anthony J. Schweiger, Madeira Beach, FL  
 Charles R. Sellnau, Fairview Park, OH  
 C. David Shaffer, Akron, OH  
 Clayton L. Shalla, Iowa City, IA  
 Marcus Shimoff, San Bruno, CA  
 Fred W. Sims, Sr., Tulsa, OK  
 William J. H. Sisson, Oak Park, IL  
 William H. Slavin, Chicago Heights, IL

Gilbert S. Small, Ann Arbor, MI  
 Robert W. Smith, Framingham, MA  
 Laszlo Sokoly, Washington, DC  
 Donald B. Stackhouse, North Reading, MA  
 Kenneth W. Stout, Jr., Philadelphia, PA  
 Lloyd H. Straffon, Birmingham, MI  
 LeRoy I. Strohman, Algona, IA  
 John E. Sullivan, Knoxville, TN  
 Hito Suyehiro, Hillcrest Heights, MD  
 Robert J. Swart, Rochester, NY  
 Thomas R. Tempel, U.S. Army  
 Glenn A. Thomas, Wichita, KS  
 James A. Thomas, Ada, OK  
 Stanley E. Turet, Pleasantville, NY  
 Robert S. Verbin, Pittsburgh, PA  
 Eugene P. Wagner, Monterey Park, CA  
 Lawrence J. Warner, Encino, CA  
 James E. Warren, Nashville, TN  
 William F. Wathen, Fort Worth, TX  
 Leonard P. Weiss, Cleveland, OH  
 Carey T. Wells, Jr., Canton, NC  
 Earl L. Williams, Jacksonville, FL  
 William E. Willoughby, Cheyenne, WY  
 Edmund G. Wilson, Somerset, PA  
 Ray D. Wiseman, Tacoma, WA  
 Ben D. Wood, Sulphur Springs, TX  
 Milton T. Wood, Tampa, FL

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Posthumously—  
 Wallace J. Haddon, Passaic, NJ

# California Establishes The Dentists Insurance Company

LORENZ F. de JULIEN, JR.\*

## SELF-INSURANCE FOR PROFESSIONAL LIABILITY ... IS IT A VIABLE ALTERNATIVE?

Prior to 1973, virtually all of the professional liability insurance in the United States was written by commercial casualty insurance companies. The rates did not seem out of line for the comfort given to the practicing physicians and dentists. Very few dental claims of a large nature (over \$100,000) had ever been filed, and most of us felt comfortable with a \$100,000/\$300,000 type of occurrence policy. There was a ready market and healthy competition among the various companies.

The professional liability crisis of 1974, 1975 and 1976 had a profound and lasting effect upon this history of stability and comfort. Rates skyrocketed, large suits become more commonplace, and worst of all, the available market for malpractice insurance dried up in many states as companies opted to cut their exposure by discontinuing the coverage. In some states, such as California, it was a virtual impossibility for a physician to purchase commercial professional liability insurance. The dentists fared a little better as the Chubb/P.I. com-

pany continued in business, but at greatly increased rates.

The physicians answered the challenge by forming their own companies (35 in number), capitalized through participant financing. To date, these companies have been generally successful, some more than others due to better management.

In 1976 the California Dental Association requested its Council on Insurance to research the feasibility of self-insurance. This was done and a suitable reciprocal framework devised. But, due to the relatively large individual assessments needed for capitalization and the availability of a viable commercial alternative, the project was temporarily shelved.

By March of 1979, uneasiness had mounted over the availability of commercial professional liability insurance and the inflated rates being charged. Consequently, the CDA Board of Trustees commissioned the Council on Insurance to form a CDA-owned professional liability company by July 1, 1980.

Professional managers were com-

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\*Lorenz F. de Julien, Jr., D.D.S. Vice President of the Dentists Insurance Company

petitively interviewed and the Council on Insurance selected the firm of Johnson & Higgins of California to form and manage the new company.

The 1976 self-insurance project was reviewed and still found to be non-competitive because of the large individual assessments it required.

Creative discussions were held with the Insurance Commissioner, and with his approval, The Dentists Insurance Company (TDIC) was formed as a stock company using borrowed funds for all but the statutory minimum of capitalization (\$575,000). This initial \$575,000 was supplied by CDA, after the members responded to a mail survey indicating that nearly 90% favored the project.

First-year participation resulted in over 9,400 dentist policyholders. This represented 80% of the total CDA membership. A gradual increase of 500 participants per year is expected until a stable level of about 12,000 is reached in 1985. Coverage ranges from \$100,000/\$300,000 to \$5 million/\$5 million in four rating classifications, based on anesthesia.

The policy written is of the occurrence type. It is a participating policy under which all premium not needed for losses, expenses and growth of statutory surplus can be returned to the participants.

TDIC is a stock company and a wholly owned subsidiary of the California Dental Association. It is governed by a board of directors consisting of ten practicing dentists elected annually by CDA, who oversee the day-to-day administration by Johnson & Higgins.

Based upon our short-term results, it seems that self-insurance through a constituent state dental association is a viable alternative to commercial insurance. It has the same fiscal good sense as home ownership versus renting. There are the headaches of ownership, but they seem worth the effort to overcome.

Major advantages are:

- Ownership of data (with easy retrieval).
- Dentist-controlled policy.
- Easier communication with participants.
- Guaranteed availability of insurance.
- Lowest actuarially sound premiums.
- Ability to use data to design and run preventive programs that get to the heart of the problems.
- Ability to find negative trends and quickly react to them by newsletter and personal counseling of participants.

Major disadvantages are:

- Need to have a dedicated board of directors willing to contribute the necessary time.
- Need to train replacement board members.
- Need to direct and monitor the performance of managers.
- Once formed, the company is going to be in business a long time and there is no longer the choice of "giving it a try." This finality of being "locked in" is a consideration that should not be taken lightly.



- The sponsoring constituent society may find it necessary to place itself "at risk" for any losses beyond those projected by the actuaries.

We feel that the gain has been worth the investment of time and capital. Our members are strongly supportive, and formation of the company is considered to be a major accomplishment of the California Dental Association.

Our experience and data gained will be shared with the rest of the dental family in the United States. Other entities studying such a concept who wish information should direct their correspondence to the California Dental Association or The Dentists Insurance Company, in care of Johnson & Higgins of California, 601 California Street, San Francisco, California 94108.

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*Dr. Nelson—*

*Continued from Page 214*

So when Dr. Draffin asked if I would serve as Chairman of a Committee to select an award for Dr. Nelsen, I said, "I would be pleased to do so."

The first question—What shall the memento be? We found out that Dr. Nelsen was enamored with the writings of Dr. Robert Jastrow, the author of several books, including *Red Giants and White Dwarfs*, *Until the Sun Dies* and *God and the Astronomers*. Why not get these books; why not ask Dr. Jastrow to autograph them to Dr. Nelsen? Dr. Jastrow not only kindly consented to do this but also presented an autographed copy of his college

textbook on astronomy. A bookbinder by avocation, Mr. Irving Paxton, and a neighbor of mine, made these boxes to contain and protect the autographed volumes. The unique covering of these boxes is a paper made by the world renowned bookbinder, Mr. Cockerell of Cambridge, England.

Dr. Robert J. Nelsen, if you will step forward, I will present these autographed volumes to you in recognition of and with appreciation for your twelve years of service to the American College of Dentists, and, as you browse through these pages, you will see reflected there the countenances and good wishes of your fellow Fellows.

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*Dr. Boelsche—*

*Continued from Page 218*

ciety in general will go on forever. Ours is a better profession and a better world because this wonderful, soft-spoken, kindly, generous man came our way. His deep faith in the Al-

mighty, in his profession and in his fellow-man has enriched us all.

Mr. President, I am greatly honored to present to you, Dr. Ralph A. Boelsche for the William John Gies Award.

# Advertising in Dentistry

**J. MARVIN BENTLEY\***

**PETER R. BARNETT\*\***

Today there are more dentists and a population of dental utilizers that has not grown significantly in the past few years. It has been said that dentists do not compete with other dentists for patient dollars; instead cars, vacations and clothes vie for the same dollars. This competition for discretionary spending requires the dentist to market his services. Advertising, one part of an overall marketing effort, has received the largest share of recent publicity because until the mid 1970's advertising was illegal, according to many state dental practice acts, and unethical, according to the American Dental Association.

The ADA has taken the position that advertising bans are necessary to ensure professional competence and to protect the public from fraud, a position which was upheld in the 1935 Supreme Court decision, *Semler v. Oregon Board of Dental Examiners*. Three Supreme Court decisions in recent years have contributed to the current levels of interest in advertising. In the 1975 *Goldfarb v. Virginia State Bar* case, the court ruled that 'learned' professions, including dentistry, are

subject to antitrust law. Subsequently a 1976 ruling, *Virginia State Board of Pharmacy v. Virginia Citizens Consumer Council*, allowed pharmacists to advertise prescription drug prices. Finally, in 1977, in the case of *Bates and O'Steen v. State Bar of Arizona*, the Supreme Court ruled that the legal profession's restrictions on advertising by its members were in restraint of trade. Based upon these three rulings in 1979 the Federal Trade Commission and the American Dental Association entered a consent decree to allow advertising by dentists.

