

# JOURNAL

## AMERICAN COLLEGE OF DENTISTS



**DENTAL MANPOWER—THE DENTAL SCHOOL'S DILEMMA**  
**THE PURSUIT OF EXCELLENCE**



## *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

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

**Keith P. Blair, DDS, Editor**  
**Gordon H. Rovelstad, DDS, Business Manager**  
*Editorial Board*  
**Leo E. Young, DDS, Chairman**  
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**W. Robert Biddington, DDS**

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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.

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# CONTENTS

From The Editor's Desk:	
Internal Marketing—One on One .....	3
The Pursuit of Excellence .....	4
<i>President Charles W. Fain, Jr.</i>	
The Future of Dentistry .....	7
<i>Lynden M. Kennedy</i>	
The Dentists' Responsibility To Health Care Delivery .....	12
<i>Harold T. Perry</i>	
Responsibility of the Dental Profession To	
Education and Research .....	18
<i>Raymond P. White, Jr.</i>	
1984 Meeting and Convocation Pictures	
Sections Meeting .....	22
Board of Regents .....	24
Convocation .....	26
Dinner Dance .....	29
Convocation Awards	
Gies Award to Floyd Dewhirst .....	30
Gies Award to Gerald Stibbs .....	31
Honorary Fellowship to William S. Banowsky .....	32
Award of Merit to Beverly Bane .....	33
Dental Manpower—the Dental Schools' Dilemma .....	34
Forces Join for Profession's Betterment .....	34
<i>Bernard Gordon</i>	
Dilemma In A State Institution .....	35
<i>Errol L. Reese</i>	
The Private Dental School's Dilemma .....	38
<i>Stanley P. Hazen</i>	
A Look At Dental Manpower and Related Issues .....	40
<i>Jeanne C. Sinkford</i>	
The Economics of American Dentistry: .....	44
No Need To Panic	
<i>Knight A. Kiplinger</i>	
Instructions for Contributors .....	48
Directory of Officers .....	49



# FROM THE EDITOR'S DESK

## Internal Marketing

We hear a lot about marketing in dentistry these days. Marketing, according to the dictionary, is the selling of goods and services. It frequently involves advertising. However, the true meaning of marketing in dentistry has been conveniently re-interpreted from "selling" to "promoting" dental care.

Marketing through the use of advertising can be used to promote business for a single dental office, or group of offices, and is recognized as *individual advertising* for the benefit of the advertisers. Marketing through advertising is also used by dental associations and other dental groups to educate and inform the public on the need for dental care and is referred to as *institutional advertising*. It is intended to increase the demand for dental care which can benefit the profession while improving the dental health of the public. Both individual and institutional advertising is done in the marketplace, outside of the dental office, and is considered *external marketing*.

But the promotion of a dental practice should go on *within* the dental office also, and since the profession is so intrigued by that word marketing, dentists call it *internal marketing*. Over the years we have variously referred to this activity as doctor-patient relationships, public relations, patient rapport or communication. Whatever it is called, the doctor and his



Keith P. Blair

staff are directly concerned with the patient and it is a one-on-one effort by the individual dentist within his office.

As he lectures to dental groups, ACD Past President James P. Vernetti presents an eye-opening opportunity for dentists when he points out that there are about 100,000 dentists in private practice who see at least 10 patients each day in the United States. That adds up to approximately 1,000,000 people who are in dental offices every day and are, in effect, a captive audience to be informed about many things related to dentistry. These people are also a prime source for referring new patients to the office. Furthermore, this captive audience changes every day as different patients are in the offices.

Up to 50,000,000 people can be contacted by dentists every year, in this way, on a one-to-one basis.

Dentists should make more of an effort to encourage their present patients, who are interested in maintaining good dental health, to refer others who need treatment. It seems that, in recent years, the profession has given more priority to recruiting patients from that other 50% of the public which is apparently not interested in dental treatment until there is pain.

There seems to be a basic difference in philosophy these days between traditional dentists who feel an individual responsibility for the growth of their practices and a new breed of dentists who expect the profession to provide patients for them as a right of being a member of the dental profession. Maybe that difference in philosophy is a separating line between external and internal marketing efforts.

Dentistry is not just a business operation and not just fixing teeth: it is solving problems for patients that sometimes requires time and concern, it is working with people and caring for them, it is relieving pain, it is preserving functions and facial contours, it is a creative art as well as a health profession. Internal marketing involves all of these different aspects of dental practice.

Perhaps it is time for the profession to put more emphasis on internal marketing.

Keith P. Blair



# THE PURSUIT OF EXCELLENCE

## President-Elect's Address

Charles W. Fain, Jr.

This opportunity comes but once to a Fellow of the American College of Dentists. It is a rare opportunity and I am honored to be in such a position. This morning, I would like to address the subject of "The Pursuit of Excellence" or, in other words, "Where Have All the Heroes Gone?"

The American College of Dentists is a very interesting organization. It reaches from coast to coast and it even spreads abroad. In addition, it crosses all disciplines of the profession and enters into all aspects of its development and growth. As an organization of leaders, it moni-

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**The college has many functions, but its basic mission—its reason for being—is leadership.**

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tors the "pulse" of dentistry. With apathy, however, it has the possibility of overlooking an "arrhythmia" or "tachycardia" of the heart of dentistry. Our responsibility is great.

When four men met in Cedar Rapids, Iowa, in 1920 and discussed some of the basic problems facing dentistry at that time, several very interesting subjects were addressed. Education was attempting to respond to the challenges of the Flexner Report in medical education. Mercenary practices had arisen, and the profession was threatened by public scandals. Also, exploitation of the profession by



Charles W. Fain, Jr.  
President 1985

commercial interests was widespread. This latter area included much that crossed the desks of dentists in their continuing education.

Interest was expressed that evening in the home of Dr. and Mrs. John Finn by the President, President-Elect and Secretary of the National Dental Association, and the President of the Dental Teachers Association about the need for a force that could offer guidance in the crisis which they felt existed. As quoted in the history of the American College of Dentists, "Every important profession, science or art has its academy, legion or court of honor, to which are elected, or appointed, those who have unselfishly devoted themselves to the advancement of each specific

cause . . . so that, by their united efforts, in a field not now covered by any other agency, they can aid in the advancement of the standards of the profession."

Thus, in 1920, in Boston, Massachusetts, a group of men were brought together in formal assembly to establish an organization, The American College of Dentists, which vowed through its charter and through its bylaws to serve the profession for its advancement.

The Purposes and Objectives of the American College of Dentists stated at that time are the Objectives of the American College of Dentists today with very little change. They focus on prevention of oral disorders, quality of care, education and professionalism. The Founders of the College focused on dentistry as a high standing profession with great responsibility to the community as well as to the profession. As Fellows of the College, we continue to strive for excellence. Thus, we are in the Pursuit for Excellence.

But where are the Heroes?

For sixty four years, the American College of Dentists has functioned well and fostered the high ideals and altruistic purposes of the founders. Past accomplishments have been enviable. However, with challenges to leadership, challenges to traditions, challenges to organizations, confrontation, exposure of records, yes, even challenges to the very foundations of our govern-



ment and moral codes, we are divided.

It should not be a surprise to anyone that the American College of Dentists has received challenges to principles, codes of ethics, and standards for professionalism. Many have chosen to question the relevancy of the College. The definition of proprietary education and proprietary journalism has been stretched. Unprofessional conduct has been accepted. Individuals have even doubted the legality of the objectives of the College.

Certainly the changes over the years have had an effect upon the College. The College has had to be more responsive to fellowship requests. It has had to look again at the objectives and the principles upon which the College was founded. The Board of Regents has had to go back into the records of the College and compare the problems that are being faced by the profession today with those of the 1920's: Third-party programs, funds with strings tied to specific actions, dental curricula changes in the disease pattern, commercial dental clinics for profit, and such other actions. There is a need to review the basic principles upon which the College and the profession have been based.

But where are the heroes?

The Board of Regents held a special workshop on Thursday, April 12, 1984, in Baltimore. The purpose of the workshop was to review the nominating procedure of the College and the Code of Conduct in relation to the nomination procedures. The agenda for this meeting included a review of

the past practices of the College in comparison to the current policies and procedures. The detailed steps taken in preparation for bringing the name of the candidate to the Board were reviewed. One session studied the requirements of the

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**Professional relationships between doctor and patient must be preserved. The care of human beings is an individual matter and cannot be put up in the marketplace for sale, as one would sell shoes or shirts.**

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American College of Dentists in relation to FTC scrutiny. The Code of Ethics of the American Academy of Ophthalmology which have been reviewed by the staff of the Bureau of Competition of the Federal Trade Commission, and had been given their endorsement, was reviewed. It was felt that this was a guideline for the College to consider.

Other problems discussed were the status of the Code of Conduct in its relationship to the Code of Ethics of the American Dental Association as well as responsibilities of a Fellow of the College who violates one or more portions of this code.

It is significant that legal expertise in membership policies and codes of non-profit organizations was sought for this meeting. Recent actions affecting organizations in general were reviewed, as well as the membership selection process relating to the professions.

The workshop was summarized by President L. M. Kennedy this

past year when he reaffirmed the present procedure as being one of the most unbiased and appropriate ways to select new Fellows for recognition by the American College of Dentists.

In spite of the fact that there has been a major push on the part of consumer groups in the United States to convert the profession for commercial exploitation, it is the belief of the American College of Dentists that the professional relationships between doctor and patient must be preserved. The care of human beings is an individual matter and cannot be put up in the marketplace for sale as one would sell shoes or shirts. Were it not so, medicine and dentistry as professions would not have developed. Medicine men and quackery would have continued to hold center stage.

What about the heroes?

Often referred to as the father of American Dentistry, G. V. Black grew up in a small town in Illinois, became interested in dentistry through contact with a dentist named C. G. Spears. He recognized the contributions that were made. Self educated and trained, he became more and more involved in the science of dentistry. A prolific writer and lecturer, he was the author of the first edition of the Dental Anatomy which became the hallmark for the study of the teeth and their restoration. He left his mark on the science of dentistry. He believed in the highest standards of health care and professional service for dentistry. "A professional man has no right to be other than a continuing student," he stated.

There was William John Gies. A

Physiological Chemist, he became the active organizer of the American Association of Dental Schools, the American Association of Dental Editors, the International Association for Dental Research, and the Dental Section of the American Association for the Advancement of Science. He founded the *Journal of Dental Research* and he became the Editor-in-Chief of the *Journal of the American College of Dentists*. He held one underlying principle: "A professional must set above all else the importance of considering principles as apart from persons or profit: that unless selflessness rather than selfishness prevailed, the profession would lose dignity in its own eyes and lose its high esteem in the eyes of the public."

There was the honorable John E. Fogarty who served in the House of Representatives of the United States for over 25 years. During this period of time, he became known as the champion of better health for the nation. Through his efforts, there was a new level of recognition given to the profession of dentistry through specific legislation and White House conferences and support for research. In 1965, Congressman Fogarty, stated, "The problems caused by dental disease are of great importance. Almost everyone everywhere is affected by dental illness and, to citizens of developing countries, those problems can be overwhelming." What did these three men, a dentist, a chemist and a legislator have in common? G. V. Black and William J. Gies have their names inscribed on our mace as two of the seven immortals in dentistry. John E.

Fogarty was an honorary fellow of the College. The common thread which ran through their lives was service to our profession and to their fellow man.

What about today's challenges? What is the impact of advertising on patient care? What is the impact of the commercially sponsored lectures on the quality and participation in continuing education courses offered by professional societies and schools?

What is expected of the Fellows of the College?

Dr. Philip E. Blackerby, in his presidential address to the College in 1963 stated, "The College has many functions, but its basic mission—its reason for being—is leadership. It has become crystal clear in our increasingly complex and rapidly changing society, that the challenges confronting dentistry, enhance the College, require a kind of professional statesmanship, and broad-gauged leadership that reflect a wholesome and exquisite balance between technical competence and social conscience."

He also said, "The College must be a symbol of the ideals that made our profession great—as Fellows, it is our duty to uphold and promote those ideals."

Where have all the heroes gone?

Look around you. The opportunity is now! Role modeling is a major responsibility for the profession that we serve.

Contrary to that which appeared on the cover of *Forbes* magazine on August 13, 1984, the dentist is not obsolete. That cover showed a patient being treated in a store front of a downtown shopping area with

a caption that read, "Dentista Obsoletum." Dentistry is not a thing of the past. It is a profession with a future and that future is in your hands.

Where have all the heroes gone?

Look around you. Is the pulse of dentistry still regular?

A favorite quotation of mine is one from Henry Van Dyke as follows: "There is a life that is worth living now as it was worth living in the former days, and that is the honest life, the useful life, the unselfish life, cleansed by devotion to an ideal. There is a battle worth fighting now as it was worth fighting then, and that is the battle for justice and equality: To make our city and our state free in fact as well as in name: To break the rings that strangle real liberty, and to keep them broken: To cleanse, so far as in our power lies, the fountains of our national life from political, commercial, and social corruption: To teach our sons and daughters, by precepts and example, the honor of serving such a country as America. That is work worthy of the finest manhood and womanhood."

Where have all the heroes gone?

By your role modeling, by your sharing, by your dedication to professionalism and the pursuit of excellence, you, the Fellows of the College, are the heroes of our profession.

Where have all the heroes gone?

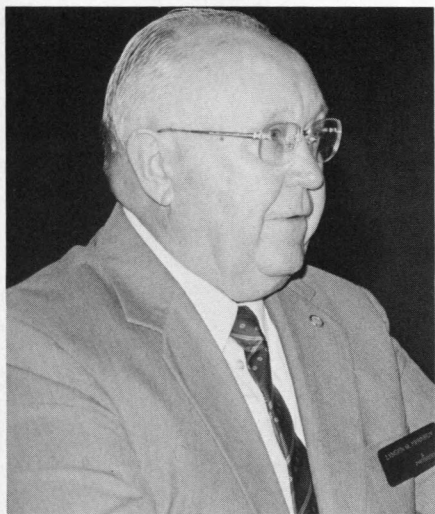
Look around you. Δ

Reprint requests to:  
Charles W. Fain, Jr.  
320 Harvey Street  
Daytona Beach, Florida 32018



# THE FUTURE OF DENTISTRY

Lynden M. Kennedy, D.D.S.\*



Lynden M. Kennedy

Exactly 170 years ago this morning, at the crack of dawn, a man peered through a spy-glass and, to his joy and amazement, discovered that the flag of our country was still flying over Fort McHenry. As he watched through the foggy dawn, his emotions were so stirred that he took a letter from his pocket and began writing phrases on the back of it. Francis Scott Key had watched the bombardment of the fort from the deck of a flag-truce ship. After going ashore, he finished his writing

\*Past President, American College of Dentists. Former President, American Dental Association.

Presented September 14, 1984, at a luncheon sponsored jointly by the American College of Dentists and the International College of Dentists during the 101st Annual Meeting of the Maryland State Dental Association in the Baltimore Convention Center.

and our national anthem, *the Star Spangled Banner* was born. I am glad to be in this vicinity on so noteworthy an anniversary.

The future of dentistry, is intriguing. I thought about trying to develop a theme for my presentation and remembered the theme of a meeting I attended in Arizona a couple of years ago: "The future ain't what it used to be!". But a better one would be the admonition of the Apostle Paul to the Hebrews (Hebrews 10: 23): "Let us hold fast to the profession of our faith without wavering." That excellent advice is as appropriate today as it was in Paul's time, for certainly, these are times to try men's souls and test their faith.

I confess to feeling a little flattered that anyone would ask me to forecast the future. I am not at all sure that my ability as a prognosticator is of much value. Surely, my track record in such areas as predicting the trends of the stock market, the outcome of the Giants-Cowboys football game, or picking the winner when the Orioles play the Texas Rangers, would lend no credence to my views. Back in the 1950's I took a course under Balint Orban at the Colorado Dental Foundation in Colorado Springs. Someone asked him how he answered when a patient would ask him for positive assurances about the outcome of his treatment. His response was, with all his education and the many courses he had

taken, he had never had a course in prophesy! I want you to know I have never had a course in prophesy either.

I see the future of dentistry as something of a battleground. Not a battle among dentists for patients, but a battle to retain professional dignity and true values—a battle to keep dentistry a recognized health profession and not let it become a common trade, a battle to repel all sorts of outside pressures and invasions that tend to de-professionalize dentistry. Let me mention some of these pressures, changes and trends. Just a few weeks ago, Chief Justice Burger, in his annual speech to the American Bar Association, said the public image of lawyers was "near the bottom of the barrel".

