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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.



# The JOURNAL

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## DENTAL HISTORY IS IMPORTANT

It is said that those who do not learn history, so as to gain the benefits of previous experience and knowledge, are condemned to repeat the mistakes of the past. That applies to dentistry, too.

Dental history is being neglected and ignored. Even worse, it is apparently considered to be so unimportant that it is rarely being read, taught or used in any way by dentists or by other entities involved with the regulation and planning of dental care. Society in general and dentistry in particular seem to be oblivious to the lessons of history and bent on repeating past mistakes that could create future problems for both the dental profession and the public it serves. According to reports, most dental schools no longer teach dental history as a part of the curriculum.

Every dentist should be aware of the problems involved with the formative years of the dental profession. Frankly, early dentists were not highly regarded by Society and for good reason. Many of them were hucksters and charlatans, poorly trained and inept. Most were primarily businessmen, many of whom advertised their services with extravagant claims for their treatment, frequently ranging to the fraudulent. The public had no protection from such unscrupulous dentists and the motto of the day for patients was strictly "Caveat Emptor" (let



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the buyer beware). There were poor educational standards for dentists and many dental schools were not associated with colleges or universities. Few states in the country had laws to protect the public and to regulate dental licensure. At best, dentistry was considered a trade.

It was for all of these reasons that early dental leaders were so insistent on establishing *professionalism and integrity* as the most important factors to be brought to a dental practice and to the profession. They understood that a profession must regulate and discipline itself. As the profession became better organized and improved, advertising was banned by those in organized dentistry. Dental schools

## FROM THE EDITOR'S DESK

became associated with universities and educational standards were set. State laws were passed to protect the public and to regulate dental licensing. That was the start of the highly respected dental profession we have today. Much was accomplished in those years.

Now there seems to be a pervading intention by Society to reverse most of these accomplishments in the name of progress and economy. A general process of deprofessionalization is taking place. The Federal Trade Commission (FTC) is pushing for deregulation of the professions and elimination of state laws that were enacted, in the first place, to protect the public. Once again, there is a plethora of misleading advertising by dentists, as invited by court decisions. There is an emphasis on the business side rather than the professional aspect of dental practice. Dental schools are being closed by major universities because they are supposedly not financially viable. Apparently, in this case, progress would be a return to the conditions of dental practice existing in the early 1900's.

Disregarding the wisdom learned from previous experience may result in Society having to "learn its lessons" all over again and may contribute to serious problems in the future. Returning to those good old days is definitely not recommended.

Dental history *IS* important. Δ

Keith P. Blair

# FAVORABLE ECONOMIC PREDICTIONS

## Some Glimpses of the Economics of Dentistry in the Year 2000

H. Barry Waldman\*

Favorable projections for dental economics for the years 1990 and 2000 are presented, in terms of number of practitioners and expenditures per practitioner

Dentistry and the general field of health services have been and continue to be buffeted by changes that seem destined to undermine the very nature of professions which once attracted so many health practitioners. Dental practitioners have been warning prospective applicants for years about the perceived dire future of the profession—and college students have been listening. As a result, the precipitous decrease, during the 1980's, in the number of applicants to dental schools should come with little surprise.

No doubt, dental practitioners will continue to be uneasy over the seeming exponential rate of developments in the delivery of dental services. But, hopefully, in line with the continuing favorable dental economic news during the mid and late 1980's, some of this apprehension has been eased. And most important, there are now favorable economic projections through the next decade of continued economic growth for dentistry.

Available projection information from a variety of federal agency reports provide a glimpse of favor-

able dental economics through the year 2000, when 156,000 professionally active dentists will be providing dental services to a national population of 275 million people.

### Overall health services

"Health care has been one of the powerhouses of the American service economy."<sup>1</sup> By late 1987, 6.9 million Americans were working in the health service industry—the fastest growing sector of the economy. Despite a host of efforts at cost containment, spending on health in 1987 passed \$500 billion for the first time and is expected to reach 11.4 percent of the gross national product (GNP)—an increase from 9.4 percent of the GNP in 1980.<sup>1</sup> It is expected that by the year 2000, national health expenditures will reach \$1.5 trillion, or 15.0 percent of the GNP. Personal health expenditures are expected to reach \$1.4 trillion. (\$.1 trillion will be spent on program administration, research and construction and government public health activities.)<sup>2</sup>

The report from the Health Care Financing Administration finds little evidence that, 1) the incentives inherent in current cost containment policies will reverse the ever increasing share of the GNP represented by total health expenditures, and 2) the demand for increased quantity and quality of health services for the general population will be reversed. "Unfortunately, it may also reflect a piecemeal and disjointed approach to reimbursement reform by the public and private sectors."<sup>2</sup>

By the years 1990 and 2000, it is predicted that there will be only

minor changes in the percent distribution of expenditures for the various categories of health services. (Table I)

### Number of dentists

Between 1985 and the year 2000, it is projected that there will be an increase of approximately 16,000 professionally active dentists. During the same period, it is anticipated that the United States population will increase by almost 30 million people.<sup>2,5</sup> The combination of these increases will result in a decrease in the population to dentist ratio from one dentist per 1,756 residents in 1985 to 1,709 residents in 1990. It is forecast that the ratio will then increase to one dentist per 1,762 residents by the year 2000.<sup>2,5</sup>

However, it is expected by the year 2000 that 25,500 (about 16 percent) of all professionally active dentists) will be female practitioners.<sup>5</sup> Studies carried out in the mid 1980's indicate that female dentists (and physicians) report shorter overall work hours than their male counterparts.<sup>6</sup> If the differences in male and female work force availability continue into the future, any determination of the economics of dental practice must reflect the difference in practice patterns.

### Economics of dentistry

By the year 2000, it is projected that national expenditures for dental services will reach \$88.6 billion or approximately \$566,000 per professionally active dentist. But any review of national expenditure data over an extended period of time must consider the effects of

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**Table I. Percent distribution of personal health expenditures: 1980-2000<sup>2-4</sup>**

	Year			
	1980	1985	1990	2000
Total Dollar expenditures (Billions)	\$219.4	\$371.4	\$573.5	\$1,398.1
Health Service Categories				
Hospital Care	45.8%	44.9%	43.7%	44.4%
Physician services	21.3	22.2	23.1	22.8
Dental services	7.0	7.2	7.3	6.4
Other professional services	2.6	3.4	3.9	4.3
Drugs & medical supplies	8.8	7.7	7.3	7.3
Eyeglasses & appliances	2.3	3.4	3.9	4.3
Nursing homes	9.4	9.5	9.5	9.2
Other care	2.7	2.9	3.1	3.6
Total	100.1%	99.8%	99.8%	99.8%

inflation. In terms of constant dollars, (i.e. eliminating the effects of inflation) the increases in expendi-

tures per active dentist which began after the last recession in the early 1980's, are expected to con-

tinue through 1990 and the year 2000. (Table II)

Projections are not available regarding the net profit for dental practitioners during the 1990's and beyond. However, Health Care Financing Administration national expenditure data, American Dental Association gross receipt information, and changing net to gross receipt ratios reported in the ADA's Survey of Dental Practice through 1986, indicate that the constant dollar practitioner net income reached levels (in the mid 1980's) above those prior to the last recession.<sup>8</sup>

The expanding population of the United States will continue to increase its expenditures for dental services from \$65.45 per person in 1980 to \$321.61 per person in 2000 (an increase from \$50.42 to \$74.21 in constant dollars). (Table III)

But, it is anticipated that there will be only minor variations between 1985 and 2000 in the source

**Table II. Number of professionally active dentists, current and constant dollar dental expenditures per active dentist: 1975-1986; projections 1987, 1990, 2000<sup>2-5,7</sup>**

	Professionally Active Dentists	National Dental Expenditures (Billions)	Current Dollar Expenditures Per Active Dentist	Dental Component CPI (1977 = 100)	Constant Dollar Expenditures Per Active Dentist
1975	112,450	\$ 8.2	\$ 79,291	87.5	\$ 83,338
1979	123,500	13.5	109,312	116.0	94,234
1980	126,240	15.4	121,989	129.8	93,982*
1981	129,180	17.3	133,921	142.2	94,179
1982	132,010	19.5	147,716	153.2	96,420
1983	135,120	21.7	161,338	163.5	98,677
1984	137,950	24.6	178,325	176.8	100,862
1985	140,770**	27.1	192,512	188.0	102,400
1986	142,768**	29.6	207,329	198.5	104,447
Projected					
1987	144,766	32.4	223,809	209.6	107,069
1990	150,760	41.1	272,618	248.3	109,445
2000	156,300	88.6	566,858	433.4	130,793

\* Note decrease during last recession

\*\* Projected



**Table III. United States population and current and constant dollar dental expenditures per person: 1980-2000<sup>2,4,7</sup>**

Year	U.S. Population	Current Dollar Expenditures Per Person	Constant Dollar Expenditures Per Person
1980	235,305,000	\$ 65.45	\$50.42
1985	247,170,000	109.64	58.31
1990	257,769,000	159.45	64.21
2000	275,493,000	321.61	74.21

of payment for dental services. During this fifteen year period, direct out-of-pocket spending will continue to constitute almost two thirds of dental expenditures; private health insurance will represent slightly more than one third; and government sources will account for less than two percent. (Table IV) The combined financing by the private sector of 98 percent of dental expenditures, is in sharp contrast to the current and projected financing of 42 percent of general national health expenditures by various governmental agencies.<sup>2</sup> Thus, while efforts should be maintained to increase third party coverage, the profession realistically must expect and plan for the ongoing emphasis in direct out-of-pocket expenditures for dental services.

### Overview

Predictions of developments in the future of our health system are based on assumptions that historical trends and relationships will continue into the future; except as modified by the various effects of the public and private cost containment initiatives. For example, the predictions by the Health Care Financing Administration (HCFA) on the slowing of general health spending are the result of deceler-

ation in expenditures because of: 1) the implementation of the Medicare prospective payment mechanisms (i.e., DRG's) and its effects on hospital in-patient services, 2) private sector efforts to reduce the rate of increase of health costs, and 3) lower projections of the rate of inflation. The HCFA reports note that the concentration of government cost containment efforts on hospital expenses may have exacerbated the problems in other health care sectors.

Focusing on dental economics, the average annual growth rate projected from 1986 to 2000 (8.2 percent) is below the 12.1 percent annual rate for the period between 1970 and 1986. The increases in the earlier years were a reflection of the substantial growth in dental insurance, higher economy-wide inflation and a rapid increase in the number of dentists. The projected lower rate in the future

would reflect the relative leveling off in health insurance development and the dentist to population ratio.

But underlying the projections of economic development in the future remains the basic reality of an unprecedented decline in the incidence of dental decay and tooth loss during the past two decades.

The Symposium on the Oral Health Status of the United States presented at the 1985 annual session of the American Association of Dental Schools reviewed the prevalence of dental caries, periodontal disease, tooth loss and edentulism, oral cancer, malocclusion, temporomandibular disorders, problems of special patients, the implications of these changes on dental education and sought to answer the question whether improved dental health leads to decreased demand for dental services.

Davies, Bailit and Holtby, in their report on the relationship between oral health status and the use of dental services, noted that, "*Intuition suggests that healthier people will demand less dental care. We have little definitive evidence, however, to support this hypothesis.*"<sup>9</sup> (emphasis added)

Their conclusions were:

1. The probability of use of dental service remains relatively

**Table IV. Sources of payment for dental services: 1980-2000<sup>3,4</sup>**

	Private		Government		Total
	Direct	Insurance	Federal	State-Local	
1980	72.7%	23.4%	1.9%	1.9%	99.9%
1985	63.4	34.3	1.1	1.1	99.9
1987	64.2	33.6	1.2	0.9	99.9
1990	64.1	33.9	0.9	0.9	99.8
2000	63.7	35.0	0.7	0.6	100.0

stable despite changes in factors that were expected to improve access to care: increased personal income, higher dentist-to-population ratios, and a substantial growth in the percentage of people with dental insurance.

2. The average number of visits for those seeking care each year has increased. Data suggest that socio-demographic variables have less influence on level of use than probability of use. For example, Hispanics are notably less likely to have dental visits than whites. But for those having at least one visit, Hispanics and whites had virtually equal number of visits on average.
3. During the past 15 to 20 years, there have been dramatic changes in the number and types of services provided during a dental visit. For example, in more recent periods, patients are more likely to receive preventive services (e.g. examinations, x-rays, prophylaxes and fluoride treatments) than patients received in previous years (e.g. fitting of dentures).

Their review indicates a number of factors may affect the relationship between oral health and demand (or utilization of services). They note that dental insurance and perceived need for care have substantial effects on utilization. What remains unsolved is the relative contribution of oral health status and other factors in explaining the use (or nonuse) of dental treatment and the nature of the relationship between these factors.

Their conclusion is that "*it is premature to predict that the current improvements in oral health necessarily will reduce consumer demand for dental care.*"<sup>9</sup> (emphasis added) One intriguing hypothesis presented is that, *improved oral health might lead to greater demand for dental services.*

This hypothesis is considered in terms of the fact that, better educated and higher income groups enjoy better oral health, but at the same time, they use more services than the less socio-economically advantaged. More education and income may lead people to demand a higher standard of oral health and enable them to obtain it. It could follow that, as a population becomes better educated and more affluent, on average, the demand for dental care could increase despite improvements in oral health. In considering this hypothesis, it is significant to note that the level of education of many segments of our society is increasing.<sup>10</sup>

Certainty, is not the name of the game, when projecting future economics. Nevertheless, current indicators for the economics of the dental profession through the year 2000 are positive. Surely, dental practitioners should be making such information available to the young men and women who might be considering a dental career for *THEIR* future.  $\Delta$

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# PATIENTS' ATTITUDES TOWARD DENTISTS AND HYGIENISTS

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What are the characteristics of a successful dental professional? Although no one would deny the importance of technical skills, an increasing number of authors are focusing on the significance of interpersonal skills for both dentists<sup>1-8</sup> and dental hygienists<sup>9-14</sup>. With the recognition that a number of people avoid dental care except in emergencies<sup>1,3,4,15,16</sup> and that a far larger number fail to comply with recommendations for oral hygiene regimens,<sup>1,4,5,10,12,13,17-23</sup> dental professionals have begun to consider seriously the factors that influence patients' selection of and satisfaction with dentists.<sup>1-9,13</sup>

Dentists who develop and maintain positive relationships with their patients may benefit in a number of ways.<sup>1-8</sup> Their patients may respond more quickly to treatment, require less medication, report less discomfort and initiate fewer malpractice claims.<sup>2,9</sup> Dentists who have good rapport with their patients may perceive fewer problem behaviors in their patients<sup>4,26</sup> and experience less stress themselves.<sup>5,27</sup> Moreover, the chance of patients changing to another dentist is substantially less if the dentist-patient relationship is a positive one.<sup>3,4,6,8</sup> Patients, of course, may benefit, too, by being less fearful of dental treatment,<sup>1,2,15</sup> by finding it less unpleasant<sup>3,4,6,8</sup> and by increasing their practice of oral hygiene be-

haviors and ultimately improving their own oral health.<sup>1,5</sup>

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**Dentists who are particularly well liked by their patients are those who are perceived as caring, interested, reassuring and friendly.**

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Although it is clear that there are a variety of models to describe the ideal dentist-patient relationship,<sup>2</sup> it is also clear that patients do have definite preferences for behaviors of dentists.<sup>8,24,25</sup> In particular, they appreciate having a dentist interact with them both verbally and nonverbally, giving them truthful and detailed information, rather than immediately getting down to work and concentrating solely on their teeth.<sup>2,7,8,17,24</sup> Dentists who are particularly well liked by their patients are those who are perceived as caring, interested, reassuring and friendly.<sup>2-4,17,24</sup>

In spite of its importance, the interaction between the dentist and patient is only one of the relationships occurring in a dental setting. Modern dentistry involves a team of dental professionals rather than a dentist alone,<sup>10,23,27</sup> and it has been suggested that the relationship between the dental hygienist and the patient is as important in the success of dental treatment as is the relationship between patient and dentist.<sup>10-14</sup> Although some patients may feel that they have "no real relationship" with their dental

hygienist,<sup>9</sup> some professionals have suggested or implied that, with the increasing number and importance of dental hygienists,<sup>28-30</sup> the educational and interpersonal roles of the dental hygienist in dealing with patients should and will be expanded.<sup>9-14,30,31</sup> The historical function of a hygienist as one who assists the dentist in the prevention of dental caries, primarily by cleaning the patient's teeth, is no longer an accurate description of all that a modern hygienist does.<sup>31</sup> In particular, the hygienist's role in patient education and motivation has been given increasing emphasis.<sup>9-13,23,31</sup>

The primary purpose of the present study was to look at the roles of the dentist and hygienist from the viewpoint of the dental patient. One recent study<sup>31</sup> suggested that many patients surveyed in 1982 were unaware that dental hygienists may perform a variety of services in addition to cleaning teeth. The present study, conducted three years later, was concerned with the extent to which patients today are aware of or approve of the many functions which a dental hygienist may perform. In particular, we were interested in seeing whether patients felt that hygienists should be educating patients rather than just cleaning their teeth and whether they viewed the hygienist as a professional of equal importance to a dentist. We also were interested in comparing patients' interactions with dentists and hygienists in terms of time spent with them and their relationship to the patient.