Studies by Darling and Bussom and by Swerdlow and Staples examined dentists' attitudes towards advertising.<sup>1,2,3</sup> Based upon data collected in their survey, they concluded that only a few dentists would advertise. Furthermore, the dentists surveyed expected that advertising would have no effect on demand, price competition or quality of dental services. Moreover, in the Darling and Bussom study, the dentists and physicians were more negative about the effects of advertising on these issues than lawyers and accountants. Meskin examined two issues

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that appeared to indicate conflicting attitudes between dentists and consumers in regards to the potential effects of advertising.<sup>4</sup> Sixty-six percent of consumers thought advertising would lower fees; only 25% of dentists thought so. Secondly, 80% of the consumers felt that they would not go to the dentist advertising the lowest fee, but only 31% of the dentists agreed. Clearly, there are differences of opinion between dentists and consumers. In addition, Meskin surveyed consumers and profiled a population group which was most positive toward dental advertising. These factors include: being male; having a larger family size; an annual income lower than \$15,000 and a strong belief that dental fees are too high.

Three studies in law and optometry are of related interest. Smith and Meyer found that when selecting a lawyer, personal information sources—primarily personal recommendations—dominate the process.<sup>5</sup> A 1979 study by McChesney and Muris for the American Bar Foundation examined the effect of legal advertising on the quality of services which were provided at a lower price.<sup>6</sup> Their findings showed that the more standardized legal ser-

vices provided by a legal clinic at lower fees were of higher quality than services provided by traditional firms. They concluded that although all firms that advertise may not provide better quality services than non-advertisers, when advertising results in lower prices, it need not result in a lower quality service. Finally, Feldman and Begun examined the effects of advertising bans on optometry and found that prices are 16% higher in states with advertising bans when the quality of care is kept constant.<sup>7</sup>

Little research has been done in dentistry examining these issues. If we are to forecast future needs and demands for dental services, the effects of advertising must be studied. Finding answers to these questions about the effect of advertising on fees, quality, services and access is important to long range planning by the dental profession. Furthermore, these answers are important to the individual dentist considering the role of advertising in his practice. This paper will raise the issues the authors believe to be pertinent to dental advertising and highlight them through a discussion of future research.

## Types of Advertising

For the purposes of this paper a dental advertisement is any message that is broadcast or published and designed to increase the demand for services provided by a particular dentist or group of dentists. In this regard,

advertising is only one method which a dentist might use to market services. Promotional messages that are directed toward patients active in the practice are not considered advertisements. Even an announcement in a neighborhood

paper is directed toward a limited population and is not considered an advertisement. These methods of promotion which stress personal contact and/or recommendation are consistent with the traditional norms of promoting a dentist.

In contrast, in this paper the focus is on advertisements that are broadcast or published and are designed to reach mass audiences. These advertisements are clearly designed to circumvent the personal contact and/or recommendation method of attracting patients. Moreover, a successful advertisement need affect only a small portion of the potential dental patients in an area.

Generally advertisements which are directed at mass audiences emphasize the price and convenience of services rather than the more traditional 'quality of service' which the dental profession has promoted.

In order for a dental practice to benefit from advertising, it must be prepared to handle a larger volume of patients. This is due to the cost of advertising as compared to the additional patient revenues expected. If the cost of an advertising campaign were spread over a limited number of patient visits, the unit cost would be impossible to pass on to patients.

### **Purpose of a Business**

The purpose of any privately owned business enterprise is to provide those people who work in the business, or invest their wealth, a fair return for their contribution. Dentists, like lawyers and physicians are considered members of a profession recognizing their unique contribution to the public good. Because clients of a professional place their trust in the competence and integrity of professionals, codes of ethics have evolved which govern the professional behavior in carrying out responsibilities to their clients. However, most dentists own their private practices which must pay a fair return to the people who contribute to the practice.

During a stable period in which there is no change in the forces that

affect the delivery of dental care, a professional would not expect any conflict between the profession's behavior standards and his role as a business expecting a fair return. However, in a period of change, a professional may find it increasingly difficult to abide by professional ethics and obtain a fair return. In such cases, restrictions placed on the methods used to deliver and market dental services make it very difficult for a dentist who wishes to invest time and wealth in the practice of dentistry to make a fair return on investment. For example, a marketing technique such as advertising could enable an individual to obtain a return on investment but advertising is prohibited by the profession. Organizing a practice



which uses dental assistants to perform intraoral procedures is another opportunity which is prohibited in many areas. Faced with similar situations the professionals who are established and practicing within the current code of ethics can be expected

to support the status quo. In contrast, the less established professionals, who are not earning a fair return for their time, are in a different position. Support of the profession's code of ethics could seriously limit their opportunity to earn a fair return.

### Nature of Dentistry as a Business

Many professionals find it difficult to reconcile the business and clinical aspects of their role. In our judgment, the dentist's clinical role revolves around the following four functions:

1. examine and diagnose.
2. provide information about the patient's current health status.
3. formulate and discuss alternative plans of action and their attendant risks and benefits.
4. treat disease.

Since all of these functions are unique to individual patients, this clinical role is critical to society today. This is the role for which most professional education currently exists.

Dentists differ from most physicians in the performance of these four functions. The technical aspects of the profession are pervasive. However, like physicians, dentists produce information for patients. If research demonstrates that advertising damages the public's perception of the dentist as a producer of information as well as a technician, it may not be to the dentist's advantage to advertise. For example, if advertising leads dentists to reduce the amount and quality of informational services rendered to pa-

tients, advertising can be considered harmful to the professional or public interest. Research is needed to explore this question and the extent to which the answer is dependent upon the quality and type of advertisement.

The functions described above constitute professional dental services which can be divided into three general areas: **diagnostic**—identifying the existence of caries, periodontal disease or malocclusion; **restorative**—restoring or changing the structure of the teeth, gums, or bone; and **preventive-prescribing therapy** that when performed by the patient will prevent disease.

The important question, because it relates to whether it is appropriate to advertise the service, is the extent to which these services can be standardized for a large percentage of the population. For example, if during the diagnostic phase, a patient is examined using a standard technique, standardized forms and procedures, then the patient is contracting for a standard service. There will be certain points in the standardized examination that will lead the examiner to a different track, but the initial examination is common to most patients. In fact, the

initial exam may be so routine and the process non-life threatening that the tasks can be delegated to an assistant with less training and experience in dentistry. The same level of standardization is possible for preventive services. Patients often receive routine instruction in oral hygiene and a six month recall with no apparent regard for their individual circumstances.

By standardizing procedures and delegating tasks to assistants who earn less and have less training and experience in dentistry, it is possible to provide these services to the public at a lower fee. However, for the dental professional to apply the principle of

standardized procedures in a cost-effective manner, it is necessary to treat a minimum number of patients. Advertising is one way of producing the volume of patients required to make standardization profitable.

However, it is clear that all dental services cannot be standardized. As McChesney and Muris reported, high volume legal centers provided routine services at lower cost; but they were not as competitive in offering more complex legal services.<sup>6</sup> It is important to examine dentistry in the same way for it is possible that the same division of services may apply to dentistry.

## Professional Ethics and Advertising

Trust is an ethical matter. Historically, dentists have placed a high priority upon acquiring and maintaining their patients' trust. There exists an implied trust when a patient chooses a dentist through personal contact and/or recommendation. If advertising can be shown to change this trust relationship, it would have a negative effect on public confidence.

Those who are concerned with the effects of advertising on professional ethics raise the issue of evaluation. Do the patients who respond to an advertisement have adequate information and criteria to evaluate the services rendered? Using textbook criteria for evaluation purposes, clearly the pa-

tient cannot evaluate the services. But if a lack of pain, a functioning mouth, and a caring office are the adequate criteria, the potential consumer may be able to evaluate dental services along with car maintenance, home repair, and other consumer services.

In our judgment, the ethical issues related to advertising dental services should be limited to its effect on evaluation of services and trust between patient and dentist. It should not focus on issues of style, such as the attitude of a practitioner or the way a practice is organized. Advertising is simply a method some practitioners may use to promote their services.

## Types of Questions That Need to be Answered

The reason it is important to study advertising is because of its possible effects on the price and quality of dental services. In addressing these issues there are three which require research: (1) What percentage of the dentist population is likely to advertise their services? (2) What impact is advertising likely to have upon the percent of the population that does not regularly use dental services? (3) Will dentists who advertise their services in general provide a higher or lower quality of dental care than dentists who elect not to advertise?

For most dentists the decision to advertise will be based on financial factors. In some cases a dentist might advertise in order to increase current income; while in other instances the goal may be to earn a minimum level of income. For example, an established dentist who elects to advertise might expand his current practice or open a new office to capture the benefit of advertising. In contrast, a recent graduate might join a retail dental practice which markets dental services by aggressive advertising. Some practices are better organized than others to capture the benefits of advertising. An important determinant of the percentage of dentists who choose to advertise is the ease with which new types of dental organizations can be created.

This leads to the second question

which relates to potential consumers. In our search of the literature there were no studies that reported a positive impact of advertising on dental utilization. Some preliminary data reported for retail practices which advertise indicates that a large portion of their patients are people who previously obtained regular dental care. What needs further study is the extent to which advertising and its associated new types of practice organizations will have an impact on the attitudes and beliefs of the population who are now episodic or non-users of dental services.