The countless number of jokes we hear impugning the barrister is something of a reflection on his image; jokes such as the one about the man who was visiting a famous old cemetery and came upon a tombstone bearing the epitaph "Here lies a lawyer and an honest man" and wondered why they buried them both in the same grave. Or another about the lawyer and his wife on a cruise; the lawyer falling overboard in shark infested waters, surely a goner. To everyone's amazement, the sharks lined up in two parallel rows and escorted him back to the ship. "Oh, it's a miracle!" exclaimed the wife. "No", said a bystander, "just professional

courtesy!"

Back to Chief Justice Burger: He scolded the lawyers for "unseemly" advertising in which professional services are sold like "mustard, cosmetics, laxatives, and used cars", citing "house to house distribution of coupons giving a \$15 or \$25 credit on the first conference with the lawyer identified in the coupon". The jurist commented, "To those who still regard the practice of law as a profession of service, with high public obligations, rather than a trade in the marketplace, the professional standards against advertising are still widely observed. Some, however, seem to treat this as a release from restraint and use it as a license." He then posed the question, "Does our profession's low public standing derive, in part at least, from the insistence of some lawyers on exercising their first amendment rights to the utmost?"

Leaving the legal profession, consider a recent letter to the editor of the *Miami Herald*: "To the Editor: Chief Justice Burger has stated that the legal profession is pricing itself out of the market. Where is the Warren Burger of the medical profession? Perhaps there is a glimmer of light on health costs in California, where doctors have promised to refrain from increasing fees for a year." The letter concluded with advice, "Pay attention, Florida doctors; if you can mute your moaning about malpractice insurance, you may hear the little voice of conscience—and the rumblings of a long-suffering and resentful public."

In many cases, public opinion is removing the physician from his

pedestal. There are those who see him as some kind of a fat cat—greedy, coldly calculating, his primary interest focused on self worth. A couple of months ago, I heard a health care professional telling two laymen about an ophthalmologist who, he said, does eight or more lense implants in his office each day at a fee of \$2,000 or more, each. One of the laymen, a retired service station operator, told of a physician who spent twenty minutes suturing a tendon on a finger. He said he was startled by the physician's fee of \$1,000, told the doctor he was accustomed to paying on the basis of time and material, and was shocked at the \$1,000 fee. He quoted the doctor as saying his fee was not related to time or material, but on how much a finger was worth.

One may suspect some degree of exaggeration, but I grieve when I hear stories of these kinds. I do wonder, though, how that physician would have reacted had his service station operator based his fees for servicing the doctor's Mercedes, not on the basis of time and material, but on the basis of how much a Mercedes is worth.

However that may be, we have now entered an era of professional marketing". The Board of Trustees of the American Dental Association reported to the 1982 House of Delegates "... a sizable portion of the Association's membership perceives urgent and immediate need to stimulate more Americans to seek regular dental care. It is the Board's opinion that the best way to satisfy this need is to provide tailored materials and services that

will help the individual practitioner, and the various dental societies that represent them, to achieve that goal." Pursuing this, a resolution was passed by the House calling for the Association to establish a new "Marketing Services Department" to coordinate all marketing research and development activities throughout the Association, and offer a broad array of marketing aids and "how to" information to individual practitioners, constituent and component societies.

It is extremely difficult for some of us to differentiate between the commercial marketing of a commodity and the professional marketing of a health service; or for that matter, to distinguish between marketing and advertising. It appears that the Association's concept of marketing is the motivating of people to seek the care they need. One definition: That human activity directed at satisfying needs and wants through exchange processes. Such concept and definition lends an aura of respectability to the process and greatly lessens the stigma of overt advertising. Much of the criticism and opposition to professional marketing is generated over concern about abuses, trends that might tend to deprofessionalize dentistry, and the downright hucksterism that is taking place. Perhaps some of the things we are presently seeing justify concern.

Under the guise of marketing, the antics of a relatively few practitioners are attracting the attention of the media and the public. A few months ago, almost the entire front page of a section of the *Miami Herald* was devoted to activities of



physicians in the area. In one-inch bold type, the article was headed "Physician, Sell Thyself"; the sub-head read "The doctor glut is forcing healers to turn to hucksterism". A cartoon occupied at least one-fourth of the page showing the caricature of a physician wearing a sandwich board, the front of which read on the first line "We Operate", the second line in huge letters "Sale", the next "Money-Back Guarantee", and below "We Accept All Major Credit Cards". At his side in the cartoon was a public relations man saying "It's boffo, Doc! Let's run it up the flagpole and see who salutes!"

The editorial portion of the article began with "Twice a year, Dr. Ian Mackenzie, who specializes in the treatment of the digestive tract, sends his patients a health-tip newsletter. Dr. Larry Seidman, a gynecologist, has offered to go on radio and TV talk shows to discuss the emotional and physical changes in women with premenstrual syndrome. Dr. Dennis Brooks, an ophthalmologist, performs cataract surgery. To attract out-of-town patients, he has run newspaper ads offering \$250 for travel expenses."

From the *Wall Street Journal* we learn that an increasingly large number of doctors are turning to press agents. Examples have been given of doctors paying them fees ranging from \$2,500 a month to \$150,000 a year. These fees buy such things as radio and TV appearances, magazine articles, and books ghost written with the doctor's name as author. Doctors did not used to do this sort of thing. Many of us find it to be beneath the

dignity of a professional man, unpalatable and downright disgraceful. It does, however, show what the fall-out of a supreme court decision can be and the aberrations it can

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generate.

I do not want you to think I am picking on the legal profession or the medical profession to the exclusion of the dental profession. Surely, we have our problems. We, too, have our microscopic minority of people who have all the moral characteristics of a preying mantis. I am on the board of an insurance company. Not long ago the vice president for dental care showed me some claims that not only boggled the mind, but were actually sickening. Unfortunately law, medicine, dentistry, even the congress, are not exempt from contempt—or to soften it—exempt from criticism.

In the past, professional people have been considered to be something very special, a cut above the average. The professions were referred to as callings. Professionals earned respect through their words, deeds, and activities. Their callings were the conscience of America, a noble lot, dedicated to things moral, helpful, idealistic, and unselfish, to

causes generated for the benefit of humanity. The energies and the abilities of professionals were pledged to the benefit of others, their personal rewards strictly secondary.

It was this kind of commitment that earned for dentistry the stature of being recognized as an honest-to-goodness health profession. Professional people have never been reluctant to make sacrifices to the benefit of others. This attitude was present in the founders of our country. The majority of the signers of the Declaration of Independence were professional people: lawyers, physicians, jurists. Paul Harvey, in his book, *The Rest of the Country*, reminds us that many, if not most, of us have forgotten the extent of the sacrifices and the scope of the commitment of the 56 men who signed that Declaration some 209 years ago. Those men believed in a cause, and backed their belief to the utmost; they pledged their lives, their fortunes, and their sacred honor to the support of that Declaration.

Here is how some of them honored their pledge: Carter Braxton of Virginia, wealthy planter and trader, saw his ships swept from the seas. To pay his debts he lost his home and all his properties, and died in rags. Thomas McKean of Delaware was so harrassed by the enemy that he was forced to move his family five times in five months. He served in the Continental Congress without pay, his family in poverty and in hiding. Vandals looted the properties of Ellery and Clymer, of Hall and Gwinnett, and of Walton, Heyward, Rutledge, and

Middleton. Thomas Nelson Jr. of Virginia raised \$2,000,000 on his own signature to provision the fleet of our allies, the French. The war over, he personally paid back the loans, wiping out his entire estate. He was never reimbursed by his government. In the final battle at Yorktown, Nelson urged General Washington to fire on his, Nelson's, own home, which was occupied by Cornwallis. It was destroyed. He died bankrupt and was buried in an unmarked grave. Thomas Nelson Jr. had pledged his life, his fortune, and his sacred honor, and was not found wanting.

Another patriot, John Hart, was driven from his wife's bedside while she was dying. Their thirteen children fled for their lives in all directions. His fields and gristmill were laid waste. For more than a year he lived in forests and caves, only to return home after the war to find his wife dead, his children gone, and his properties completely destroyed. A few weeks later he died of exhaustion and a broken heart. Of the 56 signers of the Declaration, few long survived. Five were captured by the British and tortured before they died. Twelve, from Rhode Island to Charleston, lost their homes, sacked, looted, occupied by the enemy, or burned. Two lost their sons in the army. One had two sons captured. Nine died in the war, either from its hardships or from its more merciful bullets.

It is important to remember this about those men: they were not poor men or wild-eyed pirates. They were men of means, most of them rich, who enjoyed much ease and luxury in their personal living.

They were prosperous landowners and traders, substantially secure in their prosperity; but they considered that liberty and principle are so much more important than security that they pledged their lives, their fortunes, and their sacred honor. The pledge was fulfilled, they paid the price, and freedom was born.

Some 65 years ago, a few super-professionals—such as you—people with dreams and aspirations of making dentistry a noble profession, organized and developed ethical standards and began to mold the future of dentistry. They had remarkably keen foresight. Recognizing the frailty of human morality, they would surely have agreed with Mohandas K. Gandhi on things that will destroy us: politics without principle, pleasure without conscience, wealth without work, knowledge without character, business without morality, science without humanity, and worship without sacrifice.

It has been observed that civilizations ascend the stairs in hob-nail boots and descend in velvet slippers. The same can be said about professional stature. Those of us in dentistry today are heirs to positions of respect, given by men who achieved that respect by adhering to principle, by working their way up, step by step, laying it on the line, going the extra mile, giving up their time, substance and energy; men who looked upon their fellow dentists as colleagues, not competitors; who believed we are a profession, not a trade; providers of services, not commodities; with a commitment to mankind, not to mammon.

This is what it took to get us where we are, and the challenge we face is to keep us there. This is why the future of dentistry will depend on the extent of dedication and the depth of commitment of those who claim to be its members. This is why we must be determined to be principled people and to stick to our beliefs with all tenacity. We must not despair, or become despondent over the unfortunate direction some of our colleagues seem to have chosen. Do you remember how upset and panicky so many people were a few years ago, when they were convinced a nuclear holocaust was imminent? A fall-out shelter was an absolute immediate necessity if they were to survive. Remember also, conservative bankers were allowing people to pay for those shelters over a period of twenty years!

Some see the future of dentistry as bleak, dark, and negative. I do not! I am convinced that if we keep our traditional dedication and commitment to professional ideals, the future of dentistry will be fulfilling, bright, and positive. Positive signs are evident; one the fact that recently Chief Justice Burger chastised his legal colleagues publicly for "unseemly" advertising, selling professional services as if they were "mustard, cosmetics, laxatives, and used cars". Another, that the American Medical Association showed concern for public opinion when it recently urged American physicians to freeze their fees for a year; also to consider the financial situation of each patient—especially the unemployed, the uninsured, and the Medicare client—and accept



reduced fees when warranted. Further, the press and communication media are turning the spotlight on "hucksterism" and self-promoting practitioners with increasing frequency.

Additionally, many fellow dentists are expressing their disgust and disapproval of some of the antics going on under the guise of marketing. Dade County, Florida, school teachers have left no doubt of their opposition to the school board's adoption of a preferred provider organization plan, complaining of the loss of freedom to choose their own dentist.

Many people have jumped to the conclusion that the American people, particularly the young people, are discouraged and disenchanted, have lost faith in the government, in the establishment, and in the traditional values that made our country great. Last July 4th I watched a public service television program featuring the Boston Pops Esplanade Orchestra under the direction of John Williams. It played to an immense crowd; it had to be in the thousands. The concert began with Sousa's marches, then music from *West Side Story*, some classical music, the theme from the movie *Flash Dance*, some sing-along patriotic songs, *America, America the Beautiful*, the *Star Spangled Banner*, and ended with more of Sousa. If I ever had any doubts about young America being patriotic, they were totally dispelled as I saw literally thousands of young people singing the *Star Spangled Banner* and *America*, waving flags, keeping time to the music, and demonstrating their

approval with deafening roars of appreciation.

If that were not enough to convince one, how about the magnificent performance of our young athletes in the recent Summer Olympics? The pride of our people in our athletes and in our country was overwhelming. The spontaneous flag waving and the tremendous show of patriotism produced a deep-seated glow of pride and brought tears to many, many an eye. It made me realize more profoundly than ever that, while changes are bound to occur in society, in government, in our profession, and throughout our country, the real values that count are most definitely there and always will be. Young people have not deserted the ideals that made America great, and future dentists will not desert the ideals that made our profession great.

There have been so many futile and expensive programs foisted on the pretense of looking out for the "common man" that I would like to conclude by telling you I am not very much concerned about the common or average man. According to computers, the average man is 5'11" tall, has 1-7/8 children, owns 1-3/4 automobiles, eats spaghetti on Tuesday, bowls on Thursday, gives \$2 to his church on Sunday, and likes to have his back scratched.

When I say I am not very interested in the common man, I doubt if you are either; at least you have not shown me you are so far. When you are sick, you do not go to a common doctor; you look for one that is uncommonly capable. When

your car does not start, you do not look for a common mechanic, but for one who is uncommonly competent. And when you send your children to school, hopefully, you do not send them to a common teacher, but to one who is uncommonly dedicated to their future and to the future of the nation. Certainly, when you think of your profession, you do not think of it as a common vocation, but as an uncommonly dedicated profession in the truest sense of the word.

I like the philosophy that Dean Alfange expressed when he said: "I do not choose to be a common man. It is my right to be uncommon if I can. I seek opportunity, not security. I do not wish to be a kept citizen, humbled and dulled by having the state look after me. I want to take the calculated risk; to dream and to build, to fail and to succeed. I refuse to barter incentive for a dole. I prefer the challenges of life to the guaranteed existence, the thrill of fulfillment to the stale calm of utopia. I will not trade freedom for beneficence nor my dignity for a handout. I will never cower before any master, nor bend to any threat. It is my heritage to stand erect, proud and unafraid; to think and act for myself, enjoy the benefits of my creations, and face the world boldly and say, 'This I have done . . . all of this is what it means to be an American'." . . . and in my view, to be a dentist, and a member of the College. Δ

Reprint requests to:  
Dr. L. M. Kennedy  
7110 Greenbrook Lane  
Dallas, Texas 75214

# THE DENTISTS' RESPONSIBILITY TO HEALTH CARE DELIVERY

**Harold T. Perry\***

I wish to offer a brief verse, as a prologue, which is significant to this paper for it far better expresses than can I the meaning of personal and professional achievement and commitment to excellence. It was written by a talented, brilliant, humorous orthodontist, a friend of mine, named Harvey Peck whose brief career ended at forty-four years of age and this poem was in his obituary:

## **Life's Game**

**Kick it**

**Out to the stars, the heavens**

**Way out there**

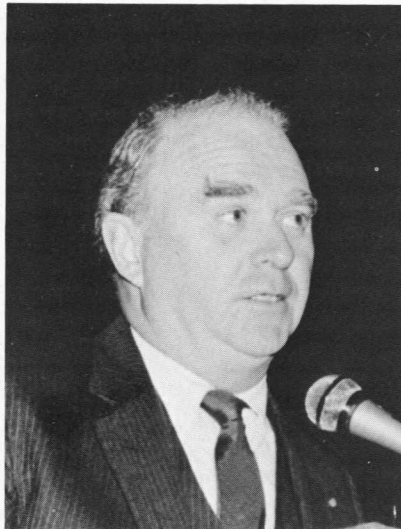
**Till you can't see it**

**But you can still feel it**

**And then go for it**

**Because you know it's there\*<sup>1</sup>.**

One day, in the preparation of this presentation, I needed a respite from thought, so I took my bicycle for a brief ride. Located near my home is a junior high school and as I rode past the playing field I saw the members of the football team



Harold T. Perry

going through their pre-practice work out. There were 30-40 team members jogging in a gaggle about the field. One runner was a good 100 yards behind the rest. As we approached each other I recognized him as one of my patients. I shouted encouragement; "Hang in there, Tom, I was always at the back of the pack." Imagine my surprise when he answered. "It's not what it looks like, Dr. Perry, I'm one lap ahead of them."

To the outsider, dentistry may seem to be in the same position as my young friend, running hard to catch-up but to many of us in the race we know we are still ahead. Hopefully my message this morning will stress why we are ahead and how we can remain there.

Excellence in dental care delivery is the responsibility of the individual dentist. Unlike our coprofessionals, in medicine, we do not

possess the guidance or monitoring facilities of a hospital Tissue Audit Committee. Rarely does anyone review our diagnostic decisions, our treatment procedures or our results. The achievement of excellence and a responsibility to it is inculcated and cultivated by our educational institutions through their clinical teaching, research achievements and the faculties individual and collective integrity. The patient's right to receive competent care is safeguarded by legislative process and state laws. Thus, those who designed this morning's symposium thoughtfully and eclectically gathered three principal topics, important and imperative to the provision of quality and excellence in dental care.

