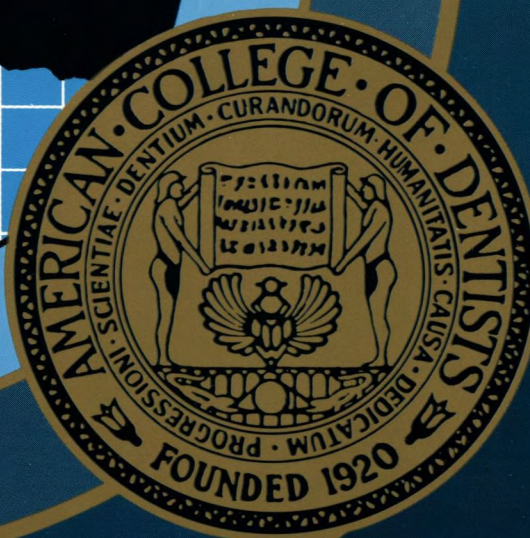
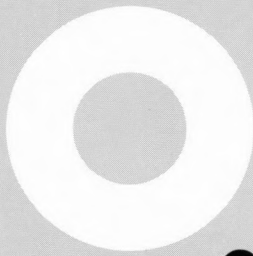


SUMMER-FALL • 1993

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





OBJECTIVES of the AMERICAN COLLEGE of DENTISTS

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

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

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

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

(d) To encourage, stimulate and promote research;

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

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

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

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

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



The JOURNAL

Keith P. Blair, DDS, Editor

Associate Editors

William D. McHugh, LDS, DDS
Richard C. Oliver, DDS, MS
Prem S. Sharma, LDS, DDS, MS
Raymond P. White, DDS, PhD

Contributing Editors

Gardner P. H. Foley, BA, MA, DSc
H. Barry Waldman,
BA, DDS, MPH, PhD

Business Manager

Sherry Keramidas, Ph.D., CAE

Editorial Board of Review

Don L. Allen, DDS, MS
Muriel J. Bebeau, MA, PhD
Wilmer B. Eames, DDS
Paul Goldhaber, DDS, MA
Deborah Greenspan, BDS, LDS
William W. Howard, DMD
James E. Kennedy, DDS, MS
Harald Loë, DDS, Dr. Odont.
James H. McLeran, DDS, MS
Lawrence H. Meskin, DDS, PhD
Alvin L. Morris, DDS, PhD
Jeanne C. Sinkford, DDS, PhD
George W. Teuscher, DDS, PhD

Publications Advisory Committee

Richard B. Hancock, DDS, Chairman
Alston J. McCaslin, V, DDS
Walter N. Johnson, DDM, MS
Richard E. Bradley, DDS, MS

Correspondence relating to the Journal
should be addressed to the Editor,
Keith P. Blair, DDS,
American College of Dentists,
839 Quince Orchard Blvd., Suite J
Gaithersburg, MD 20878-1603

The business office for the Journal of
the American College of Dentists can be reached
by telephone at (301) 977-3223.
FAX (301) 977-3330

of the AMERICAN COLLEGE of DENTISTS

A Quarterly Publication Presenting Ideas, Advancements and Opinions in Dentistry

The Journal of the American College of Dentists (ISSN 0002-7979) is published quarterly by the American College of Dentists, Inc., 839 Quince Orchard Blvd., Suite J, Gaithersburg, MD 20878-1603 and at additional mailing office. Copyright 1992 by the American College of Dentists, Inc.

Postmaster: Send address changes to the Journal of the American College of Dentists, Sherry Keramidas, Ph.D., CAE Business Manager, 839 Quince Orchard Blvd., Suite J, Gaithersburg, MD 20878-1603.

Subscription rate per year for members of the ACD is \$20 included in the annual membership dues. Subscription rate per year for non-members is \$30. Air mail to Canada and Mexico is an additional \$5, all other foreign addresses is an additional \$20. Single copies: \$6.

While every effort is made by the publishers and Editorial Board to see that no inaccurate or misleading opinions or statements appear in the Journal, they wish to make it clear that the opinions expressed in the articles, correspondence, etc. herein are the responsibility of the contributor. Accordingly, the publishers and the Editorial Board and their respective employees and officers accept no liability whatsoever for the consequences of any such inaccurate or misleading opinion or statement.

For bibliographic references, the Journal is abbreviated J Am Col Dent and should be followed by the volume number, page, month and year. The reference for this issue is J Am Col Dent 60:1-56, Summer-Fall 1993.

*The Journal is a Publication Member of the
American Association of Dental Editors*



CONTENTS

From the Editor's Desk	3
Dental Health Care Symposium	4
Introduction: Errol L. Reese	
Dental Health Care: Yesterday	6
Clifton O. Dummett	
Dental Health Care: Today	10
Jack H. Harris	
Dental Health Care: Tomorrow	18
Ben D. Barker	
Convocation Address: Reflections on a Career in Dentistry	24
Joseph A. Devine	
The Development of a Professional Role Orientation Inventory	27
Muriel J. Bebeau, David O. Born, David T. Ozar	
Dedication of ACD National Office	34
ACD Study Mission To India and Nepal	37
American People Ambassador Program	
Prem S. Sharma	
A Treasury of Dentistry	40
A Gathering of Dental Truants	
Book Reviews: Ethics in Dentistry	43
Muriel J. Bebeau	
News of Fellows	46
Section Activities	49
Information for Authors	55
Directory of ACD Officers and Regents	57

A Legacy of Leadership

The Founders and the early leaders of the American College of Dentists provided the dental profession with a legacy of leadership that was to be the role of the ACD through the years.

These were dedicated men who, in 1920, met for the purpose of taking action to bring about changes for dentistry. They were convinced that their actions were absolutely essential if dentistry were to become a true and accepted member of the health professions. In addition, they had the courage to proceed with the development of their proposed plans; and they had, above all, a monumental commitment to excellence.

They recognized that the four main areas of responsibility that a health profession must have are research, education, literature and the delivery of care.

Their first concern was with the absence of dental research and with the lack of standards for dental education. At that time, many dental schools were proprietary businesses that set their own standards and curricula for the education of dental students. The ACD leaders proposed that new education standards be developed and used by all schools and that schools should be associated with university programs. This resulted in much improved dental education and also provided dental schools with the environment to do research.

The pre-dental and dental school curricula were expanded, which produced better educated and more capable dental graduates who were able to provide a higher level of dental care for their patients.

In the delivery of dental care, one



Keith P. Blair

of the greatest concerns was the flagrant, misleading advertising of dental services existing at that time. Dental organizations, with ACD leadership, succeeded in banning advertising by all dentists who were members of organized dentistry. This ban lasted through the "Golden Years" of dentistry, until 1977 when the U.S. Supreme Court ruled that the public had the right to hear and read the "information" provided by dental advertising.

The field of dental journalism, however, was the area where the ACD leadership was able to effect the greatest changes. In the 1920's, all dental publications were owned and controlled by dental supply companies, which *allowed* dentists and dental organizations to publish articles in their company publications. This was unacceptable to the early ACD leaders. They created a *Commission on Journalism* to study the problem and its report, in 1930, made specific recommendations for drastic changes that would place all control and own-

FROM THE EDITOR'S DESK

ership of dental publications in the hands of the dental profession.

The following year, the first major result of the Report of the Commission on Journalism was the organizing and founding of the American Association of Dental Editors (AADE) by the ACD. This had a great impact on the development of dental journalism and became the springboard for several decades of journalism activities. A system for the indexing of dental literature was developed so that a permanent listing of articles, published in dental journals, could be maintained and referenced.

The ACD continued its role as a catalyst, working closely with the AADE and the ADA in developing guidelines for advertising in dental publications and, also, for the selection of dental editors. Writing awards were established, by the ACD, to encourage editors to become better trained and more competent. In turn, journalism was able to contribute greatly to the development and the success of the profession.

In more recent years, the ACD has become one of the leading advocates for the teaching of ethics and professionalism. It is sponsoring programs for the teaching of ethics in the dental schools and in continuing education. Because of these activities, the ACD is sometimes referred to as "The conscience of the dental profession," a title of respect that the College has earned and which is well-deserved.

It is hoped that this legacy of leadership will continue for generations to come.

Keith P. Blair

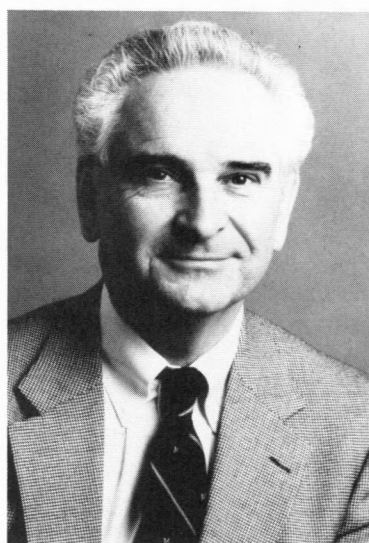
A Symposium

DENTAL HEALTH CARE: YESTERDAY, TODAY AND TOMORROW

Errol L. Reese*

As President of the American Academy of the History of Dentistry, the Academy thanks the American College of Dentists for this invitation to join them in this annual meeting program. It is a great opportunity!

The American Academy of the History of Dentistry is unique—it is the association that our profession depends upon to study, to explain, to preserve, to highlight and to communicate our great history and heritage. I believe our history and heritage are the greatest builders of PRIDE: pride in what we do as a profession, as well as builders of self-reliance in what we will do in the future. Our history and heritage are the foundation upon which we have built and sustained our Codes of Ethical Conduct.



Errol L. Reese

This joint program and its topic, "Dental Health Care: Yesterday, Today and Tomorrow," comes at a particularly critical time for our profession. It is a time of great change. The health professions are being challenged and the status quo is under attack. We live in a world of change. Leon Martel in his book titled *Mastering Change: The Key to Business Success*, has some advice. He states:

"We live in a world of change, yet we act on the basis of continuity. Change is unfamiliar, it disturbs us. We ignore it, we avoid it; often we try to resist it. Continuity, on the other hand, is familiar; it provides safety and security. Thus, when we plan for the future, we prefer to assume present conditions will continue. But they rarely do. As a result, we experience unnecessary losses and miss unseen opportunities. If we could learn to anticipate change and to prepare for it, we could make it work for us, not against us."

He also cites three errors to avoid:

1. Believing yesterday's solutions will solve today's problems.
2. Assuming present trends will continue.
3. Neglecting the opportunities of future change.

In his address this morning, Dr. Wasserman, our President-Elect, clearly outlined many of the issues dentistry is facing today. How can we confront all the forces, as well as the factors, in today's environment

* Errol L. Reese, DDS
President of the American Academy
of the History of Dentistry
President of the University of
Maryland at Baltimore

of change? This joint symposium may hold some of the keys to answer that question. It is a time for our profession to build strategic alliances among and with the various elements of our profession. This joint meeting is an example of a strategic alliance and, if we are wise, we will, as leaders, continue to bring together all the elements of profession.

As stated, the topic for this symposium is, "Dental Health Care: Yesterday, Today, and Tomorrow." Our first speaker this morning is Dr. Clifton O. Dummett, Professor Emeritus, University of Southern California. Dr. Dummett, a well-known educator, author, historian, a Fellow of the College and Past President of the American Academy of the History of Dentistry, will open the program with a "historical" review. The title of Dr. Dummett's presentation is "Dental Health Care: Yesterday (1840-1890)."

Those who cannot remember the past are condemned to relive it (George Santayana, 1863-1952)

Our second speaker this morning

is Dr. Jack H. Harris, President-Elect, American Dental Association. Dr. Harris, from Pearland, Texas, has served in the state Legislature of the state of Texas since 1985. He has been a Trustee of the ADA, President of the Texas State Dental Association, as well as a Dentist of the Year for the Texas Academy of General Dentistry. The title of Dr. Harris' presentation is, "Dental Health Care: Today (1980-1990)."

Time present and time past are both perhaps present in time future, and time future contained in time past. (T.S. Eliot, 1888-1965)

The third speaker for this morning's program is Dr. Ben D. Barker of Chapel Hill, North Carolina. Dr. Barker served on the faculty of the University of North Carolina before going to Battle Creek, Michigan as Program Director in Health for the W.K. Kellogg Foundation. He returned later to Chapel Hill to become Dean and Professor at the School of Dentistry, University of North Carolina. He stepped down from that position in 1989 to be-

come Co-Director of the Pew National Dental Education Program and Professor of Dental Ecology. Dr. Barker has entitled his presentation this morning, "Dental Health Care: Tomorrow (2000-2010)."

It occurred to me that one of the mottos found on a lapel pin designed by the American College sums it up pretty well: "A Distinguished Past—A Dynamic Future." I cannot think of a better way of ending the program than by supporting the concept that this association—the American College of Dentists, as one of the leading organizations in our profession, should continue to forge ahead. Hopefully it can encourage the formation of many strategic alliances between the various associations and organizations within dentistry and our allied dental health colleagues. There is a great level of congruency between our goals and objectives. We must face the future together: we must master change and we will take charge. Let us invent the future. These are the things that will make our profession strong.

DENTAL HEALTH CARE: YESTERDAY

Clifton O. Dummett*

The year 1840 is of the greatest significance to the history of dentistry in the United States. In retrospect, that year stands out as marking the most definitive events in dentistry's dedication to health professionalism.

The events included the birth of organized dentistry with the establishment of the first national dental society, namely, the American Society of Dental Surgeons. This took place six years before the assembly of the first national medical convention!

Some changes in dental training had already occurred when the apprenticeship system moved to proprietary dental institutions. Formal dental education waited until 1840 and emerged with the Baltimore College of Dental Surgery, the world's first dental college. It was begun by Horace Hayden and Chapin Harris, two physicians who are recognized as the honored founders of dental education. Just the year before in June 1839, along with Eleazer Parmly, this same duo had initiated the nation's first dental journal, *The American Journal of Dental Science*. Altogether, these three events validated recognition that professional excellence lay in formalized dental education.

Like medical care, dental care was dominated by dental dogma. Treatment plans were often influenced by nostrums and empiricism.

It was common knowledge that the reputation for health care superiority had spread over Europe where western European nations had already given approval to trial and error methodologies. To American practitioners, it was a mark of distinction for minis-



Clifton O. Dummett

ters of medical and dental care to have been trained anywhere in Europe. It took the innovations of Hayden and Harris in this country to begin an educational process that, through the years, has literally catapulted American dentistry into the status of world preeminence.

It is not that American dentistry was undistinguished prior to 1840. A review of dental history during the Colonial period documents contributions by practitioners like Charles Wilson Peale, Henry Villers, James Robinson, the Greenwoods—Isaac Sr, John, Issac Jr, and William; the Flaggs—Josiah and Samuel; Eleazor Parmly, Richard Skinner, John Wooffendale, Solyman Brown, Percy Lazarus, James Gardette, John Baker and many others of that period.

Growth and Development

Twenty-five years after the establishment of the first dental college, the practice of dentistry in America continued at the elemental level producing an acceptable quality of care

to patients who were afflicted with a profusion of dental ailments, but were without sophistication about dentistry's essential character. Because there were so many people with chronic and acute dental diseases, the limited number of available practitioners had much to do. Their practices were busy, and their fees were modest. Furthermore, there was little time apportioned for study and investigation. The dental field of operations was wide open for so-called "bread and butter" dentistry, and clinicians generally concentrated upon emergency treatments, exodontia, dental restorations, gold crowns, complete dentures and partial denture prosthetics. The doctor/patient relationship was relatively uncomplicated, with the doctor independently deciding what was in the patient's best interest, and the patient accepting his decisions without question or comment. The private solo practice of dentistry was the duly accepted model.

In 1867, Harvard University established its School of Dental Medicine and became the first American university with an affiliated dental school. It was closely allied with Harvard Medical School, and the founding Dean was Nathan Cooley Keep, a brilliant physician/dentist with a comprehensive and sensitive approach to health care. It is noteworthy that Dean Keep's innate humanity was responsible for the inclusion of an AfroAmerican student, Robert Tanner Freeman, as one of the members of the first dental class. In 1869, just four years after the end of the Civil War, Freeman became the first of his race to earn the DMD degree.

The original concept of the Harvard faculty centered upon the dental school being intimately allied with

* Clifton O. Dummett, DDS
Professor of Dentistry
University of Southern California

Harvard Medical School, and to this day, a close medico-dental relationship has remained the hallmark of Harvard-educated dentists.

During the years from 1867 to the end of the century, training the nation's dentists was characterized by contrasts in educational philosophy. One school of thought insisted that dentistry was neither a branch of medicine nor a specialty of surgery, and consequently, it should advance as a separate entity within the health professions.

Among some dentists, there were genuine feelings of inadequacy that emanated from medicine's domination ever since the beginnings of the two professions. Because dental problems in the general population were rampant, it was possible for dentists to practice and prosper. Another school of thought recognized that medicine and dentistry shared similar origins. They had common goals and possessed the same scientific potential. Proponents of this school believed that the missions of the two professions were intertwined and would best be served by a coalescence which placed "patient needs" and "people welfare" foremost. Intense competition could be dealt with satisfactorily, and everyone would benefit therefrom.

But the passage of time saw independence predominate, and general dentistry concentrated more upon the mechanical and technical procedures best suited to correct dental deficiencies.

The New Century

The new century saw a growing appreciation for research in independent dentistry. Led by stalwarts like Willoughby Dayton Miller and Greene Vardiman Black, dental education began to include a teaching philoso-

phy that stressed a need for dentists to know more about the diseases they were treating. There was some urgency in knowing the reasons why diseases occurred in the first place, when and where they tended to concentrate, who were most susceptible and how better to treat affected persons.

Miller spent much of his investigatory time in Europe. He was the first American to receive a professional appointment at the University of Berlin. He studied bacteriology under Robert Koch, and his basic research on the bacterial acid dissolution concept of dental caries was widely accepted.

G. V. Black remained in his home state of Illinois, taught at the Chicago College of Dental Surgery, and expertly fulfilled deanship duties at Northwestern University Dental School. Additionally, in his private office, Black practiced the highest quality of general dentistry and still found the time and energy to investigate problems which his fertile mind wanted to explore. For his good works and leadership skills he was thoroughly beloved and appreciated by faculty, students and practitioners alike. Ultimately he became known as the "Father of Scientific Dentistry."

During the first two decades of the twentieth century general dentistry proceeded in its accustomed manner. Dramatic changes occurred following the Gies Report of 1926. William John Gies, PhD, was a professor of biochemistry at New York's Columbia University when the Carnegie Foundation for the Advancement of Teaching appointed him to conduct a review of dental education in the United States and Canada.

Gies' historic report was severely critical of proprietary schools and their emphasis on the mechanical phases of dental therapy. He censured quack-

ery and recommended ways to improve the quality of dental education and care. The report spelled the doom of many proprietary dental schools.

The academic transference of dental education to the college level was a major accomplishment of the 1920s. One of the primary movers at this time was the son of G. V. Black. Arthur Davenport Black held both medical and dental qualifications. He became a stalwart dental leader and helped to push forward the frontiers of dentistry's scientific methodology.

It is fully documented that during the first 36 years of the new century, independent dentistry experienced phenomenal growth, aided by the influence of both Blacks, John P. Buckley, Harvey Burkhardt, John P. Hinman, Charles N. Johnson, Bissell Palmer, J. Ben Robinson and men of similar stature.

There was growing recognition of both the need for medico-dental cooperation and the importance of having dentists better schooled in the medical sciences. However, there still lurked an underlying fear of being overshadowed if the professions were to subvert their individual egotisms in order to grow closer functionally.

Because the popularity of dental technology claimed major interest among general practitioners, dental pedagogy, in turn, emphasized technology and devoted research efforts to clinical techniques and the physics of dental materials. These emphases did not abrogate research studies in caries etiology, oral bacteriology and physiology, water fluoridation, endodontics and oral medicine.

In the 1940s, the discomfort level with American health care standards reached as far as the White House and President Harry S. Truman convened the National Health Assembly in 1948. This was one of the first top-

level meetings of national scope that zeroed in on the problems of quality care and insufficient health personnel to serve the American people. Dentistry was well-represented in the Assembly and offered recommendations for corrections and improvements. One of these was to build more dental schools and increase the number of dental and auxiliary students to treat accumulated dental needs.

By mid-century, ferment in dentistry was at fever pitch. There was wide-ranging progress in dental educational precepts, in public health concepts, and in dentistry's scientific research. For instance, in dental education there were coordinated attempts to increase the numbers of faculty and students, to update textbooks, and to refine dental materials. There were Congressional bills to provide federal grants to the nation's medical schools for construction and expansion. Dentistry's representatives fought vigorously to have the profession included in these endeavors. A historic national survey of dentistry was authorized by the American Council on Education. The Council on Dental Education of the American Dental Association strengthened its site-visit procedures and program evaluations of the nation's dental schools. The American Association of Dental Schools and ADA worked cooperatively to improve dental education.

In dental research, the ferment was at its most spectacular! On April 30, 1953, President Dwight D. Eisenhower met with ADA officials on the importance of expanding dental research and erecting a building for the National Institute for Dental Research.

The first resolution urging research on periodontal diseases was

originated in the Dental Section of the American Public Health Association. It was adopted by the parent organization at its 1954 annual meeting.

The high-speed dental drill was developed by Robert Nelson, a former Executive Director of the American College of Dentists.

In 1956, Congress approved a grant in excess of \$6 million for dental activities of the U.S. Public Health Service. Of this amount, more than \$3.5 million was earmarked for research at dental schools and research centers.

In 1957, nine dental schools and centers received approximately \$270,000 from the U.S. Public Health Service to train dental researchers.