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If dentists and dental hygienists do fulfill different roles and/or are seen by patients as doing so, then it might be the case that the qualities viewed as desirable for the two sets of professionals will be different. For instance, studies on sex role stereotyping of women physicians<sup>32,33</sup> suggest that masculine and feminine traits may be differentially valued dependent on whether a specialty area is seen as having a relatively higher proportion of males or females. Since dental hygiene, unlike dentistry, is currently a profession composed primarily of females, one might hypothesize that feminine stereotyped qualities like patience and empathy would be considered as relatively more important for dental hygienists and masculine stereotyped traits like competence and efficiency would be considered as more important for dentists. On the other hand, the descriptions in the dental literature of the importance of interpersonal skills and competence for both dentists and dental hygienists would suggest that patients should value the same qualities in both. A secondary purpose of the present study was to see whether or not certain characteristics of the subjects were associated with their attitudes toward the roles of dentists and hygienists. The demographic variables of sex, educational level, ethnicity and age were examined along with such characteristics as time spent with the dentist and hygienist, measures of dental knowledge<sup>34</sup> and perceived responsibility for one's own dental health.<sup>34</sup> Although it was

expected that better educated people would be more likely to feel that the role of the dental hygienist should involve more than just cleaning teeth, no other specific predictions about the relationship of the demographic variables to attitudes toward dentists and dental hygienists were made.

## Method

### Subjects

The subjects in the present study were 44 male and 156 female adults surveyed in a variety of locations in a southwestern city: a university campus, two senior citizens' centers, two health fairs and a women's civic club. Their ages ranged from 18 to 81 years, with a mean of 42 years and median of 38. The majority of the respondents were Anglo American or Hispanic with at least some college education. Further details of their demographic characteristics and some aspects of their dental history are presented in Table 1.

### Procedure

Individuals at the above locations who appeared to be over 17 years of age, in no hurry, not burdened with packages, and not engaged in conversation, were the potential subjects for the study. They were approached individually by one of six graduate students in education and requested to fill out a brief questionnaire dealing with dental hygiene. They were assured that the questionnaire was completely anonymous

and that they could leave blank any questions which they did not wish to answer. The majority of the respondents took from 5-15 minutes to complete the questionnaire, but a few of the senior citizens required some assistance in filling it out.

### Instrument

The Dental Hygiene Questionnaire administered to the subjects consisted of 3 pages plus a cover letter. The first part asked for information on the subject's demographic characteristics and dental history, including the amount of time spent with the dentist and hygienist on a typical visit. Next came a test of dental knowledge, a set of questions about sources of information about dentistry and a scale measuring self-perceived locus of control for dental health, all of which are reported elsewhere.<sup>34</sup>

The final page of the questionnaire contained a set of 7 statements designed to investigate the subject's opinions about dentists and dental hygienists, each of which was scored on a 5 point scale ranging from "strongly agree" (scored as 1) to "strongly disagree" (scored as 5). The last part consisted of two open-ended questions asking subjects, "What qualities do you think a good dentist [dental hygienist] should have?"

## Results

### Roles of dentists and hygienists

The subject's answers to the questions asking about their opinions

Table 1. Characteristics of the Subjects

Variables	Number Responding	%
<b>A. Demographic:</b>		
Sex	200	
Male		22
Female		78
Age	196	
≤30		33
31-50		34
≥51		34
Ethnicity	196	
American Indian		4
Anglo		69
Asian American		0.5
Black		3
Hispanic		16
Other/Mixed		8
Educational Level	198	
No high school		0.5
High school		25
College		44
Post graduate		30
Occupation	182	
Professional		35
Clerical/sales		8
Skilled/semi-skilled		9
Housewife		15
Student		17
Retired		12
Other		4
Survey Location	200	
University		39
Senior citizen's center		14
Health fairs		35
Women's club		13
<b>B. Dental History:</b>		
Regular dentist?	198	
Yes		75
No		25
Years seeing same dentist	148	
≤1		9
2		13
3-5		24
6-10		25
11-20		18
>20		12
Visits to the dentist	193	
Never		5
Only when it hurts		14
Every 2 years		14
Once a year		31
Twice a year		36
Dentures?	199	
Yes		18
No		82
Sex of dentist	199	
Male		99
Female		2
Sex of hygienist	173	
Male		13
Female		87

of the roles of dentists and hygienists are shown in Table 2. As can be seen from the table, the majority of subjects felt that the dental hygienist should not just be cleaning teeth but rather educating patients as well and that the hygienist is just as important a professional as the dentist. Relatively few patients would be embarrassed to ask either the dentist or the dental hygienist a question about the care of their teeth, but a substantial minority agreed that they had no real relationship with either one.

Examination of the intercorrelations among the questions by Pearson product-moment correlation coefficients revealed that de-

gree of embarrassment at asking the hygienist a question was highly correlated with degree of embarrassment at asking the dentist a question,  $r(166) = .85, p < .001$ , and that perceiving no real relationship with the dentist was associated with perceiving no real relationship with the hygienist,  $r(158) = .67, p < .001$ . More interestingly, respondents who felt that they had no real relationship with the hygienist were more likely to see his or her role as merely cleaning teeth,  $r(156) = .21, p < .01$ , and to feel embarrassed at asking him or her a question,  $r(156) = .20, p < .01$ , although the subjects' perceptions of their relationship with the den-

tist and their degree of embarrassment at asking the dentist a question were not significantly related,  $r(164) = .07, p > .05$ . Subjects who believed that a dental hygienist is as important a professional as a dentist were less likely to be embarrassed at asking a question of either the dentist,  $r(169) = -.16, p < .05$ , or the dental hygienist,  $r(164) = -.17, p < .05$ .

**Dentist vs. hygienist.** T-tests revealed that the mean number of minutes spent by the subjects in the present study with their hygienist on an average visit ( $X = 29.27$  minutes) was significantly greater than the mean time spent with their dentist ( $X = 21.43$  minutes),

**Table 2. Opinions About Dentists and Dental Hygienists**

Statement	Strongly Agree (%)	Agree (%)	Unsure (%)	Disagree (%)	Strongly Disagree (%)	N
The role of a dental hygienist is just to clean my teeth.	3.4	14.9	13.1	56.0	12.6	175
The dental hygienist should be educating patients about caring for their teeth and gums.	48.6	45.2	3.4	2.3	0.6	177
I have no real relationship with my dental hygienist.	13.7	28.6	13.0	37.9	6.8	161
I have no real relationship with my dentist	8.4	22.8	15.0	36.5	17.4	167
I would be embarrassed to ask my dental hygienist a question about how to take care of my teeth.	3.6	1.8	2.4	45.2	47.0	168
I would be embarrassed to ask my dentist a question about how to take care of my teeth.	2.3	1.7	2.3	42.2	51.4	173
A dental hygienist is as important a professional as a dentist.	33.5	38.7	16.8	7.5	3.5	173



$t(153) = 4.97, p < .001$ . The subjects also were more likely to say that they had a real relationship with their dentist ( $X = 3.31$ ) than with their hygienist ( $X = 2.96$ ),  $t(159) = 4.31, p < .001$ , and to feel less embarrassed to ask their dentist ( $X = 4.39$ ) than hygienist ( $X = 4.30$ ) a question,  $t(167) = 2.30, p < .05$ .

**Other variables.** A number of subject characteristics were related to attitudes toward the dentist and hygienist. An analysis of variance revealed that females ( $X = 2.01$ ) were more likely than males ( $X = 2.40$ ) to agree that the dental hygienist is as important a professional as the dentist,  $F(1,171) = 3.93, p < .05$ . A significant age difference,  $F(2,164) = 5.16, p < .01$ , was explained by a post hoc Scheffe' comparison indicating that respondents aged 30 or younger ( $X = 2.92$ ) were more likely than those aged 31 to 50 ( $X = 3.49$ ) or over 50 ( $X = 3.60$ ) to agree that they have no real relationship with their dentist,  $F(1,164) = 10.27, p < .01$ . The only significant effect of subject's educational level concerned the statement that the role of the hygienist is just to clean teeth,  $F(2,170) = 6.39, p < .01$ . A Scheffe' comparison revealed that subjects with a high school education ( $X = 3.14$ ) were more likely than those with a college ( $X = 3.68$ ) or post graduate education ( $X = 3.83$ ) to agree with that statement,  $F(1,170) = 12.46, p < .01$ .

The Hispanics in our sample ( $X = 3.75$ ) were more likely than the Anglos ( $X = 3.24$ ) to agree that a hygienist should just clean teeth,  $F(1,145) = 6.15, p < .05$ . They also

were more likely to agree that they had no real relationship with the hygienist ( $X = 2.48$ ) or dentist ( $X = 2.67$ ) than were the Anglo respondents ( $X_s = 3.12$  and  $3.57$ ),  $F(1,133) = 5.57, p < .01$  and  $F(1,139) = 12.09, p < .001$ , respectively.

Subjects who spent more time on a typical visit with the hygienist were more likely to feel that they had a real relationship with him or her,  $r(131) = .20, p < .05$ , and to be less embarrassed to ask a question of either the dentist,  $r(136) = .19, p < .05$ , or the hygienist,  $r(135) = .19, p < .05$ , whereas time spent with the dentist was not significantly related to any of these variables. However, those who visited the dentist (and presumably the hygienist) more frequently were more likely to have a real relationship with both dentist and hygienist, to feel no embarrassment at asking either one a question and to feel that the hygienist is as important a professional as the dentist, smallest  $r(167) = -.22, p < .01$ .

Respondents who scored higher on the measure of dental knowledge were more likely to deny that a hygienist's role is just to clean teeth, to feel that they have a real relationship with the dentist, and to feel unembarrassed at asking a question of either the dentist or hygienist, smallest  $r(167) = .16, p < .05$ . Those who perceived themselves as being more responsible for their own dental health were more likely to feel that a dental hygienist should not just be cleaning teeth and should be educating patients, to feel unembarrassed to ask either the dentist or the hygien-

ist a question and to agree that the hygienist is as important a professional as the dentist, smallest  $r(171) = .18, p < .05$ . One final point is that subjects' self-reports of how much they had learned about dental hygiene from the dentist were not significantly correlated with their answers to the attitude questions. However, respondents who reported learning relatively more from the hygienist also reported denying that a hygienist's role is just to clean teeth and feeling less embarrassed about asking either the dentist or the hygienist a question, lowest  $r(141) = .19, p < .05$ .

### Desirable qualities

The open-ended questions about qualities desired in a dentist or dental hygienist provoked a variety of responses, ranging greatly in length, comprehensiveness and seriousness. Since it proved almost impossible to put them into mutually exclusive categories, due to the fact that most respondents mentioned a number of traits, a decision was made to code each response for the presence or absence of a number of attributes. The same system was used for responses to both questions.

Eleven general categories were devised, with a general term picked to represent each. For example, the category called "competent" was coded as present if words like "knowledge", "professional", "skillful", "informative" or "adroitness" were used. The quality called "empathy" was coded as present if words like "sensitivity", "compas-

sion", "open", "caring" or "understanding" were employed. However, many of the decisions about coding were more arbitrary than this description implies, and the decision as to whether they were present or absent in the responses often depended heavily on the context of the entire written response.

Table 3 presents the names of the eleven categories and the results of chi square goodness of fit tests ( $X^2$ ) comparing the number of people who mentioned each category as a characteristic of a good dentist with the number considering it as a characteristic of a good hygienist. As can be seen from the table, competence was considered the most important quality, with empathy and friendliness the next most valued traits. Only the categories of empathy and convenience were mentioned significantly more often for the dentist than for the hygienist, and the ranking of the traits for the two

dental professionals is extremely similar, Spearman's  $\rho(9) = .90$ ,  $p < .001$ .

**Undesirable qualities.** Although most of the respondents listed desirable qualities for a dentist and hygienist, as requested, several subjects wrote statements focusing more on the undesirable qualities of dentists and hygienists. Among the items mentioned were wearing heavy cologne; treating the patient as just another mouth; being condescending; charging too much; considering oneself a God; chewing gum; chatting with other personnel while working on the patient's mouth; keeping patients waiting; being judgmental; making patients feel guilty; being more concerned about whether patient's checks will bounce than about the well being of patients; being commercial; being aloof; playing loud music; "too eager to get rich at the patient's expense"; being moralistic; lecturing; calling patients by

their first names; and, most frequently mentioned, having bad breath.

## Discussion

The findings of this study must be tempered by the fact that the subjects represented a convenience sample rather than a random sample from a well-defined population. Because they were obtained from health fairs, a university campus, and a women's club as well as two senior citizens' centers, they were undoubtedly better educated and more concerned with health-related issues than people in the general population. Nevertheless, there was a wide enough range of demographic characteristics in our sample to allow them to be related to their opinions and attitudes.

The results of this survey suggest a number of conclusions about how the dental patients in our survey viewed dental hygienists and dentists. First of all, the majority felt that a hygienist was as important a professional as a dentist and that his or her role should be to educate patients rather than just to clean teeth. Moreover, these views were held particularly strongly by people who were better educated, who knew more about dentistry, who felt more responsible for their own dental health and who had spent more time with dental hygienists and learned more from them. Since our sample was generally well educated and since the majority (87%) were able to note the sex of their dental hygienist,

**Table 3. Qualities of a Good Dentist and Dental Hygienist**

Quality	Number mentioning quality for:		$X^2$ (1) for Dentist vs. Hygienist
	Dentist	Hygienist	
Competence	104	101	0.03
Empathy	84	60	4.00*
Friendliness	51	58	0.50
Patience	29	29	0
Kindness	23	25	0.08
Attractiveness	18	19	0.03
Honesty	16	7	3.52
Convenience	10	2	5.34*
Humor	7	5	0.34
Efficiency	6	6	0
Cleanliness	5	9	1.14

\*  $p < .05$

presumably indicating that they had been to one, this might explain the reason for the discrepancy between our results and those of Kviz,<sup>31</sup> who found a sizeable number of people who were unaware of the many functions of a modern hygienist. As the number and responsibilities of dental hygienists increase,<sup>9,14,30,31</sup> the number of dental patients who recognize and value these multiple roles will presumably also increase.

