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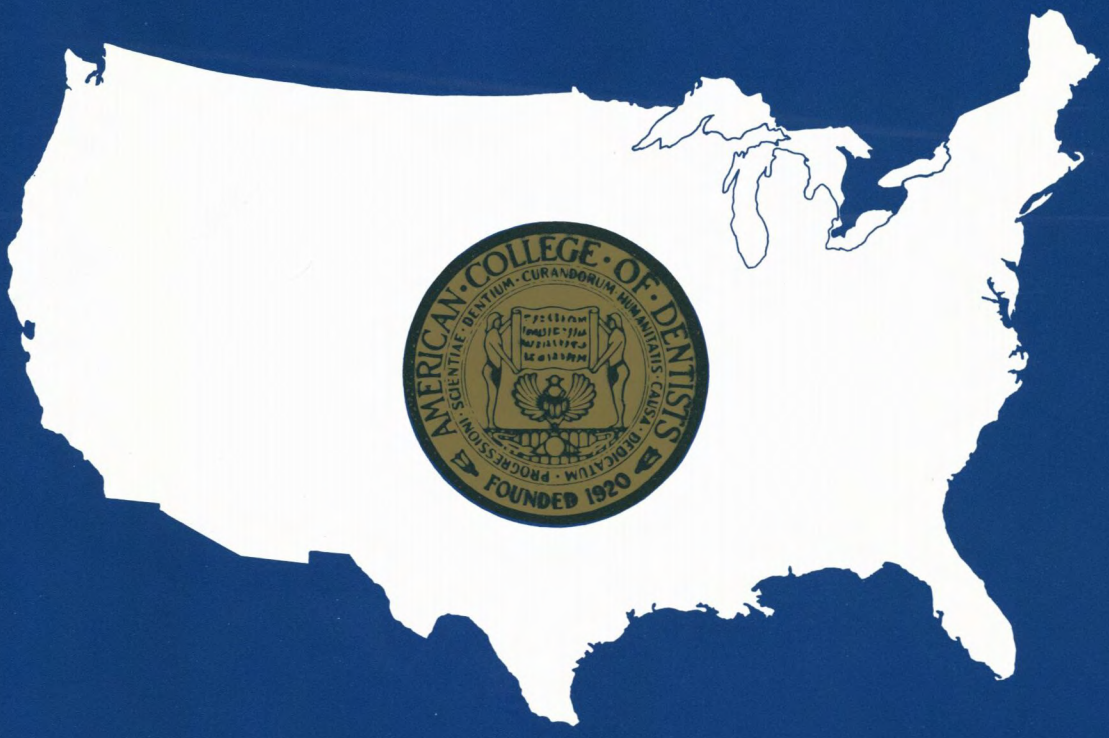
JOURNAL

AMERICAN COLLEGE OF DENTISTS



Gies Editorial Winners for 1986

A Geographic Perspective of Dentistry

Purposes and 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 graduate studies and continuing educational efforts by dentists and auxiliaries;

(d) To encourage, stimulate and promote research;

(e) To improve the public understanding and appreciation of oral health service and its importance to the optimum health of the patient;

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

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

(h) To make visible to the professional person the extent of his/her responsibilities to the community as well as to the field of health service and to urge the acceptance of them;

(i) To encourage individuals to further these objectives, and to recognize meritorious achievements and the potentials for contributions to dental science, art, education, literature, human relations or other areas which contribute to human welfare—by conferring Fellowship in the College on those persons properly selected for such honor.

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FROM THE EDITOR'S DESK

THE FTC PERSISTS

— The Costs of Dental Care Should Be Lowered

According to the U.S. Federal Trade Commission (FTC), the best way to improve our national dental health is to lower the cost of dental care. Therefore, more people will be able to afford to have treatment and the result will be a general improvement in dental health.

In recent years the FTC has been persistent and relentless in its crusade to lower dental costs. It urges more aggressive advertising to further enhance competition between dentists so that the costs of dental care can be driven down by market pressures. It obviously believes that any action that can help to achieve its goal of lower costs is worthwhile and justified. It concedes that the *quality of dental care may suffer* because of these actions, but that is a price it is willing to pay.

The following are some of the FTC proposals to eliminate specific state laws on dental practice in order to lower the costs of dental care:

- Remove state laws that restrict the number of auxiliaries that a dentist can employ for expanded functions including the placement of restorations.
- Remove state laws that place limits on the type of functions that can be performed by auxiliaries so that they can perform more treatment procedures.
- Remove state laws that limit the number of dental offices that a dentist can own so that multi-dentist networks can be formed.

Keith P. Blair

- Remove state laws that prevent non-dentists from owning dental offices so that there could be many more dental offices in existence.
- Remove state laws that restrict denturists from being licensed to treat the public directly.
- Remove state laws that restrict dentists with out-of-state licenses from practicing in any state (reciprocity).
- Remove state laws that restrict hygienists from practicing without the supervision of a dentist so that hygienists can practice independently.

The FTC views all of these proposals as an occupational deregulation program for the dental profession that would increase the freedom of individual dentists. It considers that any change in dental practice laws should be allowed that is economically efficient and that will lower the price of that function.

Most of these proposals appear in a recent publication by the FTC entitled, "Restrictions on Dental Auxiliaries" that was authored by staff members J. Nellie Liang and Jonathan D. Ogur. An FTC disclaimer states that this report represents the views of the FTC authors and does not necessarily reflect the views of the Federal Trade Commission.

FTC studies have supposedly proven that dental auxiliaries can perform expanded functions as well as dentists can and that utilizing auxiliaries for placement of restorations would not reduce the quality of services. In addition, the FTC claims that present restrictions in state laws cause higher fees, that this cost is a major reason why many consumers do not obtain routine dental care and also why 20 million Americans have never visited a dentist. Restrictions on the use of auxiliaries reduces the "efficiency of production" and therefore increase prices. The FTC states that these restrictions cost consumers approximately 700 million dollars in 1982.

Actually, this FTC plan would significantly lower the standards for dental care and would set back the practice of dentistry in America by at least 75 years. Most of the state laws that the FTC wants to remove were placed there originally in order to protect the public from getting the type of care that the FTC is now proposing. Greatly lowering the standard of dental care is not the way to make progress, no matter how economically efficient it is.

The American people deserve much better than that. △

Keith P. Blair

RELATIONSHIPS: TENDING THE GARDEN IN A HIGH TECH SOCIETY

1985 Convocation Address

Donald W. Legler*

A great transition is taking place in America today, and dentistry has a role in it. John Naisbett, in his best seller *Megatrends*, makes a powerful statement. "We are living in a 'Time of the Parenthesis', the time between eras." Although we continue to think that we live in an industrial society, we have in fact changed to an economy based on the creation and distribution of knowledge. The new wealth will be know-how; and the strategic resource, information.[1]

The centralized, industrialized, and economically self-contained America is rapidly being transformed. The Singer Company, famous for its sewing machines, is moving heavily into aerospace. Schlumberger, an oil drilling company, is involved in data collection and processing. Companies that deny changing trends have plummeted to near oblivion, as witnessed by the problems which have besieged Pullman, Swift and Co., International Harvester, and the railroads.

The occupational history of the United States tells a great deal about us. The number one occupational category in the United States was originally farmer, then laborer, then followed in 1979 by clerks. Now, there are more people employed full-time in our universities than on our farms.[1]

Today, we are moving in the dual directions of high tech/high touch, with the need to match each new technology with a compensatory human response. Naisbett suggests that people can handle just so much technology and mechanization without feeling a comparable need for the human factor: quiet time, touch, and self-fulfillment.[1] I shall return to this point of high touch later, for the "*rest* of the story".

Massive changes are occurring in the health care arena. On the medical front, a task force report of the Commonwealth Fund entitled "Prescription for Change" was recently published. This summary of problems and opportunity states that high costs, high tech, and high expectations have created pressures for marked restructuring of our health care system.[2] Federal funding on the basis of diagnosis related groups (DRGs), HMOs, rising costs of malpractice insurance and increases in claims are but a few of the factors involved.

Naisbett's latest book, *The Year Ahead 1986*, indicates that walk-in emergency centers and surgicenters are exhibiting dramatic growth, expanding from 260 in 1981 to an estimated 2,500 currently. Health care corporations are becoming all things to all people, and conglomerates operate hospitals, HMOs, clinics, insurance companies, and even home health services. HCA (Hospital Corporation of America), for example, is a 4.18 billion dollar business. Advertising plays an increasingly major role, and claims of "Mac Doctors" and "7–11" medicine are heard with increasing frequency.[3]

Not only do we see these changes in the economic and health care sectors, but the entire philosophical, religious, and social fabric of our society is similarly buffeted by the tide of change. The question of ethics needs to be examined. Webster defines ethics as (1) the discipline dealing with what is good and bad, and with moral duty and obligation, and (2) the principles of conduct governing an individual or group. Things that are ethical, then, conforms to standards of conduct.

With reference to society at large, these standards are crumbling. Changes in our basic beliefs and ethical standards can be noted in certain societal trends:

1. Television and movie productions now deal with subjects which previously were taboo in terms of sex and explicit violence but which have been accepted in large part by society.
2. Crime has increased dramatically; the capacity of our prisons has been exceeded, and pending cases crowd court dockets.
3. Experience with drugs has reached new plateaus, an increase which society has greeted with indifference.
4. A hedonistic, "look out for myself" philosophy has become widespread.

Dating back to the Ten Commandments in Deuteronomy 5, Judeo-Christian moral reasoning has been related to a legalistic ethical code. For more than 30

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centuries, moral action has been prescribed. Dramatic changes were signalled, however, with the writings of Joseph Fletcher. An alternate ethical stance was articulated that, simply stated, called for complete openness to any situation with moral action being the result of one's independent judgment of factors existing at the moment.[4]

Alasdair MacIntyre, professor of philosophy at Vanderbilt University, suggests that a moral calamity has befallen modern society. In his widely read book *After Virtue*,[5] he states that we have, very largely if not entirely, lost our comprehension, both theoretical and practical, of morality. A problem today is that our accepted professional standards are also in a state of flux. Our basic beliefs, our basic operating principles in the dental profession, are changing. This feeling of change underlies our sense of uneasiness.

Twenty-nine years ago when I entered dental practice, a dress code was understood. Lettering on office windows was restricted to three inches in height, criticism of fellow practitioners was taboo, advertising was unimaginable, PPOs and HMOs were unknown, and the word "profession" was limited to dentists, physicians, lawyers, and a few other groups with advanced educations. The ball game has changed!

Now, advertising has also invaded the dental profession, corporate dental clinics are opening, and traditional dental ethics appear to be eroding. Young dentists and dental students, growing up and entering the profession out of such a mixed milieu, may march to a different drummer than their forebears of the 40s, 50s, and 60s, the generation represented by many of us. But I submit that we need to examine the pressures on them and offer guidance and assistance to them in meeting today's problems. As Dietrich Bonhoeffer pointed out, account must still be taken of men as they are.[6] In espousing the goals and objectives of the American College of Dentists, we must use caution lest our expectations outrun reality, a danger cited by Rheinhold Niehbuhrs in his classic work, *Moral Man and Immoral Society*.[7] We must periodically reassess the position of the profession relative to its guidelines for ethical behavior.

In the case of our young dentists, these seedlings can no longer be set and left alone. The garden needs tending. Weeds must be removed, the insects sprayed, and the "varmints" run off. The garden must be tended, and the seedling nourished with friendship and watered with appropriate role modeling.

