OBJECTIVES
of the AMERICAN COLLEGE of DENTISTS

The American College of Dentists in order to promote the highest ideals in health care, advance the standards and efficiency of dentistry, develop good human relations and understanding, and extend the benefits of dental health to the greatest number, declares and adopts the following principles and ideals as ways and means for the attainment of these goals.

(a) To urge the extension and improvement of measures for the control and prevention of oral disorders;

(b) To encourage qualified persons to consider a career in dentistry so that dental health services will be available to all and to urge broad preparation for such a career at all educational levels;

(c) To encourage graduate studies and continuing educational efforts by dentists and auxiliaries;

(d) To encourage, stimulate and promote research;

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

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

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

(h) To make visible to professional persons the extent of their responsibilities to the community as well as to the field of health service and to urge the acceptance of them;

(i) To encourage individuals to further these objectives, and to recognize meritorious achievements and the potentials for contributions to dental science, art, education, literature, human relations or other areas which contribute to human welfare—by conferring Fellowship in the College on those persons properly selected for such honor.
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VOLUME 59 NUMBER 1
Where We Stand With AIDS

The Bad News and the Good News

Dr. June E. Osborn is one of the best informed persons in the country on the current status of the Acquired Immune Deficiency Syndrome (AIDS). In her address, as the 1991 ACD Convocation Speaker, Dr. Osborn discussed problems related to where we stand, as a nation, with the AIDS disease. She is the Dean of the School of Public Health at the University of Michigan, the Chairperson of the National Commission on AIDS and the Chairperson of the National Advisory Committee for the AIDS Health Services Program.

According to Dr. Osborn, there is a considerable amount of bad news about AIDS. In the ten years since the first cases were diagnosed in the United States, we have had over 200,000 cases of AIDS from whom 120,000 people have already died. The Human Immunodeficiency Virus (HIV) that causes AIDS is spreading rapidly and it is estimated that the total number of deaths will increase to over 350,000 by the end of 1993. Probably over one million people in America have the virus and most of them do not yet know that they have it. We must accept the fact that the HIV virus is not just something new that we must contend with now, but that it is a disease that will continue to be in the world from now on — forever.

Unfortunately, the American people have arrived at a crossroads in the history of the HIV virus and will have to make some hard decisions soon. There appears to be a tidal wave of the AIDS disease developing. How can we possibly explain to future generations that we saw it coming and did not prepare for it. Even worse, the country has, so far, responded to this impending catastrophe only with indifference and apathy. It is obvious that a massive national effort is needed to contain this looming epidemic. AIDS can be a life-threatening disease of global proportions, and it requires the same national resolve and commitment, to address it effectively, that we exhibit in times of war.

Surprisingly, in spite of the bad news, there is also some remarkably good news to report about AIDS: it does not necessarily have to develop into an out-of-control, world-wide epidemic. We already have the means to confine this disease to a comparatively small number of victims because the AIDS virus is relatively difficult to transmit and it has unusually few modes of transmission. It can be transmitted only through sex, through blood, through the injection of contaminated material and through birth to an infected mother — and nothing else works! It is significant that probably over 90% of AIDS transmission can be controlled by personal behavior.

Further indifference or misdirected effort spells doom for millions. We must seriously engage the issues and needs posed by this disease or face relentless, expanding tragedy in the decades ahead.

From Dr. Osborn's conclusions, it appears that the greatest weapon in the fight against an AIDS epidemic should be nation-wide and world-wide EDUCATION on how to avoid the virus. Apparently, that is the best way to control, and hopefully to prevent, a global epidemic.

Prompt and serious action is urgently needed. Can it be done? Will it be done?

The full text of Dr. Osborn's presentation is published in this issue of the JOURNAL.

Keith P. Blair
LETTERS FROM READERS

The following is a response to a letter published in the Forum Section of the Winter 1991 issue of the JOURNAL from Richard A. Lewis of Long Beach, California on problems related to the Accreditation System for American Dental Schools. Dr. Lewis's letter was initiated by an article that previously appeared in the JOURNAL entitled, "Dental Licensure in the European Economic Community."

Dear Doctor Blair:

I am certain your objectives for the Forum section do not include ongoing exchange between readers of the JOURNAL OF THE AMERICAN COLLEGE OF DENTISTS. However, as Chairman of the Commission on Dental Accreditation, I feel duty bound to correct two allegations made about dental accreditation in the letter from Dr. Richard A. Lewis, which appeared in the Winter 1991 issue of the JOURNAL.

Dr. Lewis alleges that "...it is generally acknowledged, though never publicly, that accreditation standards are not always applied equally. Dental schools which are recognized to have serious problems and do not meet accreditation standards are never denied accreditation. Instead, such schools are put on notice and given the opportunity to make necessary improvements to respective programs. Fair enough. Unfortunately, even if the program in question does not make the improvements, it does not have its accreditation removed."

In over 20 years of service to the Commission as a consultant and member of the Committee on Dental Educational Institutions, and more recently as a member of the Commission, I am unaware of any actions or circumstance that would substantiate these charges. As the current chairman, I invite Dr. Lewis to submit any sworn testimony or documentation that would provide such evidence. The Commission will guarantee the confidential management of this material and the anonymity of anyone submitting these warrants. In addition, the Commission will conduct a thorough, impartial, and objective examination of each charge and the supporting evidence. Should any of the allegations be found to be true, the Commission will publicly acknowledge these findings, while continuing to protect the individuals and institutions involved.

Dr. Lewis also asserts that "...the aforementioned accreditation system sets standards for the educational process; it does not set standards for the outcomes." He will be pleased to learn that in the 1988 revision of the accreditation standards for dental education programs, the statements within these standards specifically focus on outcomes of the educational process when appropriate and possible. This especially applies to the curriculum section and clinical dental education (Sections 5.3 and 5.4). About 22 of our schools have been formally evaluated against these new standards so far.

I fully agree with Dr. Lewis that our systems of education and accreditation, as well as licensure and credentialing, are not pure. The lower half of the class receives a diploma along with the upper half. This is not unique to dental education. Obviously, there is a lower half and upper half of classes in other disciplines as well, such as in medicine, law, or other professions. The lower half of the licensure candidates in the passing range receive a license along with the upper half. In spite of myths to the contrary, no dental school and no licensure examination can lay claim to perfection in the measurement process.

Some educational programs just meet the standards, others exceed them by good measure. Only a comparative few of the over 1,300 programs accredited by the Commission on Dental Accreditation have lost their accreditation, just as only a comparative few dentists have lost their license to practice.

Perhaps this is as it should be in a nation, and hopefully a profession, that subscribes to the principles of due process. Education, accreditation and licensure are mainstays in our efforts to serve and protect the public. We can and must do better with all three, but to borrow again from Dr. Lewis, we owe it to ourselves and the public to "be totally honest" about each.

Sincerely,

Ben D. Barker, D.D.S.
Chairman
Commission on Dental Accreditation
American Dental Association
It is possible to have an elite organization which can be made more elite, and more elite, until it is so elite that it becomes extinct.

Until today, the American College of Dentists faced extinction because nominations for Fellowship in the College appeared to be down this year. Unless we all cooperate in the future, we may again face extinction. President Robert E. Doerr recognized this problem, and I remember the disappointment in his voice, when he told me by telephone in January, 1991 that the number of nominees was down this year. By some miracle (and I believe in miracles) by the February 1st deadline, the number of nominees exceeded any in recent years. The responsibility to secure the future of the College does not rest solely with the Regents and Officers, however. It is a problem that we all share.

In 1978, two Fellows of the College in Colorado gathered some records together on me and prepared a report nominating one Thomas William Slack of Colorado Springs for Fellowship in the American College of Dentists. This took a lot of effort on the part of those two Fellows. When I received the letter of invitation to Fellowship I was, of course, elated. I was honored to have been considered and invited. However, I did not give a thought to the process that made it possible. I certainly had no idea that so much had to be entered on a nomination form to evaluate my qualifications to be a member of the College. Some years later, when I went about the process to nominate a dentist for Fellowship, I realized what was involved.

During the orientation session of the Convocation that year, I listened to the virtues of College Fellowship. I heard the Orator repeat the objectives of the College. I pledged support to the College and its objectives. I particularly vowed “to promote within the dental profession the highest ethical standards, stimulate the interprofessional relationships and urge upon the professional person recognition of the responsibility to participate in the affairs of society as a citizen of the community.”

In preparing for this address today after four years of service to the College as a Regent, and then two more years as an Officer, I reflected on the question that had gnawed at my nerves often during that time: why does the College represent less than 4% of the membership of the American Dental Association and less than 3% of all of the dentists in the United States? Is this all of the proven or promising leaders that there are in our profession. Do only 3% of the dentists in the United States have a reputation for high ethical conduct and quality professional standing? Do only 3% of the dentists exhibit high professional ideals and hold themselves out to the public for quality health care?

I think not!

I do not believe that the founders of the College ever considered that the Fellows of the College would be an elitist group. I do not believe that the concept held by the founders of the College was ever intended to be exclusive. Rather, Fellowship in the College was to be conferred on dentists in recognition of meritorious service for those who have unselfishly devoted themselves to the advancement of a higher type of professional spirit and a keener sense of social responsibility through their profession, and at the same time to stimulate and advance dental art, science and literature.