The final issue is the quality of dental services. The measurement of dental quality is a complex issue commonly evaluated by structure, process and outcome criteria. Where advertising is used to market dental services, it may result in a change in the structure and process of delivering dental care. Because of its effect upon organization and style of practice, alternate methods of evaluating quality may be required. Otherwise, the use of traditional structure and process criteria may bias the results of those practices which advertise. In other words, it is important to distinguish between the variety of styles and types of organization which deliver dental care and the quality of care that results.

## Probable Impact of Advertising

Economists have considered that firms generally advertise for two reasons: first to gain consumer acceptance for a new product or service; secondly, to increase the market share for an established product or service. Advertising dental services can be considered in a similar manner. Dentists establishing a new practice must develop a patient pool which is sufficiently large to provide them with an appropriate income and cover their expenses. In these cases dentists might advertise as a way of reducing the time required to develop the appropriate patient pool.

This paper has examined issues resulting from the advent of advertising dental services. Answers to the following questions are considered very important to the determination of advertising's impact upon the demand for dental services and the manner in which these services are supplied.

- Which segment of the population is most likely to be targeted for advertisement?
- What providers are most likely to use advertising as a means of promoting their practices?
- Will the widespread use of advertising lead to a change in the composition of teams that provide dental services?
- What effect will advertising have on the price and quality of dental services?

The impact of these issues upon the dental profession are sure to be examined in the years ahead. If dentists advertise, a larger percentage of the population might seek dental services. Dental associations that advertise are not aiming that advertising at a particular locale. Instead, it is their intent to raise the public's dental consciousness, thereby benefiting all dentists who offer those services. Still to be explored through research is the degree to which the half of the population not currently seeking services annually will be influenced by advertising. It may be that broad advertising by associations may not influence these nonutilizers, but that specific advertising by area dentists may. If that occurs, area dentists who are not advertising may benefit from increased demand created by those who do advertise.

A consideration of competitive economic theory suggests that advertising may lead to or improve the quality and ease of access to dental services. Firms in any industry become more competitive, their services typically are more responsive to consumer demands. For dentistry it will be necessary to examine the changes which occur in the variety of services rendered. Critics fear that advertising will encourage patient treatment based on profit or loss rather than on the quality of care. As a profession, we have the responsibility to determine advertising's effect on these issues in order to better evaluate



the effect on the public's trust and confidence.

Finally, the impact of dental advertising on society will depend in large part upon its ability to change the behavior of the nonuser. Dentists more readily accept that the competition for patients is not among dentists but

among the variety of uses for discretionary dollars. To the extent that advertising only reaches and has an impact on those patients currently utilizing dental services, to that extent will dental advertising primarily have a negligible effect on dentistry and society.

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# DECEASED FELLOWS

OCTOBER, 1980-OCTOBER, 1981

Abernathy, Charles L., West Memphis,  
AR

Adams, Arthur S., Durham, NH

Adams, Kinley K., Salem, OR

Allen, D. Blanton, Berryville, VA

Amundson, Benjamin, Duluth, MN

Anderson, Jimmie Lee, Harrisonville,  
MO

Applegate, Robert E., Delray Beach,  
FL

Atkins, William B., Millsboro, DE

Atwood, Theodore W., Durham, NC

Barnes, William P., Scottsdale, AZ

Berger, Morris, Elmhurst, NY

Berkey, Hugh T., Fort Wayne, IN

Bliss, Cecil H., Sioux City, IA

Bloomfield, Allan J., Glenunga,  
Australia

Blumenthal, Saul M., Baltimore, MD

Bourassa, D. Fortune, Santa Ana, CA

Boyle, Paul E., S. Waterford, ME

Brann, Bernard A., Leesburg, VA

Brown, Edward C., Atlanta, GA

Brown, Morris E., Fairmont, WV

Buchmann, Walter A., Boynton Beach,  
FL

Buonocore, Michael, Penfield, NY

Cartier, W. Claire, Grand Rapids, MI

Chanaud, Norman P., Centerville, MD

Chowning, Frank E., Indianapolis, IN

Coblin, Louis S., Louisville, KY

Colvin, E. Milburn, Catlett, VA

Connelly, Cecil C., St. Louis, MO

Coppola, Francis R., Millburn, NJ

Cosimi, Euripides, Rio Piedras, Puerto  
Rico

Crowson, A. Harris, Ottawa, Ontario  
Canada

Crum, Walter A., Richmond, IN

Cummins, Raymond L., New Port  
Richey, FL

Cunningham, Donald, Monrovia, IN

Curtis, William D., Bethesda, MD

Daniels, Wells A., Narragansett, RI

Dorsey, Frank N., San Marcos, CA

Dunn, A. Laurence, Santa Barbara, CA

Dyen, David L., Pompano Beach, FL

Ebert, Elmer M., Chicago, IL

Fenton, Harold R., Albert Lea, MN

Fisher, Roland D., San Diego, CA

Fogel, Leo J., Santa Monica, CA

Fitzgerald, Gordon M., San Francisco,  
CA

## Deceased Fellows

Fitzgibbon, David J., Washington, DC  
Folley, John F., Jr., New Hartford, NY  
Francis, Sidney R., San Francisco, CA  
Frew, Athol L., Jr., Oklahoma City, OK  
Frisbie, Harry E., Daly City, CA  
Geoffrion, Paul, Montreal, Canada  
Godfrey, Richard., Toronto, Ontario  
Canada  
Goldberg, Hyman J. V., Rochester,  
NY  
Griffith, Charles A., Minneapolis, MN  
Harrigan, William F., Rockville Centre,  
NY  
Hooker, Southern P., Nashville, TN  
Hoppe, Herbert J., Cleveland, OH  
Hornbaker, Robert W., Westboro, MA  
Hudson, Donald C., San Antonio, TX  
Humphrey, William R., Denver, CO  
Hundley, Robert A., Belleville, IL  
Hurley, Willard, Portland, OR  
Inman, Conrad L., Sr., Baltimore, MD  
Jernall, Roy M., Minneapolis, MN  
Jerrold, Theodore L., Hempstead, NY  
Jones, Harrell, Kerrville, TX  
Jordan, Frank W., Louisville, KY

Kemmet, Wilfred J., Milwaukee, WI  
Kibler, Olan B., Leesburg, FL  
Koepf, Sheldon W., Buffalo, NY  
Lathrop, Laurence L., Emporium, PA  
Lawther, William L., Lakewood, OH  
Levine, Harold J., Coconut Creek, FL  
Libassi, Joseph P., Brooklyn, NY  
Likins, Robert C., Flossmoor, IL  
Longeway, Kenneth L., San Diego, CA  
Ludwigsen, Lawrence R., San  
Francisco, CA  
Lynch, Burton, Tucson AZ  
MacQueen, Wesley, Longville, MN  
McGrath, Joseph E., Newburgh, NY  
McPike, J. Donald, Muscatine, IA  
Messore, Michael B., Cranston, RI  
Michaels, Manly, Washington, DC  
Morrison, Arthur H., New York, NY  
Mosbaugh, Richard, Fayetteville, OH  
North, Eugene J., Buffalo, NY  
Nutting, Edwin B., LaMesa, CA  
Parker, John H., Alameda, CA  
Parry, Lloyd G., Atlanta, GA

## Deceased Fellows

- Pilling, Lloyd O., Milwaukee, WI  
 Porritt, Homer B., Pittsburgh, PA  
 Porter, Lowrie J., Port Charlotte, FL  
 Pratt, Frederick W., Woodley, CT  
 Pridgen, Billy F., Antioch, CA  
 Purcell, James L., Fairless Hills, PA  
 Quick, Herbert, Brooklyn, NY  
 Rafish, Samuel M., Butte, MT  
 Ragsdale, Allan K., San Antonio, TX  
 Root, Robert W., East Lansing, MI  
 Rule, John S., Hampton, IA  
 Sanders, Cleon W., Benson, NC  
 Sauser, Clare W., Phoenixville, PA  
 Schmidt, W. George, Palm Spring, CA  
 Schunick, William, Baltimore, MD  
 Scott, Harry G., Coatesville, PA  
 Secrest, Brodie G., Sr., Cambridge, OH  
 Shames, Samuel I., Wilmington, DE  
 Sharp, J. Guilford, Knoxville, TN  
 Sharp, Thomas B., Atlanta, GA  
 Sheppard, Irving M., Riverdale, NY  
 Smith, Paul R., Lewiston, ME  
 Snider, Raymond D., Houston, TX  
 Stern, Leo, Sr., New York, NY  
 Stoker, Ralph E., Laguna Hills, CA  
 Strang, Douglas M., Los Angeles, CA  
 Straub, Walter J., Verdi, NV  
 Sundbye, John C., Laguna Hills, CA  
 Svoboda, John F., Covina, CA  
 Syrop, Harold M., Richmond, VA  
 Tanchester, David, Bronx, NY  
 Thompson, Cornelia M., St. Louis, MO  
 Totten, Arthur C., Barnegat, NJ  
 Trier, Jerome H., N. Miami Beach, FL  
 Tuck, Robert F., Longwood, FL  
 Turner, Kenneth O., Palos Verdes Est.,  
 CA  
 Ungar, Alexander L., N. Miami Beach,  
 FL  
 Vandervoort, C. Robert, Aberdeen, NC  
 Wells, Jack E., Memphis, TN  
 Weshalek, Stephen, Allen Park, MI  
 Wessels, Kenneth E., Memphis, TN  
 West, John B., Elmira, NY  
 Westerman, Harold V., Miami, FL  
 White, John G., Bakersfield, CA  
 Whiteneck, Otho R., Enid, OK  
 Williams, Frank A., Pasadena, CA  
 Wilson, David J., Athens, GA



# Decision-Making in Dental Practice

## Practical Methods to Enhance Decision-Making

**ROGER SIMPSON\***

**DANIEL HALL\*\***

**LARRY CRABB\*\*\***

Effective decision-making techniques are useful to the dentist. A review of the literature reveals that while much attention is called to the importance of right decisions in managing the dental office, there is a lack

of attention to specific techniques with which to accomplish the decision-making. This article presents a "facilitative model" of decision-making with illustrations for application to the dental office.