There is a need to establish and maintain relationships, in this case with our younger peers. Establishing and maintaining relationships takes time and commitment. Dr. James Dobson, author of the book *What Wives Wish Their Husbands Knew About Women* (a great title, but the topic of a separate discussion), makes the point that husband-wife relationships require nurturing: the commitment of time spent together, communication, some expression of caring, and sharing. This is true of marital relationships, parent-child relationships *and* professional relationships. Without proper tending, relationships dwindle and disappear.[8]

We need to take inventory of where we are in all of this—where we are coming from and where we are going.

We clearly come from a tradition of professionalism. A hallmark of the American College of Dentists is professionalism and ethics. What is professionalism? To some it is a rejection of advertising in any form; to others, it is proper dress, with a coat and tie worn at all times in public gatherings; and to others it is respect and support of one's fellow practitioners. To some degree, these are all ingredients of a professional bearing.

Let's explore this further and talk about image. I would suggest that we all hold a mental image of a true professional: our "hero" within the dental profession or in other professions such as medicine. What are the characteristics of our role model? I suggest that such a "hero" should possess the following qualities:

1. A love of the profession. This love should include embracing those qualities which the profession holds dear.
2. Skill. He or she should be regarded by patients and peers alike as the quintessential clinician, a good operator combining excellent training and a dedication to continued learning.

3. A love of people. Professionalism demands that one respect and love other people, and that care be delivered with compassion.
4. Maturity, a certain self-confidence, sense of judgment and obvious experience that is apparent to all.
5. Service to his profession. In the case of the private practitioner, this may be evident in hard work for the profession, committee service, leadership positions in organized dentistry, and community service. In the case of the academician, this may be manifested in contributions to the knowledge base of the profession.

There are other qualities which I did not include: a fatherly image perhaps, a sense of humor which always helps, and a ready and empathetic smile.

Fortunately, society has charted a course in moral reasoning in which ethical norms fall between the legalism and binding duty of the Ten Commandments and the absolute open-endedness of Fletcher's situational ethics. This middle course involves the central theme of responsibility (to profession, family, patients and self). Our image of a true professional, then, might also include the characteristic of ethical responsibility.[6]

Few of us embody all of these characteristics, but, fortunately for me, my role model did. Dr. Leo J. Schoeny, of New Orleans, Louisiana, was my professional hero: a super dentist, a member of the Sugar Bowl Committee, the Krewe of Rex, active in dental society affairs, personable, caring—and best of all—he was interested in me! As a seventh grader at P.G.T. Beauregard Elementary School on Canal Street, I knew that I wanted to become a dentist. (Although I often think that if he knew I would go astray and become a dean he would have rethought his relationship with me.) Although I am sure that Dr. Schoeny died a reasonably wealthy man, he looked only to service and caring for his patients. If financial rewards came, they were secondary.

A vision or pattern toward which we can strive is important. We, as members of the American College of Dentists, might be well advised to maintain such a vision for our profession. We need to offer support to our younger peers who need time to mature and who need guidance as they attempt to grapple with their priorities in this time of change. Behaviors may vary, but the vision must remain constant.

Why did I review these points which you realize and, in fact, have embraced? I did so because (1) we must remind ourselves of the need to serve as role models for others in the profession and (2) we must hear the bugle announcing a call to action. In short, we need to tend the garden! After today, those of you who are new inductees will have four new letters (FACD) to add to your professional title and a handsome certificate for your office wall. More than this, however, be reminded of our obligation to live out these characteristics of our role model and to influence others in a positive way.

In terms of a call to action, this is a critical point in time for the American College of Dentists to expand its active involvement in the areas of professionalism and ethics. Such involvement might include assistance to dental students in such areas as:

1. teaching courses in moral reasoning,
2. hosting dental students on office visits,
3. serving as mentors or big brothers to dental students, or
4. becoming involved in dental society affairs in such areas as advertising standards, definition of ethical guidelines, or positions on moral issues.

In short we must tend the garden in a proactive manner. Dentistry has an excellent professional image; let's keep it!

Now, "For the rest of the story", the *good news!* Earlier I referred to the relationship of high tech/high touch. It has been said that trends are like horses; they are easier to ride in the direction they are already going. High tech requires high touch, and dentistry is riding the right horse. In fact, it has done so for years.

Many individuals in our society are crying out for more high touch. James Dobson, in his book which I referenced earlier, underscores the fact that depression and apathy constitute a recurring fact of life

among women.[8] Some men, as well, exhibit these feelings as a by-product of this high tech, competitive, fast-paced, and depersonalized society in which we live. Eric Berne, in his best seller *Games People Play*, also emphasized that social interaction and stroking constitute basic human needs.[9] The need for compensatory high touch is everywhere.

Dentists are among the best practical psychologists in all of society! We work in the most sacrosanct area of the body, the oral cavity, which is filled with Freudian connotations, an area which psychologists tell us is indeed private property. Yet we get away with it! More than that, surveys tell us that dentists are among the most admired and trusted of professionals.

If you read about the psychological notion of territory, you find out that people do not like it when others get too close, talk too loud, and spray them with saliva in the course of conversation. A distance of 4-6 feet is much more comfortable. But as dentists we freely invade the territorial barrier; yet, people like us, they trust us, and they appreciate our service.

In addition to clinical expertise, members of the dental profession have traditionally enjoyed respect for their understanding of patient needs, communication skills, compassion, and genuine interest in their patients. We are masters in pain control, alleviation of anxiety, and meeting patient needs. We establish friendships. We have carved out an enduring niche in this high tech society because we are a high touch profession. The question for the 1980s is, "What business are you really in?" Our answer might very well be: we are in the people business!

Computers will be commonplace, lasers will occupy a prominent place in dental therapy, implants will be common, bonding will improve. Dentistry will have its high tech component, but our traditional skills in patient management, the doctor-patient relationship, will continue to be our secret weapon and will hold the *key* to the salvation of our profession.

Yesterday is over; the future is bright! Dentistry is postured to share in it by simply keeping and emphasizing its existing strengths: a professional image, a code of ethics, high touch, and some tending of the garden.

This afternoon I have attempted to define some of the pressures which confront us and to issue a call for action. Now, I wish to congratulate those of you who have attained fellowship in this very special organization. You have worked hard, you have enjoyed success, and you bring many talents to us. Perhaps these words of Theodore Roosevelt say it best in recognizing your accomplishments:

> Far better it is to date mighty things, to win glorious triumphs, even though checkered by failure, than to take rank with those poor spirits who neither enjoy much nor suffer much, because they live in the gray twilight that knows not victory nor defeat.
>
> Theodore Roosevelt, 1858–1919. Speech before the Hamilton Club, Chicago (April 10, 1899).[10]

New initiates: You are enjoying the triumph of high achievement, and I take my hat off to you. I ask you to hold the banner high for professionalism, and remember, tend the garden!△

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DENTISTRY IN THE MID 1980'S: A GEOGRAPHIC PERSPECTIVE

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Between 1979 and 1981, on a national basis, constant dollar (i.e. removal of the effects of inflation) dental expenditures per active dentist decreased.[1-4] Since 1982, constant dollar national dental expenditures per active dentist have increased[5]—but not on a uniform basis throughout the country. The 1986 publication of data by various federal agencies on state and regional economic and business patterns for the 1980's, and the estimates from the 1985 National Health Interview Survey, permit a review of developments in the delivery of dental services on a more regional and local basis.[6-9]

Increase In Dental Expenditures

Nationally, between 1980 and 1982, there was over a 26 percent increase in dental expenditures. However, this increase ranged from a 30 percent increase for the states in the Western region, to a 22 percent increase for the states in the Midwest region. On a more local basis, the increase ranged from 32 percent for the states in the Mountain section, to 21 percent in the states in the East South Central section. (Table I)

But, there was no consistent relation to the percent increase in dental expenditures and the number of dentists, dentist per population, or the percent increase in personal income of the residents in the respective regions and sections of the country. (Table I)

Changing Practice Configurations

The delivery of dental services is undergoing rapid changes as the profession attempts to meet rising overhead costs, the complexities of and demands by third parties, and the problems of competition between health professionals. Nationally, during the 1980's, there have been any number of changes in practice configurations in an attempt to meet these demands. One of the most pronounced has been the significant increase in the number of larger dental establishments (a single physical location where business is conducted or where services are performed). Although there was a *14.7 percent* increase in the total number of dental establishments between 1980 and 1984, establishments with:

a. 1–4 employees increased by *4.4%*
b. 5–9 employees increased by *34.7%*
c. 10–19 employees increased by *52.9%*
d. 20–49 employees increased by *28.3%*
e. 50–99 employees increased by *29.4%*
f. 100+ employees increased by *125.0%*

On an individual state basis;

1. The percent increase in the total number of dental establishments ranged from 4.5% in the State of Arkansas to 39.7% in the State of Alaska.
2. 12 states (Connecticut, Delaware, Idaho, Maine, Massachusetts, Nebraska, New Hampshire, New York, Oklahoma, Rhode Island, Vermont and Wisconsin) had actual *decreases* in the number of dental establishments with 1–4 employees.
3. The percent increase in the number of dental establishments with 5–9 employees ranged from 4.8% in the District of Columbia and 17.6% in the State of Tennessee to 89.1% in the State of Vermont.
4. The percent increase in the number of dental establishments with 10–19 employees ranged from 1.3% in the State of Arizona to 233.3% in the State of Montana and 266.7% in the District of Columbia.

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Table I. Number of dentists and percent change in number of dentists per 100,000, personal income and expenditures for dental services by geographic location: 1979 to 1982[6,7]

Region	Dentists per 100,000 1982	Percent Change		
		Dentists per 100,000 1979–1982	Personal Income* 1980–1982	Expenditures Dental Services 1980–1982
United States	54.8	4.9%	3.6%	26.3%
Northeast (N. England, Mid. Atlantic)	66.2	3.2	4.0	27.9
Mid West (E.N. Central, W.N. Central)	53.5	6.8	−4.0	22.3
South (S. Atlantic, E.S. Central, W.S. Central)	45.0	6.4	6.6	25.7
West (Mountain, Pacific)	60.8	3.6	4.1	29.7
Section				
New England (ME, NH, VT, MA, RI, CT)	65.7	2.3%	4.9%	28.2%
Mid. Atlantic (NY, NJ, PA)	66.4	3.8	3.6	27.9
E.N. Central (OH, IN, IL, MI, WI)	53.4	7.2	−1.5	22.5
W.N. Central (MN, IA, MO, ND, SD, NB, KS)	53.7	5.3	2.5	21.6
S. Atlantic (DE, MD, DC, VI, WV, NC, SC, GA, FL)	47.6	4.8	5.7	24.3
E.S. Central (KY, TN, AL, MS)	42.6	10.9	2.1	21.0
W.S. Central (AR, LA, OK, TX)	42.6	7.3	10.1	30.6
Mountain (MT, ID, WY, CO, NM, AZ, UT, NV)	54.1	5.7	6.4	31.9
Pacific (WA, OR, CA, AK, HI)	63.3	3.1	3.3	29.1

*Constant dollars

5. The percent change in the number of dental establishments with 20–49 employees ranged from a decrease of 66.7% in the State of Kansas to an increase of 400.0% in the State of Texas.
6. There were minor numeric changes in the number of dental establishments with 50–99, and 100 and over employees. In 1980 and/or 1984, the larger dental establishments were located in 27 states. In six states (Arkansas, New Hampshire, Oklahoma, Pennsylvania, Tennessee, and Washington), there was a decrease in the number of these larger establishments. (Table II)