In 1958, Congress passed a bill calling for \$7.4 million for dental health and research programs, plus more than \$3.5 million for the construction of a building to house the National Institute for Dental Research.

In public health, the mid-decade celebrated the tenth anniversary of the famous Newburgh/Kingston New York fluoridation study. A Gallup poll indicated that the American public favored water fluoridation. Public acceptance was boosted by endorsements from the nation's premier health and welfare organizations. In 1959, dentistry played a prominent role in the first national conference to upgrade health care of the elderly.

The subspecialty of Epidemiology and Oral Disease Prevention expanded contributions by dental public health, and attained a reputation as one of the specialty's valuable assets. Most importantly, general and specialty practice moved towards a new plateau. Modernized dental care characterized by innovative tech-

niques, novel materials, improved technologies, and pain reduction achieved by up-to-date procedures, resulted in less fear of dentists. Health education spread the word, helped to rid dental treatments of their "unpleasant" image, attracted patients to dental offices, and popularized private dental practice.

On the other hand, costs of dental care skyrocketed, and socioeconomic planners tried to find ways and means to solve problems of availability, accessibility, and affordability for specific segments of the population.

Throughout the 1950s and beyond, dental education, research, practice administration, and the dental industry were all competing for attention and privilege.

Turbulence of the Sixties

As America's world entered the '60s, specific disorders were brewing and they prompted interregional and interpersonal antagonisms. There was growing sensitivity to the problems of the nation's underclass.

The centennial anniversary of the American Dental Association was in 1959, and it was both appropriate and thrilling to expound on dentistry's advancements. The most spectacular accomplishments were in dental research, discovery of the role of refined sugars and carbohydrates in caries etiology, water fluoridation and the effects of fluorides and fluoride-incorporated toothpastes and mouthwashes. Tremendous advancements were also made in operative and restorative dentistry, prosthodontics, oral surgery, pediatric dentistry, orthodontics, endodontics, oral medicine, oral pathology, dental public health and dental practice.

American dentistry took center stage in the nation's consciousness when it stood up to U.S. power and the prestige of Soviet Premier Nikita Khrushchev and refused to surrender its guaranteed facilities during the ADA Centennial. In response to insistent demands from the topmost federal bureaucracy to vacate specific premises, ADA's Harold Hillenbrand and Percy Phillips refused. The national media took note and flashed around the world this ultimate spectacle of dental independence.

The next day's activities featured an ADA-invited guest, none other than Vice President Richard M. Nixon. In referring to the prior day's incident in his official congratulatory remarks, Mr. Nixon quipped, "The Russians might have got to the moon first, but the dentists got the ballroom first."

The historical record confirms that dentistry and its leaders wrestled with psychosocial problems and professional progress. The influences of public health and the maturation of public health dentistry were being experienced. Clearly, the dental profession was inspired to open its eyes to the changes occurring within the country.

Dental educational reforms continued and were in concert with recommendations by the ADA's Council on Dental Education. Reforms were also in conformity with policies of the American Association of Dental Schools and, with a reluctant acceptance of the new intrusive presence of the federal government in health education and research. All of these factors spelled a new day in American dentistry.

The Final Decades

As the '70's advanced, there was

an appreciable diminution in the magnitude but not the countenance of student unrest. In dental education, students demanded and were accorded greater consideration of their gripes, and considerably more respect for their dissatisfactions.

A sharp decline in applications to the nation's dental schools occurred during the decade. The declivity was especially noticeable among students from middle and lower-income families.

Concurrently, there were substantial increases in costs of obtaining a dental education. Sources for loans to dental students were shrinking fast and the Commerce Committee of the U.S. House of Representatives approved a three-year phase-out of capitation grants.

A 1976 dental curriculum study was acclaimed the most useful curricular review in dental history. It was funded by the W. K. Kellogg Foundation and called for dental education to be fully integrated in universities and academic health centers.

One of the features characterizing dentistry in the '70's was the burgeoning of health care delivery systems. Considering prior unpopularity of the group practice concept, it was nothing short of miraculous to view the transition and subsequent development of that idea, along with expansion and promotion of alternate delivery systems that included affiliations, associateships, free clinics, special clinics, multi-purpose clinics, neighborhood health centers, and health maintenance organizations.

Another primary characteristic of the decade was an apparent increase in patient challenges to professional authority. These were often manifested as: (a) doctor/patient discord;

(b) patient discontent with quality of care, or complaints to grievance committees of dental societies; (c) unreasonable claims and upsetting citations; and (d) embarrassing subpoenas or expensive litigations. Generally speaking, official dentistry weathered these incidents with assurance.

Conclusion

Significantly, the final year of the decade marked the tenth anniversary of the retirement of Harold Hillenbrand from the Executive Director post of ADA.

In our symposium today, it seems altogether fitting to close out this period of dental history for which I am responsible, with a tribute to Dr. Hillenbrand. During the last three decades of "yesterday's dentistry," he was certainly the most dominant figure in both American dental administration and world dentistry.

In 1979, the American Dental Association memorialized him with dedication of the Hillenbrand Auditorium in the imposing headquarters building for which he was mainly responsible. The American College of Dentists accorded him its highest honors, namely, the William J. Gies Award in 1959, and the Award of Excellence in 1983.

From every conceivable standpoint, Hillenbrand epitomized yesterday's dentistry which set the stage for the prodigious features that characterize dentistry today, and in all probability, will still be influencing tomorrow's dentistry.

Reprint requests to:
Dr. Clifton O. Dummert
P.O. Box 77006
Los Angeles, CA 90007

DENTAL HEALTH CARE: *TODAY*

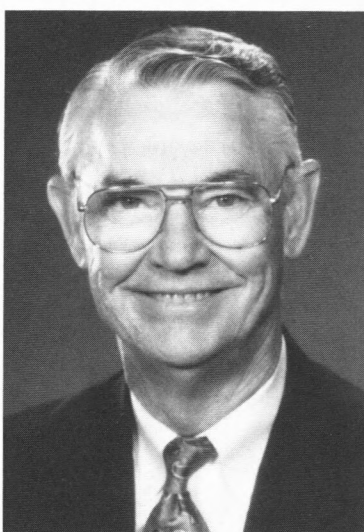
Jack H. Harris *

It's a pleasure to share this podium with three of the most distinguished individuals in the dental profession. In our discussion here today, Dr. Dummett has represented "dentistry yesterday," and Dr. Barker will represent "dentistry tomorrow." But in truth, both of them are members of the profession for all times and all seasons, and so is our moderator. I'm honored to be in their company.

The subject that's been assigned to me in this discussion is "dentistry today," and I must say I'm glad I drew that straw. It gives me an ideal opportunity to clear up misconceptions that have been circulated by the prophets of gloom and doom. Their grim assessments of the present situation in dentistry and their dire forecasts for the future don't hold up at all when you look at statistics, demographics and current trends.

In my time with you this morning, I want to share some of the information currently available to us from the ADA's own research and other sources. This information makes it clear that dentistry today is strong and that the profession is positioned to grow even stronger in the years just ahead of us.

First, though, I want to preface everything I'm going to say with a



Jack H. Harris

little caveat about statistics. It comes from Burt Borgelt, of Dentsply International.

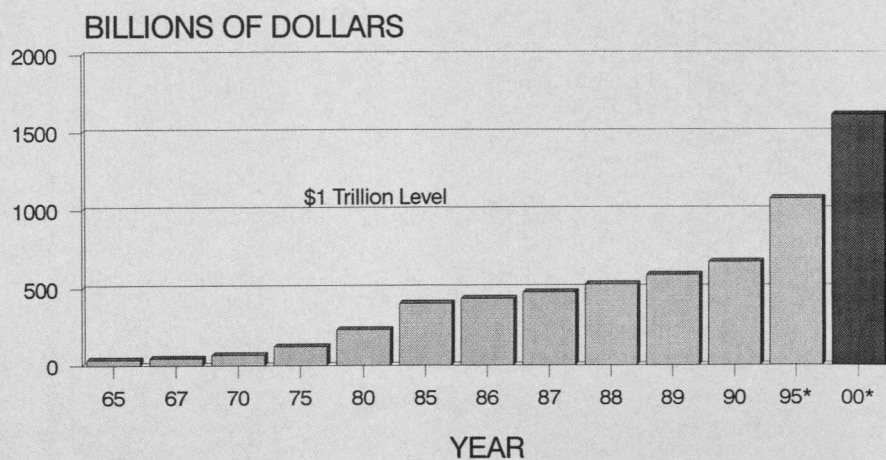
As Burt tells it, there are about 200 million Americans, 60 percent of whom are either housewives or children. That leaves only 80 million of us to pay the country's bills. Twenty million people are over 65 and on Social Security, so that cuts the number of us who support the country down to 60 million. About a million people are either in the armed services or veterans on pension, so that reduces the number of us who shoulder the burden to 37 million.

From those 37 million, we have to exclude 15 million people who are on welfare and 18 million people

Figure 1

NATIONAL HEALTH CARE SPENDING

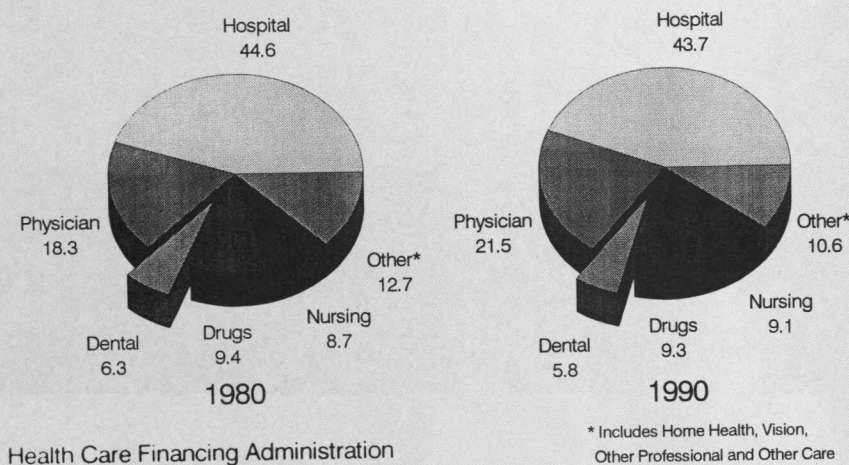
1965 - 2000



* Jack H. Harris, President
American Dental Association

Figure 2

PERCENT PERSONAL HEALTH SPENDING BY CATEGORY, 1980, 1990



who work for the government at one level or another — local, state, or national. So now we're down to four million people to foot the national bill, and we still haven't factored in 1,198,000 school teachers and administrators paid by public funds — or 2,301,998 policemen and firemen.

These are all good folks, you understand, but they have to be factored in.

That leaves only half a million of us — 500,002 to be exact — who pay taxes and don't get paid out of government funds.

But wait — don't forget the half million people who are in federal, state or local jails. In the final analy-

sis, that leaves just two of us to support the whole shebang.

For the next week, *I'm* busy here in Orlando. I sure hope the other one is in there pullin'.

You'll have to check with Burt Borgelt to find out where he got his figures and his reasoning. I share this story with you as a reminder that statistics can lead us astray just as easily as they can guide us to the truth, as those of us who lived through the dental manpower forecasts of the 60's know only too well.

Now, bearing in mind that we need to take a fresh look at any statistics from time to time to be sure that they still hold water, let's

see what we think we know at this time and what we might be able to forecast with some degree of comfort.

Figure 1 shows the increase in total health care spending in America, beginning in 1965 and projected by the Health Care Financing Administration through the end of the century.

Private spending for health care is already nine times higher than it was in 1965. Government expenditures for health care are 20 times higher. Is it any wonder that individuals and government alike are calling for health care cost controls?

Note that expenditures are expected to pass the \$1 Trillion threshold at the middle of the current decade, with escalation moving on up to \$1.6 Trillion by the year 2000.

Figure 2 shows that within the overall picture of skyrocketing health care costs, the current picture for dentistry is very favorable for practitioners and patients alike.

Note that dentistry's share of personal health care dollars declined from 6.3 percent to 5.8 percent from 1980 to 1990, while the physician share *increased* by 3.2 percent.

Over the past 30 years, dentistry's share of total national health care dollars — including both personal and government expenditures — has decreased from 7.3 percent to 5.1 percent. Dentistry is not a culprit in the health care cost crisis, and one of our greatest public relations assets is that no one really views us as one.

Even so, as Figure 3 shows, the dental profession in America has been able to achieve reasonable, consistent growth. This growth has been fueled by several factors, including a population that is growing older, is more educated and health-conscious than in the past, and enjoys greater discretionary income.

Projections for this decade are for growth averaging 6.4 percent per year, culminating in total dental expenditures of \$63 billion by the year 2000.

It's always interesting to look beyond the overall picture to see how third party payer trends figure in and how they vary over time. Figure 4 shows that in 1980 patients were paying 65.3 percent of dental expenses out of pocket, with insurance plans paying 30.6 percent and government programs paying 4.2 percent. Ten years later, the patient share had gone down by 12.4 percent, with insurance plans paying almost 45 percent and government programs paying just 2.6 percent.

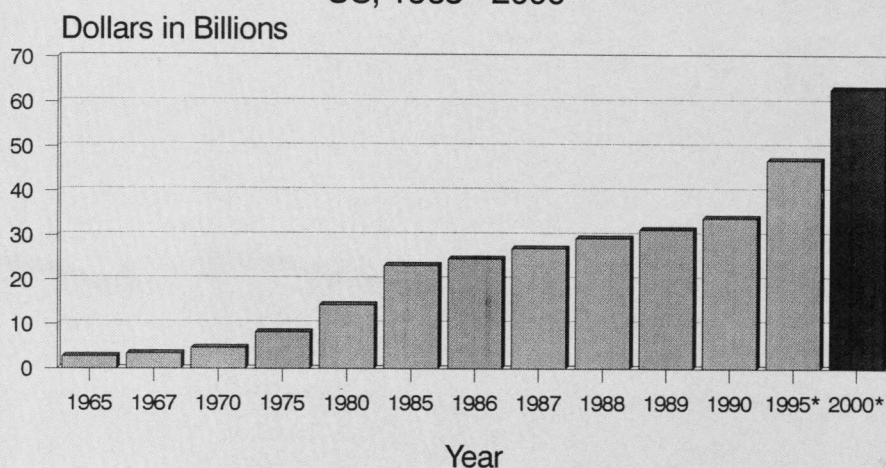
Of course, we cannot expect the growth in dental plans to continue increasing as dramatically as it did during the 1980's.

The outlook for dentistry is even better when we look at the question of dental manpower. Figure 5 shows the present forecast for growth in the number of dentists. The projected growth rate is less than 1 percent per year — *below* the projected rate of growth in the population.

After the erroneous forecasts of the 1960's I mentioned earlier, we saw the number of new dental school graduates rise throughout the 1970s and early 1980s. That's

Figure 3 DENTAL HEALTH EXPENDITURES

US, 1965 - 2000



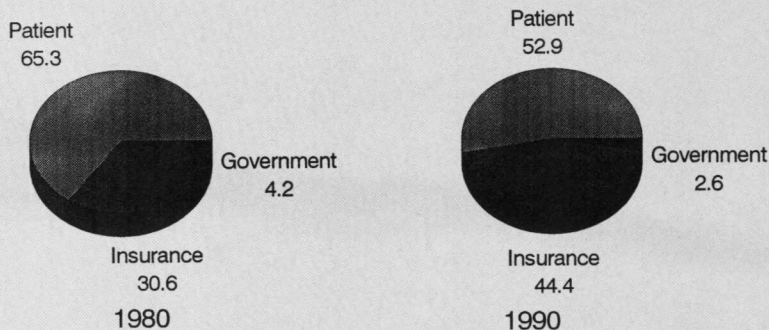
Health Care Financing Administration

* HCFA Projections

Figure 4

DENTAL CARE SPENDING

SOURCES OF PAYMENT, 1980, 1990

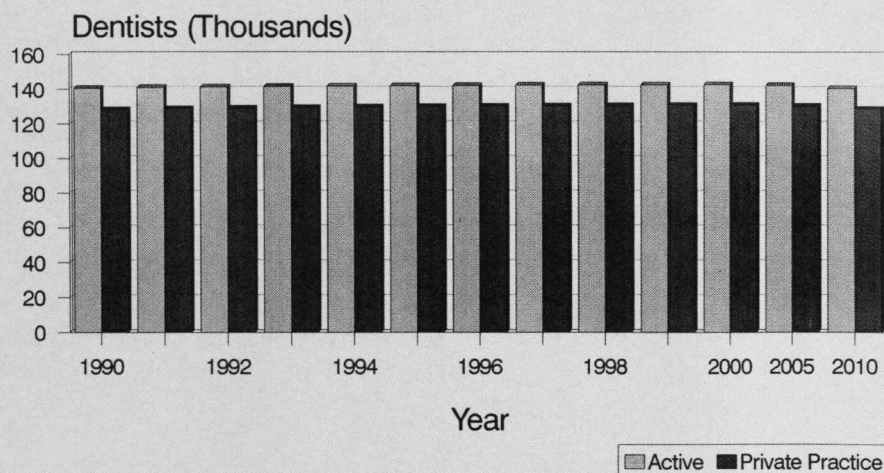


Health Care Financing Administration

Figure 5

DENTAL MANPOWER PROJECTIONS

US, 1990-2010

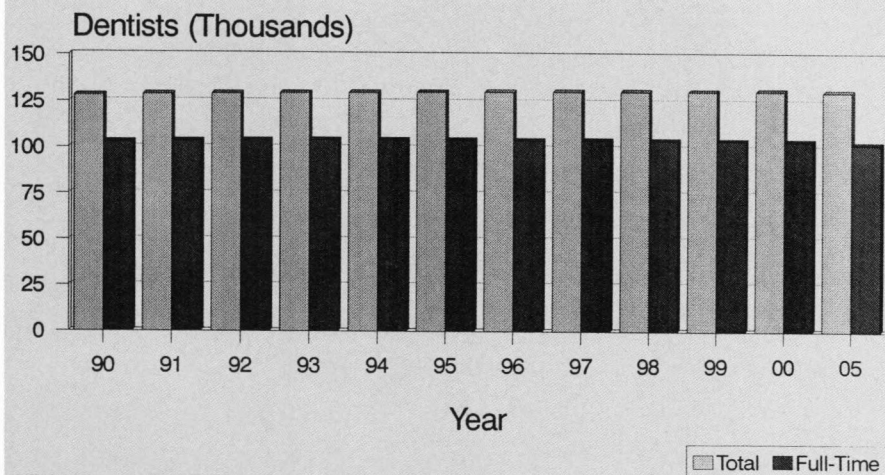


ADA, Manpower Projection Model

Figure 6

PROJECTION -
PRIVATE PRACTITIONERS

TOTAL & FULL-TIME, 1990-2005



ADA, Manpower Projection Model

over now, and those who interpret the decreased growth in the number of dentists as evidence of an impending shortage overlook an important factor — the excess capacity that was created during the build-up of those two decades. The capacity to treat more patients exists in many practices throughout the country.

And remember: the dentists who graduated during those years are still in either early or mid-career. The relative consistency in manpower through the end of the century, as shown in Figure 6, stems from the fact that almost all of these dentists will still be practicing 15 years from now. Many of them will still be productive 25 to 35 years down the line.

Figure 7 illustrates a key factor in the general picture for dentistry today: the decline in the number of patients per dentist which began in 1975 has finally bottomed out, and we expect a slight increase through the 1990's.

How did this happen despite the patterns we have experienced in dental manpower?

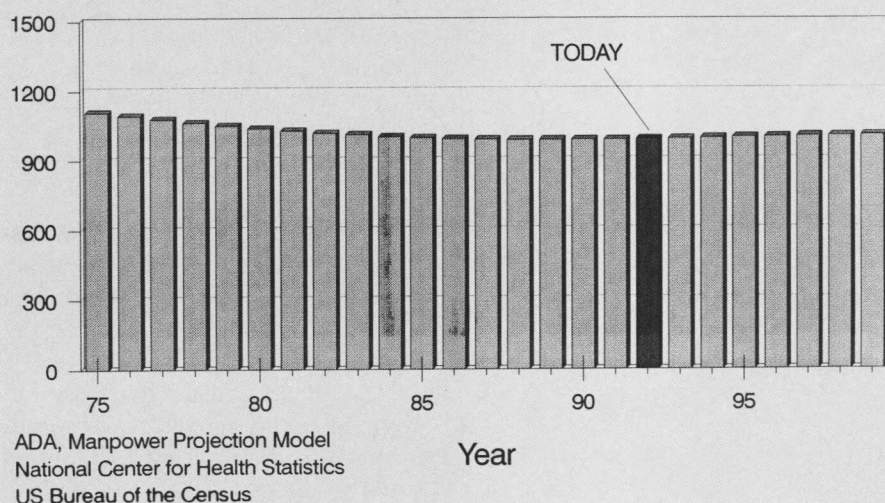
I'm reminded of something Alexander Graham Bell once said: "Sometimes we stare so long at a door that is closing that we fail to see the one that is opening."

As the door was closing on the dental manpower picture of mid-century, a significant change was taking place in the public's oral health habits. We were busy wringing our hands over the increasing number of dentists, but another important increase was occurring — an unprecedented increase in the number

Figure 7

PATIENTS PER PRACTITIONER

1975-1999



6.7 percent per year, compared to average annual inflation of 4 percent. In 1990, average net earnings reached \$96,500.

Last May, when I talked to the students at our state dental school in San Antonio at their graduation ceremonies, I was able to give them the good news that they stand to earn \$12 million over the course of a working lifetime. That's figuring a starting age of 27 and a starting income of \$30,000. Even when you allow for inflation and other factors, the present value of future earnings of \$12 million comes to about \$3 million.