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### DEFINITIONS

"Decision-making" is a structured approach to guide a person or group to workable solutions of a problem, to make plans, and to evaluate data. Decision-making is the organizational and mental framework within which problems are solved. Decision-making encompasses "problem solving", but extends to other areas such as planning and choosing priorities.

A "model" represents, in miniature, the way the particular system works. The "facilitative" nature of the model identifies its purpose as enabling decisions to be made. The success of the model, then, is in its capacity to be a means to the end of thinking through an issue to a satisfactory conclusion.

### Current Models for Decision-Making

Generally, two major decision-making models have developed out of psychology and education. One is known as the "normative" model, represented by Luce<sup>1</sup>, consists of establishing norms that are scientifically valid. This has resulted in formulas applicable to a wide variety of problem solving situations with results expressed mathematically. Chambers<sup>2</sup> presents a simplified version of such a mathematical model, and offers it for consideration by

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dentists. The use of computers in decision-making is based on such a model<sup>3,4</sup>. The second, a “*descriptive*” model, is represented by Simpson<sup>5</sup> and analyzes how individuals really make decisions. He notes that decisions are based on environmental information, much of which is ambiguous. He concludes that “decisions are made in the face of uncertainty.” This is the pure research approach that is founded on analysis of human behavior<sup>6</sup>.

### **The Facilitative Model: Another Approach**

A third model is proposed here and is called a “facilitative” model because it stresses the operational aspects of the decision process. The “facilitative” model is outcome oriented. It uses a wide variety of approaches to enable the individual or group, working with a specific issue, to arrive at acceptable plans for action. The focus is on what works well individually and interpersonally. This approach assumes that people act together to get things done in a way that benefits the greatest number. Hence, the name expresses its mission as being ‘to facilitate’: ‘to bring about’, ‘to cause to happen’.

### **Criteria for Developing the Facilitative Model**

The following specific criteria are used in the development of the facilitative model and are applicable to the dentists’ day-to-day situations.

1. *Easily learned.* The model can be taught by reading a brief one page description, or by hearing a short five to ten minute presentation, and then used immediately.
2. *Understandable.* The details of the model are explained in common, every-day language. There is no need for special vocabularies nor mathematical tables beyond those found in daily exchanges.
3. *Manageable.* There is no need for special equipment—including machines and experts—to make the model work. It is economical, virtually cost-free, and usable with a staff that has a wide range of intellectual ability.
4. *Adaptable.* The model can be applied to a wide variety of problems. It is easily modifiable to fit changing situations.
5. *Appealing.* It is an enjoyable experience and is not intimidating by appearing to be mysterious, faddish, or elitist.
6. *Rational.* It recommends itself as being reasonable.

## The Need: A Review of the Literature

It is a given fact that decisions are being made by every dentist in the day-to-day routines of office life. However, few decisions-making "tools" or techniques are identified to provide guidance in how to make those decisions. For example, practice location has been studied by Grantham and Malone<sup>7</sup> and evaluated in respect to decision-making. Their frank and helpful insight is that the dentists they studied did not use "a rational decision-making model in choosing a practice location." This illustrates the need for workable decision-making models that are broadly applicable to the key issues that a dentist confronts.

Ayers<sup>8</sup> suggests that control of the appointment book contributes significantly to solving the problem of "patient load". Here the solution is presented, but no reference is made to the decision-model upon which it was based. This is typical of problem solving discussions which omit references to decision-making models.

In respect to dental education itself, numerous studies have focused on the key issue of decision-making of students relative to choice of occupation<sup>9,10</sup> type of practice, and life goals<sup>11</sup>; yet reference is characteristically missing on the fundamental issue of how to go about making such major decisions.

The American Association of Dental Schools (AADS), in its Practice Management Curriculum Guidelines,

makes reference to "Decision-making", as one of the five major areas "to provide students with an understanding of the principles of decision-making and develop the ability to apply those principles to the management of a practice."<sup>12</sup> The obvious intent of the teachers of Practice Management is that decision-making be a major focus of their efforts. The way this is to be done is not described. A review of the contents of the AADS's "Learning Resource Survey"<sup>13</sup> identified only two specific resources for use in teaching problem solving: one is a film and the other is a "game."

A "Medline" search of the literature from 1975 through May 1981 disclosed no articles referring directly to the process of decision-making. In addition, a survey of the continuing education program titles, listed in the Journal of American Dental Association from December 1977 to January 1981, failed to discover any that dealt with teaching methods of decision-making.

The following Facilitative Model offers specific ways to go about making decisions which produce results and identify options for action. The mystique of decision-making can be dissolved in this way, and the experience becomes, hopefully, more creative and enjoyable. This, in turn, can lead to an increased sense of confidence which would benefit management.

## The Facilitative Model: Description and Applications

The following are decision-making strategies that fit the "facilitative" model criteria. These examples are presented alphabetically to indicate that there is no preference of any one over another.

1. **Alternative Search.** This is a common and popular method of making decisions which is sometimes masked by special titles such as "vignettes"<sup>14</sup> and "reality testing." It proceeds by selecting sample situations and then asking "What would happen if I did this . . . or that . . . ?" For dentists, it is found applicable in situations such as: the selections of office hours, choosing a type of equipment, considering the employment of another auxiliary, or deciding on a payment policy. For example, if there is a cash-flow problem, the alternative search strategy could propose various options ('ask for payment at each visit', 'telephone calls to negotiate pay-up arrangements', 'discounts for on-time, cash payments') and analyze the probable consequences of each.
2. **Continuum.** The extreme positions of an issue are listed, followed by a listing of options between the extremes. This rec-

ognizes that few decisions are clearly one thing or another. The continuum therefore taps the rational dimensions of people, and has high surface validity because it is the way most of us experience life day-to-day. It is most readily usable with matters of considerable complexity and of longer duration. The continuum is a natural model to use with a group or committee facing major decisions which necessitate discussion over a long period of time. For example, if a Dental Health Committee is considering whether to buy a mobile unit to service nursing homes, the issue could be presented in this way:

THE ISSUE: "DO WE BUY A MOBILE UNIT TO SERVICE NURSING HOMES?"

THE CONTINUUM:  
YES, "BUY" .....  
.....NO, "DON'T BUY"

Then, between the extremes could be listed all of the other options: lease, rent, borrow, modify a car or van, support one member to do it, etc. Once these options are listed and modified by discussion, persons can more clearly identify with their preferred solution.



3. **Contracting.** Contracting<sup>15</sup> requires a precise proposal for action, to be followed by detailing such minute and necessary facts as:

Personnel—"Who has responsibility and authority to act?"

Time—"When will the action begin and end?"

Space—"Where will it happen?"

Tools—"What equipment, space, facilities, monies are needed?"

Contracting is a mock-plan of action, which facilitates decision-making by rehearsing all factors involved in a projected action. Thus the degree of reality and appeal of the action itself is determined. This exercise rehearses the future, and should it become the chosen plan of action, a considerable amount of work has already been done. For a dental office, contracting decision-making occurs when the dentist, finding it necessary to select a lab, makes the following proposal for action:

- a. 'I will select Lab Z to do the work'
- b. 'I will specify arrangement for pick up and delivery'
- c. 'I will reach an agreement about how the models will be presented'
- d. 'I will identify factors which influence the cost'

e. 'I will discuss using the same technician for all my models'

f. 'Other items important to the contract are: —, — & —'

Another example of contracting would be with an auxiliary learning new skills as a basis for a raise. The contract might include such items as learning to take and mount radiographs, pouring and separating models, waxing crowns, casting and polishing.

A proposed contract written out and objectified, becomes subject to rational analysis. As the needed details for completion of such an action are thus spelled out, the feasibility and desirability of such an action becomes more and more apparent.

One caution to be exercised regarding contracting is that, having so carefully and thoroughly considered the details, it may seem that "the decision makes itself." One may then acquiesce, and follow through with the action simply because of inertia that makes it difficult to go through the process again; rather it is important to evaluate the pay-offs, with the possible need for rejecting the proposed plan and developing a new contract proposal.

