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.

Revision adopted November 9, 1970.
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FALL 1985
AARP AND DENTURISM

The American Association of Retired Persons (AARP) is again urging its members to support state legislation to authorize the independent practice of denturism.

This is poor advice. AARP members should consider it downright insulting for their organization to recommend that they should choose to have sub-standard care performed by technicians instead of treatment by qualified dental practitioners.

The legalization of denturism could have a serious detrimental effect on the quality of denture care. It would be a great leap backward, undoing much of the progress made in protecting the public over the past fifty years through state dental practice acts.

The main concern here should be the quality of health care. It should not be considered merely an economic issue.

AARP promotes denturism as being cost effective and a good alternative to prosthetic treatment provided by dentists. It urges the public to "evaluate" the difference in treatment by dentists and denturists. However, the public does not have the expertise to make an accurate evaluation of those differences in education, training, clinical experience and other necessary qualifications. It is obviously impossible for uninformed persons to make that kind of judgment.

Unfortunately, most consumer organizations like AARP seem to view the subject of health care through a tunnel that obscures all relevant considerations except cost.

With their minds firmly made up to favor denturism, they do not wish to be confused by facts related to quality of care.

Elderly people have as much concern for their health, comfort and appearance as do people in any other age category. They are very much interested in the quality of health care they receive and should not be directed to look for second-level care. Most people, including the elderly, want what is best for them, if they understand and perceive what is best. An informed public will choose quality in its health care in the same way it looks for quality in most other services and goods that it purchases.

Actually, the percentage of older people who wear full dentures is declining every year as more of them preserve and restore their natural teeth so each year there is less reason for even considering the licensing of denturists.

Legislation to authorize the independent practice of denturism, now being proposed in several states, varies greatly in requirements for licensure. Some of the proposals are woefully weak in protecting the public. For instance, there may be no stated minimum requirement for education standards, no provision for license renewal, no limit on the number of offices, no penalties for violation of law or no authority to regulate denturists after they are licensed.

Constructing dentures involves considerably more than just filling the space between the upper and lower ridges and processing plastic. The more that dentists study and learn about fitting a dental prosthesis to function properly, the more they realize the complexities of their work. The jaws and related structures are an extremely complicated part of the body.

There has had to be a problem of communication in this situation. Either the dental profession has not been reaching groups like the AARP with all the information it supplies to the public or the AARP has not been listening. One of the main thrusts for dentistry in the 1980's should be aimed at informing consumer groups about what constitutes acceptable standards of dental care. It is a prime challenge to the profession to try to reach such groups.

Dentistry would neglect its responsibility to the public if it did not speak out against denturism. The prime concern and the bottom line in health care should be quality, not lowest cost.

Keith P. Blair
The Candid Views of Burt Press

An interview with Burton H. Press, former
President of the American Dental Association
By the Editor of the ACD Journal

Editor: Burt, now that the proposed ADA Marketing Program was turned down by the House of Delegates at the 1984 Meeting, what is the alternative: is it marketing by state and local dental societies?

Dr. Press: We already have several instances of marketing programs at the constituent level, some more successful than others. The California program, in its third year, costing $100 extra per member, showed a recent increase of 5.6% in patient visits. This represents a significant financial return per doctor on the investment made.

But there are more alternatives. We are seeing a resultant increase in the marketing efforts of individual doctors, coalitions of dentists, and some efforts by the more aggressive entrepreneurial dentists that some of us find less tasteful. The ability of the various states to avail themselves of the A.D.A. program on a local level has proceeded in a sluggish fashion. It will cost more individually for each state than a combined effort at the national level.

Editor: As a 23 billion dollar industry, we should be promoting our services, but how can we without a national program?

Dr. Press: We should be promoting our services regardless of the financial size of the dental profession. We need to create sufficient demand to allow today’s finely trained dentists to help the American public achieve good oral health. This has a public health implication. For many years, we have been remiss in our ability to change the behavior of people who do not value excellent oral health. So in many ways the current “busyness crisis” brings about some actions by the profession that are definitely in the best interests of the American public. Your question is whether it requires a national program. There are growing groups of “for-profit” dental organizations that are bringing their message to the public using contemporary media in unique ways. We should be willing to put up five times $125 for five different programs targeted to five different audiences who neglect their teeth or fail to value their smile for different reasons. We are many years late!

Editor: Approximately 100,000 dentists see an average of at least 10 patients each day, which is at least one million patients who are a captive audience each day. If the ADA could provide to ADA members, through newsletters specifically written for that purpose, suggested information to be given to patients, this could be a great way to reach the public with lots of dental information. Do you think that such a plan would be workable and successful?

Dr. Press: No. This approach is effective for lobbying—for bringing to the attention of the public the hazards of legislation such as that now pending which would place a tax cap on health fringe benefits. But beyond that, what you describe is internal marketing. That is the essential part of anyone’s marketing effort. There’s an 80:20 relationship between the importance of internal marketing with external marketing. Dentists’ personal success and referrals vary to the degree that they are conscientious and thorough in the
implementation of internal marketing. But external marketing, in the most professional manner, to attract the non-user and the infrequent user, to motivate him to desire better dental health and a more beautiful smile, and therefore to expend discretionary dollars in that direction, requires efforts beyond the confines of the dental office.

Editor: Is the solo practitioner and the bungalow office becoming obsolete? Is the larger clinic with many dentist-employees the new way? Will non-dentist owners who provide the office building, the equipment and other facilities be the way of the future?

Dr. Press: There are many elements to this question. Certainly the traditional dentist of the 50's, 60's, and 70's will have trouble sustaining a similar practice. The disease patterns have changed, so that the services that he offers will need to vary. And his ability to market himself and compete will be almost impossible with the historical model. Yes, many more dentists will be employed, and we will see more group practices, more retail chains, more corporately based dental clinics.

Editor: What is the reason why recent graduates do not join the dental association? Is it an age gap where younger dentists don't want to participate in the older dentists' institution? Are there philosophical differences in life-styles? Is it that the dentist who merely draws a paycheck without the responsibilities and risks of running a practice feels that he is just an employee with a job, and not a colleague in a profession? Or is it that the younger generation people are just not "joiners" as dentists were 20-30 years ago when 95% of the dentists joined the ADA within one year after graduation?
Dr. Press: It is true that there has been an erosion of A.D.A. membership, and that in the past several years approximately 11,000 dentists have not renewed their membership. Some of us feel that this defection will accelerate in the coming years because of the compounding of recent events. But an understanding of the attitudes—the values—of contemporary dentists would reveal the answers. Today's young people question "relevancy." They are less likely to join just to be a member of the club. It's not right or wrong—it just is. It's a sign of the times. These young men and women are fine young professionals—with excellent clinical skills. The truth is that we need to appeal to them more than they need to earn our respect. Fifty percent of the dentists in the United States are under age 44. They are the vitality of any potential national dental organization. They would join quickly if they perceived that the actions of the American Dental Association related to their primary professional interests. So although the A.D.A. does so much that is important for them, we have certainly done a less than adequate job in communicating this effectively.

Editor: What about the decline in professionalism and ethics throughout the dental profession in recent years? The Code of Ethics has changed remarkably under FTC pressure and the yellow pages are filled with display advertising. Dentistry seems to be more of a business or trade than a profession. Are there other factors in society effecting this decline in professionalism and should these factors be addressed by the profession?

Dr. Press: I don't believe there has been a decline in professionalism and ethics! There has been a change in definition—in perception, in what is compared with what was. The world has changed—not just dentists. "The public," whoever they are, has decided in a series of social opinions and judicial opinions that the mandate they give to professionals is to be altered. They have stated that it is okay for us to compete more aggressively in the marketplace in order to lower the cost of health care, and that this does not have to affect our professionalism. Dentistry has always been a business as well as a profession. When it's a "sellers market," and you have a partial monopoly, you can give lip service to the business side and wave banners about professionalism. Now that it is a "buyers market," there is competition occurring for patients, which in moderation can be of value to the public we serve. There are no studies that show a correlation between the quality of care and the location of the dental practice, or the degree of marketing performed by the professional. There have always been better dentists and poorer dentists. They were less blatant—less garish in their display. But, please remember—the Supreme Court of the United States has decided that advertising by professionals is not unethical, unless it is false or misleading in a material respect. Many of us have failed to recognize this to the same degree that we failed to recognize the existence and potential benefits of dental insurance for the first twenty years of its incorporation into the practice of dentistry. "Caveat emptor" has changed to "Caveat vendor!"

Editor: Is professionalism really a figment of the past in all of the health professions? Now that we are a "health industry" instead of a health profession, is "What is best for the office" really going to have priority over "What is best for the patient?"

Dr. Press: All professionals need to generate a fair return for their efforts in order to sustain a high degree of professionalism. We should have no hesitancy about educating the public to this. But I really don't believe that doctors as a group are going to change their stripes because of the level of their compensation or the method of reimbursement. The young students, and the recent graduates, are as fine a group of young people as I've ever met. We need to accelerate their entrance into organizations like the American College of Dentists. This is necessary so that we may profit from their contributions, and so that our historical organizations themselves may survive.

Editor: Is the dental profession out of step with the rest of society when it tries to uphold a Code of Ethics? Most other professions, including medicine and law, are plainly not interested in maintaining codes of ethics.

Dr. Press: We still have a code of ethics—we have not abandoned it anymore than have our colleagues in medicine, law and accounting. It is true that the smallness of the world—the scrutiny of the media—the intimacy with which attorneys want to investigate our actions in our litigious society—are all reflections of the public's increased assumption of responsibility for their own health—their desire to know! One of the biggest complaints in public surveys about physicians is their failure to inform . . . to share essential information to allow the patient to participate in his own diagnosis and treatment plan.

Editor: What about the decrease in the number of applicants for dental schools? How is it affecting the schools? Is it true that we will have a shortage of dentists by the year 2000 if this trend continues?
Dr. Press: Well, I hope that we'll have a shortage of dentists by the year 2000, but I don't believe it! The applicant pool continues to decrease. The quality of the applicant in many areas of the country continues to suffer. Recently, Emory University Dental School has announced its demise, and within the educational community there are ongoing debates about which schools will thrive and survive, and which are the criteria which will sustain them. Dentists should understand that in the last four years, first-year places have decreased by 1300, which may be the equivalent of the closing of 15 dental schools. This deceleration has occurred faster than the increases in the 60's as schools were building new facilities. So the marketplace has certainly reacted to the appraisal of what has taken place.

Editor: Besides marketing programs, what other projects do you think the profession should or could undertake to encourage more of the public to have regular dental care?