Dentistry has an enormous responsibility to humanity. The College should bring together those dentists whose character, reputation and professional attainments identify them as leaders who can, working together, check exploitation and put down substandard practices which have been causing great harm to the public. The objectives of the College are to (a) encourage continued education; (b) develop
high standards and stimulate interprofessional relationships; and 
(c) participate in the affairs of society as a citizen of the community. 
President Robert Doerr said it well in his President-Elect's address last 
year in Boston, "Fellowship [in the 
College] was intended to recognize 
achievement of leadership: the fu-
ture of the dental profession is not 
very bright if only 3% of all dentists 
are making significant contribu-
tions."

This question haunts me as I face 
the year ahead serving as your Presi-
dent. It has haunted me for several 
years while sitting on the Board of 
Regents. We look at our Fellowship 
as another award, an honor to be 
worn with pride. We put it on the 
shelf to be held and looked at. We do 
not really recognize that, when we 
became a Fellow of the College, we 
took on an obligation to serve and 
that when we were invested with the 
cap and gown we pledged ourselves 
to the principles, the declarations 
and the regulations of the College. 
We also accepted the responsibility 
to uphold the honor and dignity of 
the dental profession and to meet 
obligations to our fellow practition-
ers as well as to society at large. 

Now, I ask you — can 3% of us dentists 
have a major influence on 
the nation's health care system? 

Obviously not. But there are many 
more dentists than we 3% who are 
highly ethical, unselfishly serving 
their communities and carrying out 
the highest standards of care for 
their profession. And where are 
they? Why aren't they here? 

My membership concern is un-
popular with some Fellows because 
they feel that a concern for member-
ship numbers is degrading to the 
College. In my view, maintaining 
member numbers is essential and 
vital to the College, and bring-
ing to Fellowship more qualified 
and deserving dentists can elevate 
the standards of the College. 

Today the American College of 
Dentists includes 5,691 Fellows. The 
average age of this organization is 
64.2 years. This includes 1,602 Life 
Fellows. College Fellowship includes 
54.2% who are in general practice; 
the rest are classified as specialists, 
educators and researchers. 

Thus, we are all involved: special-
ists, general practitioners, educa-
tors and researchers. However, we 
are missing some very fine, highly 
qualified dentists who should be 
within our ranks. We are failing in 
the College mission if we cannot 
influence the direction of dentistry 
and carry the mantle of profession-
alism in dentistry as it was con-
ceived in 1920. 

The challenges today are great! 

At no time in my professional 
career have I been exposed to so 
many negative opinions about den-
tistry. Commentators and column-
ists have described dental practice 
in low terms. Dental leaders have 
been projected with a poor image. 
Dental legislation being debated 
takes professional responsibility 
avay from dentists and puts it in the 
statutes. The dental profession has 
even been publicized as deliberately 
doing harm to patients. Never have 
I been challenged with such distrust. 

I enjoy a fine practice. However, 
my patients are besieged every day 
in the news, and by government 
mandate, with questions about my 
integrity and my motives. It isn't 
enough for me to engender trust 
and respect in my community. Now 
there has to be a law or a govern-
ment regulation to assure the 
public that I will do no harm! Do 
you ever feel alone out there? 

What is all of this leading up to? 
Why am I taking this time to decry 
that which we all know? My concern 
is the reputation of the dental pro-
fession. 

I believe in a strong profession 
supported by an active College — one 
that is carrying the torch for high ethical standards and quality 
care. We must be joined in that battle 
— but we must have an army large 
 enough to fight the battle. 

You and I need to recognize the 
numerous dentists who have been 
overlooked for Fellowship in the 
College. They also deserve the op-
portunity to act, through the Col-
lege, in support of ethics and profes-
sionalism. 

Please do not misunderstand me. 
I am not suggesting a membership 
drive and this is not a request to 
increase the numbers of Fellows for 
the sake of numbers. It is a request 
that each one of us should fulfill our 
role as a Fellow in the College and 
identify qualified and deserving 
dentists for Fellowship. The seventh 
objective of the College is "to confer 
Fellowship in the College on indi-
viduals in recognition of meritori-
ous achievement and the potential 
for contribution in dental science, 
art, education, literature, human 
relations and other areas that con-
tribute to human welfare and to give 
encouragement to them to further 
the objectives of the College."

I am convinced that there are
many more than 3% of the dentists, active today in the United States, who meet this qualification.

Recently, I attended a conference led by Mr. Glenn H. Tecker of Tecker Consultants in Trenton, New Jersey. He had an interesting approach to assessing an organization and its activities. He asked that each participant characterize the organization to which he or she belonged as a particular type of automobile, both make and model. It seemed kind of silly at first but, as it turned out, it became a rather interesting exercise.

The Association of Engineers characterized themselves as a station wagon with a rack on top and a trailer hitched behind.

The Bankers Association characterized themselves as a Lincoln town car with leather upholstery and a hand-finished interior. Their color was black.

The Food Service Association selected a red Ford Taurus with a bench seat.

The Plant Growers Association picked a four-wheel drive Ford Bronco, with a couple of spotlights on the top.

What make, model and color do you see as representative of the American College of Dentists? I would characterize the College as a Buick Park Avenue four-door sedan, gray with gray velour seats and a good powerful engine. It would be dignified, conservative, tough and built to serve family needs. In my view it is a standard of quality in the industry.

However, I am afraid that too many people might view the College as a "champagne-colored" Cadillac Sedan DeVille with a black canvas top and white leather upholstery, an exclusive "designer model", which would rarely be seen during the business day on the city streets.

Is this our view of the College?

Now let us face the issue. I am sure that there are many dentists, in many fields of dentistry, who are tirelessly working toward the betterment of their profession or their community, and in a highly ethical manner. They are giving of their time for charitable and public service, serving on dental society committees and involved with their profession. We need to find them and recognize their contributions.

Every one of us needs to consider our colleagues and to assess their qualifications for ACD Fellowship. A nomination form needs to be carefully completed, following the full format of the form as described. Every paragraph should be considered very carefully. There isn't any easy way to nominate. There is not any one stereotype nomination that qualifies an individual to be a Fellow of the College. The facts, however, must be on the form and in such a manner so as to describe the nominee as a leader or a potential leader. Names of nominators and seconders DO NOT go to the Credentials Committee or to the Board of Regents. Personal endorsements have no effect. Only the written description of the nominee, as it appears on the four-page form, is considered by the Credentials Committee, and political influence does not have a chance.

Additional information about the nominee is obtained from Fellows located in the community. This information is helpful in order to identify the actual application of ethical standards and practice or teaching methods that the nominee demonstrates. Not only is the written nomination form documented, but it is also supported by peers, in this way.

This does not seem to be an impossible task. Each of us should be able to identify one person who would meet the qualifications for College membership. Each of us should be anxious to carry out this simple responsibility of Fellowship. Only Fellows of the American College of Dentists, in the many dental communities all over the country, can identify worthy candidates.

We all need to help in projecting ethical standards in the dental profession. Only if we take the time to search out the facts can we expect to bring to the College the manpower needed to meet the challenges to our profession. Only through the dedication of a significant number of Fellows of the College will we be able to fulfill our pledge to the profession. After all, when the College was founded, it was organized for the purpose of creating a strong organization crossing all disciplines of dentistry and motivated toward the highest possible ideals. As Dr. Otto Brandhorst said in his book entitled, History of the American College of Dentists, "When the American College of Dentists came into being, it was conceived as an effort that had all the earmarks of an altruistic attempt to carry dentistry and the service to humanity to greater heights and create a professional environment heretofore not visualized."

That is what Fellowship in the American College of Dentists should be about. △
1991—1992 BOARD OF REGENTS

President
Thomas W. Slack

A former President of the Colorado Dental Association, Dr. Slack practices General Dentistry in Colorado Springs. The son of a dentist and the father of a dentist, he has been involved with the dental profession for his entire life. He has served on the American Dental Association’s Council on Dental Care Programs and has served in the ADA House of Delegates for twelve years. He is a Clinical Professor at the University of Colorado School of Dentistry.

President-Elect
Albert Wasserman

Dr. Wasserman is a former President of the Academy of General Dentistry, Founding President of the California Academy of General Dentistry and the Founding President of the Academy of Dentistry International. He served as President of the California State Board of Dental Examiners and as President of the San Mateo County Dental Society. He also was President of the University of California Dental Alumni Association where he was awarded the Gold Medal of Honor. He was named the Outstanding General Dentist of the Year by the California Academy of General Dentistry. A member of the Organizing Committee for the World Dental Congress in Nice, France, he has been the recipient of several international awards. He has served the College as Chairman of the Northern California Section, as Regent and as Treasurer.

Immediate Past President
Robert E. Doerr

Dr. Doerr is Professor Emeritus and a former Associate Dean at the University of Michigan School of Dentistry. He was Editor and President of the Michigan Dental Association, President of the American Association of Dental Editors and has chaired many important committees for the American Dental Association over a twenty-year period as a member of the ADA House of Delegates. He is an administrator, lecturer, clinician and widely respected as an editorial writer. He has had over 100 formal presentations.
Vice President
Chris C. Scures

Dr. Scures is in the private practice of Pediatric Dentistry. He has been President of the Southeastern Society of Pediatric Dentists, President of the Florida Society of Dentistry for Children and Chairman of the ACD Florida Section. He was Florida Dental Association Dentist of the Year, Vice Chairman of the Florida Board of Dentistry and has been a Florida Delegate to the ADA House of Delegates for the past ten years. His daughter is a dentist.