Figure 9 shows relative net earnings by age group. Note that earnings are highest among dentists 40 to 54 years of age, after they have survived student debts and start-up expenses and built their practices.

Amid all the positive economic

of people who go to the dentist.

From 1979 to 1986, the number of people who went to the dentist increased by 8 percent. Total patient visits grew from 354 million in 1979 to 467 million in 1986, and they currently exceed 500 million.

Public awareness of the importance of dental care has risen constantly. Our ability to serve our patients is constantly increasing as well—with new technologies, new skills, and less discomfort. The one thing that *isn't* increasing dramatically right now is the number of dentists.

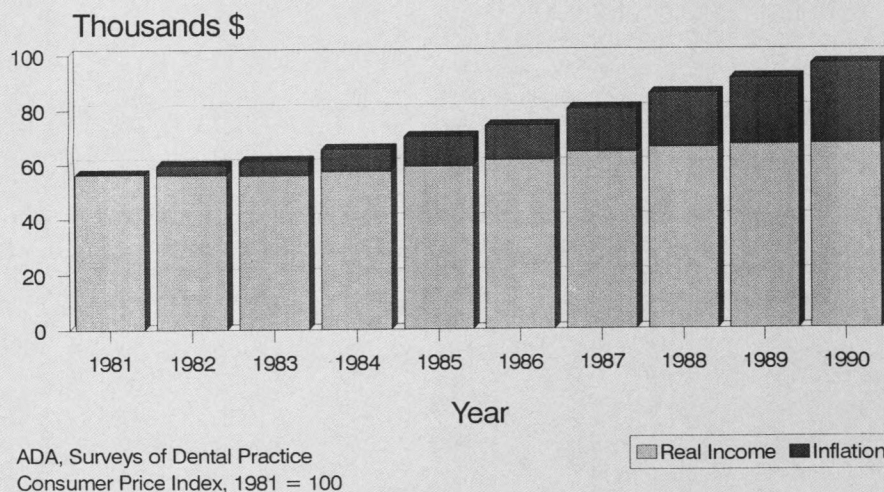
The factors I've been discussing have helped to produce the net earnings picture for dentists that you see in Figure 8.

Each year since 1983, net earnings for dentists have increased by more than the rate of inflation. The growth in net earnings has averaged

Figure 8

NET INCOME, 1981-1990

INDEPENDENT DENTISTS



factors for dentistry we've been looking at here today, there is one very disturbing factor. I don't want to gloss over this factor, because I believe we all need to be aware of it and use our collective wisdom to do something about it. I'm referring, of course, to the astronomical level of debt that so many of today's dental students face after graduation.

Figure 10 shows the increase in the level of debt for the average dental student from 1980 through 1990. Just look at the average debt in 1990 — \$45,000. And remember that this is only the *average*. For many students, the level of debt is even higher.

If the escalation continues unabated, a similar chart prepared at the end of the present decade will show average indebtedness of well into six figures.

There are two responsibilities we

Figure 9

NET INCOME BY AGE

1985 and 1990

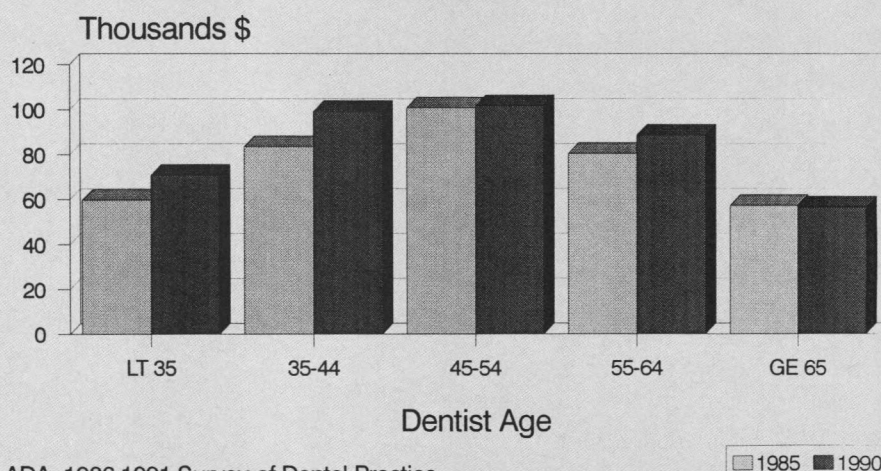
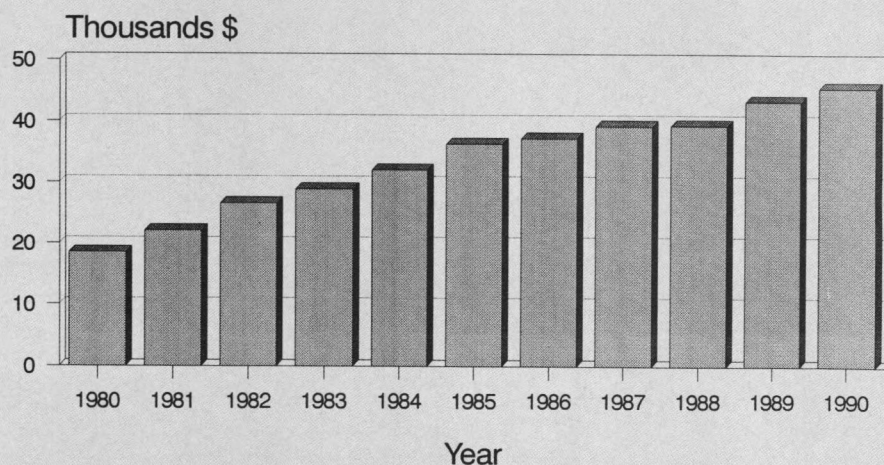


Figure 10

AVERAGE STUDENT INDEBTEDNESS

1980 - 1990



must accept with regard to this issue.

First—for the generation to come, we must take measures to assure that dentistry, as a career option, does not become restricted to the privileged few.

Secondly, we also have a responsibility to the current generation — those who have made dentistry their choice and have joined us as colleagues or will join us soon. With the quantum leap in student debt, they aren't as likely to take up solo practice from the very start as many of us who came earlier were able to do. In order for American dentistry to remain strong and continue fulfilling its public mission, we must assure that these young colleagues are able to enter associateships or make other choices that will enable them to grow professionally.

In meeting this responsibility, it seems to me that we have no greater resource than the Fellows of the American College of Dentists.

When we take a look at present trends in dental practice structure, as shown in Figure 11, we see the effect of the difficulties younger practitioners face.

Solo practice is still the predominant form. Seventy percent of independent practitioners and 66 percent of all dentists are solo dentists, and most dentists are owners of the practice where they treat patients. But the proportion of non-solo dentists shows a slight decrease, and as Figure 12 shows, non-ownership of practice is most common among those who have graduated within the last five years.

There's one additional area I'd like to examine, because I think it's unfortunate that the statistics in this area have been misrepresented in recent months.

I realize the hard realities that face anyone who's trying to run a dental school in today's economy, and I would not presume to quarrel with the decision the trustees of Loyola University made to close the doors of the dental school there.

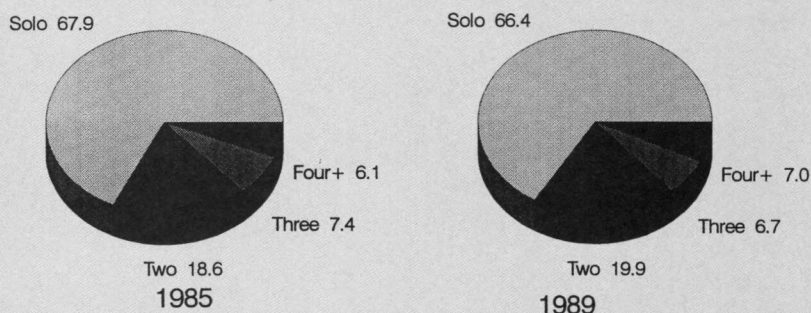
What I do quarrel with, however, is university statements that found their way into the popular press — statements that tried to explain this school closure by claiming that dentistry is no longer a popular career choice and that applications for admission to dental schools are down. The truth is quite the reverse.

Meaningful discussion of current dental school admission and enrollment trends must be placed within a perspective of at least 30 years, as shown in Figure 13.

Figure 11

SIZE OF DENTAL PRACTICE

NUMBER OF DENTISTS, 1985, 1989

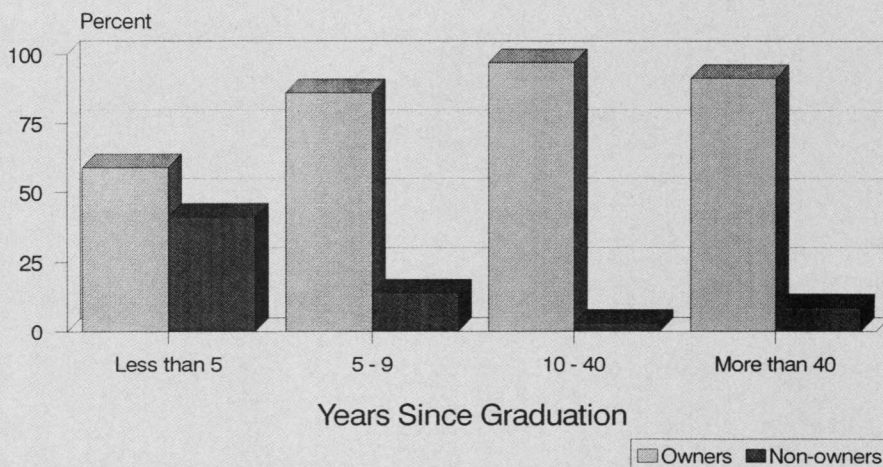


ADA, 1986, 1990 Survey of Dental Practice

Figure 12

OWNER/NON-OWNER DENTISTS

Years Since Graduation



ADA, 1990 Survey of Dental Practice

This figure isn't one that shows consistency or a smooth progression. No, it shows a *cataclysm* — the cataclysm that occurred when dental manpower needs were miscalculated in the 1960s and massive federal funds were devoted to building up dental school enrollment.

After the decline that began during the '70's, over the past three years we have seen an increase in both applicants and enrollments. We're also seeing positive results from the SELECT program jointly sponsored by the ADA and the American Association of Dental Schools.

One of the purposes of the SELECT program is to attract "the best and the brightest" to the dental school applicant pool. Since the program began, the mean DAT score of the applicant pool has risen to 4.5. And, to "the best and the brightest," we can add "the most diverse." More than half the students in our dental schools today are women or minorities.

The growing diversity in the composition of the profession will affect practice patterns. It will certainly have a profound impact on our ability to address one of the most important issues we face — the issue of access to oral health care for all the members of our diverse society.

I began by saying that current statistics and trends show us to be a strong profession in a unique position to build even greater strength. I am convinced of this, but I am also convinced that we have our work cut out for us.

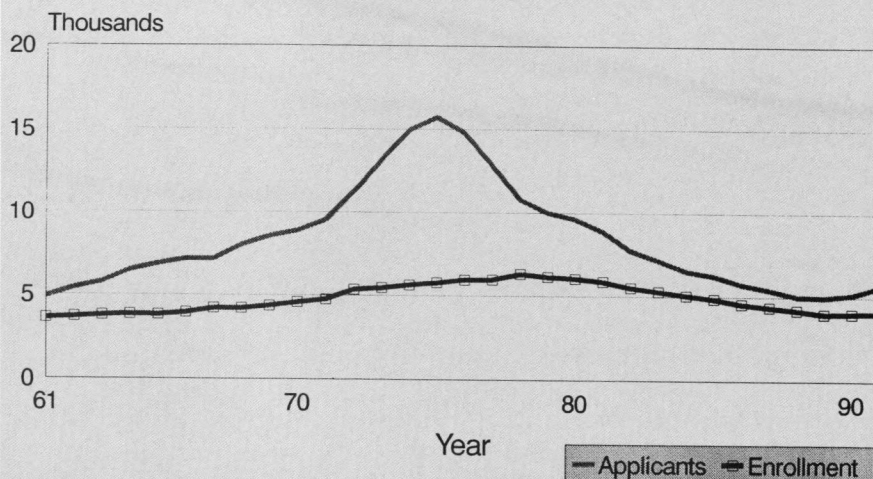
Statistics and trends can hold promise, but they, in themselves, do not build the future. **We** have to do that.

As individual members of the profession — and collectively, through

Figure 13

APPLICANTS VS 1ST YEAR ENROLLMENTS

1961 - 1991



Source: ADA Department of Educational Surveys

organized dentistry — we have to clearly envision the potential for growth and commit ourselves to making it happen.

That means we must continue to forcefully and effectively address government agencies and third-party payers, protect the doctor-patient relationship, and uphold the professional judgment of dentists.

It also means that we must use the full resources of organized dentistry to continue building public awareness of the importance of oral health — and awareness of the constantly expanding range of services available in today's dental office.

Above all, it means that we must rededicate ourselves to the Principles of Ethics, Code of Professional Conduct and nationwide peer review

system that are the cornerstone of our profession's integrity.

The legendary Broadway producer David Belasco once said, "If you can't write your idea on the back of my business card, you don't have a clear idea."

My idea, which you're welcome to write on the back of your business card, is this:

The profession that you and I share has never in its history shown greater potential for growth than it shows today. It's up to us to realize that potential.

Reprint requests to:

Dr. Jack H. Harris, President
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611-2678

DENTAL HEALTH CARE: *TOMORROW*

Ben D. Barker, DDS

It is an honor to share this occasion with the American Academy of the History of Dentistry and the American College of Dentists, most especially those of you who will be inducted into this privileged company this afternoon. It is also a special pleasure to share this platform with a distinguished historian in our profession and an active player on the current scene.

They would readily agree that I have the advantage in this lineup. Addressing the past and the present binds one to the facts and the reaction of people to those facts—one definition of history. Tomorrow imposes no such constraints, although I have pondered why the sponsors have invited one in his sixth decade to comment on that future. Occasionally such mysteries find a contemporary answer; Robert Frost writing, "Dear Lord, forgive the little jokes I've played on Thee, and I will forgive the great big one on me." In any case, we need to keep in mind that one cannot separate the past and present from our future.

In a time where values are geared to the biggest, the fastest and the mostest, society's gaze is fixed desperately upon the future—at least at the next election, or life-after-death or prosperity—whichever should happen to come first. To this, essayist Wendell Berry retorts: "This game of 'How to survive for the next 100 years' is useless. Nobody knows what is going to happen in the next 100 years. The next 100 years will be mostly surprising, as were the last 100 years."

Berry continues, "It is the present that ought to concern us, and for the present we have had good instructions, from several traditions, for a



Ben D. Barker

long time. We must quit being selfish, greedy, and violent. We must respect the works of God, and do good work ourselves. We must help our neighbors (including our enemies). We must care for the old, the poor, the infirm and the homeless. We must keep our promises. We must preserve our communities, and teach the young. Whatever we use we must preserve. If we do these things in the present, we need not worry about the future. If we don't do them in the present, the future will not be much improved by making plans."¹ Berry is correct, of course, and some years ago, I would have stopped right there and sat down. But that was when I was much younger and infinitely wiser.

The period from 1950 to 1990 has been an extraordinary epoch in our nation. The 90's usher in a new world. The Cold War is over, and the economy, such as it is, a global one. Yet the future, as ever, is unclear. In these times, fortunetellers thrive. This is the decade when all good journalists will be found writing their fare-

wells to the century. In all of this there is a pervasive hunger for examination of the future.

At moments like these one is tempted to be prophetic, but I am chastened by the memory of Cassandra, who was given the gift of prophesy. But the gods attached a troubling limitation so that her prophesies, though true, were fated never to be believed. Facing that, my goal is to try to make some sense of conflicting developments and instill some tolerance for unpredictability. Hopefully I have disassociated myself from absolute judgments, even if they reflect my own turn of mind.

I have tried to strike a balance between optimism and some caution about the future of oral health care in our nation. Our focus should be on what we know, with reasonable certainty, that will have a major impact on the mission of the profession—the improvement of oral health for all citizens. My view is that dentistry can only cope fully with this responsibility if it acquires a new understanding of the deeper trends that shape the wider world. Hopefully, you find in all of this some sense of compassion embracing the human race. If so, I will have partially succeeded, "...because what unites us—the ultimate ground of our claim to equality—is our common ignorance of the central questions posed for us by the universe: whence, and why, and whither."²

In preparing these remarks I have borrowed unashamedly from many who have written and thought about these matters.³ One phrase characterizes the sum of these explorations - **TOMORROW WILL BE DIFFERENT!** We are undergoing tumultuous, sometimes violent, often inco-

herent, social change throughout the world and in these United States. Therefore, these words are more about the larger world of which we are a part: more about the past as prologue, more about the agenda for change and less about the specifics of dental care; more about how we shall get to the visible future, and less about its precise dimensions. The truth is that our future is more likely to be influenced by the former than the latter. This approach may surprise you. I hope it does not disappoint.

To begin, permit me to paraphrase a recent international journal on this topic. Remember the paperless office predicted ten years ago; George Orwell's nightmare of 1984; the world famines of the '80's predicted in the 70's; the personal helicopters for all and holiday trips to the moon predicted by science-fiction writers of the 50's; the suffocating depths of horse dung in the streets of London projected in the 1890's; the imminently returning ice age so in vogue in the 70's? Do we need further reminders that extrapolation makes bad futurology and that predictions now being made about the future will be as wrong as those made in the past?

Extrapolation is rampant: trade deficits will grow; Japanese domination of the aerospace industry is inevitable; health care will eat the budget; dental caries will disappear; indebtedness will continue to grow. You can use extrapolation to frighten voters, inform the membership, warn the employees or impress your friends about a trend.

Three things derail extrapolations: politics, technology, and self-correc-

tion. The 70's provide bold examples of trends interrupted by politics. In 1973 the Arab reaction to loss of the Yom Kippur War derailed projections as the price of oil quadrupled.

If the 70's were the decade of unexpected politics, the 80's were the decade of unexpected technology. The fall in the price of computing power made it possible for all sorts of industries - from banks to travel agents - to use the same amount of electricity to produce vastly more information much quicker.

The 90's will be the decade of the self-correcting trend. Take health care, an increasing obsession of politicians and businessmen. Health care will have almost doubled as the proportion of GNP between 1970 and the year 2000, a dazzling performance by any industry. This has brought even greater rewards to workers in the industry, but it is plainly a case of diminishing returns for those who use it. If health has improved as fast over this period, which is doubtful but hard to measure, it is largely because of prevention: less smoking, less cholesterol, ambient fluoride and more exercise. But the growth of health spending will surely correct itself. Employers and employees alike will find the burden of paying so much of their income to the health industry ever more intolerable.

The extrapolation habits of each generation tell you much about its notion of progress. In the year 1000, just about everybody believed in progress. In Europe they could look back with awe at the organized civilization of the Romans that had made straight roads, tall aqueducts, and the poetry of Virgil. They were not especially depressed that things had not

gotten much better since. Extrapolating the future for medieval people was therefore easy. They assumed that life would stay much the same as it had, that any improvement in an individual's lot must come from the deterioration of another's. Life was a zero-sum game.

A millennium later, how different life is. A country (Argentina) with annual real economic growth averaging 0.9 percent since 1965 is considered a disaster. Even the millennial gloom-peddlers who will proliferate in the 90's will be talking about too much progress, not too little: too much atomic energy released in one place at one time; too much genetic knowledge in the wrong hands; too much carbon dioxide from too much growth.

It may take some getting used to, but the notion we need to embrace is that the World War II postwar years were aberrant. This truth will continue to be obscured as long as Americans are obsessed with the memory of those years. They were aberrant because America got fat and happy on the back of an historical accident: the consequence of two world wars in which western Europe, Russia, and Japan all temporarily lacerated themselves. So many of the "shocks" to the American system since the end of the boom years were not shocks at all; they are a return to the America of the pre-1914 years. If only we could grasp that truth we could recover our self-confidence, instead of pursuing the ultimately hopeless task of trying to recreate a dream time.

Once you get used to this idea, evidence for the proposition starts popping up all around. One can view the baby boom as a shock to the American system. It led to quite un-

usual levels of early marriage and family formation. The low divorce figures, too, were exceptional. With the exception of the postwar boom years, there has never been a period in the history of the republic when the divorce rate has done anything but head skyward.

Perhaps more interestingly, it is quite easy to show that the apparently huge growth of women in the labor force is not an oddity at all. It marks a return to the days when America was a largely agricultural nation. It would be hard to describe the life of pre-1950 American farm women, forever making clothes and canning food, as anything but "work."⁴

One other borrowed word about the post-war years. There is no evidence that the Cleaver family of "Leave it to Beaver" had a Japanese car, or for that matter, anything Korean, German, British, or French in their house. Nor is there any reason to think that any of the Cleavers' neighbors could not speak English.

The last decade has seen a redistribution of wealth in the nation and we are beginning to hear the term "working class" again, a phrase that was banished from polite American discourse in the 50's. That is because the achievements were undeniably great and are not in dispute. What about now? Listen to this comment:

"The numbers of rich will grow more rapidly in the coming years...real wages for low-skill jobs will increase more slowly, if at all... I fear the potential for producing something like a caste society, with the implication of utter social separation...all the forces

that I can discern will push American conservatism toward the Latin American model...the Left has been complaining for years that the rich have too much power. They ain't seen nothing yet."