Dr. Press: If marketing is helping the public to get what they want—if it is sensing, serving and satisfying the public's need, then that word alone encompasses all of the things we need to do in order to bring dentistry's message to the public. Now the educational process on the one hand relates to funding processes; on the other hand, in times of recession, of industrial relocation, of huge national deficits, of changing priorities, we may have difficulty in maintaining the level of funding that has been available for dental care in recent years.

Editor: Has dental insurance really contributed to the increase of mediocre or poor dental care because the same benefits are paid for the poorest work as are paid for the best work?

Dr. Press: I don't believe that statement at all. There has always been and continues to be a problem of peer review. But dental insurance has allowed the public to have access to more care of a better quality than most dentists historically were ever able to motivate their patients to request.

Editor: In what ways will the dental profession have to adapt to changes in the ways of practicing?

Dr. Press: Dentists will have to adapt in multiple ways. Historically we graduated from school, opened our office and practiced there forever, whether we liked it or not! The options are increasing. However, not all of the options will be elected. As we said earlier, more dentists will be employed. Some will be managers and more entrepreneurial. And, more will not practice dentistry at all. But certainly the management concepts of the dentist, his perception of himself as a helper, as a true doctor, will have to increase. And the organized profession must assist individual dentists in legalizing a changing definition of the dentist as the doctor of the head and neck.

Editor: The decline in the number of dental students, will there be difficulty for the schools to maintain faculties—will there also be a decline in associated activities such as research?

Dr. Press: The availability of funding for research has been a problem in the last few years; not only because of the deficits in our government, but in changing emphases of the public with available funds. It's hard to sustain a public priority for dentistry equal to cancer, heart disease, arthritis, etc. For those schools which continue to be in business, faculty appointments may be an attractive option in a dental environment which is significantly more competitive in the private sector. During the depression, the military was not a bad place for the dentist to reside.

Editor: Shouldn't the government be involved in promoting the need for dental care through its health educational programs? Dentistry is still a non-essential health service as far as government is concerned.

Dr. Press: Of course, I don't like the government to increase its involvement in anything. They don't seem to do it a cost-effective way. One of the most significant political lobbies in our society is the mature citizen. We have an aging population which is keeping their teeth, living a more healthy existence, and in many cases controlling significant discretionary dollars. We should have much better rapport with them than we do. Their consciousness level about the relationship of dental care to longevity, and to the enjoyment of life, is often less than adequate.

Editor: What can the profession do through political avenues to have a greater voice in the changes in dental practice being contemplated by government? Is there any attempt for the health professions to work together for greater strength in numbers?
Dr. Press: In my early days in the profession, the threat was socialized medicine! That's really not the threat today. Most of the changes we don't like are coming about because of activity in the private sector, and the government can sit back and observe with a smirk. Naturally, changes in laws make the private sector initiatives possible. An example is the Supreme Court law affecting advertising. But it alone would not have caused the resultant expansion in advertising had it not occurred at a time when we had greatly over-produced dentists concurrent with the curing of our assigned diseases. Health professionals, dentists or others, tend to work more in disharmony as economic pressures increase. At the very time when there is strength in unity, they become more selfish and more suspect of each other.

Editor: What about PPO's and other alternative plans? Are dentists still eager to join them, or are they weighing the disadvantages and limitations of these plans more carefully?

Dr. Press: The problem with P.P.O.'s has not been the unwillingness of dentists to participate. Over 20% of our colleagues signed with I.D.O.A. (Insurance Dentists of America) indicating a willingness to review the fee schedules of the involved companies. However, the marketplace has been slow to embrace P.P.O.'s and growth has been less than meteoric. Many benefit managers feel that potential savings with P.P.O.'s may be illusory. Capitation plans, interestingly enough, are growing at the most rapid rate—over 20%. Many large third parties are involved in capitation experiments, and many purchasers of care, i.e., the automobile industry, are experimenting more aggressively with capitation options. Increasingly, dentists will be faced with difficult business decisions about their own participation. These decisions will have to be based upon careful analysis of the demographics of the area in which they practice.

Editor: How can the leadership of organizations such as the American College of Dentists function to help maintain high standards of care and the pursuit of excellence in treatment methods?

Dr. Press: Certainly some of the finest dentists in the United States belong to the American College of Dentists. Also, many equally fine dentists do not belong; sometimes for reasons that are hard to fathom. The great majority of dentists in the United States are not sure what the American College of Dentists is or what it does, or why its actions are relevant to their goals for the future. The College will continue to be less than effective in this particular direction by decrying the loss of professionalism and by failing to be a leader in the structure of the changes that are taking place. We need to find ways to single out exceptional dentists at a younger age and facilitate their entry into the College so that the potential for two-way communication is established. In addition, the College should be more visible to the rest of the dental community. The best way for this to occur would be an aggressive program where individual members of the College assumed responsibility for welcoming new young dentists into the community and helping to assure their success in a practice mode which allows them to sustain their professionalism. It's a difficult world out there, and the options are more complicated than ever before. Members of the College need to consider taking associates into their practice, not only to establish a mentor relationship, which gives a young person the confidence to pursue excellence, but to establish and sustain the value of the senior man's practice by incorporating a ready-made buyer into the environment.

Editor: What would you like to see the profession accomplish over the next 10 to 20 years regarding the way in which dentistry is practiced to improve the dental health of the nation?

Dr. Press: If we were sitting on a mountaintop, looking down at the world and at dentistry, we would hope that all Americans came to appreciate, seek and enjoy the benefits of modern dentistry. We would like that 50% which historically has never come to the dentist to have the benefits of a beautiful smile, a healthy mouth, and the ability to speak with comfort and assurance. Not only is that our mandate—our responsibility as a profession—it's absolutely essential if these fine young people who are graduating from our schools are to have the opportunity to define their own professional future. This will be increasingly difficult as our country enters a national debate about the cost and rationing of health care. Dentistry will have to fight hard to sustain its rightful place as an essential health service. I hope that the profession seizes the opportunity to be pro-active, to program the future of dentistry in tune with the desires of the American public. Otherwise, we will continue to see a reactive posture, one which defensively attempts to put out brush fires as we slowly lose the right to govern ourselves.
A visit to dental headquarters in Chicago, just recently, helped focus anew the source of my strength and purpose.

I paused, as I most always do when visiting the ADA Building, to view the War Memorial Court area. In it stands the sculpture of three figures...father, mother and child. Done in abstract, free flowing style, the sculptor, Joseph J. O'Connel has captured the very meaning of humankind, the commonality of all of us, the unity of man as a family.

The wind was blowing off Lake Michigan with a fury causing me to shorten my stay, but today, as never before, I was moved by the significance of this magnificent bronze. As I lingered a little longer in the morning chill, contemplating, reacting to my emotions as I studied the motionless figure of mother and father hovering protectingly over their child at play, I thought how beautiful, how simple, how universal this objet d'art. In effortless unity the artist portrays our weakness and our strength, so vulnerable yet undaunted by the burden of our responsibility. People and cultures are different throughout the world, attitudes vary, goals are diverse, but there presented is the hope and vision of us all.

I think how appropriate but how paradoxical this is. The sculpture reaffirms life but its purpose is to commemorate death. It is dedicated to the memory of those dentists of the twentieth century who lost their lives in service to their country. We have honored these fallen ones in a fitting way and life goes on for us who remain. Besides, I've got a schedule to keep and must be on my way.

As my reverie merged into reality, the cold wind off the north shore ever present, I was startled by the seeming insignificance of my mission to dental headquarters, a mission so deserving yet so entangled. We struggle with the FTC, the PPOs, the DRGs and the HMOs. We cultivate harmony but reap discord. We practice for perfection and attain results beyond belief. Yet, for all of the good we do, the concern we hold, the hours we keep, it all grows pale before these fallen ones. Surely, we can do better!

My dental mission can't change, but my thinking can. For before this statute I see the spirit of America, the heartbeat of Africa, Mother Russia, the cementing bond of friend to foe. The unity of man is more than a dream. Far too long we've placed our trust in governments to settle differences peacefully...yet, all too often war is the answer. We've put our faith in religion to give us peace, but with good intention, they proselytize and polarize until oneness is impossible.

Gandhi once said, “Our life is a message, what we say means little or nothing to people, only what we do.” Is it possible that our profession can transcend the errors of government and church? Can our unity of purpose, our common meeting ground, vis-a-vis the dental seminar, the international meeting, the professional exchange, turn back the distrust of nations? I believe we must start trying...it may be our only hope.

As a profession, we are a people free of religious dogma and political ideology. We are unhampered by preconceived impressions that breed intolerance. Perhaps there has never been a better time in history, or needed more, to reach out our hand. If only we would believe, we could make a difference. It matters little if we solve the mundane problems of our professional day only to see the divisiveness of misunderstanding destroy our gain.

From where do we get our strength and purpose? Our strength...found in professional leadership and resolve: our purpose...directed by eternal goals as we see our mission clearly. To dentists around the world I am drawn closer by the unity of our professional oneness than separated by the differences of our birth. Let's begin to talk to each other, dentists of goodwill all over the globe. Our commonality cries to be heard. Who among us will take up the gauntlet?

Edgar C. Hatcher, Jr., DDS
Editor of the Journal
of the Tennessee Dental Association

Winner—outstanding dental editorial published in 1984
OPINION

Redefining Our Purposes
Redirecting Our Efforts

Kenneth D. Oler

An excerpt from a speech to the California Dental Association House of Delegates on the conclusion of his term as President by Kenneth D. Oler.

My sense is that the war in which we should be engaged in, dentistry should be refocused more toward our patients' needs. If our battle is directed principally toward ourselves and our interests, we will lose the very recognition which gives us our basis for support as a profession and consequently, the war in which we are engaged for its preservation.

I would like to share with you some observations of medicine that have impressed me, as they could reflect on dentistry:

First, from the book The Social Transformation of American Medicine by Paul Starr, a Harvard Sociologist:

“The growth of corporate medicine has simply gone too far for the AMA to oppose it outright.”

“Perhaps the most subtle loss of autonomy for the profession will take place because of increasing corporate influence over the rules and standards of medical care.”

“. . . Indeed business school graduates are displacing graduates of public health schools, hospital administrators and even physicians in the top echelons of medical care or organizations. . . . the “Health Center” of one year is the “Profit Center” of the next.”

“A corporate sector in health care is also likely to aggravate inequalities in access to health care. Profit-making enterprises are not interested in treating those who cannot pay.”