4. **Force Field.** The force field consists in stating the issue very succinctly, and then listing the "pro" and "con" aspects separately in different sections of a

piece of paper, in the following manner:

Issue: 'I will locate my dental office in Super Street.'

"Pro": benefits, reasons *for* the action:

- a. New patient potential
- b. Population growth
- c. Less competition
- d. Close to my home
- e. New facility possible

"Con": reasons *against* the action:

- a. High capital investment
- b. Further from referrals
- c. No business location image
- d. Further from labs
- e. No public transportation

This force field approach enables the major relevant facts to be written down in summary fashion, thus outlining the agenda for the decision. As these are listed, they trigger other ideas which should also be listed, even if they are to be removed later, or seem inconsequential at the time. This is not the time for censorship of thoughts, but rather of building a list of reasons "pro" and "con." When the list seems fairly complete, various strategies can be employed in objectively representing the relative strength of each item. For example, items that deal with the same

issue can be placed opposite one another, and the relative "pro" and "con" strengths can be represented by the length of a line placed below the item, in this manner:

"Pro"

1. Area of population growth.

"Con"

5. No public transportation.

This would indicate that one expects adequate patient load to be generated by the population growth, and hence would not be too strongly dependent on patient access to public transportation.

5. **Grid.** This is included as a "facilitative" option because it is a familiar pattern used in questionnaires and surveys. It has such titles as the Likert scale.<sup>16</sup> It consists in listing the topic to be considered on the left side of a page, and then a series of numbers extends out to the right, representing extremes of this view, progressing from "low" to "high" preference as the numbers increase (Table 1). Thus visualized, the relative importance (indicated by the numbers) can be balanced objectively and debated with supporting evidence being assembled for further analysis.

Table 1  
Decision-Making Grid

Topics for decision	Scale of importance				
	Low	.....	High		
	1	2	3	4	5
A. Equipment purchases					
—porcelain staining furnace		2			
—electro-surgery unit			3		
—ultra-sonic scaler				4	
B. Phone service improvements					
—add another line				4	
—inter-com system		2.5			
—unlisted number for out-calls					5

6. **Nominal Process.** The "Nominal Process" is a democratic process for group decision-making.<sup>15</sup> It can be adapted to groups of four or forty, and can take from an hour to several days, depending on the situation. This "facilitative" strategy can be broken into four steps:

- a. *Individual listing of solutions.* Each person silently writes down all possible answers. No verbal exchanges occur until after all are finished.
- b. *Sharing solution ideas.* Each shares with one or two others

the list of solutions produced. Thus, everyone explains their ideas to at least one other person. This can generate even more ideas. No censorship nor debate occurs yet. Next, groups of four to six are formed. All ideas are listed, and after discussion, each person votes privately on their top three preferred solutions.

c. *Debate.* The total group assembles. The ranking solutions are reported from each sub-group. Discussion occurs for clarification, and then debate is directed toward each possible solution.

d. *Vote.* A private vote is taken and the number of votes for each item determines the rank-order of the solutions.

Thus the group decision has been arrived at democratically and with a minimum of confusion. This process usually produces a wide range of solutions because it structures in maximum participation by each person. A bonus benefit is that each group member feels a greater degree of ownership of the solutions and will more readily accept responsibility for needed action. Topics that would lend themselves to development by the Nominal Process would be such things as "an equitable method to establish a bonus policy", and "identifying ways to reduce accounts receivable".

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# The Illegal Delegation of Duties to Dental Auxiliaries

H. BARRY WALDMAN\*

The dentist shall be obliged to protect the health of his patient by only assigning to qualified auxiliaries those duties which can be legally delegated. The dentist shall be further obliged to prescribe and supervise the work of all auxiliary personnel working under his direction and control. (Statement from the American Dental Association Principles of Ethics and Code of Professional Conduct<sup>1</sup>)

The development of state dental practice acts and the establishment of examining boards during the latter half of the nineteenth century marked the end of the era of the itinerant tooth drawers and apprenticeship form of dental education. It marked the true beginning of the dental profession. During the past century the members of the examining boards, in association with component and constituent dental societies and state legislative bodies, have labored to maintain the relevancy of the practice acts, the entry examination process and practitioner adherence to the requirements of the practice act.

The continued modification of state practice acts, particularly permitting the delegation of increasing numbers of duties to a variety of auxiliaries and

denturists in the past few years, has brought to our attention the particulars of legislative acts that were once the concerns of the board examiner, an occasional lawyer and an accused practitioner.

The bewildering changes in the state laws and their ultimate impact on the practice of dentistry, unfortunately, are all too often unknown or misunderstood by the dentist. For example, in one national study on the awareness of expanded duty dental practice acts by dentists, large numbers (in some categories, more than a majority of respondents) of state association officers and individual practitioners were unaware of the type and proper extent of duties that could be delegated to dental hygienists and dental assistants.<sup>2</sup>

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The confusion regarding the provisions of the state dental practice acts is not only the result of the many new provisions introduced, but may well be the effect of the ambiguity of terminology and mechanisms used in

the practice acts to characterize and assign functions to auxiliary personnel. In general, the methods used to assign functions may be divided into either *open provisions* or *listing techniques*.

### Open Provisions

In the *open provision* orientation, there is a broad and flexible definition of the scope of allowed auxiliary tasks. The dentist may delegate any function within the competence of auxiliaries, limited only by the prohibition specified in a list or by general restriction against delegating tasks which require "the knowledge and skill of the dentist."

An example of an open provision approach is provided in the State of Pennsylvania where a dental hygienist, acting under the supervision of a dentist, "may perform those educational, preventive, and therapeutic services and procedures that licensed dental hygienists are educated to perform." The law further specifies that the dentist may assign intraoral procedures to dental hygienists which require their professional competence and skill but do not require the professional competence and skill of the employer-dentists. However, no assignment of tasks to dental hygienists may include diagnosis and treatment planning, writing of prescriptions for drugs, or writing authorizations for restorative, prosthetic, or orthodontic appliances.<sup>3</sup>

The concept of dental hygienists performing tasks related to their educational programs is emphasized further in the Utah dental laws which state that "hygienists may engage in any of the practices within the oral cavity that are included in the curriculums of recognized schools of dental hygiene, provided these practices are performed under the direction, supervision, and responsibility of the dentist."<sup>3</sup>

The open provision approach, "in reverse": i.e. the performance of all duties not specifically prohibited, has been adopted by a number of states, including Indiana, Missouri, Montana, Nevada, and Ohio. For example, the state dental laws of Indiana provide that the dentist may delegate to "competent office personnel" (not further specified) procedures over which he exercises direct supervision and full responsibility, but may not delegate any procedures which require professional judgment and skill such as diagnosis and treatment planning, cutting of hard and/or soft tissue, and particular types of intraoral impressions.<sup>3</sup>

## Listing Techniques

The *listing approach* to auxiliary duties is a more rigid and restrictive orientation. It consists of an itemization or tabulation of the specific duties and tasks that the dental hygienist or assistant may perform. In such instances, auxiliaries may perform *only* those functions listed and no others which would constitute the practice of dentistry.

For example, under the Regulations of the Commissioner of Education of the State of New York, Section 61.10, Practice of Dental Hygiene, the specific listing of the services that may be performed by a licensed dental hygienist include:

*"Under the personal supervision of a licensed dentist (i.e., the dentist is physically present in the office, school, or public institution, personally diagnoses the condition to be treated, and personally authorizes and evaluates the work of the dental hygienist):*

1. Placing or removing rubber dam
2. Removing sutures
3. Placing matrix band
4. Any application of topical medication not related to a complete dental prophylaxis
5. Taking impressions for study casts
6. Placing and removing temporary restorations (intracoronal only)

*Under the general supervision of a licensed dentist (i.e., the dentist is available for consultation, diagnosis, and evaluation, and has authorized the dental hygienist to perform the ser-*

*vices, and exercises that degree of supervision appropriate to the circumstances):*

1. Removing calcareous deposits, accretions, and stains
2. Applying topical agents indicated for a complete dental prophylaxis
3. Removing cement
4. Providing patient education
5. Placing and exposing X-ray films
6. Performing topical fluoride applications and topical anesthetic applications
7. Polishing teeth
8. Taking medical history
9. Charting caries<sup>4\*</sup>

There is no further specification or general listing of duties for a dental assistant or dental hygienist, except under the Public Health Law on the practice of X-ray technology, wherein "a person acting as a dental assistant under the supervision of a licensed dentist (may operate) equipment for the sole purpose of routine radiography . . . (provided said) x-ray beam at the patient's face is limited to not more than three inches."<sup>5</sup> There are other statements permitting the use of "panoramic radiographic equipment" with specific limitations on radiation dosages.

Thus, under the strict listing approach used in New York State, the dental hygienist may perform *only those duties that are assigned under the law*, while the dental assistant may perform any function not assigned to

\*These duties are consistent with the regulations described in the State Education Law, Section 6606.

other professions. In fact, should a dental assistant perform any duties that are listed or assigned to other professionals (with the exception of the general exemption for all "dental auxiliaries" to expose intraoral and panorex radiographs), then the assistant may be found guilty in a court of law of practicing the particular profession without a license. The supervising or directing dentist, in addition, may himself be found guilty of aiding in the illegal practice of a profession by an unlicensed individual and thereby subjecting himself to a fine, the suspension or revocation of his license or even imprisonment.