A number of demographic characteristics besides education were associated with the respondents' views of the dentist and hygienist. The Hispanics in our sample were more likely than the Anglos to deny having a real relationship with the dentist or hygienist and more likely to feel that the hygienist's role is only to clean teeth. Perhaps both dentists and hygienists need to be particularly careful to treat their Hispanic patients with warmth and respect; perhaps more Hispanics should be encouraged to enter the dental professions. People under 30 were also less likely to have developed a real relationship with their dentist, possibly reflecting a lesser degree of acquaintance with him or her or possibly reflecting a true difference in either dentists' behavior ("condescending"? "moralistic"? "lecturing"? ) or in subjects' reactions to it, dependent on their age. Finally, the fact that women were more likely than men to view their hygienist as a professional equal in importance to the dentist may suggest either greater sophistication about dental hygiene on the

part of our female subjects or a greater degree of support for a primarily female profession.<sup>28,30</sup>

There were relatively few major differences in the ways in which our subjects perceived or interacted with their dentists and hygienists. Subjects did feel that they had less of a real relationship with their hygienist than with their dentist and were more embarrassed to ask their hygienist than their dentist a question, in spite of spending significantly more time with the hygienist than with the dentist on a typical dental visit. One possible explanation of this finding of greater rapport with the dentist would be that the patients have spent a greater total amount of time over the years with their dentist than with their hygienist. This assumption, although not directly testable in the present study, is made plausible by research suggesting that the great majority of dental hygienists have been practicing for less than ten years.<sup>28,30</sup> Another possible explanation is the relatively recent shift of the hygienist's role to include patient education and motivation, a function which is recognized and supported by the majority of patients in our study but which may be considered by them as even more appropriate for the dentist.

The high positive correlations between embarrassment at asking the dentist and the hygienist a question and between perceiving a relationship with the dentist and with the hygienist suggest a degree of similarity in how the dentist and hygienist were perceived. The fact

that the categories of open-ended responses ranked as important for the dentist and for the dental hygienist were almost identical also suggests that many patients value the same kinds of qualities in their dentist and hygienist. The hypothesis that masculine sex-stereotyped traits would be preferred relatively more for the dentist and feminine stereotyped traits relatively more for the dental hygienist was not substantiated, in spite of the fact that the great majority of the respondents went to a male dentist and a female hygienist.

The actual traits desired by the subjects in a dentist and hygienist do reflect a preference for competence, found to be important by Van Groenestijn, Maas-de-Waal, Mileman, and Swallow<sup>24</sup> but less so by Moretti.<sup>7</sup> However, the other characteristics mentioned frequently tend to be interpersonal ones, supporting the views of researchers who emphasize the importance of a good relationship between the patient and dental professional in contributing to mutual satisfaction.<sup>1-13,24-27</sup>

The fact that subjects were able to articulate the qualities of a good dentist and hygienist did not, apparently, mean that they were unable to conceive of bad ones. The long list of negative traits mentioned implies to us that some of these subjects may have had direct or indirect experiences with dental professionals who were lacking in some of the interpersonal skills which the ideal dentist and hygienist should embody.<sup>2-4,8,17,24</sup> Although it may be easier to improve



one's professional skills and competence by taking a refresher course or attending workshops or conventions than to increase one's friendliness or empathy, it appears that these personal characteristics may be the most important ones affecting the patient's attitude toward the dentist and hygienist.  $\Delta$

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# American College of Dentists Foundation Report

The American College of Dentists Foundation was formed by the American College of Dentists and the first meeting of the members of the Foundation was held on March 31st, 1973, in Bethesda, MD. At this meeting the Articles of Incorporation were presented and the Bylaws were adopted. The first Directors were elected and they included: Ralph A. Boelsche, Walter H. Mosmann, Joseph B. Zielinski, Gordon H. Rovelstad, and Robert J. Nelsen. Ralph A. Boelsche was subsequently elected to be the first President and presided over the first Board meeting. Thus, the Foundation as an organization to carry on educational, literary, scientific and charitable purposes both directly and by the application of assets to the use of the American College of Dentists, for charitable, scientific, literary or educational purposes or to any other corporation, trust, fund or foundation whose purposes and objectives are charitable, scientific, literary or educational was launched. Original pledges received at that meeting amounted to \$12,505.00.

The second meeting of the members and of the Board of Directors of the Foundation took place in Houston, TX. President Ralph A. Boelsche presided and reported that as of October 1973 the Foundation had \$15,000 in Treasury Bills and \$2,313.73 on deposit in the bank. The names of the original contributors were reported to the Board of Directors and at a later date were inscribed on a brass plaque which hangs in the Executive Office of the College to this day.

Thus, Dr. Ralph A. Boelsche, as the first President, was instrumental in organizing the Foundation as well as collecting the original contributions in order to establish this new venture for the College.

*Continued on page 18*

## Foundation Officers

President H. Curtis Hester

Vice President Robert W. Elliott, Jr.

Secretary Gordon H. Rovelstad

Treasurer Robert C. Coker

Director James A. Harrell, Sr.

## PURPOSES AND OBJECTIVES OF THE FOUNDATION

### TO CARRY ON THE FOLLOWING:

EDUCATIONAL, LITERARY, SCIENTIFIC AND CHARITABLE purposes or any of them, both directly and by the application of assets to the use of the American College of Dentists, for charitable, scientific, literary or educational purposes, or to any other corporation, trust, fund or foundation whose purposes and operation are charitable, scientific, literary, or educational.

- (a) TO FOSTER and maintain the honor and integrity of the profession of dentistry;
- (b) TO STUDY, improve and to facilitate dental health care;
- (c) TO PROMOTE the study of dentistry and research therein, the diffusion of knowledge thereof, and the continuing education of dentists;
- (d) TO CAUSE to be published and to distribute addresses, reports, treatises and other literary works on dental subjects;
- (e) TO PROMOTE suitable standards of research, education, communication, and delivery of dental health care.

PROVIDED, HOWEVER, that no part of the net earnings of the corporation shall inure to the benefit of any *private member* or *individual*, and provided further that no substantial part of its activities shall involve the carrying on of propaganda, or otherwise attempting to influence legislation.

### ALL CONTRIBUTIONS ARE TAX-DEDUCTIBLE.

- 1. All contributions to the American College of Dentists Foundation are tax-deductible as charitable gifts.
- 2. Individuals, Associations and Foundations are all eligible to support the work of the Foundation through tax-deductible gifts.
- 3. The American College of Dentists Foundation is classified as a *Section 501 (c) (3)* organization under the Internal Revenue Code.
- 4. The Foundation has material available to substantiate the tax-deductibility of your contribution.

## American College of Dentists Foundation, Inc. Balance Sheet for 1987 and 1986

	ASSETS	
	1987	1986
Cash in Bank		
Citizens Savings and Loan Association, Inc.		
Now Checking Account	\$ 16,013.12	\$ 1,790.13
Certificate of Deposit	—	12,666.41
Money Max	65,852.63	50,910.31
Money Max—Restricted for Hillenbrand Project	—	1,792.71
Maryland National Bank Certificate of Deposit	30,795.08	28,405.59
Perpetual Savings Bank Restricted for Harris Fund	29,105.29	18,010.40
Inventory—Hillenbrand Books—at cost	24,038.10	26,187.10
Total Assets	<u>\$165,804.22</u>	<u>\$139,762.65</u>
LIABILITIES AND FUND BALANCE		
Liabilities		
Accounts Payable	\$ 2,478.94	\$ 3,154.97
Fund Balance		
Operating Fund		
Unrestricted	21,671.05	23,032.13
Restricted Hillenbrand Project	—	1,792.71
Principal Fund	112,587.44	93,772.44
Samuel D. Harris Fund	29,066.79	18,010.40
Total Fund Balance	<u>163,325.28</u>	<u>136,607.68</u>
Total Liabilities and Fund Balance	<u>\$165,804.22</u>	<u>\$139,762.65</u>

## American College of Dentists Foundation, Inc. Statement of Income and Fund Balance for 1987 and 1986

	1987				1986			
	Total	Operating Fund	Principal Fund	Samuel D. Harris Fund	Total	Operating Fund	Principal Fund	Samuel D. Harris Fund
Income								
Donations								
Unrestricted	\$ 13,427.00	\$ —	\$ 13,427.00	\$ —	\$ 10,900.00	—	\$10,900.00	\$ —
Restricted for Samuel D. Harris Fund	10,000.00	—	—	10,000.00	18,304.00	—	—	18,304.00
Memorial	3,105.00	—	3,105.00	—	2,835.00	—	2,835.00	—
Sale of Hillenbrand Books	4,432.00	—	4,432.00	—	2,580.00	2,580.00	—	—
Investment Income								
Unrestricted	6,488.00	6,488.00	—	—	7,174.77	7,174.77	—	—
Hillenbrand Project	109.38	109.38	—	—	863.66	863.66	—	—
Samuel D. Harris Fund	1,094.89	—	—	1,094.89	1,569.16	—	—	1,569.16
Total Income	<u>38,656.27</u>	<u>6,597.38</u>	<u>20,964.00</u>	<u>11,094.89</u>	<u>44,226.59</u>	<u>10,618.43</u>	<u>13,735.00</u>	<u>19,873.16</u>
Expenses								
Postage	454.33	454.33	—	—	—	—	—	—
Print Ethics Booklets "Dentistry, a Health Service"	4,009.00	4,009.00	—	—	—	—	—	—
Miscellaneous Printing Expenses	470.70	470.70	—	—	11.17	11.17	—	—
Management Services	2,000.00	2,000.00	—	—	2,000.00	2,000.00	—	—
Accounting Services	1,000.00	1,000.00	—	—	750.00	750.00	—	—
Donations—American Fund for Dental Health	250.00	250.00	—	—	250.00	250.00	—	—
Hillenbrand Project								
Office Expenses	1,567.14	1,567.14	—	—	—	—	—	—
Cost of Books Sold and Distributed	2,149.00	—	2,149.00	—	3,172.34	3,172.34	—	—
Samuel D. Harris Fund—Senior Service Project	38.50	—	—	38.50	1,862.76	—	—	1,862.76
Total Expenses	<u>11,938.67</u>	<u>9,751.17</u>	<u>2,149.00</u>	<u>38.50</u>	<u>8,046.27</u>	<u>6,183.51</u>	<u>—</u>	<u>1,862.76</u>
Net Income (Loss)	26,717.60	(3,153.79)	18,815.00	11,056.39	36,180.32	4,434.92	13,735.00	18,010.40
Fund Balance, January 1,	136,607.68	24,824.84	93,772.44	18,010.40	100,427.36	13,480.19	86,947.17	—
Net Transfer from Principal Fund	—	—	—	—	—	6,909.73	(6,909.73)	—
FUND BALANCE, DECEMBER 31,	<u>\$163,325.28</u>	<u>\$21,671.05</u>	<u>\$112,587.44</u>	<u>\$29,066.79</u>	<u>\$136,607.68</u>	<u>\$24,824.84</u>	<u>\$93,772.44</u>	<u>\$18,010.40</u>



*Continued from page 16*

It is not surprising that today the American College of Dentists Foundation has a firm organizational structure, a history of biannual meetings since 1973 and total assets of \$165,804.22. There has never been a strong request for contributions from Fellows of the College until 1988 when a minimum amount of \$10 was asked to be enclosed with payment of

the dues from each of the Fellows. Since the policy has been to expend only the earnings from the principal of the Fund, the net income for 1987, \$26,717.60, was the amount expended in 1987. The net income from unrestricted donations from members was \$13,427.00, and this was placed in the principal fund. The donations from memorial gifts to the Foundation amounted to \$3,105.00.

A major gift to the Foundation

was made by Dr. Samuel B. Harris in 1986 and another in 1987, the earnings of which are to support the Distinguished Service Award of the American College of Dentists. This Award, presented every year, honors the Fellows with fifty years of Fellowship who have made significant contributions to the College and to the profession.

The list of contributors to the Foundation for 1987 are listed below.

## AMERICAN COLLEGE OF DENTISTS FOUNDATION, INC. List of Contributors January 1 thru December 31, 1987

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Sumner H. Willens	Orrin Greenberg
J. Wells Young, Jr.	Crawford McMurray
	1,435.00
ACD Memorials	93 deceased Fellow @\$15
	1,395.00
	Total Personal Memorials \$ 2,830.00

### MEMORIALS

Sections	In Memory/Honor of
Texas Section	Charles Perlman
Texas Section	Jack T. Clark
Texas Section	Charles R. Morris
Texas Section	Joseph Y. Reed
Texas Section	Joe D. Peak
Texas Section	Charles B. Price
Texas Section	Frederick C. Elliott
Texas Section	E. R. Johnson
Texas Section	J. Hobson Crook
Texas Section	Lewis C. Turner
Texas Section	Charles W. Finley
	Total Section Memorials \$ 275.00
	TOTAL MEMORIALS \$3,105.00

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Carolinas 2/19	
Florida 12/16	
Florida 10/23	
Illinois 4/24	
Metro-Washington 11/12	
Michigan 5/17	
New York 11/30	
No. Calif. 10/10	
Texas 2/10	
Upper Midwest	
(1/2 of Section dues)	
Upper Midwest 12/31/87	
(1/2 of Section dues)	
Upper Midwest	
(1/2 of Section dues)	
Total Section Donations	\$3,520.00
UNRESTRICTED DONATIONS	\$13,427.00
RESTRICTED DONATIONS	\$10,000.00
(Samuel D. Harris Fund	
—2nd installment)	
TOTAL DONATIONS	\$23,427.00

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 Wessinger, N. Carl  
 Weyer, Leland E.  
 Wheatcroft, Merrill G.  
 Wheeler, Robert L. Jr.  
 Whiston, David A.  
 Whitmarsh, Stewart B.  
 Willcox, J. Clifford  
 Willen, Raymond  
 Williams, Bernard T.  
 Williams, Donald M.  
 Williams, George H. III  
 Williams, Robert M. Sr.  
 Williams, Robert W.  
 Williamson, John H.  
 Williamson, Lewis W.  
 Wipf, Harvey H.  
 Wiseman, Ray D.  
 Wohlfarth, William C. Jr.  
 Wolford, Lloyd W.  
 Wong, Colin C.  
 Woodard, James E.  
 Workman, Richard H.  
 Wright, Robert J.  
 Yamamoto, George M.  
 Yanase, Roy T.  
 Yapple, Newell H.  
 Yent, Donald R.  
 Young, George W.  
 Young, George W. Jr.  
 Young, James W. Jr.  
 Young, Leo E.  
 Zamaludin, Mohamed  
 Zimmerman, Donald C.  
 Zimmerman, Eugene R.  
 Zumbrunnen, C. E.  
 Zwibel, Burton C.