Treasurer
Juliann S. Bluitt

Dr. Bluitt is the Associate Dean for Student Affairs at the Northwestern University Dental School. She has served all of the offices of the Chicago Dental Society where she is currently the President-Elect. She served as Secretary-Treasurer of the ACD Illinois Section for seven years and was elected Regent for Regency 4 for the 1988-1991 term. She became ACD Treasurer in 1991. Dr. Bluitt has many recognitions and awards for outstanding service to her community and the profession, most notably, being recently inducted in the City of Chicago Women’s Hall of Fame. She has served an extended tenure on the SELECT Oversight Program sponsored by the American Dental Association and the American Association of Dental Schools. She is currently on the Legislative Committee for the American Association of Dental Schools.

Editor
Keith P. Blair

Dr. Blair has been a dental editor for over thirty years, first with the San Diego County Component, then with the California Dental Association and he has been Editor for the College since 1981. He is a former President of the San Diego County Dental Society and a 30-year member of its Board of Directors. He has been actively involved with the American Association of Dental Editors and is in the private practice of General Dentistry.

Executive Director
Gordon H. Rovelstad

A former President of the College, Dr. Rovelstad has been the Executive Director since 1981. He has also been President of the American Academy of Pedodontics, President of the International Association for Dental Research and Chairman of the Section on Dentistry for the American Association for the Advancement of Science. He is a former Assistant Dean at the University of Mississippi School of Dentistry and a retired Captain, USN.
Regents

Dr. Sharma is the Associate Dean for Academic Affairs and Professor of Pedodontics at Marquette University School of Dentistry. He has been the President of the American Society of Dentistry for Children, Chairman of the ACD Wisconsin Section and President of the Wisconsin Unit of the International Association of Dental Research. A native of Mandalay, Burma, he is listed in "Who's Who" among immigrants to the U.S. He is an Associate Editor for the ACD JOURNAL. His wife and his two daughters all have M.D. degrees.

Dr. Friedman was the Director for the Dental Assisting-Oral Hygiene Program at the University of Pittsburgh School of Dental Medicine where she is now a Professor Emeritus. She has been President of the Beta chapter of the Omicron Kappa Upsilon national dental honorary society and Chairman of the ACD Western Pennsylvania Section. In 1987 she received the Award of Appreciation of the University of Pittsburgh School of Dental Medicine.

Dr. Hancock is in the private practice of General Dentistry and was the President of the San Diego County Dental Society. He has been involved with California Dental Association affairs as a long-term Trustee, with committee appointments and as a 14 year Delegate from California to the ADA House of Delegates. He has been a three-term Chairman of the ACD Southern California Section. Among his community activities: a 20-year continuing involvement with the Boy Scouts. He is presently Chairman of the Board of Directors for Delta Dental Plan of California.

Dr. Haffner is in the private practice of General Dentistry, and was President of his South District Dental Society as well as the President of the Greater St. Louis Dental Society. He has served as chairman of several Missouri State councils and committees. As a Delegate from Missouri to the ADA House of Delegates, he became a national spokesman for dental insurance. He is the Chairman of the Board of Directors of Delta Dental Plan of Missouri and is a charter member and First Vice President of the American Association of Dental Consultants. He was the Founder and Chairman of the Board of the Mid-East Health Care Company. In his community he is currently involved with aiding the rural poor and private extended care of the mentally retarded in Missouri.
Edward C. McNulty

Dr. McNulty is on the Board of Governors of the W.J. Gies Foundation for the Advancement of Dentistry. He was President of the Greenwich Dental Society and on the Board of the First District (N.Y.) Dental Society for eleven years. He has served as President of the New York Academy of Dentistry and Chairman of the ACD New York Section. Engaged in the private practice of Orthodontics, he is author of a number of publications on Orthodontics. Community service includes Presidency of the Rotary Club of New York and Vice-President of the Greenwich Council, Boy Scouts of America.

Alston J. McCaslin, V

Dr. McCaslin practices Pediatric Dentistry in Savannah, Georgia, is a Past President of the American Academy of Pediatric Dentistry, a Past Chairman of the ACD Georgia Section, and a Past President of the Georgia Dental Association. He is a Delegate to the ADA House of Delegates and served on the ADA Special Committee on Professionalism and Ethics. He is an author of several published articles and served as Head of the Department of Dental Hygiene at Armstrong State College. He is a Director of the Savannah Chapter of the American Cancer Society and serves as Mentor for Education for Ministry for the University of the South School of Theology.

James T. Fanno

Dr. Fanno is an orthodontist in his home town of Canton, Ohio. He is a former President of the Ohio Dental Association and has been Speaker of the Ohio Dental Association's House of Delegates for the past ten years. He has been a member of the American Dental Association House of Delegates for fifteen years and is Chairman of the ADA Subcommittee on Ethics Workshops. Dr. Fanno is a Registered Parliamentarian. He is also active in his community affairs and is a member of the Alumni Board for Case Western Reserve School of Dentistry.

Walter N. Johnson

Dr. Johnson is a periodontist in Astoria, Oregon and is the Mayor of the town of Seaside, Oregon where he resides. He is a full professor in the Department of Periodontics at the University of Oregon School of Dentistry and has been active in the Oregon Dental Association. Previous to being in private practice, he retired from a career with the Navy Dental Corps. He has published articles on periodontics and has presented numerous clinics and programs throughout his career. He is a former Chairman of the ACD Oregon Section.
I want to tell you today about where we stand as a nation with the AIDS epidemic, which many have termed the health crisis of our time. The HIV epidemic in America has entered the second decade of our awareness — but it is useful to recognize that HIV (the human immunodeficiency virus) that causes AIDS, has been with us for at least twice as long. Indeed, the human family has had extensive experience with this epidemic already, and we should be positioned now to respond wisely and effectively.

Our biomedical and epidemiologic scientists have indeed done a brilliant job. The first cases of AIDS were recognized only in 1981 and yet less than three years later the complexities of retrovirology had been surmounted in three separate laboratories and the causative agent underlying the striking new immune deficiency syndrome was identified as HIV. What is more, those discoveries were pressed into practical use with record speed. On the biomedical side, a laboratory test was devised and rapidly scaled up so that HIV-infected blood could be screened out, and the accruing tragedies of infusion-related transmission of HIV infection were brought to an abrupt and virtually total halt as of mid-1985.

On the epidemiological side, the precision and power of the scientists’ careful work was no less dramatic. They surmised quickly and accurately that HIV was limited to remarkably few modes of transmission: within a couple of years the assertion could be made that only sex, blood or injecting drug use, or birth to an infected mother could spread the virus of AIDS — and that nothing else worked. Epidemiologists tracked hundreds of members of families who had spent months caring for dying loved ones, sharing utensils and razors, loving kisses as well as tears, and wiping up any and all secretions — without any precautions — and not a single instance of such intense and “unprotected” contact resulted in viral transmission!

Perhaps the most dramatic demonstration of the virus’ inability to spread by other means than sex and blood came from the communities where it first hit the hardest — gay communities on either coast of the U.S. It was learned quickly that unprotected intercourse, and especially anal receptive intercourse, was vastly more efficient than were other modes of sexual transmission of HIV — although it is essential to note that all forms of sexual intercourse can work to transmit the virus. In any event, in gay communities where the incidence of new infections had been nearly 20% per year in the early 1980s, mobilization of the knowledge of risky sex, and deployment of condoms and educational interventions to promote change to safer sexual practices, resulted in a truly dramatic drop to 0% by the mid-1980s — and keep in mind that those who suddenly stopped becoming infected were people who were spending all their non-working hours with, and caring for, friends who were dying of AIDS! I point that out to underscore the message about limited modes of transmission, for their non-sexual exposure to the virus of AIDS was far beyond the day-to-day situations about which people still fret, and yet their sexual behavior change had literally eliminated viral transmission.

Throughout those early years, health care workers were truly brave in the face of the unknown; but data accrued steadily. It was quickly recognized that needles and injection of large quantities of blood could transmit HIV, and with the level of risk unknown, the situation in the health care setting was closely watched. Yet even there HIV turned out to be remarkably less threatening than were other, better known, infectious agents. By analyzing sizable groups of health care workers in many parts of the world, even before the days of “universal precautions,” the overall HIV infection rate among health care personnel
By 1987 it was evident that HIV constituted a finite but extremely small risk to health care workers; that sex and injection of contaminated material could transmit the virus with variable efficiency, and that nothing else worked! What good news! and how poorly we have taken advantage of that knowledge. It is the vulnerable factor — the Achilles heel of HIV; it means that we can teach people to avoid the virus of AIDS — and there will never be as good a vaccine as that. But it isn’t so simple as it should be, for to do so we must speak plainly, and reiteratively, and in the language of our intended listeners!

My plan in the next few minutes is to move from these introductory comments to a brief review of where we stand at present with the HIV epidemic in America. Then I am going to ask your indulgence as I read extracts from the Executive Summary of our National Commission on AIDS’ two-year report, which was released last week. I hope that plan doesn’t lead to a rush to the exits — any speaker who threatens to read from a government or commission report probably deserves that fate — but please bear with me, for I had a considerable hand in writing what I will read to you, and I assure you it is neither bland nor soporific.

Finally, I will turn briefly to the specific issue of HIV testing in the health care setting, since that is an issue of potentially great concern to this audience.