These words were not written by some politically-correct campus firebrand. Their author is Charles Murray, a leading modern social theorist of conservatism. Why does he speak like that? We need only to look at changes in family income since 1970. Drawing from figures produced by a conservative writer in an article rebutting critics of economic performance in the 1980's, it is not a pretty sight. The lowest fifth has bumped along the bottom; the second lowest is 3 percent better off than it was in 1973. And the top one-fifth is nearly 36 percent richer.⁵

For all the talk of the fragmentation of America, there is only one division that is dangerously getting worse and that is the gap between rich and poor. This gap is not just a matter of economic stratification. It is poisoned by racial difference. America cannot long tolerate that kind of gap and still keep its values intact.⁴ The profession should take note.

Is it true that the fastest-moving changes are in Europe and not this side of the Atlantic? Are we actually turning toward Europe to see the future? Is it perhaps true that the United States has become what economists call "a lagging indicator," not "a leading indicator," of worldwide trends; no longer a world power but a world player on the global scene.⁶ *Tomorrow will be different.*

Listen to another voice: "America is sauntering through her resources,

and through the mazes of her politics with an easy nonchalance; but presently there will come a time when she will be surprised to find herself grown old — a country, crowded, stained, perplexed — when she will be obliged to pull herself together, husband her resources, concentrate her strength, steady her methods, sober her views, restrict her vagaries, trust her best members, not her average ones. That will be the time of change."

There can have been no more elegant statement of the declinist case than that—which gives the modern declinist something of a problem, for the above words were written by Woodrow Wilson in 1889. Worrying about America's ability to meet the challenge of the future is as old as the republic. But remember, a tradition of meeting those challenges is just as old.

Since 1950, the dental profession along with the nation has been on a wild ride, as if its potential knew no horizon. The ride took us not into the future but back in time. In the most haunting words of American literature, the republic was borne back ceaselessly into the past. In that past we met many dragons and slayed most but not all of them. We now meet them again. The task of the old country and the old profession is to learn how it coped when it was younger.

What then can we say with any certainty about the next decade and oral health care? Who will need it? Who will provide it? How shall we pay for it? What will it be like? Good health is as difficult to define as it is important. It means different things to different people. It is influenced by many factors, including the genes we

inherit, the environment into which we are born, and our own behavior.

Health care has many goals: to prevent illness; to diagnose and treat sickness; to counsel and advise; to rehabilitate; and to palliate and comfort. It has a vast array of personal and technological services to bring to bear on those goals. The influence of health care is variable. In some cases, it is essential and its effect in preserving or restoring health is dramatic. In others it has a marginal impact. Unquestionably, good health is a highly valued attribute of life in this country, and the nation has long held a common concept of what constitutes desirable health services.⁷

The next decade will bring more action responding to the broad concerns among the health professions about the quality of health care. In addition, rising dissatisfaction about the system on the part of the public and policymakers, unremitting pressures for cost containment, and uncertainty about the effect of future cost containment on the quality of care will confront the very fabric of dental care.

What are some of our collective best judgments about the next decade? Here is a sampler:

- Dentistry has been too successful; there is a widely held perception about the demise of dental care, although there is no basis in fact for this view.
- In the next 20 or 30 years our population will need maintenance; more teeth will be at risk and these will require conventional care.⁸
- We have no evidence that caries will be eliminated.⁹

- We have considerable evidence that periodontal disease is decreasing around the world but not disappearing.⁹
- The demographics of our society have changed and continue to change; older cohorts are increasing, especially those characterized as the old old; younger components are decreasing; there are significant increases in the numbers of Spanish and Asian immigrants; the movement toward a white minority in the nation continues.⁸
- Public expectations for health care and oral health care have changed and will continue to change.⁹
- Too much of dental health policy is based upon white Anglo-American children.¹⁰
- There has been a significant and demonstrable change in the role of women and a transformation of sexual mores throughout American society in the past 30 years.¹¹
- There are clear alterations in the culture and values of the nation.¹¹
- Dentists will have placed in their hands new diagnostic tools and preventive measures and procedures that are safer, more cost effective and better for oral health.⁹
- Information management will be a key to successful practice; the computerized patient record is a current reality.
- We are not a very flexible profession.

Does this sound like business as usual? I think not: *TOMORROW WILL BE DIFFERENT.*

Economically, the profession

seems to be temporarily at a financial standstill. If the redistribution of wealth continues at current levels it is likely that physicians and dentists will make less money. Society is very likely to be less benevolent as it expresses more competitiveness, protectionism and becomes even more self-serving. If these forces are not firmly withstood within the profession, dentistry will increasingly lose control of its destiny as the discrepancy widens between professional claims and society's perception of the profession.

Who will deliver care? There are renewed calls for a reevaluation of the team delivery of dental care and a broader view about the efficient and effective use of dental allied health personnel. These advocates believe, with some justification, that this is the only means by which we can deal with future fluctuations in need and demand and the attending supply of appropriate manpower resources.

What about new dental graduates currently joining the profession? They have been too much criticized by a vocal minority within the profession. Most often targeted is their preparation for practice and the attitudes they appear to exhibit in beginning practice. The hard evidence is that they are as ready to enter practice as they ever were. But they are different in significant ways.

It is true that the materialism of the 1980's marks American youth today. Two recent analyses drew on annual surveys of high school seniors by the University of Michigan and college freshmen by the University of California at Los Angeles. These reports indicate that the desire for a lifestyle

of more goods and more leisure has increased "substantially" since 1976. More young men and women consider it extremely important or quite important to have at least two cars, the latest clothes, a high quality stereo and a vacation home. Fewer think it important to "help others," to "correct social and economic inequalities, or to "develop a meaningful philosophy of life."¹²

Two years before Kent State, 83% of entering college freshmen surveyed nationally by the American Council on Education said they placed great importance on developing "a meaningful philosophy of life." Twenty years later, student response to that question was the lowest in the long history of that annual survey. At the same time their expressed desire to be "very well-off financially" rose each year.¹³

Becoming rich and famous has become a philosophy of life, and we need not expect these new colleagues to be radically different from their peers. They are, after all, our children. Perhaps we should shift the focus to an examination of ourselves, practitioners and educators alike, as role models for the now and future profession, and we need to take the longer view. A recent *New York Times* article quoted one observer who described today's youth as "loving luxury, hating authority, being bored and ill-mannered and lacking respect for adults." *The observation was ascribed to the fourth century B.C. philosopher, Socrates.*

These transformations in our society provide new thresholds for oral health care. Dental services will continue to be improved through advances in science and technology at an ever increasing rate. Our focus

will shift to primary care if we are to attend to public need and demand. This is our historic strength. We must find ways to be perceived as more caring in our relationships with patients, our understanding of systemic disease and aging and pathophysiology must increase. We must realize that the voice of the patient will be different and that we need to listen.¹⁴

What of regulation, that bane to our existence and a central theme occupying so much of our professional discourse today. I have not met a practitioner who denies that aspects of our current regulatory circumstance have improved the overall quality of care. But we are frustrated over this issue and want someone to do something. My prediction is that we will have more, not less, regulation in the days ahead. Environmental concerns about the safety and welfare of all citizens, especially those receiving personal health care services, are not likely to decline. We must work to insure that rational policies are developed and that the profession is proactive and not reactive.

The twin issues of access and quality will continue to confront us and we must find a way to face them directly. So far, we seem to be drugged with an overdose of habit-forming words. As a result, we have given way altogether to platitudes about quality and success. The access issue is one which we share with every citizen but if we are to continue to occupy a position of respect, our advocacy for accessible, available, and affordable quality oral health care for our fellow citizens must be real and palatable.

Assuring quality of care is very much within our reach if we choose to address it. Thus far, the profession's commitment to restructuring the means and mechanisms by which it is to demonstrate continued competence represents an unfinished agenda. A foundation president describes her dentist: "He has a 1985 clinic, but he's running it with a 1954 diploma. I simply can't count on him to be up-to-date. She went on to explain that the doctor had a proclivity to collect the latest instruments and gadgets for his practice, but he had not refurbished his intellectual kit of tools since graduation nearly four decades ago."¹⁵

Education in dentistry is prolonged and generally sophisticated. But because of expanding scientific knowledge and technology, and because professional care is increasingly complex, the need for lifetime learning can no longer be ignored. Our current efforts, including mandated continuing education credits, are inadequate to the task.

What finally then shall we say is the profession's responsibility to the nation in this decade and beyond? At present this answer is little more than a hunch, and perhaps I overvalue it because it is a recent idea and they don't come along all that frequently. It seems to me that any institution (and professions run the same risks as corporations, churches, universities, schools and governments) runs the risk of becoming set in its ways, rigid in its policies and doctrine, hard in the arteries and soft in the head.

And my hunch is this: in a world growing denser in population and poorer in sources of energy, we in-

evitably will have stricter political and economic organization in order to provide sufficient food and housing and occasional comforts. And in this sort of world, the caring, up-to-date professional will continue to loom among the finest expressions of a maturing mankind. But even more importantly, for me at least, these men and women may provide the day-by-day confirmation of a creator's hand still alive and at work in the lives and affairs of men. To me, it follows that the dental profession, if it wants to keep in touch with creativity, must provide a home for all that is, and all who are, creative, lest the profession itself wither and drift into irrelevance.¹⁶

You will have your own conclusions concerning the historical currents and the tides and shapes of the evolving philosophies which brought us to our present circumstance. But does it appear to anyone else that the dental profession in our time may have become so preoccupied with the door prizes attendant upon its success that it has not nearly fathomed the humanity of its origins? And does it appear that we are obsessively preoccupied with short-term goals, and thereby increasingly losing control of our destiny. To regain those original insights would represent a renewal of our public trust and go far towards encouraging the continued freedom of the profession in the future.

From all of this, and more, I conclude:

- That our profession is in trouble, losing its way economically and drifting apart as a social institution.

- That our oral health care system (if it can be called that) has failed to

work for far too many Americans, favoring special interests and the wealthiest of us only. Far too many of our children are at risk.

- That we need to rebuild, reuniting a highly balkanized profession with policies that put people at the center, investing in the more basic aims of primary oral health care for all, world class education for the future profession, and a commitment beyond rhetoric to pull people together again.

- That while we do not have a person or an hour to waste, the problems today are not nearly as great as our lack of faith that we can overcome them. That is the real obstacle.

Finally, it is one thing to have the vision to see where things are going and what needs to be done. It is quite another to have the courage to act on that information. Change is not inevitable, nor is it an anomaly. Change is man-made. Our problems are deep seated and our renewal will require not one heroic leader, but a generation of leaders who not only have vision but are willing to hammer at the anvil for long years to come.^{17,18}

These will be leaders great enough to inspire others and humble enough to be inspired by something larger than themselves.¹⁹ Many of them are in this room today. To them, I say: you may choose to be an observer in the universe or you may be an actor—making a difference by not asking, “what about me” but rather asking, “what about us?” Anything short of that will be a disservice to the talents you bring to the task. You have my admiration and respect and I wish you well.

References

1. Berry, W., *The Unsettling of America*, Sierra Club Books, 1986.
2. Holmes, Oliver, W., Quoted by Freund, P., *New Yorker*, 1992
3. The author is especially indebted to works by Warren Bennis, Peter Drucker, John Gardner, David Halberstam, Paul Kennedy, Kevin Phillips, Robert Reich and Barbara Tuckman.
4. *The Economist*, December 21, 1991.
5. *The Economist*, October 26, 1991.
6. Broder, D., *The Washington Post*, September 1992.
7. Draft Documents, Medicare, A Strategy for Quality Assurance Institute of Medicine, National Academy of Sciences, 1990.
8. Collins, R. J., et.al., What will the Future Bring, *J. American Dental Association*, Vol. 123, April 1992.
9. Loe, H., Personal Communication.
10. Morris, A.L., Personal Communication.
11. *The Economist*, October 26, 1991.
12. *Wall Street Journal*, May 16, 1991.
13. Johnson, H., *The Washington Post*, 1991.
14. Healthy America: Practitioners for 2005, Report of the Commission on the Health Professions, Pew Memorial Trust, October, 1991.
15. Mawby, R. G., Annual Report, W. K. Kellogg Foundation, 1991.
16. Paraphrase of Shaw, R., Music and Worship, Westminster Town Hall Forum, Westminster Presbyterian Church, Minneapolis, Minn., Audiotape, March 21, 1985.
17. Barker, B. D., The Willed Future: Thoughts Garnered from the Cheshire Cat, *J. Dental Education*, Vol 56:2, 1992.
18. Barker, B. D., O'Neil, E.H., Shaping the Future Profession: A New Tableau for Dental Education, *J. Dental Education*, Vol 56:4, 1992.
19. Evans, E. N., President's Report, Charles H. Revson Fdn., 1990.

Reprint requests to:

Dr. Ben D. Barker
School of Dentistry
University of North Carolina
Chapel Hill, NC 27599-7450

Convocation Address:

REFLECTIONS ON A CAREER IN DENTISTRY

Joseph A. Devine*

I'm particularly glad to have this opportunity to speak to the best of the best, the Fellows of the American College of Dentists. Only a select group of people enter the dental profession in the first place, and today I'm talking to you, the top two percent of this already select group.

My topic here today is "Reflections on a Career in Dentistry." I want to say a bit about why I chose to become a dentist and then share my thoughts about professionalism, ethics, legislative activities, problems with licensure and relationships between specialists and general practitioners. I also want to share my thoughts about your Fellowship.

First — how did I become a dentist? Well, I barely did. I was in the half of the class that made the upper half possible.

I became a dentist because my father was a dentist and I thought he was a great person. When I was out with my father as a child in Cheyenne, I liked the way people called him "Doc." People sought his advice, and there seemed to be an inherent dignity in his professional status.

All my life since I graduated from dental school, I have felt good about being called "Doctor." I think that is

very important, and I think that what matters the most are the things you, yourself, do to earn the respect that comes with that title.

When I was getting started in practice, seven of the twenty or so practitioners in my town were dentists who had started as associates in my father's office. I naively thought that, out of some sense of loyalty to my father, they would send some patients my way. Well, they were very nice to me, but they didn't send me any patients.

The lesson that we have to get across to our young colleagues is that it's not the responsibility of the American Dental Association or your colleagues to make you successful. You're the one with the education, you're the one with the talent, and it's up to you to become successful.

ACD Fellows are the experts when it comes to practice management, and one of your responsibilities is to take every opportunity to talk to young practitioners about practice management.

While you're at it, you can preach to them a little bit about the next subjects I want to discuss here today — professionalism and ethics.

There's a dentist in a nearby town who always managed to do his dentistry a little cheaper than the offices in Cheyenne. He could always take a treatment plan of mine and figure a way to do it for a little less.

Well, I went to an older and wiser dentist, as I hope young men and women in the profession will come

to each of you, and I said, "We have to do something about this. We have to let people know that this dentist is not doing good work."

This older and wiser dentist said, "You know, he went to the same accredited dental school as we did, he has taken the board examination, he is licensed and he is our colleague. You say bad things about him and it reflects on *you*. You cannot throw mud on your colleague and not get yourself dirty."

Let me tell you another little story that occurred in my practice.

When you live long enough, you not only get to treat the children of your patients, you get to treat their grandchildren. A few years ago, a little four-year-old boy came into my office with his mother. I had treated the mother before, and I knew she was having a tough time. Her husband had left her, and she had two or three children and not very much money.

She said, "I asked my son what he wanted for Christmas and he said, 'I want my tooth to stop hurting.' I have saved up \$25. Is that enough?"

Well, I wouldn't take that money. I didn't *have* to. Many years before, the older and wiser dentists in Wyoming had started a program called the Marginal Children's Program — to provide government help for parents who couldn't afford to take proper care of their children's teeth. I treated that child for a reduced fee, and I was happy to do it.

* Joseph A. Devine
Cheyenne, Wyoming
Past President
American Dental Association

We also have a senior program now to help our older citizens maintain their dignity. They get a little help from the state, and therefore I can treat those patients for a reduced fee as well.

Professionalism and ethics means personal attention and personal interest for each patient, no matter what their circumstances are.

Now I'd like to say a few words about dental advertising:

I HATE IT!

Pardon me, but I have wanted to say that for about seven years.

There's a beautiful song that Whitney Houston sings: "If I fail or I succeed, at least I'll live as I believe." Well, I am not going to be in the Yellow Pages and I will guarantee you that. As Whitney says, "No matter what they take from me, they can't take away my dignity."

So I want you to help me remind everybody in our profession of some facts.

The Supreme Court never said that dentists have to advertise and the Federal Trade Commission never said that dentists have to advertise. What they said was that we couldn't restrict people who choose to do it unless they advertise something that is false or misleading. I hope that you will work with me to persuade the dentists, who are determined to place ads all over the Yellow Pages, to at least say something useful that will help people.

One of the reasons this American College of Dentists was formed was because of professional advertising. That was one of the purposes of the College when it got started: to get the learned professions to turn away from advertising, not because it did not work, but because patients were being deceived. Our Founders

thought that the honorable thing to do was to turn away from advertising.

Now I want to spend a little time on a noncontroversial issue — licensure.

When you are the President of the American Dental Association, members write many letters saying that you are doing a great job. But most of them go on to say that they are writing to complain about the licensure system.

And, as President, you get phone calls. We had a President some years ago who said that 90 percent of the calls were about licensure. I don't know how it is now, but I know that it is not a minor issue.

When I was President of the ADA I came up with the idea that I would call each of the members who wrote to me about licensure and I'd talk to them about ADA policy. I would call and say, "This is Dr. Devine. I'm the President of the American Dental Association." The receptionist would say something like, "We already receive all of your magazines." I would reply, "No, your doctor wrote a letter to me. I would like to talk to him."

Then the doctor would come to the phone and say, "Are you really the President of the American Dental Association?"

I wasn't surprised that they were skeptical and I would say to the dentist on the phone, "Tell me. Do you have a shortage of dentists in your state?" When the dentist answered "No," I would say, "Well, would you like the American Dental Association to come to your state and help you change the Practice Act so you could credential dentists and have a more liberal policy?"

I don't think I have to tell you how they reacted to that. You know the

famous survey that said 75 percent of the dentists in this country want credentialing or reciprocity? My answer to that is: "Then why is it that 38 states do not have it?" It's very simple. Everybody wants the law changed in another state.

Back in 1968, we did the study that reported 75.7 percent of dentists approved of reciprocity when asked the following question: "Are you in favor of complete licensure reciprocity among all states, whereby dentists licensed in any state would be allowed to practice in any other state?"

To say that 75.7 percent of dentists responded "yes" does not tell the whole story. If you do a regional breakdown, it shows that 65 percent of the dentists in the far west and 55 percent of dentists in the southwest opposed reciprocity, while 94 percent of the dentists in the midwest and 91 percent of those in New England favored it. So the figures can be misleading.

Now you all know what ADA policy on this issue is. And I think you also know what reality is. You have to accept the fact that examiners practice in the state where they give the examination. I would suspect that they are much more swayed by the feelings of the dentists in their state than they are ever going to be swayed by ADA policy.

Nonetheless, I believe progress on this issue is going to be quicker than you may think. And the younger practitioners need to understand that it is a lot better than it used to be, even now.

The reason I'm so sensitized about this issue right now is because there have been proposals to turn the licensure process over to the federal government—you know, the folks

who call everything outdoors the Department of the Interior.

I know that Florida is the state that is particularly picked on for whatever reason. But I am told that, in the past five years, Florida has licensed 1750 new dentists. That's more dentists than we *ever* had in Wyoming.

Dentists do pass the Florida test. But let me tell you, when I talked to those who didn't pass, not a one of them would say, "They flunked me," or "They would not give me a license." They are very bitter human beings. Several of them did say, "I guess I'll have to quit the ADA," and all I could say was, "We'll miss you."

Why pick on the ADA? Unlike the federal government, the ADA doesn't go anywhere it's not invited. And I think that is good policy — not just on the licensure issue but in general.

Suppose the delegates at a session of the ADA House say that they want such-and-such a policy enacted. If the ADA were to send a representative to the Wyoming legislature to testify in favor of a law, and the dentists in Wyoming were to testify against it, I think the local voice would prevail.

So I ask you to be patient. The things that are occurring this year are very beneficial. I ask you not to think of doing away with board examinations. Change them, modify them, do whatever you want — but let me tell you this: those people out there who are so anxious to give licenses have never tried to get one back. *That* is an agonizing process.

One more item, and then I'll close. Let's talk about the specialist and the generalist. This is one of the problems, for which I naively thought I might find a solution, when I was President of the ADA. I ap-

pointed a committee, and the report of the committee is buried someplace.

We have cut back freshman classes 25 or 30 percent. The specialties have cut back maybe 10 or 15 percent around the country. There is perhaps a disproportionate supply of specialists, so I guess I am going to lay this onus on the specialist.

As a specialist, be grateful to dentists like me — and I don't mean this in a self-serving way. I refer patients I cannot treat and I do it gladly. I expect you to be appreciative. I want you to go and talk with any dentists you think are giving you a bad time and be fair with them. And say to them, "If you want to attempt this procedure, come and talk to me about it. If I tell you not to attempt this case, respect my judgment. If you want to attempt the case, I'd like to help you *before* you get in trouble."

In the extreme case, the specialist can politely say, "If you continue to do this, you are going to be on your own." Maybe that would bring some sanity to this whole issue, because what really matters is that people receive the kind of care they need and deserve.

Now I'd like to close stating my feelings about your Fellowship. My father graduated during the Great Depression. He was going to lunch one day when he saw a graduate dentist from Creighton University who was *working on the railroad*. When my father asked him why he was doing this, the answer was, "Doc, I don't have any money to open an office."

My father said, "You come up to my office and start practicing there."

