

SPRING 1983

JOURNAL

AMERICAN COLLEGE of DENTISTS



CODES OF ETHICS

—An FTC View

—A Professional's View

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;

(c) To encourage, stimulate and promote research;

(d) 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;

(e) To encourage the free exchange of ideas and experiences in the interest of better service to the patient;

(f) To cooperate with other groups for the advancement of interprofessional relationships in the interest of the public; and

(g) To make visible to the professional man the extent of his responsibilities to the community as well as to the field of health service and to urge his acceptance of them;

(h) In order to give encouragement to individuals to further these objectives, and to recognize meritorious achievements and potentials for contributions in dental science, art, education, literature, human relations and other areas that contribute to the human welfare and the promotion of these objectives — by conferring Fellowship in the College on such persons properly selected to receive such honor.

The JOURNAL

Volume 50
Number 1
Spring 1983

of the AMERICAN COLLEGE of DENTISTS

**A Quarterly
Publication
Presenting
Ideas & Opinions
In Dentistry**

Keith P. Blair, DDS, Editor
Gordon H. Rovelstad, DDS, Business Manager
Editorial Board
Robert A. Cupples, DDS, Chairman
Paul S. Butcher, DDS
Robert C. Coker, DDS

The Journal of the American College of Dentists (ISSN 0002-7979) is published quarterly by the American College of Dentists, Inc., McFarland Company, Harrisburg, Pennsylvania, with Second Class Postage paid at Harrisburg, Pennsylvania and additional points. Copyright 1982 by the American College of Dentists, Inc.

Subscription \$15.00 a year. Cost of additional postage for airmail will be billed to subscriber. Single copies \$6.00.

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

Correspondence relating to the *Journal* should be addressed to the Editor, Keith P. Blair, DDS, 4403 Marlborough Avenue, San Diego, CA 92116.

Changes of address and subscription requests should be addressed to the Business Manager, Gordon H. Rovelstad, DDS, American College of Dentists, 7315 Wisconsin Avenue, Bethesda, MD 20814.

Reprint requests should be directed to the author.

For bibliographic references the *Journal* is abbreviated J Am Col Dent and should be followed by the volume number, page, month and year. The reference for this issue is J Am Col Dent 50:1-49, Spring 1983.



CONTENTS

| | |
|--|----|
| From the Editor's Desk: | 3 |
| An Ideal Dental Office | |
| —From A Patient's Perspective | |
| News of Fellows | 4 |
| What Is Professionalism? | 7 |
| —Some Worthy Definitions | |
| Section Activities | 8 |
| Codes of Ethics — An FTC View | 10 |
| <i>E. Perry Johnson</i> | |
| Codes of Ethics—A Professional's View | 14 |
| <i>Basil J. Mezines</i> | |
| Schools Are Returning To Normal | 17 |
| <i>H. Barry Waldman</i> | |
| 1982 Convocation Scenes | 24 |
| 1982 Section Officers Meeting | 32 |
| The Dentist and Voluntarism: | 34 |
| A Two-Way Street | |
| <i>Arden G. Christen</i> | |
| Pediatric Dentistry | 40 |
| (In a Low Caries Community) | |
| <i>Enrique Bimstein</i> | |
| A Treasury of Dentistry | 42 |
| <i>Gardner P. H. Foley</i> | |
| Opinions, Ideas and Views | 44 |
| Sudden Surge in TMJ Problems | |
| Only Consulting Dentists Should Make Treatment Decisions | |
| Training Program for Dental Faculty | 46 |
| <i>Charles H. Boozer and Associates</i> | |
| Directory of Officers | 49 |

An Ideal Dental Office

—From A Patient's Perspective

FROM THE EDITOR'S DESK

The ideal office can develop satisfied patients who frequently refer other patients to that office, which is a tremendous asset to any practice.

Patients cannot judge the quality of treatment, but they can quickly form an impression as to whether they feel comfortable in that office, whether the dentist and his staff are warm, friendly, helpful and concerned, and whether they feel a confidence in that office to provide capable and gentle treatment.

The first contact with the dental office is usually by telephone and people can actually "hear" a warm personality and a smile by the receptionist over the phone. That is an important first impression for the patient and becomes the office image to him. If the patient is in pain and needs to be seen as soon as possible, today is the best time.

When entering an ideal office for the first time, the patient is pleasantly welcomed by name. The patient then sees the dentist who is also warm, friendly and concerned, and who *listens attentively* to the patient's complaints and symptoms. The immediate problem is treated at that visit.

The patient is provided with a small folder briefly describing office policies, financial arrangements and a short background on the dentist's training, special abilities and activities.

On the next visit, arranged at a convenient time for the patient, a thorough radiographic and clinical examination is performed, including periodontic charting.



Keith P. Blair

At the consultation appointment, the dentist is prepared to review the examinations findings with the patient, explaining in words that the patient can comprehend. With an informed patient who understands the need for care, treatment plans may be more readily accepted. Through discussion at this time, the dentist can also understand the patient's position and his other priorities that may have a strong bearing on decisions for accepting treatment.

Pictures, illustrations, models and video cassettes are utilized so that the patient better understands the problems and the planned treatment. Folders and brochures are provided to the patient to more completely explain treatment.

By the time the desired treatment has been completed, the patient has developed some strong impressions about this ideal office. It is regarded to be a place where

people are treated with consideration and respect, in a warm and friendly manner, yet with professional demeanor. The patient has the feeling that he can place trust in the integrity of the dentist to use good judgment and to provide dental care that is in the patient's best interest.

The ideal office wants to do everything possible to make a visit to the dentist pleasant and comfortable, and to have the patient satisfied to stay in that practice. The office motto is the Golden Rule.

The ideal office knows that most patients leave a practice because of unpleasant auxiliaries, because of misunderstandings over poorly explained fees and because of long waits. The ideal office will not tolerate such inconsiderate behavior.

In the ideal office, the patient is number one and is treated with all the courtesy and respect of a guest in the living room. The patient is the most important person in the office while he is there. The total effort of the office is directed towards creating appreciative patients.

The practice of being nice to people so that they will, in turn, like you or your business, can be recognized under a number of different names. It can be called public relations, potlatch, marketing, business promotion, or just being gracious. Besides, it leaves everybody feeling good.

An ideal dental office works beautifully.

Keith P. Blair

NEWS OF FELLOWS



Philip J. Boyne

Philip J. Boyne, Loma Linda, California has been elected President of the American Board of Oral and Maxillofacial Surgeons. This organization functions as the National Certifying Board which examines over 200 Maxillofacial Surgeons yearly who have completed residency training programs and other requirements for certification. Dr. Boyne is a professor of surgery and director of the residency training program for maxillofacial surgery at Loma Linda University. He is also very active in physical conditioning programs and has participated in 33 marathon runs of 26 miles each, including the past five Boston Marathons.



Lynden M. Kennedy

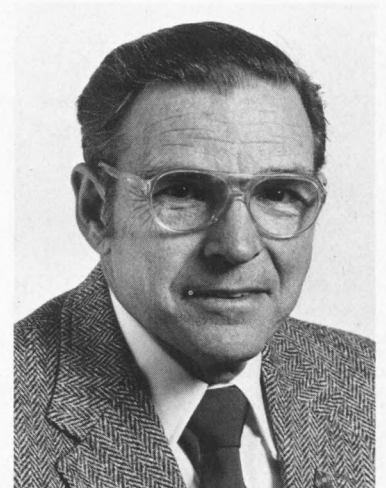
Lynden M. Kennedy, Dallas, President-Elect of the American College of Dentists, was elected Chairman of the Board of Trustees of Baylor College of Dentistry. Dr. Kennedy is a former president of the American Dental Association. Also elected to the Baylor College Dental Board of Trustees were **Walter T. Colquitt**, **Robert E. Lamb** and **Morris L. Barrington**. Elected Secretary of the Board was **Carl Gibbe**.

E. Monroe Farber of Delray Beach, Florida was recently honored by his friends and the members of the South Palm Beach County Dental Society for his many years of service to his profession and for his civic contributions and service club accomplishments.

James D. Harrison of New Orleans received an Alumni Merit Award from his Alma Mater, St. Louis University. The award is given annually and bestowed upon graduates who exemplify the University Credo in their personal and professional lives. Dr. Harrison is a professor and head of the department of fixed prosthodontics at Louisiana State University. He is a past president of the American Association of Dental Schools.

James Rogers Hayward is retiring from the University of Michigan after serving that institution for 30 years as chairman of the department of oral and maxillofacial surgery. He contributed greatly to establishing standards for the American Board of Oral Surgery and was instrumental in organizing the International Association of Oral Surgeons. Dr. Hayward has published over 175 articles, many concerned with cleft lip and palate problems. He edited a textbook on oral surgery and served as editor of the Journal of Oral Surgery for six years. He has been the recipient of many high honors in recognition of his outstanding contributions in the field of oral and maxillofacial surgery.

Ralph R. Lopez of Santa Fe, New Mexico has been selected to receive the "Man of the Year" Award for 1983 by the Colorado Section for his many contributions to organized dentistry. The award was presented on January 15 in Denver.



H. Curtis Hester

H. Curtis Hester, Regent of the College, received a Distinguished Service Award from the Orthodontic Alumni Society of Columbia University.



Ralph Bellizzi

David H. Alterman of Long Branch, New Jersey has received the Middle Atlantic Society of Orthodontist's Gerard A. Devlin Memorial Award for distinguished service. Dr. Alterman is an orthodontist and is a past president of the New Jersey Board of Dentistry.

Ralph Bellizzi, U.S. Army Colonel, was recently honored by the Surgeon General of the United States when he received the Medical Department's "A" Specialty Designator. This is the highest award that can be bestowed in recognition of professional accomplishments within the Army Medical Department. Colonel Bellizzi was recognized for his contributions in the field of endodontics as a teacher, lecturer and program director. He is presently the Chief of Endodontics at Nuernberg, Germany.

Sidney Rafal of West Hartford, Connecticut has been elected president of the medical staff of the Hebrew Home and Hospital in Hartford. Dr. Rafal is a past president of the Connecticut State Dental Association and is Editor for the American Society for Geriatric Dentistry.



Carl H. Muller

Carl H. Muller of Villa Park, Illinois has been elected president of the Illinois State Dental Society. He is a member of the Midwest Peer Review Task Force for the American Dental Association. Dr. Muller was a co-author of the first Illinois State Peer Review Manual.

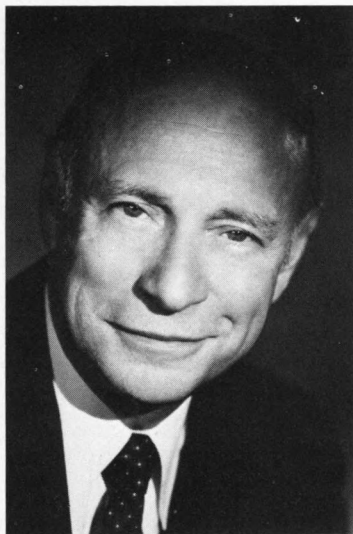


Sydney Rafal



Bertrand de Lataillade, left, Consul General of France, confers the French Government's L'Ordre National de Merite upon Dr. D. Walter Cohen, Dean of the University of Pennsylvania School of Dental Medicine for his support and assistance to dental education in France.

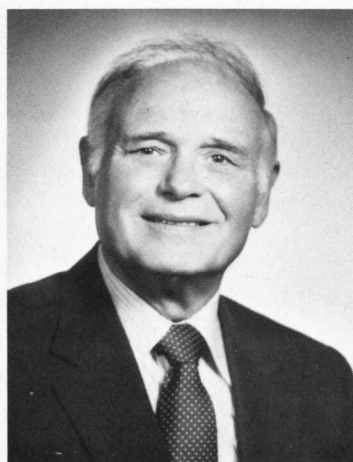
D. Walter Cohen, Dean of the University of Pennsylvania School of Dental Medicine has received the French Government's L'Ordre National de Merite for his support and assistance to dental education in France. Dr. Cohen developed educational programs and provided teaching materials for dental schools in France, established an affiliate program with the University of Paris Dental School and began an Odontological Club at the University of Nice Dental School. He has been a visiting professor at both schools. The honor was conferred upon Dr. Cohen by the French Consul General at New York.



Abraham Kobren

Clayton S. McCarl, Sr. of Greenbelt, Maryland is serving as president of the University of Maryland Alumni Association, International which coordinates alumni activities on all five campuses of the University. Dr. McCarl is a Past President of the Maryland State Dental Association.

Lionel J. French from Wickliffe, Ohio has been appointed "president emeritus" of the Ohio Academy of General Dentistry in recognition of his many years of service to the group. Dr. French organized the Ohio Academy in 1968 and served as its president until 1973. He also helped to organize the Indiana Academy.



Lionel J. French

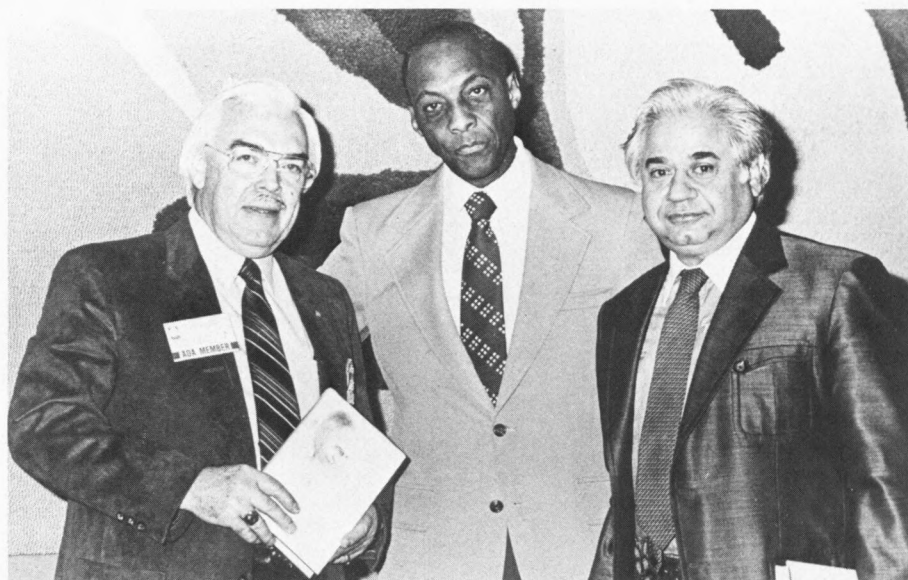
Abraham Kobren of New York, an ADA Trustee and a leading educator, author and lecturer, has been appointed as Assistant Dean for Admissions at the New York University College of Dentistry. In this newly created position, Dr. Kobren will be responsible for admission to the predoctoral program at NYU, as well as for such activities as student recruitment, student housing and student financial aid. Dr. Kobren was also recently honored by his Alma Mater, Georgetown University, with a Distinguished Service Award.



Emile T. Fisher

Emile T. Fisher of Atlanta, Georgia, a periodontist, was selected to receive the prestigious and coveted 1982 "Man of the year in dentistry" award from his colleagues in the Northern District (Georgia) Dental Society. Dr. Fisher received the

1981 Atlanta Community Service Award and the 1981 National Jefferson Award for Public Service. He is currently serving as the 1983 President of the Georgia Chapter of the Arthritis Foundation.



At the Nov. 5, 1982 annual meeting of the American Academy of the History of Dentistry in Las Vegas, Nevada, complimentary first copies of the new book "Charles Edwin Bentley: A Model For All Times" were presented to ADA President Robert Griffiths and AAHD President Edward Leone by Clifton O. Dummett, professor of dentistry at the University of Southern California School of Dentistry and AAHD president-elect. The book, authored by Dr. Dummett and his wife, Lois Doyle Dummett, is an historical account of the life and times of Charles Edwin Bentley, father of the oral hygiene movement in the United States. Pictured left to right, Dr. Griffiths, Dr. Dummett, and Dr. Leone.

WHAT IS PROFESSIONALISM?

Here Are Some Worthy Definitions

Additional definitions of professionalism are respectfully requested from our readers

Professionalism is that quality of conduct which accompanies the use of superior knowledge, skill and judgment towards the benefit of another person or to society prior to *any* consideration of self-interest by the professional person or professional organization

Robert J. Nelsen, D.D.S.
Former Executive Director
American College of Dentists

Professionalism is that demanding code of behavior practiced by its adherents which requires an unstinting commitment to ever-expanding excellence in learning and knowledge and to the application of these goals to that discipline. It calls for unswerving devotion to lofty ideals of the discipline's mission in terms of social purposefulness. A fundamental tenet is devotion to service, one that is wholehearted and genuine, even when such devotion may require personal sacrifice. Professionalism involves an attitude and use of methods that differentiates itself from occupations which are entrepreneurial in nature. It is motivated by enduring values which are human, social and ethical in their contexts. Professionalism provides that quality of nobility to a discipline which gives it its self esteem, its self restraint and its self realization.

Alden N. Haffner, Ph. D. as adapted by
ACD Regent H. Curtis Hester, D.D.S.

Professionalism is the conduct, aims or qualities that characterize or mark a profession or a professional person. A profession is a calling requiring specialized knowledge and often long and intensive academic preparation.

Noah Webster as adapted by
Don L. Allen, D.D.S.

Professionalism in the true sense involves a concept of unselfish service to others and requires adherence to a code of ethical conduct of the highest order. There is no substitute for competence and personal integrity in a profession. While codes of ethics can establish valuable guidelines, there is no substitute for personal character and dedication to the proper discharge of professional duties and responsibilities. A professional is a person who not only possesses a superior knowledge and skill but also applies this expertise for the welfare of the individual who needs his service. A true professional is committed primarily to his patient's well-being and will not exploit the patient's need for personal gain.

James P. Verneti, D.D.S.
Past President
American College of Dentists

Professionalism is nothing less than the very essence of dentistry. It carries with it certain obligations and responsibilities to principle, as well as certain expectations about a code of behavior and ethics. Professionalism is a quality that lives and thrives in the unique character of each individual person. It seeks its nourishment in the moral integrity and commitment of each of us.

Regent Norman H. Olsen, D.D.S.

Professionalism means being engaged in an occupation for which the necessary preliminary training is intellectual in character, involving knowledge and to some extent experience, as distinguished from mere skill.

Judge Louis D. Brandeis as adapted by
William F. Vann, Jr., D.D.S.

SECTION ACTIVITIES

Northern California

Charles E. Carara Dies

The Secretary-Treasurer of the Northern California Section, who was a member of the 1983 ACD Nominating Committee, died suddenly, at age 61, while playing a game of tennis. A massive heart attack ended the smile and warmth of Charles E. Carara.

True, Charley was a great dentist, but we have plenty of great dentists and new ones are getting out of school every year. There was, however, only one smile and only one way of communicating human warmth unique with Charley.

He had a way of putting his personality even into such mundane tasks as his Secretary-Treasurer's reports. He had a way of making you feel that you were the most important person in the world.

