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The
JOURNAL
of the **AMERICAN COLLEGE of DENTISTS**





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 professional persons the extent of their 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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The JOURNAL

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Correspondence relating to the Journal should be addressed to the Editor, Keith P. Blair, DDS, Suite 352N, American College of Dentists, 7315 Wisconsin Avenue, Bethesda, MD 20814-3202

The business office for the Journal of the American College of Dentists can be reached by telephone at (301) 986-0555.

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FACD RECEIVED:

—End or Beginning

When a dentist receives a Fellowship in the American College of Dentists, should that be the end of the road, a goal achieved and a time to retire from involvement in dental affairs; or should it be the point of entering onto a new, higher road in dentistry, a place from which to begin new achievements and a time to assume new responsibilities for leadership in the dental profession?

Certainly, receiving the FACD is a recognition for years of personal achievement and for outstanding contributions to dentistry. Sometimes, unfortunately, this recognition is bestowed much later in life for some dentists, frequently because they have been "overlooked" during earlier years. When they finally receive their FACD, and their retirement years are near, they sometimes consider this as their goal achieved and the end of the road. But there are other, younger Fellows who also have that same "end of the road" thinking, and this is not good.

On the other hand, and to their credit, there are thousands of older dentists who remain actively involved in dental affairs. With less demands from practice or teaching, they are free to become more productive in other ways. They enjoy being active and they know that they are continuing to accomplish professional work that is worthwhile.

Younger dentists are also becoming more involved in the College. Those people who usually attend the annual Convocation of



Keith P. Blair

the American College of Dentists may have noticed that the average age of the new Fellows is gradually becoming younger each year, and that is good because these new Fellows are the proven leaders who should continue to be leaders for years to come. These are the dentists who could be entering a new phase in their dental career and turning onto that new road to higher goals.

These new Fellows are also the dentists who will become even more effective leaders as they become more experienced and gain more purpose in their professional activities. They are the ideal dentists to become the future role models for the dental profession.

New Fellows are encouraged to continue their involvement with organized dentistry, to advocate professionalism and ethical be-

FROM THE EDITOR'S DESK

havior, to set examples for how professional persons should conduct their lives, to be model representatives for the dental profession in their communities and to speak out on issues related to dentistry.

It is also essential that new Fellows consider it their duty and responsibility to nominate other dentists to membership in the College who appear worthy of Fellowship. Encouraging other Fellows to submit nominations also can do a great deal to assure that additional deserving colleagues receive due recognition for their contributions to the profession. Since ACD rules require that only active Fellows of the College can submit nominations, it is vital to the future of the College that Fellows do nominate people.

Certainly, there are dentists in many areas of the country today who are "truly outstanding" in the profession, yet they are not members of the ACD, primarily because they have never been nominated by a Fellow of the College.

It is sincerely hoped that most new Fellows will follow the philosophy that the receiving of their FACD places them on a new plateau, initiating a new beginning toward new goals in dentistry with new challenges and new responsibilities.

All Fellows of the College can judge for themselves whether, when inducted into the ACD, they hit the end of the road or found a new beginning to higher achievements. Δ

Keith P. Blair

CAMPAIGN FOR THE 90'S

Ensuring the Future of the College Into the 21st Century

James A. Harrell, Sr.
Capital Fundraising Committee Chairman

On April 13, 1988, the Board of Directors of the American College of Dentists Foundation approved a capital fund drive which will ensure a sound financial future for the College and Foundation.

"Campaign for the 90's" will provide sufficient funds for the College to be housed in a building which includes meeting and conference facilities for the Fellows to use. This historic milestone in the legacy of the American College of Dentists will establish a center of scholarship and collegial interaction for all Fellows to enjoy.

Initial leadership for the Campaign includes ACD Foundation President H. Curtis Hester, ACD President Robert W. Elliott, Jr., ACD President-Elect James A. Harrell, Sr and Executive Director Gordon H. Rovelstad. In addition, four Honorary Chairmen have been named to assist in directing the Fund Drive: Norman H. Olsen of Chicago for the northern area, Charles W. Fain of Daytona Beach, Florida for the east, Ralph A. Boelsche of Industry, Texas for the south and Albert Wasserman of San Mateo, California for the west.

Meeting rooms for ACD committees will be available as will a college historical records section, an awards recognition area, and a dental history display. The College staff will have adequate space to perform their many responsibilities on behalf of the Fellows.

This exciting new facility for the ACD will make it possible to bring members into the national office for fellowship, Sections leadership



ACD Foundation President H. Curtis Hester, 2nd from right, presents a check to the officers of the ACD Foundation to open the account for the "Campaign for the 90's." Others pictured are, left to right, ACD President Robert W. Elliott, Jr., ACD President-Elect James A. Harrell, Sr. and ACD Treasurer Robert C. Coker.

training, continuing education, and committee meetings. It will be capable of serving as a meeting place for other dental related organizations in which we have a vital interest.

"Campaign for the 90's" is a \$750,000 effort in which all Fellows will have an opportunity to participate this fall. Naming opportunities will be made available to those wanting to honor relatives, friends, or themselves.

Gifts of \$10,000 and above will be needed to meet the goal. Of course, gifts of all amounts will be welcomed. Three permanent plaques

in the foyer will display the names of those giving \$5,000 or more, \$1,000 or more, and \$500 or more.

For many years, the Board of Regents and various Fellows have discussed the advantages of the College owning its central office. Over \$50,000 a year in rent could be shifted to programming areas of benefit to the Fellows and the profession.

During this past April, the Board of Regents participated with a professional company in a long range planning session. Building or buying a central office emerged as the number one objective.



Norman H. Olsen—North

To accomplish the Purposes and Objectives of the College as set forth in the Fellowship Handbook, a facility is needed which provides meeting and conference provisions for the Fellows and which provides



Charles W. Fain—East

adequate space for the staff to perform their duties on our behalf.

The College has hundreds of books written by Fellows about dentistry. These historical and scholarly works have never been displayed. They will be readily available for study and will be proudly displayed in the new facility provided by the "Campaign for the 90's."

The time is now to move forward with a capital fund drive on behalf of the College. Section activities have increased greatly and are dynamic in many areas. Nominations for Fellowship are at an all time high. The *Journal* was upgraded and expanded recently to include refereed scientific articles. Participation in the Annual Meeting and Convocation by Fellows reached a new milestone last year.

The College's national prominence was demonstrated recently when, in association with the American Dental Association and the American Association of Dental Schools, the Guidelines for Teaching Professionalism and Ethics in Dental Schools were introduced. This was initiated and funded by the College and is an excellent example of what the College's resources can accomplish.

During the remainder of 1988, Fellows will hear more about "Campaign for the 90's." It will be a highlight of our activities this fall. The future of the College depends upon the Campaign's successful completion. Participation by Fellows at the highest level possible will ensure success.



Ralph A. Boelsche—South



Albert Wasserman—West

WHY THEY

Anatomy of "The Demise of Georgetown Dental School"

Robert W. Elliott, Jr.*

This report was requested by the JOURNAL

As of March 1987, there had been a School of Dentistry at Georgetown University for eighty-six years. The School, in 1987, had a balanced budget, though tuition had been raised periodically over the years to achieve it. Its report for 1985-86 stated that, "for the third year Georgetown ranked number one in the number of applications" for entrance into the freshman class.¹ There were nine applicants for each student enrolled.² The following were given by students as very important reasons for selecting Georgetown as their choice for a school of dentistry: (1) its clinical reputation; (2) its high academic reputation; (3) the students general impression of Georgetown University's School of Dentistry following a visit made to the school; (4) the availability of patients for clinical practice; (5) its

financial assistance program; (6) its geographic location; and (7) the recommendation of a friend or relative who had attended Georgetown. There were other less frequently mentioned reasons.³

There was a change of administration at the Georgetown University Medical Center in 1986 when its chancellor, Dr. Matthew McNulty, retired. Dr. John F. Griffith, a physician, was named Executive Vice President for Health Sciences and Director of the Medical Center in September 1986. Soon thereafter, Price Waterhouse was "engaged to assess the financial viability of the School of Dentistry . . . and discuss issues related to the future viability of the Dental School."⁴

This firm reported its findings to Dr. Griffith on December 1, 1986.⁵ The document stated that "We are not independent with respect to Georgetown University because one of the partners is a member of the Board of Directors."⁶ In the Executive Summary of the Report, Price Waterhouse made the following statements herein paraphrased: given expected declines in enrollment the School of Dentistry will need to increase revenue other than by raising tuition and initiating cost reductions; it is unlikely that necessary restructuring to

achieve necessary financial benefits can be realized in the short-term; revenues from the Dental School are supporting a significant portion of University costs through overhead allocation—the University [if it closes the School] will have to implement other revenue generating activities . . . ; although Dental School enrollment has been declining . . . strategies used by Georgetown may give it a competitive edge over other schools as they compete for applicants.⁷

Options given in the Executive Summary of the Report to Dr. Griffith were:

FLASH

As of May 9, 1988, Judge Eugene N. Hamilton of the District of Columbia Superior Court granted a preliminary injunction preventing the Administration of Georgetown University from proceeding with the closure of the School of Dentistry. This injunction has been stayed pending oral arguments before the District of Columbia Court of Appeals and its decision in the matter.

*Robert W. Elliott, Jr., President of the American College of Dentists. Clinical Professor of Prosthodontics, Georgetown University Dental School.

Continued on page 8

CLOSED

The Closing of the D.D.S. Program at Emory University

A Retrospective View

Michael E. Fritz*

This report was requested by the JOURNAL

The first inkling of problems at Emory University School of Dentistry occurred approximately ten years ago when the Atlanta press interviewed the then Vice President of Health Affairs in Atlanta while the administration of the dental school was at a state dental meeting out of the city. A question was posed to the Vice President regarding the future of the School of Dentistry. He responded that its future was somewhat in jeopardy and would have to be examined on a periodic basis because of financial problems. This story in the Atlanta press generated many calls from concerned alumni to the administration. A major effort was then made by the administration of Emory University to mollify the dental community. However, a thread of uncertainty had been introduced.

*Michael E. Fritz, D.D.S., Ph.D., F.A.C.D., Charles Howard Candler Professor of Periodontology, Dean Emeritus, Emory University School of Dentistry.

In the late 70's a new president of Emory University, Dr. James T. Laney, Jr., was appointed by the Board of Trustees. Dr. Laney's intentions were made very clear from the outset; his major objective was to change Emory University from a regional school into a national university. Furthermore, he believed that each school should be a center of excellence and should be sound fiscally. Over the past few years, his leadership has produced many changes toward this direction, as recent surveys identifying Emory as a national university have clearly shown. Parenthetically, it should be mentioned that Dr. Laney was Dean of the School of Theology at Emory before his move into the President's office and was very much aware of problems in the School of Dentistry when he assumed the helm of the University.

Emory University School of Dentistry, in the 70's, remained the prototypical dental school of the 60's. The school provided a wonderful clinical training program, largely through a tutorial process, with the majority of the revenue being generated by tuition and income from undergraduate clinics. Minimal research, with recovery of indirect dollars from research grants, and minimal scholarship through writ-

ing in major journals was being accomplished by the faculty. The model was a highly successful one in the 1960's, as state dental schools in the South had just come into being and the dental profession was at its crest, both from the perception of the public and from an economic perspective. Therefore, there was an abundance of quality applicants for the dental school, even though it was very costly to run.

When Dr. George Moulton retired as dean in the 70's, a search committee was appointed to seek a new dean for Emory University School of Dentistry. After much deliberation and soul-searching, the committee turned internally and recommended Dr. Charles Waldron, who had served as Chairman of the Department of Oral Pathology and Assistant Dean for Graduate Education. Dr. Waldron stayed at the helm of the dental school for approximately three years, attempting to keep the model that the faculty wished intact, yet meeting regularly with the University Administration regarding constant budget deficits (with the exception of one year when a few faculty positions were not filled). At the urging of the University adminis-

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- (1) The immediate closing or phasing out of the School of Dentistry;
- (2) Retention of the School but reconsideration of closure every year depending upon anticipated enrollments and the effectiveness of actions taken to increase revenues and/or reduce expenditures; and
- (3) Retention of the School for the long-term with the objective of being one of the remaining quality private Dental Schools if appropriate restructuring can occur which effectively reduces shortfalls in revenues over expenditures.⁸

The study further stated that it would be a cost to the University for closing the School and that the Dental School's allocation of University costs for debt service, basic science programs, [35% allocated to the Dental School] space use and some academic support functions would need to be provided by other divisions of the University. It was noted that, as an alternative, the cost could be "recovered through use of Dental School space by activities which generated adequate revenue to offset these costs." The Price Waterhouse report further stated that the immediate closing or phase-out of the School of Dentistry would *not* achieve a saving equal to the net decrease [deficit] in fund balances as . . . projected.⁹ The report created concern rela-

tive to the viability of the school and rumors circulated that it might close. In the ADA News of January 19, 1987, the Dean of the School was quoted, "We've explained to the faculty that we are not closing. . . ."

During this period, the School of Dentistry developed a "Plan for the School of Dentistry-Fiscal Years 1987-1992." A balanced budget was projected for 1987 and 1988 with surpluses indicated for 1989 through 1992.¹⁰ Class size was to be reduced from 138 students in 1987 to 100 by 1990.¹¹ Decreased income as the result of a smaller student body was to be offset by gradually increasing tuition, increasing clinical income, and by a variety of strategies: increase the number and tuition of post-doctoral dental students; initiate a dental faculty practice plan; reduce the faculty and the cost of basic science instruction; and relinquish surplus space, reducing indirect costs to the School.¹²

On March 4, 1987, a group of alumni, the Ad Hoc Committee of Concern, wrote to Timothy S. Healey, President of Georgetown University, expressing concern over the rumors of the School's closing despite the Dean's published denial. They asked the University President, "Is it a possibility for the near future?" (The President's reply to this inquiry was dated 1 June 1987.)

On 13 March, the Dean of the School of Dentistry, Dr. Stanley P. Hazen, sent a memorandum to Dr. Griffith stating *inter alia* that he believed the plan referred to

above" . . . to be workable for the five years projected. However, beyond that time the future is much less clear"

On 19 March, the minutes of the March 18, 1987 Admissions Committee meeting were distributed. At that time, Georgetown School of Dentistry had 990 applicants and deposits from 110 potential students. These 110 had a GPA of 3.03, a DAT [academic average] of 4.62, and a DAT [PAT] of 4.87. (In 1986, *nationally*, the 1986 entering class had 3.02, 4.33, and 4.46 averages, respectively.) The Georgetown report, quoting the American Association of Dental School's statistics, states that only eight times in the past thirty-five years have there been more than two applicants per entering position.

That same day, 19 March 1987, the Board of Directors of Georgetown University voted not to enroll a first year class!

In a press release, issued March 23, 1987, it was stated that on March 19th the Georgetown University Board of Directors, "voted not to enroll a first year class and to phase out dental education at Georgetown over the next three years." It was further stated that, "this action was taken after examining the results of a thorough analysis conducted over a number of months The nature of the Board's vote (whether it was by secret ballot, voice vote or recorded, the number of yeas, nays, and/or abstentions) was not reported. It is understood that no member of the dental school faculty or administration personally ap-

peared before the Board of Directors to be questioned about the viability of the School or discuss the accuracy and conclusions of the Price Waterhouse report. Additionally, readers of the reports were cautioned that "The assumptions underlying the financial projections (in the report) are critical for a thorough understanding of the projection results." The Executive Summary did not include all of the assumptions.