749 Personal Donations

\$9,907.00

# CAMPAIGN FOR THE 90's, KICK-OFF IN OCTOBER FOR FUND DRIVE

**James A. Harrell, Sr., Chairman, Capital Fund Drive Chairman**

The year 1988 has many events of significance. However, for the Fellows of the College, and me in particular, the year 1988 marks the beginning of a new era for the American College of Dentists Foundation and the American College of Dentists. The reason for this is the launching of the Capital Fund Drive, entitled "The Campaign for the 90's" for a Center for the Foundation and the College where their activities can be focused and from which their influence can be spread. As Chairman of this Fund Drive, I am excited and enthused.

The time to move forward is NOW. I would like to ask each of you to start spreading the news of the "Campaign for the 90's" and share the enthusiasm of the Honorary Chairmen, the Committee, and the Board of Regents.

I recently read a quote from Sir Edward V. Appleton's, Scottish scientist, whose scientific discoveries made possible worldwide broadcasting and won him a Nobel Prize. When he was asked for the secret of this amazing achievement he replied, "It was enthusiasm. I rate enthusiasm even above professional skill, for without enthusiasm one would scarcely be willing to endure the self-discipline and endless toil so necessary in developing professional skill. Enthusiasm is a dynamic motivator that keeps one persistently working towards his goal."

The American College of Dentists Foundation was founded on March 31st, 1973, under the sponsorship of the American College of Dentists. In only the second decade of its organizational life, the Foundation has become recognized through its activities as a resource to be respected. The Foundation now has focused on the College and its activities. Recognizing the need for adequate and permanent facilities that can give stability

to the College, its sponsor, the Campaign for the 90's has been launched. This College has great potential for the future:

- to establish a center for scholarship, ethics and professionalism in dentistry.
- to provide a center for the history of dentistry in America
- to provide a conference center for scholarly research and study in dentistry

We are all fortunate to have the opportunity of participating in the beginning of a new era for the American College of Dentists.

We expect to have a large number of completed pledges to announce before the kick-off of our Campaign for the 90's during the annual meeting. The Campaign for the 90's is a \$750,000 effort in which all Fellows will be able to participate this fall. Many opportunities will be available to honor relatives and friends or themselves. Gifts of \$10,000 and above will be needed to meet the goal. Of course, gifts of all amounts will be welcome. A \$1,000 pledge over three years is only \$6.42 a week. A recent survey shows that the average income for the practicing dentist is \$88,000 a year. It is my hope that our enthusiasm for the American College of Dentists new headquarters will cause most Fellows of the College to pledge more than

\$6.42 a week. The standards and ideals of the American College deserve the very highest contribution—our best.

We are asking that you make an annual pledge of three to five years. Opportunities to name areas of the building will be available according to the following:

Amount	Recognition
\$500,000	Name the building— Plaque on building Portrait in prominent place
150,000	Name Archival Library of American College of Dentists
100,000-149,999	Name Presidents' Conference Room
75,000- 99,000	Name Regents' Board Room
20,000- 74,000	Place your name on the Office & Major Plaque

Additionally, plaques will be placed in prominent places in the Center according to the following schedule:

Amount	Recognition
10,000	Place your name on \$10,000 Plaque
5,000	Place your name on \$ 5,000 Plaque
1,000	Place your name on \$ 1,000 Plaque
500	Place your name on \$ 500 Plaque

**HELP SPREAD THE WORD!**

Dr. James A. Harrell, Sr., President-Elect and Chairman of the CAMPAIGN FOR THE 90'S, reviews the Campaign strategy with Dr. W. Robert Biddington, Vice President and participant in the leadership gifts phase of the Campaign.





# HELP WANTED FOR SELECT PROGRAM

Robert W. Elliott, Jr.

In my view, nothing will impact more on our profession in the years ahead, than the quality of the students who are entering dental school today.

If you agree with me, than it should disturb you greatly to know that in 1986 there were only 1.3 applicants for each freshman seat in the dental schools of the United States. This, in spite of the fact that the available seats had been reduced by one third since a peak of 6300 was reached in 1978.

At the same time in 1986, 30 percent of those admitted to dental school had a grade point average (GPA) of less than 2.8.

We can all agree, I believe, that there is no need for concern about the number of places for freshman in our nation's dental schools. However, if we desire that the profession prosper and continue on the upward path determined by our predecessors, we must *help* to make available to admissions committees, individuals who have the best possible qualifications. Furthermore, they should be in sufficient numbers to allow these committees to choose a class worthy of the dental profession.

We must stop the trend that, if it

continues, will find the number of applicants equal to the number of seats, or even worse, less than that number. Should this occur, the temptation would exist to accept some students far less qualified than desirable. Can something be done about these problems? The answer is *yes—the SELECT program*.

The *SELECT* program was conceived and implemented by the American Association of Dental Schools and the American Dental Association and has been supported by our College by two \$5,000 grants. Its objectives are threefold: to convey an accurate and positive image of dentistry as a career and as a profession; to encourage highly qualified individuals to consider careers in dentistry, and to involve you the dentist in the program.

The *SELECT* program is a coordinated effort among dental practitioners, dental educators, and high school counselors to identify and select individuals who are interested in and capable of providing quality health care as future dentists.

**What can you do?**—As Fellows of the College, you are the ideal role model in your practice and in your lives. Any young man or woman interested in dentistry if counseled by you, could not fail to receive an accurate portrayal of

our profession at its best.

**Here is how you can help—**You can become a **RECRUITMENT PARTNER**—part of the *SELECT* team—by calling your local *SELECT* coordinator, a list of whom can be found at the end of this article.

As a recruitment partner you will have indicated your willingness to be a reference for people in your locality who express an interest in a career in dentistry. This may involve: visits of groups or individuals to your office, permitting individuals to observe you at work, participating in career days in high schools or colleges, and/or providing information to science or pre-dental clubs.

The above activities will take no more time than you wish. At a maximum no more than one half day a month and most likely a great deal less.

Your coordinator will provide you with all the information needed to accurately provide a factual picture about our profession, financing a dental education, dental aptitude tests, and other facets about a career in dentistry.

Now it's up to you—you can make the difference in the dental profession of tomorrow—please volunteer as a **recruitment partner**—please call the *SELECT* coordinator nearest you **NOW**. ▴

\*Robert W. Elliott Jr. D.D.S. President, American College of Dentists.

# **DIRECTORY OF AMERICAN DENTAL ASSOCIATION STATE SOCIETY SELECT COORDINATORS AS OF JUNE 21, 1988**

## **ALABAMA**

Alabama Dental Association  
836 Washington Avenue  
Montgomery, AL 36104  
Mr. Wayne McMahan  
205/265-1684

## **ALASKA**

Alaska Dental Society  
406 W. Fireweed Lane, #202  
Anchorage, AK 99503  
Dr. Richard Stephens  
907/276-0708

## **ARIZONA**

Arizona State Dental Association  
4131 N. 36th Street  
Phoenix, AZ 85018  
Mr. Greg McFarland  
602/957-4777

## **ARKANSAS**

Arkansas State Dental Association  
920 West 2nd Street, #204  
Little Rock, AR 72201  
Dr. Kelley Erstine  
501/372-3368

## **CALIFORNIA**

California Dental Association  
818 "K" Street Mall  
Sacramento, CA 95814-3593  
Ms. Conni Banchero  
916/443-3382 ext 430  
(CA) 800/537-7071 ext 430

## **COLORADO**

Colorado Dental Association  
6850 E. Hampden Avenue  
Denver, CO 80224  
Dr. Richard M. Neison  
303/758-6850 or (841-2603)

## **CONNECTICUT**

Connecticut State Dental  
Association  
85 Prospect Street  
Milford, CT 06460  
Dr. Anthony J. Russo  
203/878-1445

## **DELAWARE**

Delaware State Dental Society  
5317 Limestone Road  
Wilmington, DE 19808  
Dr. Thomas P. Dougherty  
302/239-2500  
302/656-8622  
Dr. Richard Bond  
302/475-5900

## **DISTRICT OF COLUMBIA**

District of Columbia Dental Society  
4300 Fordham Road, N.W.  
Washington, D.C. 20016  
Mr. C. Jay Brown  
202/686-0817

## **FLORIDA**

Florida Dental Association  
4052 Brandon Hill Drive  
Tallahassee, FL 32308  
Dr. Marci Beck, Chair  
904/893/6746

Florida Dental Association  
1803 University Blvd. North  
Jacksonville, FL 32211  
Dr. Robert Sharp, Vice Chair  
904/743-2727

## **GEORGIA**

Georgia Dental Association  
490 Peachtree St NE 567C  
Atlanta, GA 30308  
Dr. William E. Harris  
404/525-6543 or 404/636-6465

## **HAWAII**

Hawaii Dental Association  
1001 Bishop Street  
Pauahi Tower, Suite 300  
Honolulu, HI 96813  
Dr. Marcy M. Kawasaki  
808/521-2252

## **IDAHO**

Idaho Dental Society  
333 South Woodruff  
Idaho Falls, ID 83401  
Dr. Vernon O. Gaffner  
208/524-2034

## **ILLINOIS**

Illinois State Dental Society  
9631 Gross Park Road  
Skokie, IL 60076  
Dr. Jefferson C. Brock  
312/673-6616

## **INDIANA**

Indiana Dental Association  
402 Jefferson Bldg.  
One Virginia Avenue  
Indianapolis, IN 46204  
Mr. Gale E. Coons  
317/634-2610  
Dr. William B. Risk  
216 North 4th Street  
Lafayette, IN 47901  
317/742-0202

## **IOWA**

Iowa Dental Association  
703 8th Street  
Boone, IA 50036  
Dr. David Grant  
515/432-6244

## **KANSAS**

Kansas Dental Association  
5200 Hunttoon  
Topeka, KS 66604  
Mr. Carl C. Schmitthenner, Jr.  
913/272-7360

## **KENTUCKY**

Kentucky Dental Association  
201 Geri Lane  
Richmond, KY 40475  
Dr. James C. Murphy  
606/623-8622 or (5648)

## **LOUISIANA**

Louisiana Dental Association  
1100 Florida Avenue  
Box 138  
New Orleans, LA 70119  
Dr. R. Jack Cassingham  
504/948-8570

**MAINE**

Maine Dental Association  
RFD #1 Box 225  
Houlton ME 04730  
Dr. Donald P. Woods  
207/532-7751

**MARYLAND**

Maryland State Dental Association  
21 West Road  
Suite 101  
Baltimore, MD 21204  
Dr. John F. Patterson  
301/321-1266

**MASSACHUSETTS**

Massachusetts Dental Society  
18 North Road  
Chelmsford, MA 01824  
Dr. Ronald M. Chaput  
617/651-7511

**MICHIGAN**

Michigan Dental Association  
3401 E. Saginaw, Ste. 209  
Lansing, MI 48912  
Dr. Martin Tuck  
517/351-0800  
Dr. Grace DeShaw-Wilner  
230 N. Washington Square  
Suite 208  
Lansing, MI 48933  
517/372-9070

**MINNESOTA**

Minnesota Dental Association  
University of Minnesota  
School of Dentistry  
515 Delaware Street, S.E.  
15-209 Malcolm Moos Tower  
Minneapolis, MN 55455  
Ms. Gale Shea  
612/624-6960 or 625-7149

**MISSISSIPPI**

Mississippi Dental Association  
331 W. Gallatin Street  
Hazlehurst, MS 39083  
Dr. Rick Akin  
601/894-1634 or (2154)

**MISSOURI**

Missouri Dental Association  
P.O. Box 1707  
Jefferson City, MO 65102  
Mr. Roger A. Weis  
314/634-3436

**MONTANA**

Montana Dental Association  
18 N. Last Chance Gulch  
Helena, MT 59601  
Dr. Roger L. Kiesling  
406/443-2061

**NEBRASKA**

Nebraska Dental Association  
515 W. 9th Street  
P.O. Box 787  
Hasting, NE 68901  
Dr. Paul Holm  
402/463-2416 or 402/462-2620

**NEVADA**

Nevada Dental Association  
738 East Sahara Avenue  
Las Vegas, NV 89104  
Dr. William E. Ursick  
702/733-0210

Nevada Dental Association  
2261 Pyramid Way #3  
Sparks, NV 89431  
Dr. Larry Champagne  
702/359-3934

**NEW HAMPSHIRE**

New Hampshire Dental Society  
P.O. Box 2229  
Concord, NH 03302-2229  
Mrs. Joyce A. Kimball  
Ms. Cyndi Miniutti  
603/225-5961

**NEW JERSEY**

New Jersey Dental Association  
458 Rt 10 West  
Whippany, NJ 07981  
Dr. Leslie A. Skurla  
201/386-0300

**NEW MEXICO**

New Mexico Dental Association  
3037 San Patricia, N.W.  
Albuquerque, NM 87107  
Mrs. Marjorie E. Nelson  
505/345-9135

**NEW YORK**

Dental Society of the State of New York  
158 Squire Hall  
School of Dental Medicine  
SUNY at Buffalo  
Buffalo, NY 14214  
Dr. Harvey D. Sprowl  
716/831-2383

**NORTH CAROLINA**

North Carolina Dental Society  
515 South Casewell Street  
LaGrange N.C. 28551  
Dr. Kent Denton  
919/566-9616

**NORTH DAKOTA**

North Dakota Dental Association &  
North Dakota State College of  
Science Dental Auxiliaries Dept.  
Wahpeton, N.D. 58075  
Dr. Rod Casad  
701/671-2334

**OHIO**

Ohio Dental Association  
1370 Dublin Road  
Columbus, OH 43215  
Ms. Cheri Mitchell  
State Coordinator  
614/486-2700

**OKLAHOMA**

Oklahoma Dental Association  
5950 E. 31st #206  
Tulsa, OK 74135  
Dr. James C. Geiger  
918/627-6633



### OREGON

Oregon Dental Association  
150 Madrona Avenue SE  
Salem, OR 97302  
Dr. Steve Lind  
503/362-9908

### PENNSYLVANIA

Pennsylvania Dental Association  
Northeastern Hospital Dental Center  
3258 Memphis Street  
Philadelphia, PA 19134  
Dr. Judith A. McFadden  
215/291-3700

### RHODE ISLAND

Rhode Island Dental Association  
189 Waterman Street  
Providence, RI 02906  
Dr. Gary D. Light  
401/351-1110 or (0072)

### SOUTH CAROLINA

South Carolina Dental Association  
1040 Savannah Highway  
Charleston, S.C. 29407  
Dr. B. Thomas Kays  
803/556-8030

### SOUTH DAKOTA

South Dakota Dental Association  
117 Holly Blvd.  
Brandon, SD 57005  
Dr. Jeffrey A. Wehrkamp  
605/582-6522

### TENNESSEE

Tennessee Dental Association  
3433 Park Cliff Drive  
Kingport, TN 37664  
Dr. Robert Montgomery  
615/247-9196

### TEXAS

Texas Dental Association  
1440 MacArthur Blvd.  
Suite 105  
Irving, TX 75061  
Dr. Tim Dobbins  
214/253-4411

### UTAH

Utah Dental Association  
#B-160  
1151 E. 3900 S.  
Salt Lake City, UT 84124  
Mr. Monte D. Thompson  
801/261-5315

### VERMONT

Vermont State Dental Society  
20 Western Avenue  
Brattleboro, VT 05301  
Dr. David Neumeister  
802/254-2384

### VIRGINIA

Virginia Dental Association &  
Virginia Commonwealth University  
Medical College of Virginia  
School of Dentistry  
MCV Box 566  
Richmond, VA 23298  
Dr. Marshall P. Brownstein  
804/786-9196 or (6759)