Use Of Dental Services

The reported number of dental visits per person (non-institutionalized population) in the United States increased from 1.6 visits in 1978 to 1.8 in 1983.[9] But the numbers of dental visits were not uniform throughout the country. They ranged from 1.5 visits per person in the South, to 2.3 in the Northeast, and 1.6 in non-metropolitan statistical areas to 2.0 in metropolitan statistical areas (MSA's). Similarly, while 51.8 percent of the national population reported a dental visit in the past year, a smaller percent of the residents of the South and non-MSA's reported dental visits than their Northeast and MSA counterparts. Variations in the percent of the population that had *never visited a dentist* were reported by residents of the different geographic areas—the highest percent in the South (12.8%) and the lowest percent in the Northeast (8.8%). In addition, 11.5 percent of non-MSA residents, as compared to 10.4 percent of MSA residents had never visited a dentist. (Table III)

Dental Condition

Chronically the continuing need for dental services by the general population often has focused on the results from various national and local studies which report oral conditions as observed by *trained personnel.* The National Center for Health Statistics, in its annual report from the National Health Interview, provides another perspective on dental needs and demand.* This series of reports on acute conditions** is based upon the perceptions of *lay respondents.*

Such an evaluation, to a greater or less degree, is subjective in nature and may be based upon economic, cultural, levels of education, and related factors. However, the use of these subjective evaluations does provide an opportunity to review the need and demand for dental services from the prospective of the individual(s) who will be requesting the dental services. And further, using National Health Interview Survey data permits a review of some of

*Generally, *need* is defined as a biological and psychological state of health as perceived by trained health personnel. However, for purposes of the National Health Interview Survey, need is defined in terms of the respondent's perceptions. A *demand* is related to market behavior as related to consumer wants, prices of health services, prices of other goods and financial resources.

**A condition is considered acute if a) it was first noticed no longer than 3 months before the reference date of the interview and b) it is not a condition that is considered chronic regardless of the time of onset.[8]

Table II. Number of dental establishments in 1984 and percent change between 1980 and 1984 (the weeks that included March 12); number of employees per establishment and percent change between 1980 and 1984 by state[9]

State	Total Number Establishments		Number Of Employees											
			1–4		5–9		10–19		20–49		50–99		100+	
	1984	Percent change	1984	Percent change	1984	Percent change	1984	Percent change	1984	Percent change	1984	Percent change	1984	Percent change
			Number of establishments											
Alabama	1,246	15.3%	769	5.8%	418	32.7%	58	52.6%	1	0.0%				
Alaska	190	39.7	96	21.5	86	68.6	8	60.0	0	1*				
Arizona	1,194	29.4	751	20.2	354	63.1	74	1.3	15	275.0				
Arkansas	741	17.4	502	9.4	212	38.6	24	33.3	3	200.0	0	4*		
California	13,020	17.1	7,969	8.7	4,028	32.3	875	41.3	123	19.4	17	6.3%	8	100.0%
Colorado	1,695	19.1%	1,123	8.1%	487	42.8%	76	90.0%	7	133.3%	2	0*		
Connecticut	1,615	10.8	977	− 4.0	505	41.5	116	58.9	17	70.0				
Delaware	205	12.6	92	− 4.2	84	31.2	25	31.6	4	33.0				
Dist. Col.	335	8.4	248	3.8	65	4.8	22	266.7	0	2*				
Florida	4,106	22.6	2,349	11.8	1,398	34.2	300	66.7	52	108.0	5	400.0%	2	0*
Georgia	1,933	19.0%	1,065	1.2%	695	46.9%	158	79.5%	15	36.4%				
Hawaii	516	21.4	289	17.9	178	23.6	39	21.9	10	150.0				
Idaho	428	7.5	264	− 5.0	126	28.6	33	83.3	4	0.0				
Illinois	4,437	12.5	2,846	5.3	1,223	25.1	329	43.0	36	20.0	3	0.0%		
Indiana	2,022	13.6	1,306	3.7	602	36.5	99	47.8	14	7.7	1	0*		
Iowa	1,174	10.8%	778	3.6%	313	24.2%	75	56.3%	7	−12.5%	1	0.0%		
Kansas	982	15.7	639	3.6	284	42.7	54	134.8	3	−66.7	2	100.0%		
Kentucky	1,276	18.7	961	15.5	267	29.6	46	31.4	2	0.0				
Louisiana	1,434	16.5	926	3.0	417	47.9	85	93.2	5	−16.7	1	0*		
Maine	402	8.1	261	− 9.3	118	76.1	22	37.5	1	0.0				
Maryland	1,872	17.9%	1,150	7.7%	553	35.9%	148	46.5%	19	72.7	2	100.0%		
Mass.	2,798	5.2	1,717	− 9.9	858	38.6	188	66.4	35	84.2				
Michigan	4,156	12.4	2,275	4.5	1,487	21.5	345	32.7	44	33.3	3	0.0%	2	0*
Minnesota	1,930	12.4	1,088	2.2	654	33.2	157	17.2	29	20.8	2	−33.3%		
Mississippi	712	19.3	490	9.8	192	41.2	27	92.8	3	200.0				
Missouri	1,927	12.3%	1,281	5.0%	538	34.2%	98	20.9%	8	−38.5%	2	100.0%		
Montana	413	10.4	285	3.6	117	24.5	10	233.3	1	−50.0				
Nebraska	676	4.5	458	− 5.8	183	39.6	30	7.1	5	150.0				
Nevada	391	26.9	203	23.0	162	37.2	23	4.5	3	0.0				
N. Hampshire	441	12.8	260	−13.6	147	86.1	32	220.0	2	8*	0	1*		

*Number in 1980

Table II. Number of dental establishments in 1984 and percent change between 1980 and 1984 (the weeks that included March 12); number of employees per establishment and percent change between 1980 and 1984 by state[9] (Continued)

State	Total Number Establishments		Number Of Employees											
			1–4		5–9		10–19		20–49		50–99		100+	
	1984	Percent change	1984	Percent change	1984	Percent change	1984	Percent change	1984	Percent change	1984	Percent change	1984	Percent change
			Number of establishments											
N. Jersey	3,350	13.4%	2,244	1.4%	1,019	33.9%	248	74.6%	33	266.7%	4	100.0%	2	0.0%
N. Mexico	480	18.5	274	4.2	167	50.5	36	24.1	3	50.0				
N. York	8,166	9.2	5,681	− 0.5	1,993	35.3	444	72.1	44	15.8	3	0*	1	0*
N. Carolina	1,949	13.2	1,137	2.2	692	30.3	109	57.9	11	37.5				
N. Dakota	256	12.3	175	6.7	64	20.8	15	50.0	2	100.0				
Ohio	4,301	12.1%	2,649	0.8%	1,313	33.4%	297	53.9	38	31.0%	3	0.0%	1	0.0%
Oklahoma	1,147	20.7	768	−10.9	326	43.6	49	63.3%	4	0*	0	1*		
Oregon	1,598	10.7	1,009	3.3	518	25.1	67	48.9	2	−66.7	2	100.0%		
Puerto Rico	419	22.9	387	20.2	25	56.3	6	200.0	1	0.0				
Pennsylvania	4,657	14.8	3,056	2.8	1,251	46.1	301	50.5	48	84.6	0	2*	1	0*
Rhode Island	376	9.6%	231	−10.8%	108	74.2%	34	88.9%	3	−25.0%				
S. Carolina	998	23.5	640	16.4	302	42.5	49	22.5	6	0.0	1	0.0%		
S. Dakota	260	15.5	177	6.6	66	37.5	14	27.2	2	200.0				
Tennessee	1,809	12.5	1,278	9.5	448	17.6	74	39.6	9	50.0	0	1*		
Texas	5,545	20.8	3,629	10.3	1,629	38.3	254	122.8	30	400.0	3	50.0%		
Utah	887	20.2	639	7.8	228	70.1	18	100.0	2	0.0				
Vermont	226	11.3%	144	− 7.1%	70	89.1%	10	0.0%	2	100.0%				
Virginia	2,207	17.1	1,424	5.1	642	50.4	129	44.9	11	−15.3	1	0*		
Washington	2,568	12.1	1,442	4.6	945	18.1	172	72.0	9	−10.0	0	1*		
W. Virginia	571	11.5	390	2.1	146	37.3	30	36.4	4	100.0	1	0*		
Wisconsin	2,225	11.3	1,292	− 0.5	728	30.9	181	61.6	17	−41.4	7	250.0%		
Wyoming	215	22.1	134	5.5	72	75.6	9	12.5						
United States	98,258	14.7%	61,381	4.4%	29,478	34.7%	6,116	52.9%	749	28.3%	66	29.4%	18	125.0%

*Number in 1980

Table III. Number of dental visits per person and interval since last dental visit by geographic region and place of residence: 1983*[10]

	Visits Per Person	Interval since last dental visit: Less Than 1 Year	2 Years Or More	Never Visited
Region		Percent of Population		
Northeast	2.3	57.0	20.6	8.8
Midwest	1.8	54.7	23.0	9.2
South	1.5	46.0	26.8	12.8
West	2.0	52.7	22.6	11.4
United States	1.8	51.8	23.7	10.8
Place of Residence				
MSA**	2.0	53.7	22.0	10.4
Non-MSA	1.6	48.0	27.2	11.5

*Based on household interviews of a sample of the civilian non-institutionalized population
**Metropolitan Statistical Area

the consequences of dental disease—specifically, restricted activity, bed days and loss of school days.

In 1985, almost four million acute dental conditions were reported, with residents of the states in the Southern and Western regions, and central cities of MSA's reporting a greater number of acute conditions per 100 persons.* In addition, a greater percent of the acute dental conditions were treated in the Western region and the non-central city parts of MSA, than were the acute dental conditions of residents in other geographic counterparts. (Table IV)

Restricted Activity Days

In 1985, over 11 million restricted activity days** associated with acute dental conditions were reported, with residents in the Southern region and central cities

*It should be noted that, in many instances, the ratio and percent data (e.g. acute dental conditions per one hundred persons and percent of acute conditions treated) used in the National Health Interview Survey report, have relative standard errors in excess of 30% and therefore, should be used with extreme caution. The relative standard error of an estimate is obtained by dividing the standard error (i.e. primarily a measure of sampling variation) by the estimate itself and is expressed as a percent of the estimate.[8]

**Refers to a relatively short-term reduction in a person's activities below his or her normal capacity.[8]

Table IV. Total number of ACUTE DENTAL CONDITIONS, number per 100 persons and percent treated by geographic region and place of residence: 1985[8]

	Total Number	Number Per 100 Persons	Percent of Conditions Treated
	(thousands)		
Region			
Northeast	520	1.0*	26.5*
Midwest	1,019	1.7	34.1*
South	1,564	2.0	26.7*
West	891	2.0*	63.3*
United States	3,994	1.7	36.7
Place of Residence			
All MSA	3,162	1.8	37.0
Central City	1,613	2.2	30.8*
Not Central City	1,549	1.5	43.4
Non-MSA	832	1.5*	35.8*

*Relative standard error of more than 30%

of MSA having more restricted days per 100 persons than their counterparts in other geographic regions. (Table V)