Letters sent to Dental School alumni, faculty administration and staff described the same reasons for the Board's decision: A shrinking applicant pool [Georgetown in 1987 having had the largest or second largest number of applicants of any dental school in the nation]; that the students were less qualified than in previous eras [which era?—true, if one looks at the peak applicant period, 1980, when the GPA was 3.33 compared to 1987 when it was 3.03—not true if one looks at the period 1954–1973 when it ranged from 2.41 to 2.83]; and that the School "faces continuing deficit financing." [The School had not had a deficit and the 1987 budget did not project one.] Further, the Dental School supported the basic science program of the dental, medical, and nursing schools by a University imposed allocation of 35% of its costs.¹³ [Basic science instruction could have been purchased on an hourly basis for much less.] It was further stated that advances in dental care had resulted in a lessened demand for services.

After the shock of the announcement of the projected closing of the nation's largest private dental school had been assimilated, statements were forthcoming from various dental organizations.

On March 27, Dr. Joseph Devine, then President of the American Dental Association, stated in a press release: "... we have asked that the University reconsider its decision and conduct a feasibility study that might identify options for keeping the School open." He also expressed concern about misinformation regarding the demand for dental services and the academic quality of the students that the Georgetown announcement generated.

Dr. Devine also wrote to President Healey asking for reconsideration of the closure decision. Additionally, he stated, "I was surprised to learn that the University had not communicated with nor requested input from the Commission on Dental Accreditation prior to its decision and public announcement and that the Institution has *not* (emphasis added) established a phase-out plan prior to making its judgment on closure."

On the previous day, in a statement released by the American Association of Dental Schools (AADS) and published in part in the May 4th issue of the American Dental Association News, strong exception was taken to the University announcement. Executive Director, Dr. Richard Mumma, speaking for the AADS said, "... there is no evidence to support Georgetown's statements that there are diminish-

ing career opportunities in dentistry . . . , the Georgetown University announcement creates an impression that current dental students in the country are academically deficient in comparison with the students in the 1970's, when there was an atypical surge of applicants for admission to dental school. That impression ignores the fact that academic qualifications of today's dental students are comparable to historical trends using similar criteria."

The financial picture relating to the School of Dentistry [the possibility of a deficit being given as a reason for closing the school] came into sharp focus on May 13, 1987. Though the School's plan for fiscal years 1987 through 1992 had projected a balanced budget for 1988¹⁰ and the December 1st report from Price Waterhouse projected a shortfall of \$145,000 in the same fiscal year,⁵ the revised School of Dentistry budget, allowing for the closure decision, showed a shortfall of \$4,010,565.¹⁴

On the 3rd of June, the President of the University Faculty Senate sent a letter to the President Emeritus of the American Association of Medical Colleges with copies to the President of Georgetown University, the Director of the Medical Center, and the Dental Executive Faculty forwarding a statement of the Senate expressing that body's "... extraordinary concern over the manner in which the recent decision to close the University's School of Dentistry was made, and its alarm that Georgetown's School

of Nursing and perhaps other divisions of the University will be similarly treated." It was further stated that, "the Senate's concern is rooted in process" and that in the Senate's view, "that the exercise of University authority in that decision [closure of the Dental School] did not conform to the requirements of University law . . .".

On July 8th, the "Phaseout Plan for School of Dentistry-Fiscal Years 1988-1990" was promulgated. Several items therein are worthy of note. As an incentive to retain the student body, tuition would be gradually decreased as follows: FY '88, \$15,000, FY '89, \$14,000, and in FY '90, \$13,000.¹⁵ Those full-time faculty who would accept and complete a three year appointment would receive a full year's salary as a severance incentive payment upon completion of their obligations. Lesser financial benefits were made available to those offered appointments of less than three years.¹⁶ Appendix A of the Report was a letter to the Executive Vice President for Health Sciences and Director of the Medical Center from the Secretary of the University dated April 2nd, 1987. It set forth the Resolution, adopted by the Board of Directors on 19 March, which authorized the phasing out of dental education at the Georgetown University. The letter said that the Resolution was adopted by unanimous vote. Interestingly, an item that had not been reported in the media, so far as is known, was that the Resolution authorized the

Director of the Medical Center to "... examine the individual academic components of the Medical Center to ensure that each is consistent with the goals of excellence of the overall institution."¹⁷

Articles appeared the next day in the WASHINGTON POST, and in the July 20th issue of the ADA NEWS, stating that students and faculty members had filed suit on July 6th in the District of Columbia Superior Court seeking to block, for at least a year, the planned closing of the Dental School. The POST stated, that "the suit charged Georgetown's President and its Board of Directors with fraud, breach of contract and fiduciary duty for the decision to phaseout the school by mid-1990." As reported in the ADA NEWS, the suit disputes, among other things, the assertions made relative to the declining quality of dental students, and asserts that test scores of Georgetown dental students are higher than the national average, including students accepted for fall [1987] enrollment.

On Thursday, July 23, 1987, an oversight hearing on the "Closing of Georgetown University School of Dentistry" was held by the Subcommittee on Judiciary and Education of the House Committee on the District of Columbia for the U.S. Congress. The Chairman of the Subcommittee, the Honorable Mervyn M. Dymally, presided. In his opening statement, Congressman Dymally said, "... "There are in fact more compelling reasons why,

in this instance, Georgetown University may be said to owe an extra measure of concern to the local community."

"First, Georgetown University is a federally chartered institution, and as such it should be responsive to Congressional concern about virtually any aspect of its behavior here in the Federal City. Congress, it should be recalled considers the nature, character, and social benefit of whatever work its charter organizations are involved in.

"Secondly, Georgetown University, which is situated on one of the city's most valuable land areas and, of course, pays no taxes, has been the beneficiary of much local and federal generosity. In 1970, Congress (through the District of Columbia Committee) passed the District of Columbia Medical and Dental Manpower Act (P.L. 91-650, as amended), which was twice extended [P.L. 93-389 (1974) and P.L. 94-308 (1976)] and to which I have already referred. As I stated, \$10.5 million went to the Schools of Medicine and Dentistry at George Washington and Georgetown Universities between 1970 and 1977. Many more millions of Federal dollars were granted to both institutions through Title VII of the Public Health Service Act, as amended by the Comprehensive Health Manpower Training Act of 1971. In making these funds available, neither Congress nor H.E.W. anticipated one of the major beneficiaries of their aid and largesse would decide to cease operating within a decade.

It is indeed highly probable that part of the aid extended may not have been granted had there been cause to believe that a major component of one of the recipient institutions would cease operation.

"Finally, Congress has made some very significant legislative exceptions for Georgetown University. The recently passed Highway Bill made possible the very complicated and expensive opening of the south side of the university campus at great cost to the Federal Government. Before this "gesture" by the Congress, Congressional support was extended (through the D.C. Committee) for the tax-exempt sale of bonds by Georgetown. In other words, we here in Congress have continuously shown good faith to Georgetown and backed our faith with good deeds. What we now ask is that Georgetown do no less when it comes to the interest of the local community."

Statements to the Subcommittee were given by the Director of the Medical Center, the Dean of the Dental School, by the Executive Director of the American Association of Dental Schools, faculty members, alumni, and students. Essentially, the statements conveyed the information provided in this chronology, with the Dean of the Dental School and the Director of the Medical Center supporting the University's decision and the others attempting to clarify the picture relative to enrollment, tuition, need for dental care, and to show why the school should not be closed.

The Chairman of the Operative Dentistry Department at the Georgetown University School of Dentistry, Dr. William Cotton, in a letter to Congressman Dymally dated August 8th noted that the Congressman had suggested and offered support for a national conference to examine the "dental crisis."

The next action in this chronology took place on October 16-22, 1987 in Superior Court in the District of Columbia where a hearing was held on a Motion for a Preliminary Injunction. The motion was to require the defendants [Georgetown University] "to maintain Georgetown University School of Dentistry at the same level of education, including the retention of those faculty and staff needed to maintain that proper level of education, as said Georgetown University School of Dentistry would have been had defendants not made their decision of March 19, 1987 [to close the Dental School] in an announcement of March 20, 1987, pending further order of the Court."

The WASHINGTON POST reported Friday, October 23rd, that during the hearing, Judge Eugene N. Hamilton said, "I urge, I beg you to look deeply into this problem. It wouldn't hurt anything to sit down and talk to each other . . . You see, the Courts should not be doing things like this if we can avoid it." The University's attorney is quoted in reply, "There is no possibility that the University would or could change its mind about reopening the Dental School. The decision has

been made . . ." The WASHINGTON POST stated that President Healey told the Judge that if he issued an injunction to block the closing, the University would appeal the order.

As of April 1988, neither the Congress nor the Courts have taken any further action. Δ

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13. *Ibid*. II.A.g., pg. 7.
14. School of Dentistry—FY '87 Approved Budget vs. FY '88 Plan (Revised 5/13/87).
15. Phaseout Plan for School of Dentistry—Fiscal Years 1980-1990, pg. 10.
16. *Ibid*. App. D.
17. *Ibid*. App. A.

Reprint requests to:
Dr. Robert W. Elliott, Jr., President
American College of Dentists
7315 Wisconsin Ave. Suite 352N
Bethesda, MD 20814

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tration a Board of Visitors, consisting of two dental deans and the late Dr. Harry Bruce of the American Association of Dental Schools, was established and a faculty committee was organized for the purpose of planning the future of Emory University School of Dentistry. The developed plan called for curriculum change, recruitment of individuals to perform fund raising and business tasks, change in the admissions office, and recruiting many more individuals to do research. During his tenure, Dr. Waldron led the dental school through an accreditation visit that resulted in full accreditation.

As is now recognized, storm clouds were gathering in dentistry and dental education in the late 70's in the form of the busyness issue of practitioners and a decreasing dental applicant pool. Dr. Waldron, for personal reasons, chose not to implement the blueprint developed by the faculty and relinquished the deanship. Having lived through a search three years before, President Laney and the administration did not wish to enter into another search for a dean. At the time, I had served as Chairman of the Department of Periodontology for approximately 15 years and had recently been appointed a Candler Professor at the University. I also had a record of continuous research support from the National Institute of Dental Research. Perhaps because of these factors and my friendship with President Laney, I was called to his office in November of 1981. After a discussion, the President basically said, "Either you take the deanship of the School of Dentistry or I'm going to close it." At the time,

I was in the midst of recruiting a group of very gifted young periodontal researchers, was in my early 40's, and being a dean was probably the furthest thing from my mind. However, having spent approximately 15 years in the University and the School of Dentistry, I felt an obligation to attempt to salvage the school. I advised the President that five years would be the minimum time necessary to turn the institution around. After discussing everything with my family and a few faculty members, I gave the President a five year non-renewable commitment. Because of the magnitude of the problems, I felt very aggressive leadership, not compatible with a prolonged deanship, would be necessary.

Analysis of Deficiencies

An analysis of the deficiencies of Emory University School of Dentistry, when I assumed the deanship, included the following:

1. Faculty who taught at the chair, albeit quite well, and who did minimal scholarly pursuit. This was not in keeping with the President's view of what an academician at a major national university should be.
2. A faculty which was predominantly middle aged, 80 percent tenured, and predominantly in a second career from the military.
3. Income largely related to tuition and clinic income. Minimal endowment and grant support were present.
4. Moderate alumni financial support (at best perhaps \$100,000 of a six million dollar budget), and yet alumni were constantly asking about the possibility of closure of the school.
5. An admissions office which did no recruiting, but relied on word-of-mouth of Emory's great clinical reputation to attract students.
6. Minimum research grants from peer reviewed groups.
7. A perception in the University that we, in the School of Dentistry, were really "weak sisters" because our faculty was not up to University standards. The only contact that most dental faculty had with their academic colleagues was during the provision of dental care by undergraduate students to a limited number of University faculty. There were minimal collaborative research efforts.
8. Probably most important, a school which was showing a budget deficit, not in keeping with the scenario of each "tub on its own bottom."

Positive Factors

The positive factors at Emory when I assumed the deanship were the following:

1. An excellent clinical program which was truly training dentists for the practice of dentistry.
2. What I thought was a five year commitment from the University to turn the institution around.
3. A small core of excellent

faculty who understood the precarious nature of our situation, who liked living in the Atlanta metropolitan area, and who were willing to work very hard to turn an institution around. (Parenthetically, there was a faculty group who never believed that the University would close the school.)

4. A core of residency programs (orthodontics, oral and maxillofacial surgery, and periodontics) which were in high demand.
5. A large body of alumni, most of whom lived in the Southeastern United States. Many of these alumni, however, were sending their own children to state dental schools because of the cost factor.

In accepting the position, I wrote a very detailed letter projecting and explaining possible budget deficits over the five years. The conditions put forth in the letter were agreed to and I assumed the deanship in mid-November, 1981 (officially January 1, 1982).

A series of management strategies had to be implemented immediately. Most important was to establish a management team. One faculty member, Dr. Lindsay Hunt, presently the Dean at Medical College of Virginia, accepted the position of the Associate Dean for Academic Affairs with the charge of changing the curriculum into one designed to train dentists and leaders of the future. In addition, we had to recruit a new Dean of Admissions, a new Business Manager, and a new Director of Development. A new Dean of Advanced Education was also selected and

charged to manage and expand the existing postgraduate program and to submit a grant to support a general practice residency. By the end of 1982 we also made changes in department chairmen, replacing some with younger, more energetic and creative people from within and making plans to recruit others externally.

Long range plans revolved around four areas: 1) to establish and phase in a new curriculum which would be more in keeping with the mission of excellence of a national university, while maintaining the strengths of the old curriculum and Emory's clinical reputation (this meant recruiting a new type of faculty person); 2) to set up criteria to evaluate faculty; 3) to recruit appropriate research people and obtain peer reviewed research support in order to establish us as an equal group in the University; and 4) to search for other sources of revenue in addition to alumni and corporate support (one of these sources was to establish a faculty practice, probably the most threatening issue from the perspective of the alumni).

In 1982, a faculty committee was busy at work redesigning the curriculum. It was necessary to phase out the existing dental curriculum, which was traditional, and enter into a new type of curriculum based upon scientific learning (i.e. computer technology). Additionally, in keeping with our view of the future of dentistry and to establish dentistry as an integral component of an outstanding national university, we began the establishment of joint programs within the University, including DDS/PhD and DDS/MBA tracks, and accelerated

specialty/DDS program. At the same time, the Woodruff gift of 200 million dollars had been donated to Emory University, and the President and Board of Trustees established various Woodruff scholarships providing full tuition, books, etc. to recruit outstanding students throughout the University. We at the Dental School were fortunate to receive four of these per year, which was a start in recruiting the type of student we wished. We calculated that, since the applicant pool was starting to decrease dramatically, we could not fill a class with 104 good students as had been done in the past. Because of the decreasing applicant pool, we projected cutting class size to 65, believing we could fill our class with excellent students. This belief was based on our intent to provide more loan support, hopefully raised from alumni who were very much in favor of cutting class size. We also hoped to find additional funds from research support, corporate and alumni support, and from the faculty practice.

We also worked with the newly appointed department chairmen and the School of Business to establish a Management By Objective (MBO) Program so that we could evaluate the faculty. Previously, at Emory University School of Dentistry, faculty were paid according to their rank and each faculty member made approximately the same salary regardless of whether he or she was productive or non-productive. I personally felt this was quite unfair, and wanted to introduce a productivity schedule whereby people were evaluated according to what they produced. We worked with the School of Busi-

ness and had an MBO document accepted by the department chairmen who then presented it to their faculty. The faculty was very disgruntled and many of the chairmen did not enjoy being placed in the hot seat and immediately backed away saying that "this was the Dean's idea and they just had to go along." This resulted in a major schism between the administration and non-productive faculty who were now threatened.

We also recruited a research group including Dr. Roland Arnold as Chairman of Oral Biology who exceeded the projections for obtaining extramural funds agreed to when he joined the faculty. In hindsight, however, the University officials could not have known of this success when the decision to close the D.D.S. program was made.