I may forget Charley Carara if I live too long, but when my time comes to go where all old dentists must eventually go, I'll remember that his smile will be waiting to greet me just on the other side of the curtain.

William A. Elsasser

New Jersey

Chairman Thomas De Stefano conducted the meeting at the Coachman Inn in Clark. New Fellows recently inducted at the Las Vegas Convocation were invited as guests of the Section.

Regent H. Curtis Hester reviewed the new system of life membership being offered by the American College of Dentists for active members between the ages of 60 and 70. Dr. Hester also reported on the successful annual Student's Day program sponsored by the Maryland Section.

Vice-Chairman Joseph Pollack reported on the progress of a committee to develop a Student's Day program that would be sponsored by the New Jersey Section at one or both of the dental schools in New Jersey.

A contribution of \$250. will be made to each of the dental schools in New Jersey for the exclusive purpose of purchasing books for the school libraries.

Joseph Pollack



Pictured at Ming Tombs, Peking, China are, left to right, ACD Regent Sumner H. Willens; Philip J. Molloy, former Chairman of the New England Section and Abraham Nizel, professor of Nutrition at Tufts Dental School

Western Pennsylvania

The Western Pennsylvania Section presented a plaque to the University of Pittsburgh School of Dental Medicine in honor of retiring Dean Edward J. Forrest. The unveiling took place January 20 when the plaque was hung in the Deans Hall, which is opposite the Dean's Office in Salk Hall at the University of Pittsburgh.

The Section has also previously presented plaques honoring the three previous deans of the dental school, dating from 1904. The plaques are all located in the Deans Hall.

A miniature plaque was presented to Dr. Forrest for his personal use.

Ruth S. Friedman



The Dean of the University of Pittsburgh School of Dental Medicine, Edward J. Forrest, retired on December 31, 1982. Pictured, left to right, are Dean Forrest; Robert S. Runzo, immediate past president of the Western Pennsylvania Section; Edmund A. Nicotra, president of the Western Pennsylvania Section and James W. Smudski, the new Dean at Pittsburgh.

New York

The Section held its annual meeting in conjunction with the Greater New York Dental Meeting at the New York City Hilton Hotel.

Chairman George O'Grady presented Distinguished Service Awards to Alfred J. Keck, past Section Chairman; Gerard E. McGuirk, President of the New York Dental Service Corporation and immediate past Regent; Edwin S. Robinson, Chairman of Endodontics Division at Columbia University School of Dentistry and Irving J. Naidorf.

Special senior student achievement awards were presented to Eugene Antenucci, introduced by Dean Richard Mumma of New York University College of Dentistry and to Joseph Fink, presented by Dean Allan J. Formicola of Columbia.

Among the many dignitaries present were Abraham Kobren, ADA Trustee; Edward Whalen, President of the Dental Society of the State of New York; Anthony DiMango, Chairman of the Greater New York Dental Meeting and Gordon Rovelstad, Executive Director for the American College of Dentists.

New Officers for 1983 will be Howard L. Ward, Chairman; Robert L. Fisher, Secretary-Treasurer; Irwin Kolin, Historian; Herman Bosboom and Robert Nathan, members of the Executive Committee.

Robert L. Fisher

AN FTC VIEW ON CODES OF ETHICS

The Legal Limits for the '80's

E. Perry Johnson*

Director Bureau of Competition

Federal Trade Commission

Presented to the 17th Annual Symposium on Trade Association Law and Practice of the
Antitrust Law Committee
Bar Association of the District of Columbia

My topic today is the status under the antitrust laws, both now and through the 1980's, of codes of ethics employed by trade or professional associations. What I say, of course, reflects my own views and not necessarily those of the Commission or of any individual Commissioner.

The law in this area in many respects has its origins as far back as the Supreme Court cases of *Chicago Board of Trade*¹ and *Fashion Originators' Guild*,² but it has

*These remarks represent only the views of a member of the Federal Trade Commission Staff. They do not necessarily reflect the views of the commission or of any individual commissioner.

¹Chicago Board of Trade v. United States, 246 U.S. 231 (1918).

²Fashion Originators' Guild of America, Inc., v. FTC, 312 U.S. 457 (1941).

Ethical rules that limit essential aspects of competition, such as advertising, solicitation, competitive bidding, terms of trade and the like will be carefully scrutinized as possible violations of the Sherman Act or the Federal Trade Commission Act.

offspring almost as current as today's advance sheets. In *Chicago Board of Trade*, the Supreme Court rejected an antitrust challenge of a rule of the Board that prohibited its members from purchasing a type of grain contract after the close of the day's trading at any price other than the closing bid that day. The Court examined the history and consequences of this regulation

and found that, on balance, it promoted rather than inhibited competition.

In contrast, in *Fashion Originators' Guild*, the Court condemned under the Sherman and Clayton Acts an agreement among fashion designers not to sell to retailers that also bought from so-called "style pirates" who copied the designers' creations. Although the program was justified by the Guild as intended solely to eliminate unfair and unlawful methods of competition, the Court did not hesitate to term the arrangement a group boycott, a *per se* violation of the antitrust laws. The purported ethical justification was deemed irrelevant in view of the agreement's overriding purpose and effect of suppressing the competition provided by one segment of the garment industry.

A great deal of advertising is thus permitted and relatively little is prohibited.

Although most of the current cases in this area deal with the professions, rather than the manufacturing industries, the cases nonetheless adhere to the basic analysis used in these decisions. Recent cases such as the Supreme Court's decision in *National Society of Professional Engineers*³ and the FTC's *American Medical Association* opinion⁴ have made it clear that in judging ethical codes, the antitrust agencies and reviewing courts will look directly at the nature and character of a restraint and at its actual effects on competition. Whether entered into by a professional group or an industrial trade association, ethical rules that limit essential aspects of competition, such as advertising, solici-

In effect, the Commission concluded that the AMA had engaged in over-regulation in prohibiting all advertising in order to attack only that which was deceptive. The freedom of individual doctors to advertise truthfully had been unjustifiably fettered.

tion, competitive bidding, terms of trade, and the like will be carefully scrutinized as possible violations of the Sherman Act or the Federal Trade Commission Act.

But this statement marks only the beginning of the inquiry that trade and professional associations must make, because ethical rules certainly can be permissible under

the antitrust laws. A wide variety of provisions can be placed under the rubric of industry self-regulation through the use of ethical norms, and the analysis that must be applied does not end with the fact that they can be construed as agreements among competitors. The courts, and the Commission, have made it clear that they will consider a number of factors, including the origin of and the justification for the restraint, its real purpose, the degree to which it is narrowly tailored to achieve public interest goals, the aspect of competitive behavior that it regulates, the power of the trade group doing the regulating, and its actual or anticipated effect on competition. I would like today to briefly summarize some of the recent major developments in this area and to sketch where the law may be heading.

In the *Professional Engineers* case, the Supreme Court struck down a provision in the association's code of ethics that prohibited engineers from engaging in competitive bidding. This ethical provision directly restrained a major aspect of competition—the presentation of simultaneous competing proposals, including price terms, to a prospective purchaser to aid his decision as to which proposal to select. Although the Court did not explicitly treat this restriction as the equivalent of a horizontal price-fixing agreement and thus as illegal *per se*, it found it “on its face” to be an unreasonable restraint of trade. While *Professional Engineers* might plausibly be read as a rule-of-reason case in which the rule was applied with very little detailed analysis, the Supreme Court in its recent *Catalano* decision⁵ treated it as a *per se* case. Regardless of the precise characterization, since the anticompetitive effects of the rule were so clear and there was no procompetitive justification for the no-bidding rule, the Court had no

difficulty in holding the restraint illegal.

While the Court found the particular restrictions at issue in *Professional Engineers* to violate the antitrust laws, it did recognize that ethical norms in the professions “may serve to regulate and promote” competition in those sectors, and may thus be permitted under some circumstances.⁶ Although the

The FTC's final order in the AMA case specifically permitted the AMA to formulate and enforce “reasonable ethical guidelines” governing false or deceptive physician advertising.

contours of this permission have not yet been fully delineated, it is clear that procompetitive justifications may still be advanced against challenges to ethical restraints. These justifications should, however, be directed toward goals such as increasing the amount of available information, facilitating entry, and removing from the market methods of competition that detract from informed consumer choice and economic efficiency.

The opinion of the Commission in the *American Medical Association* case, which was recently upheld by the Second Circuit, further illustrates these points. In that case, the Commission was asked to consider the antitrust legality of the AMA's near-total prohibition of physician advertising and solicitation, as well as of its restrictions on the so-called “contract practice of medicine.” These latter rules governed physicians' dealings with “lay institutions” such as hospitals and health maintenance organizations. They were interpreted by the AMA to prohibit physicians' receiving “inadequate” compensation—that is, fees that undercut prevailing rates—or “underbidding” for the purpose of receiving a contract to render medical services. Citing *Professional Engineers*, the Commission held that these advertising and solicitation bans violate the rule of reason. On the other hand,

³National Society of Professional Engineers v. United States, 435 U.S. 679 (1978).

⁴American Medical Association, 94 F.T.C. 701 (1979), enforced as modified, American Medical Association v. FTC, 1980-2 Trade Cas. (CCH) ¶63,569 (2d Cir., October 7, 1980).

⁵Catalano, Inc. v. Target Sales, 446 U.S. 643, 647 (1980).

⁶435 U.S. at 696.

the restrictions on the contract practice of medicine, insofar as they directly restrained and stabilized prices, were held to be *per se* violations and no justifications were permitted.

In applying the rule of reason to the advertising and solicitation bans, the Commission balanced the competitive injury that had resulted from the restraints against the AMA's asserted justifications that the restraints aided competition by rooting out false advertising and poor medical care. The Commission unanimously concluded that "ethical restraints can be justified under the rule of reason only if they promote competition, rather than merely other social goals, and if they are not overly broad."⁷ It found that the breadth of the restrictions was not justified by the need to protect the public from deceptive advertising and offensive solicitation. In effect, the Commission concluded that the AMA had engaged in over-regulation in prohibiting all advertising in order to attack only that which was deceptive. The freedom of individual doctors to advertise truthfully had been unjustifiably fettered.

However, recognizing that self-regulation is permissible under the rule of reason if it promotes competition, the FTC's final order in the AMA case specifically permitted the AMA to formulate and enforce "reasonable ethical guidelines" governing false or deceptive physician advertising or the in-person solicitation of unusually vulnerable persons.⁸ This permissible self-regulation can be distinguished in a number of ways from the previously-existing ethical rules that were struck down in the case. It may be instructive for the purpose of antitrust counseling to make this contrast in some detail.

First, the regulation of false or deceptive advertising does not completely eliminate a major element or method of competition.

One of the underpinnings of the AMA order is the finding that the challenged restraints had sometimes been used by established physicians to hinder the efforts of other practitioners who wished to compete in price or service, either by advertising or by working for hospitals or HMO's.

Instead, this type of regulation permits physicians to advertise in any truthful and nondeceptive manner. A great deal of advertising is thus permitted and relatively little is prohibited. Second, the ethical standard is reasonably related to a procompetitive goal—the provision of accurate information to consumers—yet does not have too broad a scope. Third, the standard does not promote the economic interests of the group that promulgated it. One of the underpinnings of the AMA order is the finding that the challenged restraints had sometimes been used by established physicians to hinder the efforts of other practitioners who wished to compete in price or service, either by advertising or by working for hospitals or health maintenance organizations. These restraints lent themselves easily to the suppression of specific forms of competition and to the restriction of new entry and innovative forms of service. Legitimate self-regulation will not ordinarily have such effects.

These types of considerations are, I believe, relevant to trade association ethical standard-setting and self-regulation generally and not solely to the professions. Although the major cases lately have been in fields traditionally thought of as learned professions, it is clear that codes of ethics in the industrial or trade setting can have much the same legitimate justifications, or create much the same kind of antitrust problems, as in the professional sphere. In 1977, for example, the Public Relations Society of

America, a trade association, signed an FTC consent order that prohibits it from limiting the manner in which its members arrange the collection of fees and from restraining the solicitation of clients by its members.⁹ The Society's code of professional standards had prohibited contingent-fee agreements and had restricted firms from soliciting the clients of other member firms. In 1979, the New Jersey Pest Control Association agreed in an FTC consent order, among other things, not to arbitrarily deny membership to *bona fide* pest control firms and not to use its rules to suppress discounting.¹⁰

Recent lower-court cases in both the professional and the nonprofessional context have re-emphasized the standards that courts will apply to ethical rules and other forms of industry self-regulation. One illustrative case is *Hatley v. American Quarter Horse Ass'n*,¹¹ in which an association applied detailed standards in refusing to register a horse owned by the plaintiff as a "quarter horse." The plaintiff sued the association for violations of the Sherman Act. Applying the rule of reason, the court found no indication that the association had any animus against the plaintiff or any desire to exclude him, nor any indication that the classification rules were being applied arbitrarily or capriciously. Concluding that "in some sporting enterprises a few rules are essential to survival,"¹² the court dismissed the claim. The detailed classification rules for quarter horses might also be upheld as procompetitive in the sense that they maintained the quality of the breed or the fairness of competition between horses in the same class. Here the ethical standard was found to be legitimately related

⁹Public Relations Society of America, Inc., 90 F.T.C. 324 (1977).

¹⁰New Jersey Pest Control Association, 93 F.T.C. 23 (1979).

¹¹552 F.2d 646 (5th Cir. 1977).

¹²552 F.2d at 652.

¹³1980-81 Trade Cas. (CCH) ¶63,651 (2d Cir., November 24, 1980).

⁷94 F.T.C. at 1009.

⁸94 F.T.C. at 1037.

to a goal of the association that was not anticompetitive.

In contrast, the Second Circuit affirmed a finding that a trade association was liable for a Sherman Act violation in a case where legitimate standard-setting activity was abused. In *Hydrolevel Corp. v. ASME, Inc.*,¹³ the vice president of a firm with a dominant share in the market for low-water fuel cut-offs for boilers was also the vice chairman of the mechanical engineers' trade association that promulgated standards related to such products. He participated in a scheme to have the association declare unfit a new product made by a competitor of his firm by deliberately misinterpreting a provision of the code of standards. The court of appeals upheld a finding that the trade association itself was liable for his acts. The court noted that "absent some internal review procedures, no individual should be empowered to rule dispositively on the fitness of a competitor's product."¹⁴ The association's decision that the competitor's product had failed the standard could not be plausibly related to any procompetitive goal; indeed its only plausible purpose was to exclude a specific competitor.

Another type of behavior that will be considered unlawful is illustrated by the *Catalano* case. There, a group of competing beer wholesalers agreed to eliminate the granting of credit to retailers and to sell only if payment were made in advance or upon delivery. Since the agreement affected a term of trade that is in fact a portion of the price charged, the Supreme Court considered it a "price-fixing agreement"¹⁵ and refused to consider any countervailing arguments. Although the agreement in *Catalano* was not explicitly analyzed as an ethical restriction, the case is suggestive in that it demonstrates that restraints that directly affect price will still generally be judged on a *per se* basis.

In an important recent case not involving a traditional "learned profession," the Fifth Circuit considered the thorny issues related to the setting of standards by real estate brokers for participation in a multiple listing service. In *United States v. Realty Multi-List, Inc.*¹⁶ the defendant had excluded from membership in the service, and

Narrow motivations, such as the desire of an established group to impede new entry, will be scrutinized when they appear under the cloak of an ethical restriction.

thus from its accompanying benefits, brokers that did not have a favorable credit report and business reputation, did not keep customary business hours, or did not pay a mandatory fee of \$1,000 to purchase stock in the service. Applying the rule of reason, the court found all three restrictions to be broader than necessary to achieve the service's legitimate goals and therefore struck down all three. The "business reputation" criterion did not pass muster because it was "inherently subjective" and was thus not narrowly tailored to achieve its ends.¹⁷ The "customary hours" requirement also was overly broad and excluded an entire class of brokers—those working off-hours and part-time.¹⁸ The \$1,000 stock purchase fee was too high to represent the actual operational needs of the service in taking on a new member and thus was an unnecessary and exclusionary requirement.¹⁹

The *Realty Multi-List* decision is noteworthy for its searching examination of the validity of the purported justifications for a self-regulatory rule. It is also significant for its consideration of two other

important issues: how directly the association is involved in its members' business and how much market power the association has. It concluded that because the multiple listing service is essential to the brokers' ability to buy and sell homes on behalf of clients, and because competition to the service is lacking, the membership rules should be examined extremely closely. These two issues will be important in other cases as well.

The considerations raised in these cases reflect, I believe, the direction in which the law is heading in the area of self-regulation and ethical restraints. The rule of reason will frequently be applied, quite summarily when the restrictions are manifestly anticompetitive and more elaborately when a restraint affects competitive vigor less directly. *Per se* treatment will still be accorded to agreements that amount to price-fixing or to group boycotts. Courts can be expected to examine the justification for a restraint and to ask whether the means devised to achieve a legitimate goal is designed only to do that and nothing more. They will not hesitate to ask, "What is this real purpose of this rule?" and "Who really benefits?" Narrow motivations, such as the desire of an established group to impede new entry, will be scrutinized when they appear under the cloak of an ethical restriction.

We at the FTC believe we have done our share, in the *AMA* case and others, to impel the law of trade association ethical restrictions in this direction. We will continue to be concerned with this aspect of trade association behavior, while being attuned to the needs of associations that wish to regulate their trade or profession in a legitimate and pro-competitive manner. Δ

Reprinted with the permission of the Washington DC Bar Association

Reprint requests to the American College of Dentists

¹⁴ 1980-81 Trade Cas. at p. 77,503.

¹⁵ 446 U.S. at 650.

¹⁶ 629 F.2d 1351 (5th Cir. 1980).

¹⁷ 629 F.2d at 1382.

¹⁸ 629 F.2d at 1385.

¹⁹ 629 F.2d at 1387.

A PROFESSIONAL'S VIEW ON CODES OF ETHICS UNDER PRESENT FTC LAW INTERPRETATION

Impact of Antitrust Laws upon Trade and Professional Association Codes of Ethics

Basil J. Mezines*

Presented to the 17th Annual Symposium on Trade Association Law and Practice of the Antitrust Law Committee. Bar Association of the District of Columbia.

Today, industry is faced with problems confronting all persons who must deal with fuel shortages, environmental problems, inflation, high interest rates, and a host of other concerns. The government and consumers are demanding that industry do something. Industry naturally turns to its associations because Americans in a pluralistic society are trained and accustomed to working together. Associations then ask the question whether they or their individual members can collaborate in meeting some of the challenges without being involved in antitrust difficulties.