But even this listing of specific categories of services may be ambiguous. When do assistants transcend the vague barrier and perform duties that legally are assigned to licensed hygienists and thus place themselves and the responsible practitioner in legal jeopardy? For example, consider the service categories, "providing patient education" and "taking medical history." Would an assistant be violating the law if (s)he explained the advantages of brushing one's teeth or eating a proper diet and limiting between meal snacks? May (s)he give a patient a printed medical history questionnaire for completion and ask a specified series of questions stipulated by the dentist for all new patients? At what point is (s)he carrying out normal duties for an assistant which improve the practitioner's efficiency?

Despite a seeming straight forward listing of duties assigned to licensed dental hygienists, similar complications can arise also for the hygienist.

For example, the development of acid-etching techniques offer the profession "relatively easy" procedures with occlusal sealants for the prevention of decay. May the hygienist apply these new sealants under the "any application of topical medication not related to a complete dental prophylaxis" category in the New York State practice act? This particular issue was resolved in New York by classifying occlusal sealants as restorations, thereby reserving the procedures for the dentist.<sup>6</sup>

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**When do assistants transcend the vague barrier and perform duties that legally are assigned to licensed hygienists and thus place themselves and the responsible practitioner in legal jeopardy?**

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Thus, by specific listing, open provisions, specific definitions and the like, the dental profession and state legislative bodies have attempted to deal with the complex issue of the assignment of duties to various auxiliary personnel.

However, periodically one reads about instances where dental auxiliaries are asked by supervising dentists to perform tasks beyond the prescribed legal boundaries,<sup>7</sup> that state dental laws are unrealistic and limit a practitioner's income,<sup>8</sup> or that hygienists throughout the country perform functions that transcend the specifics of respective state practice acts.<sup>9</sup>



## Preliminary Study

In an effort to determine the degree to which dental auxiliaries were performing duties in accordance with the New York State practice act, a pilot study was carried out involving the dental assistants and dental hygienists who had been graduated in 1975 and 1976 from six training programs in one geographic area of the state.<sup>10</sup>

In 1974, a major change was enacted in the State Education Law significantly increasing the scope of the practice of dental hygiene in the State. Based upon discussion with instructors from various auxiliary training programs, it was felt that recent graduates had received specific instruction on these practice changes and should be more aware of the newly defined scope of auxiliary activities.

Accordingly, in 1977 a single page check-off questionnaire, specifying

duties within and beyond the practice act, was sent to the address of record (generally home addresses) of each graduate. No specific identification of individual questionnaires was attempted other than color coding the questionnaires to distinguish between dental assistant and dental hygienist respondents.

*Seventy eight percent (77.9 percent) of the 77 dental hygienist respondents, and 96.9 percent of the 65 dental assistant respondents, reported performing duties which extended beyond the specifics of the state practice act.*

The study had been carried out with the assistance of the Executive Secretary of the New York State Board of Dentistry, with the results provided to the Board prior to its submission for publication.

## Change in Law

In September 1979 a significant change in the professional practice act went into effect in New York State. Whereas in the past the improper delegation of duties or the improper performance of duties under certain circumstances would be considered a class "A" misdemeanor, henceforth the improper performance under the current statute would be classified as a class "E" felony under any circumstance.<sup>11</sup> Under New York State law, class "E" felonies include:

1. Defrauding individuals of their property
2. Bribing or receiving a bribe as a public official
3. Perjury
4. Tampering with physical evidence at the scene of a crime
5. Bookmaking
6. Rendering assistance to someone committing a class "B" or "C" felony—which includes burglary, kidnapping, robbery, rape and manslaughter

A finding of "guilty" in a court of law under a class "E" felony carries with it a penalty which can include a jail sentence in excess of one year.

Some clarification would be helpful in describing the penalties for violations of the laws controlling the practice of dentistry in New York State. In New York only the legislature has the power to declare an act a "crime" and to establish, as one of the penalties, a jail sentence. Administrative bodies, such as the Department of Education and the Board of Regents, although granted statutory authority by the Legislature to adopt regulations and rules, are not empowered to declare violations as criminal, and carrying possible jail sentences. Thus violations of the Regulations of the Commissioner of Education and the Rules of the Board of Regents are classified as quasi-criminal, as are violations of other Administrative Laws. In the

situation here under discussion, it was the Legislature that declared "Unauthorized Practice" as criminal. Violations of the Regulations of the Commissioner of Education, or the Rules of the Board of Regents, although serious, do not carry with them a jail sentence.

Thus, should a dental hygienist or a dental assistant, with the knowledge of the dentist, remove a matrix band, the charge would be criminal, and the practitioner and the particular auxiliary, if found guilty, could be sentenced to more than a year in jail. In the process they would appear before a Grand Jury for possible indictment. On the other hand, if a dentist should violate the Rules of the Board of Regents on advertising, the charge would not be criminal. The practitioner would appear before an administrative tribunal and not be subject to a jail sentence.

### Follow-up Study

In an effort to determine the impact of the change in the State Law on the delegation of duties to dental auxiliaries, a follow-up study was conducted in the Fall of 1980. The same general format as established in the preliminary study was continued in the second study, with the following addition:

1. Whereas the pilot study concentrated on graduates in one geographic location, the follow-up study included 1980 graduates

from 10 dental assistant and six dental hygiene programs throughout New York State, including university, community college, high school, proprietary and hospital programs.

2. Two service categories, "injecting a local anesthetic" and "giving general anesthesia" were added to the questionnaire.
3. One week prior to the date of graduation of one dental hygiene program, an intensive review of

the pilot study was carried out with all senior students. Each student had the opportunity to review the pilot study questionnaire, the general results of the study and consider the consequences of the new changes in the law.

4. The instructors from each of the other 16 programs assured this writer that all classes had been informed of the consequences of performing duties beyond the practice act associated with the 1979 felony designation.

A total of 492 color coded questionnaires were mailed out to the address of record of each graduate; 73 to the

dental hygiene graduates who had reviewed the pilot study, 165 dental hygienists from other institutions, and 254 dental assistant graduates. There was no follow-up of non-respondents.

A total of 31 (42.4 percent) of the hygienists who received pilot study instruction, 65 (39.4 percent) of other dental hygiene graduates and 74 (29.1 percent) of the dental assistants responded to the questionnaire.\*

Most dental hygienists (both hygienists with pilot study instruction and other hygienists) and dental assistants reported their primary employment with a general practitioner.\*\* (See Table I for a report of employment)

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\*In most studies, one is concerned whether the respondents are somehow a representative sample of the general population under review. Attention is directed both to the percent of respondents and whether the respondents reflect the particular known or assumed characteristics of the population under study. The respondents in this study are not representative of all auxiliaries in the State of New York, but rather represent the activities carried out by a group of recent graduates from dental hygiene and assisting training programs. Thus, the data are presented for auxiliaries, as a general indication of the activities carried out in over 150 practices in the State of New York.

\*\*Data reported under various specialty categories are based upon the perception and statements by respondents. These perceptions of general and specialty practice may not be in line with the service limitation requirements established by the American Dental Association and the various specialty boards. Thus, some reported services may not be congruent with the types of services that one might expect for an individual who totally limits his practice.

#### A. Dental Hygienists

Dental Hygienists reported performing each of the specified categories of services listed in the questionnaire. However, only 18 of the 42 categories in the questionnaire are listed in the

New York State practice regulations under the "personal" and "general" supervision categories as being within the proper sphere of activity for dental hygienists.\*

The performance of services beyond

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\*Since the completion of the pilot study, the Executive Secretary of the State Board of Dentistry has issued a memorandum clarifying the status of one item on the questionnaire. He indicated that "dental hygienists or unlicensed auxiliary personnel may take blood pressure readings. They may record such readings for their own purposes or for the patient. They are not authorized to discuss the significance of such readings with patients."<sup>12</sup> A second item in the questionnaire, developing x-rays, may be assumed to be within the hygienist's purview, since it is performed as a laboratory procedure in the absence of the patient.

Table I. Dental hygienist respondents who reviewed the pilot study, other dental hygienist respondents and dental assistant respondents by primary place of employment

	Dental Hygienists who reviewed the Pilot Study		Dental Hvgienists All Other		Dental Assistant	
	Number	Percent	Number	Percent	Number	Percent
General Practice	27*	93.2	46**	73.0	58****	80.5
Endodontist	--	--	--	--	2	2.8
Oral Surgeon	--	--	1	1.5	3	4.2
Orthodontist	--	--	1	1.5	5	6.9
Pedodontist	--	--	2	3.2	3	4.2
Periodontist	1	3.4	10***	16.1	1	1.4
Prosthodontist	--	--	3	4.7	--	--
Specialist - Non Specific	1	3.4	--	--	--	--
Subtotal	29	100%	63	100%	72	100%
Have not been employed in the field of dentistry	2		2		2	
Total Respondents*****31			65		74	

\* Includes two dental hygienists who were employed out of New York State (New Jersey and Delaware). While data from these two questionnaires are not included in the remaining tables, commentary is reported in the out-of-state section of "The Findings".