Brief Review of Epidemic Trends

In 1981, in June, the first 5 cases of what we now call AIDS were reported in the U.S. This week or next we will approach a ghastly milestone of 200,000 cumulative cases of AIDS, of whom 120,000 have died. Gay men, men with bisexual behavior and/or injecting drug use have dominated those early numbers — note that I say “early” advisedly, for as a human family we are only beginning to know this new viral enemy in our midst; it is a new factor to be reckoned with in human ecology, and our static embrace of what has been always amazes me, for HIV is going to be with us forever. AIDS represents the definitive outcome of a decade-long “incubation” interval, and we should be alert for change and shift in epidemic patterns rather than leaning comfortably on statistics that depict a ten-year-out-of-date measure of the terrain.

As I told you, there have been no changes in the area of “casual contact” or iatrogenic or hospital spread. But otherwise, in the U.S. change in the epidemic pattern has been inexorable, and in a direction that should not be surprising, since the emerging pattern is steadily approaching one that characterizes much of the rest of the world where it has been evident that HIV spread is as universal a risk through sex as is sexuality itself. Women are the fastest growing category, followed
closely by children. Heterosexual spread is not yet "rampant" in the United States — as some would insist it must be in order to take it seriously — but the percentage of heterosexual cases increases every year, and that mode of transmission especially threatens our sexually active adolescents — which is to say a large fraction of all our adolescents. People wonder why the kids aren't listening to our warnings; and yet adults don't seem to believe it themselves, so how can they be convincing?

It is now estimated that 1 in 100 men and 1 in 600 women across America are infected — that comes to at least one million people, of whom the great majority are unaware, and of whom two-thirds should almost surely currently be under care! And yet our health care system is creaking — and in some places crumbling — under one-tenth that number. How can we possibly explain to ourselves that we have seen this tidal wave coming and have yet to prepare? We somehow must learn, as a society, to deal with chronic, large-scale human disaster with as much energy and commitment as we devote, characteristically, to acute environmental disaster or individual tragedy.

That is what we tried to convey in the Executive Summary of the Report of the National Commission on AIDS, to which I will now turn.¹

There are at least one million Americans silently infected with HIV. Most of them will get sick during the next decade.

months to come they must either engage seriously the issues and needs posed by this deadly disease or face relentless, expanding tragedy in the decades ahead. If, from this day forward, there were never another instance of new infection, the upcoming decade would still certainly be much worse. The amount of human suffering and number of deaths will be much greater.

"The face of AIDS will change as well; thus far it has focused its devastation predominantly on young men. In addition, it is also a disease that affects an entire family — now, all too often, mothers, fathers, and children die swiftly, one following the other, leaving a few orphans as a grim reminder of what was once a family.

"Workers on the front lines are struggling heroically to cope with illness and death, but their tools have been too few, their resources too constrained, and their logistics too crippled by the sabotage of disbelieve, prejudice, ignorance, and fear. "Nor has the virus followed rules of fair play. Gay and bisexual men still bear much of the burden of HIV disease. Disproportionately and increasingly the epidemic has attacked segments of society already at a disadvantage — communities of color, women and men grappling with poverty and drug use, and adolescents who have not been effectively warned of this new risk to their futures. And with these shifts have come new anger, mistrust, and attempts to assign blame, which have drowned out the warnings that should signal the magnitude of the mounting crisis. Sadly, this has permitted too many Americans to detach from the fray, to feel the problem is that of others different from themselves, and to retreat into resentful indifference. Diversity, which should be our greatest strength as a nation, has for the moment become a weakness, and has sanctioned a begrudging and sometimes callous response. Even the language of prevention, which should be tailored to the myriad subcultures and ethnicities of people at risk, is constrained in the name of morality, withholding potentially lifesaving information and devices in order to avoid offending a public presumed to be in agreement with such constraints.

"Astonishingly, even our most basic efforts to better understand and respond to this new plague have been hampered. Efforts have been made to constrain or forbid behavioral research; in the face of the most deadly sexually transmitted disease ever to confront humanity, some would prohibit even the study of the human behaviors that put our children at risk. Thus we disarm ourselves in the midst of lethal battle.

"Worst of all, the country has responded with indifference. It is as if the HIV crisis were a televised...
portrayal of someone else's troubles. It has even appeared relatively painless; many of the torments are hidden because so many people do their suffering and grieving in secret, out of fear of stigma, discrimination, or rejection. But the epidemic will not remain painless much longer even for the most indifferent observer; soon everyone will know someone who has died of AIDS. If we are to honor our fundamental social contract with our fellow citizens, with ourselves, and with our children, we must somehow develop a sense of urgency. For there is only a little time left to recognize at a deep and fundamental level that the threat of HIV is all around us and that we must all join in this battle for the sake of future generations. In order to have any chance of winning, we must first energize our nation and transform indifference into informed action... AIDS is a life-threatening disease of global proportions, and it requires the same national resolve and commitment to address it effectively that we exhibit in times of war.

"But the military analogy does not work well in this crisis. In war, we tend to look for a human enemy to attack, and alas thus far this tendency has been all too evident in our response to HIV. But in confronting AIDS, our response must be just the opposite. Compassion and concern for human suffering must direct our efforts. It is against the virus, not those infected, that this war must be waged. Tragically, to date, too many of us have failed to understand this fundamental distinction or acknowledge what a massive national effort is needed to contain the epidemic.

"The sapping of our collective strength comes from many directions. There has been a dominant undercurrent of hostility toward many people with HIV disease, as if they are somehow to blame. But no one gets this virus on purpose. We do not withhold compassion from people who suffer from other diseases related to behavior. As President Bush stated in his single speech about AIDS (in March 1990), 'Once disease strikes we don't blame those who are suffering. We don't spurn the accident victim who didn't wear a seat belt; we don't reject the cancer patient who didn't quit smoking. We try to love them and care for them and comfort them.' We must replace the innocent/guilty mindset with sympathy and care for people with HIV disease.

"[Some] politicians declare that enough has been done about AIDS, since it is 'just one disease,' and that we should redirect our attention to other diseases that currently kill more people.

"But we cannot turn away from what is coming, lest we be blinded... There are at least one million Americans silently infected with HIV. Most of them will get sick during the next decade. And in the absence of a national effort, the virus continues to spread. The cumulative deaths of the first ten years of AIDS will more than double in the next two: by the end of 1993, the toll will rise from 120,000 to over 350,000. AIDS is already the leading cause of death for young men and women in many parts of the country and is climbing relentlessly up the list of causes of 'years of potential life lost.'

"[T]here is so much that we can do to turn the tide of HIV through prevention of further spread, and so much that we must do to provide more humane and compassionate care to those who have already been caught in the path of the virus. But there are two destructive attitudes within our borders that hamper these actions. They are a thinly veiled feeling that those who acquire the virus are getting what they deserve and a collective indifference to their fate. As long as these attitudes persist there will be reluctance to engage in the effort required to surmount HIV disease.

"To accomplish the tasks that loom ahead, we must, as a society, find a way to convert anger, fear, and indifference into informed action. We must deal effectively with discrimination and prejudice, overcome present government inertia, rededicate ourselves to maintaining a necessary intensity of research endeavor, educate the public to replace panic with an informed awareness of what is needed to prevent infection, and coordinate our resources to meet the urgent health care needs of the sick in cost-efficient ways that take full advantage of our powerful science. We must recognize our obligations to future generations in these tasks, for further indifference or misdirected efforts spells doom for millions.

"For two years, the National Commission on AIDS has pursued its mandate from Congress to make recommendations to Congress and the President 'for a consistent national policy concerning AIDS' and the HIV epidemic. We have held hearings, site visits, and consultations; we have heard from over one thousand voices across the country in direct testimony, voices that have described the horror of the HIV tragedy and the heroism of brave men, women, and children as they grapple
with HIV. Some have told of their struggle with their own illnesses. Some have told of remarkable commitment to care for and about others. We have been heartened and inspired by the thousands of people throughout the land who have selflessly given of themselves to develop programs of prevention, care, and advocacy in their communities. It has been a privilege to experience the richness of diversity that could give unconquerable strength to our efforts if it were honored and fully harnessed; and it has been a source of constant sorrow to witness the accelerating loss of talent as young adults die of AIDS in ever increasing numbers.

"[Our] report attempts to address a number of the central themes that have emerged from this process. It brings out the fact that, in an important sense, the only thing new about our present quandary is the virus... most of what we are experiencing represents old problems that have been poorly patched and bandaged or ignored entirely. The HIV epidemic did not leave 37 million or more Americans without ways to finance their medical care — but it did dramatize their plight. The HIV epidemic did not cause the problem of homelessness — but it has expanded it and made it more visible. The HIV epidemic did not cause collapse of the health care system — but it has accelerated the disintegration of our public hospitals and intensified their financing problems. The HIV epidemic did not directly augment problems of substance use — but it has made the need for drug treatment for all who request it a matter of urgent national priority. Rural health care, prison health care, access to health care for uninsured and underinsured working men and women — these issues and many more form the fabric of our concern."

I will not quote further, but I welcome your interest and will be happy to provide the address of the National Commission on AIDS if you would like to learn more of what we had to say about prevention, health care, health care financing, clinical trials, and government roles.

**Testing in the Health Care Setting**

As I mentioned earlier, this is the hottest issue of the day, which it should not be. A rationale for the health care "panic" is essentially non-existent, and yet it is being fueled constantly and threatens much that we have accomplished in the name of public health, in the name of data-based policy and in the name of humanity over the past decade.