There is no question that a conflict may arise between antitrust objectives and collaborative activities among competitors attempting to solve some of the ills that have beset this country. This is especially true with regard to self-regulation by means of codes of ethics. In formulating codes of ethics, industry members and their associations should be aware that the FTC and the Justice Department are unable

Ethical precepts narrowly directed toward false or deceptive advertising and unfair solicitation may enhance competition by ensuring the communication of accurate information in a manner that allows it to be processed unburdened by unscrupulous practices.

to give an unqualified blessing to activities of this kind. In fact, it has been suggested that there is an element of risk and some peril if competitors or their associations develop potentially beneficial programs of self-regulation. The tests to evaluate such conduct are usually derived from certain key cases on the subject.

As a point of reference, *Chicago Board of Trade v. United States*¹ is most frequently cited. That case articulated the broad rule of reason to govern joint efforts of competitors:

The true test of legality . . . is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition.²

The Supreme Court, as well as the FTC, has taken what may fairly be described as an increasingly negative attitude toward restraints imposed in the name of business, ethics or public interest in a long line of cases from *Paramount Famous Lasky*³ and *Sugar Institute*⁴ in the 1930's to *Fashion Originators Guild*,⁵ *Radiant Burners*⁶ and *Silver v. New York Stock Exchange*.⁷

In *New Jersey Pest Control Association, Inc.*,⁸ the Federal Trade Commission alleged that denial of membership in the association pre-

²246 U.S. at 238.

³282 U.S. 30 (1930).

⁴297 U.S. 553 (1936).

⁵312 U.S. 457 (1941).

⁶364 U.S. 656 (1961).

⁷373 U.S. 341 (1963).

⁸[1976-1979 Transfer Binder] Trade Reg. Rep. (CCH) ¶ 21,502 (1978) (Consent Order).

*Stein, Mitchell and Mezines Law Firm Washington D.C.

¹246 U.S. 231 (1918).

vented non-members from gaining access to a substantial competitive advantage, and therefore was an unreasonable restraint of trade and an unfair method of competition under section 5 of the Federal Trade Commission Act. Under the terms of the consent order, the association was required to grant equal, uniform and non-discriminatory membership upon written application by any qualified dealer in pest control goods or services which does business in the territorial limits served by the Association.

Each of these cases, however, involved self-regulation which was a cover for clearly anticompetitive purposes or activities. Thus, these

Codes of ethics may enhance competition, at least with respect to advertising, by ensuring the communication of accurate information.

cases do not, in my opinion, indicate a hostility to *legitimate* schemes of self-regulation.

Moreover, lower courts have been more sympathetic and have dealt with the problem in a more realistic manner which indicates that the rule of reason enunciated in *Chicago Board of Trade* is still viable.⁹ Similarly, the FTC and the Justice Department have sanctioned ethical restrictions by trade and professional associations against false and deceptive advertising, as long as self-regulation does not infringe on legitimate commercial advertising.¹⁰

⁹ *Structural Laminates v. Douglas Fir Plywood Association*, 261 F. Supp. 154 (D.Ore. 1966); *aff'd per curiam* 399 F.2d 155 (9th Cir.) cert. denied, 393 U.S. 1024, (1969); *Marjorie Webster Junior College, Inc. v. Middle States Ass'n, Inc.*, 432 F.2d 650 (D.C. Cir. 1970).

¹⁰ *United States v. American Bar Ass'n*, Civ. No. 76 C-3475; *In re American Medical Ass'n*, Initial Decision [1976-1979 Transfer Binder] Trade Reg. Rep. (CCH) ¶ 21,491; modified [1979-____ Transfer Binder] Trade Reg. Rep. (CCH) ¶ 21,562 (October 12, 1979); *enforced as further modified* 1980-2 Trade Cas. (CCH) ¶ 63,569 (1980).

If the purpose of the ethical provision is to promote public welfare and not to burden a fellow competitor . . . the provision will be upheld as reasonable.

Because of these latter cases, I think I can sum up for you the current thinking of government officials when they consider self-regulative activity. **Self-regulation need not run afoul of the antitrust laws as long as the following guidelines are borne in mind:**

1. There is no interest in whether the motives of the participants are commendable or not, the actual effect of a particular program is what counts;
2. An association's bylaws or code of ethics must not contain exclusionary rules or foster tactics that would subject or would have the effect of subjecting any member to any competitive burden. Moreover, if the association administers any sanctions that result in competitive injury to any of its members, the program will probably be challenged on the theory that there is a private assumption of public power, and the extra-judicial imposition of punishment is a dangerous entrenchment upon the legislative authority of government; and
3. In sanctioning members for failure to adhere to its bylaws or code of ethics, an association must follow due process requirements, giving members the right of notice, hearing, and appeal or other review process.

Nevertheless, after we have reviewed these general guidelines, we are still faced with the possibility that conflict may arise between antitrust objectives and collabora-

tive activities among competitors. Let me illustrate this point with several examples.

Of course, we are familiar with the Supreme Court cases regarding professional self-regulation—*Goldfarb*,¹¹ *Virginia Pharmacy*,¹² *Bates*¹³ and *Professional Engineers*¹⁴—in which the Court struck down ethical canons that restricted competitive behavior among professionals.

However, in *American Medical Association v. FTC*, No. 79-4214 (2d Cir. October 7, 1980), the second circuit, under rule of reason analysis made it clear that ethical precepts narrowly directed toward false or deceptive advertising and unfair solicitation may enhance competition by ensuring the communication of accurate information in a manner that allows it to be processed unburdened by unscrupulous practices.

In the FTC's initial decision issued November 13, 1978 the administrative law judge (ALJ) held that the AMA's ethical restrictions against soliciting business through advertising deprived consumers of information necessary to make an informed choice of health care services and insulated physicians

The Antitrust division of the FTC . . . will not challenge codes of ethics unless it is clear that their design and effect has been to eliminate or restrain competition.

from the give and take of the marketplace.¹⁵ Therefore, the ALJ issued an order prohibiting the AMA from promulgating and implementing a code of ethics on advertising until two years after the order had become final, and then only with the prior approval of the FTC.

¹¹ 421 U.S. 773 (1975).

¹² 425 U.S. 748 (1976).

¹³ 433 U.S. 350 (1977).

¹⁴ 435 U.S. 679 (1978).

¹⁵ See [1976-1979 Transfer Binder] Trade Reg. Rep. (CCH) ¶ 21,491 (1978).

On October 12, 1979, the Federal Trade Commission issued its final decision and order in the AMA case.¹⁶ The Commission upheld the initial decision that AMA's *Principles of Medical Ethics* on solicitation, advertising and contractual activity, as implemented and enforced through the AMA's *Opinions and Reports*, constituted unfair methods of competition in violation of Section 5 of the FTC Act. However, the Commission eliminated from the final order the absolute ban for two years on any AMA ethical code on advertising and solicitation, and the requirement that thereafter such regulation receive prior approval by the FTC. In reversing the administrative law judge on this issue, the Commission found that the AMA has a "valuable and unique role to play with respect to deceptive advertising and oppressive forms of solicitation by physicians."¹⁷ In order to fulfill this role, the Commission's final order specifically permitted the AMA to formulate and enforce:

Reasonable ethical guidelines governing the conduct of its members with respect to representations, including unsubstantiated representations, that would be false or deceptive within the meaning of Section 5 of the Federal Trade Commission Act, or with respect to uninvited, in-person solicitation of actual or potential patients, who, because of their particular circumstances, are vulnerable to undue influence.

On appeal, the second circuit concluded that the Commission's findings were supported by substantial evidence. However, in response to the AMA's request that it be granted more leeway in determining what kind of claims are deceptive and misleading without the chilling effect that the threats

of fines and penalties could have on its regulation of false and deceptive advertising, the court amended part one of the Commission's order to permit the AMA to enforce reasonable ethical guidelines that the AMA *reasonably believes* would be false or deceptive within the meaning of section 5 of the Federal Trade Commission Act.¹⁸

Some trade and professional associations... have been quick to conclude that they cannot deal with their problems on a joint basis because of antitrust laws. Such early resignation does a disservice to the members... In short, timidity is not rewarded.

Therefore, the second circuit recognized that codes of ethics may enhance competition, at least with respect to advertising, by ensuring the communication of accurate information. The Justice Department, in dismissing its case against the American Bar Association, essentially reached the same conclusion.

Moreover, the FTC decided to forego a rulemaking proceeding regarding veterinarians' restrictions on advertising when the American Veterinary Medical Association eliminated from their code advertising restrictions on purely objective commercial information, and recommended that the states relax their laws against veterinarians' advertising. In addition, the FTC has closed investigations of other professional associations, such as the National Association of Accountants, when restrictions on truthful advertising were removed from the Associations' codes of ethics or bylaws.

However, in its AMA decision, the Commission made clear that in implementing a code of ethics, the professional or trade association must afford any member charged

with a violation of ethical standards due notice and opportunity for a hearing as described in *Silver v. New York Stock Exchange*¹⁹ before it imposes sanctions on the member. If the purpose of the ethical provision is to promote public welfare and not to burden a fellow competitor, as was the case in *Blalock*,²⁰ the provision will be upheld as reasonable.

I have cited these examples to show you that competitors and their associations must consider the antitrust implications of joint actions, such as promulgation of a code of ethics. However, this should not be used as an excuse to shirk the important role associations play in today's society. Nor should government officials avoid difficult or thorny questions by simply advising competitors and associations "you can't do it—you know antitrust, you'll get in trouble."

Therefore, I believe that taking the rule of reason approach first announced in *Chicago Board of Trade* and recently followed in *AMA* will give the right result. The Antitrust division of the Federal Trade Commission will take a realistic look at programs adopted by associations and will not challenge codes of ethics unless it is clear that their design and effect has been to eliminate or restrain competition. Some trade and professional associations as well as industry members have been quick to conclude that they cannot deal with their problems on a joint basis because of the antitrust laws. Such early resignation does a disservice to the members and to the many enlightened enforcement officials responsible for administering antitrust statutes. In short, timidity is not rewarded. Δ

¹⁹ 373 U.S. 341, 361-63

²⁰ 359 F.Supp. 1260 (N.D.Ga. 1973).

Reprinted with the permission of the Washington, DC Bar Association

Reprint requests to the American College of Dentists

¹⁶ See [1979— Transfer Binder] Trade Reg. Rep. ¶ 21,562 (October 12, 1979).

¹⁷ Final order at 58.

¹⁸ 1980-2 Trade Cas. ¶ 63,569 at 77,030.

SCHOOLS ARE RETURNING TO NORMAL

Changes in the number and calibre of dental school applicants and students

An historic perspective

H. Barry Waldman

Since the mid 1970s, the administrators and faculties of schools of dentistry increasingly have been preoccupied with the need for creative fiscal management and the precipitous downturn in the numbers of applicants for the entering classes. Ever-larger dental school classes and the accompanying enlarged physical plants of the 1960s and 1970s remain as monuments to past federal incentive funds. However, the curtailment in federal institutional support funds, student loans and scholarships have forced dental schools and their parent universities to reassess the fiscal viability of their dental education programs and the characteristics of the student able to afford ever-increasing tuition and accompanying fees.

H. Barry Waldman, D.D.S., M.P.H., Ph.D., Professor and Chairman Department of Dental Health School of Dental Medicine, State University of New York at Stony Brook, Stony Brook, New York 11794.

Reviews since the mid 1970s indicate decreases in the number of applicants to dental schools and the college academic performance of accepted dental students. However, a long term historic review of applicants, financial support programs and the calibre of students admitted, presents a general picture of a return to a more realistic state of equilibrium which existed prior to the establishment of massive federal incentive programs.

One immediate outcome of this re-evaluation has been a 8.7% reduction in the number of first year entering class places between 1978 and 1981. (Table I) It is anticipated that by the mid 1980s the decline in the number of available entering seats will amount to an additional 500-1000 places.⁵ To some degree,

this reduction in class size may serve to placate critics within the profession who have focused the cause of regional oversupply of dentists on the increase in the number of dental school graduates.⁶

Indeed dental schools administrators will continue to wrestle with the fiscal realities of decreasing federal support and the ability of lower income families to support the education of their children. However, we must not overlook the concomitant and potentially more incidious perception which seems to be finding its way into the literature and general discussions⁷; i.e. because of changes within the profession and the delivery of services, we are less able to attract qualified young men and women for the future of our profession.

It is in an effort to dispel this attitude that the following historic review of the number and calibre of dental school applicants and students is presented.

As was expected, the number of applications received by the dental schools decreased again between 1980 and 1981. The number of applications received for the 1981 year was 10.2% less than in 1980, which continues a trend begun in 1976.¹

Decline in applicants

Much of the emphasis on the decline in applicants to schools of dentistry since the mid 1970s commenced with the work by Graham and Kinsey.⁸ Their analysis of the 1975 to 1978 entering classes centered on a number of particular findings, including:

Region of parent's residence—they could offer no explanation for the more pronounced decline in applicants from the western part of the country.

Grade point average—the decrease in applicants has been primarily amongst those college students with poor grade point averages. As of their report, it had not adversely affected the quality of classes admitted to schools of dentistry.

College major—a decrease in applicants with engineering majors was attributed to the changing opportunities in the job market.

Parent's socio-economic status—the most significant decline in the applicant pool was among those students from lower middle class families. It was noted that, "there was a surprisingly large increase in applicants reporting Hispanic origins, while the decrease in Black applicants was significantly smaller than expected."

Continuing analysis by Solomon and Pait⁹ of the applicant pool and enrolled first year students between 1976 and 1980 demonstrated:

1. a continuing decline in the number of applicants,

2. an increase in the percent of first year dental students with science grade point averages of less than 3.0.

3. some fluctuation in undergraduate non-science grade point averages of first year dental students, but no overall change from the beginning to the end of the period of study.

4. scores below 5 in both DAT academic average and perceptual ability showed generally small but consistent increases from 1976 to 1980, and

5. publicly supported dental schools, as compared to privately supported schools, had consistently admitted smaller percentages of students with less than 3.0 science grade point averages.

There can be no question that continuation of these trends bodes poorly for the future of the profession and the public we serve. Yet, when these figures are placed in a longer historic context, a second and less foreboding interpretation

of these data is possible; i.e. the number of entering first year places and the number and calibre of applicants are returning to equilibrium that existed in times prior to the infusion of federal incentive funds, and general loan and scholarship programs.

However, as one reviews this alternative interpretation, we must not lose sight of the decline in applicants from the lower middle classes. Increased educational expenses and decreased availability of student aid programs pose the spectre of reserving the dental profession for the children of well-to-do families.

Applicant review

Between the mid 1940s and early 1960s there were about 6,000 appli-

Table I. Number of dental schools, first year places, applicants and applicants per first year place by year.²⁻⁵

| Year | Number Schools | First Year Places | Applicants | Applicants Per Place |
|-------------------|----------------|-------------------|--------------------|----------------------|
| 1945 | 39 | | 6,000 ^a | |
| 1950 | 41 | 3,226 | 6,000 | 1.8 |
| 1960 | 47 | 3,616 | 6,119 | 1.7 |
| 1962 | 48 | 3,680 | 6,566 | 1.8 |
| 1965 | 49 | 3,806 | 9,988 | 2.6 |
| 1966 | 49 | 3,942 | 10,177 | 2.6 |
| 1967 | 50 | 4,200 | 10,264 | 2.4 |
| 1968 | 52 | 4,203 | 9,037 | 2.2 |
| 1969 | 53 | 4,355 | 10,325 | 2.4 |
| 1970 | 53 | 4,565 | 10,413 | 2.3 |
| 1971 | 52 | 4,745 | 11,012 | 2.3 |
| 1972 ^b | 56 | 5,337 | 13,542 | 2.5 |
| 1973 | 58 | 5,445 | 14,876 | 2.7 |
| 1974 | 58 | 5,617 | 14,970 | 2.7 |
| 1975 | 59 | 5,763 | 13,102 | 2.2 |
| 1976 | 59 | 5,935 | 12,626 | 2.1 |
| 1977 | 59 | 5,954 | 10,685 | 1.8 |
| 1978 | 60 | 6,301 | 9,690 | 1.5 |
| 1979 | 60 | 6,132 | 9,811 ^c | 1.6 |
| 1980 | 60 | 5,999 | 9,601 | 1.6 |
| 1981 | 60 | 5,748 | <9,000 | 1.5 |

^a There were approximately 6,000 applicants for the dental admissions testing program per year during the 1945 to 1961 period.

^b The first year of the AADSAS system

^c Represents 15% over the 8,532 applicants to the 45 dental schools that participated in the AADSAS system

NOTE: Throughout the report a listed year represents the start of the particular academic year.

Table II. Number of applicants, applications and applications per applicant per year²⁻⁵

| Year | Number Applicants | Number Applicants | Applications per Applicant |
|-------------------|--------------------|---------------------|----------------------------|
| 1960 | 6,119 | 13,501 ^a | 2.1 |
| 1965 | 9,988 | 24,905 ^a | 2.4 |
| 1966 | 10,177 | 27,429 | 2.6 |
| 1967 | 10,264 | 29,651 | 2.8 |
| 1968 | 9,037 | 48,487 | 5.3 |
| 1969 | 10,325 | 56,939 | 5.5 |
| 1970 | 10,413 | 56,585 | 5.4 |
| 1971 | 11,012 | 61,385 | 5.5 |
| 1972 ^b | 13,542 | 82,068 | 6.0 |
| 1973 | 14,876 | 54,072 ^a | 3.6 |
| 1974 | 14,970 | 84,677 | 5.6 |
| 1975 | 13,102 | 92,508 | 7.0 |
| 1976 | 12,626 | 86,081 | 6.8 |
| 1977 | 10,685 | 81,765 | 7.6 |
| 1978 | 9,690 | 66,585 | 6.8 |
| 1979 | 9,811 ^c | 58,715 | 5.9 |
| 1980 | 9,601 | 52,218 | 5.4 |
| 1981 | <9,000 | 46,894 | >5.2 |

^aSlightly different numbers are presented in the 1974-75 and 1979-80 Trend Analysis of Dental Education. 1974-75 Analysis data used.

^bThe first year of AADSAS system. The decrease in the number of applications in 1973 may reflect the then new program.

^cRepresents 15% over the 8,532 applicants to the 45 dental schools that participated in the AADSAS system.

Table III. The average number of first year places and applications per first year place in public and private dental schools by year^{2-4, 10}

| Year | First Year Places | | Applications Per place | |
|------|--------------------|--------------------|------------------------|---------|
| | Public | Private | Public | Private |
| 1960 | 1,779 | 1,837 | 3.0 | 4.2 |
| 1965 | 1,937 | 1,869 | 5.5 | 7.5 |
| 1970 | 2,436 | 2,129 | 11.7 | 13.1 |
| 1973 | 2,974 | 2,471 | 11.9 | 15.4 |
| 1974 | 3,107 | 2,510 | 14.2 | 22.0 |
| 1975 | 3,254 | 2,509 | 10.9 | 22.7 |
| 1976 | 3,374 | 2,561 | 10.2 | 20.9 |
| 1977 | 3,387 | 2,567 | 9.8 | 21.9 |
| 1978 | 3,504 | 2,797 ^b | 7.4 | 18.5 |
| 1979 | 3,525 | 2,607 | 6.0 | 15.8 |
| 1980 | 3,547 | 2,542 | 7.0 | 11.4 |
| 1981 | 3,300 ^c | 2,400 ^c | 6.6 | 10.5 |

^aThroughout this report the division of institutions into private and public categories is based on ADA definition in its reports on Dental School Tuition.¹¹

^bNew York University School of Dentistry accepted a double class (408 students) in the process of transforming its program to a four year schedule.