Number Of Bed Days

In 1985, over four million bed days*** associated with acute dental conditions were reported. Once again, residents in the Southern region and central cities of MSA's reported more bed days per 100 persons than their counterparts in other geographic regions. (Table VI)

***A day during which a person stayed in bed more than half of a day because of illness or injury.[8]

Number Of School Days Lost

Dental conditions impact on school attendance. In 1985, school age children missed more than 1.7 million school days* as a result of conditions associated with acute dental conditions. Again, residents of the states in the Southern region and central cities of MSA's reported more school-loss days per 100 persons than their counterparts in other geographic regions. (Table VII)

Number Of Work Days Lost

Almost four million lost days of work** associated with acute dental conditions were reported for 1985. Residents of the states in the Midwest region reported more work-loss days per 100 persons than their counterparts in other geographic regions. (Table VIII)

Overview

The need and demand for dental services, and consequences of dental disease have been reviewed repeatedly in terms of family income, education of family members, age, gender, race and any number of other social, cultural

*A day on which a student 5–17 years of age missed more than half a day from school in which he or she was enrolled.[8]

**A day on which a currently employed person 18 years of age and over missed more than half a day from a job or business.[8]

Table V. Total number and number per 100 persons of RESTRICTED ACTIVITY DAYS associated with acute dental conditions by geographic region and place of residence: 1985[8]

	Total Number	Number Per 100 Persons
	(thousands)	
Region		
Northeast	1,636	3.3*
Midwest	2,830	4.8*
South	4,710	5.9*
West	2,205	4.9*
United States	11,381	4.9
Place of Residence		
All MSA	9,315	5.2
Central City	4,782	6.6*
Not Central City	4,534	4.2*
Non-MSA	2,066	3.8*

*Relative standard error of more than 30%

Table VI. Total number and number per 100 persons of BED DAYS associated with acute dental conditions by geographic region and place of residence: 1985[8]

	Total Number	Number Per 100 Persons
	(thousands)	
Region		
Northeast	534	1.1*
Midwest	1,090	1.9*
South	2,026	2.5*
West	447	1.0*
United States	4,097	1.8*
Place of Residence		
All MSA	3,517	2.0*
Central City	2,140	2.9*
Not Central City	1,377	1.3*
Non-MSA	580	1.1*

*Relative standard error of more than 30%

and related factors. In addition, review of the status and consequences dental disease on a geographic basis can provide necessary information to evaluate the outcome of efforts to increase the numbers of dental practitioners, increase the use of services (e.g. in the Southern region) and response to continuing problems associated with dental disease.

The review of developments in practice configurations, in terms of geographic variables, is of equal importance. Such an effort provides an opportunity to monitor the profession's reactions to the factors impacting on delivery arrangements.

The changes that practitioners observe in their local communities can be threatening and misunderstood. Yet national changes seem too far removed from the particular environment of individual practices. By reviewing these developments on a county (annual data on practice finances and employment are available for each county in the nation[9]), state, section and regional basis, a more rationale understanding and response by individual dentists may be possible. △

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Table VII. Total number and number per 100 youths (5–17 years of age) with SCHOOL-LOSS DAYS associated with acute dental conditions by geographic region and place of residence: 1985[8]

	Total Number	Number Per 100 Persons
	(thousands)	
Region		
Northeast	355	4.0*
Midwest	392	3.4*
South	815	5.2*
West	163	1.9*
United States	1,725	3.9*
Place of Residence		
All MSA	1,385	4.1*
Central City	720	5.6*
Not Central City	665	3.2*
Non-MSA	340	3.1*

*Relative standard error of more than 30%

Table VIII. Total number and number of days per 100 employed persons (18 years and over) with WORK-LOSS DAYS associated with acute dental conditions by geographic region and place of residence: 1985[8]

	Total Number	Number Per 100 Persons
	(thousands)	
Region		
Northeast	401	1.7*
Midwest	1,675	6.2*
South	1,297	3.6*
West	540	2.5*
United States	3,913	3.6*
Place of Residence		
All MSA	3,004	3.5*
Central City	1,109	3.4*
Not Central City	1,895	3.7*
Non-MSA	910	4.0*

*Relative standard error of more than 30%

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Gies Award Outstanding Editorial for 1986

"TELLING IT LIKE IT IS"

Daniel M. Laskin*

Malpractice litigation, which only a decade ago was a rather infrequent occurrence, has now continued to increase at such an alarming rate that what once appeared to be a small ice floe has now turned into an iceberg about to sink the Titanic. Those involved often tend to place the blame for this situation on unscrupulous attorneys seeking to profit from easily earned contingency fees. The ratio of malpractice cases filed to those in which there is judgment for the plaintiff seems to support the contention that many lawyers do file such suits without fully investigating the legitimacy of the complaints, hoping that the insurance carrier will find it more economical to settle the case than to go to trial. The recent rash of articles, books, and seminars dealing with dental negligence and how to identify it also indicates that many trial lawyers who traditionally have concentrated on medical malpractice now have suddenly found a new and untapped resource. To blame the problem solely on the legal profession, and to seek its solution merely through tort reform, however, is not being realistic. We also have to understand why the public has become more litigious and deal with this aspect of the problem as well, as lawyers obviously would not be filing suits unless requested by the patients.

One of the major factors contributing to the increase in litigation has been the growth of consumerism in our society. As a result, we have been placed in the same category as nonprofessional providers of services, and the public now has expectations of the oral and maxillofacial surgeon operating on the human jaw similar to those of the mechanic fixing an automobile; anything less than perfection is considered the basis for a potential malpractice suit. Even worse is the fact that substandard care is no longer the only issue; a significant number of cases now involve acceptable care that, in the opinion of the patient, failed to achieve the desired results. Such suits are defensible only on the basis of proper informed consent. It is therefore difficult to understand why, in some sectors, there is still resistance to taking whatever steps are necessary to deal with this issue. Perhaps the answer lies in a failure to understand fully what constitutes an acceptable informed consent and the consequences of not complying with the current legal standards.

In the strict sense, the theory of informed consent places upon the practitioner the obligation to advise patients in lay terms of all the pertinent risks of a proposed course of treatment so that a reasonable decision can be made about whether to proceed. Although there is no consensus about what might be considered too minor or too remote a risk to be included, the fact that the ultimate decision may be made by a jury speaks for generally erring on the side of being overly inclusive. Informed consent, however, does not end with a discussion of potential risks. It also requires that the patient be fully informed of the diagnosis and the treatment options, as well as the likely results if the proposed treatment is or is not rendered. When elective surgery is contemplated, it is also particularly important that the patient understand that one alternative may be doing nothing.

It is unfortunate that we use the term "informed consent" to describe the process because too often the emphasis is placed on consent rather than on information. The patient has no way of knowing when he has been given sufficient information to make an appropriate decision, and just because he puts his signature on a piece of paper does not mean that it was adequate. We must constantly remind ourselves that our obligation is to properly inform; consent is merely the termination of the process, and it is only as good as the process itself.

When one fully understands the ramifications of proper informed consent, there can be no reasonable argument against any mechanism that implements its use. Without written documentation that potential risks and alternative procedures were fully discussed, most litigated cases, even when they involve acceptable therapy, are indefensible. In the past it was often said that what the patient doesn't know won't hurt him. Nowadays, it is more likely that what the patient doesn't know could end up hurting us. We have got to tell it like it really is!

*Daniel M. Laskin, DDS, Editor of the Journal of Oral and Maxillofacial Surgery

Gies Award Honorable Mention Editorial for 1986

THE POSITIVE SIDE

Michael A. Wong*

Why is it that everything that we hear nowadays about dentistry is negative? Not only from the public, the media, but we hear it also from our own colleagues. I recently read another society's newsletter and found a "members opinion" column. The question posed read something like this: Would you recommend dentistry to someone considering it as a profession? I was surprised to see that most of the responses were of a discouraging nature. The reasons given reflected the growing negativity that I have seen. "Escalating malpractice" and "too many dentists" are just a sampling of the factors that many feel are leading to the decline of the profession.

These factors, I feel, are simply excuses that individuals fall upon to cover-up their own shortcomings and failures. Dentistry is subject to a constantly changing market like any other business. Dentists must be flexible enough to adapt to these fluctuations. Don't get into a rut and expect patients to automatically knock at your door. The field is more diverse than it has ever been and the opportunity for success is just as real. You need to use this diversity to your advantage and if need be, become as diverse as your market. Not everyone is cut out to be a dentist though! If you find yourself using excuses for lack of work, etc., perhaps you should take a closer look at yourself and your practice. Re-evaluation may be in order.

Dentistry, to me, is a fantastic profession and I would recommend it wholeheartedly to almost anyone. I can be just as negative as the next person, but I feel strongly positive above dentistry. Of course there are down sides to the profession, but they are known to all and won't be discussed here. I would like to simply elaborate on what I feel are the positive aspects. I derive a great deal of satisfaction from serving the needs of people who appreciate it. Helping others is great, but there is a certain void left if your efforts are not acknowledged. My whole day is lifted when a grateful patient pays me a compliment. When that occurs, doesn't that give you a whole different outlook? These boosts now and then make it all worthwhile.

I enjoy the independence that is possible with the profession. The independence that I'm talking about is the freedom afforded an individual by being "the boss". Whether a sole proprietor, a partner or whatever, once that level is attained the feeling is unique. For the lack of a more descriptive word, the feeling of power or controlling one's future is exciting to me. To some it may prove maddening, but most of us thrive on it. This flexibility is translated into many different facets of practice. To put it simply, financial freedom is one. The opportunity is available to be as successful as you wish. The formulas may vary, but to those with insight the possibilities are great. Success may not be as widely and easily attainable as in the past, although our average incomes still continue to rise.

The flexibility allowed by the practice of dentistry in the traditional sense is prime reason to pursue this type of career. Depending on an individual's preference and needs, one could establish his or her practice to those needs. If you want to work five days a week, fine. If three days a week are enough for you, that's fine also. The possibilities are limitless . . . you could work full time throughout the year and only part-time during ski season, for example. Your style and type of practice could be easily tailored to your lifestyle. The financial freedoms make this individuality even easier to attain. To maintain your own lifestyle, you simply practice as much or as little as you prefer. Flexibility means freedom.

Someone once told me that the three reasons you are in practice should be: 1) To serve the needs of others 2) To make a living and 3) To have fun. I feel that the practice of dentistry gives you all of these and more. The next time the "negatives" or the "doomsday prophets" get you down, take a step back and consider all the positive and fantastic aspects of our profession

*Michael A. Wong, DDS, Editor of the Mouthpiece, San Mateo County Dental Society.

Gies Award Honorable Mention Editorial for 1986

ADVOCATES OF DESTRUCTION

Robert Brundin*

There is something especially wrong with our judicial system. A system that was developed with exquisite care to provide justice for all; has, instead, become the playground of the short-sighted and greedy.

An ultimate conflict of interest has unfolded as attorneys, throughout the years, revised the body of law in such a way as to satiate their own prurient self-interest.

Now, unfortunately, that great body called the 'silent majority' has been drawn into the game of grasping for the financial resources of others, of 'nicking strangers' for an extra hundred thou' or so. After all, who can it hurt?

The cancer has even 'made it' on prime time TV, eg., "Had an accident? Let us explore the problem for you, to see if you've been 'wronged'. There's no sacrifice. No inconvenience. No cost to you. All fees will simply be deducted from the settlement." (And what large fees!)