To summarize where we should be going with these issues, let me quote from Congressional testimony given two weeks ago by Dr. David Rogers before Congressman Henry Waxman's subcommittee in hearings concerning HIV testing in the health care setting. 2 I borrow Dr. Rogers' eloquent words because he is deeply knowledgeable on this specific topic and developed his remarks with extraordinary care. He said:

"Resolution of this issue... is critically important. Concerns about HIV-infected health professionals are terrifying the public. They are driving a wedge between patients and those who care for them. They are prompting a series of well-meaning, but fear driven misdirected actions, both nationally and locally, that we will look back on with embarrassment and shame. Controversy about the nature and magnitude of the threat is costing us dearly in terms of time and lack of attention directed at the tragic problem at hand. It is diverting us from all the things we ought to be doing to deal effectively with the AIDS epidemic..."

"First, and this is [the] major message, the question, as it is commonly posed, "What should we do with HIV-infected health care professionals?" is off target. The absolutely fundamental question which [one] need[s] to address is, 'How can we best protect patients from acquiring HIV infection, or any infections, in health care settings including the possibility of acquiring AIDS from HIV-infected health care professionals?..."

"When you frame the question [that] way, the answer is quite straightforward and there is good solid science-based data to support it. The answer is careful, consistent, universal, and meticulous application of well-understood, time-tested, infection control procedures in all health care settings. Period.

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"The evidence to support this statement is very compelling. It derives from almost twenty years of experience with hepatitis B, another serious blood-borne viral infection which kills almost 250 health care workers each year. This infection is transmit-
ted in precisely the same ways as HIV, by sex and by blood and body fluid transfer. Hepatitis B is ten times more common than HIV in health professionals, and it is at least one hundred times more infectious, that is, more capable of transmission to others. Here are the facts about hepatitis B:

"We have had at least twenty episodes of infection [with hepatitis B virus] of patients in health care settings across the world during the last twenty years. Twelve of these outbreaks occurred in the United States, and they have been carefully studied. First, those infections occurring in a health care setting, have been associated with breaks in infection control procedures. Second, there was a marked drop in the transmission of hepatitis B when infection control practices were introduced. This reduction was not the result of screening health professionals for hepatitis B infection nor from interdicting their caring for patients. It was a result of the application of careful infection control procedures. Most persuasive, since 1987 when we really got serious about it and put those infection control procedures widely in place, not one — not one transmission of hepatitis B has since then been reported in the literature...[T]hat is very impressive evidence..."

Dr. Rogers went on to summarize the growing body of negative data concerning health-care-professionals' role in HIV spread, and emphasized that the singular cluster of cases in one dental practice in Florida was both unique (in the literal sense of that word) and — on continued analysis — far more likely to present breaks in procedure than direct contract transmission. He concludes as follows:

"First, we need vigorous application of universal infection control procedures in all health care settings. "Second, we need a surveillance system and a tough, hard-nosed moni-

I should remind you of the bright part — our science has served us well, and we know what we need to know to bring a dangerous epidemic under control.

"Looking at this grim picture, I should remind you of the bright part — our science has served us well, and we know what we need to know to bring a dangerous epidemic under control. What are needed most are commitment, compassionate care, and rational concern. I am reminded once again of an old favorite "good news — bad news" joke about the airline pilot who announces to the passengers: "Well, folks, there's good news and there's bad news. The good news is, we're making great time! The bad news is, we're lost." I used to tell that rather sourly.

But I no longer think we are really lost, if we can find ways to pull together as a society. The window of time to do so is closing steadily, but it is not yet shut. I am hopeful that we can yet grasp the historic challenge to deploy the fruits of our dearly-bought twentieth century science and commit them to the welfare of all the human family struggling with AIDS.

References


Reprint requests to:
Dr. June E. Osborn
School of Public Health
University of Michigan
109 S. Observatory Drive,
Ann Arbor, MI 48109-2029
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, Maryland. 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 meeting.

Dr. 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.

The second meeting of the American College of Dentists Foundation Board of Directors was held on July 19, 1974, in Bethesda, Maryland. Dr. Walter Mosmann of Ridgewood, New Jersey, chaired that meeting which included Doctors Gordon H. Rovelstad, Henry J. Heim, and Robert J. Nelsen. Dr. W. P. Humphrey was unable to attend but provided written support for the meeting. Policies established during this meeting included:

1. Funds could be accepted from any person, corporation, trust, fund or foundation.
2. Gifts to the Principal Fund would not be accepted if encumbered in any manner that would be contrary to the principles, objectives, or purposes of the Foundation.
3. Unless otherwise directed by the donor, the programs of the Foundation shall be funded out of investment income of the Principal Fund.
4. Gifts for specific purposes, not contrary to the principles, objectives, and purposes of the Foundation, may be accepted but will be held as a special fund for the stated purposes.
5. The types of programs which will be reviewed for Foundation support shall be kept flexible but not in conflict with Article 1 of the Foundation Bylaws.
6. Direct appeals for Funds shall be kept within the American College of Dentists.
7. A listing for ACD Foundation contributions shall be provided on the annual dues statement of the American College of Dentists.

Additional policy statements were given during the second meeting that related to publicity, means to increase funds, procedure for review of proposals, and management of funds. 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 operation are charitable, scientific, literary, or educational.

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.

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, communications, 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.

A list of contributors to the Foundation during the 1991 year are listed on the next pages.
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Below: ACD President Robert E. Doerr and ADA President Eugene J. Truono

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Below, ACD Executive Director Gordon H. Rovelstad and President Robert E. Doerr at the Ethics Workshop.

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Faces In The Crowd

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Faces In The Crowd

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Faces In The Crowd

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Mean Career Satisfaction and Optimism Scores Among Women

Sondra M. Gunn *
Barbara B. Maxson **
Marilyn W. Woolfolk ***

Dentistry was once an occupation of men. Often there were no women in dental classes. In the seventies, women began to occupy a larger and larger percent of the graduates of dental school. The probable causes are many. At that time the women's "liberation" movement was impacting on women's career choices. There was active recruiting by career counselors and dental schools to fill a perceived increased need for dentists.

These women were seen by the profession and themselves as pioneers. Were these women different than the average women of their age?

Since that time as the profession has welcomed many women, the presence of a woman dentist in a community is no longer unique and the dental school classes are often one-quarter to one-third women. Are these women who have selected dentistry as a postgraduate education today different than those early pioneers? Do they anticipate the same level of career satisfaction and optimism concerning the future of dentistry and their place in it as the practicing women dentists?

LITERATURE REVIEW

Career satisfaction of dentists has been reported in the literature over the last decade. Murray studied the role satisfaction of dentists in Utah and Kentucky in an effort to compare cultural differences. Murray found a greater proportion of satisfied dentists in Utah than in Kentucky although the majority in both samples were found to be satisfied as measured by Brayfield and Rothe's Index of Job Satisfaction. Lange, Loupe, and Meskin investigated professional satisfaction among selected dental graduates entering their sixth year of practice. This longitudinal study sought to determine whether there were any characteristics of the dentist or the practice that accounted for differences in satisfaction level. The most satisfied dentist was a contented, non-threatened, positive person who was active in the profession and the community.

The relation of age and income to career satisfaction among nearly 1200 graduates from an eastern dental school between 1920 and 1976 was explored by Yablon and Rosner. No statistically significant difference between age groups was reported, though they did find a general trend toward greater overall satisfaction with increasing age.

To a limited degree dental students have also been questioned concerning anticipated job satisfaction. In a study of South African students, duToit found that during the first three years of a five-year program, anticipated job satisfaction was the leading factor influencing career choice. A four-year sequential study of first-year Australian dental students found that the proportion of each first-year class satisfied with the decision of dentistry as a career choice ranged from 71% to 90%. Previously, Homan and Kruger had asked the same question to each class of a five-year program and found that the response from each class ranged from 79 to 89% satisfied students. In a prospective study of 40 Israeli dental students, Eli found that extrinsic rewards such as high income, job security, and high status are less anticipated than intrinsic rewards such as interest in work, opportunity to help others, intellectual challenge and responsibility. An earlier report of the same group identified a loss of anticipated satisfaction during dental school which

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* Sondra M. Gunn, Department of Orthodontics and Pediatric Dentistry.
** Barbara B. Maxson, Department of Oral Surgery, Medicine and Pathology.
*** Marilyn W. Woolfolk, Department of Periodontics, Prevention and Geriatrics. School of Dentistry, University of Michigan.
seemed attributable to the "lack of intellectual challenge." 10

Although they represent different cultures and educational programs, these studies suggest that anticipated job satisfaction is very important to dental students and that the level of perceived future career satisfaction tends to fall during dental school.

Attitudes of dentists regarding career future have been assessed by Gunn, Woolfolk, and Maxson 1 using questions adapted from the indices of Smith 11, Lyon 12, and Cammann 13.

Studies measuring the attitudes of other professional workers concerning the future of their careers, where existent, are specific to the occupational group, offering no basis for direct comparison. 11-13 No studies have reported dental students attitudes toward career future, although Lange 1 and colleagues have assessed career expectations.

METHODS AND MATERIALS

The survey instrument, consisting of 54 questions, included demographic information, opinion items, items from the Minnesota Satisfaction Questionnaire, and questions designed to probe attitudes about career future patterned after Smith's Index of Organizational Reaction, 11 Lyon's Propensity to Leave, 12 and Cammann's Intention to Turnover 13. Demographic and opinion questions included in the survey appear in Table 1.

This questionnaire was mailed to all licensed women dentists in Michigan whose names and addresses were supplied by the State Department of Licensing and Regulation. The mailings included self-addressed, postage-free return envelopes. There was a second mailing to non-respondents and a postcard reminder was sent after the first mailing. The response rate was 63% (n=163). Questionnaires modified in verb tense to reflect the student perspective were distributed to all the women senior dental students at the University of Michigan School of Dentistry. Seniors were the only students questioned because they were closer in time to the actual practice of dentistry. The response rate of 72% (n=23) is due perhaps in part to being completed prior to an examination.