^cApproximate data.

cants for the approximately 3200 to 3600 first year places, or about 1.7 to 1.8 applicants per first year seat. From the early 1960s through the mid 1970s, there was a 25 percent increase in the number of dental schools, a 40 percent increase in the number of first year places and a 150 percent increase in the number of applicants. By the mid 1970s, the applicant per seat ratio had increased to 2.7.

However, in 1975 a changing applicant pattern had started. By 1981, there was about a 40 percent decline in the number of applicants. As of 1981, the fluctuations in the number of applicants and the available first year places had returned the general applicant-per-place ratio to the general mid 1940's through early 1960's level. (Table I)

While increasing applicant per seat ratios permit admissions committees greater flexibility in the selection process, (not to mention flattering to our profession's collective ego) comparisons with the mid 1970s may be unrealistic because of large scale infusion of financial incentive during that period.

The dramatic increase in the number of applicants during the late 1960s and the early 1970s is reflected in the marked increase in the number of applications processed by schools of dentistry during this period. The increase in the number of applications per applicant may have reflected improving attitudes to a career in dentistry, the perceived difficulty in securing admissions to schools of dentistry, the relative ease of applying through the American Association of Dental School Central Applicant System (AADSAS system) or a possible combination of these and other factors. However, by the late 1970s the applications per applicant ratio had returned to the late 1960s level. (Table II)

The fluctuation in the number of applicants, the number of first year seats and related factors are particularly interesting when considered in terms of private and public supported institutions. In 1960, 49

Table IV. The average annual tuition and fee charges in public and private dental schools by year^{11,12}

| | Public | Private |
|------|-------------------|---------|
| 1970 | \$ 657 | \$2,027 |
| 1975 | 1,344 | 3,436 |
| 1976 | 1,638 | 4,040 |
| 1977 | 1,812 | 4,782 |
| 1978 | 1,957 | 5,584 |
| 1979 | 2,150 | 6,481 |
| 1980 | 2,315 | 7,578 |
| 1981 | 2,244* (2,800) | 8,702 |

*The 1981 figure is lower than the 1980 figure as a result of corrections made for University of Colorado tuition costs. In-state resident 1981 tuition costs were listed as \$2,844. Comparable 1980 tuition costs were listed as \$20,109. The difference results from tuition offset programs associated with work in underserved areas of the state. Over-all national average charges for 1981 under the former system would be approximately \$2,800.

percent of first year places were in public institutions. Twenty years later, 57 percent were in publicly supported schools. Throughout this period private institutions have received far more applications per first year place than their public school counterparts. Such differences could be a reflection of reputation, perceived differences in the quality of education, limitations of acceptances by public institutions to state residents or a possible combination of these and other factors. (Table III)

Both private and public institutions received the peak of their applications per place during the mid 1970s and by 1981 both experienced approximately a 50 percent decrease in the applicant to seat ratios. The relationship between public and private institutions has remained relatively constant throughout this twenty year period despite dramatic fluctuations in the numbers of applicants and a continuing difference in costs between private and public institutions (Table IV). Thus, as of 1981, the demand for a dental education at private and public institutions has returned to relatively the same ratios as existed prior to the major increases in the mid 1970s.

Finally, the decrease in the number of applicants to schools has had an impact on the rate of acceptances of individual applicants. Many more students have received multiple offers of first year seats in the last number of years. (Table V)

Financial Support Review

Between 1950 and 1964 a decline occurred in the dentist to population ratio from 57.2 to 56.1 per 100,000 and in the active non-federal dentist to population ratio from 49.4 to 44.8 per 100,000.¹⁵ By 1967, the Task Force on Health manpower of the National Commission on Community Health Sciences supported the ADA's Survey of Dentistry's estimate "that merely to maintain the current supply of dentists in proportion to the expanding population would

require a 75 percent increase in the capacity of dental schools expected in 1970 and an even greater expansion if allowance is to be made for increasing demand."^{14,15}

In accordance with these findings, the federal government passed a variety of pieces of legislation during the 1960s and early 1970s which provided funds for building new and expanding existing schools of dentistry and providing support loans and scholarships for individual students. By 1973, the Bureau of Economic Research and Statistics of the ADA had found that the trend documented in 1964 had been reversed and that the number of professionally active dentists were growing proportionately faster than the U.S. population.¹⁶ The changing picture in dental manpower of the nation was reflected in the subsequent decrease in federal government support for dental schools. (Figure 1)

Finally, as would be expected, the marked increase and following decrease in federally sponsored student loans and scholarship is closely related to the late 1960s to late 1970s fluctuation in the number of applicants to schools of dentistry. (Table VI)

Calibre of students

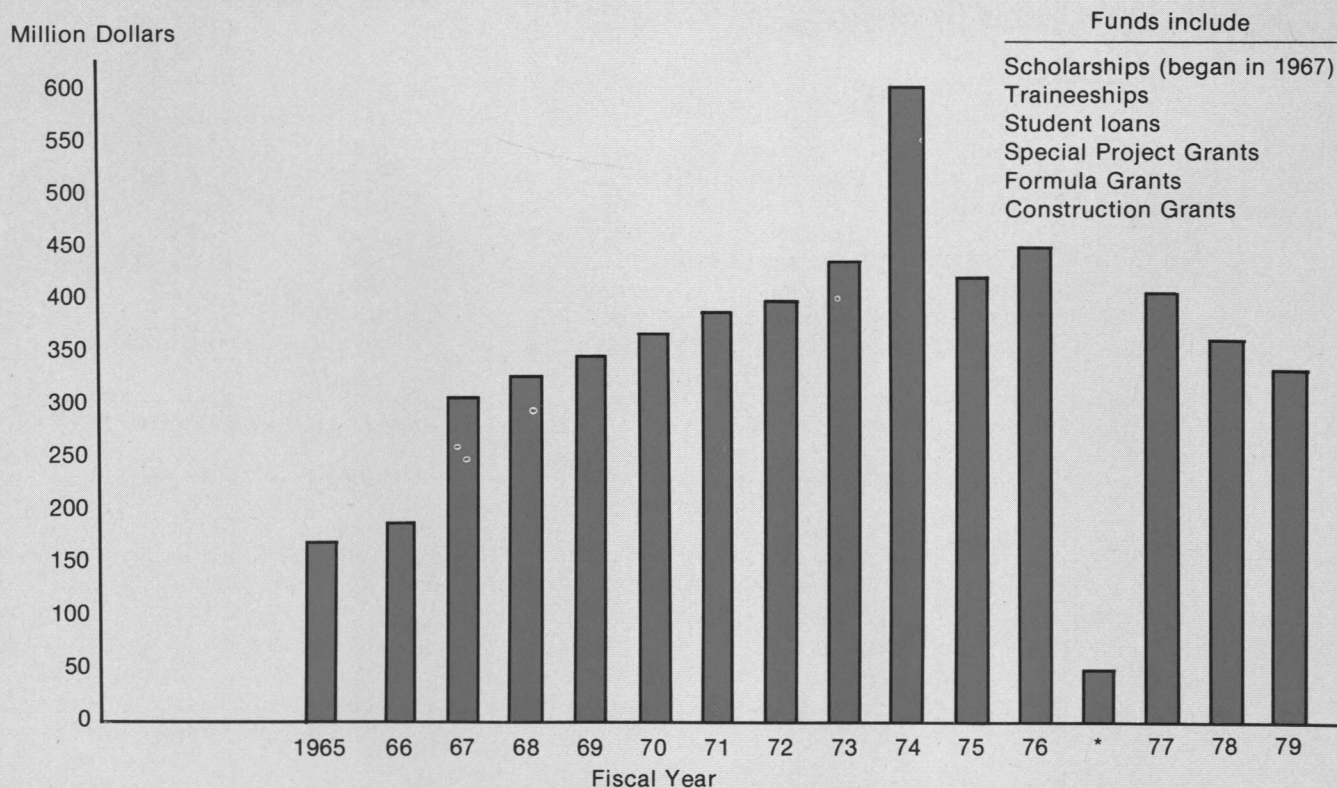
As noted previously, Solomon and Pait⁹ reported an increase (between 1976 and 1980) in the percent of entering first year dental students with science grade point averages (GPA) below 3.0. In addition, they noted a consistent lowering of academic and Perceptual Motor Ability Test (PMAT) and dental admission test (DAT) scores during this same period.

However, efforts by these and other researchers have been concentrated on the mid 1970s to 1980 period (the "down-side" of the curve of applicants and federal supported loans and scholarship programs). The mid 1970s were a very unique time in admissions to dental schools. Competition for places in the first year classes

Table V. Percentage of successful dental school applicants by the number of acceptances¹³

| Number of Acceptances | 1977 | 1978 | 1979 | 1980 | 1981 |
|-----------------------|-------|-------|-------|-------|-------|
| 1 | 83.9% | 76.7% | 61.3% | 68.0% | 59.3% |
| 2 | 11.7 | 16.3 | 24.0 | 19.6 | 20.8 |
| 3 | 3.4 | 4.8 | 9.1 | 7.7 | 10.5 |
| 4 | 0.8 | 1.5 | 3.1 | 2.7 | 4.6 |
| 5 | 0.1 | 0.5 | 1.4 | 1.2 | 2.3 |
| 6 & over | 0.1 | 0.2 | 1.1 | 0.8 | 2.5 |

Figure I. Amount of funds awarded to dental schools by federal programs, fiscal years 1965-1979¹⁷



* Transition Quarter: July 1, 1976-September 30, 1976

Table VI. Number of dental students and amount of loan and scholarship funds for health profession training by fiscal year¹⁷

| Year | Loans | | Scholarships | |
|-------------------|--------|---------------------|------------------|---------------------|
| | Number | Amount ^a | Number | Amount ^a |
| 1965 | 3,367 | \$2,871 | | |
| 1966 | 4,472 | 4,624 | | |
| 1967 | 5,530 | 7,132 | 799 ^b | \$ 808 ^b |
| 1968 | 5,944 | 6,822 | 1,869 | 1,476 |
| 1969 | 6,373 | 6,778 | 3,136 | 2,354 |
| 1970 | 5,494 | 3,584 | 4,092 | 3,165 |
| 1971 | 5,352 | 5,471 | 4,046 | 3,005 |
| 1972 | 6,739 | 6,636 | 4,168 | 2,893 |
| 1973 | 7,334 | 7,581 | 4,280 | 2,656 |
| 1974 | 6,778 | 7,165 | 3,390 | 2,463 |
| 1975 | 6,737 | 6,883 | 2,571 | 1,305 |
| 1976 ^c | 2,996 | 4,294 | 723 | 637 |
| 1977 ^c | 2,996 | 4,136 | 784 | 565 |
| 1978 ^c | 2,605 | 3,595 | na | 143 |
| 1979 ^c | 2,418 | 3,627 | 0 | 0 |

^a In \$1,000's

^b Began in fiscal year 1967

^c Figures for the year are estimated

essentially eliminated applicants to many schools whose college average dipped below 3.0, 3.2 or even higher. Applicants with advanced graduate training became increasingly common. Because of the peculiarities of this period, a review of GPA and DAT scores for students admitted to dental schools prior to the mid 1970s may offer a more "normal" base period for comparison purposes.

In this context, a review of 1980 and 1981 average undergraduate performance for students admitted to private and public institutions are not only similar to admitting averages during the earlier 1970s, but in some instances, the current scores are higher. (Table VII)

However, any effort to compare grade point averages of college students in the late 1960s and the early 1970s with those in later years

Table VII. Overall grade point average, science grade point average, academic and PMAT dental admission test average scores for entering classes in public and private dental schools by year¹⁸⁻²⁰

| Year | Overall G.P.A. | | Science G.P.A. | | Academic D.A.T. | | P.M.A.T. | |
|-------------------|----------------|---------|----------------|---------|-----------------|---------|----------|---------|
| | Public | Private | Public | Private | Public | Private | Public | Private |
| 1973 ^a | | | | | 4.81 | 4.97 | 4.65 | 4.70 |
| 1974 | 3.16 | 3.12 | 3.13 | 3.06 | 4.90 | 4.88 | 4.87 | 4.66 |
| 1975 | 3.22 | 3.19 | 3.18 | 3.11 | 4.76 | 5.01 | 5.00 | 5.21 |
| 1976 | 3.28 | 3.22 | 3.25 | 3.15 | 4.82 | 5.15 | 5.03 | 5.23 |
| 1977 | 3.27 | 3.24 | 3.21 | 3.20 | 4.84 | 5.23 | 4.79 | 5.36 |
| 1978 | 3.20 | 3.24 | 3.24 | 3.17 | 4.89 | 4.96 | 5.10 | 5.09 |
| 1979 | 3.26 | 3.22 | 3.20 | 3.14 | 4.90 | 4.70 | 5.01 | 5.25 |
| 1980 | 3.24 | 3.15 | 3.17 | 3.04 | 4.73 | 4.72 | 4.95 | 5.05 |
| 1981 | 3.16 | 3.11 | 3.20 | 2.90 | 4.71 | 4.68 | 4.89 | 4.99 |

^aThe American Dental Association and the American Association of Dental Schools did not publish national admission data prior to this period, nor is such data available from either association.

must take into consideration commentaries regarding the inflation of college grades during the earlier period. Several investigators, writing in the mid 1970s refer to the grade system as being "unreliable and corrupt",²¹ with "B having replaced C as the standard for satisfactory performance."²² The inflation of grades was often asso-

ciated with the development of pass/fail systems, competition for graduate school programs and concern by instructors that the receipt of lower grades could result in students being drafted into the Vietnam conflict.²²⁻²⁴

Although studies at many institutions demonstrated an overall increase in undergraduate GPAs, lit-

tle information is available to indicate whether the inflation of grades occurred at all or some particular levels of the grade scale, or whether the major inflation process had passed by the time the admitted dental students (in this review) had entered undergraduate college study. Therefore, overall GPA and science GPA comparisons should be considered with some degree of care.

On the other hand, the dental admission test is a competitive examination independent of inflationary factors. The mean DAT scores for each section is established at a score of 4.0 with a standardized distribution established between 9 and -1. Thus comparable admission DAT scores for the early 1970s and the early 1980s may be considered with a higher degree of confidence than comparable GPA records.

Finally, because our basic concern is whether changes in the calibre of admitted students would effect the practitioner's eventual ability to provide needed dental services a review of the performance on licensing examinations was carried out. A 30 year review of the percent of failures on state and regional boards indicates no particular relation between the rate of failure and the number of applicants or applicants per seat. The increase in the failure rate in the

Table VIII. Percent of recent dental school graduates who failed their licensure examination, and the number of applicants and applicant per entering place at the time the graduating students entered dental school by the year of graduation^{25,26}

| Year | Percent failed | Applicants ^a | Applicants per entering seat ^a |
|-------------------|----------------|-------------------------|---|
| 1950 | 7.64% | approx. 6,000 | approx. 1.7 |
| 1960 | 8.61 | approx. 6,000 | approx. 1.7 |
| 1965 | 10.01 | 5,841 | 1.6 |
| 1970 | 9.07 | 10,177 | 2.6 |
| 1971 | 8.84 | 10,264 | 2.4 |
| 1972 ^b | 8.15 | 9,037 | 2.2 |
| 1973 | 10.42 | 10,325 | 2.4 |
| 1974 | 11.71 | 10,413 | 2.3 |
| 1975 | 11.20 | 11,012 | 2.3 |
| 1976 | 10.78 | 13,542 | 2.5 |
| 1977 | 9.62 | 14,876 | 2.7 |
| 1978 | 10.63 | 14,970 | 2.7 |
| 1979 | 7.18 | 13,102 | 2.2 |
| 1980 | 9.40 | 12,626 | 2.1 |

^aassumption made that all programs were four years in length

^bfirst year of regional boards

^cchanges in 1980 ADA licensure report do not permit comparison of data with that of previous years. The recorded failure rate represents the weighted average failure rate of 3,734 recent dental school graduates who completed the four regional board examinations.

early 1970s seems to be associated with the introduction of the regional board testing programs. (Table VIII)

Some perspectives

There is no question that changes have occurred and will continue to occur in the applicant pool to schools of dentistry and in higher education in general. "Enrollments in higher education are expected to peak in 1981-82 and then begin to drop, a trend predicted to continue for 15 or 16 years. The birth rate tends to follow a 16 year cycle period and we are now at the bottom of that birth rate per capita projection."²⁷ As of the early months of 1982, a majority of colleges and universities received fewer freshman applications than at the same time a year before.²⁸

Yet, even as the applicant pool continues to decrease, other investigators are suggesting newer sources of qualified applicants. For example, Waldman²⁹ reported that students who majored in liberal arts undergraduate courses performed as well in dental school and as well or better on the licensing examinations as did dental students who majored in the physical and natural sciences in undergraduate colleges.