We then began soliciting funds from alumni and corporations. Our theme for alumni was that we would be using the money for student loan funds. With the cooperation of the Development Office, our students conducted telethon phoning. We gave our alumni the option of contributing either to the Student Loan Fund or to the Dean's Discretionary Fund. In the past, any money raised was put in the Dean's fund. To obtain funds for loans it was necessary to help recruit students; however, it contributed to shortfalls in the budget. We in the dental administration felt this was a calculated risk that had to be taken. The new Director of Development began recruiting corporate funds and funds from several of our more affluent alumni. During 1984 and 1985 (until the University decided to close the D.D.S. program) we had approxi-

mately \$1,000,000 in pledges for an endowment from affluent alumni. Some of these, however, were immediately rescinded upon closure of the D.D.S. program.

We established a Board of Visitors of prominent Atlantans, most of whom were my private patients. We established three projects with the help of this Board: 1) establishment of a geriatric dental program at Wesley Homes Geriatric Center of Emory University, 2) establishment of a craniofacial anomalies program at Scottish Rite Hospital for Children, and 3) building a dental clinic at a prominent boy's club in a depressed area. We felt that we could use these themes to recruit larger amounts of money from the corporate Atlanta community, as well as provide our students with an excellent clinical exposure. The response was very positive initially and we began to obtain significant dollars from the corporate community.

We also began building a faculty practice in the new Emory Eye Clinic building with the arrangement that the dental school would receive 12% of the gross revenues from this practice, thereby providing more capital to the dental school. In the early 1980's, with the busyness issue on the minds of practitioners, the opening of this practice proved to be a real problem. One very serious problem was that when we announced projections regarding the faculty practice to full and half-time faculty, much of this information reached the dental community, and the flames of hysteria were again fanned.

In order to rally the support of our alumni, we set up a special Dean's Advisory Committee of

prominent alumni, provided a much more in-depth continuing education program, visited constituent dental societies, hosted receptions, and encouraged the faculty to interact with the local dental community. We attempted to have every faculty member join the American Dental Association and work in local dental societies. Although some success was achieved, invariably the issue of the faculty practice raised its ugly head.

We felt that many of our plans were proceeding on schedule. The biggest overriding problem was that we just could not balance the budget. The faculty/student ratio at Emory University School of Dentistry was fifth from the bottom in the country in 1982, and we had to hire more faculty to bring this ratio to an acceptable level. In addition, it cost money to provide new faculty with an appropriate environment to perform their tasks. I told the administrators of the University to expect a deficit, but with the difficulties of filling the class, the ever increasing reliance on clinic income, and the costs related to renovations and hiring of new people, our deficits were more than even I had anticipated.

In the middle of all the above, we were informed by the American Dental Association that we were scheduled for an accreditation visit, preparation for which would require an incredible amount of work by faculty. Our faculty was in transition and was involved in teaching two curricula. We wrote, called, and begged for postponement of the accreditation visit. We were informed by the administrators in the central office of the ADA that changing the schedule for our visit

was not possible because "it had never been done before." We documented how the scheduled visit would hurt us, but, in spite of the fact that two deans served on the committee, we received absolutely no satisfaction from the American Dental Association and its Accreditation Committee.

Therefore, as we entered the middle 1980's, many positive things were occurring at Emory University School of Dentistry: we were changing our curriculum, we were recruiting exciting new faculty, we were receiving research grants and providing new clinical vistas, students were involved in the organizational process, and we had begun to raise money. We were all very excited about the prospects of pulling off a miracle. Unfortunately, the real crisis in dentistry then occurred, or as our President has said in many publications, the "bottom dropped out of the dental profession." The dental practitioners were complaining vigorously about the busyness issue, the national dental applicant pool began to approach 1 to 1, and locally, the alumni were disgruntled about the faculty practice. The President of the Dental Alumni Association and two members made a secret visit to the Vice President to tell him how much organized dentistry in the Atlanta community opposed the faculty practice. This visit was catalyzed by an inadvertent error by the Administrative Board of the Faculty Practice by making inappropriate listings in the Yellow Pages for the Emory Faculty Practice, a situation which provided some disgruntled dentists an opportunity to rally round a central theme of "down with the faculty

practice at Emory University as this will solve all our problems and we will get all those patients."

In this climate, we entered into an accreditation visit in 1984. As noted above, there was a positive sense, especially among new faculty, but we had some very serious problems. We had a faculty who felt that new people who were being recruited had better "deals" than the old people (a fact that probably had some merit), a curriculum in flux with two groups of students (those in the phase-in program and those in the phase-out program of the old curriculum), and serious budgetary problems. Adding to the budget problems was the reality that an accreditation visit probably costs a school a few hundred thousand dollars when one counts lost labor and lost production.

The predictable happened: The accrediting unit of the American Dental Association gave us a "Conditional Accreditation" because of the state of flux of the school. I have repeatedly told the deans on that committee that the report included none of the positive things that were going on and was a negative document. Yet, that did not alter the fact that a negative report was what the President and Board of Trustees received.

If this news was not bad enough, in the fall of 1984 we were having problems filling the class as the applicant pool to dental schools was approaching 1:1. We had met as a faculty to set minimum standards for admission. The faculty of Emory University had perhaps its finest hour, in my opinion, in that they refused to accept any student with a G.P.A. lower than 2.5, even

though this meant, in all probability, that we would not fill our class. Our tuition at the time was approximately 3 or 4 times that of the public universities, especially in the Southeast, and we found that we could not compete for students in this market. The standard refrain that we received was that "I would like to go to Emory because of its very innovative curriculum, but I can't afford the cost differential." Our cause was not helped by articles in *Forbes Magazine* and the *New York Times* talking about the dire future of those people entering the dental profession from an economic perspective. Public dental schools also began actively recruiting out-of-state residents to their D.D.S. programs, even though the taxpayers of those states were subsidizing the schools. Although this issue was repeatedly raised at meetings of the Deans of U.S. dental schools, the administrators of the public schools were acting to preserve their own interests and those of their faculty. This development certainly hurt our recruiting efforts.

During the fall of 1984, I was repeatedly called in for conferences with the President and Vice President for Health Affairs regarding the future of Emory University School of Dentistry. At that time we had had a certain amount of attrition of our faculty and were only about 40% tenured. The tenured faculty was, in the main, not the most creative and was ill-equipped to obtain research dollars in the very competitive market. The University kept pressing the idea that we should reduce the class size to 25 or 30 really gifted students, partially or fully-subsidized, and pro-

vide them with a significant clinical and research experience. The continuing problem with that idea was the necessity to retain tenured faculty people and release the new, very talented faculty which we had recruited. It would be very hard to do this and continuously parade the fact that one was excellent, when in fact, most of the excellence had departed.

On an evening in January, 1985, as I was doing fund raising at a meeting in Florida, I received a call from the Vice President for Health Affairs telling me that he and the President had decided to take steps to close the D.D.S. program. I felt that before this information was made public I would like to meet with the President and Vice President and attempt to change their minds, as I felt there were some very positive signs emanating from the School of Dentistry. I flew back to Atlanta and met with them on the Monday morning after I had received the phone call. They felt their decision was correct for the institution and they were polling the Board of Trustees at that time for acquiescence. They felt they would keep our strengths which were postgraduate and research programs. I met with my deans that Monday afternoon, told them of the decision, and then sent a letter to the President and the Vice President announcing my resignation, effective when a new dean was hired. I harbored no ill will towards the administration of the University, but felt that I could not function in an environment where I had made commitments to people based on a five year plan.

The other dental deans met on Monday afternoon and evening

and developed a document which they presented to the President and Vice President on Tuesday morning. They put forth the scenario that, should we not fill the class, a blue ribbon committee could be established, and that this committee would make the suggestion that the DDS program be closed and the University harness its strength in the graduate and research divisions. They attempted to show that we were on the way to achieving our goals, and needed more time. The President, Vice President and Board of Trustees felt that the result would be a self-fulfilling prophecy in that once a blue ribbon committee was announced, there would be no more applicants and the school would have to close. Because of the problems of filling the class with excellent students, budgetary problems, the reaction of the alumni to the faculty practice, and the results of the accreditation, University officials felt they were doing the correct thing for Emory University. Such is the scenario of the closing of the D.D.S. program at Emory University School of Dentistry.

Now that I am an emeritus dean, I should be allowed the opportunity to pontificate, and would like to do so. In retrospect, I believe the following can be said:

1. We have repeatedly talked about the role of dental faculty in research. In addition to providing scholarly pursuits and upgrading the role of the school in the university, recruitment of research faculty who obtain grants is essential to the fiscal maintenance of a School of Dentistry. Most NIH

grants, in addition to the face value of the grant, include approximately 50% of indirect costs back to the University. Therefore, if one has a research person who brings in \$200,000 per year in research grants, he or she brings in an extra \$100,000 to the university. In most schools, this is almost equivalent to the total alumni contribution.

2. The mission of a private and public dental school may be entirely different in the 1980's and 1990's. Private dental schools may have a mission which involves experimentation in curricula, and providing a dental experience which is consistent with the mission of major national universities, i.e. to train a high percentage of future educators and leaders. This requires recruitment of a very different type of faculty than has been present in dental schools; faculty who can provide clinical services and are trained to do research, be this clinical or basic. There is not an abundance of such individuals presently in the United States. This fact has become very apparent as many of the dental schools with extensive research faculty have obtained many faculty from Scandinavian countries or Europe. The mission of most public dental schools has been to provide dentists to the taxpayers of that state. Those public schools who have obtained extensive research dollars have the best of all worlds—appropriated public budgetary dollars, in-

direct costs from research, and a broad based faculty. Kudos should be given to their leaders who provided this direction.

3. From 1) and 2) above, it is clear that the School of Dentistry must be an equivalent member of the University community. This will allow the institution to obtain long term support from the faculty and administrators in the University. This means interacting in research projects and in treatment of patients, and in general, being a good citizen in the University. Therefore, when stronger units in the University attempt to obtain dental school space, there could well be support all over the University for the School of Dentistry. In many institutions that I have visited over the past 20 years, the School of Dentistry has functioned in a rather isolationist capacity.
4. The School of Dentistry in any institution must be fiscally sound. This means obtaining endowment and corporate support. The role of a dental school must be constantly evaluated. In today's society, the job of a dean is to be a businessman and fundraiser, as well as to provide the academic leadership. The importance of a balanced budget cannot be overstated. The dental school dean is generally equivalent to high middle management in a corporation, responding to the CEOs, who are the Vice President/President axis. In the past, it has not

been necessary for the dean to have the financial wherewithal as it is in the present and future. Since the dean's position at dental schools is a balancing act between academic leadership, raising money, accommodating faculty, and dealing with alumni who feel very pressured because of the changes going on in American society, his job, if done correctly, is usually short-term. Such a person must be rewarded financially and in other ways. I personally think that the policy of many universities to provide a five-year contractual arrangement for a dean, followed by a review, is valid.

5. We must make the American Dental Association and its accrediting body more responsive to the needs of dental education. Of all the problems at Emory, I believe we could have compensated for most of them, but the stunning blow was the accreditation visit and its report. For this group to come to our university at the time it did and refuse to change from a rigid bureaucratic stance, is unthinkable in my opinion. I believe a review of the accrediting process should constantly be done and I believe it may be time for some new blood to be instituted into the accrediting body.
6. Finally, the alumni must constantly be told how important they are to the success or failure of dental schools. As I have tried to document, even

though alumni can contribute funds, and this is important, even more important is the fact that their constituency is needed desperately. Dental schools are vulnerable at this time, and the alumni must constantly reinforce the need for these institutions in the community.

As a postscript, things at Emory are proceeding quite well at present. The Health Sciences Library occupies approximately 40% of the space of what was the dental school. Our research group has exceeded all expectations and the postgraduate programs are strong and getting stronger. I believe that the decision to harness our strengths may prove to be the correct one; only time will tell. Emory graduates its last undergraduate class of dental students this spring (May 1988), and that will be a very poignant and bittersweet moment for many of us. The Administration of Emory University has aided in placements of students who wish to transfer to other universities, has compensated faculty and has given the newly formed School of Post-Graduate Dentistry a significant endowment with which to work. Whether the Emory model of the graduate and research division will be the appropriate one for a national university on the rise will only be told in the future. Δ

Reprint requests to:
Dr. Michael E. Fritz
School of Dentistry
Emory University
Atlanta, GA 30322

MAINTAINING ETHICAL IN TODAY'S

A Perspective of the American Dental Association

Michael L. Perich*

On October 23, 1986, the House of Delegates of the American Dental Association adopted language¹ which restated for the dental profession and each of us as individual members of the profession, the ethical commitment that we must adhere to:

The ethical statements which have historically been subscribed to by the dental profession have had the benefit of the patient as their primary goal. Recognition of this goal, and the educational training of a dentist, has resulted in society affording to the profession the privilege and obligation of self-government. The Association calls upon members of the profession to be caring and fair in their contact with patients. Although the structure of society may change, the overriding obligation of the dentist will always remain the duty to pro-

vide quality care in a competent and timely manner. All members must protect and preserve the high standards of oral health care provided to the public by the profession. They must strive to improve the care delivered—through education, training, research and, most of all, adherence to a stringent code of ethics, structured to meet the needs of the patient.

The above language is the preface of the ADA's *Principles of Ethics and Code of Professional Conduct*. The Board of Trustees of the American Dental Association, in forwarding that language to the House of Delegates for adoption, reaffirmed the Association's continuing support for the highest ethical standards, and for a code of professional conduct that will assure that our profession continues to provide quality care to the patients we are privileged to serve.

Some have attempted to minimize the dental profession's commitment to ethics by quoting out of context only portions of the preface to the *Principles of Ethics and Code of Professional Conduct*. The notion

is put forward that the portions taken out of context are not a strong statement in support of ethics and professional conduct. However, when the preface is considered in its entirety, as is appropriate, it is indeed a strong commitment to the needs of the patient through the overriding obligation of the dentist to provide quality care in a competent and timely manner.

The available time on our program today does not permit me to share with you the many current activities of the American Dental Association in support of ethics and professionalism. I will, therefore, limit my remarks to certain significant activities undertaken during the past three years.

At the conclusion of the 1984 House of Delegates, then ADA President Dr. John L. Bomba of Pennsylvania, appointed a Special Committee on Professionalism and Ethics. President Bomba charged this Special Committee with responding to the dental community's concern with the status of the profession's standards for professionalism and ethics. In addition, the Special Committee was asked to

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¹An address at the American College of Dentists, Annual Meeting, Las Vegas, Nevada, October 9, 1987.

*Michael L. Perich, D.D.S., Assistant Executive Director, Division of Dental Practice, American Dental Association.

STANDARDS DENTAL PRACTICE

A Historical Perspective

Peter M. Sfikas*

In examining the dental ethical standards it is worthwhile to take a historical look at the development of professional ethics.

It appears that the origin for the modern ethical rules that exist in dentistry, medicine, and several other professions may be found in the legal profession. Although ethical codes go back at least as far as the Code of Hammurabi in 2250 B.C., the forerunner of the modern ethical codes appears to have been developed among lawyers in medieval England.

Henry S. Drinker, in his classic book about the canons of legal ethics, traces the ethics back to the middle ages and concludes that legal ethics, at least until the recent past, might be more accurately labeled a code of etiquette among lawyers rather than a code of ethics. Accordingly, the traditional emphasis behind legal ethics has been oriented more to relations between lawyers than to lawyers' obligations to the general public. This criticism, of course, in a somewhat simplified fashion, is echoed

today by many consumer advocates who criticize all forms of professional ethics.

Drinker notes that the development of the canons of legal ethics was dictated by social conditions which existed in the middle ages. Barristers in medieval England were traditionally the well-educated sons of the very wealthy. They were, in fact, individuals who had no real need to work nor to earn a livelihood.

As a result of their favored social status and because of their ties to the rulers, priesthood and other medieval social elites, these early lawyers looked down upon trade and commerce and sought to distance themselves as much as possible from tradesmen or businessmen. Moreover, the relationship of the early bar was quite close; in fact, the lawyers dined together virtually every evening after the close of court.