Mean satisfaction and optimism scores for dentists and students were calculated and subjected to Student's t-test for differences in group means. Pearson's product moment correlation was used to identify the relationship between satisfaction and optimism.

RESULTS

The mean satisfaction score was 78.4 for the dentists and 80.1 for the students. No statistically significant difference in satisfaction level was found between the two groups. The mean optimism score was 28.4 for dentists and 29.9 for the students (Table 2) with no statistically significant difference between means.

Pearson's product moment correlation between satisfaction scores and optimism scores for women dentists was 0.74 and for women students 0.54. These correlations were both statistically significant at p<0.01.

The dentists and students held similar opinions on many issues confronting the profession today.
Table 2
DENTAL CAREER SATISFACTION AND OPTIMISM AMONG WOMEN (Means)

<table>
<thead>
<tr>
<th>SATISFACTION</th>
<th>Dentists</th>
<th>78.4 (S.D. 10.2)</th>
<th>Students</th>
<th>80.1 (S.D. 7.7)</th>
<th>p = 0.4551</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPTIMISM</td>
<td>Dentists</td>
<td>28.4 (S.D. 4.5)</td>
<td>Students</td>
<td>29.9 (S.D. 4.1)</td>
<td>p = .9450</td>
</tr>
</tbody>
</table>

They agreed that income and “busyness” would be affected by the number of dentists in future. Both were uncertain as to whether the cost of malpractice insurance would affect their practice setting or their decision to begin or continue practicing. Overwhelmingly, they thought that there would be less solo practice in the future (Women Dentists 77%, Women Students 78%). Both agreed that the most satisfying aspect of dentistry was patient contact while the least satisfying was or would be paperwork.

The greatest proportion of both groups had made the decision to become a dentist between the ages of 16 and 20 years of age but did not believe that they had an accurate concept of the dentist’s role. The greatest percentage of practitioners reported supplying 40-59% of the family income, and the greatest percentage of students anticipated doing the same.

Predictable demographic differences of age, marital status and number of children between graduates and students were verified. There were no correlations between satisfaction and optimism with any of the demographic characteristics within each group.

The dentists and students did, however, display differences in attitude about several issues facing the dental profession today (Table 3). Attitudes about capitation programs, alternative delivery systems, oversupply of dentists in Michigan, and likelihood of working as a dentist in ten years, were different for the two groups.

DISCUSSION

Although applications to dental school come from a declining pool, women who choose dentistry today appear to anticipate a similar level of job satisfaction as those already in practice. Similar levels of optimism about the future of dentistry also compare to practicing dentists for today’s female dental students. The statistically significant correlation between satisfaction and optimism for both groups suggests that individuals who are satisfied tend to be optimistic about the future.

The smaller applicant pool may suggest that dentistry is less desirable as a career than in the past. However, the steady increase of female applicants over the past two decades has been an important factor in buffering the reduction of qualified dental school applicants. Today’s female dental students appear to anticipate a similar level of career satisfaction as the women who chose dentistry at a time when the competition for dental education was over two times the present level.

However, some differences in the female students and dentists were identified. Today’s woman student does not expect to become a solo

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>RESPONSE</th>
<th>YES</th>
<th>NO</th>
<th>NOT SURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>More capitation in future?</td>
<td>Dentists</td>
<td>39%</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td></td>
<td>Students</td>
<td>60</td>
<td>15</td>
<td>25</td>
</tr>
<tr>
<td>Alternative delivery beneficial to profession?</td>
<td>Dentists</td>
<td>14</td>
<td>63</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>Students</td>
<td>50</td>
<td>18</td>
<td>32</td>
</tr>
<tr>
<td>Alternative delivery beneficial to consumer?</td>
<td>Dentists</td>
<td>17</td>
<td>55</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>Students</td>
<td>56</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td>Dentist Oversupply?</td>
<td>Dentists</td>
<td>85</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Students</td>
<td>41</td>
<td>59</td>
<td></td>
</tr>
<tr>
<td>Working as dentist in ten years?</td>
<td>Dentists</td>
<td>72</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Students</td>
<td>96</td>
<td>4</td>
<td>0</td>
</tr>
</tbody>
</table>

Dentists N = 161
Students N = 23
practitioner like her practicing sister but rather sees a multi-provider practice in her future. The growth of alternative delivery systems is perceived by the students to be favorable to the consumer and does not appear to have the same negative consequences as perceived by the dental practitioners. The students do not believe an oversupply of dentists in Michigan exists to the same degree as the practicing dentists.

There are several possible explanations for these differences. For example, the students may not see the trend away from solo practice or the growth of alternative delivery systems as threatening since they do not envision these circumstances as change, but rather as the status quo. However, they may find that, once in practice, they develop a change in attitude based upon a different set of experiences. It would be interesting to see if these attitudes persist as the students become active professionals and deal with the issues in real terms.

Although they anticipate a group practice or associate position, the realities of this type of practice may change their attitudes. Solomon and Stoll15 found that the realization of a partnership practice by new dentists is only one-third of that anticipated five years earlier as senior dental students. In addition, almost 50% more new dentists are in solo practice than anticipated. It would also be of interest to see what effect exposure to the "party line" of their professional colleagues in organized dentistry will have, if any, upon their present attitudes.

In an article by Beazoglou et al", the factors affecting the economic climate of the dental profession are placed into perspective. The authors point out that the economic performance of the profession as a whole has been excellent over the past two decades in comparison to the general economy. They also identify that dentistry has experienced better economic performance than medicine. This trend is apparent when one observes the average gross incomes of physicians and dentists from 1965 to 1985. However, the authors point to regional variations in economic performance related to local economic factors which affect not the number of dentists or population of patients but the amount of dental utilization. As the local economy goes into a slump, people find themselves without jobs and dental utilization drops. Indeed the state of Michigan has been in a region which has not fared as well economically over the last decade as compared to other areas of the country. The authors suggest that where the economy is depressed, low-cost dentistry and alternative financial arrangements, as compared to fee-for-service dentistry, may prevail.

The sensitivity to these issues expressed by the female practitioners in this study may represent a reaction to local economic factors which may not be representative of practitioners in other areas of the country. The students, on the other hand, may perceive things such as capitulation and shopping-mall dentistry simply as marketing strategies which are a part of the total picture of the profession. When one considers the amount of media advertising for low-cost medical care and legal services, such marketing strategies for dentistry may not seem unusual.

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Reprint requests to:
Dr. Sondra M. Gunn
School of Dentistry
University of Michigan
Ann Arbor, MI 48109-1078

VOLUME 59 NUMBER 1
A Treasury of Dentistry

Dental Misconceptions

Gardner P. H. Foley

First, I wish to inform the reader as to the generally accepted meanings of the word misconception: An erroneous or mistaken conception, idea or notion. Many of the misconceptions included in this paper may be described as long-held assumptions, historic fallacies, or popularly accepted untruths. The chief detriment to their correction, often over many centuries, has been the compounded errors of judgment committed by almost unanimously recognized authorities.

In a famous play “The Imaginary Invalid” (1673) the French dramatist Molière (1622-1673) has a physician speak proudly of his son: “He follows my own example in his unswerving attachment to the opinions of the ancient authorities and in his refusal ever to attempt to understand or even to listen to the arguments in favor of such alleged discoveries of our own times as the circulation of the blood and other ideas of a like nature.”

The authentic history of dentistry began with the writings of Hippocrates (C.460-C.377). The Hippocratic admonition that only loose teeth are to be extracted held as that of the Bible. Montaigne, the regarded by most of the leading decayed teeth.

The centuries old worm theory of dental decay retained its wavering strength as a misconception into the twentieth century, being still used as a deceptive device by street practitioners in parts of China.

While believing in worms in the teeth, Carlo Musitano (1635-1714), a Neapolitan physician-priest, denied that they generate spontaneously. He contended that the worms result from the eggs of insects that are introduced into the carious cavities along with food and then develop by the heat of the mouth.

Lazare Riviere (1589-1655), a prominent French physician, wrote that the small veins that nourish the teeth pass through the ear; therefore, relief of toothache is obtained by the introduction of remedies (such as a suppository of garlic) into the external auditory meatus.

Caludius Galen (130-300), after Hippocrates the greatest physician of ancient times, merits strong recognition in this paper because for fifteen centuries his misconceptions had a profoundly negative influence on medical science. Because of his great reputation his interpretations were given blindly loyal support and advocacy by the majority of practitioners in succeeding centuries to the serious detriment of progress in dental science. Galen believed that the teeth are continually worn down by the effect of mastication but that nutrition repairs the losses and the teeth preserve the same size. However, where a tooth, from want of an antagonist, is consumed only a little or not at all by mastication, it grows gradually longer because the increase caused by nutrition is not offset by a corresponding waste. He also bequeathed to centuries of susceptible scientists the false humoral theory that dental caries is produced by the internal action of acrid and corroding humors. Vesalius (1514-1564) broke the influence that the authority of Galen had exercised on medical science by the publication of his great medical work On the Fabric of the Human Body in 1543.
A very obvious dental misconception still persists in the story of Saint Apollonia. She was canonized a Saint in 249 A.D., about fifty years after her death. During the centuries following her martyrdom the contemporary account by Dionysitus of "the Aged Virgin Apollonia" has been embellished by numerous additions and changes, especially as regards to her age and personal appearance. Through the centuries artists and writers have created in their varied media an extensive array of fraudulent pictorial representations and literary descriptions of the patron saint of dentistry. I have often been moved to query: Why does dentistry continue to promote Apollonia as illustrating a contrasting figure to that of the genuine identity?