Stated simply, dental education is passing through a period of readjustment with many *long term signs* indicating a return to a more realistic *state of equilibrium*. Thus fears regarding the interest of qualified young men and women in a dental career can to a degree be assuaged—at least for the present. However, continuing dental school fiscal difficulties will impact on applicants and students and must in the long run have significant impact on the future of our profession.Δ

References

1. Covering letter from Dave R. DeMarais, Director of the Division of Educational Measurement, American Dental Association, to Deans of Dental Schools and Admission Chairmen. Letter accompan-

- ied Supplement 7 to the *Annual Report on Dental Education, 1981-82*. Undated.
2. Dental Education, Trend Analysis. *Annual Report on Dental Education, 1974-75*, Supplement 10. Chicago, American Dental Association, 1975.
3. Dental Education, Trend Analysis. *Annual Report on Dental Education, 1979-80*, Supplement 11. Chicago, American Dental Association, undated.
4. Dental School Admission Information 1981/82. *Annual Report on Dental Education 1981/82*, Supplement 7. Chicago, American Dental Association, undated.
5. Personal communication, American Association of Dental Schools, April 1982.
6. Sherburne, N.J. Have the dental schools deserted us? *Dental Economics*, 71:23, December 1981.
7. Waldman, H.B. Would you want your child to be a dentist? *Dental Economics*, In press.
8. Graham, J.W. and Kinsey, R.B. A analysis of the decline in dental school applicants, 1975-78. *Journal of Dental Education*, 43:107-14, February 1979.
9. Solomon, E. and Pait, C. Impact of the applicant decline. *Journal of Dental Education*, 45:812-14, December 1981.
10. *Applicant Analysis, 1980 Entering Class*. Washington, D.C., American Association of Dental Schools, undated.
11. Dental School Tuition, 1981/82. *Annual Report on Dental Education, 1981/82*, Supplement 13. Chicago, American Dental Association, undated.
12. Solomon, E. The Applicant Decline. Report to Planning Committee on September 25, 1981 and to Executive Committee on September 24, 25, 1981. American Association of Dental Schools. 17p mimeo.
13. Letter from DeMarais, D.P., Director of the Division of Educational Measurement, American Dental Association, to Deans of Dental Schools and Admission Chairmen, undated.
14. National Commission on Community Health Services. *Health Manpower: Action to Meet Community Needs*, Report of the Task Force on Health Manpower. Washington, D.C., Public Affairs Press, 1967.
15. Douglass, C.W. and Cole, K.O. The supply of dental manpower in the United States. *Journal of Dental Education*, 43:287-302, May 1979. The authors provide an extended historic discussion on the supply of dental manpower.
16. American Dental Association, Bureau of Economic Research and Statistics. Growth in population and number of dentists to 1985. *Journal American Dental Association*, 87:901-3, October 1973.
17. U.S. Department of Health and Human Services, Bureau of Health Professions. *Trends in BHP Program, Statistics, Grants, Awards, Loans—FY 1957-79*. DHHS Publication No. (HRA) 81-3. Washington, D.C. Government Printing Office, 1981.
18. Dental School Admission Information 1975/76, 1976/77, 1977/78, 1978/79, 1979/80, 1980/81, 1981/82. *Annual Report on Dental Education, 1975/76, 1976/77, 1977/78, 1978/79, 1979/80, 1980/81, 1981/82*, Supplement 7. Chicago, American Dental Association, undated.
19. Analysis of applicants to dental school and first year enrollment, 1974. *Annual Report on Dental Education, 1974/75*, Supplement 7. Chicago, American Dental Association, undated.
20. Analysis of applicants to dental school and first year enrollment, 1973. *Annual Report on Dental Education, 1973/74*, Supplement 8, Chicago, American Dental Association, undated.
21. White, E.M. Sometimes an A is really an F. *The Chronicle of Higher Education*, 9:24, February 3, 1975.
22. Suslow, S. A report on an interinstitutional survey of undergraduate scholastic grading, 1960s to 1970s. Office of Institutional Research, University of California, Berkeley, 1976; in Singleton, R. Jr. and Smith, E.R. Does grade inflation decrease the reliability of grades. *Journal of Educational Measurement*, 15:37-41, Spring 1978.
23. Scully, M.G. Grade Inflation. *The Chronicle of Higher Education*, 9:2, October 9, 1974.
24. Birnbaum, R. Factors related to university grade inflation. *Journal of Higher Education*, 48:519-39, September-October 1977.
25. Trend Analysis 1980/81. *Annual Report on Dental Education 1980/81*, Supplement 11. Chicago, American Dental Association, undated.
26. *1980 Dental Licensure Report*. Chicago, American Dental Association, undated.
27. Smith, J.M. Perspectives on Dental Education. *Journal of Dental Education*, 45:741-5, November 1981.
28. Freshman Applications down 2 Pct. from last year, Survey shows. *The Chronicle of Higher Education*, 24:8, April 14, 1982.
29. Waldman, H.B. College major and its relation to performance in dental school and on licensing examinations. *Journal of Dental Education*, 46:163-5, March 1982.

Reprint requests to:
Dr. H. Barry Waldman
School of Dental Medicine
State University of New York
Stony Brook, NY 11794

1982 CONVOCATION LAS VEGAS



The officers of the American College of Dentists left to right, Executive Director Gordon H. Rovelstad, outgoing President Richard J. Reynolds, incoming President Odin M. Langsjoen, President-elect Lynden M. Kennedy, Treasurer Robert W. Elliott, Jr., and Editor Keith P. Blair.



Candidates and their sponsors are lined up and waiting for the Convocation procession to start.

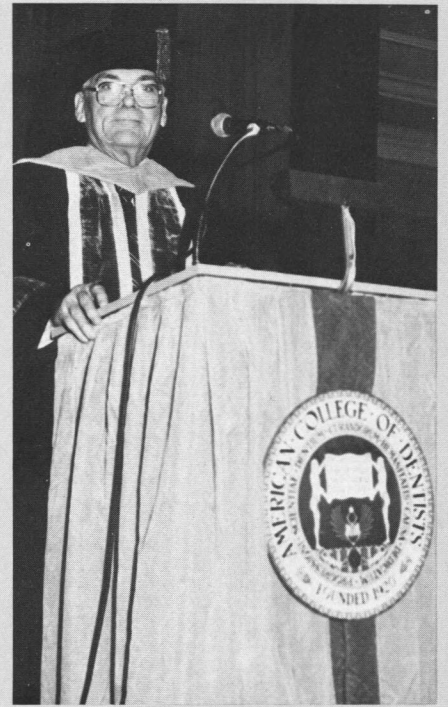
Photos by Dr. Edward F. Leone



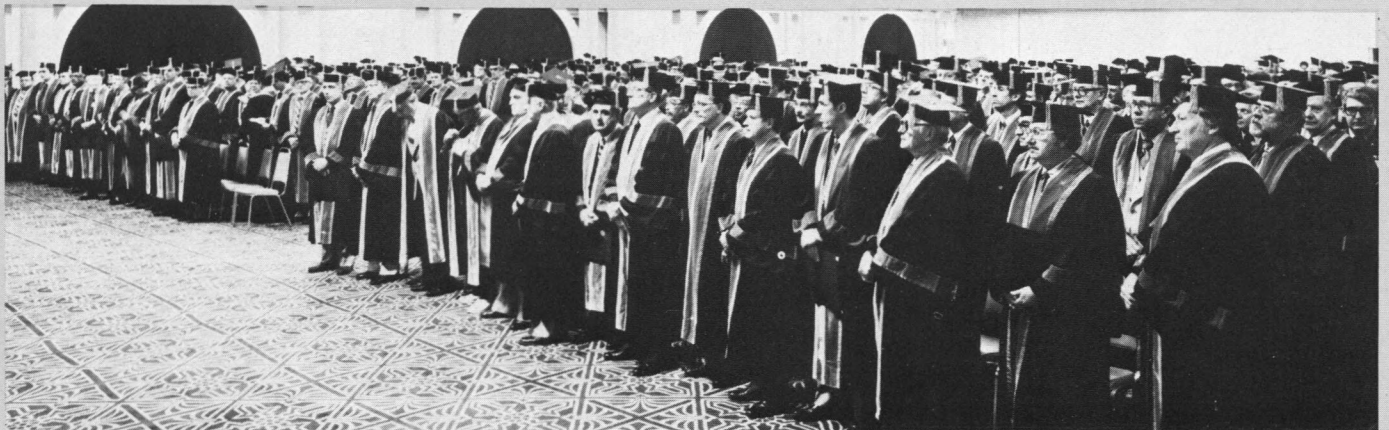
The Convocation stage during ceremonies.



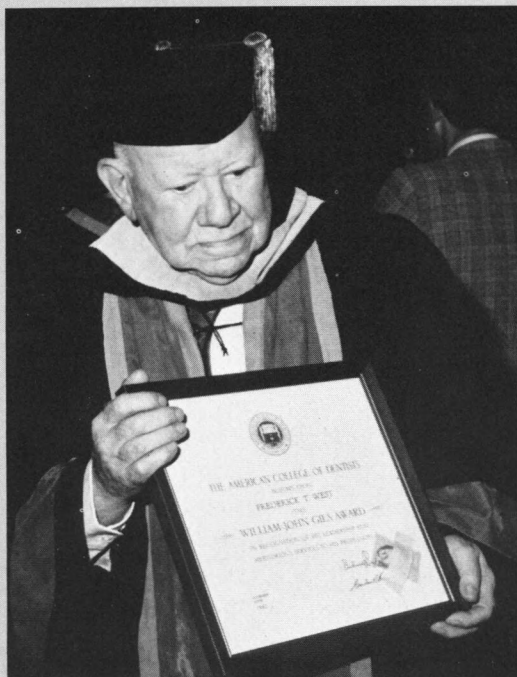
William P. Humphrey, left, bearing the Mace and William S. Brandhorst carrying the Torch.



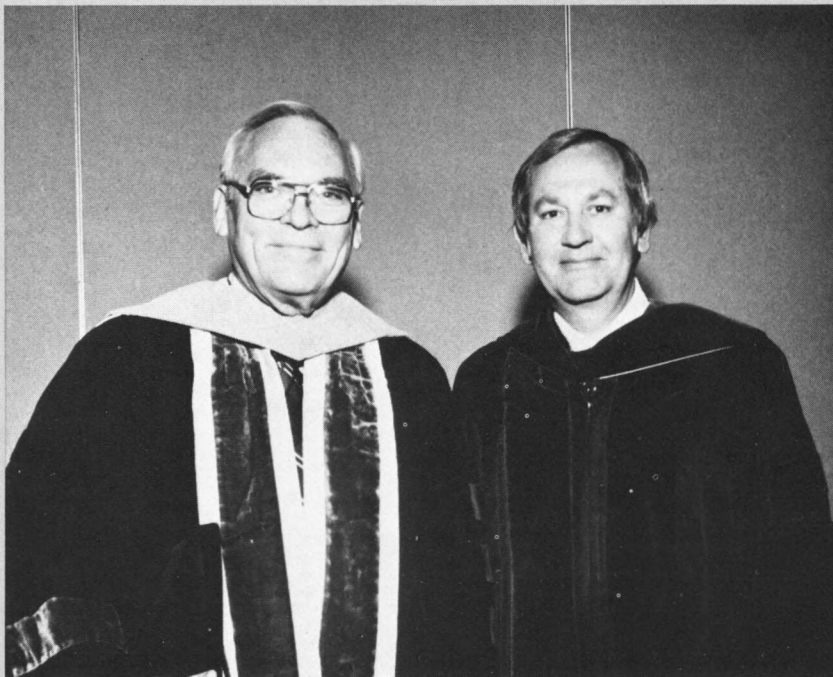
President Richard J. Reynolds.



Candidates for Fellowship and their sponsors assembled for Convocation ceremonies.



Recipient of the Gies Award for 1982, Dr. Frederick T. West of San Francisco.



President Richard J. Reynolds and Convocation Speaker James C. Hunt, M.D., Chancellor for the Center for Health Sciences at the University of Tennessee.



Waiting for the Convocation Procession to begin: left, Treasurer Robert W. Elliott; center, President-Elect Lynden M. Kennedy; background, James C. Hunt, Convocation speaker; right, incoming President Odin M. Langsjoen.

Photos by Dr. Edward F. Leone



Left to right, Regent Norman H. Olsen; Mr. Henry M. Thornton, who received an Honorary Fellowship in the College; Mr. James E. Brophy who was given the College's Award of Merit; Regent H. Curtis Hester and Regent Gerard E. McGuirk.

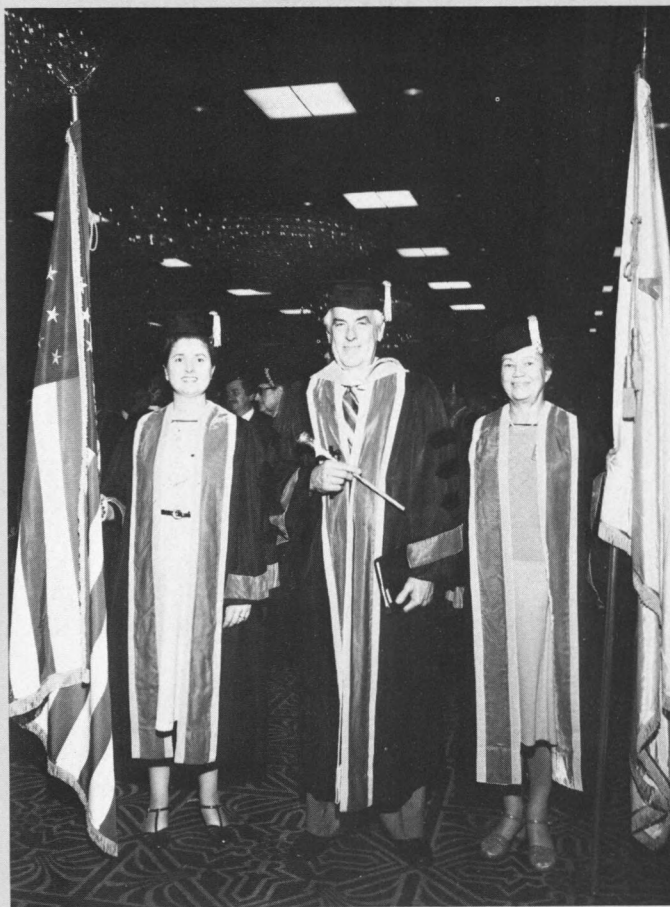


Fellows who served as ushers for the Convocation, left to right Jack F. Conley, Thomas H. Baumann, Ernest L. Casares, Robert S. Prario, J. Thomas Chess and Gale D. Kloeffer.

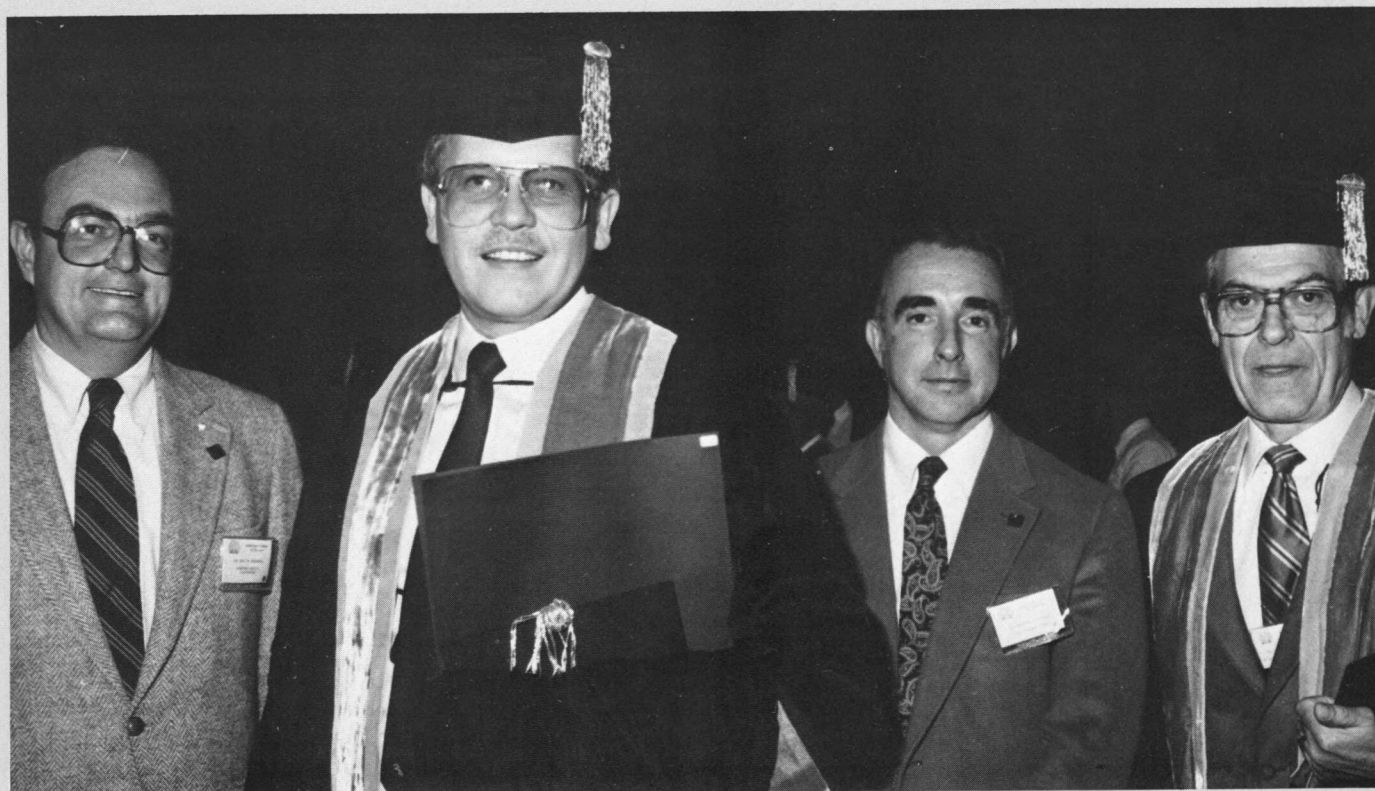
Photos by Dr. Edward F. Leone



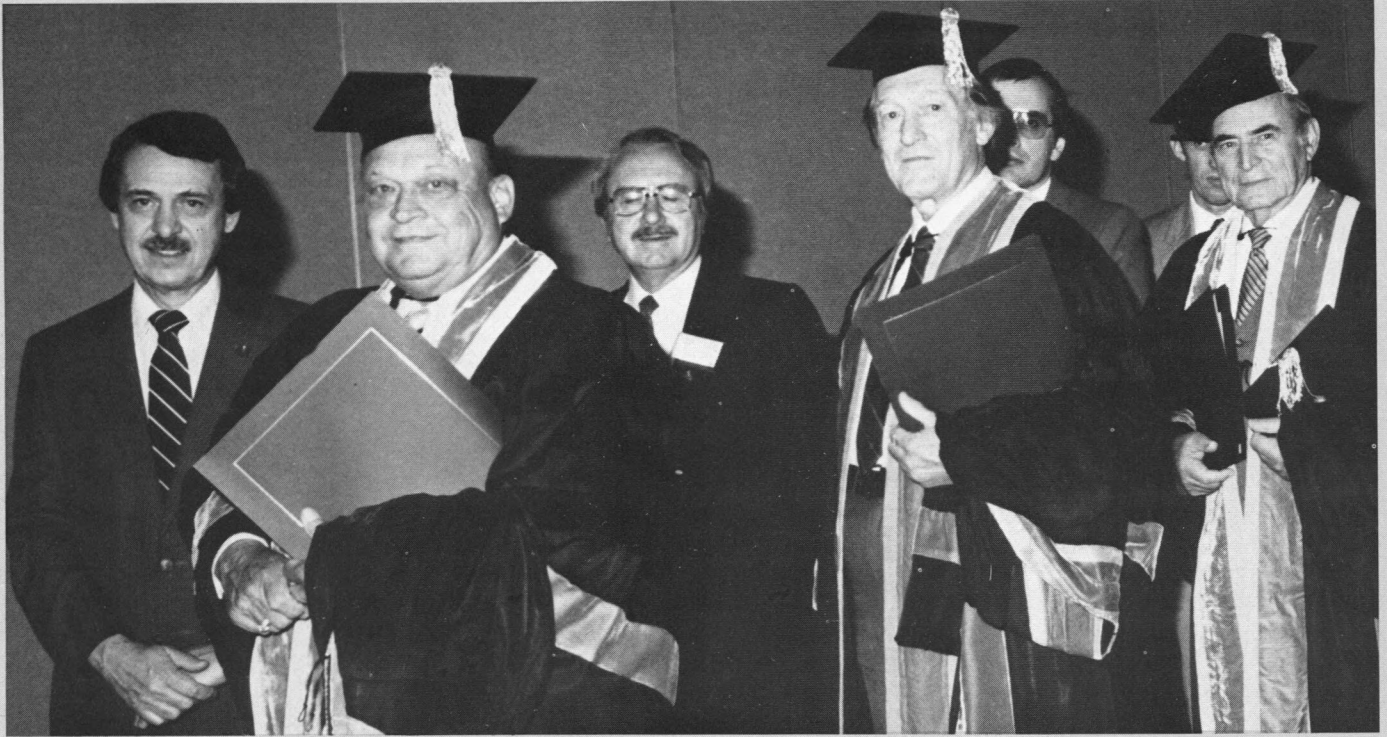
Gordon H. Rovelstad, Executive Director of the American College of Dentists