In this atmosphere, the strict rules concerning advertising, solicitation or other promotional activities developed. Since none of these well-to-do advocates really needed to attract business, they saw no need to adopt the promotional techniques of the commercial

world. Moreover, it was considered very bad form to steal clients from one's nightly dinner companions.

In this sense, Drinker's description of legal ethics as a code of etiquette, as distinguished from a code of ethics which deals with moral questions of right and wrong and obligations to other than colleagues, has some merit.

Although the American Bar Association's *Code of Professional Responsibility* and *Model Rules* have been altered in some respects and have been made more specific than during the middle ages, the *Model Rules* remain in many respects somewhat similar to the earlier codes. Drinker noted that although social conditions in early America were vastly different from those present in medieval England, the American lawyers, as with so many other things, borrowed their legal ethics largely from the English system. They maintained these traditions not only out of habit, but because early American lawyers saw the canons as a way of emphasizing their status as a profession to the rest of the public.

Despite the fact that the relation-
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An address at the A.C.D., Annual Meeting, Las Vegas, Nevada, October 9, 1987.

*Peter M. Sfikas: Special Legal Counsel to American Dental Association.

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include in its final report recommendations to enhance the Association's activities in support of ethical conduct by individual members of the dental profession. So involved and comprehensive was the responsibility of the Committee that Dr. Abraham Kobren of New York reappointed the original members of the Special Committee and added a new member subsequent to the 1985 House of Delegates. President Kobren directed the Committee to continue its important activities.

The Special Committee presented its final report to the Board of Trustees in 1986. The recommendations contained within the report were endorsed by the Board and forwarded to the 1986 House of Delegates for discussion and adoption.

The distinguished members of the Special Committee, chaired by Dr. Douglas R. Franklin of California, included: Dr. George F. Lacovara, Connecticut; Dr. Jay McCaslin, Georgia; Dr. David A. Nash, West Virginia; Dr. James R. Plihal, Washington State; Dr. Claude I. Sime, Wisconsin; and Dr. Robert C. Wescott, New York. The Committee made several important recommendations to the Board of Trustees, some of which are relevant to our discussions today.

The Special Committee recommended an expanded role by the Council on Bylaws and Judicial Affairs. These expanded activities were envisioned to allow the development of additional advisory

opinions on specific ethical issues and the dissemination of those opinions to constituent and component societies.

The reorganization of the American Dental Association by the 1986 House of Delegates supported the expansion of activity by the Council. In addition, the Council was renamed to more appropriately reflect its bylaws responsibilities. The new name is the Council on Ethics, Bylaws and Judicial Affairs. The first word in the new name of this important Council accurately reflects the Association's continuing commitment in support of ethical conduct by the members of the dental profession. Membership in the Council was expanded to 16 members. The Council sits as the appellate tribunal for disciplinary proceedings initiated under the Association's *Bylaws*. Historically, in order to preserve its impartiality when hearing appeals, the Council has been constrained in the guidance it can provide to constituent and component societies seeking to initiate disciplinary proceedings. The increase in size has allowed the Council to continue its appellate duties while simultaneously developing the much needed advisory opinions.

The Committee also suggested that an expanded role of Council activities should include periodic workshops on effective applications and enforcements of ethical codes. Such a workshop will be held on January 17-18, 1988 at the ADA Headquarters in Chicago. The program will have content for those

experienced in the formulation of ethical concepts and conduct of disciplinary hearings as well as for those looking for guidance in these areas.

For example, in addition to presentations by representatives of the Federal Trade Commission and the legal and scientific communities, Professor David Ozar, who teaches dental ethics at Loyola University Dental School in Chicago, will conduct a workshop on the subject of "The Ethical Basis for the Regulation of Advertising."

The Special Committee has recommended an increase in ethics instruction in dental schools. Encouraging the effective instruction of ethics to predoctoral students was one of the highest priorities of the Special Committee. The Committee encouraged the Board of Trustees to communicate with the Commission on Dental Accreditation to urge that the Commission's *Standards* include a requirement for instruction of ethics as an independent subject. In addition, the Committee recommended that dental school faculty be sensitized to their responsibility as role models for their students and the importance of their modeling on the students' perception of ethical practice. As a result of the Association's request, a modification in the *Standards* has been achieved.

The *Accreditation Standards for Dental Education Programs* now contains the following language²:

5.4.1. Students must be provided either structured experi-

ences or instruction to become familiar with the professional and ethical issues associated with dentistry and to incorporate ethical concepts in the practice of dentistry.

5.4.2. Students must be provided either structured experiences or instruction to become familiar with the personal and legal issues associated with dentistry and its responsibility to the public.

3.3. Faculty must have an in-depth knowledge of an experience in their respective teaching disciplines and have a familiarity with educational methodology.

At one time, there was a perception in dentistry that a student's ethical outlook and attitude has been formed by the time of entry into dental school. It is now generally held that this is not the case. Instruction at the predoctoral level, and the example set by faculty, is effective in instilling a sense of ethics in developing professionals. The teaching of dental ethics in dental school has received considerable support. *Professional Ethics in Dentistry Network* (PEDNET) is a national network of dental school faculty, dental hygiene faculty, ethicists, dental association officers, social scientists, practicing dentists and others, who are concerned about professional and ethical issues in dentistry and about education regarding them. Currently, PEDNET includes representatives of 2/3 of U.S. dental schools.

PEDNET will meet on November 6-8, 1987, in conjunction with, and at the invitation of, the Society for Health and Human Values. Members of PEDNET will present papers on ethics and discuss specific cases in dental ethics. In addition, PEDNET provides a bibliography on ethical and professional issues in dentistry. The bibliography has been increased through the addition of 171 articles in the last two years.

If you or a colleague would like to review some of the recent articles on ethics and professionalism, the American Dental Association's Bureau of Library Services can be of service to you. A package library containing approximately 20 recent articles on dental ethics is available, on loan, by request, to ADA members. The package library will be sent to you upon request.

If you request a package library on ethics and professionalism, you will note that it contains several articles from the *Journal of the American College of Dentists*. The Officers and Fellows of the College, and particularly Dr. Keith P. Blair, editor of the *Journal*, are to be commended for their continued commitment to publish articles on issues that are vital to the members of our profession.

The Special Committee on Professionalism and Ethics' recommendations concerning expansion of activities by the Council on Ethics, Bylaws and Judicial Affairs and the inclusion of ethics as a more specific part of dental school curriculums, have been responded

to with enthusiasm and significant program activity. Such responses by the members of the dental community will help restore confidence in the profession's dedication to its code of ethics and insure that dentistry's professional integrity will continue to serve the best interests of the public.

I would like to share with you another activity of the ADA that has a direct bearing on the ethics and professionalism of dental students. The Council on Dental Practice presents a popular one-day seminar entitled, "Starting Your Dental Practice," to junior and senior dental students. This seminar is presented by a practicing dentist, a member of the ADA staff and a practice management consultant, and provides another opportunity for the profession to state its commitment to ethics and professionalism for the newest members of our profession. From the title of the seminar, it is obvious that program content is heavily weighted toward the management and business side of a dental practice. Can the business aspects of a dental practice coexist with and enhance ethical standards and quality care? I believe so.

You will remember that I began my presentation by stating the preface from the ADA's *Principles of Ethics and Code of Professional Conduct*. I would now like to offer another quote that speaks more to the business aspects of dental practice. In *A Passion for Excellence*,³ by Peters and Austin, the authors state:

Excellence is attained by serving customers well, providing high quality products and services, constantly innovating, offering strong leadership through attention to details, and treating people—both customers and employees—with respect, all with enthusiasm and intensity. Quality comes from people who care and are committed.

If we substitute "patients" for "customers" and "staff" for "employees," we have a statement concerning quality and excellence in the business sense that I believe is not in conflict with the *Principles of Ethics and Code of Professional Conduct* of our Association.

The "Starting Your Dental Practice" seminar allows ethical practicing dentists and Association staff to present to the attendees a strong message which implies that a dedication to excellence and genuine concern for patients, in concert with ethical and professional conduct, will insure a successful and rewarding future in our profession. To highlight that commitment, the Council on Dental Practice has included in the program content for this year's seminar a quote⁴ from Dr. Joseph A. Devine of Wyoming, president of the American Dental Association. Dr. Devine, in addressing dental students, said:

Remember this and say it to yourself regularly: If you want to be treated like a doctor, you have to behave like a doctor. If you want the dignity that goes

with being a professional, you have to demonstrate professionalism. You have to demonstrate compassion, caring, and patience about your patients and their needs. If you remember that, you'll stay a doctor, and you'll find that's the best that you can be.

You will note that I have discussed the commitment to professionalism and ethics of Dr. Bomba, Dr. Kobren and Dr. Devine, the last three Presidents of the American Dental Association. But, what about the future? If you are privileged to hear the address of Dr. James A. Saddoris of Oklahoma as he assumes the presidency of the Association, I am certain that you will hear a continuing, strong commitment to ethics and professionalism by this outstanding leader of our profession. Dr. Saddoris believes that the dental profession's heritage is one of "service above self," a devotion to excellence which has earned the public's unwavering trust. The commitment of the officers, trustees, council members and staff of the ADA to professionalism and ethics remains high.

In closing, I would ask a favor of you. You will remember that the *Accreditation Standards for Dental Education Programs* recommends not only teaching dental ethics to professional students, but a commitment of faculty to serve as role models for the young men and women entering our profession.

What better opportunity is there than for the Fellows of the Ameri-

can College of Dentists, through our commitment to professionalism and ethics, to serve as a role model for a young dentist. I am reminded of a quote from Dexter Scott King, son of Dr. Martin Luther King, Jr., who said:

Many talk the talk—few people walk the walk.

I know, my colleagues, that you will choose to "walk the walk" with a dedicated, enthusiastic, young member of our profession. Some of you will have the very special privilege of walking with a son or a daughter who has chosen to follow you into dentistry. Thank you for considering this and for all you do for our profession. I hope to meet you on our continuing walk to professionalism and ethics. Δ

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Reprint requests to:
Dr. Michael L. Perich
Assistant Executive Director
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611

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ship between the ethical codes of lawyers and that of dentistry is not easy to prove in the literature, the similarities in approach between the two appear to be too great to be coincidental.

The earliest record of some form of dental ethics is the 1834 constitution and bylaws of the Society of Surgeon Dentists, the first organized dental group known to have existed in the United States. This society was troubled enough about the misrepresentations in dental advertising to state its philosophy prominently in its constitution and bylaws as follows:

"In order more effectively to promote the honor of the profession, as well as to preserve good feeling and harmony among its members, it shall not be deemed honorable for any member, by means of advertisements, handbills, circulars, or in conversation with his patrons, to claim to be the exclusive manufacturer of good, incorruptible, or other teeth; or to claim any superiority over any other member, . . ."

In light of modern concepts of ethics, however, it is interesting to note that this early code focused more on false advertising rather than the prohibition of *all* forms of advertising.

In 1840, the American Society of Dental Surgeons was founded and had as one of its purposes to distinguish between competent and incompetent dentists. Research indicates that its standards for quackery were based more on the use of

cheap amalgam fillings than the use of false advertising. The American Society's successor organization, the American Dental Convention, appeared to have little concern with prohibitions on advertising.

The first American Dental Association code was written in 1860. It provided for the reprimanding or expulsion of any member guilty of "any act of specific immorality or unprofessional conduct . . ." The code, however, did not define unprofessional conduct.

Five years later, Dr. Jay Allen addressed the annual meeting of the American Dental Association and suggested: "As a learned profession, the time has come when a more elevated position should be taken and maintained by its members than has been heretofore observed. As one of the means of accomplishing this object, we believe that by adopting for our guide a proper code of dental ethics, defining the position, rank and duties of the dental profession, important interests to ourselves and to the community at large will be promoted."

The first official code, adopted in 1866, was divided into four sections involving the duties of members of the profession to their patients, maintaining professional character, the relative duties of the profession and the public, and the mutual duties of the profession and the public.

One of the obligations arising from the code was: "A member of the dental profession is bound to maintain its honor and to labor

earnestly to extend its sphere of usefulness. He should avoid everything in language and conduct calculated to discredit or dishonor his profession, and should ever manifest a due respect for his brethren."

In exchange for the dentists' rendering of service to patients, patients "should always discriminate in favor of the true man of science and integrity and against the . . . imposter."

It has been said that the fundamental purpose of this code was to elevate the status of the profession. Nevertheless, there was little specific in the code to designate ethical and unethical conduct. One section stated: "It is unprofessional to resort to public advertisements, cards, handbills, posters, or signs calling attention to peculiar styles of work, lowness of prices, special modes of operating, or to claim superiority over a neighboring practitioner, . . ."

The rules also required that dentists not guarantee operations, disparage other dentists or depart from established fee schedules.

By the early 1880s, the American Dental Association was enforcing its ethics code by refusing to admit or expelling those who violated it. Another change in the code in the 1880s was an 1881 revision which allowed dentists to state in cards or in the press their name, occupation, address and office hours. This provision also allowed dentists to state their fees on their appointment cards.

In 1899, specialization became a concern, and ethics rules were

adopted which encouraged the use of consultation but required that consultants operate with courtesy and just dealing.

In the early 1900s, dentists became upset about the high royalty demanded by Vulcanite Rubber Company and Tooth Crown Company. As a reaction, they declared it unethical for dentists to claim patents on inventions since this was contrary to the best interests of the profession as a whole.

In 1922, the *Principles of Ethics* was redrafted, removing all mention about fees except for the problem of fee splitting. The provision simply stated: "It is unprofessional for dentists to pay or accept commissions on fees for professional services, or for radiograms, or on prescriptions or other articles supplied to patients by pharmacists or others."

In 1927, after several years of study, a more explicit ethical code was adopted in response to criticisms that the earlier code was overly-vague.

In this regard, a noted researcher on dental ethics says, "[t]his is the first instance where the Transactions refer to the use of the medical code of ethics in the formulation of the dental code, but undoubtedly the medical code had influenced, indirectly, the thinking of dentists from the beginning." No doubt, the medical code was in turn based upon the lawyers' codes of ethics, and that is the reason why historically the lawyers' codes of ethics appear to have strongly influenced dental ethics at least in general

approach.

By 1934, the American Dental Association code had grown to twelve sections. In 1950, the ADA adopted something very close to their *Principles of Ethics* which prevailed until 1979.

Two scholars who have studied early dental ethics have reached similar conclusions about some of the forces that were acting upon dentistry which shaped the ethical code. Both emphasize the fact that dentistry in the 1800s was an infant profession seeking an independent identity as a health profession. Dentistry therefore adopted rules not only to establish itself as a learned profession, but in response to specific problems arising from dentistry's youth as a profession.

Thus, in those early years neither dental education (if any), nor techniques, nor materials were at all standardized. Aggravating this was the problem that rival dentists refused to discuss techniques or materials with one another, since they preferred to maintain their own "secret techniques" or "patented processes." This impeded development of the science of dentistry and also allowed dentists, particularly itinerant dentists who could quickly vanish if they irritated anyone, to make wildly-exaggerated claims about their techniques or materials.

Over the years, the historical bases for some of the earlier ethical norms have diminished. The special needs of an infant profession struggling for identity and respect are no longer relevant. Dentists,

today, clearly are well-respected for the vast body of knowledge which they must master and the skills which they display and there is little reason to impose rules merely to announce to society that dentistry constitutes a learned profession. In the past few years, pollsters such as Lou Harris have consistently found that dentistry is one of the most respected professions in the United States.

Ethics Today

In the current climate, questions still arise about some of the traditional ethical principles. One source of questions is consumer advocates who object to the ethical rules which they feel are based primarily upon etiquette or the relationship among practitioners rather than on the profession's obligations to the public. These critics feel that the ethics of all professions should emphasize the profession's obligations to see that their members are competent and that professional services are available to all segments of the public.