When I was a boy I used to go down to the park a few blocks from home. The park was built in a small valley with a lake and a small island at its center. By climbing the trees at one end, I could look all across that wondrous valley which by turns became a battlefield, or an Indian village. Or I could simply hang in my swaying tower and survey my magic domain.

If I had fallen in those days and broken my arm, my folks would have shown concern, scolded me for my carelessness, taken me to a doctor, and paid the bill.

In case you haven't noticed, children aren't allowed to climb trees anymore; because an accident is an excellent opportunity for a few folks to make a lot of money . . . and for a lot of us to lose more than we would believe imaginable.

A mistake is something else again. It pays off far more handsomely than a simple accident.

Is this possible? Someone's misfortune being turned for a profit? A mistake driving someone who has lead a good life to poverty and, perhaps, destruction?

Is this the America that was built on legal precepts and concepts for the good of all of its citizens?

Portions of the law profession have become wretched ghosts of their intended selves, branching out, not only into the mass media, but also extending their greedy fingers to the farthest corners of the earth to hope for a 'killing' because of others' misfortunes. Is there any wonder why we question the law profession's integrity?

A significant number of 'professionals' have promoted greed as an acceptable mode of settling differences.

Unfortunately, this legalized grabbing is, perhaps, the most significant threat to the concept of responsible freedom extant in America; and without responsible freedom, a democratic society cannot survive. When 'responsible' is removed from 'freedom' only anarchy remains.

So the fact that one in four dentists were sued last year has far greater implications than paying higher insurance premiums. As debauchery was with the Romans, so greed is becoming the societal sickness of America; and kids should be free to climb trees.

*Robert Brundin, DDS, Editor Harbor Dental Log, Harbor Dental Society, California.

SENIOR DENTAL STUDENTS IN PRIVATE PRACTICE: A PRECEPTORSHIP PROGRAM

Robert W. Comer*
James C. Brown**
Michael J. Reed***
D. Wayne Sturdivant****

For several years, dental educators and community dentists have recognized the value of providing students with clinical training and supervised experiences in extramural settings. Generally, such preceptorship experiences are intended to achieve several major goals: (a) to give dental students the opportunity to observe and participate in "real world" clinical experiences, (b) to provide insight into the professional and personal aspects of private practice, (c) to demonstrate and hopefully reinforce the value of a career in general dentistry, (d) to improve clinical skills and (e) to provide confidence and consequently some ease of transition to private practice from dental school. The preceptorship literature in dentistry includes several reports of efforts to achieve these goals.

Rosenstein and colleagues described a program in which students were assigned to community clinics structured to simulate the private practice experience. They recognized that students needed reinforcement in applying their theoretical knowledge and training in the fundamentals of practice management. They suggested that "... community dentistry clinics can be effective laboratories for practice management if student participation is encouraged at all levels of decision making."[1] Heise and colleagues reported on an extramural preceptorship program at the University of Kentucky School of Dentistry which focused primarily on increasing students' clinical competence. In addition, they noted that such extramural experiences provide opportunities to learn and absorb facts of professional life and practice that are difficult to present in an academic environment.[2] Shapiro and Hamby noted that the extramural preceptorship had the benefit of serving as a vehicle for encouraging students to practice in underserved areas.[3] Heitke, in reporting on Marquette University's extramural clinical program, pointed out major service benefits to patients treated by students.[4] Caine reported advances in modifying social attitudes of students who worked in preceptorship settings in the Department of Institutions and Agencies in New Jersey.[5] These reports and others suggest that a variety of benefits may be realized from preceptorship programs, and the accomplishments vary according to the purpose and structure of each program.

Recognizing the need for a more uniform or consistent preceptorship experience, the American Association of Dental Schools (AADS) staff approved and forwarded guidelines to the American Dental Association Council on Dental Education. Subsequently, the curricular guidelines for extramural programs were published. These guidelines recognized four types of extramural programs: (a) dental specialties, (b) extramural assignments in the community, (c) institution-based programs, and (d) private practice (preceptorship) assignments. In 1980 the program objectives and guidelines were out-

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lined and approved by the Commission on Dental Accreditation for each of these four program types.

The purpose of this paper is to describe a private practice preceptorship program at the University of Mississippi School of Dentistry. The program was developed initially as a pilot project and later introduced into the curriculum as a component of a schoolwide senior elective program. The evaluation of the pilot phase resulted in the development of a reliable evaluation instrument to provide input from both the student and preceptor on pivotal issues relating to the program. Further, the development served as an excellent example of a cooperative effort between a dental school and colleagues in private practice.

Preceptorship Model

Alumni survey data and comments from dental association officers indicated an opportunity to expand the curriculum to supplement the theoretical practice management courses with applied experiences. Because of a general awareness of potential benefits, a private practice preceptorship program was developed at the University of Mississippi. The program was co-sponsored by the Mississippi Dental Association and was designed for senior dental students. The purpose was to provide students with an experience in private practice management to complement their traditional theoretical course in school. The preceptorship was first offered as a pilot program in the Spring Quarter of 1982. The pilot nature of the program was continued for three years with ongoing assessment, review, and evaluation. In the 1985–1986 academic year, the extramural preceptorship was offered as an elective to all senior students as a standard component in the curriculum.

The preceptorship rotation was scheduled for two weeks. Students worked with an assigned preceptor who had volunteered and had been recommended by the Mississippi Dental Association. Following approval by the School of Dentistry and official appointment to the faculty, preceptors were eligible to teach students in their offices. Preceptors received no reimbursement for their services. Students received elective credit toward graduation for the experience. They could elect to extend the rotation beyond two weeks or to select an additional rotation with a different preceptor.

The major goals of Mississippi preceptorship experience were to provide the opportunity for students to: (a) learn about the practical management and operation of a private practice, and (b) gain additional clinical experience by observing and participating in all practice activities in a private setting. It was also anticipated that the experience would facilitate the students' transition from academic dentistry to the private practice environment. Because of the diverse nature of the various preceptors' dental practices, preceptors were provided general guidelines rather than specific objectives for directing students' activities. These guidelines were that preceptors:

(a) conduct an orientation on office procedures and personnel policies in their practice;
(b) assist students in acquiring information and skills in management of a dental practice including appointments, inventory control, accounting controls, recall systems, and personnel management;
(c) allow the students to assist and observe a variety of clinical procedures;

(d) supervise the clinical patient care by students;
(e) assist students in becoming familiar with the dental profession through introductions to colleagues and invitations to appropriate society meetings, study clubs, and discussions; and
(f) evaluate the students and the course.

After discussion with the students, preceptors decided which treatment services the student would provide and the extent to which he/she would provide primary care. The decision was based on the preceptors patient flow, availability to supervise, personal philosophy, and patients' informal consent.

Evaluation

The program has completed its fourth year. An increasing number of students electing to take the preceptorship rotation each year and the number of dentists volunteering to serve as preceptors as well as preliminary evaluation data all indicate the success of the program. Questionnaires were administered and analyzed to assess scope and content of the preceptorship experience, the objectives, the impact of the program on students and preceptors, and the problems and opportunities of the program. The questionnaires were distributed to students and preceptors immediately following a student's completion of the private practice rotation. The students' evaluation questionnaire contained a series of statements in four areas: (a) impact of the preceptorship experience on the student, (b) perceived effectiveness of the preceptor, (c) assessment of the office facility and staff, and (d) an overall evaluation of the extramural experience itself. Students were asked to respond to the statements using a 5-point scale.

The student responses were overwhelmingly positive for the 1982–86 evaluation period. The data represent responses from the 27 students who participated in the 1985–1986 academic year. As can be noted from Table 2, students perceived an improvement in their practice management knowledge, increased ability to work with auxiliary staff, increased self-confidence, and a more positive attitude towards dentistry as a career. Even more positive were students' evaluations of the effectiveness of their preceptors as noted in Table 2. Students indicated that the dentists accepted students as fellow professionals, were tactful, offered positive reinforcement, appreciated the student clinical inexperience, communicated clearly, and demonstrated techniques well. Students also evaluated office facilities and staff highly. Specifically, as shown in Table 3, the students reported that physical settings were attractive; the staff were helpful and positive; and, the facilities were up-to-date and facilitated learning. Finally, the students' overall evaluation of the preceptors' effectiveness as teachers and preceptorship program impact was positive. This can be seen in Table 4.

All of the participating preceptors completed evaluation questionnaires concerning student performance. The same 5-point scale (1 = definitely false, 5 = definitely true) was utilized to rate ten aspects of students' performance. Preceptors indicated that the students exhibited a willingness to learn and benefited from the experience, showed a cooperative and positive attitude, worked well with auxiliary staff, demonstrated industry and initiative, showed clinical competence, demonstrated good problem-solving skills, was "someone I would be willing to work with as an associate in practice", demonstrated effective interviewing

Table 1. Student Evaluation of Preceptorship Experience

Item	Mean Response*
Clinical skills have improved.	4.1
Practice management knowledge improved.	4.4
Increased ability to work with auxiliary staff.	4.4
Increased self-confidence.	4.5
Improved attitude towards dentistry as a career.	4.7

*Responses are on a five-point scale: 1 = definitely false; 5 = definitely true.

Table 2. Students' Evaluation of Preceptor Effectiveness

Item	Mean Response*
The preceptor accepted me as a professional.	4.9
The preceptor was tactful in dealing with me.	4.9
The preceptor was available when needed.	4.9
The preceptor was willing to answer questions.	4.9
The preceptor was interested in me as an individual.	4.9
The preceptor offered positive reinforcement.	4.9
The preceptor appreciated my clinical inexperience.	4.4
The preceptor communicated ideas and information clearly.	4.8
The preceptor gave clear, helpful suggestions.	4.7
The preceptor demonstrated techniques well.	4.8

*Responses are on a five-point scale: 1 = definitely false; 5 = definitely true.

Table 3. Students' Assessment of Office Facility and Staff

Item	Mean Response*
The physical setting of my preceptorship was attractive and pleasant.	4.7
The office staff members were positive and helpful.	4.9
Equipment and facilities were up-to-date and facilitated my learning.	4.5

*Responses are on a five-point scale: 1 = definitely false; 5 = definitely true.

Table 4. Students' Overall Evaluation of Preceptor and Preceptorship

Item	Mean Response*
The preceptor's general effectiveness as a teacher.	4.7
The value of the preceptorship experience as a whole.	4.7

*Responses are on a five-point scale: 1 = Poor; 5 = Excellent.

Table 5. Preceptors' Evaluation of Student Performance

Item	Mean Response*
The student exhibited willingness to learn and perceived the preceptorship as a positive experience.	4.9
The student exhibited industry and initiative.	4.7
The student demonstrated effective interviewing and communication skills.	4.4
The student demonstrated knowledge and expertise in office management procedures.	4.0
The student worked well with auxiliary staff.	4.8
The student showed competency in clinical dentistry.	4.6
The student was cooperative and exhibited a positive attitude.	4.9
The student was decisive in making clinical judgments.	4.3
The student demonstrated good dental problem solving skills.	4.6
The student is someone I would be willing to work with as an associate in practice.	4.5

*Responses are on a five-point scale: 1 = definitely false; 5 = definitely true.

and communication skills, made decisive clinical judgments, and demonstrated knowledge and expertise in office management procedures.