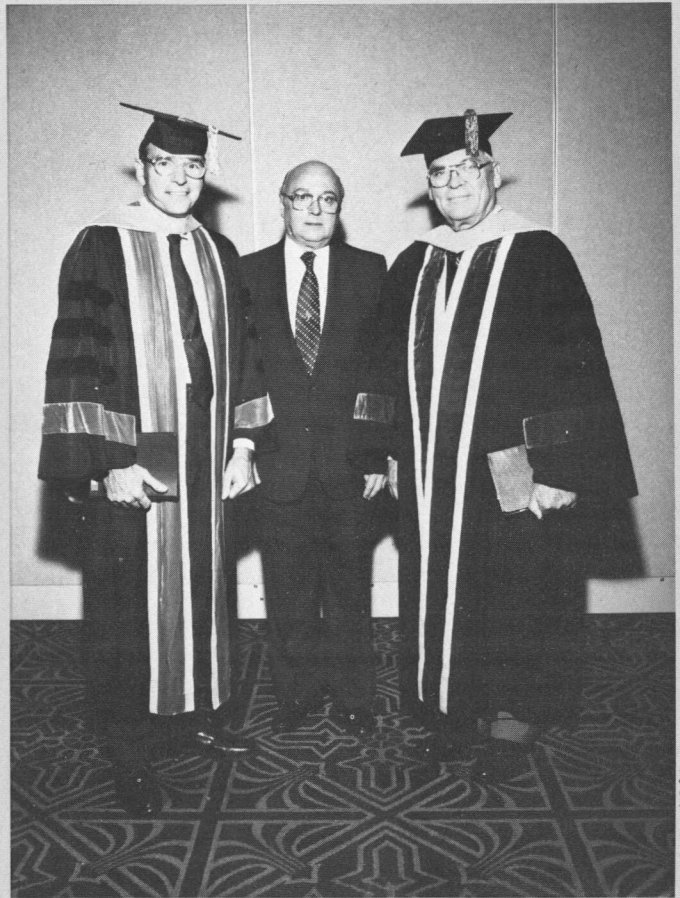
Assistant Marshal for the Convocation, Regent Paul S. Butcher with Flag Bearers Jean E. Campbell, left, and Frida A. Khonga



Photos by Dr. Edward F. Leone



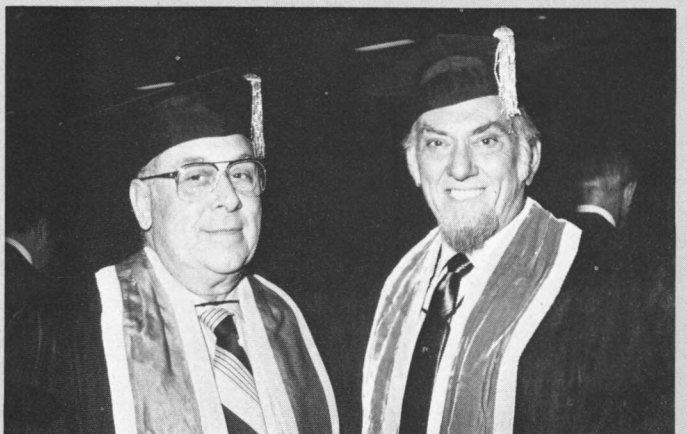
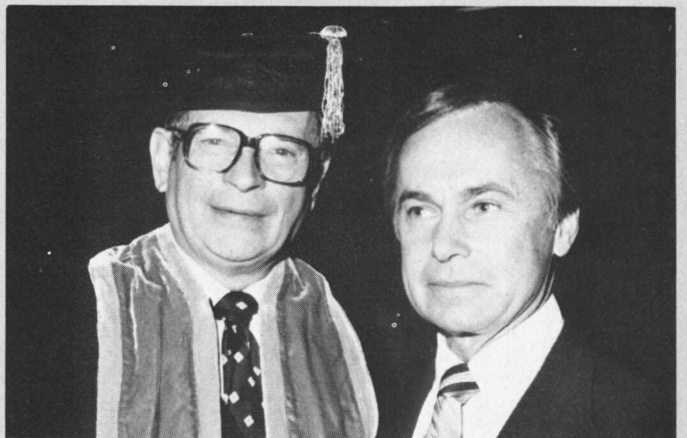
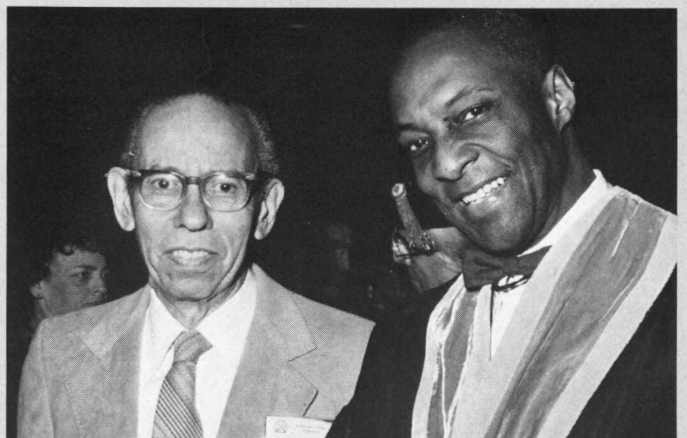
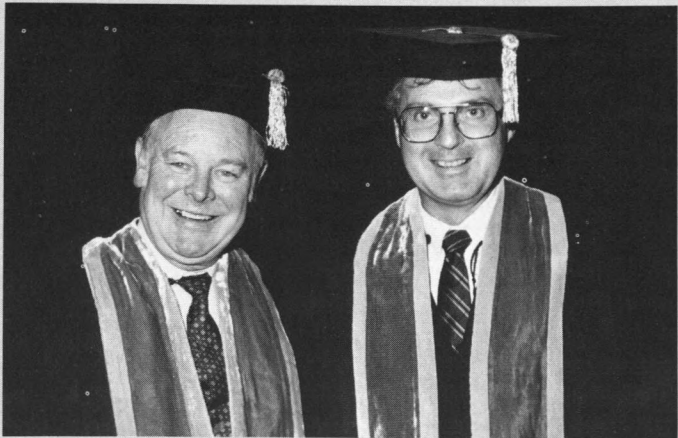
Left to right, Regent Robert A. Cupples; recipient of the Gies Award, Dr. Frederick T. West and President Richard J. Reynolds.



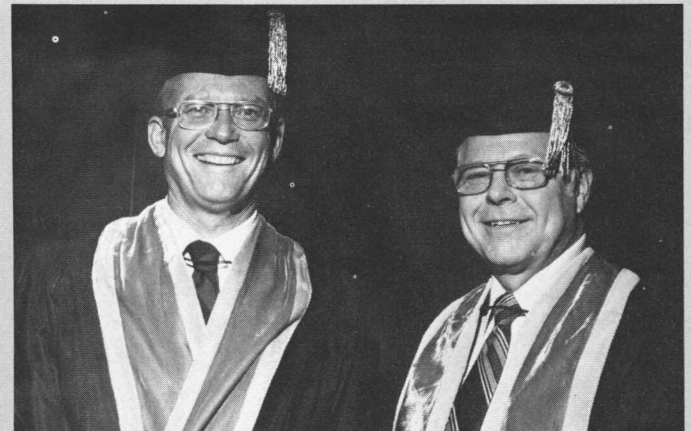
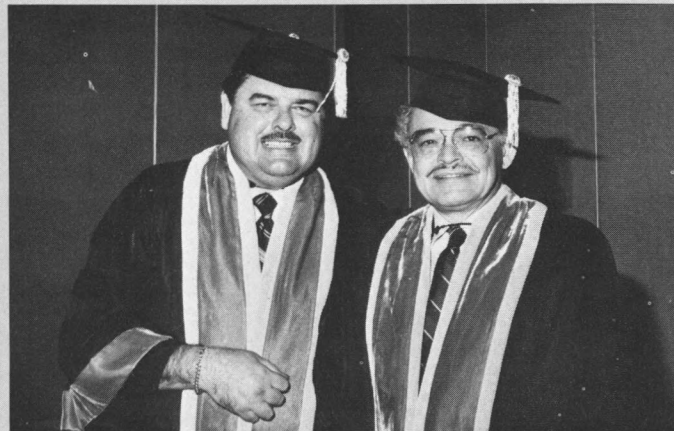
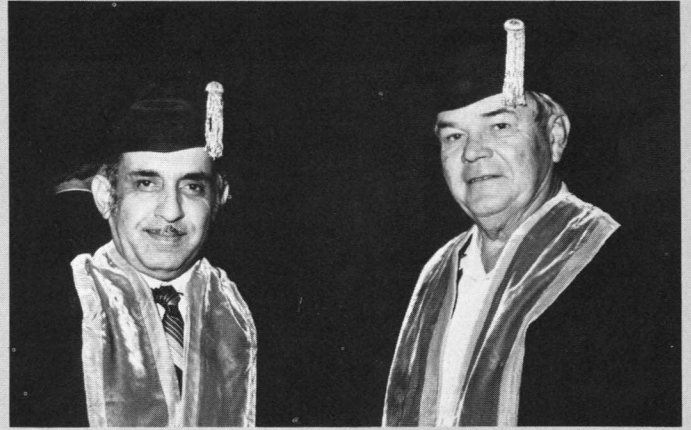
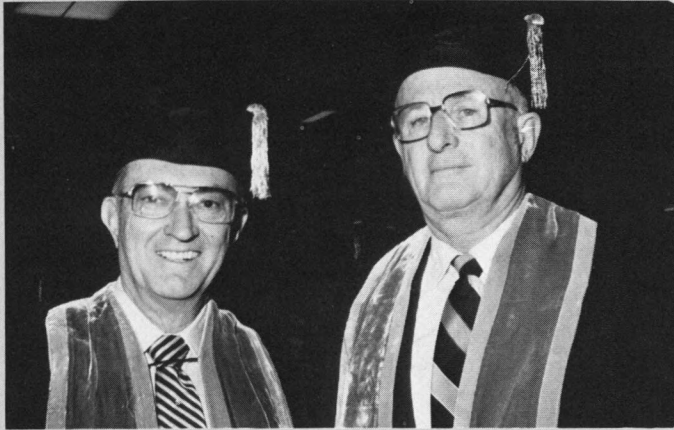
Left to right, Regent H. Curtis Hester; Mr. James E. Brophy, who received the College's Award of Merit and President Richard J. Reynolds.

Photos by Dr. Edward F. Leone

FACES IN THE CROWD



Photos by Dr. Edward F. Leone



Photos by Dr. Edward F. Leone

MEETING OF SECTION OFFICERS AND REPRESENTATIVES



This page top left, President Reynolds addresses the Sections Meeting. Seated, left to right Treasurer Robert W. Elliott, President-Elect Odin M. Langsjoen and Regent Charles W. Fain, Jr. This page, top right, Regent Norman H. Olsen, speaking to the group regarding Section Activities. Below, a view of some of the Section officers and representatives attending the Sections Meeting. Opposite page, Section representatives at the meeting. Each Section that was represented received an attendance plaque.





THE DENTIST AND VOLUNTARISM: A TWO-WAY STREET

Arden G. Christen*

Voluntarism has been defined as the "giving of one's self in the service of needy individuals or for the sake of a charitable cause—the philanthropy of self."¹

Many dentists across our nation generously contribute their time, energy and money in a wide variety of unpaid, volunteer-community work. These individuals want to be involved in actively promoting human welfare and values. They participate in a wide spectrum of organizations including voluntary health societies, professional dental associations and groups dealing with charity work, educational undertakings, museum projects, nursing/retirement home programs, political endeavors, religious causes and other philanthropic activities.

However, there is evidence that some dentists do not understand the personal benefits of volun-

tarism.² It is the purpose of this article to present a current overview of voluntarism and to dispel the notion that this activity is a one-way street for the dentist. As a currently involved volunteer for the American Cancer Society and as an observer of many other voluntary agencies, I will express by means of a personal perspective, the enriching and rewarding aspects of voluntarism.

Importance of Voluntarism

Presidential Perspectives: In 1976, President Jimmy Carter stated that, "We must fully pursue a voluntary society, whereby citizens can work in partnership with public and private efforts to accommodate human and environmental needs."³ In 1981, President Reagan further expressed his feelings concerning the importance of voluntarism to our country. He said, "Voluntary agencies offer creative, less expensive ways and more efficient alternatives to

In a modern, fragmented society which places an increasing emphasis on individualism and egoism, many persons no longer consider themselves as joiners.

solving our social problems. That energy will accomplish far more than governmental programs ever could."⁴ In March 1982, President Reagan visited the Fort Wayne (Indiana) flood disaster victims. As he helped place sandbags along the dike of the swollen St. Mary's River, he stated that he was proud of the volunteer workers, calling their efforts the "Spirit of America."⁵

Current Status: In 1980, an estimated forty-seven percent of Americans (84 million) volunteered 8.4 billion hours (100 hours per person) for all causes.⁶ The total value of these services was worth about \$64.5 billion each year. This makes voluntarism the biggest business in the United States, the veritable "grease of American Society." In today's world, volunteer power is

*Arden G. Christen, D.D.S., M.S.D., M.A. Chairman, Department of Preventive Dentistry, Oral Health Research Institute, Associate Professor, Indiana University, School of Dentistry.

far from a luxury. Every aspect of American life is touched and influenced by the volunteer industry. (The American Cancer Society alone has an estimated 2 and 1/3 million volunteers).⁴

A Recent Volunteer Slowdown

In spite of these statistics, the number of present volunteers in American society has been dwindling, and some programs are being cut back, due to a lack of workers.² Why is it becoming more difficult to interest dentists in serving dental and/or community organizations? Although the issue is complex, a number of factors seem to be operating.

As a result of recent economic hard times (including the well-known dental "busyness" problem), almost everyone seems to be feeling pressure to devote more time and energy to solve financial problems, and to meet personal and family needs.² Many younger dentists believe they cannot afford to donate their time, as it would rob

them of hours needed in their new practice. With dental advertising being greatly expanded in recent years, the dentist may feel that he or she can turn to ads to gain patients, rather than getting them through personal contacts made in community pursuits. A number of the old guard volunteers have become burned out, disinterested or disillusioned from their previous experiences. Some volunteers have been overwhelmed with work in the past, and are "gun shy" and reluctant to accept additional responsibilities. Others are unwilling to put in the amount of time they previously did, saying, "I've paid my dues. We need some new blood in this organization."

In a modern, fragmented society which places an increasing emphasis on individualism and egoism, many persons no longer consider themselves as joiners. Presently, there is definitely less emphasis on fraternalism and organizational work, while more groups are competing for an individual's time. Our parents were taught the importance of developing and practicing

altruistic values. In yesteryear, these "ought to do" influences were strongly emphasized and reinforced in a variety of widely-supported social institutions, including churches, schools and community organizations. These social pressures are greatly diminished or attenuated in today's world. Nowadays, the tendency is to ask, "What's in it for me?"

Openly negative and hostile attitudes toward voluntarism have cropped up recently, especially in trade unions and in the women's movement.³ Volunteers have been charged with undermining the economic equality between the sexes. Unpaid workers are seen by some as unfairly depriving others of gainful employment. The question is asked, "Why should one work for no pay?" At one time, only women were perceived as being volunteers. Now, for every 8 hours given by women, men volunteer 10 hours, in performance of the same service.¹ Furthermore, volunteer services have expanded to include youth, handicapped persons, professionals and retirees.

**Table 1—A Bill of Rights for Volunteer Workers
(The United Way).⁸**

1. The right to be treated as a co-worker—not just as free help . . . not as a *prima donna*.
2. The right to a suitable assignment . . . with consideration for personal preference, temperament, life experience, education and employment background.
3. The right to know as much about the organization as possible, its policies . . . its people . . . its programs.
4. The right to training for the job . . . thoughtfully planned and effectively presented training.
5. The right to continuing education on the job—as a follow-up to initial training . . . information about new developments . . . training for greater responsibility.
6. The right to sound guidance and direction . . . by someone who is experienced, well informed, patient and thoughtful . . . and who has the time to invest in giving guidance.
7. The right to a place to work—an orderly, designated place . . . conducive work . . . and worthy of the job to be done.
8. The right to promotion and a variety of experiences—through advancement to assignments of more responsibility . . . through transfer from one activity to another . . . through special assignments.
9. The right to be heard—to have a part in planning . . . to feel free to make suggestions . . . to have respect shown for an honest opinion.
10. The right to recognition—in the form of promotion . . . and awards . . . through day-by-day expressions of appreciation . . . and by being treated as a *bona fide* co-worker.

Motivations for Volunteering

In 1976, Howarth⁷ suggested that the volunteer worker is "one who has a well-developed social conscience, and concern for the welfare of others; who is relatively low in anxiety (neurosis) manifestations, including health worries, who is trusting and persistent." He surmised that the volunteer was impelled by conscience, a feeling that a helping hand should be extended, regardless of any monetary reward.

People engage in volunteer work for one or more of five major reasons (not necessarily in this order): (1) Self Interest (egoism), (2) Unselfish concern for the welfare of others (Altruism), (3) Companionship; enjoying the company of others (Sociability), (4) Social Responsibility, and (5) Religious Duty.⁷

The "Give and Take" of Volunteering

In my opinion, any worthwhile volunteer activity should serve both the needs of others *and* those of the volunteer. As Cirigliano² has so aptly expressed it, volunteer motivation should be "compared to a pair of scissors; one blade consists of the needs the person brings to a situation, and the other blade is what the situation brings to the person."

The United Way, recognizing these facts, has published a "Bill of

Rights" and "Code of Responsibility" for volunteer workers (Table 1 and 2). These guidelines stress the fact that volunteer activities should not become trivial "busy work." e.g. Ideally, voluntarism should meet a specified need of a target audience and match the talents, interests, and capabilities of the volunteer to the responsive organization. If voluntarism is not rewarding, few individuals are going to stick with it. A person's abilities, time and worth are too valuable to be wasted!