These critics argue that since society affords special privileges to professions, professionals in turn owe higher obligations to society.

Probably as a result of this form of criticism known as the age of consumerism, the federal enforcement authorities and the courts have been more willing than in the past to scrutinize the internal professional rules of professional associations for any aspects which may be unduly anticompetitive.

This process began in earnest in 1975 when the United States Supreme Court in *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975), decided that the promulgation of minimum fee schedules by lawyers constituted illegal price-fixing and that professions are not automatically exempt from the federal antitrust laws. Prior to this extremely significant decision, most lawyers thought there was some form of exemption for professionals.

In 1977, the court in *Bates v. Arizona State Bar*, 433 U.S. 350 (1977), ruled that even states may not prohibit attorneys from truthfully advertising about their routine services and fees because this kind of activity was constitutionally protected. Finally, in 1978, in *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978), the Supreme Court determined that the professions are fully subject to the antitrust laws and that, although the nature of competition may differ somewhat in the professions thereby allowing for somewhat different competitive rules, professions may not adopt rules which clearly restrain or diminish competition.

As a result of the foregoing decisions, the professions may prohibit false or misleading advertising, but many believe that there is some general slippage in professionalism which results from the atmosphere in which these prohibitions are enforced. First of all, at the federal level, there is no serious interest by government agencies in controlling

false advertising by professionals.

On the state government level, funds and personnel are usually scarce and in my experience the states tend to focus their limited resources on activities which are more "newsworthy." Even if the Dental Board is concerned, it may have a difficult time interesting the attorneys from the Attorney General's Office in pursuing the matter.

Even economists who basically favor advertising by professionals have recognized the potential for abuse. In a 1985 FTC seminar on advertising that I participated in, Professor Steven R. Cox, a Professor of Economics at Arizona State University, expressed the expected viewpoint of an economist that advertising will promote efficiency, but noted that the advertising with the most potential for profit is quality advertising. However, he noted also that quality advertising has the most potential for false advertising because quality is very difficult to define. As a solution, he suggested involvement by voluntary associations, but voluntary associations who police false advertising zealously run the risk of costly antitrust litigation with the government or the professional who has been disciplined. Thus, the associations are left in a dilemma and the public runs the risk of being largely unprotected.

The federal government's intrusion into the dental profession, in an apparent effort to emphasize the marketing and solicitation of dental business, has had the pronounced effect of making dentists

feel less professional. The dental profession has always prided itself on its professionalism, and the government's efforts at underscoring the business rather than the altruistic notions of the profession have led to conferences such as these and former ADA President John Bomba's appointment of a special committee on professionalism.

The dental profession appears, as do the legal and medical professions, somewhat wounded by the profound changes which have occurred. Since the clock cannot be turned back to the pre-*Goldfarb* days, I respectfully suggest that the dental profession should continue to stress its commitment to competence and service as a way of heightening professionalism for dentists.

It is very unfortunate that a healing science such as the dental profession should feel as it does because of federal intervention. The dental profession, no less than the legal and medical professions, believes that it has been betrayed by the federal government, and perhaps the federal government must realize this before the wounds may be fully assuaged.

In closing, I think that each individual dentist should consider carefully what activities he or she undertakes which may have an adverse impact on his or her profession. Δ

Reprint requests to:
Mr. Peter M. Sfikas
200 East Randolph Drive-Suite 7300
Chicago, IL 60601-6969

KEEPING PACE WITH CHANGE: WHEN THE DDS IS NOT ENOUGH

Michael A. Heuer*

Education of the profession following graduation from dental school has both a long tradition and an immediate urgency. There are moral and rational imperatives as to why dental schools should take an active role in continuing education to which the turbulent times in which we live add new dimensions of experience and potential. The opportunities opening before us are limited only by our visions of our past and future.

In this year of 1986, we have devoted ourselves to the recognition of the 150th Anniversary of the birth of Greene Vardiman Black, and rightfully so. However, I would like to dedicate my remarks not to the father but to the son, Arthur Davenport Black, Dean of the Dental School from 1917 to 1937. The father was the great self-taught dental scientist which we all recognize. The son was the administrative and organizational genius

*Michael A. Heuer, DDS., MS., Associate Dean for Academic Affairs, Dental School, Northwestern University, 311 East Chicago Avenue, Chicago, IL 60611.

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Reprint requests to Dr. Heuer.

whose contributions to organized dentistry, dental education, dental literature and the entire dental industry are ever present today. In truth, as I was preparing these remarks in the very office of which Arthur D. Black was the first occupant I could not help but conclude that as great as his father's contributions were, his contributions will ultimately prove to be greater and more lasting. Arthur D. Black was the transformer of dreams into reality, the catalyst who brought together and focused the talents of many to the benefit of even more and the skillful architect who built not only the first modern dental school in history but also the organizational structure of dentistry, dental education and every organization of which he was a part, and of which we are the beneficiaries.

On the frontpiece of your program for this Symposium is the quotation from Greene Vardiman Black who expressed most eloquently an ethic for his time and ours, "A professional man has no right to be other than a continuous student." At the close of the Victorian Age and the dawning of the Twentieth Century, prior to the cataclysm of World War I that was to change the course of history, this ethic was most certainly in the

"A professional man has no right to be other than a continuous student."

spirit of the times. Science and the advancement of knowledge was very much the business of 'gentlemen scholars' who were in debt to the enlightenment philosophers of the 18th Century whose economic, political and social theories launched that great human experiment we know as the United States of America. Black, like his contemporaries, assumed that the intellectual curiosity of childhood persisted throughout life, required nourishment from within, and those with the social and economic ability to 'pursue happiness,' in the sense that 'happiness' meant the good life well lived, had a moral obligation to do so. The greatness of G.V. Black's admonition lies in his belief that if dentistry was to become truly a 'learned profession' it must recognize its moral obligation to become a body of continuous scholars. Arthur Black built a prestigious educational institution and contributed to the development of a great University with the belief that you did not go to a University to learn to make a living but rather you went to a University to learn to live. Both father and son would be distressed to learn that as a nation and as a profession, we are passing through a vale of darkness in the sense that too many of us perceive our profession or our work in life to be only a means to an end and that end to be a hedonistic pursuit of pleasure rather than the pursuit of a life well lived. To me continuing education is a quest, a lifetime quest, in the pursuit of true

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happiness and it is in this context I wish to address my remarks this evening.

How would I define continuing education? To me, continuing education consists of all those learning experiences which do not in a structured sense lead to the awarding of an academic or professional degree but are essential and meaningful to living and working. What is a university's role in continuing education or more specifically a dental school's role in continuing education? To answer those questions we must address the more fundamental question of what is the nature of the educational business we are in as a dental school or a university. I for one do not believe that we are in the exclusive business of putting people through a sequence of courses so that in good conscience we can award degrees. True, it may be that this activity is an essential part of our enterprise, but neither the mission statements of the University or the Dental School would lead one to such a narrow view. And yet that would appear to be our main, if not only, educational preoccupation. It certainly is what we give credence to when the only alumni we officially recognize are those who were granted degrees (A policy not pursued by comparable institutions of higher learning). A recent survey I read indicated that nearly half of the adults in the United States who attend courses in institutions of higher learning do not do so in the

pursuit of academic or professional degrees. It seems to me that we really are, or ought to be, in the complete business of education. To dismiss half of the adult population as potential consumers of our educational services or to ignore those who have in fact received them is to compromise our future as a dental school or as a university. Continuing education to meet public and professional needs must therefore appeal to the demands of as broad a range of formats and subjects as possible. To do this well, we must stress those things we alone are able to do or can do well and not waste our resources in attempting to do those things that are better done by others. This Symposium has been designed to address these issues and to solicit your input in planning and implementing future directions.

This afternoon we focused our attention on organizational formats for continuing education in a dental school and university environment. Tomorrow morning we will concentrate on the subject matter, or content, that is currently presented in dental schools. If time permits, we should address the issue of what audiences we ought to be addressing in continuing education. If one grasps the concept that as a dental school we have a considerable body of unique knowledge and expertise that is potentially beneficial, and perceived to be worth obtaining by potential students who are not only practicing dentists but also students who have a wider range of occupations with vested interests in dentistry, dental practice and the dental profession, our horizons are limitless. I most certainly argue for the broader viewpoint.

Why continuing education? In addition to the moral imperative I considered in my introduction, there is of course the ever present rationale that our patients are bet-

Human endeavors that depend upon conscience for enforcement are prejudiced in favor of those who have no conscience.

ter served by an up-to-date, current and skilled professional. That rationale also assumes an ethical and moral imperative upon the professional. Human endeavors that depend upon conscience for enforcement are prejudiced in favor of those who have no conscience. Therefore, we have professional societies and state legislatures who in recognition of this axiom have passed regulations requiring continuing education for the continuation of membership or licensure. I propose a very pragmatic reason for continuing education and that is the need for the practicing profession, dental education, the dental industry and the dental patient to keep pace with change. To deny change is to deny life itself. This should be self-evident for students of life science but apparently it is not. To ignore the ever accelerating pace of change in our own time is to be out of touch with the world as it exists. In this context I firmly believe, as does Miss Piggy, "that the road to success is always under construction!"

Walter B. Wiston, Chairman of Citicorp in 1981 put it very suc-

I propose a very pragmatic reason for continuing education and that is the need for the practicing profession, dental education, the dental industry and the dental patient to keep pace with change.

cinctly when in an address to businessmen he noted that there is no devine right of inherited markets just as there is no devine right of kings! The false notion that there is dies hard, not only among businessmen, but also among dental practitioners as well as dental educators. Just as no businessman in a free society can control a market when customers decide to go elsewhere, no dentist can control his practice when patients decide to go elsewhere or no dental school can control its future when students decide to go elsewhere. All of us are helpless in the face of a better product or service, or what is perceived to be a better product or service. This is the way of events as they are and not of events as we would like them to be.

Continuing education programs that are well conceived, well presented and well received are some of the most valuable marketing tools we as an institution can employ. Every student who is a satisfied consumer of our educational services is a recruiter for future potential students and supporters of the institution. It should go without saying that quality attracts quality and that to survive and prosper in our times we must market whether we like it or not.

If keeping pace with change is the compelling force that necessitates continuing education, what are some of the particular implications of this for dentistry? To understand our present situation as well as the potential of our future we must understand the reality of our immediate past as a national society and its relationship to our profession. Harold Hillenbrand and I once had a discussion here in the Allen Center about the ADA Report on the Future of Dentistry. Both of us were of the opinion that the preliminary drafts of this report were flawed in that they contained no references to the economic, politi-

cal and social climate of the Nation as a whole and therefore perpetuated a naive notion that the present and the future of the profession is separate from, and unrelated to, the larger issues before the Nation. Fortunately, this oversight was brought to the attention of the Committee by many individuals and was in part corrected in the final document. Harold was most complimentary of the report as a meaningful resource document but was very critical of the proposed plan for action. In his view, it ignored the facts presented and addressed itself to self-serving 'good intentions.' For those of us who knew Harold, we were very aware that he never confused good intent with the realities of action or events.

The Civil Rights movement of the 1950's has had a lasting and profound effect on American society, the American work ethic and the dental profession. A glance at the newspapers this morning with commentary on the US Attorney General's attack on the 1954 Supreme Court's decision of *Brown vs Board of Education* is an object lesson for us all. Until the 1950's, most black dentists were educated in the black dental schools of Howard and Meharry. There were exceptions of course but these exceptions were not the rule. Northwestern University Dental School refused to treat black patients in the late 1940's and early 1950's on the premise that its graduates did not practice in black areas. It was not until after Federal Court decisions against the segregated South Carolina Dental Society that the American Dental Association acted in 1962 to refuse to seat Constituent Society delegations who denied membership to black dentists. In the 1950's, there were very few women in dentistry and the majority of these were trained in Eastern or Northern Europe but by the Year 2000 we

anticipate that 20-25% of the practicing profession will be women. An indirect result of the Civil Rights movement has been the public challenge to the authoritarian role of professionals in the delivery of health care and the determination of health care policies that affect them as individuals.

The fear of socialization of the health care system in the 1950's, intertwined with the political hysteria of McCarthyism, set in motion an entire chain of events that led to direct and indirect appeals for the support of health care education, research, and the involvement of educational institutions and government in their present relationships. The medical approach was to fight direct support of education and as an alternative seek indirect support through research based in medical schools and support for patient care in the hospitals. Not unrealistic when one considers the nature of medical education and the fact that the bulk of clinical education in medicine is based in and supported by hospitals. The dental approach, with a different and distinct educational structure, was to seek direct support for dental education through capitalization programs and support for physical plant construction and renovation as well as to establish a research enterprise at both institutional and governmental (NIH) levels. For dentistry both programs were outstanding successes. The National Institute for Dental Research has funded from 80-85% of all dental research in the past twenty years, dental school enrollments increased from 4000 to 6000 in entering classes, auxiliary training programs were instituted in a wide variety of educational institutions, and dental schools were constructed or rehabilitated throughout the United States. Much of what we so proudly accept today as our national resources in dental

Much of what we so proudly accept today as our national resources in dental education are the result of the success, not the failure, of public policy and government programs.

education are the result of the success, not the failure, of public policy and government programs.

The delivery of health care and its financing in America has evolved into major social, political and economic issues in the decades since 1950. Prior to World War II there were few alternatives to the direct payment of fees for services paid by patients. United States national economic policies of management versus labor, with government as a 'referee' rather than as a participant, was followed by aid to the aged (Medicare/Medicaid) as an extension of Social Security. Of primary concern today on both sides of the legislative aisle are the rising costs of health care and perceived limitations on access to health care by citizens. The medical approach to this issue was to join with the emerging systems and attempt to control them (Blue Cross/Blue Shield) for as long as possible. This delayed the entry of independent for-profit medical insurers into the marketplace. The dental approach was to avoid as long as possible any alternatives to the direct payment by patients of fees to dentists. As a profession, we are still struggling with this mind set.

An immense explosion of science and technology has not only increased the efficiency and effectiveness of dental practice but has also significantly reduced and altered the need and demand for dental care. I need not elaborate on the impact of high speed instrumenta-

tion, fluoridation, composite restorative materials and techniques, computer technology and the increased use of auxiliaries in dentistry to this audience. But I would be remiss if I did not remind you that most of the financing for the basic development of these advances in dentistry came from public, primarily federal sources, rather than private ones. The private sector, however, did indeed capitalize on them and distribute them widely to the profession. Paralleling the public initiatives was a consolidation of the dental industry into conglomerate corporations with sufficient enough capital to engage in dental research, development and marketing on an international scale. I attended a preview of the forthcoming National Study of Dental Disease Conference given at the recent ADA meeting in Miami in which adult populations of ages 17-65 and 65 and over were examined nationwide. Preliminary data demonstrates that dramatic decline in coronal caries in all but the over 65 age group (90% of which was restored), the widespread prevalence of root caries in all age groups (less than 30% restored) and the extensive distribution of gingival and periodontal disease throughout the US population (largely unrecognized and untreated). This report brings into sharp focus the growing dichotomy between the disease patterns that dentists have been trained to treat and the dental diseases that patients actually have. Compounding the problem is the fact that less than half of the population examined either sought or obtained dental care on a regularly sustained basis. I asked myself, what are Black's principles for the treatment of diseases that did not exist in his time? Can the materials and technics that Black championed be used to treat today's patients or should they? Greene Vardiman Black believed in the

discovery of facts and Arthur Davenport Black believed in taking actions based on those facts. Both Dr. Blacks were progressives in their time. So we have a very real task before us, not only to retrain and retool an entire profession but also those faculty who would take a leading role in the process. And let us not leave out those others with a vested interest in dental care such as industrialists, managers, businessmen, hygienists, assistants, laboratory workers, and patients.