Eventually, this dentist, Jack Ryan, became the President of the Chamber of Commerce. Every week,

his picture was in the local paper with a story about something he was doing for the city of Cheyenne. As a child, I found all of this interesting but when there was a notice in the paper that Jack Ryan was going to become a Fellow of the American College of Dentists, I didn't know what that was. I think I was already beginning to understand the very basic principle that Jack Ryan's life represented—the principle that you can't expect your community to support you if you don't support your community.

Jack Ryan was community-minded. He was a good dentist. He was kind to the young dentists. He practiced quality care. And he deserved that Fellowship, just as each of you do. He didn't know anything about practice management, but I think he discovered some of our modern principles of marketing by just doing what he was doing.

So I'm going to ask all of you now to cultivate your relationships with your colleagues, especially the younger ones. Remember — you are the professional experts. Do not be discouraged!

I want to close by reminding you of my motto: "If you want to be treated like a doctor, you have to behave like a doctor." You're no longer just doctors — you are Fellows of the American College of Dentists. Be a role model. Make me proud of you.

Thank you for listening.

Reprint requests to:
Dr. Joseph A. Devine
219 East 20th Street
Cheyenne, WY 82001

The Development Of A Professional Role Orientation Inventory

Muriel J. Bebeau*

David O. Born**

David T. Ozar***

This paper describes the development and testing of the Professional Role Orientation Inventory, a 40-item Likert-type instrument designed to assess a dentist's perception of his or her professional role. The test includes four 10-item scales representing four attitudinal dimensions: Authority, Responsibility, Agency, and Autonomy. The study describes differences between and among groups of professionals and dental students who took the test. Responses to the various scales suggest that practitioners do have different conceptualizations of their professional role, though these conceptions vary somewhat from the various models of professionalism described in the literature.

Philosophers^{1,3} describe several models of professionalism to explain the interactions between professionals and their patients or clients. Although each of the eight or ten models described presents a plausible explanation of the way a practitioner might articulate his/her professional role, there is no empirical evidence that professionals see themselves in terms consistent with the various models, or that such conceptualizations actually guide daily practice.

In a preliminary study,⁴ we noted that simply asking practitioners to describe their role concept, or to select from model descriptions a view most consistent with their role concept, did not reveal differences among practitioners. We hypothesized that practitioners, familiar with the changing rhetoric⁵ of an ideal doctor/patient relationship, simply describe themselves in terms of the most socially desirable ideal. In other words, they recognize socially accepted values, and appear to subscribe to them. A key question is whether these "socially desirable" ideals actually guide daily interactions. In lieu of direct behavioral observation, we believe that sets of items describing various dimensions of the professional's role (organized around themes common to the various models) could tap into a more valid view of the professional's role concept. Further, an instrument for role model classification might be useful for diagnostic and educational purposes.

The objective of this research was to develop an instrument which would differentiate among professionals who hold alternate views of their professional role. This paper describes the development of the measure and reports differences within and among groups of dentists and dental students who might be expected to hold different views of their professional role.

Methods

The Authority and Responsibility Scales

Scales were developed to assess four dimensions of role concept. Existing models¹⁻³ were reviewed to identify underlying themes. Two themes, Authority and Responsibility, emerged.

Authority refers to the degree to which a person sees the self as knowledgeable, a good judge of outcomes, respected, and deferred to for expertise. Persons having a strong sense of their own authority believe that their judgments and opinions ought to be respected and given weighty consideration. They believe that they typically know "what's best" for themselves and others in matters dealing with their profession. Persons for whom authority is not a critical component of their cognitive-moral makeup tend to believe that other people's judgments are as deserving of consideration as their own. Items reflecting current professional issues were written to represent either a strong or weak Authority dimension.

* Muriel J. Bebeau, Ph.D.
Associate Professor
Division of Health Ecology
Department of Preventive Sciences
School of Dentistry
University of Minnesota

** David O. Born, Ph.D.
Professor
Division of Health Ecology
Department of Preventive Sciences
School of Dentistry
University of Minnesota

*** David T. Ozar, Ph.D.
Associate Professor
Department of Philosophy
Loyola University Chicago

For example: 1) "Once a patient decides to use my service, he/she should follow my advice without questioning my authority," as compared to 2) "The public should have more control over health related policy and regulatory agencies."

The notion of **Responsibility** refers to the breadth of an individual's commitment to others. The notion of "sense of responsibility" represents a continuum of feeling. At the strong end, we find individuals who typically see their role as including some direct or indirect caretaking of the disadvantaged and the public at large. In contrast, at the weaker end, we find individuals who tend to believe that each individual is fully capable of taking care of him or herself and that if people look after their own affairs, then society will function most effectively.

Items were written to represent either a strong or weak Responsibility dimension. For example: 1) "I feel I have an obligation to use my knowledge and skills to help those who cannot pay for my services," as compared to 2) "My first professional obligation is to myself."

None of the models described in the literature neatly fit the operational definitions that emerged for the four possible combinations of these two dimensions: 1) high on Authority, low on Responsibility (a version of Ozar's commercial view); 2) high on Authority; high on Responsibility (a version of the guild model); 3) low on Authority, high on Responsibility (a kind of service model); and 4) low on Authority, low on Responsibility (a kind of agent model — reminiscent of the "hired-gun" in law). Thus, we developed model descriptions that borrowed from existing models and which were consistent with our operational definitions. The following model descriptions corre-

spond to the four sets of conditions stated above. None represent an ideal.

The Commercial Model. Persons ascribing to this model take the view that the dentist has products and services to sell to patients. The doctor-patient relationship is a function of marketplace exchanges, with neither party having obligations to the other until a "contract" is agreed upon. Relationships among professionals, though friendly and supportive, are seen essentially as competitive. Extending this view, it can be seen that in the competitive marketplace, patients and third-party providers are out to minimize costs, dentists are out to maximize profits. The notions of quality and excellence are benchmarks against which competitors may be judged and which can be held out to consumers (patients) as "reasons to buy." Public regulation and involvement in the profession's activities ought to be minimized since it represents an intrusion on the dentist's ability to practice his profession freely and unencumbered.

The Guild Model. Persons ascribing to this model hold to the notion that the dental profession has a tradition of developing and perpetuating an exclusive domain of knowledge and skills. The dental professional is, therefore, an expert whose judgment should be respected and followed. Laypersons cannot be expected to understand what the dentist has been taught, nor can they possess the clinical and decision-making skills the dentist has. Therefore, in treatment decisions, the patient should follow the dentist's judgment about what is best. Because the profession has been entrusted with this exclusive knowledge, dentists have an obligation to society to respond to patient's needs, even when it may be inconvenient or

unprofitable. Public regulation and involvement in the profession's activities ought to be minimized because it is unnecessary. The profession itself assures the public of the best possible care. Thus, holders of this view believe that the profession is essentially maternal or paternal and will automatically look after the good of society without the need for governmental involvement.

The Service Model. Persons to whom the Service Model seems most reasonable tend to approach their profession with a nearly selfless devotion, often sacrificing personal and familial needs in favor of serving their patients and the public at large. These persons see that they have been given special privileges (i.e., advanced training and skills) which are not readily available to most people. Having had this privilege, they are obligated to serve humanity. The public's health and welfare ought to come first; remuneration and status rewards are of secondary concern and it is assumed that they may follow in due course. Public involvement in the regulation and administration of health care ought to be encouraged because, in a fundamental sense, the profession belongs to society. Additionally, persons holding this view generally believe that disadvantaged persons ought to be assisted and protected.

The Agent Model. Agents are essentially persons with skills and knowledge "for hire." Persons who hold this view of their profession believe that their primary, if not sole obligation is to fulfill the patient's goals. The extent of this obligation is such that the dentist ought to comply with the patient, who is given the last word in making decisions on what services should or should not be performed. Since the commitment is to

the patient exclusively, there is little or no sense of obligation or responsibility to external organizations such as insurance companies or governmental agencies. Likewise, the dentist has little or no obligation to non-patients, since they can, if they so desire, find another dentist to take care of their problems. Regulatory agencies have certain policing functions to help keep "renegade" practitioners in line, but such activities ought to be controlled so that they do not interfere with meeting the patients' needs. Ultimately, the dentist is an independent operator who is free to develop and promote his or her own career in the most advantageous way possible.

(These model descriptions were used in a construct validity study, currently in progress.)

The Agency and Autonomy Scales.

Recognizing that how one sees his/her role is only part of whether one will act on that perception; we also developed item sets around the ideas of Agency and Autonomy. These ideas come from the psychological literature on "locus of control," showing that individuals differ considerably in perceptions of agency and autonomy.

Agency refers to the extent to which an individual feels a sense of control and power in his/her life as a practicing professional. A person with a strong sense of agency would feel that he or she can control his/her own destiny, can effect significant changes in the course of the profession, and can play an active role in making things happen. Those feeling a lower sense of agency feel comparatively powerless and controlled by external events. The following items are ex-

amples of the pool of items created to reflect a strong and weak Agency dimension: 1) I am effective in resolving office personnel problems. 2) It's nearly impossible to influence regulatory bodies that control auxiliary utilization.

Autonomy refers to the extent to which an individual feels freedom and independence in his/her role. A person with a strong sense of autonomy is self-assured and feels comfortable acting on his/her own judgments with little concern for approval of patients or peers. In contrast, a person with a low degree of autonomy would feel most comfortable operating with organizational support, and would tend to seek approval of patients and peers. The following items are examples of the pool of items created to reflect a strong and weak Agency dimension: 1) I feel free to practice my profession in my own style and according to my own preferences. 2) Regulations and the threat of lawsuits make it nearly impossible to manage my practice as I wish.

Eighteen items were developed for each of the four dimensions. Each of the three authors agreed on the face validity of the items in the context of its associated dimension. Of the 18 items related to Responsibility, nine focused on responsibility to one's self versus responsibility to one's patients. The other nine focused on responsibility to one's self versus more generalized "others" (such as insurance companies, auxiliaries, family members, or society-at-large). Items tapping the Authority dimension were split between the respondent's perception of appropriate authority relationships between the profession and society, on the one hand, and those between the practitioner and patient, on the other. Items assessing Agency and Autonomy reflected the degree of

identification with one's sense of personal empowerment (Agency) or personal competency and self-directedness (Autonomy). Respondents were instructed to indicate (on a scale ranging from 1 to 6) their agreement with strongly worded statements addressing the four dimensions. While we believed reasonable people might hold the extreme view on some statements, few were expected to hold extreme views on all dimensions.

Sample

A 72 item instrument (4 x 18) was pre-tested with a small sample of dentists to assess item and instructional clarity. A modified form was distributed to 116 members of the Upper Midwest Region of the American College of Dentists. Three undeliverable and 76 completed forms were returned; a response rate of 67 percent. Shortly thereafter, 78 first year and 66 third year dental students also completed the instrument. Based on an examination of raw scores and of correlations within and between individual scales (dimensions), ten items were retained for each of the four dimensions. The authors currently are preparing a report examining validity and reliability issues associated with the 40-item instrument.

The 40-item version of the instrument was administered to 40 dentists (all members of the American College of Dentists) and eight ethicists who attended the Seattle seminar (sponsored by the American College) to train ethics workshop leaders. The 40-item version was also administered to 78 graduating dental students. The results presented below reflect data on two dental and two dental student groups. For the groups which took the original, 72-item version, only scores for the final set of 40 items are included in this analysis.

Results and Discussion

Table 1 shows subscale means and standard deviations for each group. Examination of these data indicates considerable variability, suggesting that professionals have distinctly different views on each of the dimensions represented in the inventory. Thus one of our objectives, to create sets of items that would differentiate between professionals, was achieved.

Figures 1-4 show individual scores plotted on the Authority and Responsibility dimensions for each group of respondents. To determine an individual's preferred model of professionalism, individuals were located on these grids, with locations determined by plotting sums of the Responsibility and Authority item scores. Scores on each dimension range from 10 to 60. We classified an

Table 1. Scale Means and Standard Deviations for Groups completing the Professional Role Orientation Inventory

Scale	1st Year Students (n=78)		4th Year Students (n=78)		Upper Midwest ACD Fellows (n=76)		Seminar Participants (n=48)	
	\bar{X}	S.D.	\bar{X}	S.D.	\bar{X}	S.D.	\bar{X}	S.D.
Authority	35.9	5.3	36.4	4.5	36.7	5.7	38.2	6.4
Responsibility	39.3	5.3	42.7	4.6	38.5	6.9	44.3	6.2
Agency	41.3	4.8	38.6	6.0	34.1	7.6	40.0	9.2
Autonomy	37.8	4.1	34.5	5.5	34.7	5.9	34.8	7.4

individual as a clear proponent of a particular model if his/her score fell on or outside the second concentric circle. The first circle represents five points on either side of the midpoint (35) of the scale. The second circle represents 10 points on either side of the midpoint, etc. These circles are not empirically derived, but serve as a point of reference for comparing the distribution of the various

groups. Scores within the second circle were identified as leaning toward the model identified by the quadrant. Scores falling within the first concentric circle chose a middle ground between the extremes, but should not yet be interpreted as an ideal, such as Ozar's interactive model. Identification of an "ideal," and even whether a score in a particular quadrant actually represent

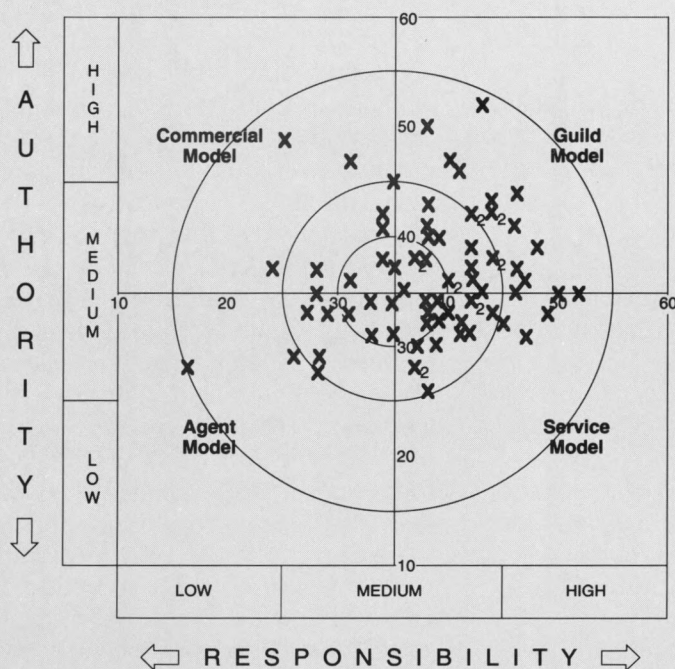


Figure 1: Upper Midwest ACD Fellows

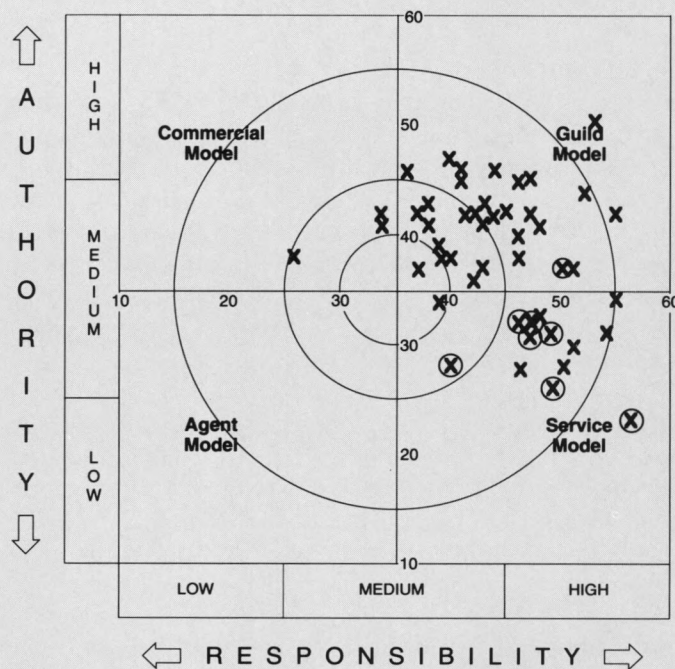


Figure 2: Seattle Seminar Participants

the model implied by the location of the score within the quadrant, awaits further validation.

Figure 1 plots the 76 American College Fellows from the Upper Midwest Region of the College. These dentists hold rather diverse views of their role, with 14 rather clearly holding to the guild model of professionalism, and about equal numbers tending toward the guild and service models. The agent and commercial models each drew three practitioners who clearly subscribed to those views of the professional's role, and three or four practitioners who tended toward the agent and commercial views.

Figure 2 shows the scores of 40 American College Fellows and eight ethicists. As shown, these respondents demonstrate a sense of their professional authority which is consistent with the group of fellows from the Upper Midwest Region (the means

are not significantly different), but they express a significantly ($p < .00004$) greater sense of responsibility to others than do their Upper Midwest Colleagues. Figure 2 also shows how the eight ethicists (circled x's) compare with the views of the dentists in attendance. As a group, the ethicists hold a slightly stronger view of the professional's responsibility toward others and think that less authority should be vested within the profession and the professional. In other words, the ethicists generally subscribe to the service model of professionalism.

Figure 3 shows the scores of 78 first year University of Minnesota dental students and Figure 4 shows the scores of 78 graduating seniors. The seniors had all completed a well-validated ethics curriculum.⁶ As you can see, the first year students' pattern of scores is more similar to the

upper Midwest dentists than to seniors or seminar participants. First year students Authority and Responsibility scores were not significantly different from Upper Midwest dentists, but first year students' Responsibility scores were significantly lower ($p < .00008$) than either seniors or seminar participants. Differences on the Authority dimensions reached significance only between first year students and Seminar participant ($p < .02$), with Seminar participants scoring 2.3 points higher. Differences between groups may become apparent when the five items examining practitioner/patient issues are compared with items evaluating profession/society issues.

Figures 5-8 show individual scores plotted on the Agency and Autonomy dimensions for each group of respondents. Individuals were located on these grids, with locations determined

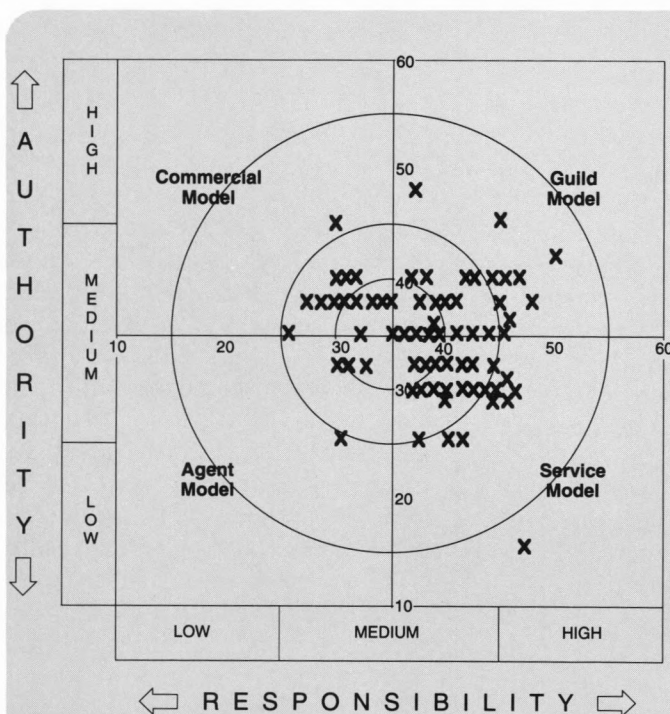


Figure 3: First Year Dental Students

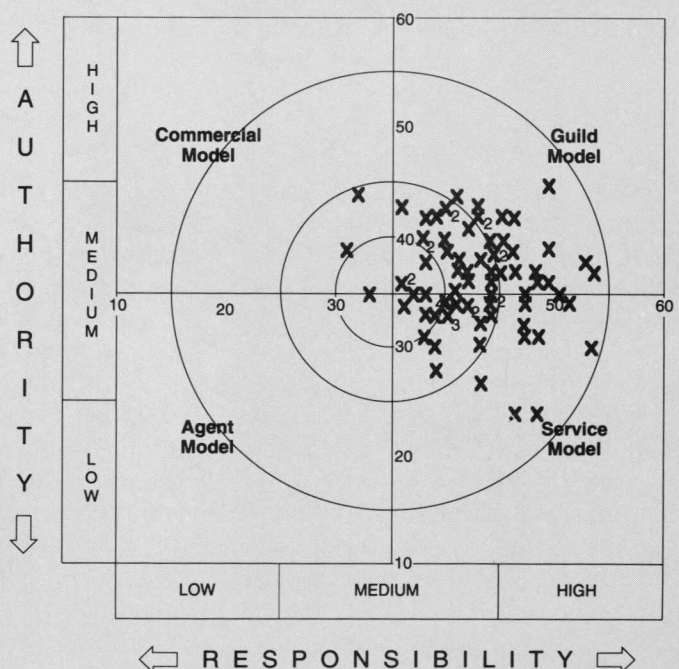


Figure 4: Fourth Year Dental Students

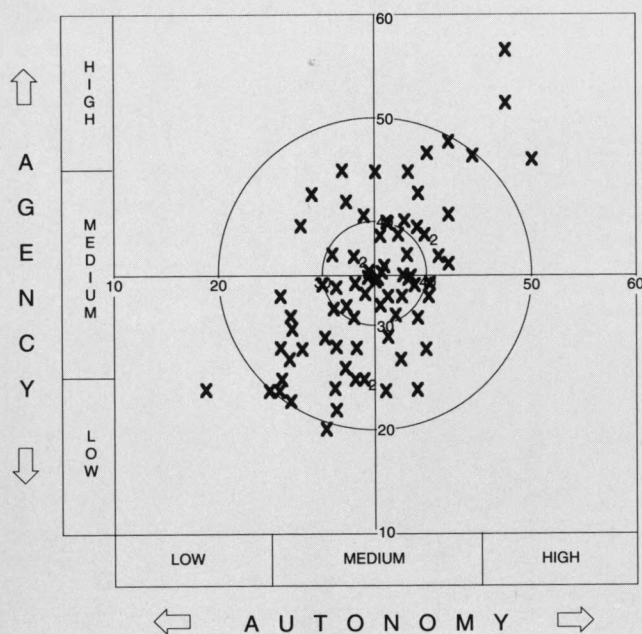


Figure 5: Upper Midwest ACD Fellows

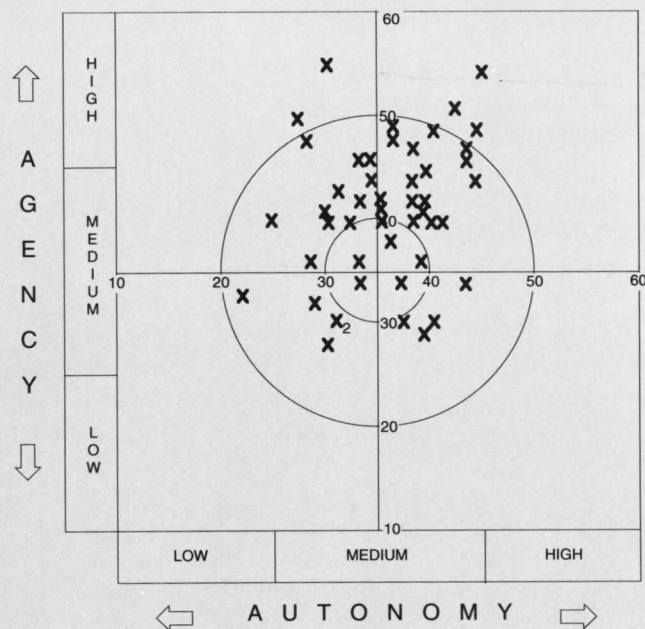


Figure 6: Seattle Seminar Participants

by plotting sums of the Agency and Autonomy item scores. As with the Authority and Responsibility scales, scores range from 10 to 60 on each dimension.