During the Middle Ages there was a Christian concept of the punishment of sinful conduct that was a serious deterrent to oral hygiene. Throughout that period Christians believed that cleaning of the teeth and operations on the teeth, except extractions, were motivated by personal vanity and thus were not to be tolerated by the faithful professors of the faith.

Another curious concept established by those of the Christian faith during the medieval period was the belief that the toothache was caused by the evil actions of the sufferer and therefore the victim should not receive any show of sympathy for his deserving punishment.

The idea that there was a relation of mutual importance between the eyes and the teeth flourished for several centuries — the highly regarded Walter Herman Ryff (1500-1562) published at Wurzburg (c. 1544) a pamphlet intended for the instruction of the public in which he wrote: "The eyes and the teeth have an extraordinary affinity to one another by which they very easily communicate to each other their defects and diseases so that one cannot be perfectly healthy without the other being so too." — Anton Nuck (1650-1692), a Dutch surgeon and anatomist, counseled strongly against the extraction of the eye-teeth during pregnancy, the operation being capable of producing a pernicious effect on the visual organs of the fetus. In 1741 Robert Bunon wrote for the Mercure de France a letter on the eyeteeth, in which he inveighed against the belief that the extraction of the eyeteeth was a perilous threat to the health of the eyes.

Some of the dental misconceptions achieve great significance in relation to their influence on the progress of dentistry. However, rarely considered as a misconception is the long prevailing opinion that dental ills are matters of little account. Nicholas Tulp (1593-1674), physician and anatomist of Amsterdam, contradicted that retardatory medical opinion by his contention that diseases of the teeth and their adnexa often have serious consequences and therefore should be given consideration equal to that given to other diseases of the human body. This judgment of Tulp did not attain strong support by the health professions until the early twentieth century.

Over many centuries the cutting of the deciduous teeth was ignorantly given, privately and officially, as the cause of many fatal diseases and other conditions incurred between the ages of six months and two years. The London Bills of Mortality list a shocking number of deaths from "Teething." There is a long list of diseases that were ascribed solely to the eruption of teeth because of their coincidence with dentition. Serious maladies of the brain, lungs, stomach and intestines were overlooked and believed to be symptoms and complications of teething. A Spanish proverb expressed for the people of many countries the incidence of death ascribed to this dreadful misconception: "When the child cuts its teeth, death is on the watch."

The maleficent influence of pregnancy upon the teeth of so many mothers is the result of a strangely common dental misconception; the harmful belief that "for every child a tooth is lost." Why is it that so many pregnant women still are not informed that lack of good oral hygiene and inadequate diet should be among their primary concerns during and after pregnancy? Dentistry has accomplished an excellent course of propaganda in its continuing campaign to make the pregnant woman aware of the importance of a program of regular visits to a dentist.

Gradually, over the centuries, the proper care of the deciduous teeth has become recognized by parents and dentists as an essential part of dentistry's contribution to the health of children. The success of its mission to negate the misconception that the care of the primary dentition is unnecessary has been one of the most proudfful achievements of the dental profession.

The official color of dentistry is my choice as one of the most blatant misconceptions associated with the story of dentistry. I have come, from stubbornly repeated evidence, to believe that the majority of American dentists regard the true color to be lavender or purple. The error is so ingrained in their carelessly nurtured knowledge of this phase of their profession's history that I wonder if what I have to say about the lilac color will receive the merited consideration from your readers. The persuasive action of printers in substituting lavender or purple is probably why dentists are often easily induced to accept the inaccurate choice.

The claim that William T. G. Morton attended and was graduated from the Baltimore College of
Dental Surgery has been made by biographers of Morton, and the misconception has been repeated by scores of speakers and writers affiliated with the dental profession. For example, in an editorial in *Dental Facts* (February 1921) Dr. B. J. Cigrand stated: "Morton was a graduate of the Baltimore College of Dental Surgery, having entered that institution in 1840." The refutation is easily made by citing a passage from Dr. Chapin A. Harris in April, 1859 issue of the *American Journal of Dental Science*:

> We will not controvert the statement that "during the next eighteen months Morton diligently pursued the study of his profession," but we do deny that the few weeks spent in Baltimore were devoted to the systematic study of his profession. He never was so much as a matriculant of the College of Dental Surgery, far less did he graduate.

Although this abrupt dismissal of the "fact" was made over a century ago, the latest biographer of Morton—Grace Steele Woodward in *The Man Who Conquered Pain*, 1962)—repeats the long and stubbornly nourished error.

Back in 1972, I wrote in *Foley's Footnotes* about twelve major leaguers who did practice dentistry. (There are now fourteen in my files). But I received an impressive volume of correspondence criticizing my omission of Casey Stengel from my listing, and I still receive inquiries about his role as a "dental truant." So I quote a statement by Casey: "My first two years in baseball I saved enough money to go to Western Dental College (in Kansas City, Missouri) after the season. When I made the big leagues the third year, I dropped out (of dental school). There were times later when I thought of switching back to dentistry." Casey was led to sever his academic association with dentistry because of difficulties encountered by his being a southpaw operator with the dental units of his period of study.

For years I was keenly interested in the probable elimination of what I regarded as a misconception that affected the health and happiness of thousands of disappointed adults who seemed to be logical candidates for orthodontic treatment. Encouraged by dramatic orthodontic improvements obtained by members of the contemporary child generation, the hopeful adults sought similar oral betterment. But they were generally informed that orthodontics was a phase of dental service limited to the child's dentition. Now we can register the presence of adult orthodontics among the misconceptions that have been converted to the assured practice of dentistry.

American dentistry has wrongly claimed to have been the source of the beginning of the dental profession by its foundation of the remarkably provident tripod in 1839-1840: the world's first dental journal, the world's first national dental organization, and the world's first dental college. This major misconception should be given its proper recognition, not as the founding factor, but as the second great period in the development of the dental profession.

American dentists should become cognizant of some of the many primary achievements that marked the true beginning of professional dentistry. George Denton, a highly regarded American dental historian, wrote this worthy note on the subject at hand: "The eighteenth century was marked by the first accounts of the technical procedures of the dental profession. It was also characterized by the beginnings of several new departments of dentistry. Among these were oral surgery, preventive dentistry and comparative dental anatomy."

Pierre Fauchard, the most important single contributor to dental progress, effected the definite separation between the art and science of dentistry and general medicine and surgery. He collected and incorporated in *Le Chirurgien Dentiste* (1728) the entire doctrine of dental art, theoretical and practical, thereby establishing dentistry as a specialty and providing it with a good scientific basis. He presented, clearly and vigorously, all the known methods of procedure in all the areas of dental practice. He severely criticized the pretenders and stressed the values to be derived from improved educational standards in dentistry.

Robert Bunon (1702-1788), of France, contributed many writings for both laymen and dentists that made a strong impression on the thinking of the public and his fellow practitioners. He was a pioneer in advocating that special attention be given to the treatment of the child patient in dental practice.

Thomas Berdmore's *A Treatise on the Disorders of the Teeth and the Gums* (1768) was the first English dental textbook. — John Hunter (1728-1793), famous English surgeon and anatomist, contributed his very influential *Natural History of the Human Teeth* in 1771.

In 1778 A.J.L. Jourdain (1734-1816), a French dentist, published *Surgical Diseases of the Mouth*, the first book devoted to oral surgery.

The most important German dental text of the century was the *Treatise on the Human Teeth and Their Diseases* (1756) by Philip Pfaff (1716-1780). Noteworthy contributions to the development of prosthetic dentistry were made by the French writers Etienne Bourdet and Claude Mouton. Bourdet published *Recherches et Observations* (1757). — In 1764 Mouton published his *Essai d'Odontotechnique*, the first work devoted to prosthetic dentistry. \(\triangle\)
Janet G. Bauer and Jay F. Watson were recently appointed co-directors of the June and Paul Erhlich Endowed Program in Geriatric Dentistry at the University of California, Los Angeles, School of Dentistry. Dr. Bauer is an Associate Professor and Dr. Watson a Clinical Professor at the UCLA School of Dentistry.

Samir E. Bishara, Professor of Orthodontics at the College of Dentistry, University of Iowa was recently elected President of the College of Diplomates of the American Board of Orthodontics.

Robert J. Collins, Jr. was recently promoted to Rear Admiral and appointed chief Dental Officer of the United States Public Health Service. Dr. Collins is also serving as Chief of the Indian Health Service Dental Program.

Donald E. Campaan of Seattle was the recipient of the 1991 University of Washington Dental Alumni Association Distinguished Alumnus Award. Dr. Campaan has served as Editor and President of the Washington State Dental Association and as Chairman of the ADA Council on Annual Sessions and International Affairs.

Bill K. Forbus of Dumas, Texas was recently elected to the Board of Trustees of the Baylor College of Dentistry. Dr. Forbus has received the Mastership Award from the Academy of General Dentistry and the Gold Key from the Academy of Gold Foil Operators.

W. James Dawson of San Rafael, California was recently honored by the American Association of Dental Examiners as "The Citizen of the Year" award for 1991. Dr. Dawson was also elected to a second term as President of the California Board of Dental Examiners.