One of the primary strengths of dentistry has been the one-to-one relation that we are fortunate to have with our patients. We have often been labeled and castigated as a "cottage-industry" because of this individual and seemingly inefficient relation; however I believe it is the source of our present strength and if properly nurtured and husbanded it will assure us of continued professional prominence and strength. How much more satisfying and psychically rewarding is the thought of being *the* doctor and not *a* doctor? Undoubtedly our happiness and that of our patients will depend upon our personal commitment to, and professional objectives for, our individual patients. A misanthropic, dour, pessimistic, and gloomy dentist will not achieve a significant or lasting pa-

\*H. T. Perry, D.D.S., Ph.D., Professor & Chairman Department of Orthodontics, Northwestern University Dental School.

Presented as a part of a symposium at the annual meeting of the American College of Dentists, October 20, 1984.



tient following despite the excellence of his work and solicitude. As a corollary an altruistic, cheerful, optimistic dentist without superior concern and excellent clinical efficiency will be unable to maintain an active, vital and sound practice; for the lack of quality and permanence of his work will, in time, turn his patients away to seek acceptable care elsewhere.

Our dental journals, trade journals and even national financial magazines have cited the current lack of business within dentistry. *Forbes Magazine*<sup>2</sup> recently presented an article concerning this matter with the cover title "Why Everybody's Smiling but the Dentist". *Forbes* accurately cited the cost of dental education, office start up expenses and the increased dentist ratio to general population as primary problems facing the recent graduate. *Forbes* erred in their reference to the occurrence of insurance fraud and to unnecessary therapy by dentists, both of which are happily extremely rare.

I am suspect of the article's accuracy when they cite the Merck Manual as the definitive authority on TMJ therapy, by stating that most of this type of disorder is "Psychologically rooted". *Forbes'* utilization of this manual as a guide is akin to the Space Shuttle crew seeking space flight information from Charles Lindberg's flight records.

The underlying theme of the *Forbes* article, and others like it, stress the lack of 'busyness' in the American dental practice of today.

The accuracy of this assessment can be debated. The belief that it exists has created a blizzard of post graduate and continuing education flyers in the mail emphasizing the need for and the methods of practice volume enhancement. Some of

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**Personal ethics of today's professional is not learned nor is it specifically taught in many of our dental schools.**

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these have merit, others are ludicrous and some are outright fraud. I often receive questions from recent dental graduates who sincerely seek answers concerning the cost-benefit value of numerous non-university sponsored programs. It seems that the alleged lack of business has created a proliferation of nonbusy dentists giving courses to those who would like to be busier on how to become more busy. Who gains? I believe the individual or foundations giving the courses come out several laps ahead.

We, as members of the College, are in a unique position to influence the quality of dental care. Amongst us are educators, researchers, practitioners—we represent the many facets of American dentistry and the fact that we are Fellows indicates that others had faith in our dedication to and our desires for dentistry. We cannot, in cautious, collegial fashion, sit annually at this convocation as gods in our Pantheon. We should daily interact, influence, encourage and illustrate

by our own actions a constant faith in our profession and especially to those young professionals entering dentistry. Their entrance to clinical dentistry and their exit from our schools has put many of them in a very competitive and financially burdensome theater. We, who have preceded them into practice, should not observe their efforts as spectators. We are obligated to find means and methods to give them active, positive and meaningful support.

Previously, all of us, with a few exceptions, had entered the arena of private practice. If I am any judge of average age of those present today, it was a far different market place; it was devoid of such buzz words as hype", "P.R.", "positive reflective communication" and Madison Avenue personality projections. I would not demean the FTC and the rulings of the court related to professional advertising. They have stated that as professionals we can advertise but nowhere do they say we must advertise. Our efforts should be to direct and illustrate to our new colleagues that the best advertising is by the proper ethical and premier care of patients. If we could accomplish that, the satisfied and well served public will do more for each of us than a full page ad in the Wall Street Journal. We enhance our patient load by the excellence of delivered dental care, our personal interaction with our patients and their families as well as by active support and work with social, professional and community groups

requiring extra office hour commitments. Many community service groups are there waiting to gratefully accept dedicated, interested individuals who wish to become involved. This type of public service enhances your public relations better and is more lasting than many of the present 'paid for' public pronouncements. The significance of this community service is that it is not an obligation but rather voluntary dedication.

Each of us, in our own special way and fashion, have a significant role in the projection and protection of a fine profession. It need not always be in our office or in our patient's mouth. The communities we live in will and do provide us with a superior opportunity to enjoy a good life. We have an obligation to return something to that community above and beyond superior dental care to a few of its citizens.

Too frequently I hear a lament from individual dentists that they are lone voices crying in the wilderness unheard and unheeded by any of the other 160,000 members. Their attitude is: "What difference does it make if I, as one, do as I please?" This perception is erroneous and all of us are duty bound to emphasize to each that we are all part of a team and as such each must play his role and play it well. Our professional leaders and spokesmen are the coaches of that team. Certainly, they can be replaced, in a democratic fashion, if they are not doing their part or we are not winning. However the entire team must work and play for the win.

There are some features of our individual practices that can put us on the team or find us benched on the sidelines. One of these is our own personal ethics in dealing with our patients. There are many opportunities for the individual dentist to strain or rend the concept of personal ethics by cutting corners, assigning questionable duties to

ancillary personnel, engaging in procedures he is unqualified for or in criticizing the work of his colleagues. In the latter instance no one has ever elevated or enhanced his personal or professional status by deprecating the work of another. Certainly, instances of frequent or constant abuse of professional re-

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**For better or worse the disguise and guise, the masquerades and mirrorings of government, labor and insurance companies have entered our market place.**

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sponsibility by a member of our team should be dealt with strongly by our ethics committees and our various state and national licensing groups.

Ethics in the market place can be historically, politically, socially, ethnically and geographically different. Personal ethics of today's professional is not learned nor is it specifically taught in many of our dental schools. The fabric of personal ethics is achieved early in life with the warp of religious teaching and the woof of cultural, intra and extra family social interaction. Ideally the pattern of the cloth should be present and well imprinted before the age of maturity and the subsequent entrance to a professional school. It has been said: "No man is wholly free and no man is wholly a slave. To the extent to which a man has freedom, he needs personal morality to guide his conduct."<sup>3</sup>

The quality and quantity of that personal morality is difficult to assess prior to acceptance as dental school freshmen. There is no true measure or even recognition of its presence in any specific individual, so our admission committees are often at a loss to give it a value. The actions, behavior, personal social relations of our dental students

with their peers, faculty and patients will often give distinct clues to the moral foundation of the individual. We, who are faculty, must be ever alert for evidence of unacceptable, questionable or marginal moral ethics and behavior of our students. If we are truly dedicated to the excellence of dental care for our citizens and the accepted prominence of our profession we are duty bound to alter or prune those, who in student life, violate the concepts of acceptable ethical modes. We cannot, we must not, pass them on to society in hopes that the force of political, legal and social persuasion will insure acceptable ethical behavior. Many an orchard has been lost because of a blight on a single limb of one tree. The duality of ethics—political and moral—invokes that we as faculty become involved and responsible to not only the excellence of health care delivered but also to the ethical behavior of the deliverer we produce for society.

Those that have preceded us, those amongst us and assuredly those that follow will do much to assure us of a respected profession. The fruit of past labor is revealed in the 1983 Gallup Poll<sup>4</sup> rating the professionals in terms of honesty and ethical standards. We find that dentistry was ranked fourth preceded by the Clergy as first, pharmacists as second and physicians as third. It is anecdotal and interesting to note that those whose life's work is advertising ranked 24 of 25. It is hoped that their input into dentistry will not dilute or pollute our present status and standing.

The ranking of dentistry as fourth certainly would indicate that our behavior and endeavor to date has been commendable but as a team we should try harder to involve the entire team for future wins. We cannot afford to be trapped or stymied in the shadow of our past success.

If we can impress upon our



students and recent graduates that forethought differentiates man from animal and adult from child and we stress that forethought often entails unpleasant risks in order to achieve a goal we will have done much to impose the concept that there is a difference, and a significant one, between the means and the end. Often a recent graduate will perceive that the means of immediate success has no bearing on the end. This is when forethought is significantly important. A well laid plan envisions the end. The means should be secondary with considerable weight attached to which means one wishes to achieve his ends. The practice of dentistry can be as much as you wish to make it. To some it will be a constant worry, incessant care and eternal annoyance. To others it will be a life of extreme happiness, daily joy and as much pleasure and success as one could pack into a single lifetime. There is a means to the better or best end and that means requires forethought, knowledge, sacrifice, dedication, care, humility, confidence, skill and pride. There is no instant success, there are no *guarantees* from society, the dental school or the dental profession that the dental degree is Carte Blanche for a lifetime annuity. The means for a happy, successful and rewarding life is provided with the dental education. It is up to the individual to provide the method to those desired ends. Hopefully the recipient of the degree will opt to provide the very best professional care, attention and concern to each and every one of his patients on every occasion; if he does this he is assured that his will be a successful and rewarding professional career.

It is interesting at this juncture to consider the role of the state in assurance of quality dental care delivery. There are those who believe that the government and its friends can provide an excellence of health care above the common

denominator of the individual practitioner. Upon occasion the recent graduates believe that state guarantees of care and specific reimbursement will ease their early financially difficult professional life. It is well to remember that bureaucracies and the men in control of them tend to be too abstract and forgetful of what the human being is and feels. In this vein, those in sway endeavor to fit men to the system instead of the system to men. Here again, government by edict is lost in an inefficiency of individual delivery. The wage continues for the practitioner but soon he is an A-Tom'o Ton (automaton) working an assembly line waiting for the day's end whistle. There is little personal interaction, professional involvement, ethical concern in these situations and the practitioner is reduced to an intermediary in a state-citizen social agreement. I could envision the same evolution of social sets in many franchised dental care units. However, their attraction to our young professionals is the guarantee of income with little or no overhead but I fear this professional environment could on occasion be extremely counter to the achievement of the highest dental goals.

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**We should show . . . that we are able to cope, to adapt and to modify our efforts in what will be the best for society and our profession.**

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Recently, in the *American Dental Association News*<sup>5</sup> a former secretary of U.S. Department of Health, Education and Welfare, Califano, told a group of Rotarians that: "... Americans can get quality health care at far less cost". He was referring to a dental care delivery system negotiated by Chrysler Corporation where Califano is on the Board of Directors. He described the system as similar to a

medical HMO with pre-negotiated costs for Chrysler. He went on to state: "Unless action is taken to form a national health policy, the United States will face the same pattern of health care problems Great Britain has, which means rationing of the various levels of health care". One of his remarks directly quoted is significant to our intent today and I quote: "Dentists who still operate on a fee-for-service basis now have to compete to attract patients".

It is interesting to note that in the same issue of the *Association News*<sup>6</sup> and on the very next page there appeared a report that the American College of Hospital Administrators predicted a multi-tiered health care service with probable minimal care for all and for those who opted to personally pay more there would be available additional service.

This tier system of dental care delivery is not a new concept. One of the earliest references to it was voiced by Avrom King in 1975. Mr. King, in a *Nexus* news letter of 23 August 1984 goes even further to predict that by 1990 the three tiers he referred in 1975 will be "... politically structured and, thereby, culturally explicit".<sup>7</sup>

I believe we always have had three gross tiers of dental care delivery, perhaps not structured as King envisioned but certainly evident in a survey of oral cavities of a heterogeneous cross section of American populace. The lower tier would be those who have had minimal care—most usually tooth removal because of pain. The second tier would be those who have passed from that first level to the next and would have restorations of decayed teeth but no replacement of missing units and very infrequent dental visits. The third tier would be those with regular dental visits, restored teeth and replacement of lost units and generally excellent dental care and dental health. These three tiers of care have been established by the

patient's actions or inaction. Our current A.D.A. public relations drive is aimed at the 50% of the population who make up the first two groups.

How does all this relate to our current topic? To the astute observer it should indicate that there are some strong currents outside the profession directed at the method, costs and frequency of the professional dental care delivery. No longer can the recent graduate hang out his shingle, open his office and expect a deluge of patients with unquestioning trust and complete faith that was possible only 15-20 years ago. For better or worse the disguise and guise, the masquerades and mirrorings of government, labor and insurance companies have entered our market place.

We here, today, give emphatic evidence that American dentistry has not entered its phase of eschatology, deprived of its sociologic, economic, political, ethical and professional purpose. Despite the buffeting the profession has experienced and will continue to witness from adverse internal and external currents, seemingly beyond our control, we must steer a steady course and continue to provide premier dental care to the American people. How best can we do this?

I believe that the means to our end, which is *Excellence in The Delivery of Dental Care* can be assured if based upon four ingredients of good dentistry we all know and easily recognize.

1. **Quality students**
2. **Superior academic facilities**
3. **Knowledgeable faculty**
4. **An active professional society**

The first is the primary feature in our professional perpetuation—the dental student, our germ plasm. The second is the educational environment of those students, the womb of development. The third is the faculty of the educational institutions and their environmental

impact, and the fourth and final ingredient is the profession itself, their peers, colleagues and coprofessionals.

First and foremost I believe we are to be eternally vigilant in regard to the quality of those we give the honor to enroll in our dental

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**If . . . we suspect the worst can happen, we are wise. If we believe the worst will not happen, we are optimistic and if we believe that nothing worse can happen we exhibit foolishness. We must be prepared.**

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schools. The excellence of any product from college graduate to manufactured goods is dependent upon the quality of the original raw material. As a member of the loyal opposition I strenuously object to the concept that class rolls should be filled regardless of academic qualification to ensure academic financial balance. Such decisions by private or state schools will only see the future of ethical and excellent dental care deprived of our superior heritage. It would be far better to accept the most superiorly qualified students and fill only 1/2 to 3/4 of the class than to have a full class with poor to mediocre ability. I fully realize this could and would cause administrative apoplexy but challenges exist to be met and problems occur to be solved and I am certain this one could be solved and must be. Our inability to improvise and achieve a solution only leads to a future treacherous to our favored profession. It is just as important to 'weed out' for scholastic inadequacy as it is for ethical inadequacy.

Secondly we must provide above average to superior academic and clinical facilities to the students. This matter is practically dealt with

and hopefully mastered by our Council on Dental Education with their periodic site reviews of all accredited schools. However, all dental professionals should be individually and universally alert to political polarization or bureaucratic cronyism corrupting or obscuring the intent of review.

Thirdly we are obliged to assure that the superior student, in a superior environment receives his education from a knowledgeable and ethical faculty. This feature of a role model education is under the aegis of the individual dental schools and the University. A degree of evaluation is provided by the Council on Dental Education but the primary responsibility resides within the academic community. Our failure to strictly adhere to professional excellence would indicate additional tumult to the grave of dentistry just as surely as our acceptance of marginal students or a poorly provisioned clinical and academic environment.

The fourth and final constituent essential to excellence of delivered dental care is strongly dependent upon and innately associated with the three preceding factors. It is a cohesive, attentive, responsive and concerned professional society or dental profession membership. Such a society membership will not exist without proper fulfillment of the three previously cited components. Our profession has been exceedingly kind and good to all of us as well as our new young colleagues and will be to the thousands yet to follow. However, we have individual and group responsibilities that require thought, patience, deliberation, decision and action. These are exciting times for American Society and all of its varied and diverse citizens. Dentistry has before it many challenges, many changes, many problems and many possible solutions. We can deal with them in constructive, optimistic and positive fashion. Those of us



who have experienced the Golden Age of American dentistry cannot turn our back on the inevitable change and adhere to our ways of 20 or 30 years ago. We should show society, our younger colleagues, our patients and ourselves that we are able to cope, to adapt and to modify our efforts in what will be the best for society and our profession.

It will be our responsibility to see that any changes are for the greatest good based upon our professional judgment; also that any changes will be for the enhancement of dental health for the total population which now includes the uncared for or the minimally cared for members of our society.

If, as a concerned profession, we suspect the worst can happen we are wise. If we believe the worst will not happen we are optimistic and if we believe that nothing worse can happen we exhibit foolishness. We must be prepared.

Cicero, the Roman orator, wrote to his wayward son Marcus, attending college in Athens, and urged that there can be no real conflict between what is right and what is to our advantage; that we should always by human standard do what is right and not compromise ourselves. He summarized it well by stating: "To everyone who proposes to have a good career, moral philosophy is indispensable."

Aristotle in "Ethics" suggested that young people were largely incapable of knowing many morally true things because of the lack of experience in themselves and in the action of others. Thus, as members of a profession, we are required to teach by doing what is right and morally expected, in hope that our colleagues will follow in step.

Edmund Burke wrote about the 'spirit of the gentleman', he was referring to more than fashion, friends and powerful influence and associated apparent external gen-

tility. Burke was referring to the refinement of the mind and the character which helps each of us to distinguish between truth and falsehood, right and wrong, the noble and the base.