From the book addressed to patients, entitled Matters of Life and Death Eugene D. Robin, M.D., a Stanford faculty member, makes the following statement:

“The impact of basic changes in economic practices on the quality of medical care remains to be seen.” “Several things seem obvious. One is that the poor and disadvantaged will bear the brunt of deterioration in the quality of health care. Another is that the savings will be less substantial than predicted. . . . Still another is that no one, including the planners, can predict the changes in the quality of health care. This should be of concern to you.”

Alternative delivery systems will continue to evolve and, until we judge them more for their effect on the patient's dental health, than on the dentist's inconvenience and income, we will not successfully mobilize our patients' support of the demand of purchasers and third parties on the types of systems which should prevail. Similarly, resolving the fragmentation of the profession in the name of economics, women's rights, career ladder development, preservation of territory or whatever, is inconsequential when compared to the possible negative impact on the dental welfare of the public.

Further, the ability of a professional organization to survive on the basis of whether or not its members can total a dollar value of membership services received equal to their dues paid will be short lived. Unless the members judge the value of their organiza-

• A tort reform initiative to appropriately compensate injured parties while controlling the excessive costs of the adjudication process will soon surface. It will deserve our wholehearted support.

• The development of associate membership for auxiliary groups based on dentistry's commitment to the provision of quality dental care. With such membership would come a better investigative process and forum in which to properly identify and resolve how the public could best be served by the dental team.

• The responsibility of the profession to establish appropriate standards of care must be preserved, even if it requires legal action to respond to the "processing policies" and other intrusions of third parties.
• A continuing effort must be made to see that the financially disadvantaged are not ignored, by mobilizing public pressure on the medicaid standards and compensation levels and, if necessary, legal action to control the program's administrative harassment.
• An expanded marketing/public awareness program, whose objectives are directed beyond encouraging people to obtain proper levels of care, is a worthy effort. It should also inform the public of how to identify what these levels of care are, whether or not they are being provided and how well the delivery system in which they are involved is functioning.
• A continuing and heightened commitment to strongly support care programs for the elderly and physically disadvantaged in institutions, extended care facilities and our private offices must be emphasized. These individuals require and deserve mainstream, complete dental care and we dentists must make certain that it is provided.

Are our challenges too numerous, too great or too unimportant for us to meet? Most emphatically, they are not! To redirect a statement by President Eisenhower, from our nation to our profession: “We must be willing individually and as a profession, to accept whatever sacrifices may be required of us. A profession that values its privileges above its principles soon loses both.”

THAT’S THE WAY THE GENES FELL

George C. Paffenbarger

And that’s the way the genes fell. Maybe Calvin and his Presbyterian theology were not entirely off base with predestination and thus certain individuals were elect—because no two of us are exactly alike and the chemical composition of each individual is so different that not even a skin graft will survive except on identical twins and even there identical spreads over a domain. Why is this so? It is pure chance because That’s the way the genes fell. There have been billions of individuals that have peopled this planet, but only a few hundred thousand through the ages really contributed to the knowledge that advanced the human race. That, too, was pure chance because That’s the way the genes fell. If ten individuals of equal age and sex were placed on a track and told to run a fixed distance, one would be first, one would be last, and the rest in between because their neuromuscular coordination was different, and why was that so—because That’s the way the genes fell! If a number of people were isolated on an island, soon someone would emerge as the leader and almost all the others would be followers or subleaders. And why is that—that is because That’s the way the genes fell! If someone is born with a sharp intellect so that he finishes high school at 14 years of age and at 17 has a Ph.D. degree or if an individual has an aptitude for mathematics, music, story telling, etc., we call that individual gifted and why is he gifted—because That’s the way the genes fell! and that’s pure chance. But of course there are other aspects, for instance, circumstance. Chance and circumstance play tremendous roles in our lives, and as we get older and retrace events, we realize that environment plays an important role too. So the individual who is able to take advantage of circumstance and environment in combination with the right genes is fortunate because really That’s the way the genes fell.
Ethical Problems in Dental Practice

Jeffrey A. Hollway*
Donald R. McNeal**
Stanley Lotzkar***

Dentistry is very much a human to human profession which has as its end the well being of the people served, and inherently involves the public trust. As a result, every day the dental practitioner, whether recognized or not, faces ethical dilemmas that arise from the nature of the professional relationship with patients. These daily encountered situations are all value based in some way and require value judgments at a very concrete level. In response to this atmosphere of professional accountability, dental schools are manifesting greater interest and concern with the ethical behavior of their students and are helping students to confront and grapple with ethical issues and problems before they even step into a dental operatory. (Odom, 1982)

The University of Florida's College of Dentistry offers a formal course in dental ethics and jurisprudence as well as integrating in the curriculum other, less formal, instructional opportunities for students to increase their acumen in dealing with ethical problems in dentistry. The dental ethics and jurisprudence course was modeled after a successful professional ethics program developed by the University of Minnesota School of Dentistry (Bebeau, 1982). The primary course objectives are to increase student competence in recognizing underlying ethical dilemmas in daily practice, and to help them acquire sufficient skill in the process of ethical inquiry and decision-making so that they can deal with ethical dilemmas in a moral and responsible manner. The instructional methodology used in this course centers on a series of small group seminars which critically examine hypothetical as well as student generated dental ethics problems. Case histories are used to increase interest and relevance as well as to draw out broad ethics principles which may be in conflict. In an attempt to make this course work as pertinent and practical as possible, a group of active Florida practitioners were surveyed in order to identify moral and ethical issues of concern among members of this state's dental community.

It is important to realize that the image of the dental profession is exactly what dentists have made it over the years.

Academy One Hundred Survey

The Academy One Hundred is an alumni association committed to the achievement of quality dental education in Florida. A brief questionnaire was sent out to the Academy membership under the signature of the chairman of the University of Florida College of Dentistry's Department of Community Dentistry. The members were asked to respond candidly and anonymously to each of the following open-ended questions:

1. Please describe briefly the two or three (or more) most troubling moral/ethical dilemmas which you have experienced in the course of your dental career in the last several years.
2. What training did you receive in dental school which helped you to deal with these dilemmas?
3. What improvements/changes could have been made in your dental education which may have better prepared you to deal with moral/ethical dilemmas in dentistry?

Of the 268 questionnaires mailed out, 78 were answered and returned—a 29 percent response rate. Such a disappointing return may have been due to the format and content of the questions. That is to say, the open-ended questions required the respondents to write out their answers in contrast to more traditional questionnaires that allow the busy dentist to quickly and conveniently "check the appropriate box." Also, the content of the questions dealt with a topic about which many of the
practitioners may have felt too uncomfortable or too unknowledgeable to discuss openly even though asked to do so anonymously.

**Question #1: Troubling moral/ethical dilemmas experienced in the course of one's dental career in the last several years.**

Sixty-one of the seventy-eight respondents addressed this question and identified specific situations in dental practice which they perceived as creating troublesome ethical problems. The remaining eleven respondents either did not answer the question or wrote a very broad answer describing their general concern and frustration with the overall ethical climate in dentistry. A total of 123 ethical problems or issues were contributed by the sixty-one respondents. Each cited problem or issue was written on a separate index card, and then all were carefully read, labeled, and sorted according to common themes. Five major categories of ethical problems in dentistry emerged from this card sort. These categories are presented in Table I along with a listing of the specific ethical areas of concern cited within each category. The categories are rank ordered beginning with the category having the most citations of ethical problems or issues.

1. Policing and Protecting the Profession

Overall, this was the most cited category of troublesome ethical

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<tr>
<th>Category</th>
<th>Percent</th>
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<tbody>
<tr>
<td>Policing and Protecting the Profession (32%)</td>
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<tr>
<td>a. Advertising and marketing practices</td>
<td>16</td>
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<tr>
<td>b. Methods of charging and collecting fees</td>
<td>11</td>
<td></td>
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<tr>
<td>c. Closed panel practices and 3rd party control</td>
<td>4</td>
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<tr>
<td>d. Performing specialty services when not qualified</td>
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<tr>
<td>e. Reporting an incompetent dentist</td>
<td>2</td>
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<td>f. Prescribing drugs for nonpatients</td>
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2. Interactions With the Patient (31%)

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<th>Category</th>
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<tbody>
<tr>
<td>a. Communicating without critically reflecting on professional peers</td>
<td>19</td>
<td></td>
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<tr>
<td>b. Patients requesting the falsifying of billing</td>
<td>10</td>
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<tr>
<td>c. Informing patients of dental needs and treatment choices</td>
<td>5</td>
<td></td>
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<tr>
<td>d. Establishing a respectful interpersonal relationship with patient</td>
<td>2</td>
<td></td>
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<tr>
<td>e. Unprofessional personal involvement with patient</td>
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3. Clinical Treatment Practices (22%)

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<thead>
<tr>
<th>Category</th>
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<th>Citations</th>
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<tr>
<td>a. Compromising the quality of delivered dental care</td>
<td>18</td>
<td></td>
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<tr>
<td>b. Promotion of overtreatment</td>
<td>9</td>
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4. Working Relationship With Professional Colleagues (8%)

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<tr>
<th>Category</th>
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<tr>
<td>a. Pirating patients or staff from professional colleagues</td>
<td>4</td>
<td></td>
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<tr>
<td>b. Dealing with conflicting opinions or treatment plans of professional associates</td>
<td>3</td>
<td></td>
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<tr>
<td>c. Confronting a professional peer about inadequate performance</td>
<td>2</td>
<td></td>
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<tr>
<td>d. Referral practices among professional colleagues</td>
<td>1</td>
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5. Personal Professionalism (7%)

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<tr>
<th>Category</th>
<th>Percent</th>
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<tr>
<td>a. Monitoring and evaluating the quality of one's personal performance</td>
<td>3</td>
<td></td>
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<tr>
<td>b. Putting the patient's interests ahead of one's personal interests</td>
<td>2</td>
<td></td>
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<tr>
<td>c. Placing patient service before monetary gain</td>
<td>2</td>
<td></td>
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<tr>
<td>d. Taking a responsible attitude toward employee well being</td>
<td>1</td>
<td></td>
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<tr>
<td>e. Serving as an ethical role model in the community</td>
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problems or issues. As Table 1 shows, the greatest concern within this category was with advertising and marketing practices. Some of the expressions of concern included statements that any type of advertising was professionally unethical, that some dentists were resorting to any means possible to increase their patient volume, and that retailing dentistry will lead to a reduction in the quality of dental services. One dentist noted the practice of "advertising basic services at a low fee then adding extras or conditions which bring the fee up to or above the usual fees charged within the community." Another respondent warned that "bait and switch" practices and "hucksterism" will reduce dentistry to the merchandising level and, thereby, lower the image of dentistry as a profession.