### WASHINGTON

Washington State Dental Association  
14810 Lake Hills Blvd.  
Bellevue, WA 98007  
Dr. Rodney C. Dubois  
206/747-9210

### WEST VIRGINIA

West Virginia Dental Association  
4004 MacCorkle Avenue, S.E.  
Charleston, WV 25304  
Mr. Richard D. Stevens  
304/925-7201

### WISCONSIN

Wisconsin Dental Association  
633 W. Wisconsin Avenue  
Milwaukee, WI 53202  
Dr. David A. Sampe  
414/276-4520

### WYOMING

Wyoming Dental Association  
642 Val Vista, Suite A  
Sheridan, WY 82801  
Dr. George Mohatt  
307/674-9222

### PANAMA CANAL DENTAL SOCIETY

Panama Canal Dental Society  
PSC Box 347  
FPO Miami, FL 34061  
Dr. Cleo Walker

### PUERTO RICO

Colegio de Cirujanos Dentistas  
de Puerto Rico  
Avenue North Main, Bldg. 10 #5  
Sierra Bayamon  
Bayamon, PR 00619  
Dr. Jose A. Aguirre  
908/787-7540

### VIRGIN ISLANDS

Virgin Islands Dental Association  
P.O. Box 3978  
Christiansted  
St. Croix, USVI 00820  
Dr. Michael Bricker  
809/778-5455

## DIRECTORY OF DENTAL SCHOOL SELECT COORDINATORS AS OF JUNE 21, 1988

### ALABAMA

University of Alabama  
School of Dentistry  
University Station  
Box 82 SDB  
Birmingham, AL 35294  
Dr. Charles Barrett  
205/934-4788  
Dr. David Greer  
205/934-5470

### CALIFORNIA

University of California  
Los Angeles  
School of Dentistry  
Office of Student/Alumni Affairs  
Los Angeles, CA 90024  
Dr. Stephen M. Blain  
213/206-1719

University of California  
San Francisco  
School of Dentistry  
Office of Student Affairs, S-619  
San Francisco, CA 94143  
Dr. William E. Hoskins  
415/476-2712

Loma Linda University  
School of Dentistry  
Loma Linda, CA 92350  
Mr. Clair Meske  
714/824-4621

University of the Pacific  
School of Dentistry  
2155 Webster Street  
San Francisco, CA 94115  
Mr. Alfred E. Gilmour  
415/929-6492

University of Southern California  
School of Dentistry  
Admissions Office  
University Park  
Los Angeles, CA 90089-0641  
Ms. Sandra Clark Bolivar  
213/743-2841 or (8717)

### COLORADO

University of Colorado  
School of Dentistry  
Campus Box C-284  
4200 E. Ninth Avenue  
Denver, CO 80262  
Ms. Kathy Stinehagen  
303/270-7250 or 270-7259

### CONNECTICUT

Connecticut School of Dental Medicine  
263 Farmington Avenue  
Farmington, CT 06032  
Dr. Christine Niekrash  
203/679-2207 or (2175)

### DISTRICT OF COLUMBIA

Georgetown University  
School of Dentistry  
3900 Reservoir Road, N.W.  
Washington, D.C. 20007  
Ms. Marguerite J. Dennis  
202/625-2047  
Ms. Judith Giuliani  
202/625-7639

Howard University  
College of Dentistry  
600 "W" Street, N.W.  
Washington, D.C. 20059  
Mrs. Debra T. Plunkett  
202/636-6400

### FLORIDA

University of Florida  
College of Dentistry  
Box J-445  
Gainesville, FL 32610  
Dr. Carrol G. Bennett  
904/392-4866

### GEORGIA

Medical College of Georgia  
School of Dentistry  
Augusta, GA 30912  
Dr. William R. Wege  
404/721-3012 or 404/863-8892

### IOWA

University of Iowa  
College of Dentistry  
Iowa City, IA 52242  
Dr. Nelson S. Logan  
319/335-7162  
Dr. Yvonne Chalkley  
319/335-7164

### ILLINOIS

University of Illinois at Chicago  
College of Dentistry  
801 S. Paulina Street  
Chicago, IL 60612  
Dr. Donald Rice  
213/996-3547

Loyola University  
School of Dentistry  
2160 S. First Avenue  
Maywood, IL 60153  
Dr. James J. Koelbl  
312/531-4903

Northwestern University Dental School  
311 E. Chicago Avenue  
Chicago, IL 60611  
Dr. Juliann S. Bluit  
312/908-7928  
Dr. Jay Geaman  
312/908-5910

Southern Illinois University  
School of Dental Medicine  
2800 College Avenue  
Alton, IL 62002  
Dr. Kenneth E. Beach  
618/463-3977

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1121 W. Michigan, Rm. 105  
Indianapolis, IN 46202  
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317/274-7302  
Ms. Carole Busch  
317/274-7302

# **KENTUCKY**

University of Kentucky  
College of Dentistry  
D155 Chandler Medical Center  
Lexington, KY 40536-0084  
Mr. Daniel C. Seaver  
606/233-6071

University of Louisville  
School of Dentistry  
Louisville, KY 40292  
Ms. Anne Wells  
502/588-5081  
Dr. Michael J. Wahl  
502/588-5081

# **LOUISIANA**

Louisiana State University  
School of Dentistry  
1100 Florida Avenue  
New Orleans, LA 70119  
Dr. Howard Bruggers  
504/948-8504

# **MARYLAND**

University of Maryland-Baltimore  
Baltimore College of Dental Surg.  
666 W. Baltimore Street  
Baltimore, MD 21201  
Dr. James R. Swancar  
301/328-7472

# **MASSACHUSETTS**

Boston University  
Goldman School of Grad Dentistry  
100 East Newton Street, Rm 305  
Boston, MA 02118  
Dr. Sydell Shaw

Harvard School of Dental Medicine  
188 Longwood Avenue  
Boston, MA 02115  
Dr. Gerard Kress, Jr.  
617/732-1443

Tufts University  
School of Dental Medicine  
1 Kneeland Street  
Boston, MA 02111  
Dr. Jay Stinson  
617/956-6641 or (6639)  
Mr. Lawrence Shattuck  
617/956-6639

# **MICHIGAN**

University of Detroit  
School of Dentistry  
2985 Jefferson Avenue  
Detroit, MI 48207  
Dr. Donald A. Nitkin  
313/446-1858 or (1825)

University of Michigan  
School of Dentistry  
Ann Arbor, MI 48109-1078  
Dr. Donald S. Strachan  
313/763-3316

# **MINNESOTA**

University of Minnesota  
School of Dentistry  
515 Delaware Street, S.E.  
15-209 Malcolm Moos Tower  
Minneapolis, MN 55455  
Mrs. Gale Shea  
612/624-6960 or 625-7149

# **MISSISSIPPI**

University of Mississippi  
School of Dentistry  
2500 North State Street  
Jackson, MS 39216-4505  
Dr. James C. Brown  
601/984-6009

# **MISSOURI**

University of Missouri  
Kansas City  
School of Dentistry  
650 E. 25th Street  
Kansas City, MO 64108  
Dr. Daniel E. Tira  
816/276-2080  
913/451-2341  
Ms. Dianne D. Beard  
816/276-2080

Washington University  
School of Dental Medicine  
4559 Scott Avenue  
St. Louis, MO 63110  
Dr. Richard W. Brand  
Ms. Marie Liddy  
314/454-0323

# **NEBRASKA**

Creighton University  
School of Dentistry  
2500 California Street  
Omaha, NE 68178  
Dr. Frank J. Ayers  
402/280-2881  
402/339-0704  
Ms. Patricia Churchill  
402/280-2881

University of Nebraska  
Medical Center  
College of Dentistry  
40th & Holdrege Streets  
Lincoln, NE 68583-0740  
Dr. David Brown  
402/472-1341  
Dr. Jack Knodle  
402/472-1280 or (1363)

# **NEW JERSEY**

Fairleigh Dickinson University  
College of Dental Medicine  
140 University Plaza Drive  
Hackensack, NJ 07601  
Dr. F. Balise Curcio  
201/692-2606

University of Medicine &  
Dentistry of New Jersey  
101 Bergen Street  
Newark, NJ 07103-2425  
Dr. Stephen Wechsler  
201/456-4617 or (4583)

# **NEW YORK**

Columbia University  
School of Dental & Oral Surgery  
630 West 168th Street  
New York, NY 10032  
Dr. Thomas J. Cangialosi  
Ms. Joan Jaffe  
212/305-3478

New York University  
College of Dentistry  
421 First Avenue  
New York, NY 10010  
Dr. Abraham Kobren  
212/998-9821  
Ms. Virginia Dosch  
212/481-5884



SUNY Buffalo  
School of Dental Medicine  
Dental Society of the State of New York  
158 Squire Hall  
Buffalo, NY 14214  
Dr. Harvey D. Sprowl  
716/831-2383

SUNY at Stony Brook  
School of Dental Medicine  
Stony Brook, NY 11794-8709  
Dr. Mortimer L. Shakun  
516/632-8980

#### **NORTH CAROLINA**

University of North Carolina  
School of Dentistry  
CB #7450, Brauer Hall  
Chapel Hill, N.C. 27599  
Dr. Kenneth N. May, Jr.  
919/966-4451

#### **OHIO**

Case Western Reserve University  
School of Dentistry  
2123 Abington Road  
Cleveland, OH 44106  
Dr. Vibeke Nygaard  
216/368-2486

Ohio State University  
College of Dentistry  
305 W. 12th Avenue, Box 209  
Columbus, OH 43210  
Dr. Donald F. Bowers  
614/292-3361

#### **OKLAHOMA**

University of Oklahoma  
College of Dentistry  
P.O. Box 26901  
Oklahoma City, OK 73190  
Dr. Kevin T. Avery  
405/271-5444 or 405/751-4569

#### **OREGON**

Oregon Health Science University  
School of Dentistry  
611 S.W. Campus Drive  
Portland, OR 97201  
Ms. Nora L. Cromley  
503/279-5274

#### **PENNSYLVANIA**

University of Pennsylvania  
School of Dental Medicine  
4001 Spruce Street  
Philadelphia, PA 19104-6003  
Dr. James F. Galbally, Jr.  
215/898-4973

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## THE HILLENBRAND ERA

Dentistry has not always occupied the position among the professions that it does today. The transition to the status of respected profession took place during the period of Dr. Harold Hillenbrand's association with American organized dentistry.

The Dummetts, in their book: *The Hillenbrand Era: Organized Dentistry's Glanzperiode*, state that in the 30's: "The nation's dentists had little or no appreciation of their potential to be members of a vibrant profession with expanded responsibilities and accountabilities to the American public. The main concern of dentists centered on rendering oral health ministrations to individual patients in a private practice setting with prompt remunerations for all services rendered, which led critics to indict the profession as insular, impassive, and generally unresponsive to many social concerns."

Into this arena in 1938 came Dr. Hillenbrand. His first assignment was as Secretary to the ADA's National Health Program Committee chaired by Dr. Harold Oppice. In 1939, the Association was testifying before Congress on the Wagner Health Bill—the first time the profession was asked to testify before the U.S. Congress. Harold H. Hillenbrand prepared the testimony following the lead of the American Medical Association but was sufficiently innovative as to offer a dental section for the Bill. His efforts in this matter came to fruition in the Wagner-Murray-Dingle Bill of 1945; health legislation for the first time contained an extensive dental program.

From this point on, Hillenbrand became increasingly involved with the American Dental Association, becoming editor of the JADA on January 1st, 1945. He was named as General Secretary of the Association in October 1946, and as of January 2nd, 1947, assumed the title and position of Executive Director.

It was his decision, and his alone, to resign on December 31st, 1969, seven years before the mandatory retirement age of 70.

During his years with the Association:

- the ADA budget rose from \$600,000 to \$8,000,000
- membership rose from 62,000 to 112,000
- the headquarters building at 211 East Chicago Avenue was built and occupied
- the ADA was reorganized
- discrimination in membership due to race, creed, or color was removed
- the ADA's seal of acceptance gained national and state recognition both intra and extra professionally
- the Khrushchev incident was resolved
- the ADA championed a drive for a special building for the National Institute of Dental Research—completed in 1961
- accreditation of dental schools and development and implementation of the Dental Aptitude Test were supported

These and many other accounts of the triumphs, travails, and accomplishments of American dentistry during the Hillenbrand years are documented succinctly and interestingly in the Dummett's book.

All American dentists owe it to themselves to read this book about their profession. It should be *required* reading for all dental students.

It would be a fine gift to give someone interested in dentistry, enrolled in dental school, or in their early years of dental practice.

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# LEADING TRUE PROFESSIONAL LIVES

Lynden M. Kennedy\*

You people are being honored today because you are the cream of the crop, the chosen few who believe in, who are committed to, and who demonstrate the characteristics of professionalism which have earned for the healing arts the gratitude and respect of the people. If it weren't so you wouldn't be here.

The commitment of this Academy to worldwide continuing education is well known. When one sees the results of your Facial Disfigurement Project one quickly realizes that your gift to humanity is of such magnitude that it is immeasurable. Additionally, the Academy's commitment to excellence in clinical practice, research, education, literature and service to the profession makes the justification for the Academy's existence readily evident.

I submit that all of these goals are noble in nature and are wonderful, but I suggest that there are some ingredients of professionalism which make the attainment of these goals possible. Without impeccable ethics and the confidence of the public our achievements would be minimal at best. If we expect a patient or an organization to accept

and to follow our recommendations for their best interests, then we must be sure that they do not construe them to be for *OUR BEST INTERESTS*.

Let me read a couple of letters to the Editor of Modern Maturity Magazine, which as most of you know, is the organ of the American Association of Retired People. One letter said: "We are dealing today, not with gentle healers, but with hard-nosed businesses and we should treat them as such. Doctors and hospitals are providers of services just like auto dealerships or department stores. If service is bad we should get our money cheerfully refunded and be free to sue for damages.

"No more of this patients' rights stuff. Let's demand value for our money."

Another reported: "I have just paid my doctor \$50 (nonreimbursable) for a two-minute office visit to refill a \$7.50 prescription.

"While hospitals and doctors look at a \$50 bill with derisive contempt we, the old, go from place to place in search of a discount on an item of necessity. It is the theater of the absurd, very soon to become a tragicomedy."

The last one I will read stated: "You're helpless in the hospital bed. Dr. X walks in, takes a brief look, checks the chart, grunts and walks out. Who was that? You'll find out when you get the bill for the consultant's fee."

The course of history has almost never been changed by what is

actually true, but has always been changed by *WHAT PEOPLE THINK IS TRUE!* Historically, the public has thought of doctors almost as saints: as people who unselfishly and sacrificially do things for them that they are unable to do for themselves. But when people begin to believe that doctors are more interested in them as a source of income rather than as people in need; when the patient thinks the services are no longer a part of professional commitment; when he feels that his interests, his illnesses, comfort, function and appearance are considered to be secondary to the doctors personal benefits—then the professions are in deep trouble. I submit that some of the professions are to varying degrees in that uncomfortable position today.

Think of some of the tongue-in-cheek jokes on professionals we hear today. True, the lawyers are in first place as far as being the butt of the greatest number of jokes is concerned—at least so far. For example, there is the old joke about the lawyer and his wife who were taking a Caribbean cruise and the lawyer fell overboard in some shark-infested waters. Everyone just knew he was a goner! But, to everyone's amazement, the sharks lined up in parallel rows and escorted the lawyer back to the ship. The lawyer's wife sobbed, "It's a miracle—a wonderful miracle!" A man standing closeby said, "No, Lady. That's no miracle—that's just professional courtesy!"