Before I leave the general topic of the national economic, political and social agenda and its impact on dentistry, I would remind you to examine closely the effects of the creeping anti-intellectual sentiment in America exemplified in the creationism movement in our public education, the mounting national debt plus the adverse balance of trade in our economy, and the impact of the new tax laws on institutions of higher learning (as well as their students) particularly in the private sector.

Dental students must be futurists, as must be all professional students. From the time they leave high school to the time they graduate from dental school, for most of them eight years will have elapsed. For physicians this interval is ten to twelve years. The interval between entry into professional education and exit into the marketplace for jobs is twice to three times that for recipients of the Baccalaureate degree. The irony is that those professional students who most need exposure to education and experience in social studies and humanities in order to prepare them as futurists are the least likely to receive it in our present educational system. Further, the overcrowded curriculums of dental and medical schools precludes anything other than at best the attainment of a baseline level of clinical competency at the time of graduation,

even in the finest institutions. No wonder, under these circumstances, professionals have perceived themselves to be either the only ones affected by change or threatened by its inevitability.

What can they and we anticipate for the future? Applications to dental schools have declined by 67% since 1978. First year enrollments have dropped 23% and are expected to drop to 69% of 1978 levels by 1989. Based upon projections of public and private national agencies we can anticipate the following:

1. Continued decreases in applicants and enrollments in dental schools will lead to increasing competition between schools as well as the search for alternatives to dental student tuition as a means of financing dental schools (ie: research, patient care, continuing education).
2. The DDS/patient population will stabilize by the turn of the century followed by a loss of over 1000 DDS's per year after the year 2020.
3. There will be a prolonged period of prosperity for DDS's if they can and will adapt to changing market conditions.

The U.S. population will continue to grow particularly with regard to its Black, Hispanic and Asian segments. The European/Caucasian segments of the US population will continue to decline in proportion to the whole. Increases in women DDS's and DDS's of Hispanic and Asian heritage will occur with the role of Blacks remaining uncertain. By the 1990's over 50% of practicing DDS's will be under age 40 and over 15% will be women (Dental leadership today is usually exclusively white male with an average age of 58).

The indebtedness of dental students will continue to accelerate. Over \$40,000 for all graduates and over \$51,400 for private school graduates in 1985. This debt burden is forcing graduates into new practice settings. Only 9.4% entered directly into solo practice in 1985. More and more graduates are becoming employees by choice or until they can retire debts and raise enough capital to establish independent practices. More and more are seeking advanced education as means of deferring debt retirement and enhancing future earning potentials.

Changing economics and delivery systems in dental practice are creating a new class of DDS employees (employees per se or independent contractors). This new class seeking jobs requires credentials beyond the baseline DDS in order to compete in the market for jobs. There is not only competition for patients among all dentists but more important to the recent graduate there is competition for jobs and/or educational opportunities as well. Clinical enterprises of increasing size and complexity are arising to meet the changing situation. These are controlled by venture capitalists and entrepreneurs from both within and without the profession. This has the direct effect of intensifying the competition for jobs, patients and sources of funding as well as to lower profit margins, intensify marketing and create internal 'specialization' of professional staffs. The entire process plays into the hands of those who control the capital necessary to set up modern dental facilities and practices not unlike what has occurred in medicine with the shift of the physician from his own office to that of the hospital or medical center.

The effects of all these events on

... we must perceive ourselves as others perceive us, not as we perceive ourselves ...

the quality of professional care, the substance of dental education, the practice of dentistry and the availability or cost of professional services to patients is uncertain and at this point in time largely unknown.

This is one factor however that is certain and that is that the holder of the DDS degree with no other credential or experience, will be at a distinct disadvantage and that increased emphasis on continuing education is very likely to be a key element in his or her future as well as that of the entire profession. Therefore, as a profession and as an educational institution, we must:

1. become knowledgeable in the realities of the present situation and futuristic in our outlook.
2. be honest with ourselves as to our strengths and weaknesses and we must perceive ourselves as others perceive us, not as we perceive ourselves, in order to maximize our strengths and minimize our weaknesses individually and collectively.
3. recognize and seize opportunities for new knowledge, experience new things, develop new skills and experiment with new strategies for coping with change.
4. adopt as a model for our lives Dr. Black's ethic and commit ourselves to the pursuit of the 'good-life well lived' through continuous education. Δ

ETHICS CURRICULUM IDENTIFIES ETHICAL CONFLICTS

Victor M. Coury*
William F. Slagle, Jr.**
W. Thomas Fields***

A series of courses in professional ethics have been added to the undergraduate curriculum in the University of Tennessee, Memphis, College of Dentistry. The rationale for this addition is described and the logistics of implementation are discussed. Student feedback verified the need for teaching ethics in dental school and singled out a particularly disturbing ethical dilemma faced by dental students—the resolution of conflict between departmental requirements and patient needs.

Recent violation of ethical standards in such areas as the Iran-Contra affair, the Wall Street Scam regarding inside trading, TV evangelists (pearlygate), recruitment violations by colleges, revocation of licenses of physicians and dentists, disbarment of attorneys, criminal charges brought against

the military industrial complex, etc. have shaken the moral fiber of America. The age-old questions arise again—to what degree is ethical behavior teachable? At what stage(s) of life should it be taught?

In an era of competition for patients, controversy over the proper role of marketing activities in dentistry, and mushrooming malpractice claims and premiums, these questions become directly relevant to dental education. It is thought that ethics is taught in the home, church and school; however, we should not conclude a priori that ethical principles have been internalized by students matriculating in dentistry.

Dr. Lawrence Kohlberg, a professor of education at Harvard, introduced a new concept of moral development.¹ He suggests there are six fundamental, ascending stages of moral decisions in people. Dr. Kohlberg began a twenty year study in 1956 in which he asked people to resolve hypothetical moral dilemmas. The results of his study are outlined in the accompanying Chart. Dr. Kohlberg concludes that the first two levels of moral judgment occur by the age of 10. At these levels, children simply make a moral judgment based on avoiding punishment, or to further their own desires. The third and fourth stages extend from adolescence into adulthood and are the stages at which most of

the adult population operate. As individuals attain these levels, they appear to become less self-serving and begin to rely upon rules and expectations of others. Simply, they are "eye servants". Principles have not been internalized logically, but rather reflect expected behavior. Stage 4 expands to include concern for the larger society. A child at Stage 1 who refuses to steal because he fears punishment upon getting caught may, at age 16 and Stage 4, choose not to steal because he knows stealing is against the law. However, if there were no law against stealing, the 16 year old might steal, since the principles of justice have not been internalized by Stage 4. Such internalization does not occur until Stage 6. No more than 20-25 percent of the adult population reach the last two stages, with only about 5-10 percent achieving Stage 6. Individuals in Stage 6 depend on their own fully developed ethical principles, based on such universal standards as respecting the rights of others. Stealing would violate these rights, and thus is inconsistent with Stage 6 moral development. Stage 6 involves critical thinking and problem solving necessary for resolving ethical dilemmas in the dental school clinic and in private dental practice. It represents the level of ethics espoused by and aspired to by the dental profession; thus, the inclusion of ethics in the dental

*Victor M. Coury, B.A., M.A., Ed.D. Professor of General Dentistry and Coordinator of Behavioral Sciences.

**William F. Slagle, Jr., B.S., D.D.S., M.Ed., Dean

***W. Thomas Fields, DDS, M.P.H. Associate Professor of General Dentistry and Coordinator of Community Dentistry. College of Dentistry, University of Tennessee.

Chart: STAGES OF MORAL DECISIONS

- I. Preconventional Level
 - Stage 1: Orientation to punishment, obedience, and physical and material power. Rules are obeyed to avoid punishment.
 - Stage 2: Naive instrumental hedonistic orientation. The child conforms to obtain rewards.
- II. Conventional Level
 - Stage 3: "Good boy" orientation designed to win approval and maintain expectations of one's immediate group. The child conforms to avoid disapproval. One earns approval by being "nice".
 - Stage 4: Orientation to authority, law, and duty, to maintain a fixed order, whether social or religious. Right behavior consists of doing one's duty and abiding by the social order.
- III. Postconventional, Autonomous, or Principal Level
 - Stage 5: Social contract orientation, in which duties are defined in terms of contract and the respect of others' rights. Emphasis is upon equality and mutual obligation within a democratic order. There is an awareness of relativism of personal values and the use of procedural rules in reaching consensus.
 - Stage 6: The morality of individual principles of conscience that have logical comprehensiveness and universality. Rightness of acts is determined by conscience in accord with ethical principles that appeal to comprehensiveness, universality, and consistency. These principles are not concrete (like the Ten Commandments) but general and abstract (like the Golden Rule, the categorical imperative).

curriculum appears justified and should be designed to facilitate the achievement of Stage 6.

Planning the Professional Ethics Curriculum

In 1982, Dr. William F. Slagle, Dean of the College of Dentistry, University of Tennessee, Memphis, initiated discussions concerning the need to develop and implement courses in human values and professional ethics. In 1983, represen-

tatives from the Tri-State Section of the American College of Dentists contacted the Dean to offer both financial and moral support in strengthening the ethics courses. At their annual meeting in 1984, the members of the American College of Dentists voted to offer substantial financial support in bringing two noted consultants to conduct a workshop for both faculty and practitioners. The two consultants were Drs. Muriel Bebeau, University of Minnesota College of

Dentistry, and Marcia Mentkowski, Alverno College, Milwaukee, Wisconsin.

A two-day workshop was held in September, 1984. The first day was designed for twenty dental faculty members and thirteen dental practitioners who would become group facilitators. The subject matter introduced the dilemma discussion approach: 1) experiencing a dilemma discussion; 2) setting goals for the dilemma discussion; 3) assisting student performance; and 4) defining the facilitator's role. The faculty and practitioners were active in the discussion.

On the second day, ten members of the American College of Dentists, twenty dental faculty members, and one faculty representative from Meharry College of Dentistry attended. The topics covered were: 1) distinguishing the problem from the dilemma; 2) experiencing the professional problems; 3) assessing student performance; and 4) questions and issues. Faculty and practitioners were assigned to small groups for discussion of professional dilemma cases.

After the small groups were terminated, discussions continued involving the entire group of attendees. At the end of the workshop, ninety-five percent of attendees rated the workshop as outstanding, reporting they would feel more comfortable in dealing with small groups of dental students.

The Educational Experience

Based on a review of the literature, consultation with experts in

ethics, and input from workshop participants, it was decided that a series of courses should address the issues of the three P's shown in Figure 1: 1) *personal* ethics in the life of a dental student; 2) professional ethics regarding the treatment of dental *patients* in the dental clinics; and 3) professional ethics related to the *practice* of dentistry.

In an attempt to address relevant material in a timely manner, a course in personal ethics is presented in the freshman year. The Junior students are introduced to professional ethics in patient treatment through a course presented when they enter the clinics. Senior students are offered a course that addresses professional ethics re-

lated to dental practice, as they prepare for graduation. In each course, students are presented lectures with cognitive concepts regarding basic issues in dental ethical dilemmas. These dilemmas are then explored in small groups in order to assist students in the development of a moral point of view.

Dental students in the first and third years receive lectures on the "five components of a moral point of view," which are:

1. Being adequately informed
2. Being conceptually clear
3. Exercising free decision—devoid of bias
4. Being impartial

5. Being willing to universalize one's moral judgment

A further presentation discusses the concepts of conscience and guilt. Conscience is defined as "the faculty of recognizing the distinction between right and wrong in regard to one's own conduct." Simply, conscience is the mind deriving a judgment based upon knowledge or evidence. Dental students are directed to the following sources of knowledge:

1. common sense
2. revelation theory—Talmud, Koran, and Bible
 - a. three kinds of faith or beliefs
 - 1) faith in spite of evidence
 - 2) faith in the absence of evidence
 - 3) faith because of evidence
3. authority
4. intuition
5. customs and traditions
6. experience
7. scientific inquiry—inductive reasoning

Senior dental students participate in a course focusing on dental practice. Six dental practitioners were involved in presenting five lectures and dilemmas in dental practice. Realistic dilemmas selected for presentation addressed the questions of: internal and external marketing and advertising, falsifying third-party billings at the request of patients, writing drug prescriptions for non-patients or for patients who are excessive

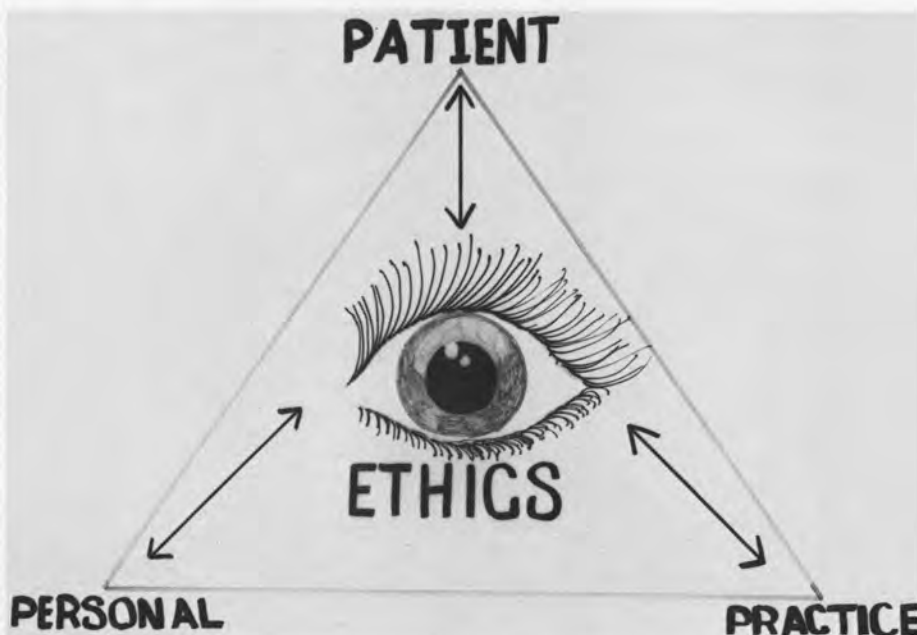


Figure: Dental Student Ethics—Three P's

users, compromising the quality of delivered dental care, criticizing fellow practitioners to patients, and charging and billing through questionable procedures. After each lecture, the class was divided into 10 groups of nine students for a seminar to discuss the lecture and address the presented dilemmas. Fifteen practitioners belonging to the American College of Dentists participated and contributed to the seminar group discussions. Dental practitioners were paired with dental faculty as facilitators for the small groups. The majority of these practitioners and faculty had participated in the 1984 workshop.

The American College of Dentists continues to support the ethics program by direct involvement with the dental administration and the dental students. The fifteen practitioners volunteered one-half day of practice per week for five weeks in order to serve as role models and seminar facilitators in the program.

Discussion

As a result of the faculty's preparation during the workshop, the small groups for first and third year students functioned effectively and efficiently. The faculty facilitators presented student life and clinical dilemmas and experienced sincere concern and active participation by the students. Faculty reported that the small group experiences were most productive.

Through these ethics courses, faculty, practitioners and students

have identified numerous actual and/or realistic ethical dilemmas for discussion. One dilemma is particularly alarming. In classroom discussions and required ethics papers, students expressed the opinion that the departmental clinical system promotes ethical violations. Faculty have known empirically for many years that potential for conflict between departmental requirements and ethical principles is inherent to the clinical teaching system. Few would have suggested that this potential was being realized, and perhaps none could have foreseen the frequency with which requirements apparently receive priority over ethical principles.

Basically, the students reflected the attitude that patient needs are subservient to requirements. According to student comments, verbal and written, there are three points at which ethical principles are most frequently violated:

1. During diagnosis, emphasis is placed on finding needed requirements rather than diagnosing comprehensive patient needs.
2. Patients are encouraged to have more expensive inlays/onlays when amalgams/composites would be sufficient and appropriate.
3. Uncompleted patients are placed on "will call" when the remaining dental work does not fulfill needed requirements.