The second leading ethical issue in this category related to the methods of charging and collecting professional fees. Some of the unethical practices frequently cited included: varying fees for the same service performed, charging higher fees for insurance cases, charging for services not rendered, not declaring cash received to avoid taxation, and referring dentist collecting the consulting dentist's fee.

A number of respondents raised the issue of professional qualifications. That is to say, dentists who stretch their limitations and perform services for which they are underqualified, and the dilemma of reporting an incompetent professional colleague to the State Board or the A.D.A. Other respondents complained about closed dental practices, government intervention, and third party payments, and the negative impact these were having upon the professional freedom of dentists. Finally, under this category there were two references made about the prescribing of drugs to nondental patients.

2. Interactions With the Patient

The most critical issue within this category was the criticizing of previous dental care performed by one's professional peers in the presence of the patient, especially when uncertain about the conditions under which the dentistry was done. The focus of concern was how to appropriately communicate to the patient that substandard or inadequate dentistry exists without critically reflecting upon or indicting the previous dentist(s) or the dental profession as a whole.

Another common dilemma noted was a patient requesting the falsifying of billing or the adjusting of data on insurance forms so that some benefit can be gained by the patient. A number of citations dealt with improving interpersonal communication with the patient such as: talking to the patient in a respectful, tactful and clear manner; properly informing the patient of existing dental problems; and allowing the patient to make an informed choice of treatment. Two respondents referred to incidents of unprofessional contact with the patient; one example involved improper physical advances toward a patient, while the other warned against becoming involved with the outside personal affairs of a patient.

3. Clinical Treatment Practices

Two primary areas of concern were identified within this category, namely: the delivering of substandard or compromised treatment, and the promotion of overtreatment. The primary motive for overtreating the patient was seen by the respondents as being a means to increase the dentist's financial gain, however, a number of reasons were given for compromised dental treatment. The compromising of the quality of dental care was often the result of ethical dilemmas such as a patient's insisting on a specific treatment, or constraints created by the patient's age, health, or financial status, or problems in working with an uncooperative patient, or needing to increase profit margins.

4. Working Relationship With Professional Colleagues

In comparison to the preceding categories, this was a minor area of concern since only ten citations were classified within this category. The practice of "pirating" staff personnel or patients from other dentists, and dealing with differing opinions or treatment plans of professional associates were the two most troublesome issues. Two respondents raised the issue of how to properly approach and discuss with a colleague that he is doing poor dentistry or is developing a bad reputation by his poor chairside manner. One respondent was troubled by observing "referrals based upon personal loyalty to another practitioner rather than upon his capabilities."

5. Personal Professionalism

Citations which were classified under this heading seemed to focus upon the development of a personal sense of responsibility and integrity in one's professional role. This encompassed such examples as: honestly monitoring and evaluating the quality of one's dentistry, being responsible for the well being of one's patients and employees, leading an exemplary life as an ethical role model in the community, and finally, putting service before remuneration and the patient's interests ahead of one's own. As aptly stated by one
practitioner, "The test of integrity is how well I treat my patient when it costs me something to do it."

**Question #2: Training received in dental school which helped one to deal with ethical dilemmas?**

Forty-five of the seventy-eight respondents answered this question; of these, only eleven (24%) indicated having received any type of formal instruction in ethics during their dental training. Eight mentioned having had one course although three of these specifically stated that the course content centered on dental jurisprudence rather than ethics per se. Two respondents had participated in an ethics program that extended through an entire semester, and one other respondent was involved in a year long ethics program. The remaining thirty-four respondents stated that they had not received any type of formal training while in dental school that would help them deal with the ethical dilemmas they are now encountering in practice. However, eight of these practitioners did point out that they acquired some degree of learning about dealing with ethical problems through informally observing and interacting with dental faculty who were perceived to be good professional role models. As expressed by one practitioner, "the instructors' commitment and dedication instilled in me a strong sense of professionalism and a dedication to excellence."

**Question #3: Improvements or changes that could be made in dental education to better prepare one to deal with ethical dilemmas in dentistry?**

Forty-eight Academy One Hundred practitioners offered suggestions in response to this question. Twenty-five (52%) recommended the inclusion of more formal instruction within the dental curriculum to better equip dental graduates to confront ethical problems which may arise in their practice. Other suggestions for helping students strengthen their professional ethics during their dental education career, included:

- Placing greater emphasis on assessing students' moral/ethical perspectives during the initial admission procedures. (5 citations)
- Inviting successful and respected practitioners to participate in school seminars and share their experiences and philosophy for success. (4)
- Provide students with more training in practice administration, particularly in principles of business and law. (4)
- Provide dental students with more extensive training in interpersonal communication skills. (2)
- Promote a more strict enforcement of ethical conduct while students are in dental school. (2)
- Encourage students to become more actively involved with organized dental associations and local community affairs. (2)
- Encourage dental faculty to be good role models. (2)
- Offer students internships in dental offices which are generally recognized for their professionalism. (1)
- Develop and distribute through the Florida Dental Association an instructional pamphlet which addresses dental ethics (1).

Interestingly, eleven of the respondents (23%) regarded students' ethics as being a fixed entity by the time they have reached dental school and that there was little one could do to significantly change their ethical attitudes. As noted earlier, five of these respondents advocated finding some way to evaluate a student's moral and ethical outlook prior to their admission to dental school.

As shown by the seventy-eight Academy One Hundred practitioners, a variety of unethical behaviors have been personally observed or encountered during their professional careers. The three professional behaviors which caused the most concern, ordered by the number of contributed incidents, were: critically reflecting on a professional peer in the presence of a patient (19), compromising the quality of dental service delivered to the patient (18), and unprofessional advertising and marketing practices (16). These three ethical problems comprised 43 percent of the 123 incidents cited. With the presence of so many potential ethical problems that can arise in one's professional dental practice, it is troubling to discover that less than a quarter of the respondents had received any type of course work in ethics during their dental education. The inclusion of some type of ethics offering in dental curricula has likely increased since these Academy One Hundred practitioners graduated from their respective dental schools. In a 1982 survey of the 60 dental schools in the U.S., only 13 schools reported that no formal instruction in ethics was available. However, an examination of available course syllabi from the schools offering ethics coursework showed evidence of great diversity in the content of ethics instruction. Many ethics courses consisted "primarily of malpractice and jurisprudence, and review of the American Dental Association's and the State's Code of Ethics and Conduct with little emphasis on bioethics, values, or a humanistic approach to ethical problems in dentistry" (Odom, 1982).

As noted earlier, a number of respondents considered the teach-
involve the use of dental case histories which are rigorously examined to determine the most ethically acceptable action under the given circumstances. To assure relevance and the meaningfulness of the instruction, case content should focus on ethical problems which, as suggested by these findings, are likely to be encountered later in practice. For example, troublesome situations could be presented which depict: various pressures weighing on the dentist to compromise the quality of the dental care given to the patient, or talking to the patient about dental work needing to be redone without casting blame on the previous dentist(s) or the profession, or advertising and marketing techniques that raise the question of ethically acceptable methods of soliciting patients.

Numerous suggestions for improving ethics instruction in dental education were contributed by many of the respondents. However, in a lengthy letter submitted by one practitioner, some general thoughts on professionalism in dentistry as well as specific advice to those entering dental practice were candidly and articulately shared. It is with excerpts from this letter that we would like to bring closure to this report. These remarks seem to summarize well some preventive measures which can eliminate or, at least reduce, the prevalence of ethical dilemmas encountered in one’s dental practice. He begins by pointing out that “it is important to realize that the image of the dental profession is exactly what dentists have made it over the years. A profession, like a neighborhood, is a reflection of the people in it . . . We have a professional responsibility that goes far beyond that required in most human endeavors. The reason is simple: our patients are not able to judge professional services; they can only rely on our intellectual and ethical honesty. We must not betray that trust!”

He continues with the following advice to those about to embark on their dental careers:

a. Don’t get so money hungry that you prostitute your profession.

b. Don’t over-promise or over-charge.

c. Be honest and candid with patients.

d. Improve your interpersonal communication. Most problems arise from improper or inaccurate communication.

e. Get involved with your dental association. Every dentist owes part of his time and money to a professional organization that is striving to improve working conditions.

f. Get involved in your community by lending your talent to civic and charitable groups. We must not extract more from a community than we put back into it.

Finally, he concludes with the contention that the true moral obligation of any dentist is first to his patient, second to his profession, and third to himself. And, he proposes that all dentists commit to the moral charge: “I shall, in the light of circumstances surrounding my patient, give to him that service which were I in like circumstances, I would apply to myself.”

References


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FRUSTRATION AND VALUES

A LOOK AT FRUSTRATION AND VALUES IN THE PROFESSION OF DENTISTRY

James E. Mozer*

Having been a member of the dental profession for 15 years in various of its modalities, including military dentistry, private practice, third world dentistry and dental education, it has occurred to me that there is a growing frustration—a malaise of sorts—in the profession. One picks up on this malaise by inward examination of one's own experiences and feelings, observation of the lives of colleagues, reading the local newspaper and various journals, interviewing potential candidates for admission to dental school, talking with students at parties, and by simple honest conversation with one's peers. No, the profession is not falling apart. It is a noble, strong, sophisticated, intensely demanding and highly respected profession. Yet perhaps it would be permissible to take a look at a potentially serious and insidious enemy of dentistry.

The symptoms of the malaise include: a general discontentedness, an internal uneasiness that things just aren't quite like one expected, with problems like divorce, drug abuse, burn-out, drop-out and suicide. Such symptoms speak of an underlying frustration that is probably complex and the result of a multiplicity of factors. However, three major categories of etiology come to mind:

1) unrealistic expectations on the part of the dentist in regard to what the profession can provide;
2) intensified demands of production amidst feelings of inability to measure up;
3) inadequate values.

In this writer's opinion, the root of the malaise is to be found in a value system based on self-pursuit.

The Historical Foundation on Values

Both medicine and dentistry have their roots in a regard for the highest ideals and values. In the Hippocratic era of early Greece, medicine was an art in which science and philosophy were one and healing and wholeness were intertwined. To the early Greek physicians effective treatment required understanding the patient as a whole and as a part of the world in which he lived. The man who knew the reasons for his actions stood distinguished from the man who merely employed knowledge for practical skill. The Hippocratic treatises alluded to various hallmarks of the doctor’s calling: sympathy with his patients’ sufferings, benefits to his patients at the sacrifice of personal inconveniences, and a deferral from complaints on his own account. In regard to the Hippocratic oath Heidel writes,

“One seems to sense in the provisions of the oath something more personal than a concern for the integrity of a profession—the determination to guard the honor of the family.”