As indicated in Table 1, Seattle Seminar participants exhibit a significantly greater ($p < .00009$) sense of agency than do their Upper Midwest colleagues, but do not differ on the sense of autonomy. Likewise, seniors expressed a sense of agency comparable to Seminar participants, but significantly stronger ($p < .00009$) than the Upper Midwest Fellows. Interestingly, first year students demonstrate the highest scores on both the Agency and Autonomy dimensions. Their Autonomy score is significantly higher than any other group ($p < .00003$), and their Agency score is significantly different from each group ($p < .002$ when compared with seniors) except the Seminar

participant. It will be interesting to follow this group of first year students to see whether their sense of agency and autonomy alters as a result of socialization to the profession.

A person with a strong sense of agency would feel able to effect changes in the course of the profession, and would more likely play an active role in making things happen. Those feeling a lower sense of agency feel comparatively powerless and controlled by external events. What we don't know, is how strong a sense of agency and autonomy one needs to be an effective change agent. Seminar participants are expected to work actively to implement ethics workshops in their region. They volunteered for this task, and they did demonstrate a greater sense of agency (40.0 vs. 34.1) than their colleagues.

Summary and Conclusions:

How a professional decides to act when confronted by an ethical problem depends in part on how he or she conceptualizes his or her role and responsibility toward others. Though professional values and ideals are presented in codes of ethics, in ethicists' descriptions of the professionalism models, and in the rhetoric of reform,⁵ there is little research indicating how such ideals have been internalized and how they influence professional behaviors. Moral psychologists⁷ believe that professional behavior is dependent upon the development of four complex processes: moral sensitivity; moral reasoning and judgment; moral motivation and commitment; and moral implementation. Role concept is seen as a dimension of motivation and commitment which influences the prioritization of professional over

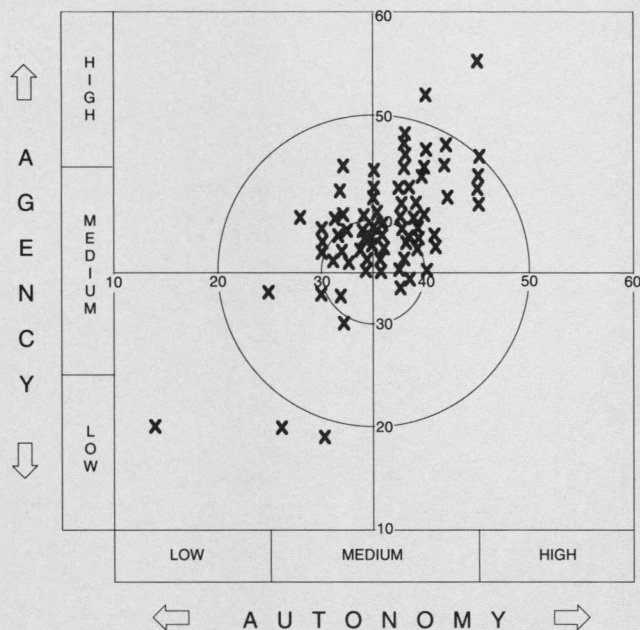


Figure 7: First Year Dental Students

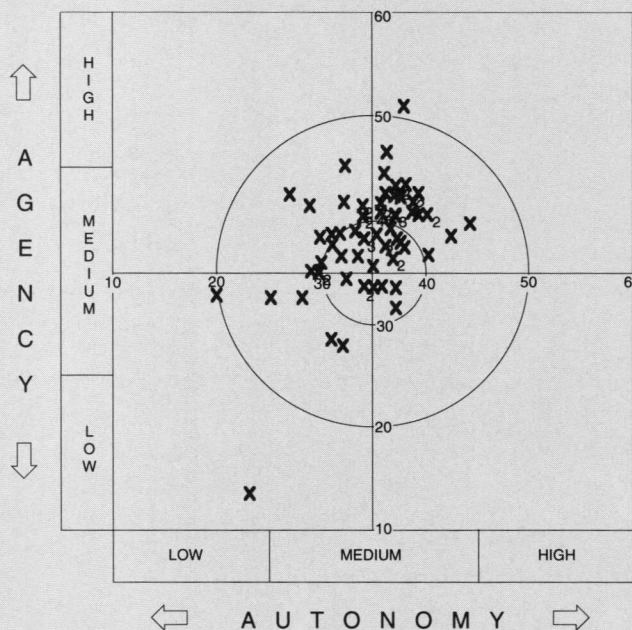


Figure 8: Fourth Year Dental Students

personal values. Prior research⁷ on motivation and commitment has assessed values and value preferences, but these have not been operationally linked to the various models of professionalism philosophers see operating in professional contexts. This research is a first step in that direction.

This study investigated the potential for developing an objective measure of a professional's role concept based on philosophers' conceptions of role-concept differences. Preliminary findings from the testing of four scales designed to assess role concept indicate that each scale is sensitive to individual differences, and at least three of the scales are sensitive to differences between groups within the dental profession. Differences are apparent between beginning and advanced dental students and between dentists who are members of the

American College of Dentists, an organization committed to promoting the profession's values, and their colleagues who demonstrated special commitment to professionalism by volunteering to become ethics seminar leaders. Though these preliminary results are encouraging, further work on the validity and reliability of the measure is warranted. Also, adaptation of the measure for work with other professional groups could enhance our understanding of role concept development and the factors that influence it.

References

1. May, W.E., *The Physician's Covenant: Images of the Healer in Medical Ethics*. Philadelphia: Westminster Press, 1983.
2. Veatch, R.M., *Models for Ethical Medicine in a Revolutionary Age*. Hastings Center Report, 2:5-7, 1972.
3. Ozar, D.T., *Three Models of Profession-*

alism and Professional Obligation in Dentistry. *Journal of the American Dental Association*, 110:173-177, 1985.

4. Bebeau, M.J., *Dentists' Perceptions of their Model of Professionalism*. Technical Report #27. Center for the Study of Ethical Development, University of Minnesota, 1989.
5. Priester, R., *Rethinking Medical Morality*. Center for Biomedical Ethics, University of Minnesota, 1989.
6. Bebeau, M.J., *Teaching Ethics in Dentistry*. *Journal of Dental Education*, 49(4):236-243, 1985.
7. Rest, J.R., *Morality*. In *Manual of Child Psychology*, (Edited by P. Mussen), Vol 3: Cognitive Development, Edited by J. Flavell and E. Markham. (556-629) New York: Wiley, 1983.

Reprint request to:
Dr. Muriel J. Bebeau
School of Dentistry
University of Minnesota
Minneapolis, MN 55455

Dedication of ACD's New Office

The College officially dedicated their Executive Offices on April 17, 1993. The dedication ceremony was held in the courtyard at the Gaithersburg, Maryland office complex. A reception followed the ceremony and allowed guests to tour the new facilities.

The offices leased to the American College of Dentists by the American College of Dentists Foundation include three adjoining condominiums integrated to form an efficient environment for management and support.

Upon entering the offices, one steps into a large reception area with a glass-enclosed loft. This reception area provides space for a staff member, as well as for recognition of the Founders of the College, the Founders of the Foundation, the Past Presidents of the College and the display of historical records of the College. A special display identifies all those who supported the Campaign for the 90's, the fund drive of the American College of Dentists Foundation that made the purchase of the new facilities possible.

The loft area, named The Charles W. Fain, Jr. Room, serves as a library/conference room. Books authored by Fellows of the College, together with the official records of the College are housed in enclosed bookcases. In addition, the Malcolm W. Carr Alcove houses the library of the late Past President, including a comprehensive collection of books on the history of dentistry. The conference table provides facilities for committee meetings and individual study.

After leaving the reception area, one enters the executive office area. Strategically located, all operational activities of the College originate



The New ACD National Office at Gaithersburg, Maryland.

here. This space includes the office of the Executive Director which provides ample room for individual conferences with visitors and staff. The Executive Assistant is located immediately outside the executive office.

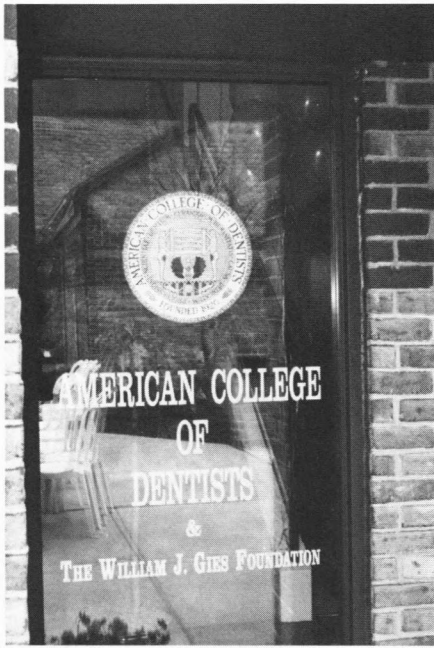


ACD President Albert Wasserman addresses the group at the Dedication Ceremony.

Adjacent to the executive area are the administrative areas. This space provides workstations for three staff, with direct access to member files, administrative records, mailroom packaging and all other support facilities for membership Section support, annual meeting, publications and correspondence. This area flows into a large multifunction room equipped with a sizeable conference table, copy and fax machines, microfiche reader and supplies. This room, named the Samuel D. Harris Room, provides the facilities for staff conferences and for assembly of materials and mailings.

The William J. Gies Room adjoins this area and houses PC computer equipment used for desk-top publishing and other special functions. All records of the William J. Gies Foundation for the Advancement of Dentistry, Inc., for which the College

Continued on page 35

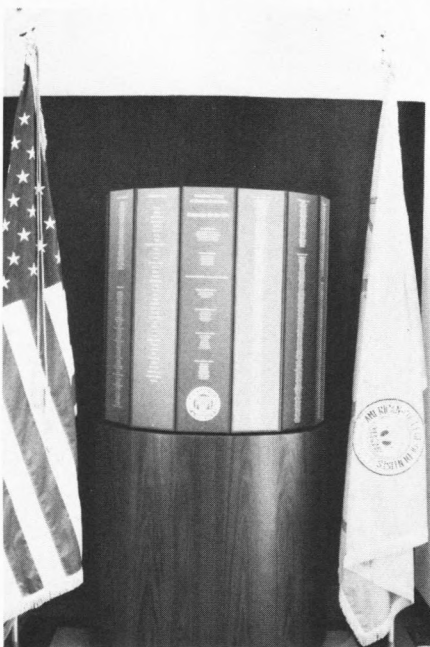


The entrance to the new ACD National Office.

provides administrative support, are housed here, as well as selected William J. Gies memorabilia, particularly those items noting Dr. Gies' contribution to the College and to the *Journal of the American College of Dentists*.

A room housing the College's central computer and a large file room link together the administrative work areas.

Continued on page 36



The Carousel in the reception area which contains the names of all contributors to the Campaign for the 90's.



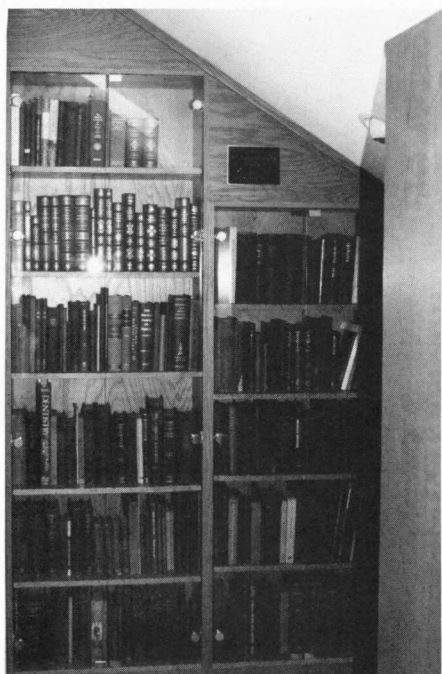
Pictured cutting the ribbon to formally open the new ACD National Office are, left to right, President Albert Wasserman, Immediate Past President Thomas W. Slack and James A. Harrell, Sr., the Chairman of the Campaign for the 90's.



The stairway to the Charles W. Fain, Jr. Room with portraits of the four Secretaries who have served the College since it was founded: left to right, Albert L. Midgely, Otto W. Brandhorst, Robert J. Nelsen and Gordon H. Rovelstad.



Executive Director Sherry Keramidas addresses the group who attended the Dedication Ceremony on a sunny, but brisk and windy, April day.



The Malcolm W. Carr Alcove in the library includes a comprehensive collection of books on the history of dentistry.



The conference area of the Charles W. Fain, Jr. Room, located in the loft area, which provides facilities for committee meetings and individual study.

The finance office is at the end of the facilities. The Comptroller of the College and all accounting and financial records are located in this area.

The new facilities include two additional spaces. The first is a general store room and bulk storage area. The offices also include a small

kitchenette that accommodates staff and committee functions.

With all spaces open and easily accessible, one notes that it is possible for staff members to effectively carry out individual and group tasks. In addition, with windows throughout the office looking out on landscaped courtyards and a suburban neighborhood, the of-

fices offer the staff and visitors a pleasant atmosphere within an efficient work environment and certainly an impressive home for the American College of Dentists, the American College of Dentists Foundation, and the administrative support of The William J. Gies Foundation for the Advancement of Dentistry, Inc.



One wall of the reception area where a listing of Past Presidents is placed on a plaque (center) over a table which displays books on the organization of the College, original letters and other College memorabilia.



Pictured is one of the bright and pleasant working areas of the office with Pamela Montano (foreground) and Jo-anne Frost at their desks.

Study Mission to India and Nepal

American People Ambassador Program

Prem S. Sharma*

A delegation of eight Fellows of the American College of Dentists participated in a study mission to India and Nepal March 12 - 28, 1993. The Study Mission was sponsored by the American People Ambassador Program of People to People International. The delegates were Dr. Raymond T. Bond, Alexandria, Virginia; Dr. Malcolm D. Campbell, Plymouth, Michigan; Dr. L. J. "Bud" English, Arcadia, Wisconsin; Dr. Robert E. Friedman, Fairfield, Connecticut; Dr. Aubrey N. Stephens, Ketchikan, Alaska; Dr. Harvey H. Wipf, Redlands, California and Dr. Julian B. Woelfel, Columbus, Ohio. I was honored to be asked to serve as the delegation leader.

People to People International was founded by President Dwight D. Eisenhower in 1956 with the idea of having an organization with a nucleus of business leaders dedicated to the pursuit of world peace through personal contact. Delegations travel abroad to "meet with their counterparts and share ideas, methods and techniques, successes and failures, dreams and goals." Since 1957, more than 60,000 delegates have made such contacts in almost every country of the world.

March 14, 1993 New Delhi, India

Members of the delegation arrived in New Delhi on Sunday, March 14 and met for an orientation session at their hotel. Seven of the delegates were accompanied by their wives and the delegation was also joined by a tour manager.

Arrangements for visits to dental schools, clinics and private offices were made by Dr. Lovelin Gandhi, President of the Indian Dental Association. Dr. Gandhi is a Fellow of the American College of Dentists and is the recipient of the highest civilian award presented by the President of India for his humanitarian work.

In New Delhi the delegation visited the All India Institute of Medical

Research and Sciences, as well as two private general dental practices and one private orthodontic practice. In addition, the delegation attended the annual convocation and banquet of the India Section of the International College of Dentists. This event was attended by approximately 120 dentists which gave the delegates an excellent opportunity to discuss issues of mutual interest. The delegation also visited Dr. Gandhi's dental office where Dr. Julian Woelfel presented Dr. Gandhi with his textbook on dental anatomy as well as a volume of research papers to be presented to the All India Institute of Medical Research and Sciences. Dr. Harvey Wipf also presented Dr. Gandhi with reprints of some of his articles.



Photographed at the ICD Convocation in New Delhi are, from the left, Drs. Raymond T. Bond, Aubrey N. Stephens, Malcolm D. Campbell, Julian B. Woelfel, Robert E. Friedman and Harvey H. Wipf.

* Prem S. Sharma, D.D.S., M.S.
Associate Dean
Marquette University Dental School
Delegation Leader

March 17, 1993 Katmandu, Nepal

In Katmandu the delegation visited the Central Oral and Dental Clinic of the Nepal Oral Health Society. Following a tour and discussions with the staff of the clinic the delegation met with several dentists and volunteer administrators of the Society. Nepal, with a population of 18 million, has only 32 qualified dentists most of whom practice in Katmandu. The delegation also met Dr. John Mercurio, a Peace Corps volunteer from Boston, Massachusetts. Another American dentist Dr. Brian Hollander, who practices at the Everest Base Camp, was also present at the meeting. The delegates received an overview of the oral health problems of the people of Nepal and the limited resources available through the Volunteer Nepal Oral Health Society. The delegates presented a brief overview of the latest innovations in dentistry and discussed the role of People to People International, as well as the American College of Dentists.

March 19, 1993 Varanasi, India

In Varanasi, the delegation visited the Department of Dentistry of the



Photographed during a visit to a dental office in New Delhi are, from the left: Drs. Aubrey N. Stephens, Julian B. Woelfel, Robert E. Friedman, Harvey H. Wipf, Lovelin Gandhi, David Campbell, L.J. "Bud" English, R.K. Bali, President Indian Dental Council and Raymond T. Bond.



Members of the delegation had extensive dialogue with dentists and officers of the Nepal Oral Health Society. The delegates were presented with Nepalese caps and are photographed with their hosts during a reception in Katmandu.



The delegates and wives were able to see some of the great sites of India and Nepal. Photographed in front of the Taj Mahal in Agra, India are, from the left: Raymond Bond, Barbara Bond, Julian Woelfel, Bud English, Marcia Woelfel, Ramona English, Elaine Friedman, Robert Friedman, Aubrey Stephens, Beth Stephens, David Campbell, Janet Campbell, Bernice Wipf and Harvey Wipf. Seated in the front are tour manager Margriet Slaager and delegation leader Prem Sharma.

Institute of Medical Sciences and had extensive discussions with members of the staff. Presentations were once again made by Dr. Woelfel and Dr. Wipf of their textbook and research papers. Several of the Indian dentists mentioned that they had never seen an implant and were pleased when Dr. Woelfel agreed to let them examine an implant in his mouth.

March 22, 1993 Jaipur, India

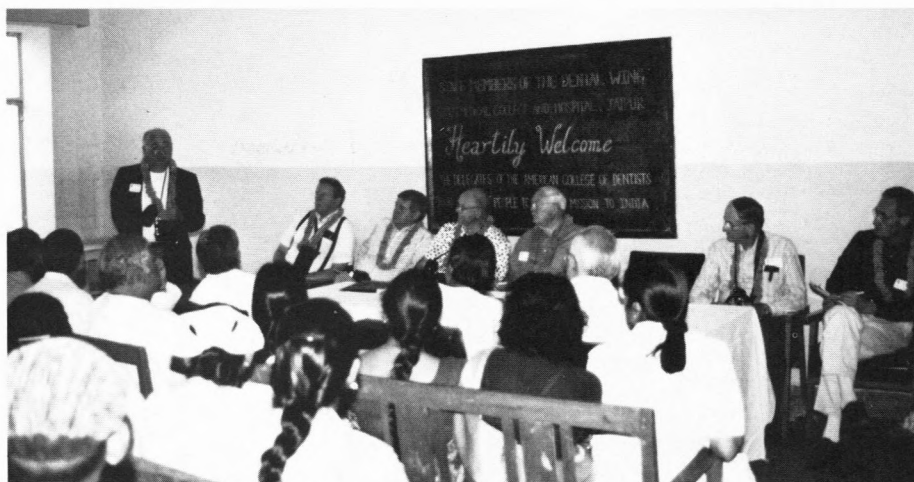
In Jaipur, the delegates visited the Department of Oral Surgery at the SMS Hospital and Medical College and met with the hospital staff, dental faculty and students. The dental school enrolls 40 freshmen students each year selected from a pool of 15,000 applicants. Some of the problems facing the dental school are lack of journals, periodicals and publications, as well as the lack of adequate supplies.