Olaf E. Langland, Professor and Head, Department of Dental Diagnostic Science was the recipient of the 1991 Presidential Award in Teaching Excellence at the University of Texas Health Science Center at San Antonio.

Theodore R. Hunley of Spencer, Indiana recently received a special honorary award from the Indiana University School of Dentistry. Recognized for his very significant contributions to dentistry, Dr. Hunley has served the majority of his career in the Dental Corps of the U.S. Navy. He was Chairman of Operative Dentistry at the Naval Dental School in Bethesda and Commanding Officer of the 4th Marine Dental Corps and Naval Dental Clinic in Newport, Rhode Island.
Daniel M. Laskin, Professor and Chairman of the Department of Oral and Maxillofacial Surgery, School of Dentistry, Medical College of Virginia was recently honored by the American Association of Oral and Maxillofacial Surgeons which dedicated its 73rd Annual Meeting to Dr. Laskin. Editor of the Journal of Oral and Maxillofacial Surgery since 1972, Dr. Laskin has won five William J. Gies Editorial Awards, eight honorable mentions as well as several other awards.

Frederick G. More was recently appointed Associate Dean for Academic Affairs at the New York University Affairs of the New York University College of Dentistry. Dr. More previously served as Associate Dean for Academic and Student Affairs and as Program Director of Pediatric Dentistry at the University of Michigan, School of Dentistry.

Robert E. Reagan of Lowell, Michigan was recently named Person of the Year by the Lowell Chamber of Commerce. A Past President of the West Michigan Dental Society, Dr. Reagan was recognized for his extensive service to his community.

Richard R. Ranney, Professor of Periodontics and former Dean of the University of Alabama School of Dentistry was named Dean of the Baltimore College of Dental Surgery, Dental School, University of Maryland. Dr. Ranney is the Immediate Past President of the American Association for Dental Research.

Linda C. Niessen, Associate Professor and Director of Geriatric Oral Medicine at Baylor College of Dentistry was elected to the National Examining and Certifying Board of the American Board of Dental Public Health. Dr. Niessen is a Diplomate and a Past President of the American Association of Public Health Dentistry.

Arthur J. Stumpf, Jr. recently retired from his position as Associate Professor, Department of Oral & Maxillofacial Surgery at the University of Texas Health Science Center at San Antonio Dental School. Dr. Stumpf has also served for 30 years in the United States Air Force.

John D. Wilbanks of El Paso, Texas was recently elected to the Board of Trustees of the Baylor College of Dentistry. Dr. Wilbanks is a Past President of the Texas Dental Association and the Texas State Board of Dental Examiners. He was the recipient of the Texas Dentist of the Year Award in 1972.
SECTION ACTIVITIES

Arkansas

The Arkansas Section held its Annual Meeting recently and elected the following officers: Chairman Faye O. Wardlaw, Chairman-Elect Marvin D. Loyd and Secretary/Treasurer William M. Kaldem.

Photographed from the left are the newly elected officers of the Arkansas Section: Chairman Faye O. Wardlaw, Secretary/Treasurer William M. Kaldem, Chairman-Elect Marvin Loyd and Immediate Past Chairman Lester Sitzes, Jr.

Florida

The Florida Section held its Annual Fall Meeting in Orlando October 26th and 27th. The days’ activities consisted of scientific presentations followed by evening social activities.

At the business meeting Regency 3 Regent Alston J. McCaslin, V, installed the following new officers for 1991-92: Chairman Robert T. Ferris, Chairman-Elect José E. Medina, Vice Chairman C. William Blosser, and Secretary-Treasurer Chris C. Scures.

Regency 3 Regent Alston J. McCaslin, V, installed the 1991-92 Florida Section officers who, from the left are: Vice Chairman C. William Blosser, Chairman-Elect José E. Medina, Chairman Robert T. Ferris, Immediate Past Chairman Robert W. Williams and Secretary/Treasurer Chris C. Scures.

Newly installed Florida Section Chairman Robert T. Ferris presented a Certificate of Appreciation to outgoing Chairman Robert W. Williams.
The Maryland Section concluded a very impressive calendar of events for 1991 with an annual business meeting and election of new officers.

The Section held its J. Ben Robinson Memorial Lecture May 23rd delivered by Rear Admiral Milton C. Clegg on the topic of "The Importance of Quality". On June 13th the Section held a dinner at the Annapolis Yacht Club and Commander Tom Zeleber spoke of the F-14 Fighter/Bomber Activities in the Gulf War.

On August 16 the Section conducted a joint luncheon with ICD at the Chesapeake Conference and the J. Ben Robinson award was presented to Gardner P. H. Foley and H. Berton McCauley. The Section conducted its Senior Student Luncheon and Table Clinics’ Day on October 30 with 14 clinics being presented by Section Fellows and a panel discussion moderated by Joseph P. Cappuccio.

The Section’s annual business meeting was held November 13 and Chaired by Section Chairman Laurence E. (Bud) Johns. Drs. Harry W. Dressel, Jr. and Joe N. Price were honored in recognition of 25 years of Fellowship. The following officers were elected for 1992: Chairman W. Michael Kenney, Vice Chairman Frank J. Romeo, Secretary Stanley E. Block, Treasurer George F. Buchness and Editor Harry W. Dressel, Jr.

The Western New York Section of the College recently presented a sum of $1000 for the Campaign for the 90s. Photographed on the left is Regency 1 Regent Edward C. McNulty receiving the Western New York Section’s check for the Campaign for the 90s from Section Chairman James R. Orcutt.
The Ontario Section formally received its Charter recently and became the 45th Section of the American College of Dentists. The Section conducted its Chartering Ceremonies at a very elegant and gala affair in Toronto attended by a large number of Fellows and guests. A reception and banquet was followed by an excellent program arranged by the Chartering Committee Chairman Kenneth F. Pownall, who was assisted by Edward G. Sonley and Philip A. Watson.

Ontario Section Chairman E. J. Rajczak called the meeting to order and Robert A. Clappison gave the invocation. Kenneth F. Pownall welcomed the Fellows and guests to the meeting and Arthur Schwartz and William J. Spence made brief presentations. Edward D. Barrett, Chairman of the Michigan Section, was in attendance and delivered congratulations and greetings from the Fellows of the Michigan Section. Regency 5 Regent Prem S. Sharma presented an address tracing the history of the American College of Dentists and the significant role that Canadian Fellows have played in the activities of the College. Dr. Sharma stated that among the 35 dentists who were inducted as Fellows at the first convocation of the College in Milwaukee, Wisconsin on August 13, 1921, were A. W. Thornton of Montreal and Wallace Seccombe of Toronto. Four distinguished Canadian Fellows have served as President of the American College of Dentists starting with C. N. Johnson (1926), Harry S. Thompson (1954), Donald W. Gullett (1969), and Percy G. Anderson (1966). Ontario Section Chairman E. J. Rajczak was then presented the Charter by Regent Sharma.

Photographed at the Ontario Section’s Chartering Ceremonies are, in the front row from the left: Michigan Section Chairman Edward D. Barrett, Jack Kreutzer, Ontario Section Vice Chairman Edward G. Sonley, Ontario Section Chairman E. J. Rajczak, ACD Regency 5 Regent Prem S. Sharma, Ontario Section Secretary - Treasurer Kenneth F. Pownall, Harry M. Jolley and Roger L. Ellis.

Standing in the middle row are, from the left, W. Robert Patrick, Ronald S. Anco, Irving Siegal, Robert A. Clappison, Patricia A. Main, Jack G. Dale and Nyle L. Diefenbacher.

Ontario Section Chairman E. J. Rajczak, on the left, receives the Charter for the Section from ACD Regency 5 Regent Prem S. Sharma.

Photographed at the Ontario Section’s Chartering Ceremonies are, from the left, Ontario Section Vice Chairman Edward G. Sonley, ACD Regency 5 Regent Prem S. Sharma, Ontario Section Chairman E. J. Rajczak, Ontario Section Secretary-Treasurer Kenneth F. Pownall, Michigan Section Chairman Edward D. Barrett and Ontario Section Editor Philip A. Watson.

Western Pennsylvania

The Western Pennsylvania Section held its annual breakfast meeting during the Three Rivers Dental Conference in Pittsburgh. The guest speaker at the breakfast was Dr. David King, one of two dentists in the Pennsylvania House of Representatives.

The Section also conducted its annual business meeting and dinner December 4 at the University Club in Pittsburgh. Regency 2 Regent Ruth S. Friedman spoke at the dinner and the Section welcomed new Fellows who were inducted into the College in Seattle. The following new officers were installed: Chairman F. Eugene Ewing, Vice Chairman Andrejs (Andy) Baumhammers, Secretary-Treasurer Robert S. Runzo and new Directors Dennis Ranalli and Jay Wells, III. The other Directors of the Section are Norbert O. Gannon, John S. Fridley, Robert S. Verbin and Thomas L. Perkins.

Newly elected Chairman F. Eugene Ewing photographed presenting a plaque of appreciation to outgoing Chairman Kay F. Thompson at the Western Pennsylvania Section.

Photographed at the Western Pennsylvania Section’s annual meeting are, from the left, Newly elected Chairman F. Eugene Ewing, Vice Chairman Andrejs (Andy) Baumhammers, Immediate Past Chairman Kay F. Thompson, newly elected Director Dennis N. Ranalli and Secretary-Treasurer Robert S. Runzo.
INFORMATION 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 of dentistry. Papers do not necessarily represent the view of the Editors, Editorial Staff or the American College of Dentists.

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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.

CORRESPONDENCE
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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. References 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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