For the Hippocrates of the fifth century B.C. there was a component to their healing art beyond mere applied knowledge. There was a base in values which is reflected in the Hippocratic oath, “I shall keep my life pure and undefiled, and my art also.”

This great physician also recognized the importance of teeth and was familiar with diseases of the dentition, gingiva and mouth. Years later as dentistry developed to take its place alongside the medical profession, it was men who placed a value on something dear who made possible the evolution of dentistry into the profession it is today.

Men such as Hayden, Harris and Keep placed a high value on

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quality dental education grounded in the medical sciences, when such was not popular in their day. G.V. Black saw something of great value in precision technique work in the dental course of study. Pierre Fauchard, the famous French dentist of the early eighteenth century, valued sharing his knowledge with others in the profession. The dental historian Bremner writes:

"Fauchard's unselfish attitude inspired other men to share their knowledge through lectures, books, and essays in journals, with the humblest members in the profession, and dentistry was changed from a trade wherein the profit motive was dominant, and technical secrets zealously guarded, into a profession that placed the patient's interest above private gain. For this more than for anything else, Fauchard deserved the title "Father of Dentistry."2

One senses with each of these men an inner depth of character and a corresponding outer display of values which have borne the fruit of a tangible contribution to the image of dentistry. Theirs was a value system not skin deep—it originated in the inner man.

The Search for Values

For several years dental educators have been showing an increasing interest in the values and personality traits of dental students. They are keenly concerned about the type of person who is choosing a career in dentistry, why they choose this particular profession, and how the educational process affects their values.

In a 1958 survey of motives of the entering class of 53 dental schools in the United States, Canada and Puerto Rico, More tabulated that 90% checked "desire to work for and with people", although this does not necessarily imply altruistic service and could as easily apply to sales or any other work involving a great deal of interaction with people. Other major motives included: "desire to be my own boss" (84%), "prestige of the profession" (80%), "desire to work with my hands" (74%), and "monetary advantages of the profession" (74%).

However, when the same students responded to an open-ended question about what they would stress in counseling a younger person (an indication of one's own motivation), the idea of satisfying one's own desires was most often mentioned (50%). Only 1.3% spoke of serving others or wanting to work with people.

This appears to be contradictory. Indeed, More and Kohn raise the issue that the motive of pure service is at least slightly incompatible with the drive for financial rewards, with striving for prestige and status, and with insistence on being, to a large extent, independent of many of the usual constraints of occupations. However, they conclude that such motives, if kept within bounds, are strongly viewed as positive in our culture.5

A 1984 survey of 126 dental students at The Medical College of Georgia revealed that the major motivations have not changed much over the years. However, the autonomy category, "opportunity for self-employment", gained the ascendency as the most prevalent motivation with 77% checking it as either a first, second or third ranked motive. In descending order other categories included: "health service to others" (72%); "income potential" (56%); "time for outside interests" (48%); "status" (43%); "variety of career options within dentistry" (22%); "opportunity to work with hands" (.8%); "enjoyment of the profession" (.8%).

It is interesting that the Georgia study surveyed two entirely new motives not pursued in the 1958 study—free time to do as one pleases, chosen by nearly 50% as a first, second or third ranked motivation, and actual enjoyment of what one is doing, chosen by less than 1%.6

This writer's analysis of both these studies is that two major categories of motivation become apparent: service to others (self-sacrifice) and the potential to control one's environment (self-assertion), apparently even at the expense of enjoying one's work.

Along this same vein, other recent research has identified an increase in Machiavellianism, a decrease in consideration, and an increase in the need for expressed control, progressing from freshmen to senior dental students.7 According to Christie and Geis, a Machiavellian individual has a relative lack of affect in interpersonal relations, is not concerned with conventional morality, views interaction from a utilitarian point of view, and has a low ideological commitment.8 In essence he is driven to control his environment—at the expense of sensitivity to others.

It is most obvious that the pursuit of control of one's environment is an ever-increasing quest in our culture. This is interesting since psychiatrists, such as Karl Menninger, are telling us that men are living in an age when they feel bewildered and not in control of their environment.9 Control seems to be eluding men and its elusive-ness drives them even harder.

In his book Surviving the Future, Arnold Toynbee fingers what is driving men to feverishly pursue such control. He states,

"Science has never superseded religion, and it is my expectation that it never will supersede it. . . . Science has also begun to find out how to cure psychic sickness. So far, however, science has shown no signs that it is going to be able to cope with man's most serious problems. It has not been able to do anything to cure man of his sinfulness and his sense of insecurity, or to avert the painfulness of failure and the dread of death."
Above all, it has not helped him to break out of the prison of his inborn self-centeredness into communion or union with some reality that is greater, more important, more valuable, and more lasting than the individual himself. . . .

I am convinced, myself, that man's fundamental problem is his human egocentricity. He dreams of making the universe a desirable place for himself, with plenty of free time, relaxation, security and good health, and with no hunger or poverty. . . .”

Menninger and Toynbee have thus described a general malaise in society characterized by striving for control and a resultant frustration from not gaining it, with self-centeredness at its core.

Now, if the dental research is reliable and a certain high percentage of students have developed values which tend toward self-pursuit rather than altruistic service, from where did such values arise? Most certainly basic values have their origin in the home, but family upbringing is not the only entity involved in shaping values.

**False Values—the Root of False Expectations and Frustration**

Strangely from time to time one hears in dental circles, often coming from quite respected members of the profession, a self-pursuit sermon. I call it dental humanism, for the dentist becomes the center of various self-acquisitions. In this sermon the dentist is a self-made man. As a result of his ability and hard work alone, he has single-handedly reached the mountain-top (self-effort). He has prestige in his community (self-recognition). He is the king in his own business (autonomy or self-control). He is able to come and go as he pleases as a result of his financial prowess (self-acquisition). He is the epitome of success (falsely defined as self-sufficiency with self-prominence in our culture).

On the outside we appear to buy it. As we sit and listen on the inside, we wonder if this is a true picture of dentistry. For we know some of our own experiences. We are aware of many of our peers' frustrations. We read the articles on burn-out, drug abuse and suicide.

As a young dental student whose mind was partly shaped by this humanistic sermon, my perception of the dentist who had “made it” was that of a professional sitting atop the pinnacle of prestige, a tower of strength, a financial fortress, a self-made man—a true success. And in order to become a true success it was my belief that I needed to climb this same mountain—to be like this image. Of course, such thinking was a false value in the making, for who could truly attain to such heights. But even more important, is this the standard to which one should seek to attain, if even possible? But even more important yet, should the aspiring young dentist actually seek to ascend such a mountain, he will encounter enormous frustration along the steep hike upwards, for it is an unrealistic goal and a barren peak at best where such self-pursuits perch.

Herein lies the source of the malaise: false values lead one down the windy path of unrealistic expectations, pass through the thicket of frustration and potentially terminate in the valley of personal problems—not on the mountaintop of ecstasy.

Well—these were the signals I had heard as a young man—in particular as a young dental student. Were they the signals that had been sent out? Was there perhaps another definition of success out there? Was there another story, another way, another view of the dental profession that had escaped my limited vision?

**Relearning—Another Way**

In October and November of 1981 my wife and I enjoyed the opportunity to supervise and train five Cambodian dentists and four auxiliaries in a refugee camp in Sakaeo, Thailand, under the auspices of World Concern.

This was the beginning of a relearning experience for me—relearning that dentistry is a healing, helping profession. Out there in the “boondocks” there was no transfer of money. For me, economic factors had faded into the distance for a while, as all dental services were rendered at no expense to the refugees. There was an accompanying sense of freedom in this situation.

For the first time in my dental career I saw hundreds of patients in desperate need receiving dental care, who would not otherwise have it, and showing gratitude such as I had never imagined possible, humbly performing the Cambodian “wai” (a bowing gesture of politeness) following treatment.

One such patient, a 45 year old man, came into the clinic with swelling extending to one eye from multiple abscessed teeth. He was in intense pain and following incision a copious flow of pus exuded. After receiving injectible penicillin at the camp hospital, he subsequently spent the night there on a grass mat. When I came to check on him the next morning, he immediately jumped up and bowed right before my eyes. The swelling and pain were gone and he was so grateful. I still have a mental image of that man leaping up and doing the “wai”—it simply made a lasting impression. Subsequently we went back to the dental clinic where one of the Cambodian (Khmer) dentists, trained only on the job, performed multiple extractions.

One morning an attractive young lady in her early twenties, but having massive carious lesions in all her maxillary anterior teeth, came into the clinic. Several of the men proceeded to restore the teeth with composite resin. The young lady was in near disbelief
when she looked in the mirror after that treatment. When she returned the next day for the final restoration she was like a new woman. Having fixed her hair and wearing a clean colorful sarong (a native wrap-around skirt), she walked into the clinic with a radiant smile and immediately performed the bowing “wai” in gratitude. And how beautiful she was, but equally as beautiful was the warm sense of satisfaction we all experienced deep down inside. Dentistry is truly a healing profession—of more than teeth.

However, our time was drawing to a close, and as we looked into their faces we saw a growing sadness. Tears began to form in our eyes—tears we had not expected. After all, we had only been with them for a month.

Later as we reflected on our experience there and the incredible bond of friendship that had formed in such a short time, we came to realize that it was a direct result of the mutual giving of two people to each other—a total involvement with one another. For 30 days they had been the reason for our lives and they had given us so much in return. Here in this refugee camp I learned something which should have been learned much earlier—dentistry is a helping, healing profession and herein lies its true ability to satisfy.

During our time at the refugee camp dental clinic we noticed Mr. Wat, my most proficient Khmer dentist, was growing thinner. He routinely worked hard six days a week. When we questioned him about his eating, he admitted he had been giving much of his share of food rations to his pregnant wife. A physician friend from Australia examined him and diagnosed tuberculosis, urinary tract problems and hook worms, endemic in the camp. Of course he was removed from the dental clinic and underwent treatment for the various problems, but how we missed his presence.