Discussion

Data indicated that the private practice preceptorship experience in Mississippi was successful in providing a positive learning experience for senior dental students. In follow-up discussions with students, they expressed enthusiasm for what was perceived as a valuable opportunity to gain clinical experience, to observe practical staff and office management skills, and to increase awareness and appreciation of the private practice of dentistry. The timing of the preceptorship, i.e., during the senior year, seems especially appropriate in terms of the motivation and confidence provided to students.

Specific evaluation comments by students and preceptors alike have been useful in highlighting both strengths and deficits of the program. A key to a successful preceptorship program of this type is that the practicing dentists who volunteered as preceptors found the experience rewarding and perceived it as important. To date, the program goals are being met as assessed by evaluation data and the increasing number of both preceptors and students who desire to participate.

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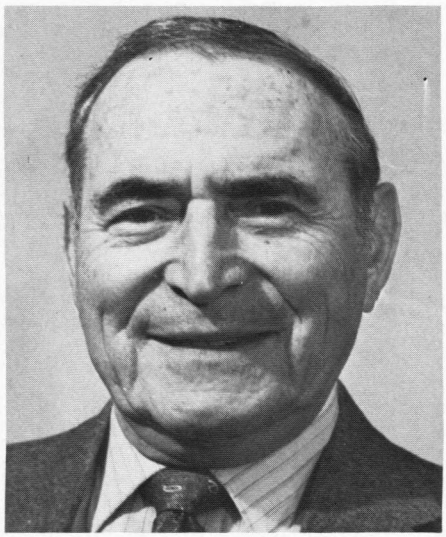
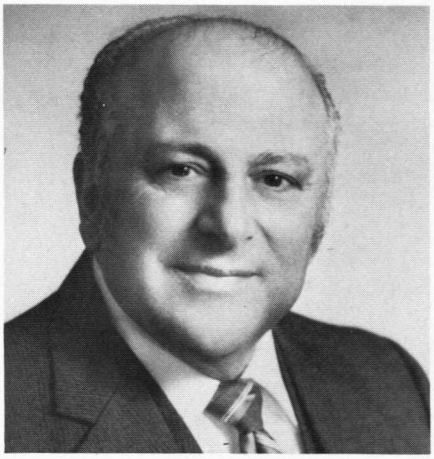
NEWS OF FELLOWS

Abram I. Chasens was recently honored by the Alumni Association of Fairleigh Dickinson University with the presentation of the 1987 Great Teacher Award. The award is presented annually to a member of the faculty for long-term excellence in teaching, scholarly achievement and overall service to the University and community. Dr. Chasens' teaching career at Fairleigh Dickinson University spans nearly 3 decades and he presently serves as professor and chairman of the Department of Periodontics. Dr. Chasens was earlier honored by the American Academy of Periodontology and presented a gold medal and a check for $1,000 in recognition of outstanding contributions to the field of periodontology.



Abram I. Chasens

Anthony J. Cuzenza, was recently installed President of the California Dental Association. A graduate of Loyola University School of Dentistry, Dr. Cuzenza practices in Modesto, California and was the recipient of the California State Senate resolution for service to the dental profession in 1983.



Anthony J. Cuzenza

John F. Nelson, Professor and Chairman of the Department of Oral Diagnosis and Radiology at Baylor College of Dentistry in Dallas, was appointed Assistant Dean for Clinical Affairs of the College. Dr. Nelson served in the U.S. Army Dental Corps for 19 years and was discharged with the rank of Colonel. Before joining Baylor in 1984, Dr. Nelson was a Professor at the University of Iowa where he was twice named "Instructor of the Year".

John F. Nelson

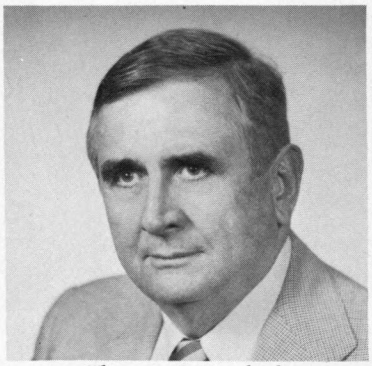
Charles K. Emery was recently named 1987 Distinguished Alumnus by the Baylor College of Dentistry Alumni Association. Dr. Emery, who is in private practice in Corpus Christi, has served as president of the Texas Academy of General Dentistry and the Texas section of the International College of Dentists and as vice president of the Texas Dental Association. He has received the Distinguished Service Award from the Texas Dental Association and the Dentist of the Year award from the Texas Academy of General Dentistry.

Charles K. Emery

Leon A. Leonard was recently named acting dean of the Medical College of Georgia School of Dentistry. Dr. Leonard joined the Medical College of Georgia School of Dentistry in 1969 and served as an associate professor of oral medicine and director of the oral diagnosis section. He also served as professor and chairman of the department of endodontics. Since 1975, Dr. Leonard has been associate dean for clinical services at the School of Dentistry.

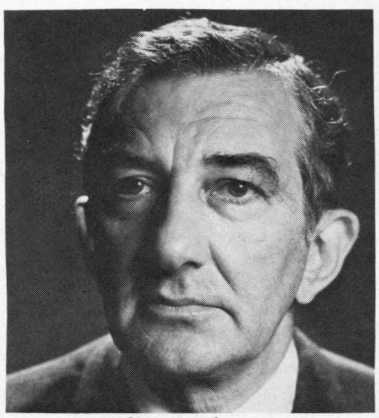
Leon A. Leonard

Thomas J. Murdoch was recently honored by being presented the "Dentist of the Year" award by the Oklahoma Dental Association. Dr. Murdoch received the award during the Association's 1987 annual meeting in Tulsa for his outstanding contributions to dentistry. Dr. Murdoch served as president of the Oklahoma County Dental Society in 1966. He has served as editor or advisory editor of the Oklahoma Dental Association Journal since 1979. He also developed and edited "Flight Watch", the official national publication of the Flying Dentists Association. Dr. Murdoch is in private practice in Oklahoma City.



Thomas J. Murdoch

Ashur G. Chavoor is presently serving as the U.S.A. Treasurer for the Federation Dentaire Internationale. Dr. Chavoor is a past president of the American Association of Orthodontists and a past trustee of the American Dental Association. He is presently the Assistant Dean for Graduate Education at Georgetown University School of Dentistry.

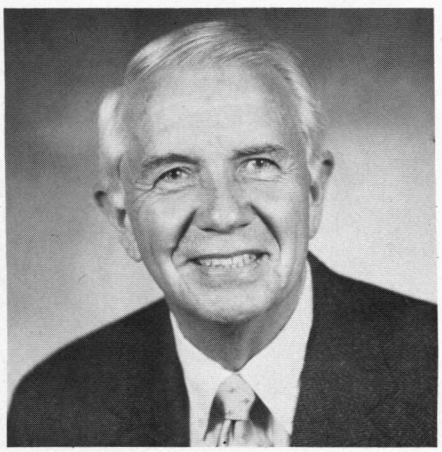


Ashur G. Chavoor

Charles J. Cunningham was recently installed president of the American Association of Endodontists in San Antonio, Texas. Dr. Cunningham is a Diplomate of the American Board of Endodontists and is presently the Assistant Dean for Clinical Affairs at the University of Kentucky College of Dentistry. He served in the U. S. Navy Dental Corps until 1977 when he retired and joined the faculty of the University of Kentucky.

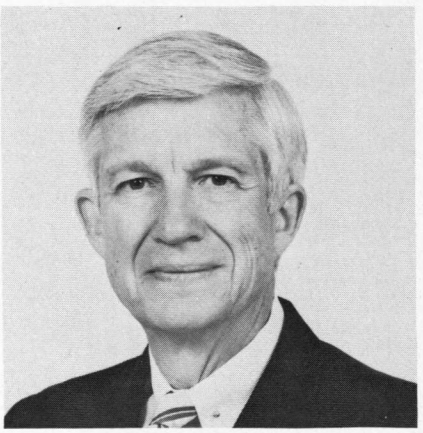
Charles J. Cunningham

Charles F. Rau was recently appointed Professor and Chairman of the Department of Oral Medicine and Periodontics at the University of Detroit School of Dentistry. Dr. Rau served in the U.S. Navy Dental Corps until 1972 when he retired with the rank of Captain. Before assuming his present position, he was on the faculty of the University of Florida College of Dentistry.



Charles F. Rau

Ralph V. McKinney has been awarded the Isaiah Lew Research Award for distinguished research in the field of dental and oral implantology by the American Academy of Implant Dentistry Research Foundation. Dr. McKinney who is the Professor and Chairman of the Department of Oral Pathology at the Medical College of Georgia was cited for his significant scientific achievements resulting in a greater understanding of the cellular reaction of oral tissues for dental implants.

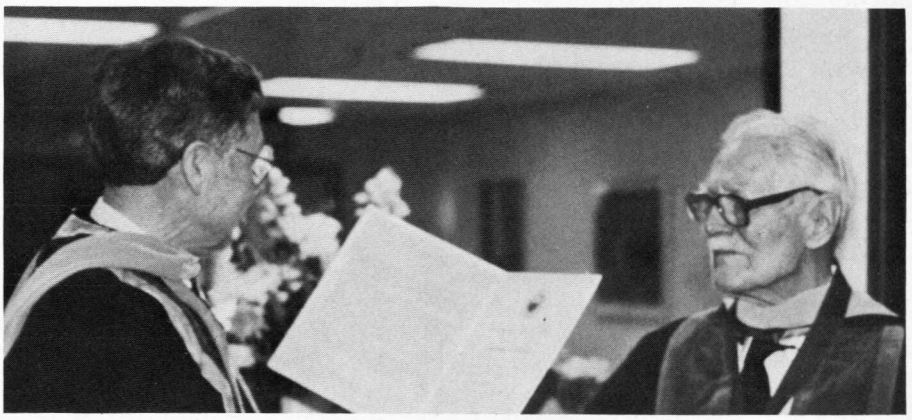


Ralph V. McKinney

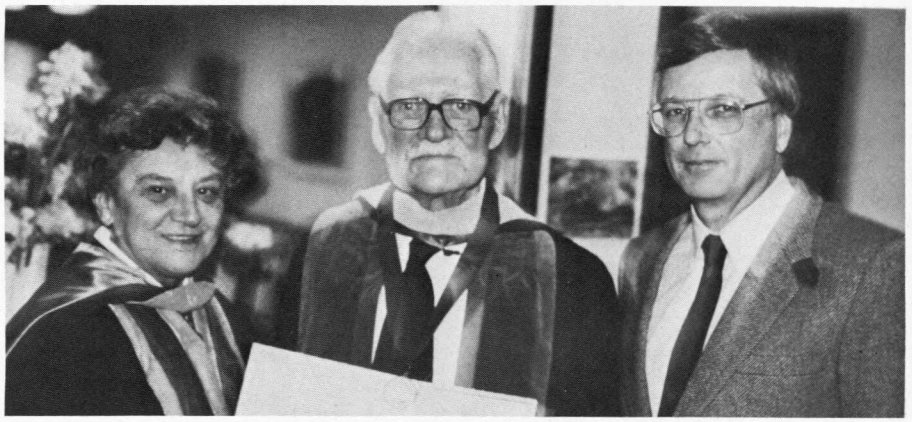
Gerald A. Larson was named the recipient of the 1987 Distinguished Alumnus in Dentistry Award by the Marquette University Dental Alumni Association. Dr. Larson, who is in private practice in Brookfield, Wisconsin, is presently the 9th District Trustee to the American Dental Association. He has served as the president of the Wisconsin Dental Association and received its Outstanding Service Award in 1972.