As dentists we should be vigilant and alert to the siren calls and words of the Cassandras within and without our profession. Despite my doubt of the Forbe's predictions of 'Dentistry Future' we should be wise enough to expect the worst. Who in the thirties would believe that Orwell's "1984" would have any actual examples or parallels by this date? The ego-bruising facts are there that a degree of Big Brother does exist, therefore let us not totally reject as out-of-hand the Forbes concept of dentistry's demise. To do so is to believe the worst will not happen which is sheer madness.

To me the two most important words for the future of our profession are words of action and they are *adaptation* and *modification*.

White water canoeing is a favorite of mine and, just as in white water, to control your craft you should be going at a speed greater than the current, so too for our profession. We cannot idly seek all eddies or backwaters, nor should we foolishly descend a Class V rapid. When we see problems for our profession approaching, just as in canoeing, we should survey and study the current for rocks, drops and hidden forces. We must readily and rapidly assess the situation and act with deliberation and force to achieve the best for our patients and profession. We have to be ever ready to adapt and modify our professional concepts if the change is acceptable for greater good and is morally and ethically tenable.

Those of you who are leaders either in the stern or the bow are responsible for reading the waters and safely delivering our craft with deliberate action and coordinated effort. You are in the lead canoe, we

who follow are at the mercy of your knowledge, skill and ability. Foolish paddling or unplanned runs can lead to dangerous results for all of us, just as certainly as too cautious and slow action in rough or white water can lead to capsize.

As a corollary, smooth sailing should not lull us into acceptance of the status quo—which is something that I suspect my generation has been guilty of. Often a bend in the river will reveal an unexpected drop, or an abrupt change in course direction will bring a freshening of the wind with unexpected gusts and tumultuous waves. A false feeling of security that nothing can go wrong, or that the worst will not occur is, as I said, madness. Dentistry can not become an impassive monolithic structure perpetuated and protected by unyielding and unadaptable bureaucrats. Such a scenario would be portentous of our demise and if we as concerned members permit this, we all will have been responsible for the hollow and unhallowed mausoleum that will house the last survivors of Forbe's 'Dentista Obsoletum'. Δ

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Reprint requests to:

Dr. Harold T. Perry  
Northwestern University Dental School  
240 East Huron Street  
Chicago, Illinois 60611

# RESPONSIBILITY OF THE DENTAL PROFESSION TO EDUCATION AND RESEARCH\*

Raymond P. White, Jr.\*\*



Raymond P. White, Jr. addresses ACD Annual Meeting.

A profession must have a productive base of education and research to serve society. Dentistry is no exception. This paper discusses the status of dental education and research, identifies impediments to

future productivity and suggests solutions to problems that hinder progress.

Dental education has expanded greatly in the past two decades. Schools have become components of a health science center which includes a medical school, other health science schools, a health

sciences library and affiliated teaching hospitals. From 1962 to 1979 the number of dental schools increased from 47 to 60, and almost all schools acquired new or renovated facilities equipped with modern dental treatment units. Dental

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**The application of research findings has altered dramatically the practice of dentistry.**

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schools are staffed primarily with full-time faculty whose professional efforts are directed to the programs of the dental school and the parent university (1983: 4,130 clinical and 1,788 basic science faculty).<sup>1</sup> A much smaller cadre of dental faculty staff teaching hospitals. Almost all clinical faculty have training beyond the dental degree which prepares them for clinical teaching and patient care.

The primary focus of the dental education community until very recently has been the education of dentists. In response to a perceived national need, the first year enrollment in dental schools was expanded from 3,600 in 1962 to 6,301 in 1978.<sup>2</sup> Enrollment in advanced education programs continues to rise. First year places in specialty programs have declined slightly over the past decade (1973 1,213 to 1983 1,202) while first year places in general practice residency programs and advanced general dentistry programs have doubled (1973 at 587 to 1983 at 1,015).<sup>3</sup> Although educational methods can always be improved and faculty need to continually expand their teaching skills, dental faculty today employ

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**A profession must have a productive base of education and research to serve society.**

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\*\*Raymond P. White, Jr., D.D.S., Ph.D., Director, The Robert Wood Johnson Dental Services Research Scholars Program, Health Services Research Center. Professor Oral and Maxillofacial Surgery, School of Dentistry, University of North Carolina.

\*Adapted from a paper presented as part of a symposium at the Annual Meeting, American College of Dentists, October 20, 1984.



methods in the classroom, laboratory and clinic as advanced as their peer faculty in other health science schools.

The application of research findings has altered dramatically the practice of dentistry. As examples, preventive methods to control dental caries and advances in biomaterials have modified techniques of restorative dentistry. Pharmacologic advances and an improved understanding of human behavior have enhanced methods of pain control. Advances in anesthesiology, surgery, and orthodontics have allowed significant modifications in a patient's jaw function and facial form. All disciplines in dentistry can provide improved patient care as a direct result of dental and related biomedical research. Dental schools are recognized as having the primary responsibility for research and development in the field of dentistry. The major external support for biomedical and clinical research comes from the National

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Institutes of Health (NIH) through the National Institute of Dental Research (NIDR FY 1983 \$54,874,000).<sup>4</sup> Education research, health services research and policy analysis received funding from philanthropic foundations e.g., Robert Wood Johnson Foundation and non-profit organizations e.g., the American Fund for Dental Health (AFDH).

The Special Committee on the Future of Dentistry (American Dental Association 1981-83) acknowledged the contributions of dental schools to improve the dental

health of American citizens.<sup>5</sup> The Committee espoused fundamental principles which must serve planning efforts for the dental profession. These include a commitment to maintain a strong educational system, and an emphasis on the discovery of new knowledge and the transfer of that knowledge and technology into the delivery of patient care. Specific recommendations from the Committee are directed toward a broad scope of dental research to be conducted in great measure in schools of dentistry. In the same time frame a national conference addressing the role of research in dental education (University of Minnesota, October 1982) reaffirmed that dental schools have a primary responsibility for research in dentistry.<sup>6</sup>

Dental schools and their companion teaching hospitals serve as an important source of patient care for the community. A faculty practice exists in two-thirds of the dental schools where faculty provide referral services which address the most complex clinical dental problems. The dental school and the dental department of a teaching hospital are increasingly seen as the place to send patients for consultation and treatment when a complicated clinical problem exists. The development of this service role of the institutions is a direct result of the availability of full-time clinical faculty.

But in 1984 the focus of dental education is shifting. The federal and state government, the dental profession, and potential students believe that there are adequate numbers of dentists being trained to meet the demands for dental care. In fact the number of first year students in schools of dentistry have declined by over 15 percent from 1978 to 1983 (6,302 to 5,274).<sup>1</sup> Recent projections from the Ameri-

can Association of Dental Schools estimate that first year class size will continue to drop until it reaches 4,300 places.<sup>7</sup> Unless faculty effort and resources are redirected, dental schools could face a period of serious retrenchment where indi-

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**The major external support . . . comes from the National Institutes of Health through the National Institute of Dental Research.**

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vidual schools close and the number of faculty is reduced proportionate to the reduction in numbers of dental students.

The education effort of the faculty must change. As the scope of dental services provided by the general dentist and the specialist have increased, the curriculum of the dental school has been expanded resulting in an extremely crowded schedule for the student at any level. A mandatory fifth year of dental school has been discussed and actually implemented in a few dental schools e.g., Harvard, LSU. Study groups have recommended the addition of one year to the dental curriculum, a general dentistry residency program (Task Force on Advanced Dental Education, 1980;<sup>8</sup> Special Committee on the Future of Dentistry, 1983).<sup>5</sup> The problem of financing and implementing these recommendations are considerable, but dental education appears to be slowly moving toward the adoption of a fifth year as a residency program.

The fifth year of dental education should accommodate 75 percent of the dental graduates, requiring a threefold increase in general dentistry residency places. The general dentistry programs should be developed in concert with changes in

the predoctoral dental curriculum. Each general dentistry residency program should be affiliated with a faculty of a dental school, assuring a level of educational experiences of increasing difficulty as the student progressed from one clinical level to the next. A faculty must evolve to teach students at an advanced clinical level. New faculty must acquire appropriate skills, and current faculty must retrain for new teaching roles. Curriculum modification is most difficult. Yet, the program for educating dental students can be modified if the education process can be seen as a continuum including predoctoral education, advanced education and

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**Dental schools and their companion teaching hospitals serve as an important source of patient care for the community.**

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continuing education.

There is room for considerable innovation in continuing education programs. Members of the dental profession recognize that the knowledge base in dentistry is expanding, and dental practice is changing rapidly as new technology is adopted. Dental schools are in the best position to develop appropriate continuing education programs for the profession. The redirected effort of dental faculty can accommodate an approach that would include a combination of didactic and clinical training for the dentist participant. At the same time the dentist participating in continuing education must be able to be available for blocks of time on a repetitive basis.

The products of research and innovation will continue to profoundly change the practice of dentistry. But the bulk of the funding for basic biomedical research is

centered at one institute, NIDR, among the eleven at NIH. The NIDR budget has not kept pace with inflation nor with increases in funding of other NIH institutes. The budget of NIDR has doubled over the past decade (1974, \$43,959,000; 1984 \$88,163,000) but it reflects the smallest increase at NIH.<sup>9</sup> In constant dollars support has declined since 1972 (1972, \$43.3 million; 1983, \$35.1 million).<sup>10</sup> Funds are not evenly distributed among dental schools. In FY 1980 50 percent of NIH funds went to 10 percent of the schools (6) and 70 percent of NIH funds went to 20 percent of the schools (12).<sup>11</sup> The drop in support from NIDR for research training is dramatic. In FY 1970 454 individuals received training support, 238 of them dentists; by 1980 only 152 individuals of whom 49 were dentists were in training. Dentists receiving research training fell by 79 percent over a decade when major scientific advances were being made in biomedical research.<sup>12</sup> The NIDR budget for training fell across a similar time frame (1972, \$5.9 million; 1982, \$3.4 million current dollars).<sup>13</sup>

Faculty in dental schools are prepared for teaching and patient care. But most faculty have minimal training and experience in research methods. In addition faculty are hampered by a narrow view of research, limited almost to biomedical and materials science. Today research or scholarly effort encompasses a wide array of disciplines including those in basic biomedical science, clinical fields, education and health services research. Different skills and perspectives are required for the conduct of research across these fields, but they offer faculty a broad opportunity to solve problems relevant to dental health and the delivery of health care. If the profession of dentistry is to continue to expand

its knowledge base, funding for research and research training must improve, current faculty must acquire additional research skills, our brightest students must be attracted to education and research careers, and the dental profession must achieve a better understanding of the scope and impact of the current and a potential research effort.

The efforts of the American Association of Dental Research (AADR) have begun to focus on the limited budget of NIDR. Other dental organizations must join AADR to secure a wider base of support from Congress for basic biomedical research and expanded clinical investigation. The American Fund for Dental Health (AFDH) supports the greatest diversity of education research and health services research through its small grants program. It is contributions from dentists that fund the AFDH effort. The ADA House of Delegates 1983 strongly recommended an expansion in dental health services research and policy analysis.<sup>5</sup> Traditionally funding for major projects in health services research has come from private sources; non-profit organizations such as AFDH in a combined effort with philanthropic founda-

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**Dental education appears to be slowly moving toward the adoption of a fifth year as a residency program.**

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tions, e.g. Robert Wood Johnson Foundation, all of whom must be stimulated to increase their support.

Students now planning for education careers must spend additional time in training, one or two fellowship years to acquire research skills. Stipends for these additional years in biomedical and clinical research are being discussed at



NIDR. The Dentist-Scientist Award for clinicians is under consideration but Congress must provide budget support. AFDH is studying possible alterations in the Teacher Training Fellowship with a focus on the fellowship year and faculty who seek added research skills. But AFDH is limited by its available funds. The Robert Wood Johnson Foundation offers faculty two years of support in training for health services research through the Dental Services Research Scholars Program. This new program shows promise, but the Foundation must be assured that the profession wants this research training continued. Many more opportunities for current faculty must be developed, enhanced by a collective initiative by the dental profession.

Only two percent of fourth year dental students express an immediate interest in a career in education and research.<sup>14</sup> Dental faculty have the first chance to recruit our best students to academics. But the beginning dental student needs encouragement and financial support to participate in existing research projects. NIDR and dental professional organizations give a minimum number of small grants; this number could be greatly expanded.

Dentists in practice seem to realize how research findings are altering methods of patient care. Dental journals and newsletters now focus more on current research and its implications for practice. This trend can be expanded and is endorsed by the Report from the ADA Special Committee on the Future of Dentistry.<sup>5</sup>

The dental schools of the nation are a valuable resource capable of direct patient care and consultation for the most complicated dental problems analogous to the resource provided by major teaching hospitals and medical schools for com-

plicated medical problems. The patient with a severe dental problem serves the teaching program of a school and may participate in research protocols. But the faculty of dental schools have had difficulty articulating patient care as a goal; dentists in the community have not always seen faculty as a resource for consultation and patient care.

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**Traditionally funding for major projects in health services research has come from private sources.**

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An improved communication between the dental community and our dental schools can improve the collective ability of the profession to provide care while at the same time enhancing the education and research programs of the dental schools. A cooperative effort among the professional organizations in dentistry could foster a national initiative which focuses on care of patients with complex problems. In the process the relationship between the dental faculty and the dentist in the community could be better understood improving dental care for all patients.

In summary the dental profession has made great strides in improving its education and research base. The collective resources of the educational institutions have provided the dental manpower for our nation. Now faculty effort must be redirected toward: curriculum revision and a continual improvement in educational methods, an expansion in quantity and scope of research, and providing care for patients with the most complicated dental problems. Only through an awareness and a concerted effort by dental professional organizations acting with the dental education community can this be accomplished.  $\Delta$

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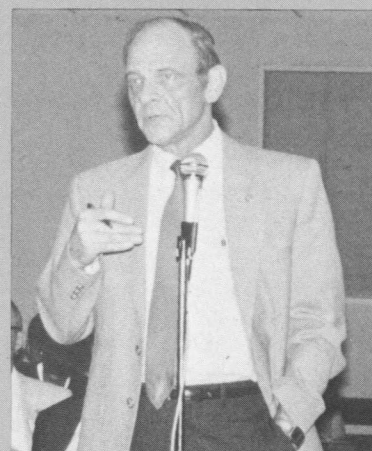
Reprint requests to:

Dr. Raymond P. White, Jr.  
Health Services Research Center  
Chase Hall 132A  
University of North Carolina  
Chapel Hill, N.C. 27514

# MEETING OF SECTION OFFICERS AND REPRESENTATIVES



A portion of the audience at the Sections Meeting.



Claude L. Ruby, Jr., Michigan, addresses the meeting.

The Meeting of Section Officers and Section Representatives was held Friday, October 19, 1984 at Atlanta, Georgia. For the past several years, these meetings have shown increasing attendance each year with a corresponding increase in participation and interest.

Section representatives have the

opportunity to ask questions, to offer suggestions and to comment on College activities. Lively discussion has allowed the meetings to run longer than planned several years in a row.

Dr. Ralph A. Boelsche of Houston, Texas addressed the group regarding the history and formation of the

American College of Dentists Foundation.

Again, this year, attendance plaques were presented to those Sections which were represented at the Annual Sections Meeting. Representatives were photographed in Regency groups.



Regency 1: (L to R) Milton Jacobson, Western N.Y.; George O'Grady, NY, Regent Sumner Willens.



Regency 2: (L to R) George August, Maryland and Bernard Yanowitz, Metro-Washington DC





Regency 3: (L to R) Regent James Harrell, Sr., Rupert W. Bodden, Jr., Alabama; F. Lee Eggnatz, Florida; Pitman B. Cleaveland, Jr., Georgia; Walter H. Dickey, Virginia; William A. Mynatt, N. Carolina.



Regency 4: (L to R) Regent Robert Biddington, Varoujan Chalian, Indiana; Julianne Bluitt Foster, Illinois; John L. Campbell, W. Virginia.



Regency 5: (L to R) Claude L. Raby, Jr., Michigan; Thomas J. Murdoch, Oklahoma; Anna T. Hampel, Minnesota; Henry M. Cherrick, Nebraska; Regent Paul Butcher, Ralph E. Lassa, Wisconsin.



Regency 6: (L to R) Regent Robert C. Coker, James G. Price, Texas; John G. Durham, St. Louis; Charles H. Boozer, Louisiana.



Regency 7: (L to R) Regent Leo E. Young, Roy Reger, Colorado; John Berry, So. California.



Regency 8: (L to R) Regent Albert Wasserman, Harold Pressman, Montana; John Fujioka, Hawaii; Edwin Hyman, N. Calif., Charles V. Farrell, Wash.-British Columbia; Robert Sheridan, Oregon.