About 6 months after leaving the camp we received a letter from Mr. Wat informing us that he had undergone surgery for removal of a stone in his ureter. Although the surgery had been performed a month earlier, he was still so weak he could hardly write. Frankly we were concerned that he might not recover. However, approximately two years after our time at the camp we received a letter from Canada. Mr. Wat, his wife, and two daughters now had an address and phone number in the free world. We called him and learned of all that had transpired since our departure. He and his family were now living in a basement apartment. He was studying English half-time and had applied for a part-time position as a janitor’s assistant, not exactly circumstances that would thrill the average dentist. But what exuberant hope echoed from his voice. Mr. Wat was now a free man in a free country living in safety. A man who had known so little now seemed to have so much, in comparison.

Very interestingly, on the exact same day that I had telephoned the ebullient Mr. Wat, just a few hours earlier I had called a dentist friend of mine in the United States. He was depressed. His voice was low. You could sense his total discouragement. For even though he enjoyed the amenities of life in this country, something was wrong. Dentistry had simply not turned out to deliver the rewards of which he had dreamed in school and it was not satisfying to him. I did not judge him, for at times I had experienced the same feelings and had also known times so low I could hardly get up to go into the office. But I wonder—had those early dental school expectations of all that dentistry would deliver to the self (ourselves) produced a self-pursuit and self-orientation that could never be satisfied by anything, as well as an underlying guilt over our lack of contentment when we already had so much? How striking the contrast between these two voices I heard that day. One had so little, yet his hope and spirit ran so high—the other had so much, yet his spirit was so low.

In my 13 years of dentistry I had never experienced anything quite like this refugee camp. In dental school I had never imagined it—never dreamed of it—for there our conversation and expectations as students centered around our hopeful future financial rewards (self-acquisition), anticipated prestige (self-recognition), the supposed joy of being one’s own boss (self-control or autonomy), and eminent success (self-sufficiency with self-prominence). However, at this particular moment in this camp of displaced people struggling to survive, what hollow rewards these seemed to be, compared to the satisfaction of helping those who had received so little help.

Role Modeling—Where Values Are Built

As dental educators and practitioners we hold an important stake in the future of dentistry in relationship to the values we are transmitting and the signals we are sending to potential candidates for dental school, our students and young dentists, for they have a strong tendency to become like us.

Have we been sending out the right signals? Are we communicating to them that what makes dentistry so attractive is that it is a healing, helping profession?

As educators, are we sending them signals that say we care about them as individuals? In the midst of our demands of them we so often fail to communicate we care about them, and if we don’t care about them, how can we expect them to view dentistry as a caring profession. In the melee of the high pressure, performance atmosphere of dental school a certain number of students are experiencing self-doubt, feelings of inadequacy and discouragement—feelings they probably hide for the
most part. Why? Too often their role models also hide such inner feelings due to the societal stigma of such. We display our strengths to our students so well, but it’s far more difficult to openly and honestly convey our human vulnerability.

The same process, the display of strength and the success image while concealing weakness and human vulnerability, is also true of too many private practitioners in relating to young potential candidates. However, such inward honesty is vital in facilitating meaningful communication with them as well as role modeling a more complete person.

Perhaps in education we have become top heavy operating in the realm of the cognitive and objective—urging our students on to ascend the magic mountain of technical knowledge, psychomotor skills and production capacity—at the expense of the affective, the subjective, the feeling. I firmly believe it is in this latter realm where values, a positive image of the profession and oneself, and true inner satisfaction are born, bringing balance to the whole man.

It is all our responsibilities to paint a true picture of ourselves and the dental profession to the young aspirant. Yes, one can provide a comfortable living, usually as a result of some loving parents and mates who helped finance the education, but only a few rise to affluence as apparent self-made men. Most of us are quite vulnerable and quite human underneath it all. Prestige is not the ultimate goal of life, but should one ultimately find he is truly admired by others, it probably came as a result of his inner character rather than outer flash. Neither is success in the eyes of the world, but have passed a step far beyond such limited, inadequate values to invest themselves in the lives of others.

They have modeled something powerful and contagious—a set of values worth living for—values encompassing not only technical competence in their chosen endeavor, but values saturated with the deeper things of life that spring forth from the well of the inner man.

These are not the “self-seekers.” Rather, they are the “others seekers,” and hopefully to them belongs the future of dentistry as a healing, helping profession.

References


Reprint requests to:
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Houston, Texas 77225
When a writer constructs a collection of paragraphs for the entertainment or edification of his readers, he usually binds them together so as to present related material on an embrace titled subject. However, now and then the author will decide to write an offering that will contain several paragraphs, but with a different subject for each one of them. So it is that in this production I have tried to provide a variety of subjects in brief formations.

James Kendall Burgess was a dentist who merited a fine distinction among dentists of his era. A graduate of the Baltimore College of Dental Surgery in 1891, he practiced in Baltimore, 1892-1909. During that period he served on the faculty of his alma mater as Professor of Prosthetic Dentistry. In 1909 he removed to New York, but for five years he commuted one day a week to lecture on Crown and Bridge Work at the B.C.D.S. He developed the Burgess pinledge and pinlay attachments for interior fixed bridges and the twin-lock attachment for molars. He received a very unusual distinction when his name was given as the author's dentist in Robert Benchley's widely read "The Tooth, the Whole Tooth, and Nothing but the Tooth." But I particularly wish to present a memorable quotation from Burgess' paper "Dentistry is a Composite Profession" read before several dental societies in 1916:

Dentistry is a composite profession. Perhaps no other callings demands of its followers greater variety in the matter of intellectual attainments and physical accomplishments. The dentist, in his highest development, must combine within himself some of the special and peculiar mental and practical qualifications that belong to the surgeon, the engineer, the artist, and the artificer.

During World War I, Clark Williams, a prominent figure in New York banking circles, served as a Red Cross representative with the First Division. In his The Story of a Grateful Citizen (1934) he tells this provocative story: "On a field trip to Field Hospital No. 13, I met General Bullard, who requested me to secure a large number of tooth brushes for the men of his command (1st Division). I stated my willingness to comply with his request provided he would promulgate a general order to accompany the tooth brushes that in no case were they to be used for cleaning rifles. To this, with a smile, he gave consent."

From reading hundreds of biographical and autobiographical volumes I have gleaned a large body of evidence that many important and usually wealthy persons, especially English, pay very little attention to the care of their teeth. Even after losing their natural teeth, they seem to be indifferent to the quality of their prosthodontic replacements. Patrick O'Higgins, following fourteen years of close business association with Helena Rubenstein, the cosmetic tycoon, wrote an "intimate biography" of his former employer. There are two sentences in the book that certify Rubenstein's membership in the paradoxical class of intelligent and wealthy dental cripples who were shamefully neglectful of their dental health.—"While working Madame was prone to suck on sugar balls, toffee or crystal mints." and "Her dentures clattered like castanets on crusts of French bread."

During my career as a writer of dental notes and articles, I have received an interesting and often challenging "dividend": requests from scores of readers for information on dental subjects, some of them recondite indeed. An example of this really troublesome class of inquiries came from a faculty associate several years ago. While attending a fraternity convention he was invited to give a paper at the next year's meeting. He casually accepted the honor, and when the program chairman asked for his subject, he recklessly replied, "Sex and Dentistry." The chairman was delighted and predicted that the essayist would have a large audience, with the wives also in attendance out of curiosity. He came to me in desperation and begged for help. With materials from my files and from references I gave him, my friend was enabled to work up a surprisingly interesting and certainly an amazingly extensive coverage
of his once worrisome subject—and he did have the largest audience in the history of the fraternity’s annual meeting!

In 1903 the dental journals were proclaiming the historical importance of a meeting held in February in Chicago under the auspices of the local Odontographic Society. *Items of Interest* gave this “epoch-making meeting” representative praise: “No meeting of such magnitude has ever been held before.” The statistical information provides interesting comparative data. There were five essayists, twenty-five clinicians, and more than two thousand dentists in attendance. Over eighty years later the figures seem to reflect a relatively humble organizational effort by a Chicago society, but that 1903 meeting became historically a landmark among dental meetings.

The Civil War literature provides only widely scattered and short references to the dental experiences of the men who were engaged on both sides. However, in reading the autobiographical accounts written by the Blue and the Gray participants, the researcher now and then comes across items of dental interest. Also the noncombatant writer may provide a brief note on Civil War dentistry. In *A Vanished World* (1964) Anne G. Sneller wrote about the town of Cicero in up-state New York in the second half of the nineteenth century. In her description of the town’s activities during the Civil War she wrote: “But hiring a substitute was not the only method of escaping the war. Two of the prominent men of the town had all their teeth pulled so that they could plead inability to chew hardtack and be declared unfit for service.”

On March 21, 1900, the Reverend George A. Gordon, pastor of the Old South Church, addressed a joint meeting of the New York Institute of Stomatology and the venerable American Academy of Dental Science in Boston. From this address I quote a very discerning observation that can be gratefully accepted as a potent tribute to the contributions made by dentists to the health and well-being of their patients: “I looked at the titles of these two societies and I thought that the dreadful thing would not be to have a congregation with teeth, but to have one without teeth. What could one do with such a congregation? Bad digestion, eternal dyspepsia; could it issue in anything other than unhappy, pessimistic souls, impatient, impossible?”

To find dental anecdotes one has to count on the blessed aid of serendipity—read loads of books and find them in unexpected sources. Thus I discovered this strange story in Dorothy Rice Sims’ *Curiouser and Curiouser* (1940). Her father had a strong philanthropic bent that led him to give monetary aid and persuasive encouragement to several young men whom he regarded as prodigies. His daughter recalled vividly one of those “prodigies” who made good: “A recognized chess kibitzer, he suddenly felt the call to be a dentist. Father paid for his education. The prodigy graduated and became a dentist. He needed an office. Father found one and fitted it up. Along came a chess outing; naturally he had to attend. Father advanced him the cash. In his absence some crooks broke in and stole his office equipment. He sued Father. His point was that if Father hadn’t advanced him money for the outing, the crooks wouldn’t have been able to steal the office equipment.”

When Edward Weeks, later to be a notable editor of the celebrated *Atlantic Monthly*, was finishing his campaign to ready his physique for the arduous experiences he anticipated as an ambulance driver for the American Field Service with the French Army in 1917, he received an exceptionally frank sendoff from his family dentist. In *My Green Age* (1973) Weeks recalled that episode of chairside humor: “I took my typhoid shots, after which I went to the family dentist, Dr. Walter Woolsey [Elizabeth N.J.] to have my teeth filled. There seemed to be a good many cavities, and on the last appointment, as he reached in with the buzzer, he remarked in his dry humor, ‘I don’t see why we bother with all this when you’ll probably be torpedoed on the way across.’”