Gerald A. Larson

Raymond E. Johnson was recently presented the Distinguished Service Award of the American College of Dentists. The award presentation was made in St. Paul by Dr. Odin M. Langsjoen, past president of the College and the Secretary/Treasurer of the Upper Midwest Section. Also present were Dr. Anna Hampel and Dr. Eric Stafne, the chairman and past chairman, respectively, of the Upper Midwest Section. Dr. Johnson graduated from the University of Minnesota School of Dentistry in 1918 and after a tour of duty in the Army, joined the faculty at the University of Minnesota School of Dentistry, holding appointments as Instructor, Assistant Professor, Associate Professor and Professor of Periodontics over a period of 30 years. He served as the President of the American Academy of Periodontology in 1947.



Photographed making the presentation of the Distinguished Service Award to Dr. Johnson is Dr. Odin M. Langsjoen.



Drs. Anna Hampel and Eric Stafne photographed with Dr. Johnson.

Dr. Miles Markley photographed with Dr. Lawrence Meskin in front of the plaque outside the University of Colorado School of Dentistry's new Miles Markley clinic. Dr. Meskin served as the Dean of the University of Colorado School of Dentistry until June, 1987 and is presently the Dean of the Graduate School at the University of Colorado Health Sciences Center.

Miles R. Markley was recently honored by the University of Colorado School of Dentistry where a new dental clinic and a scholarship fund was named after him. Dr. Markley was honored for his high standards of professionalism and service. He graduated from the University of Denver School of Dentistry in 1927 and devoted the next 50 years to practicing dentistry, teaching and conducting extensive research. Dr. Markley has served as the President of the Colorado State Board of Dental Examiners, the Metropolitan Denver Dental Society and the Colorado State Dental Association. Dr. Markley has also received numerous awards for his extensive service to the dental profession.

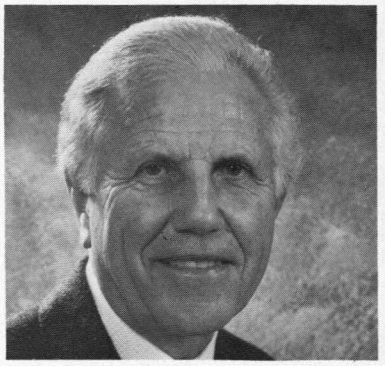
Walter C. McBride was recently honored by being presented the Distinguished Service Award of the American College of Dentists. The award was presented to Dr. McBride by Dr. Leslie B. Bell of West Palm Beach, Florida.

Dr. McBride has been a Fellow of the College for 53 years and was honored for his loyal and dedicated support of the goals of the College. Dr. McBride received his dental degree from the University of Michigan in 1922 and entered private practice in Detroit where he practiced and taught for 39 years. He was professor of pedodontics at the University of Detroit School of Dentistry from 1932 to 1949 and is a Diplomate of the Board of Pedodontics. He has published widely in numerous professional journals on pediatric dentistry and is the author of a textbook. He is a past president of the Michigan Society of Dentistry for Children and the American Association of Dental Editors. He was co-founder of the American Society of Dentistry for Children and also served as the president of the American Academy of Pedodontics.

Dr. and Mrs. Walter C. McBride in their home in Boca Raton, Florida, photographed with the award.

Edward F. Furstman of Los Angeles has been named the national chairman for the 1987 National Dentist Fund-raising Campaign being conducted by the American Fund for Dental Health. Dr. Furstman is coordinating the efforts of volunteer state chairpersons to solicit donations to the Fund which has a goal of $480,000 to support the many projects and programs of the Fund.

Judson C. Hickey was recently named Acting President of the Medical College of Georgia by the Board of Regents of the University of Georgia. Dr. Hickey established the Medical College of Georgia School of Dentistry in 1966 and, until recently, served as its Dean.



Judson C. Hickey

Dr. Rovelstad presents Award to Dr. Swanson

Henry A. Swanson was recently presented the Distinguished Service Award of the American College of Dentists. The award presentation was made at Dr. Swanson's residence in Bethesda by Dr. Gordon H. Rovelstad, Executive Director of the College. Dr. Swanson has been a Fellow of the College for 51 years and served as its president from 1961 to 1962. Following graduation from George Washington University Dental School in 1920, Dr. Swanson established the first clinic for underprivileged Eskimos on the Pribilof Islands in Alaska. He entered private practice in the District of Columbia in 1921. Dr. Swanson has served as president of the District of Columbia Dental Society, the American Academy of Dental History and the District of Columbia Board of Dental Examiners. He played a very important role in the growth and development of the American College of Dentists and served as a Regent from 1956 to 1960. Dr. Swanson was the recipient of the William John Gies Award of the College in 1965.

SECTION ACTIVITIES

Carolinas Section

The North Carolina component of the Carolinas Section recently conducted its annual meeting in Myrtle Beach in conjunction with the meeting of the North Carolina Dental Society.

Dr. Robert M. Wilkinson, President of the Carolinas Section photographed with Dr. Arthur L. Haisten, Dean, College of Dental Medicine, Medical University of South Carolina.

Attending the North Carolina component meeting are from the left: Dr. Ben D. Barker, Dean, University of North Carolina School of Dentistry, Dr. James H. Gaines, Trustee 16th District American Dental Association and Dr. Stuart B. Fountain, President of the North Carolina Dental Society.

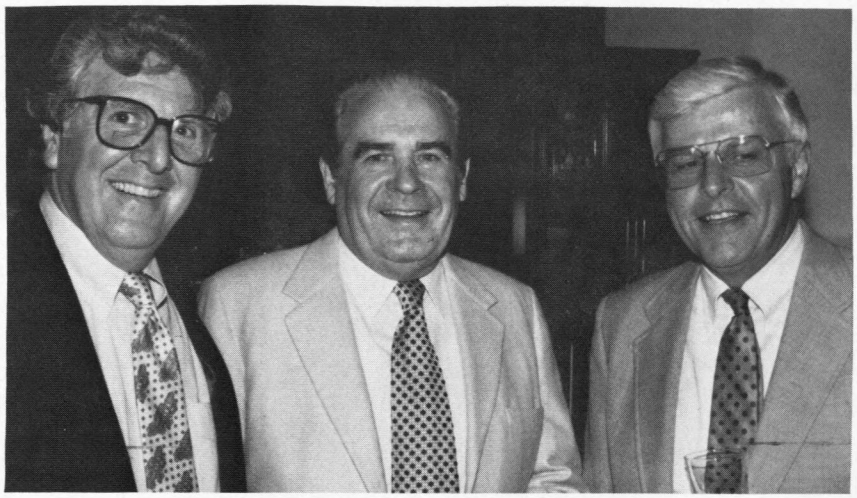
Georgia Section

The Georgia section each year honors a senior dental student and a faculty member of the Medical College of Georgia School of Dentistry in recognition of behavior exemplary of the high standards and professional ethics of the dental profession. A committee consisting of student representatives and faculty considers nominations for both the student and faculty award. The Georgia section has made these awards for the past three years, and the 1987 awards were presented to senior student Glenn C. Alex and to Dr. James G. Keagle, Associate Professor of Periodontics and a Fellow of the American College of Dentists.

Maryland Section

The Maryland Section recently held its annual meeting together with the International College of Dentists at the Engineering Society of Baltimore in Mount Vernon Place. A reception and dinner was followed by an illustrated lecture on China presented by Dr. Raymond T. Bond, a Fellow of the American College.

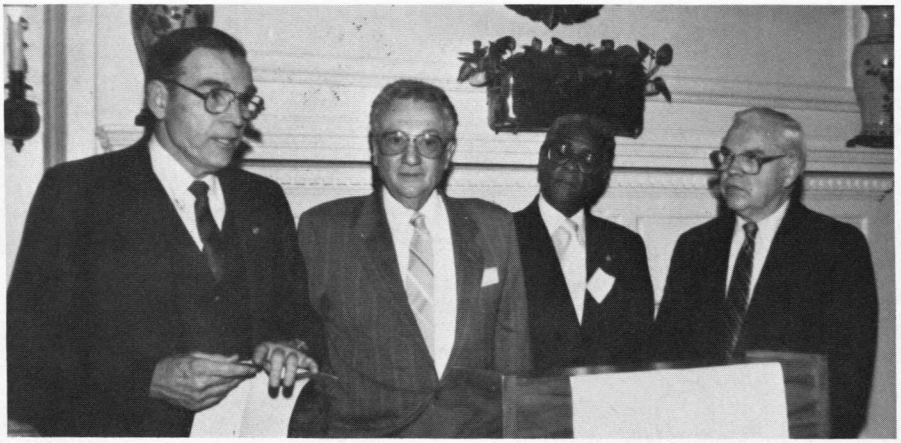
Dr. Raymond T. Bond gave an interesting slide and lecture presentation on China.



Photographed at the Maryland Section's meeting are from the left: Dr. Arnold S. Feldman, Dr. H. Burton McCauley, Section Chairman, and Dr. Dennis N. Dalton.

New Jersey Section

The New Jersey Section held its Spring meeting earlier this year and honored Dr. H. Curtis Hester of Upper Montclair, New Jersey, the President of the American College of Dentists. Among Fellows who commended Dr. Hester for his many accomplishments were Dr. Gordon Rovelstad, Past President of the American College of Dentists and its present Executive Director, Dr. Abraham Kobren, Immediate Past President of the American Dental Association, Dr. Ashur G. Chavoor, Past Trustee of the American Dental Association and Past President of the American Association of Orthodontists and Dr. George L. O'Grady, Regent of ACD Regency 1.



Photographed at the New Jersey Section meeting are from the left: Dr. H. Curtis Hester, President, American College of Dentists, along with New Jersey Section officers, Chairman, Dr. Anthony La Forgia; Vice Chairman, Dr. Francis D. Davis and Secretary/Treasurer, Dr. Daniel E. McIntyre.

Metropolitan Washington Section

The Metropolitan Washington Section held its annual meeting earlier this year at the Bethesda Naval Officer's Club. The meeting, attended by 65 Fellows and their guests, was addressed by Dr. Joseph P. Cappuccio, Regent of ACD Regency 2 who spoke on "Professionalism and Ethics". Two dental students from Georgetown University were also honored for outstanding academic achievement and leadership qualities.

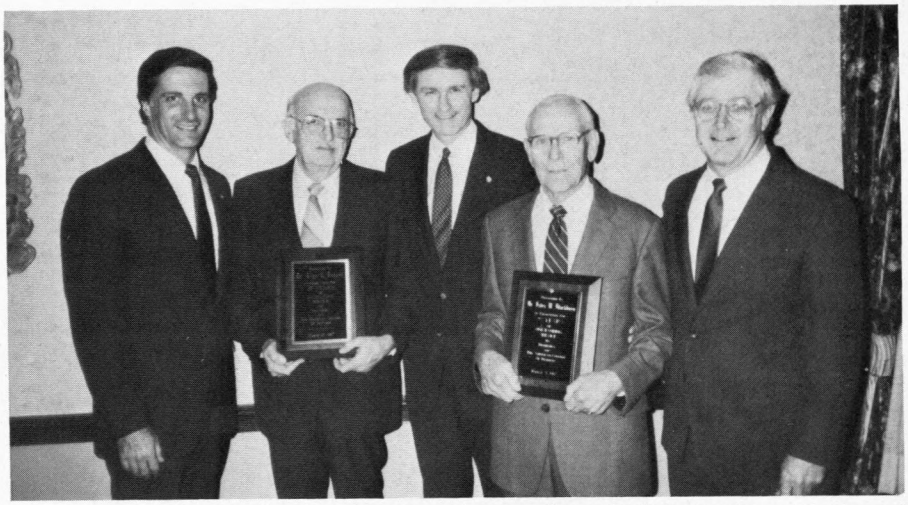
Photographed at the Metropolitan Washington Section's meeting are from the left: Dr. Aida A. Chohayeb, Editor of the Section Newsletter, Dr. Joseph P. Cappuccio, Regent, Regency 2; Dr. James T. Jackson, Vice President of the Section; Mr. John White, Junior dental student; Dr. Joseph R. Salcetti, Section Chairman; Mr. Michael Wolfgang, Junior dental student; Dr. Stanley P. Hazen, Section Secretary/Treasurer and Dr. Robert W. Elliott, Jr., President-Elect of the American College of Dentists.