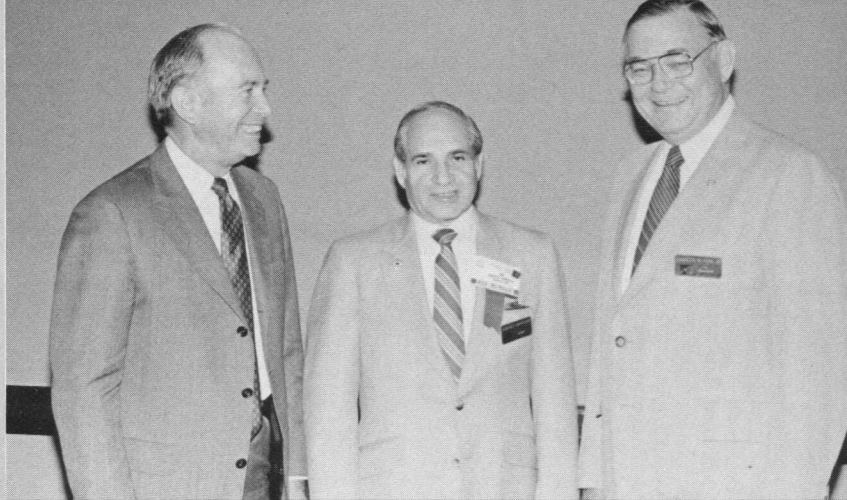
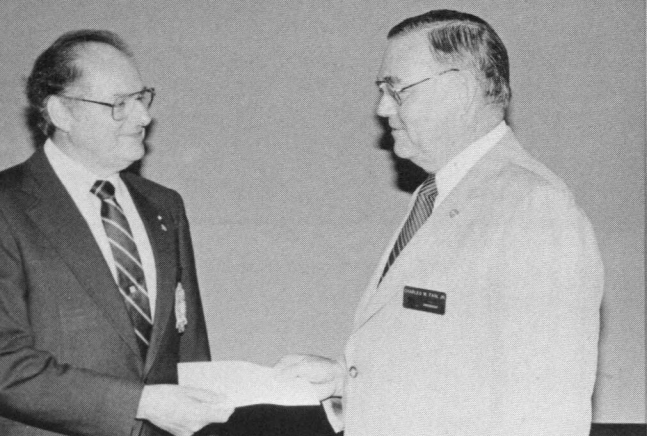


Above, 1984 Officers of the American College of Dentists: Seated, (L to R) President Elect Charles W. Fain, Jr., President Lynden M. Kennedy, Vice President Norman H. Olsen. Standing (L to R) Editor Keith P. Blair, Executive Director Gordon H. Rovelstad, Treasurer Robert W. Elliott, Jr.

Pictured below at the Fall 1984 Meeting of the ACD Board of Regents are (L to R) Regent Elect Robert E. Doerr, Regent Leo E. Young, Regent Robert C. Coker, Regent Paul S. Butcher, Treasurer Robert W. Elliott, Jr., Regent Sumner H. Willens, Regent H. Curtis Hester, Vice President Norman H. Olsen, President Lynden M. Kennedy, Executive Director Gordon H. Rovelstad, Executive Assistant Jo Clark, Staff member Karen Matthiesen, President Elect Charles W. Fain, Jr. Regent James A. Harrell, Sr., Regent W. Robert Biddington, Regent Albert Wasserman, Comptroller Mae Hom and Pat Flinton, staff member.







Top Left: Regent Albert Waserman, left, presents a check from the Northern California Section to the ACD Foundation. President-Elect Charles Fain, Jr., graciously accepts on behalf of the Foundation.

Top right: President-Elect Charles W. Fain, Jr., right, welcomes the two new Regents. On the left is Robert E. Doerr of Ann Arbor, Michigan. Center is Joseph P. Cappuccio of Baltimore.

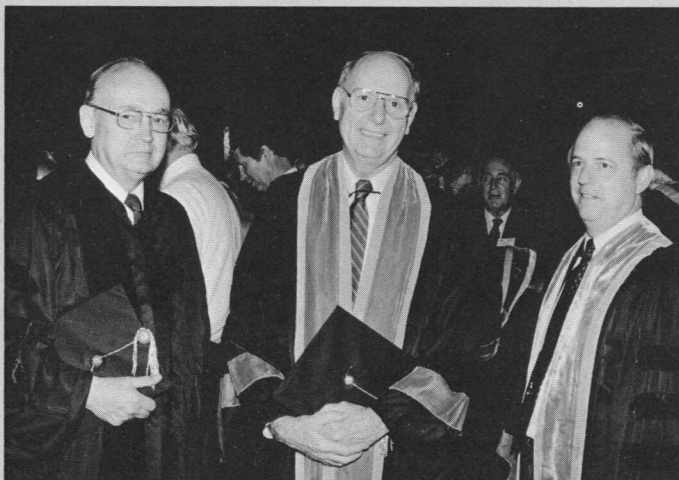
Left: Regent W. Robert Bidington, left and Charles W. Fain, Jr., engage in a serious discussion.

Right: Executive Assistant Jo Clark prepares to register candidates and sponsors for the Convocation.

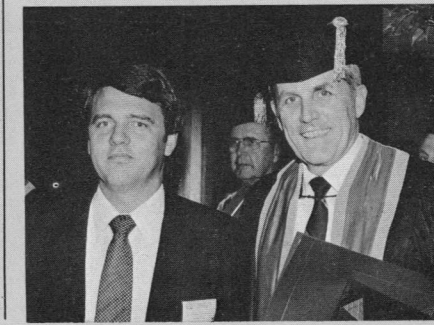
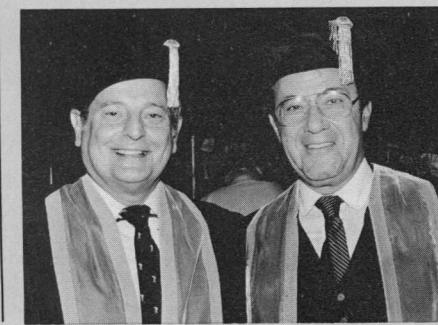
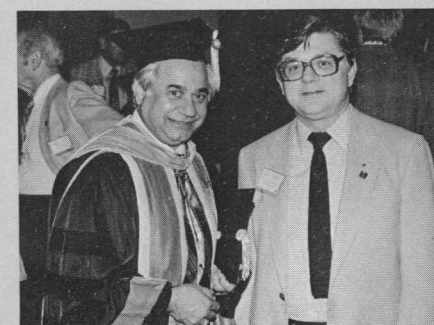
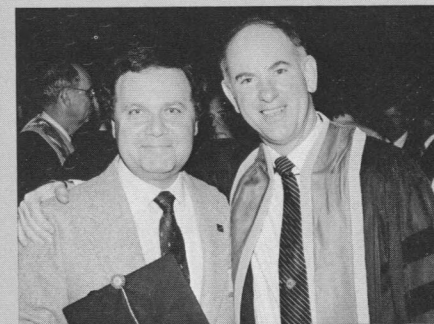
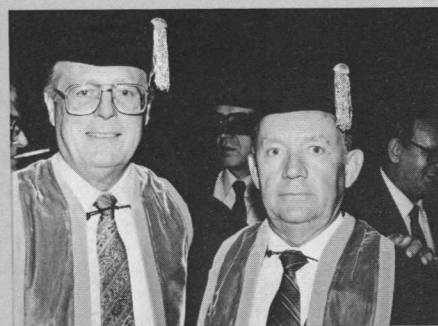
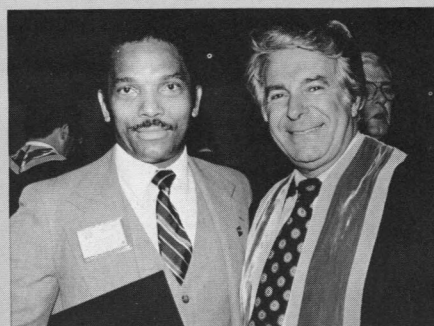
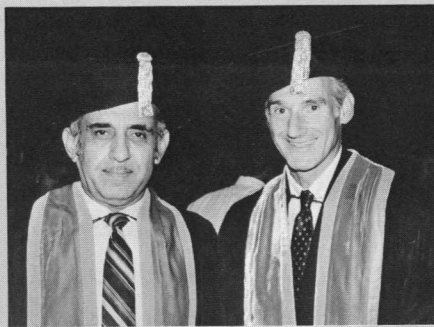
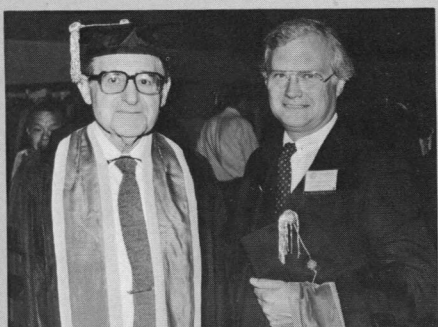


The eight Regents on the 1984 Board of Regents are pictured in a happy mood.

# 1984 CONVOCATION —ATLANTA, GEORGIA



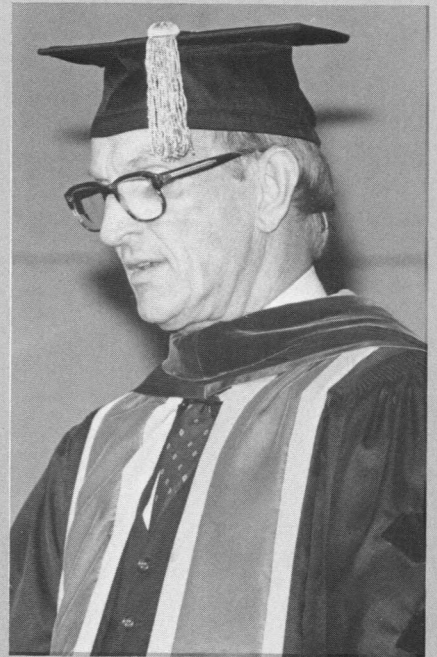




# 1984 CONVOCATION —ATLANTA, GEORGIA



The Convocation begins and the new stage setting is very impressive.



Executive Director Gordon H. Rovelstad reads the roll of new Fellows.



Officers of the American College of Dentists for 1985 at the Convocation, left to right, Editor Keith P. Blair, Treasurer Robert W. Elliott, Jr., Vice-President H. Curtis Hester, President Elect Norman H. Olsen, President Charles W. Fain, Jr., and Executive Director Gordon H. Rovelstad.



## DINNER DANCE



Lynden M. Kennedy, right, President of the American College of Dentists, welcomes the President of the American Dental Association, Donald E. Bentley, to the ACD Dinner Dance.



James L. Cassidy, ACD Past President, acted as Master of Ceremonies for the Dinner Dance.



The prestigious setting for the head table at the Dinner Dance utilized the backdrop of the new Convocation stage. A huge crowd of over 1200 people attended the affair.

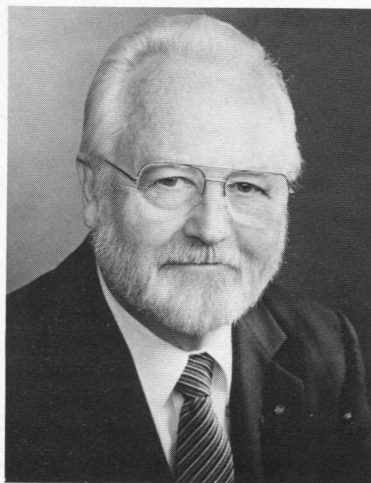
# GIES AWARD TO FLOYD DEWHIRST

**Citation Presented by Regent Leo E. Young**

The William John Gies Award was established by the American College of Dentists in 1939 in order to recognize Fellows of the College for outstanding service in dentistry and its allied fields. This award honors Dr. Gies not only for his outstanding contributions to all facets of the profession of dentistry, but it also serves as an index of appreciation and esteem for those Fellows of the College whose works have merited exceptional recognition. There have been 58 distinguished Fellows of the College honored by this award. These 58 Fellows represent the most noble and dedicated among us and personify professionalism in the finest form.

Floyd Everett Dewhirst, Jr. of Los Angeles, California has been selected to receive the 1984 Gies Award of the College.

Dr. Dewhirst has served his profession in many capacities. His contributions to organized dentistry and to the profession have been nationwide if not worldwide. Having served in all of the offices and as President in 1962-63 of the Southern California Dental Association, he has also been President of the Beverly Hills Academy of Dentistry, President of the Western Dental Society, President of the Loma Linda University School of Den-



Floyd E. Dewhirst

tistry Century Club and a member of the Board of Directors of the Los Angeles County Dental Society. He was elected Delegate to the House of Delegates of the American Dental Association, serving from 1959 through 1972 when he was elected Trustee from the 13th District and served in this capacity until 1978. Although a member of the American Dental Association Council on Legislation, he continually found time to serve as a Clinical Assistant Professor of Operative Dentistry at the University of Southern California, Loma Linda, as well as a guest lecturer at the University of California in Los Angeles and the University of the Pacific in San Francisco.

In 1973, Dr. Dewhirst traveled to New Zealand to make a comprehensive study of the dental nurse program in the public schools. His report of this study was published in the Journal of the Southern California Dental Association in April 1973. In 1972, Dr. Dewhirst was named to a special advisory position of the American Medical Association Council on Legislation. This appointment was recommended by the Board of Trustees of the American Dental Association and carried full voting privileges on the AMA Council. This was the first time that a dentist served and voted on an AMA Council. This recognition followed many years of active participation on legislative bodies, both in California and on a national level.

Dr. Dewhirst is a native of Harvard, Illinois and a graduate of the University of Southern California. Dr. Dewhirst has made many contributions to his profession. He will be remembered by many, however, for his special expertise in operative dentistry which he has shared widely with his students and colleagues alike.

Mr. President, it is with great honor and pleasure that I present to you, Dr. Floyd E. Dewhirst for the William J. Gies Award of the American College of Dentists.



# GIES AWARD TO GERALD STIBBS

Citation Presented by Regent Albert Wasserman

The American College of Dentists has selected Gerald D. Stibbs of Seattle, Washington, to be a recipient of the William John Gies Award of the American College of Dentists for 1984.

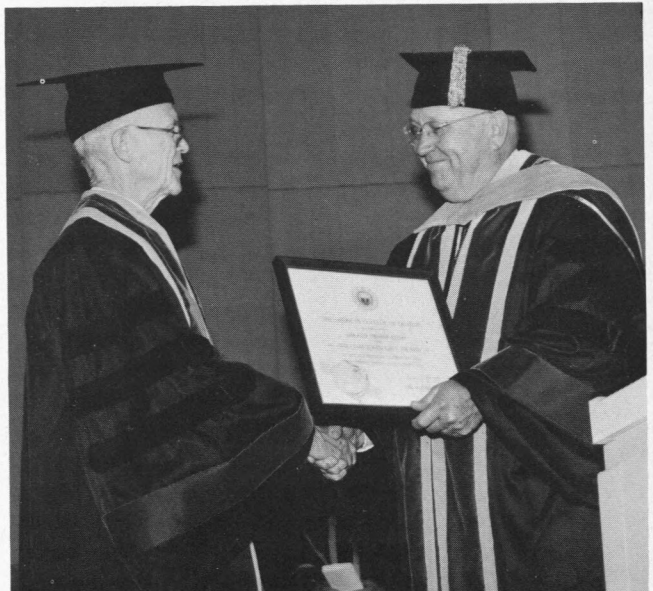
A native of Ontario, Canada, and currently Professor Emeritus in Restorative Dentistry at the University of Washington School of Dentistry in Seattle, he has served dentistry for over 58 years. A graduate of North Pacific College, now the Oregon Health Sciences University in Portland, Dr. Stibbs practiced in British Columbia for 17 years where he was active in dental affairs locally, provincially and nationally. He served as President of the Vancouver Dental Society, Secretary and President of the British Columbia Dental Association, a member of the Council of College of Dental Surgeons of British Columbia, and British Columbia Representative on the Dental Committee of National Research Council of Canada.

He joined the faculty of the University of Washington in 1948 as Professor of Operative Dentistry. He served as Chairman of the Department of Operative Dentistry and Clinic Director; and for seven years as Chairman of the Department of Fixed Partial Dentures at the University. He was Special As-

sistant to the Dean prior to election to Professor Emeritus. During this time, he developed a graduate program in Operative Dentistry at the University that drew highly talented people from various parts of the world as well as from the United States.

Dr. Stibbs has published widely and given numerous clinics and demonstrations. He has been Associate Editor or Contributing Editor for Operative Dentistry to the Journal of Prosthetic Dentistry, Audio Journal of Dentistry, Hines' Review of Dentistry, and Boucher's Clinical Dental Terminology, 1st and 2nd editions. He also contributed significantly to the Dental Science Handbook, edited by Doctors Lon Morrey and Robert Nelsen. He is presently instructor of three gold foil study clubs and Associate Editor of the Journal of "Operative Dentistry."