While I was in Atlanta attending the 1984 A.D.A. meeting, I carried out a long cherished desire to visit the Stone Mountain area so that I might view with enthusiastic appreciation that glorious memorial to Davis, Jackson, and Lee, the great leaders of the Confederacy. Naturally I visited the Museum in the Park. I was surprised to find among the Civil War exhibits a Maynard rifle, invented by Edward Maynard, a famous Washington dentist. Until I informed her, the curator had not known the identity of the rifle’s inventor. For gun and Civil War buffs particularly I quote the information card: “This 50 caliber, single shot, breechloading carbine represented one of the many attempts to develop serviceable breechloading weapons. The barrel tipped forward allowing the insertion of the single metal cartridge. In excess of 20,000 were purchased.” Absent from the placard was the information that the rifle was a Yankee production and probably a captured firearm. The Smithsonian Institution has on display a Maynard rifle in pristine condition. The largest collection of Maynard rifles that I know of is in a very unlikely location: the Coors Brewery in Golden, Colorado. I was delighted to respond two years ago to a request from the Coors company for information about Dr. Maynard.Δ
RECRUITMENT OF APPLICANTS

The future of dentistry will be different—so why not look for different applicants?

H. Barry Waldman

As I write these words, there is a teen-ager (possibly female) having her dental service needs provided by an owner or employed dentist (either male or female) in a solo practice, dental franchise, department store, large partnership, professional corporation or any number of other practice arrangements. The young patient is satisfied with the service and increasingly becomes interested in the possibility of a career as a dentist in a similar setting. Such an event is not too different from that of teen-agers (probably male) in past decades who had their service needs provided by solo practitioners (most certainly male) and developed an interest in the profession of a dentist in a similar setting. Such an event is not too different from that of teen-agers (probably male) in past decades who had their service needs provided by solo practitioners (most certainly male) and developed an interest in the profession of a dentist in a similar setting. Such an event is not too different from that of teen-agers (probably male) in past decades who had their service needs provided by solo practitioners (most certainly male) and developed an interest in the profession of a dentist in a similar setting.

To some degree, the continuance of the traditional forms of dental practice was the result of solo dentists encouraging young men and women who were attracted to the solo entrepreneurial form of business (i.e. practice). It requires little imagination to envision an increasing emphasis in the changing patterns of dental practice as different women and men are attracted in the 1980's and beyond to the profession because of the compatibility of their interests with the changing modalities of practice. Although almost three quarters of private practice dentists in the early 1980's remain in solo practice, the continuing trend in practice patterns seems to be away from this arrangement—especially for younger practitioners. (In 1982, the average age of dentists in a non-solo practice was 43 years; 46 for solo dentists. The median year of graduation from dental school was 1967 for non-solo dentists; 1964 for solo practitioners.) While the evolving pattern of dental practice may be disconcerting to many current practitioners, understanding the course of this change and the effect on the interests of prospective recruits for the profession could aid in the efforts to increase the number of applicants to schools of dentistry.

Applicants—

Reports of the literature since the late 1970's repeatedly have reviewed the decline in the number of applicants to schools of dentistry and have emphasized the need to establish recruitment programs to attract qualified young women and men to the evolving profession of dentistry. Many of the writers describe the changing negative environment for the practice of dentistry (e.g. increasing costs for dental education with resulting major debts as students graduate, increasing numbers of practitioners and declines in practitioner busyness and income). But few have related the general changes to more complex practice arrangements and the difficulty in attracting applicants to the profession.

The sincere efforts by family dentists to encourage young men (and occasionally women) were successful because the would-be
dentists were hearing about the profession from enthusiastic recruiters and were seeing the actual practice setting which stimulated this encouraging attitude. The outcome of this effort by these solo practitioners was (and is) as expected. The majority of applicants (both in the past and the present) sought a career in dentistry because of the "desire to be my own boss." But "being one's own boss" is but one of a number of available options; and for many, it may no longer be a viable alternative. Yet, because most individuals continue to receive dental services from solo entrepreneurs, solo practitioners may unconsciously be presenting (by example) the traditional practice role model as the only available alternative.

In an earlier study by this writer, an effort was made to determine the extent of knowledge that predental college students had of the evolving delivery patterns of dental services and the degree to which these changes would affect their interests for particular careers in dentistry. For the most part, the respondents demonstrated a general lack of knowledge of particular changes (except for a very few respondents who commented on commercialism in the profession, developments in prevention, esthetics in dental restorations and the profession's concern for nutrition). Virtually all respondents expected eventual self-employment and individual practice—even those few students who were aware of the increasing number of practices with two or more dentists. The general findings of the study were summarized with the thought that, "Hopefully, the current generation of predental students is not to be our profession's dinosaurs; i.e. attracted because of their experiences and interests to a system of care which has moved to other modalities."

Expectations—

Whether because of the changing realities of practice or initial differences in the interests of students, recent senior dental students increasingly report expectations of changing practice arrangements. In some cases, these differences become even more pronounced when these expectations are considered by gender.

I. Immediate expectations—
(Changes between the classes of 1979 and 1984)

a. Generally, a decrease in immediate plans to open a practice (either solo or with partner[s]). However, this is a reflection of a major decrease in the number of male graduates who anticipate starting a practice. The number of female graduates expecting solo practice arrangements increased somewhat, while the number anticipating immediate partnership arrangements increased by approximately 50%.

b. Marked increase in expectations of employment, for both male and female graduates.

c. Marked increase in postgraduate education plans.

d. Marked decrease in gov-
ernment employment expectations. (Table I)*

II. Five year postgraduate plans—(Changes between the classes of 1980 and 1984)

a. Decrease in number of male graduates, and increase in female graduates who anticipate solo practice.

b. Increase in male and female graduates expecting partner arrangements.

c. Decrease in male and increase in female graduates who anticipate employed arrangements.

d. Decrease in male and female graduates who anticipate teaching, research and administrative positions. (Table II)

Over time, the combination of different practice expectations by graduating male and female dental students and the continuing increase in the percent of female students in entering dental school classes (e.g. in 1980, 19.8% of entering classes were women; 27.1% in 198411,14) may prove to be a significant aspect of the evolving pattern of dental practice.

Economics—

The prospects of changing patterns of practice is of secondary importance in the recruitment process if the general economy of dentistry does not improve. Fortunately, since 1982 there have been increasing signs that the economics of dentistry are rebounding! For example:

1. Between 1982 and 1983, expenditures for dental services increased at a rate greater than all other areas of health expenditures (including hospital, physician, drugs and medical supplies, eyeglasses and appliances). In addition, in 1983, the annual rate of change for national dental expenditures was about four times the change in the Consumer Price Index.15

2. Between 1979 and 1981 there was a decrease in constant dollar expenditures (i.e. after the removal of the effects of inflation) per active private practitioner. However, by 1982 and 1983, the decline had been reversed. Despite continuing increases in the number of practitioners, constant dollar expenditures per active practitioner had increased. (Table III) (Note: between 1978 and 1984, there was a decrease in the number of entering places in dental schools by over 1,200 students (from 6,301 to 5,047 places.10,12)

3. Department of Commerce reports on the dental supply

| Table I. Immediate post-graduate plans for dental school seniors, 1979 and 1984 graduation class, by gender<sup>(9-12)</sup> |
|---------------------------------------------------|------------------|------------------|-------------|-------------|------------------|------------------|
| **All seniors**                                   | **Males**        | **Females**      |             |             |                  |                  |
| Solo Priv. Pract.                                 | 1014             | 624             | 967         | 576         | 43              | 51              |
| Priv. Practice with partner(s)                    | 813              | 699             | 728         | 576         | 83              | 120             |
| Employed in a practice                            | 1155             | 1830            | 981         | 1423        | 174             | 402             |
| Advanced education                                | 911              | 1243            | 785         | 965         | 124             | 275             |
| Other professional activities (teach, research, admin) | 37              | 48              | 28          | 34          | 9               | 11              |
| Gov't service                                     | 862              | 437             | 747         | 359         | 110             | 79              |
| Undecided                                         | 629              | 458             | 541         | 333         | 88              | 124             |
| Total graduates**                                 | 5424             | 5337            | 4790        | 4274        | 634             | 1063            |

* Prior to 1984, the response rate for the Survey of Dental Senior was between 62 and 67 percent; for 1984, the response rate was 70.4% (13)

** Sums of individual categories do not equal totals because of rounding.
industry for 1983 indicated that, industry shipment increased by two percent (after adjustment for inflation) following a non-growth year in 1982. In addition, industry employment increased to 18,000 from 15,400 in 1982.\textsuperscript{19,20}

While there are still areas within the country where economic problems exist, and changes are proposed in tax legislation which could impact negatively on dental insurance programs (e.g. maximums for tax free health insurance fringe benefits), the general signs would seem to indicate that the profession has weathered the recession of the early 1980's.

**Number of dentists—**

Despite improvements in the economics of dentistry in the mid 1980's and a 20\% reduction between 1978 and 1984 in the number of entering places in dental schools, questions regarding the number of current and future practitioners must be considered in any effort to stimulate recruitment to the profession. There are any number of studies and anecdotal presentations in the literature during the late 1970's and early 1980's describing local, regional and national oversupply of practitioners. However, the May 1984 Report to the President and Congress on the Status of Health Personnel in the United States\textsuperscript{21} (based on computer modeling procedures) predicts that within 15 years, (the period when near-future applicants would be developing practices) there will be a shortage of at least 4,000 practitioners to meet the demand for services.

The report reviews the inter-

relations of applicants, minorities and women, numbers of graduates, current supply of dentists, geographic distribution, specialization, characteristics of practice, auxiliaries, practitioner income and numbers of other related factors. Essentially, as a result of the decline in dental school enrollment and anticipated increasing demand for dental service, it is estimated that by the late 1980's "\ldots the growth in aggregate demand (for care) catches up with the growth in aggregate supply."\textsuperscript{21}

From the latter half of the 1980's through the end of the century, employment of personnel and equipment in the typical dentist's office is expected to increase to meet the increasing demand for services. At the same time, consumers will face a slightly rising price for dental care relative to the overall rate of inflation. This

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**Table II. Five year postgraduation plans for dental school seniors, 1980 and 1984 graduation class, by gender\textsuperscript{(9-12)}**

<table>
<thead>
<tr>
<th></th>
<th>All Seniors</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solo Priv. Pract.</td>
<td>2191</td>
<td>2007</td>
<td>179</td>
</tr>
<tr>
<td>Priv. Practice with partner(s)</td>
<td>2086</td>
<td>1776</td>
<td>319</td>
</tr>
<tr>
<td>Employed in a practice</td>
<td>378</td>
<td>295</td>
<td>86</td>
</tr>
<tr>
<td>Advanced education</td>
<td>189</td>
<td>163</td>
<td>28</td>
</tr>
<tr>
<td>Other professional activities</td>
<td>120</td>
<td>81</td>
<td>42</td>
</tr>
<tr>
<td>(teach, research, admin)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gov't service</td>
<td>78</td>
<td>68</td>
<td>12</td>
</tr>
<tr>
<td>Undecided</td>
<td>210</td>
<td>158</td>
<td>49</td>
</tr>
<tr>
<td>Total graduates*</td>
<td>5256</td>
<td>4541</td>
<td>715</td>
</tr>
</tbody>
</table>

*Sums of individual categories do not equal totals because of rounding.