Western Pennsylvania Section

The Western Pennsylvania Section recently presented an award to dental student Walter Schratz, the President of the American Student Dental Association, for his outstanding leadership and service. Photographed at the award ceremonies are from the left: Dr. W. Arthur George, Associate Dean Emeritus, University of Pittsburgh School of Dental Medicine; Dr. H. Curtis Hester, President, American College of Dentists; Mr. Walter Schratz and Dr. Paul B. Johnston, President of the Western Pennsylvania Section.

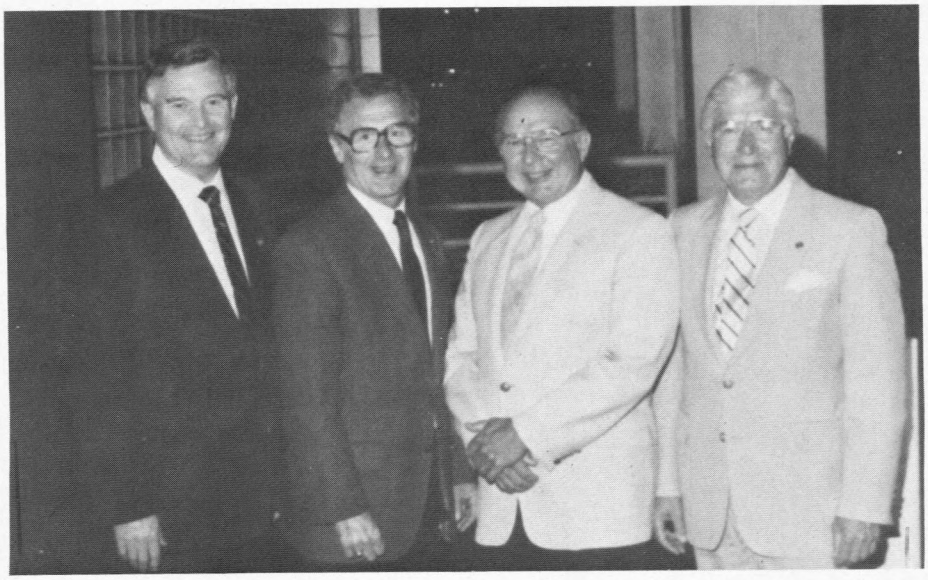
Mississippi Section

The Mississippi Section, at its annual meeting this year, recognized three of its Fellows for 25 years of membership in the College and for their outstanding service to dentistry. Section Chairman, Dr. Robert T. Ragan presided and a reception and dinner was followed by a scientific program. Dr. Samuel G. Sanders was elected Section Chairman, Dr. Rudolph A. Posey, the Vice Chairman and Dr. Robert T. Ragan, Secretary/Treasurer. Awards for 25 years of membership and outstanding service to dentistry were presented to Dr. John Clark Boswell, Dr. Estes M. Blackburn and Dr. Bernard A. Cohen.



Photographed following the award presentations are from the left: Dr. Bryant R. Boswell, Dr. John C. Boswell, Dr. Robert T. Ragan, Dr. Estes M. Blackburn and Dr. Mark W. Blackburn.

Photographed from the left are: Dr. Samuel G. Sanders, Dr. Robert T. Ragan and Dr. Rudolph A. Posey.



Photographed at the annual meeting of the Washington-British Columbia section are from the left: Dr. Frank B. Guthrie, Secretary/Treasurer; Charles V. Farrell, Vice Chairman; Thompson M. Lewis, Chairman and Basil M. Plumb, Past Chairman.

Washington-British Columbia Section

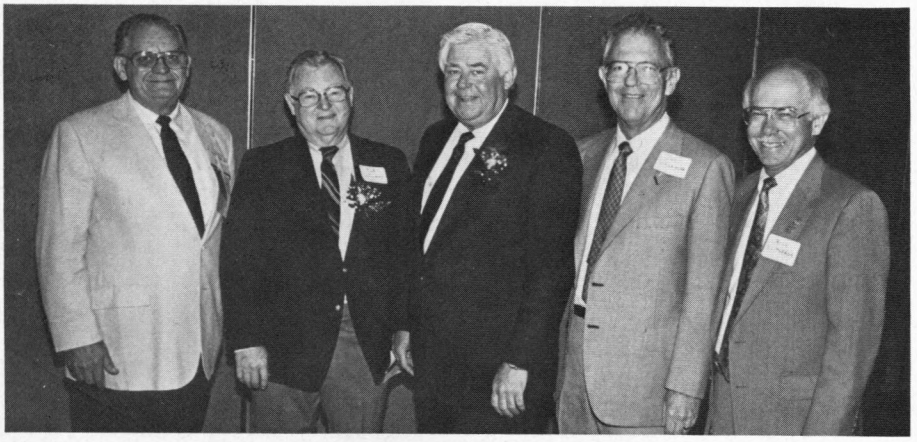
The Washington-British Columbia Section held its annual meeting recently in Vancouver, British Columbia at the site of Expo 1986. The dental meeting was addressed by the Honorable Chief Justice, Nathan Nemetz of the British Columbia Supreme Court on the subject of an independent judiciary. Dr. George Beagrie, Dean of the University of British Columbia Dental School also spoke and thanked Justice Nemetz for his support of dentistry and the University of British Columbia Dental School while he was Chancellor of the University.

An annual scholarship of the Section was awarded to a junior student from the University of Washington School of Dentistry and the following were elected section officers: Dr. Thompson P. Lewis, Chairman; Dr. Charles V. Farrell, Vice Chairman and Dr. F. Burns Guthrie, Secretary.

Oklahoma Section

The Oklahoma Section held its annual meeting in Tulsa recently and installed Dr. Dan E. Brannin, President, Dr. Dean L. Johnson, President-Elect and Dr. Evangeline G. Greer, Secretary/Treasurer.

Some of the Fellows of the American College at the Oklahoma Section's annual meeting are from the left front row: Drs. Dean Robertson, Dean L. Johnson, Evangeline G. Greer, Dan E. Brannin, William C. Hopkins and William E. Brown. Second Row: Drs. French E. Hickman, Hugh A. Sims, Thomas L. Coury, Robert L. Bartheld, William E. Goodman and James A. Saddoris.



Photographed at the Texas Section annual meeting are from the left: Dr. Ernest H. Besch, Section Secretary/Treasurer; Dr. Joseph G. Schneidler, Immediate Past Chairman; Dr. James A. Saddoris, President-elect of the American Dental Association; Dr. Thomas R. Williams, Section Chairman-elect and Dr. William R. Clitheroe, Section Chairman.

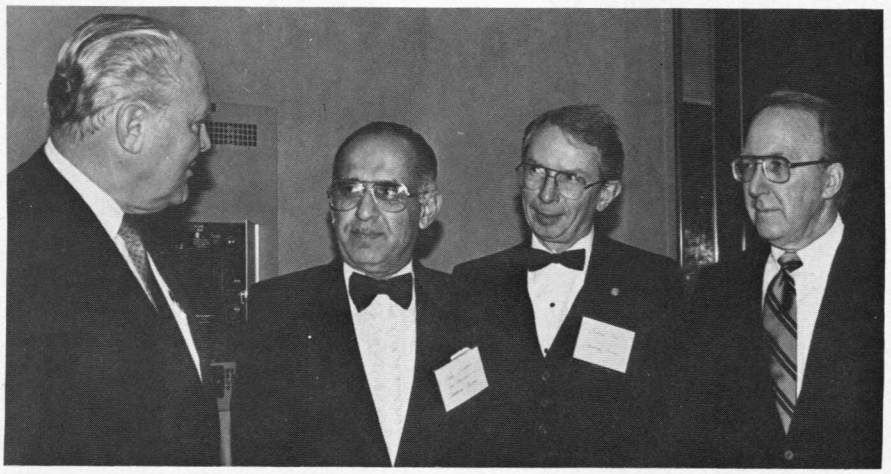
Texas Section

The Texas Section recently held its annual meeting in San Antonio when Dr. H. Curtis Hester, President, American College of Dentists installed the new officers of the section. Dr. Robert E. Lamb, Regent of ACD Regency 6 and Dr. James A. Saddoris, President-elect of the American Dental Association also attended the meeting.

The Texas Section will conduct its 10th annual continuing education program sponsored jointly on a rotating basis with one of the dental schools in Texas. The program is open to all dentists and guests at no cost to the attendees.

Wisconsin Section

Several Fellows of the American College of Dentists attended the Wisconsin Section's meeting in Milwaukee recently. Also present at the meeting was the immediate past president of the College, Dr. Norman H. Olsen who inducted the new officers of the Section. Following the business meeting, Fellows of the American College and their spouses were joined by Fellows of the International College at a reception and dinner. The Lt. Governor of Wisconsin, Scott McCallum, gave an interesting presentation on the present and future economic plans for the State of Wisconsin.



Dr. Norman H. Olsen, Immediate Past President of the American College of Dentists, installed the following new officers of the Wisconsin Section: Dr. Prem S. Sharma, Chairman; Dr. Claude I. Sime, Vice Chairman; and Dr. Russell Kittleson, Secretary/Treasurer.

NOMINATION FORM REQUEST

Name _____ F.A.C.D.

Address _____

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Signature

A nomination portfolio to be used in nominating to Fellowship is obtained from the Executive Office upon the signed request of any Fellow in good standing.

February 1, 1988 — Closing Date for 1988 Nominations

INSTRUCTIONS FOR CONTRIBUTORS

INTRODUCTION

The Journal of the American College of Dentists is published quarterly 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. It is the official publication of the American College of Dentists which invites submission of essays, editorials, reports of original research, new ideas, and statements of opinion pertinent to dentistry. Papers do not necessarily represent the view of the Editor or the American College of Dentists.

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The editorial staff reserves the right to edit all manuscripts to fit within the Journal space available and to edit for conciseness, clarity, and stylistic consistency. A copy of the edited manuscript will be sent to the author.

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Papers should be in English, typed double space on white 8-1/2 × 11 paper. Left hand margins should be at least 1-1/2 inches to allow for editing. All pages should be numbered.

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

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

The second page should be an abstract of 250 words or less summarizing the information contained in the manuscript.

Authors should submit five copies of the manuscript and two original sets of illustrations to: Dr. Keith P. Blair, Editor, Suite 352N, 7315 Wisconsin Ave., Bethesda, MD 20814-3304.

Only original articles that have not been published and are not being considered for publication elsewhere will be considered for publication in the Journal unless specifically requested otherwise by the Editor.

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

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