Rewards To Be Experienced in Voluntarism

Since 1969, I have been involved with volunteer activities in the quit-smoking and tobacco education arena. They have been by a variety of voluntary health, community and religious organizations. I believe that the major satisfactions and benefits I have derived are shared by my colleagues who are actively giving of their time and talents. In the following section, I shall list and briefly describe six of the major benefits that one can receive from voluntarism.

(1) Voluntarism can provide challenging opportunities which can produce change and lead to significant contributions.

Dentists can stimulate community interest in dental health by their participation in health and science fairs, school screenings, fluoridation initiatives and by speaking before local audiences. Voluntary

Table 2—A Code of Responsibility for Volunteer Workers (The United Way).⁸

Be sure: Look into your heart and know that you really want to help other people.

Be convinced: Don't offer your services unless you believe in the value of what you are doing.

Be loyal: Offer suggestions but don't "knock".

Accept the rules: Don't criticize what you don't understand. There may be a good reason for it.

Speak up: Ask about things you don't understand. Don't coddle your doubts and frustrations until they drive you away, or turn you into a problem worker.

Be willing to learn: Training is essential to any job well done.

Keep on learning: Know all you can about your hospital or agency and your job.

Welcome supervision: You will do a better job and enjoy it more if you are doing what is expected of you.

Be dependable: Your word is your bond. Do what you have agreed to do. Don't make promises you can't keep.

Be a team player: Find a place for yourself on the team. The lone operator is pretty much out of place in today's complex community."

organizations have provided encouragement, money and resources, which enable dentists to produce films and videotapes, to develop and publish books, scientific articles, pamphlets and news stories.

Through existing organizational structures, dentists have a showcase for expressing their talents and a platform where their ideas and opinions can be questioned and re-evaluated. As a result, many dentists have been able to effectu-

ate policy decision changes and/or influence events within the organizations or communities. The dentist/volunteer often has the chance to help raise the standards, image and prestige of the dental profession. This active contribution is in contrast to the position of being on the outside looking in, helplessly and passively unable to exert influence. The entire shape and direction of a profession can be affected by the efforts of a single, dedicated volunteer!

As a result, professional or social problems can be solved and a significant, lasting contribution can be made to a profession or community. Consider, for example, the dentists who are actively involved in helping their patients quit smoking. This valuable service is greatly needed in the community. A life may actually be extended in the process. As a volunteer, I have known the satisfaction of having an emphysema victim say to me, "Doctor, remember me? Because of you, two years ago I was able to give up smoking. Thanks!"

My American Cancer Society volunteer efforts have produced some positive "spill-over" effects within my own family. My wife and four daughters have been supportive of my work, even when it has infringed on "family time". As my daughters entered their teens, they helped in conducting quit smoking clinics and school-oriented tobacco education programs. The negative aspects of smoking have been impressed upon their minds since early childhood, and as they have

matured, smoking has never had an allure for them.

Volunteer activities are often a labor of love as opposed to a duty. Work which allows a person to feel needed, appreciated and rewarded by positive results raises self esteem far beyond the rewards offered by labor which is undertaken primarily for financial gain.

Nowadays, the tendency is to ask, "What's in it for me?"

(2) Voluntarism acquaints people in the community with the volunteer and his or her profession, serving as a legitimate form of business advertisement. Dentists often report making personal contacts with potential dental patients during their highly visible volunteer activities. This could be especially valuable early in the dentist's career when the practice needs building. People in the community learn to think of the volunteer as a caring person and this favorable opinion is spread by word of mouth (still the best form of advertisement!). A future-oriented, unconscious mind set has been created. The caring volunteer may soon find his dental appointment book is being filled with names of those who have been positively affected or impressed by his community efforts.

For the dentist working in an

institutionalized setting, voluntarism could help in career advancement. Many private companies, military organizations and universities place importance on active involvement in the local community. These efforts bring credit to the organization and extend its mission. For faculty members, these activities are often considered proof of continuing professional development, and can assist in qualifying one for academic advancement. These volunteer activities may be mentioned in an academic promotion dossier, military efficiency report or a periodic personnel evaluation form.

(3) Voluntarism can help the dentist develop contacts and working relationships with a varied group of people from all social and economic levels. Interacting with such a wide variety of individuals gives the professional person a broader view of life and teaches one the intrinsic value of all humankind. We may indeed profit from associations with those who are wealthy, highly educated and famous, but we can also learn a great deal from the most humble and least visible of persons. Lasting friendships may result with others of like mind and persuasion, and also with those totally unlike ourselves.

Many individuals have later used their volunteer activities as a springboard to gainful employment in a new career. A reference from a respected voluntary agency has real value in the job market.

(4) **Volunteering can help the dentist acquire and develop important interpersonal skills and interests in human relations, writing, parliamentary procedures, and public speaking.** Many of these skills were not a part of the highly technical training procedures of dental school. There are ample opportunities for exercising leadership among voluntary groups. Committee-work can sharpen one's ability to interact with people. By involvement in fact-finding, problem-solving and decision-making, volunteers may be asked to appear on television or radio talk shows, as representatives of the organization and its causes.

(5) **Volunteering offers the opportunity for the dentist to develop identity, special credentials, expertise and prestige in a field.** My volunteer efforts during the past 13 years have enabled me to develop a special interest and working knowledge of the oral ill-effects of tobacco. As a result, I have been able to collect and classify hundreds of scientific articles, photographs and case reports related to this topic. This has naturally led to speaking engagements, writing for publication, active research projects and consultation activities. One can thus become identified both locally and nationally as an "expert" in a field of importance. Certainly, being held in high esteem by my peers is very rewarding, and the plaques, certificates and small intangible gifts of appreciation I have received, have meant a great deal to me. It is a prominent part of our human nature to desire to have

influence; to serve as a role model or mentor to others.⁸

Volunteer organizations publish free lay and professional literature and journals which help keep one informed and motivated. Volunteer organizations, periodically sponsor delegates to attend board meetings, conferences, dinners and workshops within and out of the state, sometimes giving financial compensation for travel. Nationally known speakers often contribute to the programs.

(6) **Voluntarism is one activity that can be continued into one's retirement years.** Many retired people who serve as volunteers, have been able to garner a great deal of self-respect and feelings of worth, and obviously experience continued feelings of usefulness and pride in their accomplishments, long after their professional careers have ended. Not only do retired people have the time to do volunteer work, but they have learned how to overcome one of the most severe problems experienced by the elderly, loneliness and social isolation. Most older Americans are mentally alert and physically active. They have the talent, experience and knowledge that is needed by voluntary agencies.⁹ The donation of these human resources can be used to fulfill the needs of the giver and of society.

In summary this article presents an overview of voluntarism. It describes some benefits which a dentist can derive from engaging in this activity. Voluntarism can (1) create opportunities to produce change and significant contribu-

tions, (2) acquaint people in the community with the volunteer and his or her profession, thereby creating a potential practice building situation, (3) help the dentist to form contacts and working relationships with a varied group of people throughout the community, (4) aid the dentist in developing and sharpening important interpersonal skills and interests, (5) offer the opportunity for the professional to develop special credentials, expertise and prestige in a field, and (6) provides a challenging activity which can be extended into one's retirement years.

References

1. Rockwood, B. Myriad of programs serve well. *Hospitals* 50:121-124, 1976.
2. Cirigliano, L. Volunteers: the new challenge. *Calif Assoc Dent J* 9:28-35, 1981.
3. Rommel, B. Voluntarism in throes of change. *Hospitals* 51:147-152, 1977.
4. Adams, L.W. The volunteer commitment. *Cancer News* 36:14, 1982.
5. Associated Press News Clipping. *Indiana Daily Student*, March 17, 1982.
6. News article. *Worldscan*. *The Lutheran* 20:19, 1982.
7. Howarth, E. Personality characteristics of volunteers. *Psychol Rep* 38:855-858, 1976.
8. Stephenson, M. Why volunteers for a council. *Dent Hyg* 56:16, 1982.
9. Beverley, E.V. Retirement: values and volunteerism. *Geriatrics* 30:122,127,129, 133,137, 1975.

Reprint requests to:

Dr. Arden G. Christen
School of Dentistry
University of Indiana
1121 West Michigan St.
Indianapolis, IN 46202

PEDIATRIC DENTISTRY

The Advantages of Practicing in a Low Caries Rate Community

Enrique Bimstein *

Preventive programs in dentistry have been most effective^{1,2} Due to this success, the economic security of a pediatric dental practice may be questioned, but on the other hand, a pediatric dental practice that provides treatment to a community with a low caries rate has various positive aspects.

The purpose of this paper is to emphasize the advantages of practicing pediatric dentistry in a community with a low caries rate, based on a comparison with a practice in a community with a high caries rate. This comparison is based on impressions from my professional experience in two communities, Jerusalem and San Francisco. It does not intend to be a comprehensive comparison, it merely uses the possible faults of one situation to stress the advantages of the other.

*Lecturer in Pedodontics, Hadassah Faculty of Dental Medicine, Hebrew University of Jerusalem. Actually visiting professor in the Department of Pediatric Dentistry, University of the Pacific, San Francisco, Ca.

A Pediatric Dental Practice In A Community With A High Caries Rate. The Undesirable Effects.

In Jerusalem, where I have had most of my professional experience, 7 year old children have shown an average of 7.9 carious teeth and 13.2 carious surfaces.³ A caries rate like this together with a low dentist/patient ratio may lead to an imbalance between the treatment needs and the ability of the dental profession to provide treatment. Under these conditions, each dentist based on his own ethical principles must decide to provide either:

- a) comprehensive treatment to a relatively low number of patients.
- b) a less than ideal comprehensive treatment to a large number of patients.

A pediatric dental practice based on the second choice may lead to

an undesirable situation in which the practice of dentistry will be:

- 1) Very limited.
Most of the dentist's time and energy is involved in one topic: caries. Not enough attention is given to other areas such as prevention, periodontics and orthodontics.
- 2) Frustrating.
A high caries rate will facilitate the appearance of recurrent caries, the amount of chair-time required for maintenance treatment is excessive and limits the capability to accept new patients.³
A high rate of interproximal caries⁴ will often indicate the need for pre-formed crowns and the use of sealants will be limited.
- 3) With a low quality of care.
The aim to increase the num-

ber of patients and the treatment of emergencies may cause pressure on the dentist, long working days, fatigue and impatience. This will eventually cause a reduction in quality both in the management of patient behavior and dental procedures.

A Pediatric Dental Practice In A Low Caries Rate Community. The Advantages.

In a community with a low caries rate the economic security may cause some concern. At the same time when compared with a practice such as the one described previously some advantages may be achieved:

- 1) comprehensive pediatric dental treatment is more easily performed.

When the need for treatment of caries is not excessive, examinations are more thorough. Early diagnosis and treatment of periodontal di-

sease and malocclusion are possible. Preventive measures can be established, keeping the caries rate low or even lowering it further.

- 2) The prognosis of treatments are better.
A low incidence on recurrent and interproximal caries will facilitate the success of sealants and restorations.
- 3) Treatment may be provided to a larger number of patients due to the minimal chair-time required for each patient.
- 4) Professional satisfaction.
As a result of the performance of high quality dentistry and the establishment of reasonable working conditions in which fatigue is avoided.
- 5) Behavior management of children may be easier when the treatment is simple and requires less chair-time.

Conclusion

Preventive measures benefit the population and at the same time

provide to the pediatric dentist the possibility of establishing a practice with an enjoyable environment in which good comprehensive dentistry may be performed.Δ

References

1. American Academy of Pedodontics: Fluorides an update for dental practice. Medcom, Inc. New York. 1976.
2. Bureau of Economic and Behavior of Research Council on Dental Health and Health Planning, American Dental Association: Changes in the Prevalence of Dental Disease, J.A.D.A. 105:75-79, 1982.
3. Bimstein, E., Eidelman, E. and Chosack, A.: Chair-time Needed For An Incremental Dental Care Program For School Children In Israel, Comm. Dent. Oral Epidemiol. 4:94-97, 1976.
4. Bimstein, E., Eidelman, E., Klein, H. and Chosack, A.: Distribution Of Caries In Difference Tooth Surfaces In Seven Year Old Children. Caries Res. 15:324-330, 1981.

Reprint requests to:
Enrique Bimstein
School of Dentistry
University of the Pacific
2155 Webster Street
San Francisco, CA 94115

A Treasury of Dentistry

Dental Experiences of James Joyce

By Gardner P.H. Foley

The presentation of a prominent author's physical afflictions is not an unusual subject for the medical historian, but it rarely has been the theme of the dental historian. In the research for this study I have examined the whole complex of Joyce's personal memoirs, his fictional literature, and the biographical works of several writers. By far the most important source of information was the three-volume edition of Joyce's letters edited by Stuart Gilbert and Richard Ellman (1957-1966).

Because of the multiplicity of Joyce's essentially medical problems and their probable relation to his dental ills, I consider it important to mention them. In 1924 Joyce wrote that he was "underfed, overworked, with a septic poisoning gradually undermining my health and unable to attend to it for sheer want of time and money." In 1928: "I have at the present moment episcleritis, conjunctivitis, and blepharitis" and "I have been and am painfully ill with inflammation of the intestines." In 1932: "The cataract is total and complicated with glaucoma and a partial atrophy of the retina." In 1933: "Grippe and then had larynx tracheite" and "I recovered from breakdown No. 4 this year." In 1934: "Right eye; lens much calcified." The courageous Joyce also endured "frightful attacks of neuralgia," lumbago, and arthritic pains in the right shoulder. The fear of total blindness tortured his mind and led to treatment by a host of ophthalmologists in several cities. Certainly

Joyce was correct in his pitiable analysis: "a dreadful lot of physical hardships."

There were other troubles ("one damn worry after another") that severely handicapped Joyce in his long struggle to achieve literary fame: chronic pennilessness, irregular living ("we are always homeless"), alcoholism, disturbing relations with his wife, vexatious experiences with publishers, and the exhausting anxieties caused by his daughter's mental difficulties. During the seven years of arduous labor devoted to the writing of *Ulysses* (1922) Joyce had eight illnesses and nineteen changes of address.

As an introduction to my citing of Joyce's references to his dental afflictions, I shall quote a significant commentary by Herbert Gorman in his *James Joyce* (1939).

During this winter [1902-3] Joyce suffered from ferocious toothaches, toothaches so intense that though he was ravenously hungry he dreaded the effect of the first mouthful. The pain in his teeth that followed rendered him speechless for several minutes. It is important to remember this trouble of the teeth, for certain authorities have assumed that from it were engendered the grave eye ailments of his later years. And if this is so it may be postulated that the toothaches of 1902-3 have indirectly affected the progress and development of English letters, for it is demonstrable that



James Joyce

Joyce's eye afflictions have shaped his handling of creative literature to a surprising degree.

Pola, Austria 12-04. I am going to the dentist next week. I shall spend the 'Speaker' cheque on my teeth and I hope in six months to have all my teeth settled.

Pola 2-05. As soon as I get money I shall have my teeth set right by a very good dentist here. I shall then feel better able for my adventures. Trieste, Austria 7-05. I am having my teeth attended to at last.

Rome 2-07. My mouth is full of decayed teeth and my soul of decayed ambitions.

Paris 5-22. I have been so plagued with nerves, toothache etc. all last week I could not write.

Nice 10-22. When I am settled I shall have the dental operations done here if possible or in Marseille or even go to Paris and I hope the result will be to stave off the other operation.

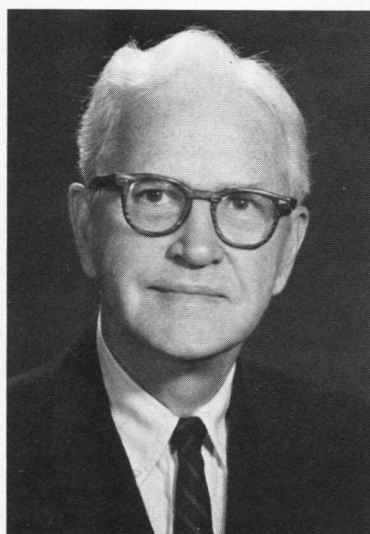
Paris 10-22. Dr. Borsch (ophthalmologist) says that probably both iritis and persistence of that nebula are due to root abscesses of teeth which should be drained or removed.

In July 1922 Dr. Louis Berman, a New York endocrinologist then visiting Paris, examined Joyce at the urging of Ezra Pound. Because the x-rays showed that the teeth were in bad condition, Berman advised complete extraction.

Paris 2-23. Personally I am sceptical about the effect of the dental operation, but since Dr. Borsch will not do his operation till the dentist has done his, let it be so.

Paris 3-23. On Tuesday I go into the hospital. [The first dental operation occurred on April 4, the second a few days later.] I am rather sceptical as to the elimination of arthritis by removal of teeth or abscesses. However if it should turn out well I shall be the first to admit it.

Paris 5-23. As for the dentist he is equally optimistic and has even



Gardner P. H. Foley

begun to test me for the permanent plate. I know that both these doctors are the best in their branches in Paris and are very conscientious and so all I can do is assent.

Paris 6-23. The dentist has now supplied me with the permanent set. Till today found it difficult to eat and talk. I feel in much better health however.

Paris 12-23. The dentist is to make me a new set for nothing as with this one I can neither sing, laugh, shave nor yawn.

For clarification it seems advisable to include here a supplementary statement by Gorman, Joyce's biographer: "A number of the teeth turned out to be abscessed. One good result of this multiple operation was the cessation of the attacks of iritis that had annually tortured Joyce for eighteen years."

Paris 3-25. An x-ray examination is

to be made first to see if any of the old abscesses have reformed and if so it is to be removed before the other operation (capsulotomy) is done. [The x-ray indicated that there was an imbedded fragment of tooth.]

Paris 3-31. As I cannot dispose of three thousand francs to pay my dentist, I keep on juggling with the broken plate in my mouth. This was a novel occupation when I began it in London last August, but I am thoroughly tired of it now.

Paris 6-34. I am having my teeth fixed.

Paris 8-35. I am very pleased with my lovely new teeth.

As there are no more references to his teeth in his letters it may be assumed that Joyce had no other dental difficulties or that he refrained from mentioning them in his last several years. Of course, it may also be concluded that later letters of dental interest were not available to the editors of the *Letters*.

James Joyce died in Zurich on January 13, 1941. His final illness was complicated by gastrointestinal hemorrhage, but the cause of death was peritonitis following a perforated duodenal ulcer. Although his *Ulysses* has been widely accused of being a pornographic book it has also summarily been judged to be "the most important contribution that has been made to the fictional literature in the Twentieth Century." Despite an horrendous experience of physical and mental troubles Joyce achieved his life's noble purpose: literary fame. Δ

James Joyce (1882-1941) was one of the most controversial writers of his time. He revolutionized the style of fiction, and changed traditional approaches to plots and characters. His most famous book was Ulysses.