Numerous honors have been



President L.M. Kennedy, right, presents the Gies Award to Dr. Gerald D. Stibbs

awarded to Dr. Stibbs, including OKU honor fraternity, Sigma XI membership and, in 1981, he was recipient of the Distinguished Member Award of the American Academy of Gold Foil Operators. He is listed in Who's Who in America and in American Men of Science.

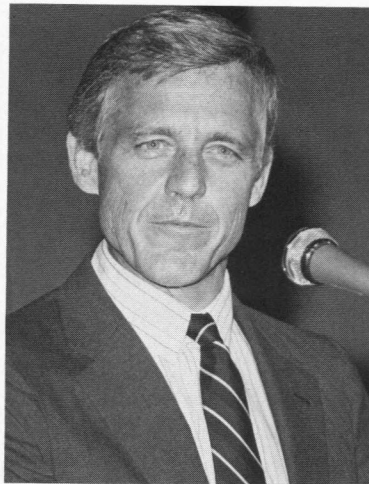
Mr. President, it is with great honor and pleasure that I present to you, Gerald D. Stibbs for the William J. Gies Award of the American College of Dentists.

# HONORARY FELLOWSHIP FOR WILLIAM S. BANOWSKY

**Citation Presented by Regent James A Harrell, Sr.**

The College from time to time considers it a privilege to confer Honorary Fellowship on persons who, though not holding a dental degree, have contributed to the advancement of dentistry and to its service to the public. These contributions may have been made in many areas—education, research, administration, public service, public health, medicine and many others. To acknowledge such leadership and contributions, the College confers Honorary Fellowship upon those selected.

This year the person so honored is William S. Banowsky. Dr. Banowsky is currently President of the University of Oklahoma and our Convocation speaker today. He holds the B.A. degree from David Lipscomb College, the M.A. degree from the University of New Mexico, and the Ph.D. degree from the University of Southern California. Named by Time magazine as one of the top 200 leaders of the future when he was President of Pepperdine University in California during the 70's, Dr. Banowsky built an entirely new 30 million dollar oceanfront campus at Malibu. Currently, heading a three-campus institution of 25,000 students enrolled in 17 colleges with an annual budget of 150 million dollars, he has brought about significant improvement in faculty salaries, doubled



William S. Banowsky

the library, strengthened the admission standards, and established the immensely successful University of Oklahoma Associates Program. His concern for the environment has also been expressed with the launching of an extensive campus beautification program.

Dr. Banowsky is a Director of several corporations, Director of the Public Broadcasting System, and serves as a member of the Oklahoma Educational Television Authority. He holds a regular television program entitled, "Bill Banowsky Visits" which is aired statewide in Oklahoma. He has been honored with the Liberty Bell Award from the American Bar Association, the Distinguished Edu-

cator Award from the Jewish National Council, and the George Washington medal from Freedom's Foundation at Valley Forge. For the United States Information Agency, he has led the official inspection team into Zaire, Africa. In 1981 he was appointed by President Reagan to the Intergovernmental Advisory Council on Education.

President Banowsky is no stranger to dentistry or to the American College of Dentists. As Convocation Speaker in San Francisco in 1972, he was received so enthusiastically that he was invited for a return engagement in 1984. Having a brother in the practice of dentistry in Irvine, Texas, he is quite familiar with the profession and its objectives. And, further, as President of a university which has a very active College of Dentistry, he is recognized for his enthusiastic support of quality dental education with the highest of ethical standards.

Bill and his wife, Gay, live in Oklahoma City. They have four boys, three of whom are Oklahoma University graduates; one a navy pilot, two who are law students, and one who is a freshman majoring in engineering.

Mr. President, it is an honor for me to present Dr. William S. Banowsky to you for Honorary Fellowship in the American College of Dentists.



# AWARD OF MERIT TO BEVERLY BANE

Citation Presented by Regent Robert C. Coker

The supporting services of dentistry are universally recognized as being very important to the mission of the profession. From these derive many of the elements which enhance the effectiveness of dentistry for the delivery of care and the management of its own affairs. The Award of Merit of the American College of Dentists was established by the Board of Regents on February 8, 1959 in order to recognize unusual contributions made toward the advancement of the profession of dentistry and its service to humanity by persons who work with the profession in common purpose but are not Fellows of the College.

Beverly Bane, Administrative Secretary of the Texas Dental Association, has been selected to receive the 1984 Award of Merit. Miss Bane became an employee of the Texas Dental Association while still in her teens and has faithfully served the profession for 42 years. As Administrative Secretary, she has far exceeded any reasonable expectations of performance. During her tenure with the Association, she has served with 42 Presidents and five Executive Secretaries and/or Executive Directors.

Miss Bane has a computer like memory that would compare favorably with a main frame computer and a vast amount of information is

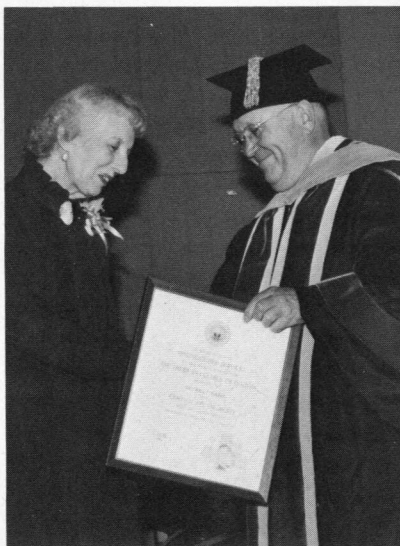
stored in her memory and can be retrieved on an instant's notice. She can almost recite the name of every person who has been a member of the Texas Dental Association as well as all of the procedures and resolutions considered in the past 40 years. One example of her love and dedication to the profession arose at the time when the central office of the Association was moved to Austin from Dallas. Miss Bane was happily situated in Dallas, owning her home, active in her church, and with many friendships made over her lifetime. Concurrently with the move of the office to

Austin was the assumption of the office by a new Executive Secretary. The profession was greatly concerned that the move would be made with a staff of new personnel and a loss of any continuity. Because of her love for the profession, Miss Bane sold her home and, with her widowed mother, moved to Austin and began making a new circle of friends.

As Miss Bane completed 40 years of service, the Texas Section of the American College of Dentists together with the Past Presidents and Past Vice Presidents of the Texas Dental Association, dedicated their respective annual luncheons in her honor. At that time she received many gifts, letters of congratulations and appreciation for her service.

Miss Bane has truly been a person for all seasons in Texas dentistry. She exemplifies magnificently all of those characteristics which are appropriate for the individual to receive this award. She goes down in the records of the College, along with her many predecessors, as having made unusual contributions towards the advancement of the profession of dentistry and its service to humanity.

Mr. President, it is a privilege and an honor for me to present Miss Beverly Bane to you for the Award of Merit.



President Kennedy presents the Award of Merit to Beverly Bane

# DENTAL MANPOWER—THE DENTAL SCHOOLS' DILEMMA

A Symposium at the 1984 Meeting of the Maryland State Dental Association.  
This series of four speeches is published jointly with the Journal of the Maryland State Dental Association.

**Dean Stanley P. Hazen, Georgetown University**

**Dean Errol L. Reese, Maryland University**

**Dean Jeanne C. Sinkford, Howard University**

**Knight A. Kiplinger, Kiplinger Publications**

## Forces Join For Profession's Betterment

The Maryland State Dental Association appreciates the opportunity to have its papers, "Dental Manpower—the Dental School's Dilemma," published jointly in this issue of the Journal of the American College of Dentists and in the April 1985 issue of the Journal of the Maryland State Dental Association. These manuscripts were presented at the MSDA's 101st Annual Meeting, September 13–16, 1984 at the Baltimore Convention Center.

Since the beginning of the Maryland Section of the American College of Dentists, there has existed a close-working relationship with the College. This "Love Affair" is the result of history, individual effort, leadership and proximity.

Fifty-two years ago, at the suggestion by Dean J. Ben Robinson of the University of Maryland Dental School, the twelve Fellows of the American College of Dentists who were practicing in Maryland met to discuss the advisability of a local organization. Those men were the real founders of the Maryland Section, although formal recognition, with the approval of the Regents of the College, did not occur until one year after the first meeting.

The Maryland Section was the third Section in the country to receive formal recognition, following Kentucky and Northern California. Although the College was established in 1920, there was no sectional organization until 1933. Certainly, this 13–14 year span, from 1920 to 1933, should not be interpreted as indicating an initial lack of interest in the

College on the part of the Maryland Fellows because Clarence J. Grieves, a prominent Maryland dentist-pioneer in the field of dental metallurgy, is recorded as one of the twenty-three founders of the American College of Dentists.

A Reisterstown, Maryland native, William J. Gies, although not a dentist, was credited with important advancements in dental education and served as national Editor and Assistant Secretary for the American College for many years. By 1938, seventeen Maryland dentists were Fellows of the College. One year later, the Section was asking questions that required group study and decision: how may dentistry meet its responsibility to those unable to pay the current cost of adequate dental care for all in need of it? In what respects are the problems of dental service for the masses different from those of medical practice and how should these differences affect plans for general health care?

Thus was launched the Maryland Section of the American College of Dentists and the dental profession in Maryland was given representation in an elite group to cope with rising professional problems. The College and the Maryland Section began the search for ways and means to improve the distribution of dental services, and this search is still in progress. Much has been done, but there is much more to do.

Bernard Gordon, Editor  
Maryland Dental Association



# DENTAL MANPOWER— THE DENTAL SCHOOL'S DILEMMA IN A STATE INSTITUTION

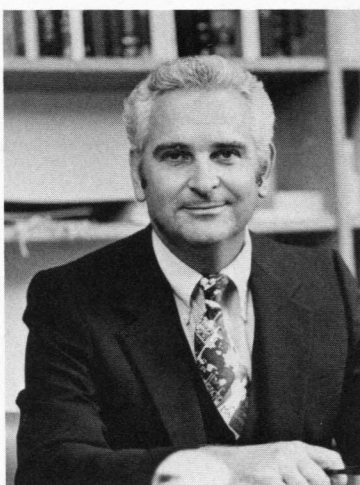
Errol L. Reese\*

It is a great honor for me to share the podium with three very distinguished individuals. It is also interesting to note that the three deans of dental schools represent schools with three distinctly different missions—

- one of the schools has traditionally served the black community since its founding
- another school, which is privately supported, traditionally has accepted students from all corners of the United States
- the third school, as a state-supported School, has accepted the majority of its students from the State of Maryland; but, because of its unique history, has served young men and women of the world.

I would like to focus my remarks on two (2) thoughts that I believe are crucial to this subject of Dental Manpower. The first issue concerns the ownership of the problem—is it really the dental schools' dilemma? And the second issue is related to the public's perception of how we are addressing the dilemma.

Dental manpower is an extremely complex issue, compounded by a number of factors. Like so many issues facing the health profession today, it really depends upon who's at bat, or who you are talking to, as



Errol L. Reese

to whether or not there is a problem; and if there is a problem, what is the solution. Those of you who are familiar with this subject know that we studied the manpower requirements, we debated the issues and we made a recommendation, and for your information, great things are being accomplished—*progress is being made.*

The Baltimore College of Dental Surgery (BCDS) was the first dental school east of the Mississippi not only to develop a plan but to *implement* the plan. Many of us who hammered out the enrollment plan for the eighties at BCDS believe it is still valid, and we would have difficulty modifying it. The number of those who agree with the enrollment reduction may be small, for there are large segments of our population who have good reason to disagree.

All schools have a mission, and this mission may differ for each school. The University of Maryland mission is clearly stated as being the training and graduation of sufficient numbers and types of dental manpower to the oral health care needs of the citizens of Maryland/nation/world.

Who should decide on the *number* and types of dental manpower, and how should the decision be made? *This is the real dilemma!* The obvious group should be the citizens of the State of Maryland, and some would say the group that should NOT be involved is the practicing dentists represented by organized dentistry. One could assume that practicing dentists would like to preserve, as much as possible, the goals of the profession as well as their personal goals, and under no circumstances do they want the threat of competition. If dental educators determine the number and of type dental manpower, many would cry "foul" and say that the fox is being permitted to guard the hen house. I can assure you that faculty also have the human trait known as self-preservation. If we turn to the behavioral scientists or public health dentist who have been trained and educated to make these kinds of decisions, (those who not only want a chicken in every pot, but who believe that every citizen in the United States has a right to dental care), this group would surely say we need more dentists.

Should we turn to state and

\*Errol L. Reese, DDS, Dean University of Maryland School of Dentistry.

federal agencies to solve this dilemma? The Federal Government has never hesitated to tell us the appropriate numbers needed! Recently a report by the U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Bureau of Health Professionals was issued to the President and Congress on the status of health personnel in the United States, dated May, 1984. This document serves as an excellent review of what has occurred in the health professions in the past several decades. A brief summary of dental progress states that, "Over the past 20 years, dentistry has experienced unparalleled development and growth. The resulting changes have rendered obsolete many of the assumptions of the 1960s concerning dental manpower supply, care needs, education, technology, materials and traditional delivery system practices. The profession of dentistry is actively planning and preparing for the future of den-

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**The dilemma of manpower does not rest entirely within the walls of dental schools.**

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tistry and for the education and training of dental care providers capable of meeting the future requirements of practice and the needs of the U.S. population". The report goes on to cite critical areas and issues that will be confronting dentistry in the future. "Three areas that have been identified are:

- ply of *qualified* dental care providers;
- 2) The extremely *high cost* of dental education; and
- 3) The need for future changes in dental school *curriculum*."

The above issues will definitely fall on the shoulders of our profession, as well as state and federal governments. As one begins to read the section in this report on "Future Requirements" there is a tendency to hold one's breath. Our thoughts immediately flash back to projections of the sixties and involvement of the Federal government in health manpower planning. Time does not permit a full analysis of this section of the report, therefore, to stimulate your interest, I would like to present the first sentence and the last. I am providing copies of the report to all the leaders here today and, therefore, you should have no difficulty in obtaining a copy for your own review. "Forecasting future requirements is much more complicated than projecting future supply." . . . "The requirements forecast constrained by the assumptions presented earlier indicates that within the next few years growth in aggregate *demand* for dental services should approach the expected growth in *supply* and remain in close *balance* through the year 2000."

The perspective of the practicing dentist tied the dilemma to the issue of "busyness". One often hears the refrain, "Oh, how I would like to return to the good ole days". Do you remember the "good ole days" when you picked up a magazine or newspaper and saw headlines that announced patient visits to dental

offices have increased and had almost doubled in a five (5) year period, or "Dentists Cash Receipts Increase", and that there were more patient visits than in the previous year, and would it not be nice to read "Dental Market Expands"? Or remember the time when the solo practitioner was king, and we read such things as solo practices were becoming more efficient and more productive, and almost ¼ of all solo practitioners grossed \$200,000 per year? All of those quotes from the "good ole days" can be found in publications that crossed your desks during the last six (6) months! The point is, when we talk about "good ole days" we are talking about yesterday and today. We tend to lend credence to the casual comments and anecdotal stories that we hear at dental meetings, in the hallways of dental schools, and in newspapers around the nation. But, do we have the facts to face the dilemma?

The dilemma of manpower *does not* rest entirely within the walls of dental schools. All groups (practicing dentists, faculty, public health dentists and citizens) should be involved in making the decision as to the number and types of dental manpower that should be trained; but as you know, those kinds of joint decisions rarely happen.

I would now like to turn to the second issue that I would like to discuss. Dean William E. Brown, Dean of the Dental School at the University of Oklahoma and presently serving as President of the American Association of Dental Schools, recently stated in an editorial in the *ADA News* the following: "The intraprofessional attitudes and behavior have been mighty



chilly of late, if not downright cold. It is time to re-establish the professional collegiality with which many of us have grown up and warm up the professional climate. The relations between the profession and the media have been especially heated in recent months, and it is time to cool them down." It seems to me that there has been a proliferation of stories in both local and national media which casts shadows over the manner in which our profession is dealing with the manpower dilemma and the "busyness" issue.

I can assure you that recent publications in the press bring about many comments from the public concerning the greed and selfishness of physicians and dentists. The ADA and AMA published the average income of dentists and physicians. Consider the fact that if you have a net income of \$75,000, you are within 1.2% of all earners in the United States; and if you earn \$50,000, you are within 4.1% of all wage earners in the United States (Bureau of Labor Statistics). The *Baltimore Sun* recently had a series of articles which dealt with "poor" dentists and physicians. Do you really think that your patients, and the citizens of Maryland, shed a tear for you? The recent article in *Forbes Magazine*, clearly informed the public that last year's average net income for dentists and physicians was just under \$60,000 per year. It mentioned the expenses of doing business, but it still impresses the public that no matter what the expenses are, the ADA says that the average dentist/physician nets \$60,000 a year! In discussing the *Forbes* article with a number of practicing dentists, they felt that it

is about four (4) years too late, but does provide some interesting reading for physicians!