I recognize I am speaking to a

\*Lynden M. Kennedy, Former President of the American Dental Association, Former President of the American College of Dentists.

Convocation Speech for Academy of Dentistry International, Las Vegas, Nevada, October 8, 1987.



group with international interests and backgrounds. I am also aware that there may well be some provincial bias in my observations. I do believe, however, that with our common interests, educational backgrounds, and common purposes there will be some things applicable to all.

Shortly after I received the invitation to be here today, I read an article in the Dallas Morning News by Felix G. Rohatyn which was adapted from a commencement address at Long Island University. The title was: "ETHICS ISN'T SOMETHING YOU LEARN IN COLLEGE."

Let me share a few excerpts of his article with you. He began by saying: "I am an investment banker. For the last two years, many of the best and brightest in my business have been pleading guilty to illegal acts and marching off to jail. Successful, wealthy, intelligent men turned out to be greedy, arrogant and corrupt."

"Why? Because, as much as anything else, this situation is one of the realities of the so-called service society. Whereas making things, and the activities related to products, were the main preoccupation of prior generations, making money, and the activities related to money, are the driving forces of our society today."

"To be wealthy is not sinful; nor is poverty a virtue. But the pursuit of wealth and power is so pervasive today as to create something

that may be entirely new—namely, a money culture. When such a culture grows cheek-by-jowl with extreme poverty, it is potentially dangerous."

He continued; "A recent article indicated that business schools were going to encourage the study of ethics as part of the curriculum. If graduate schools have to discover ethics, then we are truly in serious trouble."

He went on to say that the issue of ethics takes on a sharper focus in the money culture of a service economy than in the earlier industrial days. In the dispensing of many services (health and others) virtually the only discipline that can be applied is ethical. At the same time, those institutions that historically provided the ethical basis to society—the family, the church and the primary school—are getting weaker and weaker.

Then, Mr. Rohatyn said: "Ethics is a moral compass. It should coincide with enlightened self-interest, not only to avoid jail in the short run but to avoid social upheaval in the long run. It must be embedded early, at home, in grade school, in church. It is highly personal. I doubt it can be taught in college."

It seems to me that those of us in the dental profession can profit from some of Mr. Rohatyn's observations. Surely we are practicing in a money culture. Unfortunately, almost the only criterion used by society in judging success is one's

financial statement. All too frequently little or no weight is given to the provision of comfort and health for one's fellow man.

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**Unfortunately, almost the only criterion used by society in judging success is one's financial statement.**

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Today, in my view, there is an overwhelming confusion between the terms "legality" and "morality." All too often society is taking the position that if something is legal it is also moral. That simply is not necessarily true. Legality embraces the lowest form of acceptable behavior whereas morality approaches the highest and most noble standards. Unfortunately, in the last few years we have seen an emasculation of high ethical (moral) standards, reducing them to a level more consistent with what is merely legal. A prime consideration when the professions were given the exclusive right to practice in the chosen fields for which they were qualified was the

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presumption that they would discipline their own. High moral and ethical standards were indispensable to that end. These standards have become so eroded as to be almost meaningless insofar as allowing a profession to discipline itself.

But we should recognize and emphasize that while some of the "Thou Shalt Nots" of Codes of Ethics are no longer legally permissible there is nothing to prevent us as individuals from conducting our personal lives in a manner we consider to be ethically and morally appropriate.

Sometimes there is a tendency for some of us in the profession to think that the world, including the profession, is going to Hades in a handbasket. This is particularly true of those of us who have been around for a while and have witnessed so many imposing changes in our profession and in our society. Actually, of course, our profession is a part of society and what affects society also affects our profession.

I had hoped to spare you any trip into the past but, right now, the temptation to recite an instance or two is too great. I came into the profession before penicillin, polio shots, frozen food and the Kinsey report. For us, time-sharing meant togetherness, not computers or condominiums. A chip was a piece of wood and hardware was just that—hardware. Software wasn't even a word. We got married first and then lived together—How quaint can you be?

Closets were for clothes, not for coming out of, bunnies were small rabbits and rabbits were not Volkswagens. We thought a deep cleavage was something a butcher did.

Grass was mowed, Coke was something you drank and pot was what you cooked in.

We were not before the difference between the sexes was discovered, but we seem to be the last generation that was so dumb as to think a woman needed a husband to have a baby.

There have been changes in the professional environment too. It isn't always easy but some of us do strive to live in today's world and not think all good things were in the golden past. We do wonder, from time to time, just where are our heroes? As Andrea Sarti says in Brecht's play entitled, *Galileo*, "It is an unhappy country that has no heroes." The world does seem to be a bit short on patriots and heroes. We are prone to ask where are our Patrick Henrys, our Mother Thesas, our Dr. Livingstons and our deeply committed people. Well, thank Goodness, they're still around but it just doesn't seem to be as popular to praise the positive as it is to publicize and scrutinize every real or imagined defect in our country, our leaders and our traditional ways of life. We live in a disposable society—throw it away—tear it down—but don't build it up!

But then, if the Iran hearings did nothing else, they did show, with emphasis, that the American people are eager for a hero and jumped at the opportunity to recognize Oliver North as one.

At the risk of being presumptuous I will voice my opinion that we have too many politicians and too few statesmen. It seems to me that too many of our legislators are far more interested in making an appearance before national TV for purposes of self-promotion than are interested in making decisions for the good of our country.

I have some skepticism when I

hear a politician expound in sonorous tones about his concern for the common man—unless he considers himself to be that common man. I have long admired the view of Dean Alfange when he said: "I do not choose to be a common man. It is my right to be uncommon . . . if I can. I seek opportunity . . . not security. I do not wish to be a kept citizen, humbled and dulled by having the state look after me. I want to take the calculated risk; to dream and to build, to fail and to succeed. I refuse to barter incentive for a dole. I prefer the challenges of life to the guaranteed existence; the thrill of fulfillment to the stale calm of utopia. I will not trade freedom for beneficence nor my dignity for a handout. I will never cower before any master nor bend to any threat. It is my heritage to stand erect, proud and unafraid; to think and act for myself; enjoy the benefits of my creations and to face the world boldly and say, this I have done. All this is what it means to be an American." And I might add . . . to be a professional!

I suspect most of us are far more interested in the uncommon man than we are in the common man. Dr. William Teague said, When we have a problem with our automobile we don't look for a common mechanic . . . we look for one who is unusually talented. If there is an illness in our family, certainly we don't want a common doctor . . . we want a highly skilled physician. Nor do we want a common teacher for our children. We want a gifted, understanding, compassionate educator.

Neither do I want to be a part of a common profession—or a quasi-trade. I want very much to be a member of a profession with the highest ethical and moral stand-



ards in every respect . . . one with the expressed goals of this Academy.

Nothing very much worth while was ever accomplished that didn't require both effort and sacrifice. It will take a great deal of both if we are to attain and retain that kind of profession. It was the unselfish commitment to health service that earned for dentistry the status of a profession. To succumb to the tenets of the money culture—to become competitors rather than colleagues, to be guided by what is legal rather than what is moral and ethical would be a step backwards, a return to the status of a commercial venture—a trade. We mustn't fall for the line that says you've got to go along to get along or if you can't beat 'em join 'em. We are so prone to take the easy way out and say, "What can I do? I'm just one person and one person can't make any difference."

It is then that I think of the time my wife and I visited Rome and the Coliseum. It was fairly late in the afternoon and after we passed the hawkers and the souvenir sellers, we walked down the steps of that historic structure. We could see the area which had been occupied by the screaming crowds. We could see the remnants of the rooms and passages which had been below the floor of the arena—the areas where the wild animals and the Christians were kept. I had to think of the horrible indignities to which those Christians were subjected—all because they refused to sacrifice principle and say that Caesar was all powerful. I could imagine one Christian saying to another, "Man, we're crazy! I'm tired of fighting these lions. All we've got to do is just say, 'Yes sir, Caesar, you're the greatest—almighty.' We don't have to mean it,

just give it lip service and get 'em off our backs."

But you know, if those men hadn't stood up for their belief and their principles I wonder if we would be here today in a free society, free to practice our professions, to pursue our goals and to attend the churches of our choice.

As I look at you and think of your avowed principles and goals I see the nucleus of a tremendous force for good—professional missionaries, so to speak. People dedicated and committed to professionalism, knowing that it is *this* which will generate the best possible service for our fellowmen—our fellow human beings.

This world, our country and our profession desperately need good role models. Your recognition and the honor you are receiving today is a testimonial to your abilities to serve in that capacity. Important people, substantial people, principled people, invite imitation. Unfortunately, many of the people in the limelight—some who are actors, some who are government officials and yes, even some of the clergy, by their actions and ideals have greatly lessened their capacity to serve as inspiring role models. Today's heroes—as seen on prime time TV and the soaps—are crooks and con men. The bounds of behavior have been stretched to incorporate deceit, adultery, and blackmail. Everyone with an IQ higher than room temperature knows how badly we need moral models for observation and emu-

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**This world, our country and our profession desperately need good role models.**

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lation. You folks are in a remarkable position to help fill those roles and my hope and prayer is that you will—with diligence!

My mother used to tell us about a man who never said anything unkind or uncomplimentary about anyone. In fact, he could always come up with something good about everyone. Finally one of the town's most reprehensible reprobates passed away and they thought for sure at long last here was an occasion wherein old John couldn't come up with one single good thing to say about him. They came up to old John and said, "Well, old Bill went to his Maker, didn't he?" Old John thought for a minute and replied, "Yes, and old Bill sure could whistle pretty couldn't he?"

I'd hate to think that when our allotted time is up that all one could say about any of us would be that we could "whistle pretty." I have no concern about you folks. As I see it, you are the principled people who insure a magnificent future for the profession. I congratulate you for the honor you have earned. My wishes and prayers for you are that you will enjoy all the peace and inner satisfaction that comes from leading true professional lives. . . . I think Edgar Guest expressed it beautifully for all of us when he wrote:

"I'd like to think, when life is done that I had filled a needed post. That here and there I'd paid my fare with more than idle talk and boast. That I had taken gifts divine, the breath of life and manhood fine; and tried to use them now and then in service for my fellowmen. . . .

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\*Reprint requests to  
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The following three editorials have been selected by the Editorial Award Judging Committee of the William J. Gies Foundation as the outstanding editorials published in 1987. Presentation will be made at the Annual Meeting of the American Association of Dental Editors on October 6, 1988, in Washington, D.C.

### Gies Award Outstanding Editorial Published in 1987

# THE NEED FOR ETHICAL AND MORAL STANDARDS

Howard I. Mark\*

In the present maelstrom of changing values, of uncertainty in the behavior of elected and appointed officials, of impingement on the quality of health care provided in this country, a standard must be set and adhered to by professionals that can serve as an example for the population at large, as well as for those entering into dental practice. Ideally, an individual's principles of ethics and moral behavior have been well-established prior to entry and graduation from professional school through the role model and behavior patterns of parents, relatives, teachers, and other individuals involved in the molding of character. However, the pressures of peer groups, the exhilarating adventure of being on one's own in preparatory schools, colleges, and advanced training centers, all certainly play a part in the final evolution and emergence of those we call colleagues.

The impact of the Federal Government through the Federal Trade Commission and other bureaucratic agencies; the lowering of professional standards re: advertising and the marketing of services; the increase in litigious activity; and the advent of HMOs, PPOs, IPAs have all severely altered, perhaps never to be retrieved, the reactivity of dentists to a Code of Professional Conduct long established by the parent organization, the American Dental Association. Sunset Laws enacted in almost every State in the Union have further compromised in many detrimental ways the ability of State Dental Commissions to regulate effectively the practice of Dentistry, ethical behavior, and questionable professional conduct. In the face of all these influences is it any wonder that there is difficulty in maintaining the high ethical and moral characteristics so essential to professionalism?

And yet this is most imperative, if there is to be any meaning to the striving for the quality of care to which our patients are entitled. We cannot assume that financial reward is to be judged the pinnacle of success, nor can activities on a local, state, or

national level be assumed to be a reflection of the capabilities of the individual practitioner as they relate to the quality of care provided. Rather the commitment to continuing education, the maintenance of skills, the consideration for one's patients, and the willingness to propose necessary treatment compromises that do not adversely affect the quality outcome, mark the practitioner as one devoted to his profession and to its high standards. The example of this type of practitioner must be emulated by all if the dental profession is to continue to be as respected tomorrow as it still is today.

The duties and obligations of the ethical dentist to his patients include the evaluation of their presenting conditions; development of appropriate treatment plans; the obtaining of valid informed consents (meaning consents based on the clear understanding of treatment options, costs, and potential results); and the rendering of treatment in a capable, competent, and quality manner. The risks and benefits of care under each option presented must be described to the patient in layman's terms for clarity. The important component of patient acceptance and willingness to participate actively in the treatment phases must be stressed to further insure a more beneficial result. It is incumbent upon all of us to rededicate ourselves to these high ethical and moral standards.

Regardless of the setting in which dental care is rendered, be it institutional, clinic, private office, or dental school, the quality and level of care provided must be judged on a similar basis. There should be no lessening or lowering of the minimal standards established to assure and insure a reasonable outcome for the patient, while the specific standards to which a practitioner must adhere should be directly related to his training and expertise. Lowering of these standards and the imperiling of the treatment outcome need to be evaluated by committees of peers on both ethical and patient care ground—and these committees must act responsibly within the dictates of their charge. If we are to be truly professional according to the career choices we have made, then we must abide by the rules we ourselves have established!

\*Howard I. Mark, DDS, Editor Journal of the Connecticut State Dental Association. This editorial was published in the April 1987 issue of that publication.

Gies Award Honorable Mention Editorial Published in 1987

# THE RIGHTS OF AUTHORSHIP

Daniel M. Laskin\*

Because of the great difficulty in evaluating the ability to teach well or in determining excellence in clinical care, publications have become the standard on which academic appointments and promotions are based. The resultant pressure to publish, while having a positive effect in stimulating new research and expanding the distribution of information, has also had many deleterious effects. Perhaps the most serious offense in scientific publication is fraud, which appears to be on the increase. The blame for this has been placed upon the high pressure of professional and economic competition within the university and also the inadequate supervision of young investigators by increasingly busy mentors.

While the publication of fraudulent information can have obvious damaging results, and this problem needs to be carefully addressed by program directors, there are lesser, more frequent, offenses that also need our serious attention. One such offense, referred to as "salami science" by Edward Huth (editor of the *Annals of Internal Medicine*), involves the division of a single study into a series of papers to increase the length of the publication list. These efforts can lead to a number of problems, particularly when publication occurs before all of the data have been analyzed and the ultimate findings negate some of the earlier results. Yet, even a sound study, when unnecessarily divided into pieces and published sequentially, has adverse economic and time-related implications since it involves repeated duplication of the editorial process and the unavoidable waste of space in the repetition of material and references.

Equally as inappropriate as divided publication is the repetitive publication of essentially the same material in separate journals. The old excuse of trying to reach different audiences is no longer valid because of the ease with which a thorough literature search can now be done and the ready availability of numerous abstract sources and services. A variation on the theme of repetitive publication termed a "meat extender" by Huth in his menu of gastronomic literary misadventures, also warrants avoidance. This refers to a paper where there is addition of data to previously reported information without reaching any new conclusions. All these forms of wasteful pub-

lications not only lead to unnecessary expenditure of time and money, but also provide manuscripts for unneeded new journals that further dilute the pool of quality papers and make keeping abreast of the literature even more frustrating.