The delegates visited a private dental office shared by a father, mother, two sons and two daughters-in-law who are all dentists.

March 24, 1993 Bombay, India

Bombay was our last stop and we stayed in a hotel across the street from the Stock Exchange Building which had been the site of one of the fourteen bomb explosions about 10 days earlier. The delegation visited one of the two dental schools in the city and were impressed with the oral surgery department which has its own inpatient facility for major oral surgery procedures. Once again, the visit to the dental school gave the delegates an opportunity for extensive dialogue with their Indian counterparts.

As delegation leader I was very proud of the members of the delegation who admirably represented the American College of Dentists as well as the United States. Our Fellows and their wives made many friends and contributed significantly to the success of the mission. Additionally, I



The delegates were welcomed to the Department of Oral Surgery in Jaipur with flower garlands. Photographed is Dr. Robert Friedman addressing the faculty and students of the dental school.



Dr. Julian Woelfel presented a copy of his textbook on dental anatomy and a volume of research papers to the Dean of the dental school in Jaipur.

was pleased that my colleagues were able to experience the ancient culture of India, my old country.

We had ample opportunity to discuss the assistance that the American

College of Dentists can provide to our professional counterparts in India and Nepal. A report and several recommendations have been submitted to the ACD Board of Regents. ▲



In Bombay the delegates visited one of the two dental schools. Photographed is the Chief of the Department of Oral Surgery showing the delegates a patient who had recently undergone major surgery for the removal of an intra-oral tumor.

A TREASURY OF DENTISTRY

A Gathering of Dental Truants

Gardner P.H. Foley

Dr. Alfred Owre (1870-1933), who was Dean of both the Minnesota and Columbia dental schools, was one of the most interesting truants among American dentists. He became widely known as a cross-country hiker, not only for his many long journeys in this country and Canada, but in several European countries. In 1924, the total of his hiking mileage was estimated at 120,000 miles. His second major area of truancy was his collection of cloisonne (books) that became regarded as one of the largest and finest ever accumulated. Dr. Owre loved books and his library was a source of prideful interest. He had his favorite volumes covered in attractive bindings. As he continually added to his highly variant collections, his home became full of treasures that he brought back from his trips abroad—lovely Japanese bowls and vases, hundreds of canes, gorgeous pieces of Russian embroidery, Mandarin robes, and strange knives and swords. (I heartily recommend Netta W. Wilson's excellent *Alfred Owre: Dentistry's Militant Educator*, 1937).

Dr. Frank C. Wilson (Baltimore College of Dental Surgery, 1891), President of the Georgia Dental Association in 1927, was a crack shot with rifle, pistol, and shotgun. At the Carteret Gun Club of Garden City, N.J., he established a world's record at live birds by killing 107 straight. For four consecutive years he won the National and International Championships with the rifle.

Dr. Willard A. Howarth (U. of Pennsylvania, 1948) practiced in Up-

per Derby, PA. for 35 years. He bred and showed Great Danes and was an officer of the Great Dane Club of Pennsylvania.

Dr. Edward S. Hodgson (Washington University, 1904), who practiced in East St. Louis, Illinois, was a fan of many sports, especially archery. In that field of competition, he became Archery Champion of the State of Illinois for successive years and Champion of the Missouri Valley Archery Association for three straight years.

Dr. Gordon White (Baltimore College of Dental Surgery, 1879), who practiced in Nashville, achieved prominence as a dentist and also as a truant. He served as President of the Tennessee State Dental Association (1888) and of the Southern Dental Association (1892). An inventor of several small dental instruments, he was nationally recognized as a superior clinician with gold. A very active truant, he became an earnest student and patron of art. Dr. White visited many of the art museums of this country and Europe, and he collected many valuable original paintings. He was the leading spirit in the Nashville Art Association. He was also a collector of books and possessed a fine library.

In 1942 **Dr. William S. Garrick** (Temple University) was awarded a Fellowship in the Royal Geographic Society of London, England, becoming one of the 23 American recipients of that honor. He received the recognition on three points: his extensive travel in general, his 14 years of travel in the jungles of Central and South

America and for having given, in the previous six years, over five hundred public lectures on his travels and natural history. During his years of foreign visits he had practiced oral surgery in a large number of locations.

Dr. John W. Meng (Baltimore College of Dental Surgery, 1870), enlisted in the Confederate Army at age 16. He practiced in Lexington, Missouri for 44 years. For many years he made annual trips to the Rockies to spend several weeks in hunting big game.

Dr. Arthur H. Merritt (New York College of Dentistry, 1895), who was from New York City, was President of the American Dental Association in 1939-1940. He was one of the rare dentist-autobiographers. He also merits high ranking among dental truants. Dr. Merritt possessed an unusual number of paintings by many of the leading American artists. He also was a philatelist with a notable collection of American commemorative postage stamps with a complete set, mostly blocks of four, starting in 1893. One of the remarkable features of his home was his professional library containing several hundred bound volumes of the leading dental journals and a large representation of the most worthwhile textbooks. From my conversations with Dr. Merritt, I would conclude that his favorite truant interest was what might have been the largest collection, in the United States, of Staffordshire china, with many rare specimens. An active supplement to his collection of the china was his lectures on the subject of china.

Goethe wrote truly that "Collectors are happy creatures." So I have chosen to include in this "*Gathering*" several collectors who also have a happy profession.

Dr. Albert S. Loewenson (Maryland, 1944), of Baltimore, became an expert in the Japanese art of paper folding (origami) and made hundreds of folded paper decorations. He was my former student, continuing good friend and, before his death in 1969, he had created two other collections that merited keen attention from his fellow hobbyists; as a collector of playing cards, he developed an impressive knowledge of the history of that ancient and internationally represented field of studied interest. His other pursuit of a sideline to his dental practice was an ever-enlarging file of movie memorabilia, especially star photos and still scenes.

In 1959 **Dr. Frederick Franck** published his well regarded *Days with Albert Schweitzer: A Lambarene Landscape*, illustrated by the author. He first went to Africa in 1958 at the request of Dr. Schweitzer to establish a dental clinic in Lambarene. Out of this experience he wrote what the *New York Times* called "the best book on Schweitzer." Dr. Franck devoted two days a week, eight months of the year, to his New York practice. He spent the other four months in Africa under the sponsorship of the Medical International Corporation teaching emergency dental diagnosis and treatment to physicians and paramedical personnel. His articles and drawings have appeared in *Fortune*, *Atlantic Monthly*, and *Art in America*. Over 20 museums include his work in their

permanent collections, and he has had one-man shows in New York galleries. Other books by this notable dental truant are *African Sketchbook* and *My Friend in Africa*.

Dr. Ezekiel Etheredge (University of Maryland, 1896) had an uncommon combination of dental and political careers. He practiced in Leesville, SC (1896-1913) and was President of the South Carolina State Dental Association in 1908. He also practiced in Sebring, Fla. (1913-1926). Dr. Etheredge was a member of the South Carolina General Assembly for two terms and was elected to the Florida State Senate for two terms.

Dr. Bernard R. Ederer (Marquette, 1923) made an exciting contribution to the literature of dental truants by his 1954 publication of *Through Alaska's Back Door*. The book is a colorful account of a dentist's adventures with a young companion. He became the first white man to travel by canoe, in a single season, both the Mackenzie and Yukon river systems of 3,400 miles during the summer of 1939. His book is based on the daily log he kept during that heroic trip.

Dr. William Fishbough, of Brooklyn, N.Y., died in 1881 at 68. For many years he not only practiced dentistry but also served as a minister of the Universalist Church. He was the author of many philosophical articles in magazines and newspapers and published several books.

Dr. Fayette Hall (1825-1913) was a New Haven dentist who achieved

awkward recognition as a writer who did not like Abraham Lincoln. Shortly after the Civil War he published *The Real Lincoln*, a scathing criticism of the martyred President that received a sensational reception. Dr. Hall's chief theme was that the country had failed to understand Lincoln and had exaggerated his qualities.

Dr. Henry L. Ambler (1843-1924) was a graduate of the Ohio College of Dental Surgery (1867) and practiced in Cleveland. He published a book titled *Facts, Fads, and Fancies* and wrote many articles for the popular magazines. He became well-known to his profession by his many dental inventions.

Dr. Lehman Wendell (Minnesota, 1917) was widely regarded as an authority on Esperanto, the universal language. He wrote three books on the subject and translated several books into Esperanto. He also taught the language in evening classes at the University of Minnesota.

Dr. James W. Kesler, of Wilkes-Barre, PA, served during the Civil War in the U.S. Navy. He became a frequent contributor to the newspaper press and wrote a number of articles on naval operations during the War for several magazines.

The inclusion of **Calvin S. Case** (1847-1923) in this *Gathering* will undoubtedly surprise a large segment of dentists, especially orthodontists, who know of his qualifications for membership in the mythical Hall of Fame of American Dentists. Dr. Case was a graduate of the Ohio College of Dental

Surgery (1871). I had previously written about his several important contributions to his profession, but until recently I did not know that he was a devotee of outdoor sports: in a National Archery Tournament held in Boston he won second place in a field of 700 competitors.

Dr. J. Roy Strickland of Evansville, Indiana, made a remarkable record as a writer. His "J. Roy" column was published in the Evansville *Courier* for 37 years. Previously he had written a column for the Indianapolis *News*.

Dr. George E. Hunt (Indiana Dental College, 1890) became Dean of his alma mater. He wrote a series of humorous stories for several magazines.

Dr. Daniel O. Le Cron (U. of Maryland, 1890) practiced chiefly in St. Louis until 1912 when he moved to London. At the outbreak of World War I, although he had retired, he offered his professional services and was assigned to a hospital at Neuilly, France. He was awarded medals of honor by both France and Great Britain. Dr. Le Cron is present in this *Gathering* because he achieved distinction in two truant fields: as a student of Civil War campaigns and as a distinguished craftsman in designing and finishing jewelry and trinkets in gold.

Dr. William J. Morrison (U. of Tennessee, 1897) developed, during his practice years in Nashville, a number of additions to his major area of activity. He published a se-

ries of books about the natural history of Africa and South America. Among his inventions were a process for making lard out of cotton and the Fairy Floss Machine for making the once popular cotton candy.

Dr. Samuel Greif (College of Dental and Oral Surgery of New York, 1914) was a versatile and prolific writer. Among his books were *Dentistry in the Talmud* and *Who's Who in Dentistry*. He also was the author of numerous short stories.

Dr. Frank L. Sage (Ohio College of Dental Surgery, 1969), of Cincinnati, is one of the few dentists who have earned a substantial income from their writings. For his short stories in *The Youth's Companion*, *Harper's Weekly* and other magazines he became a well-known writer in the early decades of the twentieth century.

Dr. Harvey J. Burkhart (Baltimore College of Dental Surgery, 1890) was President of the National Dental Association in 1899. He practiced in Batavia, N.Y. for 25 years. I am making a concession to interpretation by including him in this *Gathering*. Dr. Burkhart was mayor of Batavia for four terms (1904-1916) and President of the Board of Education for 14 years. In 1916, George Eastman selected him as the first Director of the Rochester Dental Dispensary. Later he also became the director of Eastman Clinics in London, Brussels, Paris, Rome and Stockholm. In 1931, Dr. Burkhart was made a Commander of the Royal Order of Vasa by King

Gustaf of Sweden and, in 1935, King Leopold of Belgium decorated him with the Order of Leopold II. He was the recipient of many other important awards: the Jarvie Fellowship Medal (Dental Society of the State of New York, 1920); the Jessin Prize (Federation Dentaire International, 1934); the Callahan Medal (Ohio State Dental Association, 1937); and the Fauchard Medal (Fauchard Academy, 1941).

Dr. Mortiz A. Jagendorf gained a wide measure of recognition as a writer of American folklore. While in the Army during World War I he used his leave-time in researching local folklore. Over the years Dr. Jagendorf turned what began as a hobby into a major truancy. His list of books grew to exceed two dozen volumes. His first book *New England Bean Pot* was followed up by *Up State Down State*, tales of the middle states. He served as President of the New York State Folklore Society and Director of the American Folklore Society.

Dr. Henry N. Dodge (Philadelphia Dental College, 1869) practiced for over 50 years, in New York City and Morristown, N.J. His *Christus Victor* was originally published in 1899 and its seventh edition in 1926. In recognition of that very successful book, Dr. Dodge was awarded the A.M. degree from St. Lawrence University and the Lit. D. degree from Tufts College, both in 1902. Among his other books were *Mystery of the West* (1906), *John Murray's Landfall* (1911), and *A Flower of the Field* (1914). Besides his books, he wrote many articles for religious and dental journals. ▲

BOOK REVIEWS

A Review of Two New Books: Dental Ethics Ethical Questions in Dentistry

Dental Ethics Comes of Age

Muriel J. Bebeau*

This year, for the first time, two ethics textbooks join the Professional Ethics in Dentistry Network (PEDNET) bibliography of 663 publications. How do these new texts contribute to dental ethics, to practitioners' and students' development of ethical decision making, and to the work of professional school educators?

It is helpful to review contributions to dental ethics in the context of the American bioethics movement. In the late 60s, philosophers helped scientists and practitioners identify questions at the interface of medicine, technology, and biology. Gradually, health care centers asked ethicists to analyze problems arising at bedside, and to design ethics education. Simultaneously, psy-

chologists articulated adult moral development and created teaching and assessment strategies for effective ethical decision making. They determined four critical skills: moral sensitivity, moral reasoning and judgment, moral motivation and commitment (the will to prioritize professional over personal values), and interpersonal and problem solving abilities for implementing a moral action plan. Today, while a burgeoning biomedical ethics literature is available, including case books and texts, medicine has, nonetheless, been slow to integrate contributions from moral and educational psychology. A shortcoming of most texts is lack of attention to learner outcomes other than ethical reasoning and judgment.

In contrast to medicine, dentistry's ethics initiative originated with dental faculty, practicing dentists, and educational psychologists and, in 1980, the American Fund for Dental Health funded the first ethics curriculum at the University of Minnesota. In 1982, Minnesota sponsored a conference on teaching dental ethics, Ozar organized PEDNET to facilitate dentistry's engagement in

ethical issues, and Odom reported on the status of dental ethics instruction. By the mid 80s, W. Robert Biddington, President first of American Association of Dental Schools (AADS) and then the American College of Dentists (ACD), championed the ethics in dentistry movement. Sponsored by ACD, he convened a multidisciplinary group to develop outcomes-based AADS curricular guidelines. The American Dental Association (ADA) accreditation standards now require outcomes assessment and ethics instruction. It is fitting then, that the book of essays edited by philosopher Bruce Weinstein is dedicated to Biddington. The second book, coauthored by dentist James Rule and philosopher Robert Veatch, assembles cases around ethical issues arising in dental practice. In the context of these historical developments, how do these texts compare, particularly in reference to the AADS guidelines for critical skills and the ADA's requirement for outcomes assessment?

First, the contents: each follows an established formula, initially setting forth theoretical foundations,

* Muriel J. Bebeau, Ph.D.

Associate Professor, Department of
Preventive Sciences
School of Dentistry

Faculty Associate
Center for Biomedical Ethics
University of Minnesota

then discussing topical issues illustrated with profession specific cases, finally confronting the professions' current problems. Weinstein's foundations section begins with "Virtues, Values, and Norms," wherein Ozar reflects on the role of the professional and the extent to which virtue, rather than minimally prescribed professional duties, guides decision making. Campbell and Rogers (Chapter 2) outline normative principles and Weinstein then details the ethical decision making (Chapter 3) process. Illustrative cases are incorporated throughout, but absent is a chapter on moral theories. Section II considers the dentist-patient relationship (Kahn and Hasegawa) and informed consent (Odom and Bowers). It then switches to topical issues—AIDS (Keyes and Waithe), incompetent or chemically dependent colleagues (Parker and Hollway), relationships with auxiliaries (Gaston and Gladwin), advertising (Scheirton and Boerschinger), and dental research (Meslin and Main). Section III, Case Studies and Commentaries, deals with esthetic dentistry (Gilbert and Waithe) and authority conflicts between dentist and auxiliary (Hawkins). The ADA Code of Ethics and the PEDNET Bibliography close the volume.

Rule and Veatch's Part I presents an overview of ethics, followed by basic ethical theories, ethical principles, and Rule and Veatch's protocol for ethical decision making. Parts

II and III consist exclusively of ethical analyses of cases. Each is based on actual events in patient care, selected from a broad array of problems. In Part II, ethical principles are deliberated via case histories that illustrate principles of beneficence, nonmaleficence, autonomy (including informed consent), truth telling, obligations related to trust and confidentiality, and justice in the allocation of dental resources. Part III introduces an array of cases and commentary on patient care in dental school, third-party financing, dental research, AIDS, and dealing with incompetent, dishonest, and impaired colleagues. Appendices include the Hippocratic Oath and American Medical Association (AMA) and ADA codes.

Who could benefit from these books and what needs would be served? Both texts expect to develop ethical reasoning and judgment, but they differ in their targeted audience and their assumptions about the audience's needs. Weinstein contends that students and practitioners in dentistry, dental hygiene, and assisting are increasingly asking ethics related questions, but have not had a book to help them find "answers." Rule and Veatch argue that dental practitioners and students need a general approach to ethical reasoning in dental problem solving, and emphasize forming questions. Rule and Veatch's strength is a valuable combination of perspec-

tives. Consistency in theme and presentation of principles, theories and decision making processes make the book very readable for the uninitiated. In contrast, Weinstein's chapters are developed more or less independently and sometimes with redundancy. For example, Gaston and Gladwin's chapter for auxiliaries presents a five step decision making model (Weinstein's four step model precedes it in Chapter 3) before the case analysis. Thus ethical analysis is limited to the least challenging case of the seven presented. Similarly, Meslin and Main outline ethical principles and issues (discussed earlier by Campbell and Rogers) and then describe approaches for ensuring ethical research in the more didactic and less interactive way that limited space requires. In contrast, Rule and Veatch rely on principles and issues established in earlier chapters and use cases to highlight the subtle dilemmas that challenge researchers. They also help the reader apply utilitarian and deontological (moral obligation) theories in reconciling tensions between generating new knowledge and providing patient-centered clinical therapy.

A strength of the Weinstein work is the comprehensive coverage of topics and the inclusion of topics seldom treated in ethics curricula. Chapters on AIDS, informed consent, advertising, and esthetic dentistry are more thorough and useful

for the dental educator preparing lectures or guiding discussion than are similar ones by Rule and Veatch. The latter excel in cases that dental students confront and in those involving morally questionable practices of the insurance industry that often bewilder a new graduate. Chapters on race, gender, and class and the dentist's relationship with hygienists and assistants present issues of equality not treated by Rule and Veatch. Hawkins' distinctions between ethical problems faced by nurses and those by dental auxiliaries are particularly insightful. Overall, I recommend Weinstein for the dental educator.

What should the educator consider when selecting these texts for student use? The texts appear to be grounded in different assumptions about learning. Weinstein's assumptions seem content based; Rule and Veatch's seem process based; neither is performance or outcome based. Weinstein seems to assume that students learn by reading theory illustrated by cases and by responding to discussion questions at chapter's end. Rule and Veatch seem to assume that students learn by encountering problems and questioning what to do. Their 111 cases are extraordinarily abundant in technical detail and obviously collected by a practitioner with an uncanny sense of the breadth of issues dentists confront. Rich, descriptive cases appeal to students. By organizing

cases from simple to complex, Rule and Veatch enhance students' appreciation for complexity. Rather than providing "answers," they offer just enough guidance to support the reader's thinking. Then, a more perplexing case propels one to a new principle and a more sophisticated level of understanding. I think Rule and Veatch have a greater appreciation of students' epistemological development. They tacitly acknowledge what psychologists have documented—that young adult students have not abandoned relativism. Rule and Veatch are careful not to provide "answers," but show how decisions can be approached from diverse moral orientations. In so doing, they enhance students' appreciation for complexity, and promote intellectual development and commitment rather than reinforce relativism. I recommend Rule and Veatch for educators, students, and practitioners alike. Reflective students and practitioners are both well served.

What needs of the educator are not addressed? Rule and Veatch attend to the learning process that concerns the educator but, like Weinstein, fail the educator in other ways. For example, both books provide chapters on incompetent and impaired colleagues and can convince the reader of his or her moral obligation to take action. However, many a good intention is countered by ineffectual implementation skills.

Although both volumes contribute to the development of reasoning and judgment, they do not—with the exception of Ozar's chapter—address other, equally important, components of morality specified by psychologists and the AADS curricular guidelines. Further, neither text incorporates an essential learning principle. Students learn when assessed on their performance and receive feedback that leads to improvement and further learning. I was not able to infer criteria from these texts that educators might use to provide feedback and evaluate outcomes. Given the ADA requirement for outcome assessment, this is a significant shortcoming.

In sum, Weinstein and Rule and Veatch deserve our kudos for contributing new topics in the first case and a teaching text in the second. Dental ethics has come of age. Inclusion of other essential ethical processes necessary for moral behavior are next steps for the field. Future authors are now free to concentrate on what makes curriculum really work for students, and how to know if "ethics in dentistry" has made a substantial difference in student learning and dental practice. ▲

Dental Ethics. Edited by Bruce D. Weinstein. Philadelphia: Lea & Febiger, 1993. 243 pp. \$29.95 paper.