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**The real dilemma is who should decide on the number and types of dental manpower, and how should the decision be made.**

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I would like to propose that one way of improving our intraprofessional attitudes and behavior is that, as professionals, we turn more toward factual data than rumors, anecdotal comments and one individual's perception of what is going on in the world. As professionals we should read every publication concerning our profession that is available. These include not only articles about basic as well as dental research, new techniques of practicing dentistry and managing a dental practice, but also the newspapers and journals that cross your desks each month. As professionals we must have the necessary information to understand the dimensions of these issues.

There are many complex issues facing our profession today, and I believe that the one that remains the highest priority is how to provide oral health care to more than just one-half of our population. As professionals, how can we help those who do not necessarily seek our help? How can we, through our actions, influence that lost 50% of our population to understand and enjoy the benefits of good oral health? There is no question that if we were to meet that theoretical goal of providing sufficient dental

manpower to meet the oral health care needs of *all* the citizens, we would have to double the enrollment of our dental schools. We as professionals are committed to pursue excellence. We must act as professionals; we must act responsibly. So many people depend upon us—we cannot let them down, today or in the future! *AND THAT IS THE DILEMMA!* Δ

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Reprint request to  
Dr. Errol L. Reese, Dean  
Baltimore College of Dental Surgery  
666 W. Baltimore Street  
Baltimore, Maryland 21201

# THE PRIVATE DENTAL SCHOOLS' DILEMMA

Stanley P. Hazen\*

I would like to provide some historical perspective to my presentation. I recently heard a lecturer note that there is recorded evidence that the government of the city of Alexandria commissioned a study to determine the number of physicians in the city, due to the perception that there were too many physicians for the population. When the study was completed, the report submitted stated that there were not too many physicians for the population, but there was a problem of maldistribution. Problems appear to be cyclical, and often we do not learn from the past but must experience for ourselves. By the way, the study cited was conducted several hundred years before Christ was born.

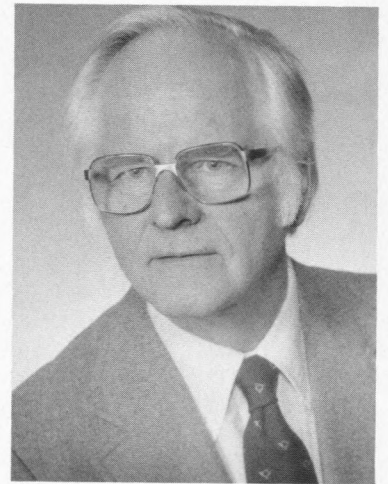
Time limits discussion, and my mandate was to limit my presentation to our School's dilemma of today related to the supply of dentists and the economy.

Georgetown, as a private school, by that I mean that we obtain absolutely no budget support from any government source, has similar but different concerns. By the way, I will take the presenter's prerogative and substitute the word *concern* for dilemma to make my points.

1. We are concerned by the present apparent oversupply of dentists in this country. As you know, we do not have any valid studies to support

this attitude, but there is a feeling of a lack of busyness among dentists and recent graduates have greater difficulty in becoming established in practice. Perhaps some of us like to remember the days when we graduated and could readily establish a practice wherever we desired, and would like it to stay that way.

2. We are concerned with the decreasing number of applicants to dental schools in this country. This has been a continuing trend since 1975. Nationally we have gone from 15,734 in 1975 to 7,803 in 1982.<sup>1</sup>
3. We are concerned with the diminishing quality of applicants to dental schools based upon grade point averages and Dental Aptitude Test scores. Annual reports compiled by the American Association of Dental Schools indicate a gradual decline in these quality indicators.<sup>2</sup>
4. Dentists are a vital resource in recruitment efforts to dentistry. Today we are concerned with an apparent lack of enthusiasm for dentistry on the part of many practicing dentists. As a result many dentists are not encouraging young persons to go into their profession.
5. We are concerned with the lack of federal support for professional education that extends from student loan programs, to patient care, to



Stanley P. Hazen

programmatic support.

6. We are concerned with aspects of the changing spectrum of dental diseases in the United States; such as the decrease in the incidence of dental caries primarily due to the fluoridation of public water supplies, teeth being retained longer; the need for fewer complete dentures, and the realization that the needs of an aging population are already upon us.
7. We are concerned that dental schools are closing in Scandinavia, England and the Netherlands. What impact will this have on the profession and the oral health of the population in those countries?
8. We are concerned that there are huge populations in this world without oral health care and many countries without dentists available to

\*Stanley P. Hazen, DDS, M.S., Dean, Georgetown University School of Dentistry, Washington, D.C. A presentation to the Maryland State Dental Association.



provide any oral health care.<sup>3</sup>

9. We are concerned with the maldistribution of dentists in this country and in the world. There are over 900 shortage areas identified in the United States alone.<sup>4</sup>
10. We are concerned that dentistry should continue to develop as a scientifically based, patient care oriented profession that demonstrates its concern for all people.

Concerns are evidence of a level of awareness and sensitivity; but in reality what are we, as a school of dentistry, doing about these concerns?

1. We have decided that private dental school education should be maintained as a choice for students seeking a dental education.
2. We are studying our entering class size as it relates to our programs, the demand for dentists and the economy. At this time we have realized a 5% reduction in our entering class size. We will continue to study this problem and will make a decision on the size of our 1985 entering class in December 1984.
3. We have developed an affiliation program with feeder colleges to assist in assuring the quality of students entering our School. This program permits a student to enter dental school after three years of undergraduate college. The baccalaureate degree is granted after successful completion of the first year of dental school. Thus, the baccalaureate degree and dental degree can be achieved in seven years rather than eight.

Student progress is carefully monitored throughout the program. The college student is expected to spend some time at the dental school during an intercession to learn more about the

professional school's educational environment. The object of this is to improve the transition from college to professional school.

4. We are conducting an international recruitment program. The intent is to educate and train persons that will go back to their countries to provide oral health care to their populations. This is not a program to provide an opportunity for foreign trained dentists to get an American degree. It does provide the opportunity for a qualified foreign college student, who wishes to be a dentist in his/her own country, to achieve that goal. Remember, caries is reduced in this country, but it is still a major problem for most of the world's population.
5. We will provide information as necessary and work as necessary to provide assistance to federal agencies or any other groups that could aid in developing programs for educational opportunities for professional students and for oral health care to populations that are presently neglected.
6. We will continually study curriculum needs related to disease patterns and adjust our curriculum to meet those needs.
7. We will maintain efforts to keep education costs down. This is difficult in an economy that continues to grow each year and requires studied budgetary constraint.

Several loan programs that are available to students have high interest rates and require interest payments while the students are in school, creating financial problems that are difficult for them to manage. Therefore, we have initiated a Revolving Student Loan Fund that provides low cost loans to needy

students. We intend to encourage contributions to this fund to make it a viable loan option for our students.

8. We are dedicated to increasing our knowledge of the orofacial environment that will provide future challenges to us as dental professionals. As we resolve disease problems in our population we must look toward dealing with other problems that have been ignored previously or about which little had been known.
9. We will continue to seek faculty that will provide an educational environment that deals not only with the present status of dental practice, but also has the ability to assist students to prepare for future changes.
10. We will continue to provide continuing education courses to assist in updating professionals to current knowledge.
11. Finally, it is intended that we maintain a close interaction between dental education and dental practice so that together we strive for excellence in dental education, patient care and community service. Δ

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Reprint requests to:

Dr. Stanley P. Hazen, Dean  
Georgetown University School  
of Dentistry  
Washington, D.C. 20007

# A LOOK AT DENTAL MANPOWER AND RELATED ISSUES

Jeanne C. Sinkford\*

The 1984 Report to Congress from the Department of Health and Human Services (DHHS) predicted a shortage of 4,000 dentists in the U.S. by the year 2000!<sup>1</sup> This figure takes into consideration the national decline in first year dental student enrollment that we have seen which went from 6,030 in 1980-81 to 5,855 in 1981-82. The DHHS projection is based on the assumption that first year dental school enrollment will continue to fall to 4,719 by 1987-88 and stabilize at that level. At the same time, the American Association of Dental Schools (AADS) estimates<sup>2</sup> that there will be 240 fewer first year

**The dental care received by the American public is disproportionate in that 80% of the care goes to 20% of the population.**

students by 1987-88 than the DHHS projection, and that enrollment will continue to decline until the first year class size reaches 4,300 students. Thus, the DHHS data may, in fact, underestimate the dentist shortage for the year 2000! If either of these predictions proves to be true (and we are seeing a continued enrollment decline—3.6% since 1981-82), the challenge

\*Jeanne C. Sinkford, D.D.S., Dean, Howard University College of Dentistry. Presented at the Maryland State Dental Association Annual Meeting, Baltimore Convention Center, September 13, 1984.



Jeanne C. Sinkford

to dental schools and to the profession will be to maintain a viable applicant pool of dentists for the future who will be responsible for the oral health care of U.S. citizens for generations to come. We must do this in the face of a changing economy, increased competition for gifted students in the health and other arenas, changing disease patterns, changing health care delivery systems, changing attitudes of the public toward health and health financing, increased concerns regarding busyness of dentists, and a major federal move for health care cost containment.

Some of the facts that I consider to be important to rational solutions to our present dilemma regarding supply/demand projections for the future are:

1. The physician "glut" must not be interpreted or trans-

lated as a dentist "glut." The increase in medical student enrollment from 1970-71 to 1981-82 was 68.9%; for dentistry that increase was 36.6%. The overproduction of dentists is still highly questionable especially when we consider that the U.S.P.H.S. has identified some 1,000 dental shortage area communities in the U.S.<sup>3</sup> where the dentist to population ratio exceeds 1:5,000 (and we accept 1 to 1,900 as a desired ratio) and where we are losing 2,500 dentists per year due to deaths and retirement.<sup>1</sup>

2. Fluoridation, the most effective preventive oral health measure, will produce a 60% reduction in tooth decay for those individuals who have access to optimal fluoride water supplies.<sup>4</sup> However, 50% of the people of this nation reside in non-fluoridated communities. This figure is not expected to change significantly during the next decade.
3. Dental visits, which are an indication of health care, are seriously deficient when one considers that half the population does not visit the dentist on an annual basis. The average annual number of patient visits was estimated at 2,840 per dentist in 1981 compare with 2,890 in 1978 (a 2% decline).<sup>5</sup>



4. The dental care received by the American Public is disproportionate in that 80% of the care goes to 20% of the population, especially to those of higher educational and socioeconomic backgrounds.<sup>6</sup>
5. Less than one-third of the U.S. population has some form of prepaid dental health insurance. Unlike medicine, dental health care is largely a fee for service, out-of-the-pocket endeavor for most Americans.<sup>5</sup>
6. There has been a significant increase in the attempts of the American public at self-medication as evidenced by increased over-the-counter drug sales in an attempt to offset rising health care costs and to reduce physician/dentist visits.
7. There is a national schizophrenia regarding rising health care costs, efforts for cost containment and the resistance of the American public to change substantially the way in which they receive health care.<sup>7</sup> Recent surveys continue to show that less than 40% of the American people would like to save money by giving up their personal doctor and being treated by a group of practitioners. Approximately 2% of Americans receive their dental care in non-traditional settings, e.g., retail dentistry, HMO's, hospital-based care (ADA, September, 1982).
8. With the exception of dental caries reduction resulting from preventive efforts, the status of dental health of Americans has not increased significantly during the past decade. The Surgeon General's 1982 Report to the Nation still included dental diseases as a major national health problem.<sup>8</sup> There are still 1 billion unfilled cavities and 100 million man hours of

**Table 1. Black Dental Students and Graduates by School Year: 1969-1970 through 1983-1984**

School Year	Total Dental Student Enrollment*		Dentist Graduates**	
	Black Students	Percent of All Students	Black Graduates	Percent of All Graduates
1969-70	357	2.3	85	2.3
1970-71	453	2.7	55	1.5
1971-72	597	3.5	74	2.0
1972-73	765	4.2	110	2.8
1973-74	872	4.5	154	3.4
1974-75	945	4.7	187	3.8
1975-76	977	5.2	213	4.0
1976-77	955	4.5	215	4.1
1977-78	968	4.5	203	3.8
1978-79	977	4.5	182	3.3
1979-80	1,009	4.4	190	3.7
1980-81	1,022	4.5	214	3.9
1981-82	999	4.5	227	4.2
1982-83	1,001	4.5	200	3.5
1983-84	1,000	4.7	—	—

\*1983-84—21,428 Total Dental Enrollment

\*\*1983 Graduates = 5,756 Total (—)Data are not available

Source: Council on Dental Education, Annual Report on Dental Education, American Dental Association, Chicago, Illinois.

**Table 2. U.S. Black Dental Student Data 1983-84**

Educational Institution(s)	Number of Blacks	Percentage of Black Enrollment	Total Enrollment
Howard University	297	29.7%	46.2%
Meharry Medical College	165	16.5%	
All Schools except Howard, Meharry and Puerto Rico	538	53.8%	
All Schools	1,000	100.0%	21,428 Blacks 4.7%

Source: Council on Dental Education, Annual Report on Dental Education 1983-84, Supplement #3 Minority Report. American Dental Association, Chicago, Illinois.

production time are lost because of dental diseases. Oral cancer causes 1 in 50 deaths annually.

9. Health care to targeted segments of our population has been drastically reduced during the present administration, particularly those services that would benefit the aged, the youth of our country and the poor. We have

suffered severe cuts at the national level and Block Grants to states are not adequate to achieve acceptable levels of health care at state and local levels. For example, in the District of Columbia, dental benefits have been reduced along with reduction in funds for Title IX, WIC, rodent control and lead poison control programs.

10. We have seen a significant increase in the number of women entering the profession of dentistry—231 (1.4%) in 1970–71 to 4,227 (18.7%) in 1981–82 with an expected plateau at 30% by 1987.<sup>5</sup> Black minorities, during this same period of time, have gone from 597 (3.5%) in 1971 to 999 (4.5%) in 1981 (Tables 1 and 2). Thus, Blacks continue to be seriously underrepresented in the dental profession in the U.S., especially when we consider that there are 28 million Black Americans or 11% of the population. Neither the ADA *Future of Dentistry Study* nor the more recent *Report to Congress* by the Department of Health and Human Services adequately addresses Black minority manpower needs. A projection that the number of Black dentists is expected to double by the year 2000 is included in the DHHS report. The ADA study does recognize a need to recruit minority students to the profession. However, at the present time, there are only 500 Black dental student applicants in the pool each year and only 200 Black graduates (3.5%) in a total of 5,756 graduates (for 1983). The total number of Black students enrolled in 1983 in U.S. dental schools was only 1,000 students in a total enrollment of 21,428 (4.5%).

11. The availability of student financial aid at acceptable interest rates poses a serious problem for us since 85% of minority students are in need. We have seen, during this administration, a reduction in the National Health Service Corps (NHSC) trainees, a reduction in scholarships for the exceptionally needy and proposed legislation that will significantly alter the eligibility requirements for new

borrowers for the Health Professions Loan Program. In 1980–81 at Howard, we had 45 NHSC trainees; by 1983–84 and at present, we have only ten continuing in the program. Interest rates in the Health Professions Loan Program and the Guaranteed Student Loan Program are projected to be at 8 and 9 percent, respectively (for eligible schools), while the Health Education Assistance Loan Program (HEAL), and

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**Dental education in the U.S. is a \$715,000,000 enterprise rising at a 4% rate annually with tuition rates providing only 24.6% of the cost.**

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the Auxiliary Loans to assist Students Program (PLUS/ALAS), are at 11¾ and 14 percent. The national average student indebtedness at graduation is \$26,700.<sup>9</sup> This indebtedness is expected to increase in the future. Dental education in the U.S. is a \$715,000,000 enterprise rising at a 4% rate annually with tuition rates providing only 24.6% of the cost.<sup>10</sup>

12. The National Commission on Higher Education in the U.S., in its report to the President, has called for educational reform throughout the system.<sup>11</sup> Greater emphasis on excellence in education is expected for the future with special focus on careers in mathematics, the physical sciences, aerospace technology, engineering and computer science. The health professions will be in serious competition for gifted youth of the future who are looking toward careers with shorter training periods, lesser financial indebtedness and greater potential for career development and financial rewards.