Student needs (spelled r-e-q-u-i-

r-e-m-e-n-t-s) must be met in order to avoid attending school during the summer. Attendance during the summer session increases costs for room and board, transportation, and other general costs, as well as tuition. Furthermore, summer clinic attendance excludes vacation and the possibility of working for extra money. The bottom line may be that "conscience follows money instead of money following conscience." Idealistically, the entering student sincerely wants to help people and to respond, uninfluenced by other factors, to their dental health needs; but the student finds he/she is limited in fulfilling that goal. Students are placed in an ambivalent state regarding the best interests of patient and self, e.g., "Yes, I want to treat my patients ideally, but requirements limit my ability to do so because I must fulfill the departmental requirements to prevent additional costs and possible delay in graduation."

Undoubtedly, the above problems generate guilt feelings in the students, which could be expressed in anger toward faculty and the institution. Guilt is defined as the realization that an individual has transgressed a moral, social or ethical principle which may result in lowering of self-esteem. This realization of transgression is a learned response that has been taught and reinforced from childhood through all life stages of development. Authority figures, such as parents and social institutions (church and school), teach and demonstrate a

relationship between transgression of principle, guilt and punishment. When principles are transgressed, one learns of wrong doing and therefore deserves to be punished. Punishment is administered as a result of an undesired behavior in an attempt to suppress that behavior in the future. Authority figures reinforce the learning cycle (transgression—guilt—punishment) through demonstration by the application of punitive measures for the transgression of a principle. It is a universally held belief that the guilty deserve to be punished. Unfortunately, very little has been achieved in identifying effective means for teaching individuals how to dispose of guilt other than by deserved punishment. Some cope with guilt feelings by resorting to a defense mechanism, termed displacement. Displacement shifts and discharges aroused emotions from the transgressional situation (patient treatment and student) to another person (faculty) or object (College of Dentistry).

Participation in the small group discussions of an ethics course constantly reminds the students of their unethical practices in the clinics, thereby magnifying their guilt and anger. However, students recognize and admit these dilemmas as a common problem. Therefore, no one student sees him/herself as the sole culprit, thus lessening the impact of the guilt.

Conflict Resolution

While it is obvious that some students have resolved the conflict

between departmental requirements and patient needs, it is obvious, though dismaying, that their resolution is inconsistent with professional ethics and dentistry's mission to promote the oral health of the public. The problem underlying this ethical dilemma cries out for attention from faculty and administration.

Two actions are needed. The ethics courses must be modified to emphasize the promotion of moral behavior in the clinics. The more critical need, however, is to modify student needs so that they are no longer incompatible with patient needs. This modification requires change in the requirement system. For some time, members of the administration have promoted the concept of total or comprehensive patient care. It is felt that the total patient care approach sharpens the students' patient management and communication skills, and promotes students' self-fulfillment and self-esteem when patients respond positively to total care rather than complaining about incomplete care. Interestingly, dental students have bought into the concept of total patient care, a fact reported in over one hundred ethics papers entitled, "The Need for Professional Ethics in the Dental Clinic." Clinical departments, however, continue to emphasize numbers or requirements as a convenient means of developing and assessing competency and proficiency in dental students. Many faculty have been hesitant to adopt the concept of total patient care as an appropriate means of assuring competent graduates. Whether or not total patient

care is the appropriate answer, there is a desperate need for a meeting of the minds and some modification of the existing requirement system to alleviate the current ethical problem.

Conclusion

1. Many dental students arrive in the teaching clinics without having achieved the internalization of high ethical principles.
2. The critical thinking and problem solving demanded by ethical dilemmas in patient treatment requires the teaching of ethics in dental school.
3. The departmental requirement system must be modified to such an extent that it no longer represents a conflict between student needs and patient needs.
4. Graduating dental students must be taught to demonstrate professional and ethical behavior in their dental practice.

△

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Reprint requests to:
Dr. Victor M. Coury
College of Dentistry
University of Tennessee
Memphis, TN 38163

THE ELDERLY LEAD IN SEEKING TREATMENT

The elderly are leading the increasing use of dental services during the second half of the 1980's

H. Barry Waldman*

Data are now available from the 1986 National Health Interview Survey which document that most segments of the population have increased their use of dental services in the second half of the 1980's. However, it is the marked increasing use of services by the older population which augurs most favorably for the future of dental practice activity.

Source of information on the use of dental services

The National Health Interview Survey (NHIS) is a continuous cross-sectional, nationwide survey conducted by household interview. Each week a probability sample of households is interviewed by personnel of the U.S. Bureau of the Census to obtain information on the health and other characteristics of each member of the household. Available information from various national studies on overall dental use patterns permits a review over a period of time. (The NHIS did not collect data on dental visit patterns in 1982, 1984, 1985.) Information available from the 1986 Survey of the civilian noninstitutionalized population represents data from 61,522 interviewees. (There was approximately a one percent non-response rate to the dental section of the survey.)^{1,2}

*H. Barry Waldman, DDS, MPH, PhD, Professor and Chairman, Department of Dental Health, School of Dental Medicine, State University of New York at Stony Brook.

General increase in the use of dental service

Over time, there has been a progressive increase in the percent of the population with reported visits to a dentist. In 1978-1979, 50 percent of the civilian noninstitutionalized population of the United States had a reported dental visit in the previous year.³ By 1983, 55 percent of the population reported a visit to the dentist in the previous year; 58.5 percent in 1986. (Note: Total population data for 1983 and 1986 represent information for individuals over two years of age.)

Between 1983 and 1986, children between two and four years of age had the greatest percent increase in the percent of individuals with reported visits in the previous year (17.9% increase). The 65 and over age cohort had the second highest increase (8.0%). (Table I)

During this same period, there was a 10.6 percent increase in the annual total number of dental visits. The almost 19 million visit numeric and 47.5 percent increase in the number of visits (in 1986 as compared to 1983) by the 65 and over age cohort, far surpassed the increase in all other reported age cohorts. In fact, the 19 million visit increase represented 44 percent of the total population visit increase. (Table II)

In addition, there was a 5.3 percent increase by the general population in the number of dental visits per person. Once again, the 65 and over age population had the greatest percent increase in the number of dental visits per person (28.6%). (Table III) Finally, in line with the changing pattern of dental disease (between 1983 and 1986) the 5-17 age group reported a decrease in the total number of dental visits

Table I. Percent of the population with a dental visit in the past year and the percent change between 1983 and 1986 by age (1,2)

Age	1983	1986	Percent Change
2-4	28.4%	33.5%	17.9%
5-17	67.0	71.5	6.7
18-34	57.0	58.0	1.8
35-54	57.4	60.5	5.4
55-64	51.3	51.2	<0.1
65+	38.6	41.7	8.0
Total Population*	55.0%	58.5%**	6.4%

*Over 2 years of age

**Excludes individuals with unknown intervals since last visit

Table II. Total number of dental visits and the percent change between 1983 and 1986 by age (1,2)

Age	1983	1986	Percent Change
(in thousands)			
2-4	7,166	8,108	13.2%
5-17	110,630	106,386	- 3.8
18-34	113,147	122,115	7.9
35-54	106,408	117,577	10.5
55-64	45,118	54,207	20.1
65+	39,574	58,381	47.5
Total Population*	422,043	466,775	10.6%

* Over 2 years of age

and visits per person. (Tables II and III)

Increasing use of dental services by the elderly

In a series of earlier presentations, efforts were made to present

the perspective that the increasing and changing use of dental services by the elderly could provide an answer to some of the economic and business problems facing the dental profession during the early 1980's.⁴⁻⁶

The general improvement in the

economics of dental practice in the mid 1980's^{7,8} and the dramatic decrease in the numbers of entering dental school students and expected short fall in replacement numbers of current practitioners,* may have lessened the immediate and short term future "dependence" on elderly patients. Nevertheless, the changing needs and use of dental treatment by this population does represent a major growing patient service pool and should be monitored.

Percent of the elderly population with a dental visit

Between 1983 and 1986, the increase in the percent of the general population (over 2 years of age) with a dental visit in the previous year was mirrored by increases reported by the "young elderly" (between ages 65 and 74) and the "older elderly" (75 years and older). The "near elderly" (between ages 55 and 64) reported no change in the percent with a visit in the previous year. (Table IV) (The "near elderly" age cohort data will be considered from the prospective of

Table III. Number of dental visits per person and percent change between 1983 and 1986 by age (1,2)

Age	1983	1986	Percent Change
2-4	0.7	0.7	0.0%
5-17	2.5	2.4	- 4.0
18-34	1.7	1.8	5.9
35-54	2.1	2.1	0.0
55-64	2.1	2.5	19.0
65+	1.5	2.1	28.6
Total Population*	1.9	2.0	5.3%

* Over 2 years of age

*Between 1978 and 1987 there was a 31 percent decrease in entering class sizes. It is estimated that as a result of the continuing decrease in the entering class sizes in 1988, the 3,600 graduates from that year's entering classes (and beyond) will no longer be replacing the number of dental practitioners who leave the practice of dentistry each year. "In fact, by the early 1990's we will probably begin to see an actual decrease in the number of active full-time general practicing dentist(s) in this country."⁹

Table IV. Number of individuals in age groups and percent of the older population with a visit in the past year by age: 1983, 1986 (1,2)

Age	Number in age group		Percent with visit	
	1983	1986	1983	1986
	(In thousands)			
55-64	22,004	22,033	51.3%	51.2%
65-74	16,045	16,987	43.2	46.2
75+	9,847	10,551	31.1	34.4
Total population*			55.0%	58.5%

* Over 2 years of age

changing and potential use patterns as this group ages.)

a. By gender and race

Between 1983 and 1986, men, women and white respondents between 55 and 64 reported no real change in the percent with a dental visit in the past year. There was a decrease during this period in the percent of "near elderly" blacks who had a dental visit in the past year.

In both years, in all older age categories, blacks reported significantly smaller percentages with visits in the previous year—one half the rate of whites in the "young elderly" and one third the rate of whites in the "older elderly" category. (Table V).

b. By income

In both 1983 and 1986, there was a direct correlation between increased family income and an increased percent of the older population with a dental visit in the past year. However, during the period, there was no general pattern of

change (by family income level) in the percent of the two older population groups with a visit in the previous year. The greatest change

was the increase by the more than two million "older elderly" in the \$35,000 and over income category. (Table VI)

Number of dental visits by the elderly

As noted previously, the elderly reported the greatest percent increase in the total number of dental visits. Of particular significance, was that each of the three older categories reported a greater percent increase in the total number of dental visits than that for the general population; *and* that the increase was progressive through the three aged groups.

Table V. Percent of the older population with a dental visit in the past year by gender, race and age: 1983, 1986 (1,2)

	1983	1986
55-64 years		
Male	50.4%	50.1%
Female	52.1	52.1
White	53.4	53.4
Black	33.2	30.6
65-74 years		
Male	42.1	45.2
Female	44.1	47.0
White	45.2	48.5
Black	23.6	24.8
75 years +		
Male	29.9	32.6
Female	31.8	35.3
White	33.0	36.1
Black	11.2	13.3

Table VI. Percent of the older population with a dental visit within the past year by age and family income: 1983, 1986 (1,2)

	1983	1986	Population (in thousands)
65-74 years			
Less than \$10,000	26.0%	23.2%	3,877
\$10,000-\$19,000	44.6	44.3	11,590
\$20,000-\$34,999	61.5	63.9	12,342
\$35,000+	73.7	72.0	7,083
75 years +			
Less than \$10,000	22.2	21.2	3,749
\$10,000-\$19,000	34.6	38.4	4,376
\$20,000-\$34,999	52.4	52.6	3,181
\$35,000+	48.0	54.8	2,358

Table VII. Number of dental visits and visits per older person by age: 1983, 1986 (1,2)

Age	1983	1986	Percent Change
Total number dental visits (in thousands)			
55-64	45,118	54,207	20.1%
65-74	28,496	41,465	45.5
75 +	11,078	16,916	52.7
Total population*	422,043	466,775	10.6%
Dental visits per person			
55-64	2.1	2.5	
65-74	1.8	2.4	
75 +	1.1	1.6	
Total population*	1.9	2.0	

* Over 2 years of age

Again, as noted above, the elderly had the highest increase per person visit rates. And most significant, in 1986, the "near" and "young elderly" visit rates per person were the highest for all age categories (except teenagers). (Table VII)

a. By gender and race

The increase in the visits per person in each of the three older age categories was reported by men and women and white respondents. The black "young elderly" respondents reported a greater than doubling in the per person visit rate. Nevertheless, in 1983 and 1986, blacks reported significantly smaller per person visit rates than their white counterparts.

Although in all younger age categories (except 5-11 years) females reported higher per visit rates than their male counterparts, men in the 55-64 and 65-74 age categories reported higher visit rates than their female counterparts. The 2.8 visits per person reported in 1986 by the "near elderly" males represented the *highest rate for all age categories over two years of age*. The significant increase may represent extensive service needs that had been delayed for extended periods of time. (Table VIII)

b. Visit pattern

Between 1983 and 1986 there was an increase in the percent of the 65 and over age population reporting dental visits in all annual numeric visit categories (i.e. 1,2,3-4,5 visits per year). Overall, an increasing population of elderly are increasing their use of dental services. (Table IX)

Table VIII. Number of dental visits per older person by gender, race and age: 1983, 1986 (1,2)

	1983	1986
55-64 years		
Male	2.0	2.8
Female	2.1	2.2
White	2.1	2.6
Black	1.3	1.3
65-74 years		
Male	1.7	2.7
Female	1.9	2.2
White	1.9	2.5
Black	0.8	1.7
75 years +		
Male	1.0	1.4
Female	1.2	1.7
White	1.2	1.7
Black	0.2*	0.1*

* Figure does not meet standards of reliability or precision

c. Dental insurance

In 1986, (based on the availability of dental insurance) for each of the three older age categories, there were marked differences in the percent of individuals who reported a dental visit in the previous year. More than 60 percent of older individuals with dental insurance reported a visit in the past year. The wide gap between those with and without insurance increased progressively through the three older age categories. (No data are available to determine the extent and type of dental insurance, or whether the particular services provided during these visits were covered by the dental insurance.) (Table X)

Edentulous population

Over an extended period of time, a continuing series of studies have documented the decline in the percent of the population that is edentulous.⁶ By 1986, less than 30 percent of the population 55 years and over were edentulous. While the rate of edentulism continued to increase with increasing age, between 1983 and 1986, there was a noticeable decrease in the number and rate for the 65-74 year age cohort. (Table XI) And most significant:

1. a far smaller percent of edentulous persons, as compared to dentate persons, reported a

visit to the dentist in the previous year, and

2. between age 55 and 84, there is only a minor decrease in the percent of the dentate population that reported a visit to the dentist in the previous year. (Table XII)

Overview

Available survey data document increases in the uses of dental services by the general population in the second half of the 1980s—with dramatic increases by older population cohorts. The significant increase in the use of dental services by the elderly is part of a continuing trend since the 1960's.¹¹ These changing dental use patterns by the older population may reflect any number of socio-demographic and economic developments. For example:

a. Socio-demographic

The evolving makeup of the elderly segment of the population is transforming the stereotypical "grandparent image" to the more realistic view that many of the older populations of our nation are "survivors, resilient and very much alive."¹² Increasingly, they expect and are demanding services to which they feel they are entitled. And these are not expectations for some short defined period. They expect extended life spans with needed health and social services throughout these periods.