Joyce was born in Ireland but lived most of his adult life in Trieste, Zurich and Paris.

OPINIONS IDEAS AND VIEWS

Sudden Surge of TMJ Problems

Robert T. Kirk, D.D.S.*

Listening to dental professionals throughout the United States I have often heard statements similar to this: "I have been practicing dentistry for more than fifteen years, and I rarely see any TMJ problems with my patients." These statements are being made by bewildered practitioners who are hearing about how busy their colleagues are in treating patients with Temporomandibular problems.

The sudden increase in the number of patients suffering from TMJ disorders may be startling to some. However, if one takes a closer look at the evolving dental profession, this recent trend is not as surprising as it may at first appear. There are a number of reasons which account for this apparently sudden change.

TMJ problems have always been in existence, but it is only recently that these problems are being recognized for what they are. Previously patients seeking medical cures for their head, neck, and facial pains, were often told it was, "All in their minds". After years of unsuccessful treatment, many such patients learned to live with

the pain. However, with today's new knowledge, dentists are able to diagnose and treat TMJ problems which might previously have been overlooked. Additionally, the medical profession is becoming more aware of dentistry's involvement in this area, and physicians are referring their patients to knowledgeable TMJ Dentists, or collaborating with them in treatment.

As new TMJ knowledge is gained, the profession will continue to evolve. More accurate diagnoses are being obtained using panoramic, laminographic, arthrographic, and transcranial radiography. Isometric exercises, modest equilibration, splint therapy, electrogalvanic muscle stimulation, ultrasound therapy, bio-feed back, kinesiology, nutrition, and surgery are spectrums of treatment feasible today. The broad range of new methods gives evidence of a changing profession. Yes, I am excited! These new treatments and other changes point the way and signal the mood for new research. Evolution of TMJ treatment to total patient care is clearly ahead. And finally, the medical profession is now acknowledging the need for a combined effort in finding solutions to the problems presented by Temporomandibular disorders, an area which is surfacing in the 80's as fast as the field of computer science.

*Robert T. Kirk, D.D.S., Managing Editor, Journal of Craniomandibular Practice, 1154 Carter Drive, Chattanooga, TN 37415.

Only Consulting Dentists Should Make Treatment Decisions

Manuel I. Weisman, DDS*

The term dental insurance is certainly a misleading concept. Since the risk factor is almost nil in these types of contracts, "dental insurance" should be properly termed "dental benefits."

There is an apparent and very real basic conflict at the very heart of third-party dental benefit problems. There is the doctor-patient relationship which is the professional care aspect of the benefit. On the other hand, there is the third-party—the insurance company—that is going to pay for "part of the action." There is no problem with an insurance company stating what it will charge, what will be covered, who is eligible and other factors not relating to the actual diagnosis and planned or performed treatment. However, when the dentist places his professionalism in the hands of lay personnel by submitting radiographs, complex treatment modalities and other items pertaining to his patient's professional care, he is in essence "tearing up his degree" for some so-called "dental expert," who is generally an insurance clerk, to render medical decisions. Are you willing to abdicate your professionalism and tear up your degree for an insurance clerk?

Now, you may say that the dental aspect of the claim is examined by the insurance company's dental consultant who is a dentist. But is it? Thousands of radiographs, treatment plans and dental procedure reports are sent in to the insurance company every day. Do these companies employ scores of dentist consultants? No. They only have a certain number of professional consultants, and these handle only specific problems.

In the more than 30 years I have been in practice, it has been my policy to send any radiographs, diagnoses and treatment reports directly and only to the dentist consultant of the insurance company. Other data is certainly a matter for the logistics of the insurance company. Because of this communication system, I deal with a doctor on a one-to-one basis in every case. I will not convey my patients' dental matters to monolithic nonentities whose lay personnel change with the time of day, and I have had only the smoothest and most trouble-free dealings with insurance companies. In fact, I rarely ever have to send any radiographs to any insurance company any more. Insurance companies respect my office because of my high regard for patient care. The insurance companies do deserve a diagnosis and treatment report or plan, but this information, along with the dentist's signature, should be adequate. In my practice, it has been. If you stand up, act, and behave like a doctor, you will be respected as such.

We are only a speck on an insurance computer. My patient's dental care is very dear to me. I treat people—not teeth in jaws. I plead with you to separate your mailings to third parties. Find out the names of the dentist consultants; they are not secret. Mail all your radiographs, diagnoses and treatment plans to the personal office of a specific dentist who represents the insurance company and is paid by it to consult with you. Whether it is a simple MOD alloy, a complex surgical procedure or gold foils in class V areas, it is your duty to talk only to the dentist on these matters.

It is interesting to note that in Georgia, it is against state law for

Example of Letter to Dental Consultants

In accordance with the Dental Practice Act of the State of Georgia and the guidelines of the American Dental Association, all radiographs sent to third party insurance carriers must be read by a dentist or physician.

In keeping with the highest standards of patient care, the enclosed radiograph, which has been requested, is being sent to you, the dentist consultant of this insurance company.

Sincerely,
Manuel I. Weisman, D.D.S.

anyone but a physician or dentist to read, diagnose or make professional judgments from radiographs.

I realize that insurance companies do not relish employing more dentist consultants. However, with the surplus of dental manpower, perhaps they should. But if you are going to be a professional—be a professional! Do not tear up your degree for some clerk or layperson, called a "dental expert," to make professional decisions that cannot be made by anyone who hasn't studied dentistry in school for many years and obtained a dental or even more specialized degree. This would not be in the best interests of your patients.

In conclusion, I am not an anti-third party dental benefit doctor. There are matters that are well taken care of by the third party insurance company. I only demand that dental decisions remain in the hands of dentists.

This letter first appeared in the CDS Review.

*Manuel I. Weisman, D.D.S. Practice Limited to Endodontics, 1519 Laney-Walker Blvd., Augusta, Georgia 30904.

AN EVALUATION OF A FORMAL EDUCATION TRAINING PROGRAM FOR DENTAL FACULTY

Charles H. Boozer

James Gardiner

Mickey M. Lee

Jack Rayson

The need for formal educational training for both full and part-time dental educators has been well documented.¹⁻⁶ This need has been further underscored by the Council of Dental Education of the American Dental Association which has endorsed the concept of teacher training in dental education for over ten years.⁷ Even with this documented need, however, and support of an accrediting body, few programs have been specifically designed to train dental faculty in educational teaching/research techniques.^{2,4}

Previous research on the impact of such training programs has been sparse. Jedaychowski and Galligani reported on the impact of a short-term conference which increased "interactions between dental educators interested in educational research . . . and changed the subsequent professional activities of the participants."⁸ Their research on the effects of short-term instructional courses, however, indicated that in order to assure long-term behavioral changes, longer

This study investigated the effects of an eight year formal training program on dental faculty's acquisition of educational knowledge. The evaluation followed Tyler's model of evaluating a program by objective. Of the six primary program objectives, four were cited by respondents as being successfully accomplished. These included: to understand issues and trends associated with dental education problems, to identify and select pertinent educational problems for future study, to identify and learn new paradigms for teaching, and to test newly acquired knowledge and skills in dental teaching situations. The two objectives which were not successfully accomplished including encouraging dental faculty to increase educational research efforts and to increase the number of educationally related reports. It is speculated that the unsuccessful accomplishment of these latter two objectives may be a failure in the program or of a disinclination of some clinicians to become involved in research regardless of the stimulus.

and more substantial courses of instruction were needed.

To overcome the lack of educational training among faculty, a program was initiated at the Louisiana State University School of Dentistry (LSUSD), in conjunction with the College of Education at the University of New Orleans, to allow the dental faculty an option of receiving a Master of Arts (M.A.) or a Master of Education (M.Ed.) degree. Both options consisted of thirty-three semester hours. Students were required to take the same nine core courses, including Foundations of Dental Education, Educational Research, Educational Measurement and Evaluation, Introduction to Educational Statistics, Communication and Persuasion in Dentistry, Analysis of Classroom Learning, Evaluation of Curriculum Programs, Instruc-

tional Systems, and Educational Psychology.

The M.A. degree was intended for students with a strong research interest. Students choosing this program were required to take six hours of research and write an original thesis. Students choosing the M.Ed. degree complete the same number of hours but substitute courses in selected areas of interest for the six hours of research.

The overall goal of the program was to provide the dental educator with the ability to assess, analyze, and improve the quality of dental education. To achieve this goal six major objectives were established:²

1. To promote students' understanding of previous trends, current issues, and future directions in dental education;
2. To assist students in identifying

Mickey M. Lee, Ph.D., Associate Professor, Office of Instructional Services.

James Gardiner, D.D.S., M.P.H., M.Ed., Associate Professor, Department of Community Dentistry.

Charles H. Boozer, D.D.S., M.A., Professor & Chairman, Oral Diagnosis/Medicine/Radiology.

Jack Rayson, D.D.S., M.A., Professor and Dean, School of Dentistry, Louisiana State University.

and selecting pertinent problems for future study in dental education;

3. To provide students with the conceptual tools needed to conduct educational research and evaluation studies in their own instructional area;
4. To provide students with a number of conceptual paradigms for promoting the instructional process which could be tested in their own teaching;
5. To assure the opportunity for trainees to apply the knowledge and skills developed in actual teachings situations;
6. To produce a series of published reports relevant to the problems of dental educators.

The purpose of the present study was to evaluate the effects of the program on the dental faculty's acquisition of educational information.

The study employed Tyler's⁹ model of evaluation which determines whether program objectives are being achieved. The population consisted of the 57 dental educators graduated in eight years. Forty-six have been graduated with M.Ed.'s and 11 with M.A.'s. Of this group 54 were male and three female; 57 were teaching faculty of whom eight had administrative experience. All 57 were sent questionnaires and 20 of the 57 were randomly selected for interviews. The questionnaire consisted of 14 questions based upon the previously cited program objectives and utilized both Likert-type and open ended questions. The questionnaire was administered during December 1982. The interviews were conducted approximately two weeks after the questionnaires were administered and collected information that supplemented the questionnaire data.

Of the 57 graduates of the program 51 completed the questionnaire. This was a return rate of 89 percent. Of the six non-respondents five were no longer with LSUSD, and one was deceased.

The first group of questions

asked the participants if the Masters in Education program helped them to understand issues and trends associated with past, current, and future problems in dental education. Of the 51 respondents, 78 percent felt that the program had been very helpful while the remaining respondents felt that the program had been slightly helpful. Specific responses during the interviews included such statements as, "the Masters program helped me better understand the philosophical basis of

Although the educational program was designed to improve faculty directly, the ultimate objective of improving their skills was to benefit students.

dental education" and "the program helped me better grasp current dental education issues and problems."

The second group of questions asked if the program aided them in identifying and selecting pertinent problems for future study in dental education. Twenty (39%) indicated the program was very helpful, 30 (59%) thought it was somewhat helpful, and one person (2%) thought it was not helpful at all. Responses during the interviews indicated much more variability than in the previous area. Several graduates felt that the program significantly contributed to their being more cognizant of current issues and problems. This group, however, tended to be those individuals who received an M.A. instead of an M.Ed. The remaining individuals indicated that although they thought the program was helpful in identifying problems in general education, it was not particularly successful in helping them relate the problems in dental education.

Several other questions inquired whether or not the program provided the conceptual tools needed to conduct educational research and evaluation studies in dental

specialty areas. Eleven students (22%) indicated that they thought the training was very helpful; seven (20%) thought it was moderately helpful; and 30 (58%) indicated that it was not helpful for conducting educational research in their own areas. Follow-up questioning on this topic brought a wide range of responses. Again many of those individuals who actually conducted educational research were those who had obtained an M.A., and probably possessed a higher degree of interest in research from the start. Those individuals who responded negatively generally made such statements as: "I don't like to conduct educational or any other type of research," or "statistics is too difficult for the average dental clinician."

Responses to questions of whether the program successfully provided students with varied paradigms for teaching indicated that the program had been very beneficial in providing them with different teaching models. All participants stated that they had been provided with alternative approaches ranging from variations of the traditional lecture to self-paced instructional methods.

The fifth group of survey questions asked if the graduates had opportunities to test the knowledge and skills learned in actual teaching situations. The majority (69%) indicated that the program provided ample opportunities and that the transfer of those skills from the program to the dental classroom was easily accomplished. The remaining 31 percent indicated that the program provided some opportunities and that only some of the knowledge and skills were readily transferable. Several of the latter group stated during the interviews that much of the material taught was theoretical and difficult to transfer directly to the dental classroom or clinic.

The last group of questions asked whether the program facilitated publication of educational research. Twelve individuals (24%)

indicated that they had published articles in educational areas as a result of the program. Ten (20%) indicated that the program was useful by making them aware of specific publishing opportunities and that they were currently researching topics in education. The remaining 29 students (56%) indicated that the program had not helped them in publishing any educationally related articles. When members of this latter group were interviewed, it became clear that they were all clinical faculty with a stronger interest in clinical teaching than educational research and publications.

The Masters in Education program for dental faculty at LSUSD assumed that formal training in educational theory and practice over a long period of time would make better teachers out of dental faculty than short courses or symposiums. Another assumption was that faculty would participate more readily if the course of study led to the tangible achievement of an advanced degree.

The evaluation conducted in 1982 after eight years of the program has confirmed the original assumptions. The LSUSD faculty who graduated from the program reported that it provided them with theory and application of educational techniques. In addition, the program gave teachers the opportunity to be students again, and this perspective helped them empathize with ongoing student concerns. Examples of this change of roles included being forced to meet assignment deadlines, experimental classroom techniques, forced examinations and evaluations, and lack of control over course direction. It also allowed participants to observe their peers in the role of teacher, to critically assess themselves in that role, and to formulate new approaches to teaching based on the experience of comparing personal educational preferences with that of others. One additional benefit was cited during interviews. Since most

faculty taught material most familiar to them (that is, material from their own specialty areas), the teaching practicum served to update faculty on current information from other specialty areas.

The program was only moderately successful at encouraging research in educational areas among its participants. Although faculty reported that they learned about research theory and statistics, few who were not already interested in research became researchers as a result of the program. This result was expected however, since most dental clinical faculty appear to have little interest in theoretical research and prefer dealing in the concrete terms of specific tasks.

Although the educational program was designed to improve faculty directly, the ultimate objective of improving their skills was to benefit students. In this regard, the program appears to have been successful if one considers that the use of educational terminology has increased, course outlines have become clearer and more precise, tests are regularly constructed based on a table of specifications and the results subjected to item analysis, and more innovative teaching techniques are being employed.

The results of the evaluation indicate that the formal education training program succeeded in accomplishing four of the six primary program objectives. These included: Seventy-eight percent of the 51 individuals (89%) indicated that the program was very helpful in aiding them to better understand issues and trends associated with past, current, and future problems in dental education; ninety-eight percent felt that the program was very to moderately helpful in aiding them to identify and select pertinent problems for future study; all individuals indicated that the program was very beneficial in providing them with different paradigms for teaching; and 69 percent indicated that the program pro-

vided ample opportunities to test newly obtained knowledge and skills in dental teaching situations. The two objectives which did not achieve majority success were that the program was not helpful in providing the conceptional tools needed to conduct educational research and evaluation studies (58%), and that the program had not helped in publishing educationally related articles (56%). It is speculated that the lack of interest in educational research and publishing may be a result of a real weakness in the educational program, or a predisposition of clinical faculty toward clinical teaching over research. Δ

References

1. Richardson, J., and D. Nuckles. What Makes a Good Dental Teacher? *Dental Student*, 51(1):60-61, 1972.
2. Boozer, C., W. Gaines, A. Copping, and R. Rasmussen. Formal Training in Educators for Dental Educators: A Pilot Program. *Journal of Dental Education*, 41(5):248-51, 1977.
3. Evans, J., and M. Massler. The Effective Clinical Teacher. *Journal of Dental Education*, 41(10):613-17, 1977.
4. Nelson, J., and P. Tsaknis. The M.E.D. Degree in Dental Education: A Survey. *Journal of Dental Education*, 42(4):198-99, 1978.
5. Little, R., B. Williams, and M. Fey. An Interdisciplinary Teacher Education Program. *Journal of Dental Education*, 44(5):257-260, 1980.
6. Powell, G., and J. Barrett. Inservice Training for Part-time Dental Faculty. *Journal of Dental Education*, 45(2):68-70, 1981.
7. Coady, J. Structure and Function of the Council of Dental Education. *Journal of Dental Education*, 35, 33-44, January 1971.
8. Jedrychowski, J., and D. Galligani. Longitudinal Evaluation of a Teacher Education Course Presented to Dental Faculty. *Journal of Dental Education*, 42(10):579-583, 1978.
9. Tyler, R. General Statement on Evaluation. *Journal of Educational Research*, 35:492-501, 1942.

Reprint requests to:
Dr. Charles H. Boozer
School of Dentistry
Louisiana State University
1100 Florida Avenue
New Orleans, LA 70119

OFFICERS

President

ODIN M. LANGSJOEN

301 Morley Parkway
Duluth, Minnesota 55803

President-Elect

LYNDEN M. KENNEDY

1918-A Skillman Avenue
Dallas, Texas 75206

Vice President

CHARLES W. FAIN, JR.

320 Harvey Street
Daytona Beach, Florida 32018

Treasurer

ROBERT W. ELLIOTT

8732 Falls Chapel Way
Potomac, Maryland 20854

Editor

KEITH P. BLAIR

4403 Marlborough Avenue
San Diego, California 92116

Executive Director

GORDON H. ROVELSTAD

7315 Wisconsin Avenue
Bethesda, Maryland 20814

REGENTS

Regency 1

SUMNER H. WILLENS

Connecticut, Maine, Massachusetts, New Hampshire, New York, Quebec, Rhode Island, Vermont

Regency 5

PAUL S. BUTCHER

Iowa, Kansas, Manitoba, Michigan, Minnesota, New England, North Dakota, South Dakota, Oklahoma, Ontario, Wisconsin.

Regency 2

H. CURTIS HESTER

Delaware, District of Columbia, Maryland, New Jersey, Pennsylvania

Regency 6

ROBERT C. COKER

Arkansas, Louisiana, Mississippi, Missouri, Tennessee, Texas

Regency 3

JAMES A. HARRELL, SR.

Alabama, Florida, Georgia, North Carolina, South Carolina, Puerto Rico, Virginia

Regency 7

LEO E. YOUNG

Arizona, Southern California, Colorado, Nevada, New Mexico, Utah, Wyoming

Regency 4

NORMAN H. OLSEN

Illinois, Indiana, Kentucky, Ohio, West Virginia

Regency 8

ROBERT A. CUPPLES

Alaska, Alberta, British Columbia, Northern California, Hawaii, Idaho, Montana, Oregon, Washington, Saskatchewan

American College of Dentists
7315 Wisconsin Avenue
Bethesda, Maryland 20814

Return Postage Guaranteed

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