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**Table III. Number of active private dentists and current and constant dollar national expenditures for dental services per dentists: 1979-1983. (15-18)**

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Number of active dentists</td>
<td>104,905</td>
<td>108,672</td>
<td>112,439</td>
<td>116,208</td>
<td>119,975</td>
</tr>
<tr>
<td>National dental expenditures per dentist</td>
<td>$126,781</td>
<td>$141,709</td>
<td>$153,861</td>
<td>$167,802</td>
<td>$181,704</td>
</tr>
<tr>
<td>Expenditures in constant dollars per dentist</td>
<td>$58,236</td>
<td>$57,372</td>
<td>$56,504</td>
<td>$58,143</td>
<td>$61,179</td>
</tr>
</tbody>
</table>

*Represent reported data by the American Dental Association for active private practitioners. Data for other years were estimated by prorating the ADA data.
increase in costs could dampen, to some extent, the growth in the consumption of dental services.

...within 15 years, (the period when near-future applicants would be developing practices) there will be a shortage of at least 4,000 practitioners to meet the demand for services.

Overall, it is estimated that, by the year 2000 there will be shortage of 4,000 dentists. The requirement for additional dentists is defined as, "the number of dentists needed to prevent inflation in the dental sector."21

The role of current practitioners—

No doubt, from the perspective of some dental practitioners, the potential recruit to the dental profession has become a "potential competitor." But in reality, the teen-ager (possibly female) who is having her dental services provided by an owner or employed dentist in any number of practice arrangements (as you read these words), is considering a career for his/her future, not for some time in 1985 or even 1990. Do we not owe that youngster and the patients for whom he or she will provide care, the best objective advice possible for their future—not for our future here and now?

But as we provide the necessary encouragement, we must remember that the future of dentistry will be different and we must look for applicants who may not replicate the past or even the present. But has it ever been different?

References


Reprint requests to:
Dr. H. Barry Waldman
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Arthur A. Dugoni, Dean of the School of Dentistry, University of the Pacific in San Francisco, was elected President of the American Board of Orthodontists. This Board is the official certifying agency in orthodontics and is sponsored by the American Association of Orthodontists. Dr. Dugoni is currently a Trustee of the American Dental Association representing the Thirteenth District.

George C. Paffenbarger of Gaithersburg, Maryland has been honored by the American Dental Association Health Foundation when the Foundation renamed the dental research unit at the National Bureau of Standards as the Paffenbarger Research Center. Dr. Paffenbarger has been instrumental in improving dental care over the past fifty years, most of those years as director for dental research at the Bureau of Standards. He contributed greatly to the ADA specifications and certification programs. During his tenure at the Bureau of Standards, inventions that changed the practice of dentistry such as the high speed contra-angle handpiece, panoramic X-Ray and composite restorations were all developed.

Dr. Paffenbarger has also been honored by his Alma Mater, the Ohio State University College of Dentistry, when that institution established its first chair in his honor. In addition, the school is constructing a research laboratory for restorative dentistry to be named “The George C. Paffenbarger Dental Research Laboratory.”

Max Chubin of Chicago has been honored as Alumnus of the Year by the Loyola University School of Dentistry Alumni Association.

Eugene Schlagel of Brooklyn, New York has been appointed to the New York State Board for Dentistry. Dr. Schlagel is an endodontist and is associated with an endodontic group in Brooklyn.

Robert V. Walker of Dallas has been designated by the Baylor University Dental Alumni Association as Distinguished Alumnus of 1985. An oral surgeon, Dr. Walker is professor of surgery at the University of Texas Health Science Center. He has published widely with a primary interest in TMJ research.

I. Lawrence Kerr of Vestal, New York, former ADA President, has received the Thomas Evans Award from the International Friends of the University of Pennsylvania School of Dental Medicine. The Award was in honor of Dr. Kerr’s lifetime of dedication to dental medicine and public education. Dr. Kerr recently served as the first chairman of the newly established United States Olympic Committee on Dental Health.

Prem S. Sharma, Milwaukee, was elected secretary-treasurer of the American Society of Dentistry for Children. Dr. Sharma is associate dean at Marquette University School of Dentistry.

Max Chubin

George C. Paffenbarger

I. Lawrence Kerr

Prem S. Sharma

Robert V. Walker
James W. Smudski, Dean of the University of Pittsburgh School of Dental Medicine, received an honorary fellowship from the Academy of General Dentistry for his support of continuing education programs.

R. Chester Redhead, Sr., an oral surgeon in New York City has been honored by the Greater Metropolitan New York Dental Society for his many years of service to the profession and for continued dedicated assistance to young dental students.

Harriet S. Goldman of New York City has been elected president of the American Academy of Oral Medicine. Dr. Goldman is associate professor of oral medicine and of behavioral sciences and community health at New York University College of Dentistry. She is a member of the New York State Board for Dentistry.

John G. Kramer of Martins Ferry, Ohio was named to a three-year term to the fifteen-member University Hospitals Board by the Ohio State University Board of Trustees.

Arthur C. McFeaters, Jr., Pittsburgh has been selected as the Distinguished Alumnus of the University of Pittsburgh School of Dental Medicine for 1985. He was honored for his services to the dental school, the profession and the community. Dr. McFeaters is an endodontist.

James W. Holley, III of Portsmouth, Virginia was elected Mayor of Portsmouth and serves on the Housing and Economic Development Committee for the United States Conference of Mayors.

James J. Caveney, a Wheeling orthodontist, has been elected president of the West Virginia Dental Association. He is the first president of the WVDA to be a graduate of the West Virginia School of Dentistry.
The Northern California Section has established two American College of Dentists Perpetual Plaques, one for each of the dental schools in the San Francisco area: the University of California School of Dentistry and the University of the Pacific School of Dentistry. Each year there will be a student award "In Recognition Of Exemplary Professionalism While A Student Of Dentistry". The current recipient of the student award for each year will have his or her name engraved on the plaque of the school that the student attends. Each of them also receives a perma-plaqued certificate from the Section. This year's awardees were Dr. Charles Jackson of the University of the Pacific and Dr. Constance Whisler, University of California at San Francisco. The Section also presented its annual award for Meritorious Service to Dr. William L. Gee for his many years of contributions to community and civic affairs.

Dean Arthur A. Dugoni, left, University of the Pacific School of Dentistry and Dean John C. Greene, University of California School of Dentistry (at San Francisco) exhibit the American College of Dentists perpetual plaques that will be on display at each dental school. The awards are projects of the Northern California Section.

Section Representatives to Meet in San Francisco

Section Representatives of the American College of Dentists will meet at 4:00 p.m. on Friday, November 1, 1985, at the Westin St. Francis Hotel in San Francisco. The Section Committee, consisting of Doctors Harold Pressman, Chairman, Leslie Bell and Ralph Lopez, as members, and Robert Elliott and Joseph Cappuccio as Board Representatives, have developed a program which is of great interest to Sections. Not only will the speakers be sharing ideas of Section activities, but will also be providing opportunity for discussion and comments about individual Section programs. Each Section is to be officially represented by a member. However, all Section Officers and Fellows of the College are most certainly invited to attend. Upon completion of the formal program and the discussion period, Section Representatives will meet with their respective Regents.

Chairman Pressman hopes that each Fellow of the College who is present for this meeting will be challenged to go back to his home Section and inspire the Section to a rebirth of the ideals for which the College stands. A large attendance is expected at this annual meeting.
Michigan

A group of Fellows in the West Michigan area, several years ago, decided that something should be done to recognize outstanding service and contributions by dentists in their area. They decided on a Distinguished Service Award in recognition of members of the West Michigan Dental Society who deserved this honor. One member would be selected each year for this honor by an Awards Committee composed of Fellows of the American College of Dentists. Fellowship in the College was not a requirement for receiving the annual award.

The Award is a "Silent Bell", an engraved brass bell without a clapper, symbolic of quiet, dedicated contributions made to the profession or community without self aggrandizement or commercial interests. The award was established in 1981.

This year's recipient was Dr. Julius Franks, Jr. of Grand Rapids. A leader all his life, Dr. Franks was an All-American Football player at the University of Michigan in 1942.

Upper Midwest

Upper Midwest Section activities are centered mainly at the University of Minnesota Dental School and with its curriculum to teach ethics. This year over twenty Fellows were involved in this important activity. This study is one of several designed to establish the validity of the Dental Ethical Sensitivity Test and the participation of the American College of Dentists locally continues to play a vital role in the Ethics Curriculum. The project has attracted national attention and several other dental schools are exploring the use of this curriculum.

A University-wide task force was initiated to develop a mission statement and a budget for the Study of Ethics.

As a result, a generous grant of $300,000. has been made by a Foundation that enables the establishment of a Center for the Study of Ethics at the Health Sciences Unit of the University of Minnesota.

Colorado

The Colorado Section presented its "Man of the Year" award to Dr. Wilmer B. Eames of Aurora, Colorado. The award was presented by Dr. Miles R. Markley. Dr. Eames has been a practitioner, a teacher and researcher. His research in restorative materials has influenced dentistry internationally.

Regent Leo E. Young was guest speaker and his address covered the present functions of the College, as well as future growth and goals.

The Southern California Section has established its Achievement Award for senior dental students from Southern California Dental Schools "who have shown great potential for future contribution and service to the dental profession and to the public the profession serves." 1985 Achievement Award winners are, left, Gregory Matthew Brooks of the University of Southern California and, right, Beth Rhode Hamann of Loma Linda University. Section Chairman Richard B. Hancock, center, presented the awards at the Annual ACD-ICD Meeting held in conjunction with the Annual Session of the California Dental Association at Anaheim.
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