Because promotion is so closely linked to publication, another common ploy used to extend the publication list is multiple authorship. Whereas the increasing complexity of research and the diversity of disciplines involved in the treatment of patients may justify a multiauthored paper in many instances, it is the number of these authors that is usually in question. A departmental chairman who did not participate in the study or treat the patient, a pathologist who made the diagnosis as part of his routine responsibilities, the resident who held a retractor during the operation, or the colleague who generously added an author's name to one of his papers are a few examples of persons who might be considered inappropriate co-authors. Why all this concern, you may ask, when the number of persons listed really has no direct bearing on the quality of the paper? It would make no difference if all that we had to concern ourselves with was the content of the publication. However, as long as academic promotion and qualification for new jobs leans heavily on contributions to the literature, it is essential to be able to identify the role of each author, and this becomes increasingly difficult with every name added.

Many editors share this concern, and there have been a number of attempts to develop guidelines on authorship. In a recent publication (*Ann Int Med* 104:269, 1986), Huth offers some valuable suggestions. He believes that every author should have participated sufficiently on the work represented by the article to take public responsibility for the content. Such participation must include involvement in the conception or design of the study and/or analysis and interpretation of the data, and drafting or critically revising the article. Participation only in data collection does not justify authorship, nor does advising about statistical analysis or rendering technical assistance; such contributions can be acknowledged in a footnote. Authorship is a responsibility that should not be conferred lightly. Only when one has played a significant role in the design and execution of the study, and in the interpretation of the results, is there justification for including that name on the title page.

\*Daniel M. Laskin, DDS, Editor

Journal of Oral and Maxillofacial Surgery. The editorial appeared in Vol. 45:1 of that publication.



Gies Award Honorable Mention Editorial Published in 1987

# THE WHOLE WORLD IS WATCHING

Victor J. Barry\*

As I passed by a hospital on a sunny day recently, I noticed a group of white-clad staff sitting on the grass and all smoking cigarettes. It struck me that in that location and in those uniforms, these were not simply individuals indulging in their right to smoke. To the public who viewed them, they were representatives of their chosen profession—and indeed of the entire healthcare industry—caught in a somewhat hypocritical mode.

As dentists, we carry the same burden throughout our daily activities. We cannot escape the responsibility of whom we represent. We are more than the sum of our degrees.

If a dentist is caught doing drugs, all of dentistry is disgraced. If a dentist injures a patient while attempting treatment beyond his/her training, the ensuing headlines bring everyone's competence into question. (And you don't have to guess what happens to liability rates.).

If a dentist runs a "tacky" ad in the yellow pages, everyone's marketing efforts are undermined. If a few dentists let their hygienists work alone now and then the state legislators find out through the hygienists' lobby, and this hurts our own lobbying efforts.

If a dentist submits a fraudulent claim or forgives the co-payment, then insurance companies put all dentists under suspicion, and call it "cost-containment".

Every bad action has a reaction that is not good. Whenever dentists succumb to unethical temptations, they not only bring injury to their own integrity, but to that of the entire profession. There is no sidestepping that spotlight. This is part of what being a professional is all about.

I fear that with the advent of aggressive advertising, the emphasis on business management courses that push profit-driven practices, the perceived short-

age of patients that turns colleagues into competitors, the lure of alternative delivery systems, and the drop in the ranks of organized dentistry, there has been a degradation of professionalism in our profession.

And professionalism is the ultimate bottom-line we should be concerned with. A profession without its backbone of integrity intact is like a tent without a pole and will quickly succumb to the winds of change.

Dentistry still has a good professional image in the public eye. What can be done to protect it for the future? Some suggestions:

- First of all, encourage our nonparticipating colleagues to join organized dentistry and take an active role in their local component.

- See that dental schools maintain their admission standards despite the temporary drop in applications.

- Have these admissions committees screen more closely for an applicant's moral and ethical background, and not just for good grades.

- Give ethics courses the proper emphasis in the dental school curriculum.

- Have our dental societies' Ethics Committees informally counsel members in need, much like the Impaired Dentists Committee handles substance abusers.

- Lastly, look in a mirror. Ask yourself before embarking on a self-serving course of action if it could have negative ramifications for the profession.

In a word—be professional.

A major corporation has been running a series of full page ads in the *Wall Street Journal* that are written in poetry and promote self-improvement. The tag line is always: "How we perform as individuals determines how we perform as a nation."

The corollary is obvious: How we practice as individual dentists determines how we perform as a profession.

So it is up to you and me.

And the whole world is watching.

\*Victor J. Barry, DDS, Editor  
Washington State Dental Association News. The editorial appeared in the April 1987 issue of that publication.



# A TREASURY OF DENTISTRY

## Toothpicks

Gardner P. H. Foley

The toothpick is an historical and well used device for cleaning the teeth. Often it has been the only resource used or perhaps available for the practice of oral hygiene. Toothpicks have been made of various kinds of wood and of several metals. They have been of humble design and also of expensive creation. I have selected a few interesting items that contribute color to the story of the toothpick. Of course, the writer realizes that part of the story is emphatically related to the esthetic phase of its use.

In 1876 United States toothpick patents were awarded to at least two applicants. George Clark, Jr., of Boston, was granted a patent for "a wooden tooth pick, artificially impregnated with a flavor or perfume." W. W. Wallace, of Philadelphia, patented a toothpick described as "a bow shaped piece, from the ends of which an elastic cord is stretched." The latter design seems weird to me.

Early in his practice career (1867) the great Greene Vardiman Black wrote an article for the Jacksonville, Ill., paper in which he made a surprising judgment on the toothpick: "One of the most common errors is the rubbing or washing them (the teeth) with a napkin or rag . . . (The toothpick) is capable of doing more to prevent decay of the teeth than any other instrument ever used upon them."

In 1896 the *British Journal of Dental Science* published a note on

a new industry that had been started in Alaska, the preparation and sale of walrus whiskers for toothpicks: "When a walrus is killed, the natives pull out each separate hair. They are thoroughly dried, arranged in neat packages and exported to China, where they are much sought after by the upper classes."

For many years I have welcomed to my files notes, usually brief, on the dental history of the American Indians. It is a subject that is rarely the concern of the dental historian, primarily because of the scarcity of materials. But the factor of difference in the dental beliefs and practices that constitute a very interesting component of the Indian culture should offer a peculiar attraction to the American dentists.

In *Red World and White* John Rogers (Chief Snow Cloud) wrote of his memories of a Chippewa boyhood in Minnesota. I particularly enjoyed reading his explanation of a phase of dental care that was probably universal among the many tribes scattered over all areas of the present United States.

The meat was hung in strips over poles to dry in the sun and to absorb the heat from the fire. The shrinking worried the boy because he thought it would become tough. But his mother explained: "It will be good for your teeth, having to chew the food well. It will make your teeth stronger and you can use them longer." As an adult Rog-

ers commented: "The jerky meat needed a lot of chewing and this was supposed to be one reason for Indians having such beautiful teeth."

Roger's book was issued in 1974 by the University of Oklahoma Press, the leading publisher of books on the American Indians.

In Gerard B. Lambert's autobiography *All Out of Step* (1956), I found one of my favorite toothpick anecdotes. Lambert was an advertising pioneer, who became well known for the popularization of his family's Listerine product. Lambert had sailed on his yacht *Atlantic* in a race from Sandy Hook to Spain sponsored by King Alfonso XIII of Spain in July of 1928. Lambert was often the guest of the royal family at Santander, the summer capital.—"The table was set in gold plate. It was at these dinners that I encountered something I have never seen before or since. Each guest had by his plate a gold toothpick. This was not a decoration. It was used vigorously and with evident delight."

One of the finest tributes to a tooth in recognition of its dedication to its owner was written by Osama Ibn Murshid, a Persian of the thirteenth century: "I had a companion of whom I was never tired, who suffered in my service, and labored with assiduity; while we were together I never saw him; and when he appeared before my eyes, we had parted forever."

# NEWS OF FELLOWS

**I. Kenneth Adisman** was recently honored by the New York University College of Dentistry with the presentation of the 1988 Alumni Achievement Award. Dr. Adisman was recognized for his contributions to the dental profession, dental education and research.



I. Kenneth Adisman

**Edward D. Barrett** recently completed his year as president of the Academy of General Dentistry. Dr. Barrett is currently Director of Continuing Education and Alumni Relations at the University of Detroit School of Dentistry. He has served as president of the Michigan Academy of General Dentistry. He is the editor of the Michigan Dental Association Journal.



Edward D. Barrett



James A. Saddoris

**James A. Saddoris**, President of the American Dental Association, was named the 1988 Distinguished Alumnus by the Baylor Dental Alumni Association. Dr. Saddoris, who is in the private practice of dentistry in Tulsa, Oklahoma, has also served as the President of the Oklahoma Dental Association.

**Robert W. Baker, Sr.** was recently awarded the University of Pennsylvania School of Dental Medicine's Alumni Award for Merit for outstanding accomplishments in dental medicine and loyal service to the school. Dr. Baker is a Senior Clinician in Orthodontics at Eastman Dental Center, University of Rochester, and is past president of the Edward H. Angle Society of Orthodontics. He was also recently recognized by the Eastman Dental Center with an award for excellence in teaching.



Robert W. Baker, Sr.

**Clarence F. Barrett** was the recipient of the Iowa Dental Association's 1988 Distinguished Service Award. Dr. Barrett, who practices in Davenport, Iowa, was recognized for his distinguished service to the Association, as well as to the profession. Dr. Barrett served as President of the Iowa Dental Association in 1974 and is presently a member of the Iowa Board of Health.



Clarence F. Barrett

**Gerald M. Bowers** Professor of Periodontics, coordinated a four-day Continuing Education seminar at the University of Maryland Dental School for twenty-three members of the Societe de Parodontologie du Sud-Est, an organization of French periodontists. Dr. Bowers, who had earlier lectured in several french cities, was assisted in presenting the seminars by several faculty, including ACD Fellows Dr. John Bergquist, Professor and Department Chairman and Dr. Charles E. Hawley.



Gerald M. Bowers

**Keith P. Blair** was honored on June 24th by the San Diego County Dental Society when he retired after serving 30 continuous years as a member of the Society's Board of Directors. Dr. Blair was recognized also for his outstanding contributions to the profession as a dental editor at component, state and national levels. Dr. Blair served as the President of the San Diego County Dental Society in 1975-76 and was appointed Editor of the Journal of the California Dental Association in 1977. He was appointed Editor of the Journal of the American College of Dentists in 1980 and received a second five-year term in 1985. Dr. Blair is in full-time general practice in San Diego.



Keith P. Blair

**Stanley A. Hoch** was recently honored by the New York University College of Dentistry by being presented the Alumni Association's 35 Year Faculty Service Award. Dr. Hoch is Associate Professor of Pediatric Dentistry at the College of Dentistry.



Stanley A. Hoch



Ralph R. Lopez

**Ralph R. Lopez** was recently honored by the State of New Mexico when the Governor of the State proclaimed March 1, 1988 as "Dr. Ralph R. Lopez Day". Dr. Lopez is a past president of the New Mexico Dental Association, a member of the New Mexico Board of Dental Examiners, past editor of the New Mexico Dental Journal and the recipient of the 1974 New Mexico Dental Association's "Meritorious Award". He has served as a member of the Board of Regents of the University of New Mexico and was charged with the responsibility of starting a medical school at the University. He is a member and former secretary of the New Mexico State Board of Health, Chairman of the United States Border States Commission, a Director of the Santa Fe Chamber of Commerce and a past president of the Alumni Association of the University of Missouri. Dr. Lopez has been extremely effective in his foundation, the "New Mexico Plan on Student Aid for Dental Education" which has provided scholarships for more than five hundred dental students from New Mexico to attend dental schools in other states. Dr. Lopez is in the private practice of dentistry in Santa Fe, New Mexico.

**Juliann S. Bluitt** was recently named treasurer for the 1988-89 Chicago Dental Society Board. Dr. Bluitt is the Regent for Regency IV of the American College of Dentists and the Secretary/ Treasurer of the Illinois section of the College. A recipient of many honors and awards over the years, Dr. Bluitt is presently the Associate Dean for Admissions and Student Affairs at Northwestern University Dental School.



Juliann S. Bluitt

**Don-N. Brotman** was recently appointed to his second six-year term on the Maryland State Board of Dental Examiners. Originally appointed to the Board in 1981, Dr. Brotman has served as its president and secretary. He was recently elected president of the Alumni Association of the Baltimore College of Dental Surgery, University of Maryland, and has served as president of the Maryland State Dental Association.



Don-N. Brotman



**Benjamin A. Blackburn, II** was recently appointed to the Board of Trustees of Morehouse College, Atlanta and the Meharry Medical College, Nashville, Tennessee. A Diplomate of the American Board of Prosthodontics, Dr. Blackburn is in the private practice of prosthodontics in Atlanta.



Benjamin A. Blackburn, II

**Emile T. Fisher** was honored by the Medical College of Georgia School of Dentistry which designated March 16 as the Emile Fisher Appreciation Day. Dr. Fisher was recognized for his role in helping to organize the Georgia Dental Education Foundation, of which he is now President. Dr. Fisher has contributed towards attracting high quality applicants for dental careers and has given forty-five \$1,000 dental scholarships since 1969 through a program called "Investing in the Future of Dentistry." Dr. Fisher, a Periodontist, received the Atlantic Community Service Award in 1981.



Emile T. Fisher



Thomas J. Ginley

**Thomas J. Ginley** was recently honored by the Academy of General Dentistry which bestowed its honorary fellowship upon him. Dr. Ginley was recognized by the Academy for his exceptional contributions to the art and science of dentistry and to the promotion of the objectives and goals of the Academy. Dr. Ginley has held several responsible staff positions for more than two decades at the American Dental Association and is presently its Executive Director.

**Leo Botwinick** was recently honored by the New York University College of Dentistry with the presentation of the College's Alumni Association's 25 Year Faculty Service Award. Dr. Botwinick is in the private practice of Endodontics in New York and serves as Clinical Professor of Endodontics at the College of Dentistry.



Leo Botwinick

**John C. Brown** of Claremont, California, was recently installed president of the Academy of General Dentistry. Dr. Brown has served as the president of the Southern California Academy of General Dentistry and is the co-director of the Orthognathic Seminar at the University of Southern California.



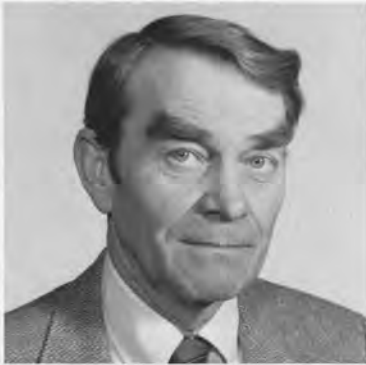
John C. Brown

**John S. Greenspan** was recently installed president of the American Association for Dental Research at the Association's meeting in Montreal. Dr. Greenspan is professor and chairman of the Division of Oral Biology at the University of California-San Francisco School of Dentistry and Professor of Pathology in the School of Medicine. A specialist in the causes and development of oral tissue disease, particularly oral manifestations of AIDS, Dr. Greenspan was also recently named Director of the new UCSF Oral AIDS Center.