## Howard University—A Unique Mission

Howard University, the institution which I represent, is unique in its mission in that it is a national resource for minority manpower. Howard is a private, nonprofit institution, founded by an Act of Congress in 1867, and located in the nation's capital. The College of Dentistry, founded in 1881, is the fifth oldest dental school in the United States. The Dental School is part of the Howard University Health Center, which includes the Colleges of Medicine, Nursing, Pharmacy, and Allied Health, a 500-bed hospital, and the Centers for Cancer, Hypertension, Child Development and Sickle Cell Disease. Howard University receives 52% of its budget from a congressional appropriation, and the mission of the University, since its inception, has been directed toward minority education.

The College of Dentistry has a total enrollment of 477 students in undergraduate dental and dental hygiene programs, postgraduate programs in Oral Surgery, Orthodontics and Pedodontics, and a hospital-based general practice residency program. We are admitting 94 dental students per year (reduced from a high of 108) and 80% of our students are black. Our full-time equivalent faculty count is 112, not including the basic science faculty.

While we anticipate enrollment reductions as seen in other schools, we will continue in our efforts to recruit minority students and to provide for them the academic support required for successful matriculation in dental school.

I have the following recommendations that should be considered by the profession as it seeks to address dental manpower issues for the future:

## Recommendations

1. Increase public demand for dental services by the promo-



tion of oral health as a part of general health and the quality of life with a focus on biologic, physiologic and psychosocial aspects of oral diseases and disorders.

2. Review the impact that existing federal "cuts" have had on dental services for targeted population groups in your own communities. Relate these impacts to total health quality, costs and priorities for care.
3. Increase the lobby for federal and state appropriations for dental care for special population groups, e.g., children, the aged, the poor and the needy.
4. Promote dental research funding, especially related to improved diagnostic procedures and technology transfer and health services research which will make us more efficient in health predictions and in the evaluation of health services in the future.
5. Review "outmoded," archaic practice styles, locations, behavior, patient payment and other reimbursement modes with the objective of improving the quality of care while making dental care more accessible and a priority health concern for the American public.
6. Assist dental schools in their effort to recruit gifted and talented students to the profession of dentistry. Refrain from negative, misrepresentations regarding the future of dentistry. Remember that we are in serious competition with computer science, engineering and aerospace technology as we enter the communications era now and for the future.
7. Assist the dental schools and the ADA in advice and direction to recent graduates that would influence their choices for location of practice. The

mal-distribution of dentists can be solved by local and regional planning efforts which include the dental educational institutions.

8. The ADA and state licensing boards should find ways to facilitate regional or national licensure to allow for greater mobility of dentists in an effort to correct the mal-distribution of dentists. The 1,000 dental manpower shortage areas should be targeted areas for dental manpower placement.
9. The number of Americans aged 65 and older is expected to double by the year 2000. The specific oral health needs of this population group, modes of delivery and reimbursement mechanisms must be addressed by the profession today in manpower projections for the future. The aging American public will carry with them increased needs for dental and other support services.
10. Dental schools will need support for curriculum research and development necessary to implement curriculum changes that meet the requirements of a society that is undergoing rapid demographic, epidemiologic and socioeconomic changes.

### Summary

Factors have been presented that should be considered in dental manpower predictions for the future. A specific addressment has been made related to the recruitment of dental students for the future and for minority dental manpower needs. It is through a unified effort of dental educators, dental practitioners and dental researchers that we will be able to meet the challenge that lies ahead and that challenge is:

**"HEALTH FOR ALL BY AND BEYOND THE YEAR 2000."**

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Reprint requests to:

Dr. Jeanne C. Sinkford, Dean  
Howard University College of Dentistry  
1765 Verbenia St. N.W.  
Washington, D.C. 20012

# THE ECONOMICS OF AMERICAN DENTISTRY: NO NEED TO PANIC

**Knight A. Kiplinger**

It's an honor to be with you here today. I have long held your profession in high esteem, and I have the deepest personal regard for your outgoing president, Dr. Morris Antonelli, whom I've had the pleasure of knowing for many years.

For a journalist in the field of business and economics, a speaking engagement is an opportunity for learning—a chance to study the special concerns and problems of the audience I'm addressing.

The factual basis for my remarks today is primarily the ADA's remarkable report on the future of

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**You continue to enjoy public respect and the satisfaction of working in a field that has a proud tradition of innovation and service to society.**

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dentistry. I call it remarkable because I have rarely seen a profession discuss its own problems and prospects with such perception, clarity, and objectivity.

From reading about your profession and talking to your colleagues, it quickly became clear to me that the critical issue facing your profession today is an apparent imbalance between a growing supply of dental manpower and a fairly flat demand for your services.

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Remarks by Knight A. Kiplinger, Vice President, *Kiplinger Letters* and *Changing Times* magazine, Before the Maryland State Dental Association, Baltimore, Md., September 13, 1984.

This imbalance between supply and demand is due, as you all know, to a variety of factors. They include advances in dental health, the low birth rate in America over the past 20 years, and the fickle whim of Uncle Sam, who lavished aid on dental education and then, finding he had overdone it, pulled the plug on that very aid.

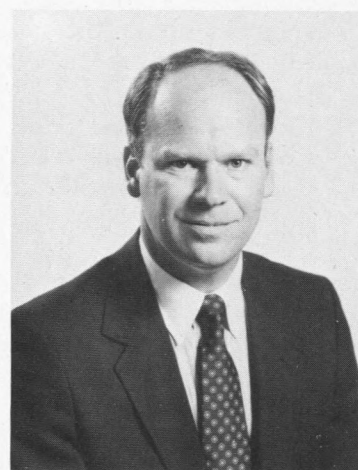
When I first began hearing and reading about this "problem" of an over-supply of dentists, a lot of questions came to my mind.

First of all, I wondered, "Whose problem is this? Is it society's problem, or just the profession's?" More on this point later.

And then I wondered how severe a problem of over-supply this is. In economics, when we talk about labor-surplus fields, we often mean that veteran workers in a certain occupation can no longer find work in it, or at the very least, they are suffering an absolute reduction in their earnings, down from what they used to earn.

When one speaks of an over-supply of dentists, does it mean that well-established dentists are abandoning their practices, driven out by the price competition of other dental-care providers? No, apparently not.

Does it mean, perhaps, that well-established dentists are making less money than they used to, in absolute terms? No, that's not the case either. ADA figures show that the average income of dentists rose from about \$48,000 in 1978 to a



Knight A. Kiplinger

current level of about \$60,000.

Does over-supply mean the average dentist is less busy than he used to be? Now we're getting warm.

If this is the case, is it mostly a function of increased competition from other providers, or could it also be that increased productivity has contributed to the "problem," by enabling dentists to handle more patients in a shorter time than before?

Does oversupply mean that some established dentists are earning less money than they used to, in *relative* terms—adjusted for inflation, and/or relative to other professions? Now we're getting much closer to the real issue.

Most studies indicate that, adjusted for inflation, dental earnings are no higher today than they were 15 years ago, and are probably lower. Other studies suggest that dentists have lost ground to such



other highly paid professionals as physicians and lawyers.

Finally, to really get a grip on the meaning of an oversupply of dentists, we must recognize that this has become a generational split within your profession. By and large, it's not the veteran practitioner who's hurting, it's the newcomer.

The young dentist, especially since the cutbacks in federal tuition aid for dental education, paid a hefty price for his training. And the cost of setting up a private practice—that is, if the market enables him to—is staggering.

But price competition in dentistry today, coupled with soft demand for dental services, makes it unlikely that the young dentist will ever realize the return on his investment that dentists have traditionally enjoyed.

For many young dentists, a practice of his own is not even in the realm of possibility. The big quest is for employment of any kind, even at a store-front clinic.

I've heard stories of young dentists working as clerks in shoe departments. Although it's scant consolation, these young professionals have plenty of company in today's society.

I know of PhDs in French literature who are driving taxis because there are no teaching slots in universities for them.

I know of classical musicians waiting on tables until they can get a break with a small symphony

orchestra, at very low pay.

And I know of recent law school graduates who, in the face of hiring freezes at many firms and government agencies, may never practice law in their lives.

For the veteran in any profession, there is probably a certain ambivalence about the plight of the young newcomer. On the one hand, sympathy for him; on the other hand, anxiety at the competitive threat he could pose, once he finds his way—somehow—into the profession.

You often hear people say that there really isn't an over-supply of dentists, just a misallocation geographically. It's undoubtedly true that more dentists are needed in many remote, low-income areas of America.

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**Educational institutions are not servants of the professions they feed. They are, like the professions themselves, servants of society at large.**

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But the fact seems to be that dentists, like most other people, prefer to live in more appealing areas, like Montgomery County, Md. And like most people who are not saints, dentists have a strong desire to make money.

There's absolutely nothing wrong with that. So you won't hear me argue that the over-supply problem will evaporate if only all new the graduates of dental school would

go practice dentistry on an Indian reservation or in the ghetto. That may be true, but it's not a realistic contribution to the debate.

I told you earlier that I would return to this thorny question of whether your misfortune is society's good fortune. I occasionally read in editorials that society is benefitting from increased competition in dentistry, because dental care is now more readily available and less expensive, in relative terms, than ever before.

On the surface, the public appears to be the winner here, at least in the short run.

But don't throw your salad forks at me quite yet. In the long run, I see real problems for society arising from this current over-supply. Here are a few:

If the financial return to dentistry continues to decline, relative to other professions, dentistry will not attract as high a caliber of practitioner as it once did. The quality of dental care may decline, which is not in society's interest.

Those newcomers who do manage to set up private practices, at great expense, may be tempted to maximize their revenues in a variety of ways that are not be in society's best interests.

There may be an accelerated rush into the dental specialties, to the detriment of general practice, the mainstay provider of dental services.

For the newcomer who finds patients in short supply, there may

be a strong temptation to generate more revenue per patient. This could bring a tilt away from the traditional emphasis on prevention—which is not remunerative at all—and a new emphasis on expensive restorative procedures that may not be necessary.

Finally, the growth of third-party payment plans may tempt the struggling private dentist or clinic to illegally pad the bill or unethically talk the patient into procedures he doesn't need.

All of these potential problems would be lessened if the supply of dental manpower and the demand for dental services came more into balance.

So as I see it, the issue of over-supply is not some imaginary complaint of a greedy profession. It's a real dilemma for everyone who values the role of dental health in our society.

When I say that supply and demand should be brought more into balance, I arbitrarily define that balance as the equilibrium that existed before 1965.

That's the year that the federal government began stimulating a surge in dental school enrollments at just the wrong moment—just as America was embarking on a 20-year decline in its birth rate.

Over the past two decades, the growth rate of the dental profession was double that of the population at large. This might not have posed problems if the surge in dental manpower had not been paralleled by great strides in dental health, due primarily to fluoride, better nutrition, and advances in your profession.

But your ranks were swelling just

as the demand for your services began to decline.

I sense that, in the profession today, dental colleges are being cast as the villains in this drama.

They are being accused of aggra-

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**Ultimately, your best bet for prosperity in dentistry lies in bringing non-utilizers of dental care into your fold . . . overcoming barriers of ignorance, fear and apathy. As I see it, imaginative dental marketing is the way to do it.**

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vating the plight of underemployed dentists by churning out too many new dentists.

Whatever the merits of the argument, I think the profession should be more understanding of the difficult bind dental schools are in.

Who could resist Washington's patriotic call, during the 1960s and '70s, for a new army of dental professionals? More to the point, who could resist the freely offered money?

Today the federal funds have dried up, but the dental schools, like many other post-graduate schools, still have their over-expanded plants to run, their dorms to fill, their faculties to pay.

The dental schools know that free-market conditions will eventually dictate a contraction of their programs, but in the meantime, they deserve a lot of compassion as they go through a painful process.

If dental schools cut their enrollments, it should not be because the dental profession is pressuring them to do so. Educational institu-

tions are not servants of the professions they feed. They are, like the professions themselves, servants of society at large.

If dental schools cut their enrollments, it should be not because there are too many dentists, but because there are too few applicants of the highest quality.

The message of the marketplace seems to be getting around: dentistry is not as lucrative as it once was. This is having a predictable effect, according to ADA studies, on both the number and quality of applicants to dental school.

The best reason for cutting enrollments would be to preserve the selectivity of the profession, and ultimately, the quality of dental care.

Meanwhile, what should dentists be doing to cope with this situation of over-supply and competition in your profession?

Frankly, there is little you can do about the supply side, either in the short run or the long run.

The reason is this: the large numbers of dentists who came into the profession over the past 30 years are still highly productive, and most will practice far longer than dentists used to. Attrition by retirement and death will be lower than the influx of new dentists, even if the influx slows down.

So reducing enrollments in dental school is not a panacea. Even with declining enrollments, dentists will be more prevalent in America, in every way you want to measure them—absolute numbers, the rate of growth relative to the population, and finally, the density of dentists per 100,000 citizens.

So don't dwell on the supply side



of the equation, unless you want to get needlessly depressed.

Focus, instead, on the demand side, where there are lots of silver linings.

First, let's look at the demographics of America over the next 15 or 20 years.

Over the last two decades, demography was the dental profession's dismal science.

The size of your key constituency, children, was shrinking rapidly. Your least-needy constituency— young and middle-aged adults with a mouthful of fillings and otherwise healthy teeth—was growing rapidly.

Today the population trends are once again in your favor. The birth rate is creeping back up, and there is a mini-Baby Boom coming along. Children under the age of five are now only about 8 percent of the population, but that proportion will probably rise to more than 10 percent by 1990. It could continue rising thereafter.

As these kids grow, they will have fewer cavities than kids used to have, but, because of their numbers, they will still constitute a growth field for general dentistry and especially orthodontics.

And how about today's young adults and middle-aged people, who have relatively little need for your services today?

As they join the ranks of the elderly, more of them will retain more of their teeth than ever before, and these teeth will require more maintenance than any elderly group ever needed from the dental profession.

Barring some unforeseen breakthrough against gum disease, the need for periodontal care is ex-

pected to grow dramatically in the next several decades.

Of course, to translate need into actual demand for dental services, society must have the money to pay your bills, either as individuals or through health insurance.

Your biggest enemy over the next few decades would be a sick economy, characterized by high inflation, sluggish growth, and little rise in real personal income.

Fortunately for all of us, this is not the kind of economy I foresee. For a variety of reasons, we at the Kiplinger Letter and Changing Times magazine are predicting a vibrant economy that will pull out of the severe economic dislocations that have rocked the world in recent years.

Third-party payment and prepayment for dental services will increase, although probably more slowly than over the past 20 years.

Ultimately, your best bet for prosperity in dentistry lies in bringing non-utilizers of dental care—nearly 50 percent of the population—into your fold.

Extending your care to these people is not simply a matter of affordability, as you know. There are barriers of ignorance, fear, and apathy that must be overcome. As I see it, imaginative dental marketing is the way to do it.

Yes, marketing. But I don't mean newspaper ads that shout out deceptively low prices for dental procedures.

I mean a broad program of public education on the importance of dental health. This can be everything from speaking at PTA meetings and school assemblies to circulating to prospective patients

informative newsletters about nutrition and the latest advances in dental techniques and materials.

If you're in a traditional private practice, you might feel hostility towards the new breed of dental care providers.

But keep in mind that these alternative providers have the potential of bringing dental care to previously unserved individuals, raising public awareness of the importance of dental health.

Heightened awareness of dental health will mean, ultimately, a greater demand for the services of *all* dentists, whatever their method of practice.

I am optimistic about the future of dentistry in this country, and I hope mine is an informed optimism. This is not to say that the challenges facing you are not immense, because they are.

But in many ways, your profession is better equipped to adjust than many others—the teaching profession, for example. While your level of compensation has slipped in relative terms, it is still at an enviable—and deservedly—high level.

Most importantly, you continue to enjoy public respect and the satisfaction of working in a field that has a proud tradition of innovation and service to society.

I wish you the best of good fortune in the years ahead. Thank you very much. Δ

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It may be used in college registers or following the name of an author of an article published in a journal. It should be used on title pages of textbooks of which the author is a

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At the time of the 50th Anniversary of the American College of Dentists, a logo was adopted by the College which included within its center the seal of the College. At the

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It is recommended to Section Officers that consideration be given to the use of this logo. It is particularly applicable to Section stationery, Section programs, Section certificates, and activities involving the Section in which identification is needed. The use of the logo is authorized by the Board of Regents with Section supervision. Copies for photocopying may be obtained from the Executive Office.

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The Index Medicus and The Index to Dental Literature should be consulted for standard abbreviations.

The title page should contain: The title of the paper, suggested short titles; the author's names, degrees, professional affiliations, addresses, and phone numbers in a list of four to six key words. All correspondence from the editorial office will be directed to the primary author who shall be named on the title page.

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1. Smith, J. M., Perspectives on Dental Education, *Journal of Dental Education*, 45:741-5, November 1981.
2. White, E. M., Sometimes an A is Really an F. *The Chronicle of Higher Education*, 9:24, February 3, 1975.

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