\*\* Includes three dental hygienists who were employed out of New York State (Connecticut, Massachusetts, New Jersey). Data from these two questionnaires are included in the out-of-state section.

\*\*\* Includes one dental hygienist who was employed in the State of California. Data included in out-of-state section.

\*\*\*\*Includes one dental assistant who was employed in the State of Illinois. Data included in out-of-state section.

\*\*\*\*\*The term "respondents" henceforth throughout this report shall refer to to all respondents who were or are employed in the field of dentistry in in the State of New York (i.e. 86 dental hygienists and 71 dental assistants) except as specified.



Table II. The performance of dental services by 86 dental hygienist respondents as listed in the New York State Dental Hygiene Regulations that may be performed under the personal supervision and the general supervision of a dentist, by the particular service.

A. Permitted under the personal supervision of a dentist

	<u>Number of dental hygienist respondents.</u>
Place and remove temporary restorations	25
Remove sutures	40
Impressions for study casts	48
Place rubber dam	13
Remove rubber dam	16
Place matrix bands	12

B. Permitted under the general supervision  
of a dentist

Take medical history	75
Chart caries without dentist	65
Polish teeth	86
Place and expose bitewing and periapical x-rays	83
Patient education	85
Remove excess cement	58
Apply topical agents for prophylaxis	85
Place topical fluoride	77
Place topical anesthetic	62
Remove hard deposits and stains from teeth	84
Develop x-rays*	85
Take pulse and blood pressure**	38

\* While not specified within dental hygiene regulations, it may be assumed to be within the purview of hygienists since it is performed as a laboratory procedure in the absence of the patient

\*\*See earlier commentary



the limitations of the practice act was as widespread among the dental hygienists who had reviewed the pilot study questionnaire prior to graduation as it was among all other dental hygienist respondents. Twenty (74.1 percent) of the dental hygienist respondents who had reviewed the pilot study reported performing services not listed in New York State Dental Hygiene Practice Regulations. Similarly, 46 (76.7 percent) of all other dental hygienist respondents reported performing services beyond the practice act. Indeed, the performance of duties within and beyond the practice regulations was so comparable for both groups in all practice situations that, in an effort to simplify the reporting of the study, all references to dental hygienist data shall refer to a combination of both groups. (See tables II and III for a report of performed services within and beyond the practice act specifications).

In addition, dental hygienist respondents added several categories of services that they performed which were not specified in the questionnaire and which extend beyond the limitations of the practice act regulations. These included,

1. Adjust bite plates
2. Adjust night guards
3. Cement orthodontic bands
4. Curettage
5. Tie arch wires
6. Remove loose bands
7. Remove orthodontic brackets

Despite the directions in the questionnaire for completing the form, it could be suggested that there may have been confusion regarding the proper column to check off for each service category (i.e. "personal" vs "general" supervision\*). Thus the emphasis on the non-listed duties is critical since these duties may not be performed by a dental hygienist under any circumstances.

If one were to consider that the "personal" and "general" supervision differentiations were properly reported by respondents, then the findings that were noted above would be an underestimate of the duties which were both improperly and illegally performed. (See Table IV for the reported incidence of the performance of services under "personal" and "general" supervision categories).

#### B. Dental Assistants

Dental assistant respondents reported performing each of the specified categories of services listed in the questionnaire, except "injecting local anesthetics." However, only five of the 42 categories can actually or "possibly" be provided by dental assistants. All other listed categories in the questionnaire are either within the areas that may be performed by a dental hygienist or are reserved to the dentist. (See Table V and VI for an overall reporting of duties by all dental assistant respondents). In addition, den-

*Continued on Page 257*

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\*It should be noted that the wording for the definitions in the questionnaire were taken directly from the Dental Hygiene Practice Regulations.

Table III. Dental services NOT listed in the New York State Dental Hygiene regulations reported as performed by 86 dental hygienist respondents employed by general practitioners and various specialists by the particular dental service categories.

	<u>General Practitioner</u>	<u>Oral Surgery</u>	<u>Orthodontist</u>	<u>Pedodontist</u>	<u>Periodontist</u>	<u>Prosthodontist</u>	<u>Specialist Non-specific</u>	<u>Total</u>
Number of respondents	68	1	1	2	10	3	1	86
Expose cephalometric x-rays	5	1	1	-	1	-	-	8
Cement temporary crowns	21	1	-	2	4	2	-	30
Recement temporary bridges	23	-	-	2	5	2	-	32
Apply cavity liners and bases	3	-	-	-	1	-	-	4
Place periodontal dressings	6	-	-	1	6	1	-	14
Remove periodontal dressings	11	-	-	1	9	1	-	22
Check orthodontic bands for looseness	12	1	1	1	-	-	1	16
Place sealants	12	-	-	1	-	1	-	14
Remove matrix bands	8	-	-	2	-	-	-	10
Condense amalgams	3	-	-	1	-	-	-	4
Carve amalgams	1	-	-	1	-	-	-	2
Polish amalgams with finishing burs	10	-	-	2	-	-	-	12
Place sutures	2	-	-	-	2	-	-	4
Recement loose bands	2	1	-	2	1	-	-	6
Take impressions of prepared teeth	9	-	-	1	2	-	-	12
Adjust denture sore spots	3	-	-	-	1	-	-	4
Minor occlusal adjustments	3	-	-	-	1	-	-	4
Cementation of crowns	5	-	-	-	-	1	-	6
Cementations of inlays	1	-	-	-	-	-	-	1
Minor gingivectomies	2	-	-	-	1	-	-	3
Remove arch wires	-	-	1	-	1	-	-	2
Take final impressions for partial and/or full dentures	5	-	-	-	-	-	-	5
Inject local anesthesia	1	-	-	-	1	-	-	2
Give general anesthesia	5	-	-	-	2	-	-	7

**Table IV.** Incidence of performance of dental services under the "general" supervision of a dentist which are specified in the Dental Hygiene regulations to be performed under "personal" supervision, as reported by 86 dental hygienist respondents employed by general practitioners and various specialists, by the particular dental service categories.

	<u>General Practitioner</u>	<u>Oral Surgeon</u>	<u>Orthodontist</u>	<u>Pedodontist</u>	<u>Periodontist</u>	<u>Prosthodontist</u>	<u>Specialist Non-specific</u>	<u>Total</u>
Number of respondents	68	1	1	2	10	3	1	86
Place and remove temporary restorations	10	-	-	1	1	1	-	13
Remove sutures	11	-	-	-	5	1	-	17
Impressions for study casts	25	-	1	1	6	2	-	35
Place rubber dam	5	-	-	1	-	-	-	6
Remove rubber dam	9	-	-	1	-	-	-	10
Place matrix bands	4	-	-	-	1	-	-	5

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tal assistant respondents added several categories of services that they performed which were not specified in the questionnaire and which extend into the jurisdiction of the dental hygienist and dental practitioner, including:

1. Place simple orthodontic wires
2. Bond metal brackets to teeth
3. Fit orthodontic bands
4. Fit orthodontic head gear
5. Fit temporary crowns
6. Pack gingabraid cord (sic)
7. Condense composites
8. Remove intravenous needles

Finally, and most important, 67 (94.4 percent) of the dental assistant respondents reported performing services which placed them and their employers in violation of the dental practice act. It should be noted that the remaining four dental assistant respondents reported performing cate-

gories of service which were only "possibly" within the realm of approved activities.

Any concern regarding the proper completion of columns in the questionnaire (i.e. "personal" vs "general" supervision) would essentially be meaningless for dental assistant respondents. Since there are no statutes which specify the duties (other than

those for x-ray procedures) for the dental assistant, the recording in either column would indicate non-compliance with the State regulations. Nevertheless, many respondents reported performing many service categories, both under the personal and general supervision of practitioners. (See Table VII)

*Continued on Page 261*

**Table V.** Performance of dental services actually or "possibly" permitted under the supervision of a dentist, as reported by 71 dental assistant respondents employed by general practitioners and various specialists, by service categories.

	<u>General Practitioner</u>	<u>Endodontist</u>	<u>Oral Surgeon</u>	<u>Orthodontist</u>	<u>Pedodontist</u>	<u>Periodontist</u>	<u>Total</u>
Number of respondents	57	2	3	5	3	1	71
Take medical history	43	2	2	4	3	1	55
Place and expose bite-wing and periapical x-rays	48	1	3	5	3	1	61
Develop x-rays	52	2	3	5	3	1	66
Take pulse and blood pressure	20	1	3	1	2	1	28
Patient education	39	1	1	4	2	-	47



Table VI Performance of dental services which may NOT be performed by a dental assistant, as reported by 71 dental assistant respondents employed by general practitioners and various specialists, by service categories.