As time passes, the elderly, who were willing to "survive" on their Social Security checks with mini-

Table IX. Percent distribution of the population 65 years and older, and population size, by the number of dental visits in the past year: 1983, 1986 (1,2)

	1983	1986
Number of visits	Percent	
None	60.9%	58.2%
1	13.9	14.9
2	12.7	14.7
3-4	7.6	7.7
5+	4.0	4.5
Number of visits	Population (In millions)	
None	16.7	17.0
1	3.8	4.4
2	3.4	4.3
3-4	2.1	2.3
5+	1.1	1.3
Total Population	27.4	29.2

mal third party programs for health and social services, are being replaced by a changed new generation of "near elderly" and "young elderly."

The 80 year olds in today's world are individuals who weathered the depression, matured prior to Social

Security, and were not influenced significantly by federal taxes. In general they are "... proud and independent and certainly did not look to government for economic and social help in their later years."¹³

On the other hand, the current 65

year olds spent their adolescent years in the turmoil of the depression, survived the second world war, and some experienced free medical and dental care in the armed service. Women became an increasing part of the work force and broke away from being totally homebound. They paid Social Security taxes most of their working lives and increasingly are looking to the government for retirement assistance, including Medicare and Medicaid programs. "This consumer will be healthier, better educated, more politically aware, more demanding of social services, and have greater economic security, and the majority will have some teeth."¹³

b. Economic

Major changes have occurred in the economics of dentistry during the 1980's. During the early 1980's, (mirroring the national general recession) there were decreases in national constant dollar dental expenditures (i.e. removing the effects of inflation) per active dentist and constant dollar dental practitioner net income. In turn, the economics were reversed by the mid 1980's, with dental practitioner constant dollar net income reaching all time highs.⁸ Thus, to some extent, the data from the 1983 and 1986 National Health Interview Surveys (NHIS) may reflect the contrasting periods of the economic swings during the 1980's.

Yes, national economics may impact on demands by older population groups for dental services during specific periods. However, the

Table X. Percent of the older population with a dental visit in the past year by private dental insurance coverage and age: 1986 (2)

Age	Private Dental Insurance	No Private Dental Insurance
55-64	62.8%	45.8%
65-74	66.6	43.7
75 +	61.2	33.0

Table XI. Number and percent of the older population that are edentulous: 1983, 1986 (1,10)

Age	Number Edentulous		Percent Edentulous	
	1983	1986	1983	1986
	(in thousands)			
55-64	4,904	4,771	22.4%	21.7%
65-74	5,453	5,048	34.1	29.7
75 +	4,449	4,887	45.4	46.3
75-84		3,791		44.3
85 +		1,096		54.8
Population				
55 +	14,806	14,706	30.9%	29.7%

Table XII. Percent of the population with a visit to the dentist in the past year by dentate status and age: 1986 (2)

Age	Dentate	Edentulous
55-64	62.8%	12.7%
65-74	62.4	9.8
75-84	59.6	8.0
85 +	50.1	7.4*

* Figure does not meet standards of reliability or precision

long term decrease in the numbers of edentulous persons, increased anticipation of longevity, an evolving "new" older population which expects and demands a variety of health and social services, increasing third party coverage programs, and a willingness to increase out of pockets expenditures for dental services,⁵ all portend favorably for the future of dental practice. But most probably, improvements in dental practice activity will come to those dentists who are able to bring together an understanding of the complexities of the physiological changes which are a component of the aging process and an appreciation of the social, psychological and

behavioral realities associated with older patients. Δ

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Reprint requests to:

Dr. H. Barry Waldman
School of Dental Medicine
State University of New York
Stony Brook, NY 11794-8715

NEWS OF FELLOWS

Manuel M. Album is serving as the General Chairman for the 9th International Congress on Dentistry for the Handicapped to be held in Philadelphia during August, 1988.

Dr. Album is in the private practice of pediatric dentistry in Jenkintown and is a Clinical Professor of Pediatric Dentistry at the University of Pennsylvania School of Dental Medicine. He is a past president of the American Society of Dentistry for Children, the International Association of Dentistry for Children, the American Academy of Dentistry for the Handicapped and the International Association of Dentistry for the Handicapped.



Manuel M. Album

J. David Allen was recently appointed to the Founding Board of Governors of the Association of Emory Alumni. Dr. Allen is a Fellow of the American Association of Oral and Maxillofacial Surgeons and has served as an examiner for the American Board of Oral and Maxillofacial Surgery for the past five years. He is an Honorable Fellow, Secretary-Treasurer and Vice President-Elect of the Georgia Dental Association.



J. David Allen

Orren Anthony Bolt recently received the West Michigan District Dental Society's 1988 Distinguished Service Award. Dr. Bolt, who was honored for his dedication, loyalty and service to the profession, was in the private practice of Endodontics in Grand Rapids, Michigan until his retirement in 1984. Dr. Bolt continues to be active in his professional organizations and religious and civic work.



Orren A. Bolt

Stuart H. Coleton of White Plains, New York, was recently elected President of the Ninth District Dental Society of the State of New York. Dr. Coleton is the Chief of Periodontics at the Westchester County Medical Center and an Assistant Clinical Professor at New York Medical College.



Stuart H. Coleton

Theodore T. Fortier recently received the Dentist of the Year Award from the Howard University College of Dentistry. Dr. Fortier was also elected to serve on the Board of Trustees of the California Dental Association and was reappointed to the Fellowship Examination Committee of the Academy of General Dentistry. Dr. Fortier is in the private practice of dentistry in Los Angeles, California.



Theodore T. Fortier

Bernard Edwin Erikson Honored by the American College of Dentists. Dr. Bernard Erikson was presented a bronze medallion bearing the seal of the College and a certificate recognizing his fifty years of distinguished service to the profession. Dr. Erikson graduated from the George Washington University in Washington, D.C. in 1919 and entered into a preceptorship in orthodontics. He established his private practice in 1924 in the District of Columbia where he remained until his retirement in 1964.



Dr. Robert W. Elliott, Jr., President of the American College of Dentists, presented the award to Dr. Erikson. Looking on is Dr. Gordon H. Rovelstad, Executive Director of the College.

Theodore C. Levitas was recently honored for service and dedication to Scottish Rite Children's Hospital in Atlanta. Dr. Levitas who is in the private practice of pediatric dentistry, was recognized for his devotion to his patients and for outstanding service to the hospital. Dr. Levitas is a Fellow of the American Academy of Pediatric Dentistry and is a past president of the Academy. He has served as president of the American Society of Dentistry for Children, the Georgia Society of Pediatric Dentistry and of the Medical/Dental Staff of the Scottish Rite Children's Hospital.



Theodore C. Levitas

Pierre Albert Jacques Marois is serving as the President of the European chapter of the Pierre Fauchard Academy. Dr. Marois is in the private practice of dentistry in Paris, France and is a past president of the American Dental Society of Europe and a former Secretary of the American Dental Club of Paris. He is a member of the Board of Examiners at the Dental School of Paris and The Paris Medical University. He is the recipient of the French National Order of Merit and the Legion of Honor.



Pierre A. J. Marois

Robert E. Mecklenburg recently received the Surgeon General's Medallion for his contributions to international health. Earlier, he received the President's Award from the American Association of Public Health Dentistry for his contributions in public health and service to the Association. Dr. Mecklenburg recently retired from the U.S. Public Health Service as an Assistant Surgeon General after 31 years of service. A Diplomate of the American Board of Dental Public Health, he was also the Chief of Dental Services for the Indian Health Service for 14 years.



Robert E. Mecklenburg



Unveiling the portrait of Dr. Goldstein are Dr. Judson C. Hickey, Acting President of the Medical College of Georgia (left), and Dr. William R. Wege, Professor and Coordinator of Dental Radiology at the Medical College of Georgia School of Dentistry. Both Dr. Hickey and Dr. Wege are Fellows of the American College of Dentists. Looking on are Mrs. Rita Goldstein and Dr. Marvin Goldstein. Photo—The Georgia Gazette.

Samuel S. Wald was recently honored by the New York University College of Dentistry by being presented the first David B. Kriser Medal in recognition of his significant contributions to dental health services and for his extraordinary commitment to New York University. Dr. Wald is a Clinical Professor of Radiology at the New York University's College of Dentistry and School of Medicine. He holds the rank of Rear Admiral, Dental Corps, United States Naval Reserve (Retired) and among the many awards that he has received are the New York State Conspicuous Service Medal and Service Cross, the United States Coast Guard's Distinguished Public Service

Award, New York University's Sesquicentennial Crystal Award and the Alumni Council's Distinguished Service Award.

William Allan Kuebker was recently installed President of the American College of Prosthodontists in San Diego, California. Dr. Kuebker is Professor and Head of the Complete Denture Division, Department of Prosthodontics at the University of Texas Health Sciences Center Dental School in San Antonio. He is a Diplomate of the American Board of Prosthodontics and a Charter Fellow of the American College of Prosthodontists.

Marvin C. Goldstein was recently recognized by the Medical College of Georgia School of Dentistry which named its orthodontic treatment center in honor of Dr. Goldstein. A Diplomate of the American Board of Orthodontics, Dr. Goldstein is a past president of the Georgia Society of Orthodontists, as well as a past president of the Fifth District Dental Society. He has served as Chairman of the Editorial Board of the American Journal of Orthodontics and is a past international president of the Alpha Omega Dental Fraternity. A Clinical Professor at the Medical College of Georgia, and a lecturer at Emory University, Dr. Goldstein has an extensive record of civic and religious service.

William C. Hurt, who has served as Professor and Chairman of the Department of Periodontics at Baylor College of Dentistry since 1972, recently retired. Dr. Hurt is a Fellow of the American Academy of Periodontology and the American Academy of Oral Pathology and has served as Editor of the Journal of Periodontology since 1980. He received the Legion of Merit from the U.S. Army where he served for 22 years. Dr. Hurt plans to pursue his interests of fiction and non-fiction writing.



Samuel S. Wald - Photo by Phil Berkun



William A. Kuebker



William C. Hurt

Memorial Fund Established to Honor Dr. F. Harold Wirth

The Louisiana State University School of Dentistry recently established a memorial fund in memory of the late Dr. F. Harold Wirth. Proceeds from the 1988 New Orleans Dental Conference, which was dedicated to the memory of Dr. Wirth, were presented to the F. Harold Wirth Memorial Fund by Dr. Emmett Zimmerman, General Chairman of the Conference.

Dr. Wirth, who received his D.D.S. degree from Tulane University School of Dentistry in 1928, and a B.Sc. Degree in Dentistry from the University of Toronto in 1929, was in private practice from 1929 until 1972. He received a faculty appointment at the LSU School of Dentistry in 1974 and taught there for over 20 years. Dr. Wirth had served as President of the New Orleans Dental Society and the Louisiana State Dental Society. He was the recipient of the Thomas P. Hinman award and was honored by the New Orleans Dental Association in 1983. In 1986, he received the Pierre Fauchard medal.



Photographed in front of the portrait of Dr. F. Harold Wirth are from the left: Dr. Jack H. Rayson, Dean of the Louisiana State University School of Dentistry, Mrs. Sybil Wirth and Dr. Emmett Zimmerman, General Chairman of the 1987 New Orleans Dental Conference. Dr. Rayson has served as Dean of the LSU School of Dentistry since 1976 and is a Fellow of the American College of Dentists.

Pasquale Tigani recently received the Distinguished Service Award of the Georgetown University Dental School. Dr. Tigani is in private practice of dentistry in Washington, D.C. and has served as the President of the District of Columbia Dental Society and as a delegate to the American Dental Association since 1982.



Pasquale Tigani

Jean P. Roger practiced restorative dentistry in Paris, France until his retirement in 1982. He is a past president of the American Dental Club of Paris and the American Dental Society of Europe. He is also a former chairman of the European chapter of the Pierre Fauchard Academy and an officer of the French Legion of Honor.



Jean P. Roger



Ronald I. Maitland

Ronald I. Maitland will serve as the General chairman of the 64th Annual Greater New York Dental

Meeting to be held in New York later this year. Dr. Maitland is in general dental practice in Manhat-

tan and is a past president of the First District Dental Society of New York.

SECTION ACTIVITIES

Arkansas

The Arkansas Section recently held its annual meeting in Little Rock, Arkansas. The meeting, chaired by Section Chairman, C. W. Nickels, was attended by Regent Robert E. Lamb who gave a report on the activities of the College and urged the Fellows of the Arkansas Section to help with the SELECT Program in recruiting qualified young people as applicants to dental schools.



Photographed at the meeting of the Arkansas Section are left, ACD Regent Robert E. Lamb and Section Chairman C.W. Nickels.

Kansas City Midwest

The Kansas City Midwest Section recently held its meeting at the Crown Center in Kansas City in conjunction with the University of Missouri-Kansas City School of Dentistry's Annual Alumni Meeting. Twenty-four Fellows of the College were presented with an informative talk on financial planning. The Section also installed its new officers for the 1988-89 year.



Photographed from the left are: The Kansas City Midwest section Secretary/Treasurer, Ray E. Parsons; Vice Chairman, Jack L. Haden; Chairman, Ronald R. Davis and Past Chairman, Mike J. Baba.

Illinois

The Illinois Section is in its second year of an innovative Fellowship program which provides preceptorships in general dentistry to one graduating dentist each year. The Fellowship begun in 1986 gives a young graduate an opportunity to work in a large group practice setting, while receiving a stipend of \$15,000 a

year. Announcements on the Fellowship program are placed on the bulletin boards of all Illinois dental schools and senior students are invited to apply. With the cooperation of the Dean's of the dental schools, the Illinois Section selects one student to participate in the program following graduation. The participant receives the

benefit of being exposed to all aspects of a private practice group setting with a multi-disciplinary approach to dental health care delivery. According to Section Chairman, Frank A. Schroeder, the Illinois Section hopes to expand the Fellowship program so that more recent graduates can participate in it.

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THE JOURNAL OF THE AMERICAN COLLEGE OF DENTISTS is published quarterly by the American College of Dentists, Suite 352N, 7315 Wisconsin Avenue, Bethesda, Maryland 20814. Editor: Keith P. Blair, D.D.S., Managing Editor: Gordon H. Rovelstad, D.D.S.

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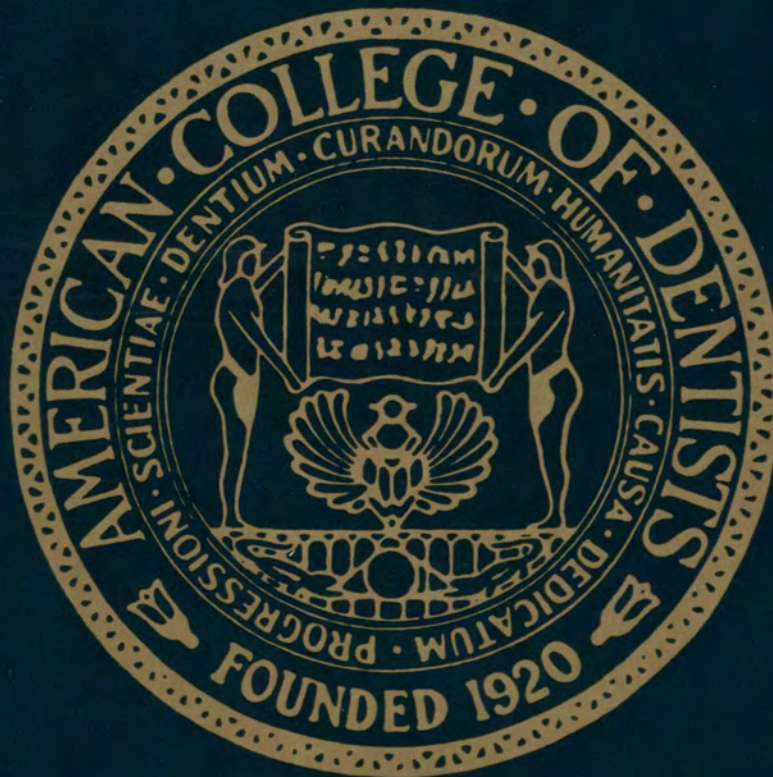
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