John S. Greenspan

**Everett N. Cobb** was elected president of the Supreme Chapter of Omicron Kappa Upsilon, National Dental Honor Society. Dr. Cobb is the chairman of the Department of Dental Materials Sciences at Georgetown University School of Dentistry and is also in the private practice of General Dentistry. He has served as a consultant to the ADA's Council on Dental Materials and has been the recipient of the University's Distinguished Service Award. He was the recipient of the 1987 Award for outstanding service to the University and the community.



Everett N. Cobb

**Melvin A. Noonan** was the recipient of the Michigan Dental Association's prestigious "Meritorious Award" presented at the Association's annual meeting in Grand Rapids recently. Dr. Noonan, a pediatric dentist who practiced in Birmingham, Michigan for 38 years, is presently the Executive Director of the Oakland County Dental Society.



Melvin A. Noonan



William W. Howard

**William W. Howard** was recently elected to his fifth three-year term as editor of General Dentistry and the Academy of General Dentistry Impact. Dr. Howard is professor and chairman of the Department of Fixed Prosthodontics at the Oregon Health Sciences University. He is the author of four textbooks and also serves as an associate editor of the Journal of American College of Dentists.

**John G. Kramer** was elected Chairman of the Ohio State University Hospitals Board. Dr. Kramer has served as Chairman of the Ohio Section of the American College of Dentists, and was the first President of the University of Ohio College of Dentistry Alumni Association. He has also served on the Alumni Board of the Washington and Jefferson College and received a distinguished alumni award from that institution in 1980.



John G. Kramer

**Stephen H. Leeper** was appointed as interim dean of the University of Nebraska Medical Center College of Dentistry. Dr. Leeper has been a member of the College of Dentistry faculty since 1964 and prior to his present appointment, served as assistant dean of clinics. He has held editorial positions with the Lincoln District Dental Association, the Omicron Kappa Upsilon Supreme Chapter Bulletin and the Journal of the Nebraska Dental Association.



Stephen H. Leeper

**Robert G. Schallhorn** was recently installed President of the American Academy of Periodontology. Dr. Schallhorn is professor and chairman of Periodontics at the University of Colorado School of Dentistry and served as consultant in Periodontics to the Surgeon General of the U.S. Air Force and for the National Institute of Dental Research, Public Health Service, Fitzsimmons Army Medical Center and the Veterans Administration.



Robert G. Schallhorn

## SECTION ACTIVITIES

### European Section of the American College of Dentists Chartered

Porto Carras, Greece was the location of a significant event in the history of the American College of Dentists when a European Section was chartered on June 28th. A set of Constitution and By-Laws were presented to the Section by Dr. Joseph Cappuccio, Regent, Regency II. The following officers were elected for two-year terms: Dr. Pierre Marois, France, Chairman; Dr. Franciscus Lankhof, Netherlands, Vice-Chairman; Dr. Donald Derrick, United Kingdom, Secretary/Treasurer; and Dr. Runo Cronstrom, Sweden, Editor. The meeting was addressed by Dr. James A. Sadoris, President of the American Dental Association. The European Section decided to have its next meeting in Washington, DC at the time of the College's annual meeting.



Dr. Joseph Cappuccio seen presenting the charter of the European Section to Dr. Pierre Marois (left) and Dr. Donald Derrick.



Photographed at the European Section's meeting in Porto Carras, Greece are from the left: Drs. Ashur G. Chavoor, Washington, D.C.; Michel Varin, Paris, France; Juan Serrano, Menton, France; Joseph P. Cappuccio, Baltimore, Maryland; Pierre Marois, Paris, France; Donald Derrick, London, England; Yves Fissore, Monte Carlo, Monaco; Gerry Leatherman, London, England; and Helyn Leuchauer, Los Angeles, California.

### Hudson-Mohawk

The Hudson-Mohawk Section conducted its annual meeting recently. Dr. Robert W. Elliott, Jr., President of the American College of Dentists, attended the meeting and discussed the Select Program, as well as incorporation of Professional Ethics into dental school curriculum.

Photographed at the Hudson-Mohawk Section meeting are, from the left: Dr. Robert W. Elliott, Jr., President of the American College of Dentists, Dr. Ernest F. Reimann, Secretary/Treasurer of the Hudson-Mohawk Section and Dr. Donald Wallace.





## Michigan

The Michigan Section held its annual banquet recently in Grand Rapids and installed the following officers: Dr. Robert A. Meyers, Chairman; Dr. Melvin A. Noonan, Vice Chairman; and Dr. Edward D. Barrett, Secretary/Treasurer. The banquet was addressed by Dr. Robert W. Elliott, Jr., President of the American College of Dentists and also by Dr. Robert E. Doerr, Regent, Regency V. The Michigan Section donated \$500 to the American College Foundation.



Dr. Robert W. Elliott, Jr., President of the American College of Dentists, installed the Michigan Section officers. Photographed from the left are Dr. Robert Doerr, Regent, Regency V; Dr. Mel Noonan, Dr. Elliott, Dr. Edward Barrett and Dr. Robert Meyers.

## New England

The New England Section conducted its annual meeting during the Massachusetts Dental Society's annual meeting May 1st. As the New England Section is comprised of six states, the annual meeting of the Section each year is held in a different state. The Section annually presents an award of \$100 to a student who best represents professionalism at each of the four dental schools in New England.



Photographed from the left are: Incoming Chairman, Dr. Henry Pollard; outgoing Chairman, Dr. Herbert Schilder; Chairman-Elect, Dr. Robert E. Hunter and Secretary/Treasurer, Dr. Donald B. Stackhouse.



Honored for 25 years of Fellowship in the American College of Dentists are, from the left: Dr. Joseph M. Gaynor, Dr. R. Sheldon Stein and Dr. Henry D. Epstein.

## Puerto Rico

Some of the officers of the Puerto Rico Section of the American College of Dentists met with Dr. James A. Saddoris, ADA President, and Dr. Joseph P. Cappuccio at the meeting of the Colegio de Cirujanos Dentistas de Puerto Rico in San Juan.



Photographed at the meeting are, from the left: Dr. Leo Korchin, Dr. Luis Blanco-Dalmau, Vice-chairman; Dr. Carlos J. Noya, Chairman; Dr. James A. Saddoris, Dr. Domingo Donate, Secretary-Treasurer; and Dr. Joseph P. Cappuccio, Regent, Regency II.

## Mississippi

The Mississippi section held its annual meeting in Jackson recently with Dr. Samuel G. Sanders presiding. The section presented ethics awards to an outstanding senior dental student and an award to Dr. Buford O. Gilbert, for excellence as a member of the faculty.

Photographed are officers of the Mississippi section for the 1988-89 year. From the left: Chairman, Dr. Rudolph A. Posey; Secretary/Treasurer, Dr. Robert T. Ragan; Vice Chairman, Dr. Heber S. Simmons, Jr. and Dr. Samuel G. Sanders.



## Montana

The Montana Section of the American College of Dentists, recently mailed a copy of the American College of Dentists' publication "Dentistry—A Health Service" to all 390 members of the Montana State Dental Association. The following message from the Section Chairman, Dr. David W. Downey was also sent:

Dear Dentist Colleague:

These are troubled times for many of us dentists. Some of these troubles stem from the fact that there are more dentists now than are needed to satisfy

the demand for dental care. So one naturally asks oneself "what shall I do to have enough patients for a satisfactory dental practice?" With this in mind, it's understandable why dentists turn to promotions and advertising. However, I feel we should look at what long range effects these promotional practices will have on our profession.

The American College of Dentists is very concerned about the trends in dentistry which seem to be detracting from professionalism. It is felt that if we are to continue to enjoy the respect of the public as a profession, we

should adhere to ethical standards whether they are dictated by government bureaucracies or not. That is why you are receiving this brochure. It is very brief, but does express the ideals of the American College of Dentists. I hope you will find it inspirational and helpful and that you will find the applications of its principles a benefit to you, as well as to your patients.

Sincerely yours,  
David W. Downey, D.D.S.  
Section Chairman

## Texas

The Texas Section held its annual meeting in San Antonio on Friday, May 6 during the annual session of the Texas Dental Association. The meeting, presided upon by Dr. William R. Clitheroe, was attended by a large number of Fellows and distinguished guests. Newly elected Section officers were as follows: Chairman, Dr. Thomas R. Williams, Chairman-Elect, Dr. William F. Wathen; Vice-Chairman, Dr. David L. Heinrich; and Secretary/Treasurer, Dr. Ernest H. Besch. The Texas Section will conduct its 11th annual ACD Continuing Education course, held jointly with the University of Texas Dental Branch in Houston this year, on September 17th. The course is offered at no costs to all dentists interested in attending.

Texas Section photographs by Dr. Robert T. Maberry.



ADA President, Dr. James A. Saddoris is seated at a table with members of the Texas Section, all of whom are past presidents of the Texas Dental Association. From the left, clockwise: Dr. John H. Park, Jr., Dr. James E. Bauerle, Dr. Byron N. Coward, Dr. John T. Weatherall, Dr. Robert B. Dixon, Dr. James A. Saddoris, and Dr. Thomas R. Williams.



Photographed at the Texas Section annual meeting are from the left: Dr. William H. Gilmore, Dr. Robert E. Lamb, Regent, Regency VI; Dr. Malcolm R. Overbey, Dr. Joseph G. DiStasio and Dr. Jack H. Harris.

## Southern California

The Southern California section held its annual meeting recently in Phoenix, Arizona in conjunction with the Arizona State Dental Association's Scientific Session. Dr. Richard J. Geyer, Second Vice President of the Southern California section, presided and presented a check from the Southern California section for \$100 to the joint scholarship fund with the International College of Dentists. Four \$100 scholarships are presented annually from this fund to dental hygiene and dental assisting students from Arizona.

A copy of the "The Hillenbrand Era: Organized Dentistry's Glanzperiode" has been presented to the Arizona Foundation Library by ACD Fellows from Arizona.



Newly installed officers of the Texas Section from the left, are: Dr. Ernest H. Besch, Dr. David L. Heinrich, Dr. Thomas R. Williams and Dr. William F. Wathen.



# NOMINATION FORM REQUEST

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Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Signature \_\_\_\_\_

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

February 1, — Closing Date for Nominations. Send the form to the American College of Dentists, Suite 352N, 7315 Wisconsin Ave., Bethesda, MD 20814-3202.

## INSTRUCTIONS FOR AUTHORS

### INTRODUCTION

The Journal of the American College of Dentists is published quarterly in order to promote the highest ideals in health care, advance the standards and efficiency of dentistry, develop good human relations and understanding, and extend the benefits of dental health to the greatest number. It is the official publication of the American College of Dentists which invites submission of essays, editorials, reports of original research, new ideas, advances and statements of opinion pertinent to dentistry. Papers do not necessarily represent the view of the Editors, Editorial Staff or the American College of Dentists.

### EDITORIAL POLICY

The editorial staff reserves the right to edit all manuscripts to fit within the space available to edit for conciseness, clarity, and stylistic consistency. A copy of the edited manuscript will be sent to the author. All manuscripts are refereed anonymously. Only original articles that have not been published and are not being considered for publication elsewhere will be considered for publication in the Journal unless specifically requested otherwise by the Editor.

The primary author must ensure that the manuscript has been seen and approved by all co-authors. Initial receipt of all manuscripts submitted will be acknowledged and, at the conclusion of the review procedure, authors will be notified of (1) acceptance, (2) need for revision, or (3) rejection of their papers.

### PREPARATION OF MANUSCRIPTS

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

All pages, including Title Page, Tables and Figure legends, should be numbered consecutively in the top right-hand corner. The first page should list title of manuscript with the first letters of the main words capitalized (do not use Part I, etc.), author's (or authors') initials and name(s) in capitals (no titles or degrees), complete professional address(es) (including ZIP or Postal Code), a short title of NOT more than 45 characters in block capitals, and, as a footnote, any change in corresponding author's address since the paper was submitted. With multiple authors, relate them to their respective institutions by superscript numbers. The first author is assumed to be the one to whom correspondence and reprint requests should be directed unless otherwise stated.

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

Authors should submit an original and four copies of the manuscript and three original sets of illustrations to: Dr. Keith P. Blair, Editor.

Dorland's Illustrated Dictionary will be used as the authority for anatomical nomenclature. The American Heritage Dictionary will

be used as the authority for spelling nonmedical terms. The American English form of plurals will be used where two are provided. The Index Medicus and Index to Dental Literature serve as authorities for standard abbreviations.

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Address all manuscripts and related correspondence to: The Editor, JOURNAL OF THE AMERICAN COLLEGE OF DENTISTS, Suite 352N, 7315 Wisconsin Ave., Bethesda, MD 20814-3202.

### REFERENCES

A list of references should appear chronologically at the end of the paper consisting of those references cited in the body of the text. This list should be typed double space and follow the form of these examples:

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

Each reference should be checked for accuracy and completeness before the manuscript is submitted. The accuracy and completeness of references are major considerations in determining the suitability of a manuscript for publication. Reference lists that do not follow the illustrated format and punctuation or which are not typed double spaced will be returned for retyping.

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A form for reprints will be sent to the corresponding author after the manuscript has been accepted and edited. He/she then shall inform all other authors of the availability of reprints and combine all orders on the form provided. The authors shall state to whom and where reprint requests are to be sent. Additional copies and back issues of the Journal can be ordered from the Business Manager of the Journal.

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All manuscripts must be accompanied by the following statement, signed by one author: "The undersigned author transfers all copyright ownership of the manuscript entitled (name of the article) to the American College of Dentists should the work be published. The undersigned author warrants that the article is original, is not under consideration by another journal, and has not been published previously. I sign for and accept responsibility for releasing this material on behalf of any and all coauthors". Authors will be consulted, when possible, regarding republication of their materials.

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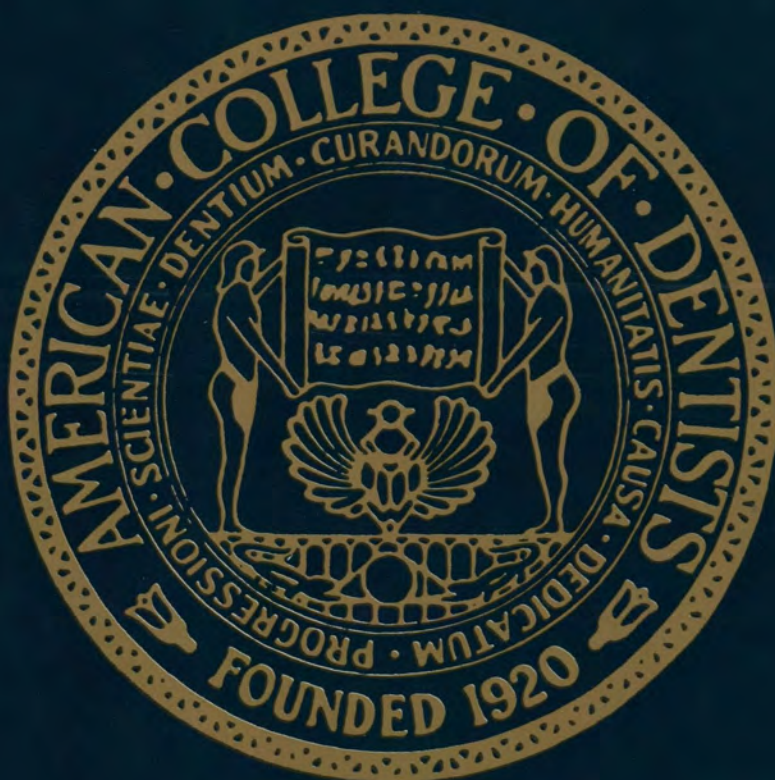
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