	General Practitioner	Endodontist	Oral Surgeon	Orthodontist	Pedodontist	Periodontist	Total
Number of respondents	57	2	3	5	3	1	71
Chart caries without dentist	28	1	-	3	1	-	33
Polish teeth	13	1	-	4	1	-	19
Expose cephalometric x-rays	17	-	3	2	-	-	22
Cement temporary crowns	25	-	2	-	-	-	27
Recement temporary bridges	22	-	1	-	-	-	23
Remove excess cement	27	1	1	3	1	-	33
Apply topical agents for prophylaxis	17	-	-	2	1	-	20
Apply cavity liners and bases	10	-	-	-	-	-	10
Place periodontal dressings	10	-	2	-	-	-	12
Remove periodontal dressings	11	-	1	-	1	1	14
Check orthodontic bands for looseness	9	-	-	4	1	-	14
Place and remove temporary restorations	13	-	1	-	-	-	14
Place topical fluoride	23	-	-	2	1	-	26
Place topical anesthetic	14	-	1	-	1	-	16
Place sealants	8	-	-	-	1	-	9
Remove sutures	18	-	2	-	-	1	21
Inject local anesthetic	-	-	-	-	-	-	-
Remove hard deposits and strains from teeth	7	-	-	2	2	-	11
Impressions for study casts	39	1	1	4	2	-	47
Place rubber dam	16	-	-	-	2	-	18
Remove rubber dam	20	-	-	-	2	-	22
Place matrix bands	16	-	-	-	1	-	17
Remove matrix bands	13	-	1	-	-	-	14
Condense amalgams	16	-	-	-	2	-	18
Carve amalgams	4	-	1	-	-	-	5
Polish amalgams with finishing burs	3	-	-	-	1	-	4
Place sutures	1	-	-	2	-	-	3
Recement loose bands	4	-	-	3	-	-	7
Take impressions of prepared teeth	25	1	2	2	2	-	32
Adjust dentures for sore spots	3	-	-	1	-	-	4
Minor occlusal adjustments	4	-	-	1	-	-	5
Cementation of crowns	10	-	2	1	-	-	13
Cementation of inlays	7	-	1	1	-	-	9
Minor gingivectomies	-	-	-	1	-	-	1
Remove arch wires	6	-	-	3	1	-	10
Take final impressions for partial and/or full dentures	20	-	2	1	1	-	24
Give general anesthesia	5	-	2	1	-	-	8



Table VII Incidence of performance of dental services under the personal and general supervision of dentists as reported by 71 dental assistant respondents, by service categories.

<u>Actually or possibly permitted</u>	<u>Personal Supervision</u>	<u>General Supervision</u>
Take medical history	18	37
Patient education	12	35
Place and expose bitewing and periapical x-rays	16	45
Develop x-rays	14	52
Take pulse and blood pressure	9	19
<u>Not Permitted</u>		
Chart caries with dentist	23	10
Polish teeth	5	14
Expose cephalometric x-rays	5	17
Cement temporary crowns	13	14
Recement temporary bridges	12	11
Remove excess cement	12	21
Apply topical agents for prophylaxis	8	12
Apply cavity liners and bases	7	3
Place periodontal dressings	6	6
Remove periodontal dressings	7	7
Check orthodontic bands for looseness	6	8
Place and remove temporary restorations	8	6
Place topical fluoride	12	14
Place topical anesthetics	12	4
Place sealants	5	4
Remove sutures	14	7
Inject local anesthetics	—	—
Remove hard deposits and stains from teeth	8	3
Impressions for study casts	13	34
Place rubber dam	11	7
Remove rubber dam	11	11
Place matrix bands	10	7
Remove matrix bands	9	5
Condense amalgams	12	6
Carve Amalgams	3	2
Polish amalgams with finishing burrs	2	2
Place sutures	2	1
Recement loose bands	3	4
Take impressions of prepared teeth	11	21
Adjust dentures for sore spots	1	3
Minor occlusal adjustments	4	1
Cementation of crowns	6	7
Cementation of inlays	4	5
Minor gingivectomies	—	1
Remove arch wires	5	5
Take final impressions for partial and/or full dentures	8	16
Given general anesthesia	3	5

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### C. Out of State Respondents

Six dental hygienists and one assistant reported employment out of New York State. The categories of service checked in each questionnaire were reviewed with the practice act

specifications of the respective states (California, Connecticut, Delaware, Illinois, Massachusetts, and New Jersey).<sup>13</sup> In each case, the respondents performed services beyond the limitations of the respective state practice acts.

## Discussion

As in the pilot study, virtually all responding dental assistants (96.9 percent in the pilot study and 94.4 percent in the follow-up study) and a comparable majority of dental hygienists (77.9 percent in the pilot study and 77.6 percent in the follow-up study) reported performing duties which placed them, and their employers, in conflict with the New York State practice act.

There was concern, similar to that in the pilot study, that this reported high rate of illegal activities (conviction of which would now be considered a felony) could be an indication that respondents checked off service categories for which they provided assistance to the practitioner instead of actually personally performing them, or that the dental hygienists and assistants simply were reporting duties they felt they were qualified to provide. However, a review of the individual questionnaires in the follow up study (as in the pilot study) would seem to indicate that the reported performances were probably a reasonable approximation of the practice situation. For example:

1. Repeated statements on many questionnaires attesting to the respondent's awareness that they assisted dentists in some duties, while performing other services themselves. One dental assistant wrote, "The dentist tells me what to do and leaves to go back to sit in his office. I show him the work done and approves." (sic) Another assistant commented, "The answers that are not answered are due to that (sic) fact that I don't attend to these duties just merely assist." One dental hygienist wrote,

"My training was extensive, either change the laws or tighten the study load. It is very frustrating to know the how's and why's but not be able to do something because it is a felony—I know I perform illegal services as it is."

A second dental hygienist commented,

"The dentist I am employed by gives me very little supervision and hardly ever evaluates my work. I am constantly asked to

administer nitrous oxide to the patients who ask for it. I feel that hygienists who have had advanced training (B.S. degree) should be allowed *by law* to perform certain duties that are now illegal but their employers have them do anyway. P.S. even better, hygienists should be able to practice independently!! Watch out—because its *up and coming soon*."

Finally, a third hygienist also commenting on being required to provide services while administering nitrous oxide reports,

"I am aware of the workings of the unit but the idea that my license could be taken away stays uppermost in my mind. . . . He doesn't understand about Class III felony" (sic) (Note: should be Class "E" felony).

2. Many respondents, as in the pilot study, selectively checked off categories which are somewhat similar in terms of the actual assisting duties (e.g. impressions for study casts, vs. final impressions for partial and/or full dentures; condensing vs. carved amalgams; cement temporary crowns vs. recement temporary bridges; and place and expose bitewing and periapical x-rays vs. expose cephalometric x-ray).
3. Again, as in the pilot study, few respondents checked off some of the categories for which there has been particular demand by some advocates for expansion of duties (e.g. the placement of sealants by dental hygienists and the carving

of amalgams and removing of matrix bands by dental assistants).

In addition, during the course of the pilot and follow-up studies several dentists in practice in the State expressed little to no surprise with the results of the studies, adding the commentary that they thought that the findings may be an underestimate of the extent to which these services may be performed by dental auxiliaries. One practitioner volunteered the information that his assistant performed duties beyond those permitted under the practice act. He questioned the licensing board's ability to enforce the regulations when the misuse of auxiliaries was the rule rather than the exception.

Many dental hygienists and dental assistants commented about the boredom of practice, the adverse working conditions and poor remuneration, the limited opportunities for advancement, the willingness and capability to perform additional duties, and the particular concern by hygienists that dental assistants were performing duties reserved for their profession. "And how about those assistants out there—doing hygiene—People don't understand the difference—They don't realize you need a license to do dental hygiene. The public should be made aware!!!"

Finally, attention must be directed to the failure of efforts to reduce the performance of duties beyond the practice act by an intensive review of the pilot study material with a class of dental hygiene students. Possibly the explanation by one of the dental hygienist respondents from the group

that reviewed the pilot study may offer some direction.

"I know I perform illegal services as it is—but it would definitely

slow our office up if the dentist had to do every little thing. He doesn't force me to do anything and I have refused to do some things—but common sense must prevail."

## Conclusion

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**And how about those assistants out there doing hygiene—people don't understand . . . you need a license to do dental hygiene.**

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In reviewing the results of the study it should be repeated that the 306 respondents in the pilot and follow-up study were not a statistically drawn sample of the general population of auxiliaries functioning in the State of New York. Nevertheless, 262 out of a group of 306 auxiliaries (85.6 percent) (including a number from out of state) reported performing functions that are in violation of state practice acts. Seemingly the change in penalties associated with the violation of the act has had limited impact on curtailing the disregard of the law; at least for the group under study. Undoubtedly, the pressure (by both the practitioners and the auxiliaries) surpasses the expected consequences of a law that is *perceived* as seldom being enforced.

If the delegation of dental service activities to dental auxiliaries through-

out New York State is comparable to the widespread disregard of the practice act noted in these studies, then as health practitioners, we cannot ignore these findings. There are a variety of alternative actions which should be considered including, but not limited to,

1. Enforcement of the current practice act regulations,
2. Adoption of a series of modifications in the current listing approach reflecting the behavioral norms of the practice of dentistry in the state, and
3. Adoption of an open provision approach used by many other states.

Surely, the members of the State Board of Dentistry, in association with the component and constituent dental societies and the state legislative bodies must address this issue if we are to ensure the best interests of the general public and the dental and dental auxiliary professions.

The purpose of the Principles and Code (of Professional Conduct) is to uphold and strengthen dentistry as a member of the learned professions.<sup>1</sup>

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## *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

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