Ethical Questions in Dentistry. By James T. Rule and Robert M. Veatch. Carol Stream, IL: Quintessence Books, 1993. 282 pp. \$28.00 paper.

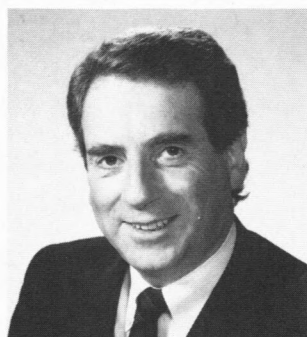
NEWS OF FELLOWS

Ian C. Bennett recently took early retirement from Dalhousie University and now resides in Vancouver, British Columbia. Dr. Bennett was appointed Dental Dean at the University of Medicine and Dentistry of New Jersey in 1969 and at Dalhousie University in 1976. He has served as President and Executive Director of the Canadian Academy of Pedodontics and as Vice President of the American Association Dental Schools.



Ian C. Bennett

William H. Binnie, Professor and Chairman of the Department of Diagnostic Sciences at Baylor College of Dentistry, is serving as President-Elect of the International Association of Oral Pathology. Dr. Binnie served on the faculty of Guys Hospital University of London for 12 years before coming to Baylor in 1979.



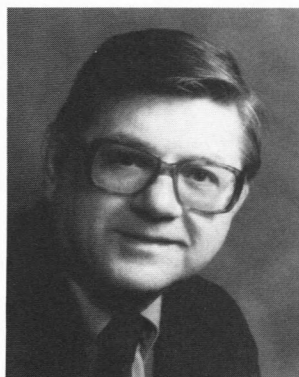
William H. Binnie

Lindsay M. Hunt, Dean of the School of Dentistry at Virginia Commonwealth University, has been named the first Harry Lyons Professor of Dentistry. Dr. Hunt was recognized for his leadership and contributions to the School. The Lyons Professorship was named for Dr. Harry Lyons, Dean Emeritus of the Virginia School of Dentistry who served as the Dean with distinction until his retirement in 1970. Dean Lyons was also a Past President of the American College of Dentists.



Dr. Lindsay Hunt on the left photographed with Dr. Harry Lyons.

Robert J. Karczewski was recently honored by Marquette University with the presentation of its 1993 Distinguished Alumnus in Dentistry Award. Dr. Karczewski is in the private practice of dentistry in Milwaukee and has served as President of the Marquette University Dental Alumni Association.



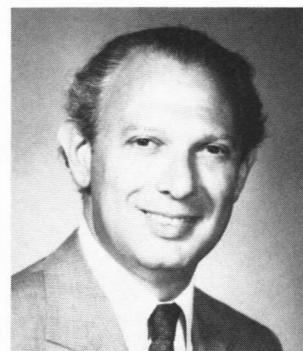
Robert J. Karczewski

Frederick G. Preis was recently installed as Trustee to the American Association of Orthodontists from the Middle Atlantic Society of Orthodontists of which he is a Past President. Dr. Preis is in the private practice of Orthodontics in Bel Air, Maryland.



Frederick G. Preis

W. Paul Radman was recently elected to the Baylor College of Dentistry Board of Trustees. A Past President of the Dallas County Dental Society, Dr. Radman is in the private practice of Endodontics in Dallas.



W. Paul Radman

Ronald P. Stifter is currently serving as the President of the Wisconsin Dental Association. Dr. Stifter is in the private practice of dentistry in Milwaukee.



Ronald P. Stifter.

W. Robert Biddington, former ACD President and former Dean of the West Virginia University School of Dentistry has been honored by having a new book on Dental Ethics dedicated to him. Dr. Biddington served as the ACD member of the American Association of Dental School's (AADS) Special Committee to Develop Guidelines for Teaching Ethics and Professionalism in Dental Schools. He is a former President of the AADS.

Bruce D. Weinstein, Ph.D., right, presents a copy of his recent book entitled *Dental Ethics* to former ACD President W. Robert Biddington. The volume is dedicated to Dr. Biddington.



Paul H. Loflin of Beckley, West Virginia was the recipient of the Academy of Operative Dentistry's Award of Excellence. A Past President of the Academy, Dr. Loflin was recognized for his service to the Academy and to the profession.

Photographed from the left are: Paul H. Loflin, Mrs. Loflin and ACD Fellow D. E. Neil also of Beckley, West Virginia.



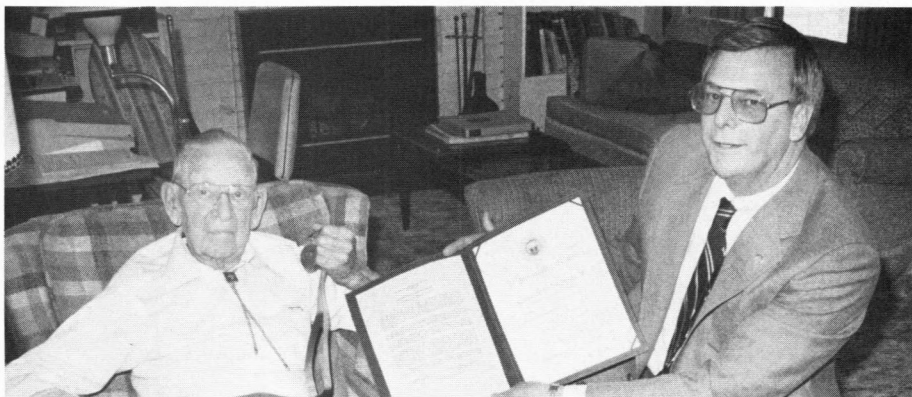
William L. Nequette was recently installed as President of the American Academy of Fixed Prosthodontics. Dr. Nequette is in the private practice of Prosthodontics in Milwaukee.

Photographed from the left are: ACD Fellow Gerald J. Ziebert, Chairman of the Department of Restorative Sciences at Marquette University School of Dentistry; William L. Nequette and ACD Fellow Francis Panno, Chairman of the Department of Restorative Sciences at New York University.



Clarence H. Swanson, Sr. of Columbus, Montana was recently presented the American College of Dentists' Distinguished Service Award for 50 years of Fellowship. The presentation of the award was made to Dr. Swanson by ACD Fellow Bruce L. Barrow of Billings, Montana.

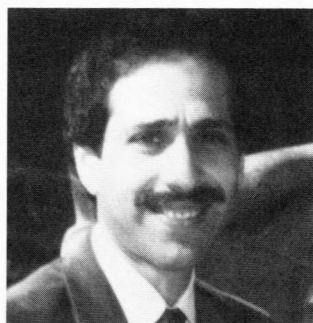
Dr. Clarence H. Swanson, Sr., on the left, receives the ACD Distinguished Service Award from Dr. Bruce L. Barrow.



American Academy of Periodontology Honors Several ACD Fellows

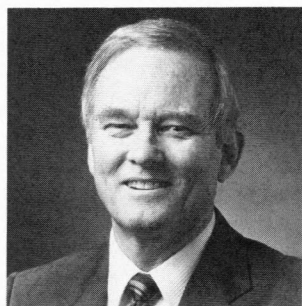
Several ACD Fellows were honored by the American Academy of Periodontology at its 78th Annual Meeting in Orlando. Fellows were either installed officers or were recognized for their contributions to the specialty of Periodontics.

Michael G. Newman, Adjunct Professor of Periodontics at the University of California at Los Angeles and co-director of its Center for Periodontal Research, was installed as President of the American Academy of Periodontology.



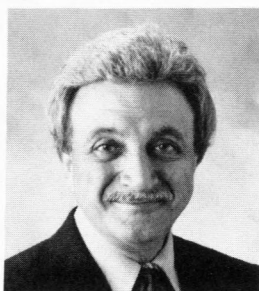
Michael G. Newman

Donald F. Adams, Chairman of Periodontics at Oregon Health Sciences University, was installed as Vice President of the Academy.



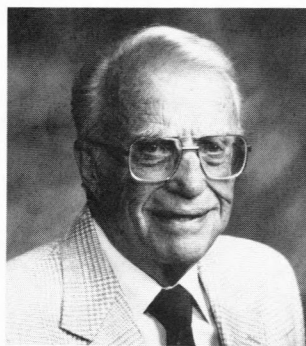
Donald F. Adams

Robert T. Ferris of Altamonte Springs, Florida was installed Secretary of the Academy.



Robert T. Ferris

Arnold A. Ariaudo of San Diego, California was named a Fellow of the American Academy of Periodontology for 40 years of contribution to the Academy.



Arnold A. Ariaudo

Roland M. Meffert, Clinical Professor of Periodontics at University of Texas Health Science Center at San Antonio, received a special citation from the Academy for his contributions to the Association's In-Service Examination.



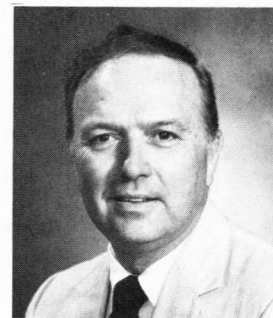
Roland M. Meffert

James T. Mellonig, Associate Professor of Periodontics at the University of Texas at San Antonio, was installed Treasurer of the Academy.



James T. Mellonig

Gerald M. Bowers, Professor and Director of the Post Doctoral Program in Periodontics at the Baltimore College of Dental Surgery, University of Maryland, received the Academy's Gold Medal Award. Dr. Bowers currently serves as Executive Secretary and Treasurer of the American Board of Periodontology of which he was Director and Chairman for nine years.



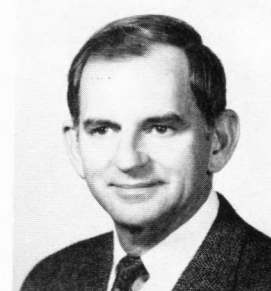
Gerald M. Bowers

Stanley P. Hazen former Dean of the Georgetown University School of Dentistry was named a Fellow of the American Academy of Periodontology for more than 30 years of service to the Academy.



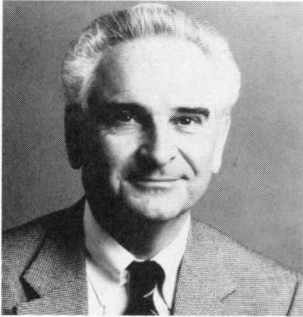
Stanley P. Hazen

J. Gary Maynard, Jr. from Richmond, Virginia was named a Fellow of the American Academy of Periodontology for his years of distinguished service to the Academy.



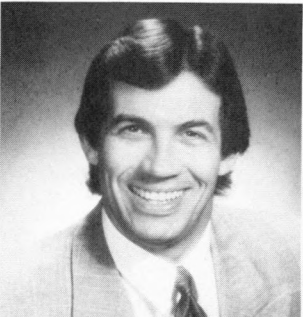
J. Gary Maynard, Jr.

Errol L. Reese announced that he will leave the Presidency of the University of Maryland at Baltimore effective December 31, 1993. Prior to being named President, Dr. Reese served 15 years as the Dean of the Baltimore College of Dental Surgery University of Maryland at Baltimore.



Errol L. Reese

Kenneth L. Zakariasen, Jr. was appointed as Dean of Marquette University School of Dentistry effective October 1992. Dr. Zakariasen has served as the Chairman of the Department of Endodontics at the University of Minnesota School of Dentistry and was appointed Dean of the Faculty of Dentistry, Dalhousie University in Halifax, Nova Scotia in 1986.

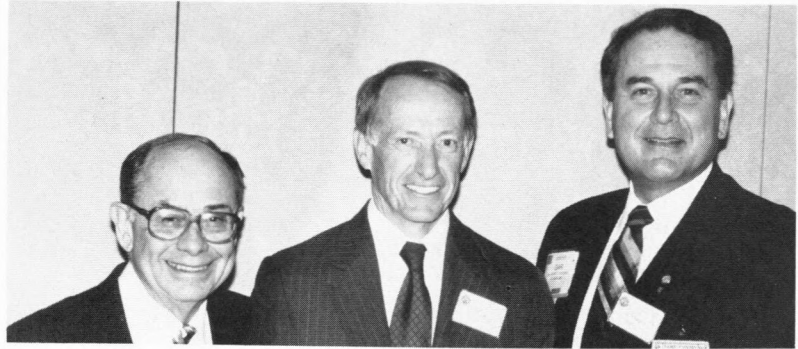


Kenneth L. Zakariasen, Jr.

SECTION ACTIVITIES

Georgia

The Georgia Section held its Annual Meeting recently in conjunction with the International College of Dentists and the Pierre Fauchard Academy during the Hinman Dental meeting in Atlanta. A large gathering of Fellows and guests attended the business meeting and heard featured speaker Dr. Jack Harris, President of the American Dental Association. On behalf of the American College of Dentists, Regency 3 Regent Alston J. McCaslin, V, presented a letter written by Dr. Thomas P. Hinman to Dr. Arthur D. Black in 1921 when Dr. Black served as the Secretary of the American College of Dentists.



From the left, are Georgia Section Officers: Secretary-Treasurer Manuel I. Weisman, Vice Chairman Larry C. Miller and Chairman Gerrit C. Hagman.



ACD Regent Alston J. McCaslin on the right presented a letter from Dr. Thomas P. Hinman to Arthur D. Black. Receiving the gift is Dr. Johnny Maloney Chairman of the Hinman Dental Meeting.



ADA President Jack Harris addressed the meeting of the Georgia Section.



Photographed at the Georgia Section Meeting are, from the left: ACD Fellow and President of the Pierre Fauchard Academy Martin Naimark and Fellow Marvin C. Goldstein.

Carolinas

The Carolinas Section held its Annual Meeting February 5, 6, and 7 in Charleston. A large number of Fellows and guests attended scientific programs, as well as social and cultural events, and received a historic tour of Charleston. Louis E. Costa, II, D.D.S., M.D. presented a very interesting program on facial surgery. The Carolinas Section contributed an additional \$800 to the Campaign for the 90s.

Florida

The Florida Section held its Annual Breakfast Meeting in Orlando at Marriott's World Center on June 4th in conjunction with the Florida National Dental Congress. Seventeen students and 123 Fellows were present and heard an excellent address by ACD Executive Director Sherry Keramidas. The Section presented the 1993 C.W. Fain Award for professionalism to a graduating student from the University of Florida College of Dentistry. The award, consisting of a plaque and \$200, was presented to Dr. Norbert Leo Misch.

This year the Florida Section asked the 1993 graduating class at the University of Florida College of Dentistry to select a faculty member as the individual who has best exemplified the principles of professionalism and ethics in the daily interaction with the class members, patients and the dental profession. The students selected Dr. Larry Clark and the Section presented him with a plaque and a check for \$500.

New England

The New England Section met in conjunction with the Yankee Dental Congress in Boston. Awards were presented to the top graduating Seniors in the New England Dental Schools. Dr. Sherry Keramidas, ACD Executive Director, addressed the Section.



Photographed at the Carolinas Section meeting are, from the left: ACD Past President James A. Harrell, Sr., Carolinas Section Vice Chairman W. Lynn Campbell, Chairman William C. Bean and Past Chairman Thomas B. Kays.



Photographed at the Florida Section's meeting are, from the left: Section Vice Chairman Edward Gonsky, ACD Executive Director Sherry Keramidas and Section Chairman José Medina.



From left to right: Erling Johansen, Dean of Tufts University School of Dental Medicine; Spencer Frankl, Dean of Boston University Dental School; Student Awardees Shahana Khan of Boston University, James Rice of Tufts Dental School and Shelley McBride of Connecticut Dental School; Howard McLaughlin, Past Chairman of the New England Section and Bruce Donoff, Dean of Harvard Dental School.

Illinois

The Illinois Section held its annual luncheon meeting during the Mid Winter meeting of the Chicago Dental Society.

American College of Dentists President Albert Wasserman photographed presenting Dr. Thaddeus V. Weclaw's William John Geis Award posthumously to Mrs. Weclaw.



ACD Executive Director Sherry Keramidas attended the meeting and addressed the Fellows.



ADA President Jack Harris was the featured speaker at the meeting.

Kansas City Midwest

The Kansas City Midwest Section held its annual meeting February 26. Drs. Lorenz Bunker, Edward Hall, Ray Parsons and Russell W. Sumnicht were recognized for 15 years of Fellowship. Drs. Donald Amend, James Andrews and Richard Hamilton were honored

for 25 years of Fellowship in the College. The Section installed the following new officers: Chairman Michael C. Reynolds, Chairman-Elect Larry A. Jones and Secretary-Treasurer John I. Haynes.



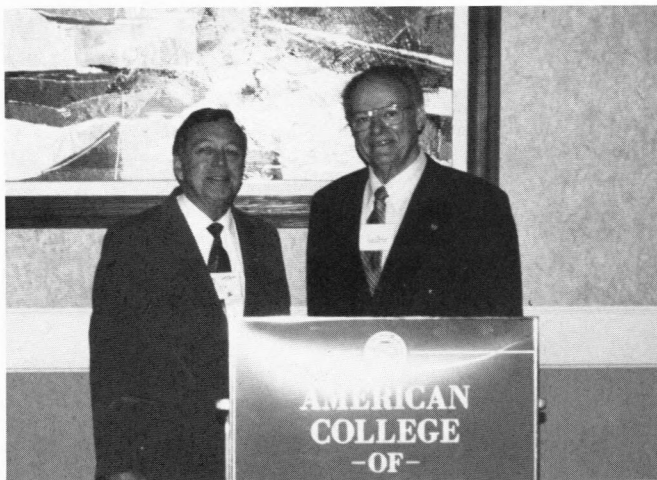
Chairman Michael Reynolds, on the left, presents a certificate of appreciation to Immediate Past Chairman Ray E. Parsons.



From the left, are John I. Haynes, Larry A. Jones, Michael Reynolds and Michael Reed, Dean of UMKC School of Dentistry.

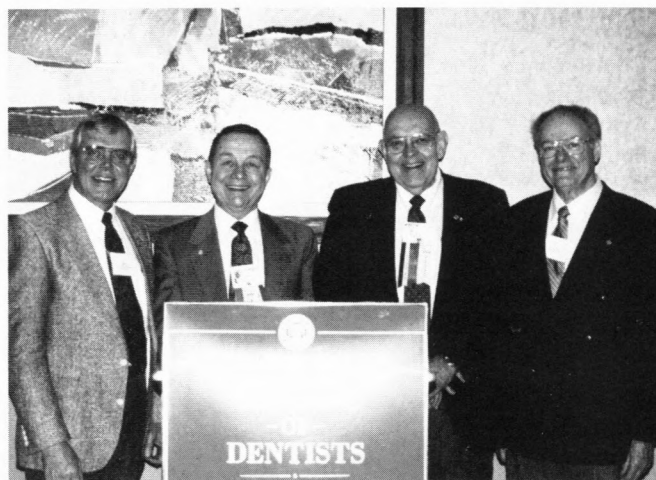
Southern California (Arizona Component)

The Arizona Component of the Southern California Section held its Annual Breakfast Meeting in Phoenix on February 27, during the Annual meeting of the



At the Southern California-Arizona Component meeting are, from the left, Section Second Vice-Chairman Richard J. Geyer and ACD President Albert Wasserman.

Arizona State Dental Association. ACD President Albert Wasserman attended the meeting along with Regency 7 Regent Richard B. Hancock.



From the left are ACD Regency 7 Regent Richard Hancock, Fellows Curtis Zent and William Boyington and ACD President Albert Wasserman.

New York

The New York Section held its annual meeting and dinner, which was attended by over 60 Fellows and guests. ACD awards were presented to outstanding

students from the area dental schools and ACD President Albert Wasserman addressed the meeting.



The New York Section held an Ethics Leadership Workshop on March 16 at which Fellows reviewed case presentations and discussed ethical problems. The Workshop facilitators were Dr. Andrew M. Lenz and Dr. James Dwyer. From the left, are ACD Regency 1 Regent Edward C. McNulty, Section Secretary-Treasurer Malcolm E. Meistrell, Historian Daniel D. Epstein, Facilitator James Dwyer, Chairman R. Chester Redhead, Section Representative Andrew M. Linz and Chairman-Elect John M. Scarola.

Iowa

The Iowa Section held its annual meeting on May 2, 1993 with a large gathering of Fellows and guests present. Recognition was provided to those who had completed 15 and 25 years as Fellows in the College. An Outstanding Student Award was presented to Scott Clemons, a University of Iowa senior dental student, by his father ACD Fellow W. Bryan Clemons. The Section voted to contribute \$500 to the American College of Dentists Foundation and is planning an ethics course to be lead by a University of Iowa faculty member. ACD Regency 5 Regent Richard E. Bradley attended the meeting and the following Section Officers were installed: Chairman Dean D. Ray, Vice Chairman James N. Clark and Secretary-Treasurer James H. Sommers.



Photographed from the left are: W. Bryan Clemons, Iowa Senior Dental Student Scott Clemons, John C. Montgomery and Thomas V. Gardner, Jr.



Photographed at the Iowa Section meeting are, from the left: Regent Richard E. Bradley, Immediate Past Section Chairman John C. Montgomery, Vice Chairman James N. Clark, Chairman Dean D. Ray and Secretary-Treasurer James H. Sommers.

Oklahoma

The Oklahoma Section held its annual meeting on April 24, 1993 and new Fellows of the College were introduced and welcomed. Discussions were held on the dental student recruitment program of the Section and an award was presented to a graduating senior dental student. American College of Dentists Regency 5 Regent Richard E. Bradley attended the meeting and gave a report on the activities of the Board of Regents. A special award was presented to Secretary-Treasurer James B. Roane.



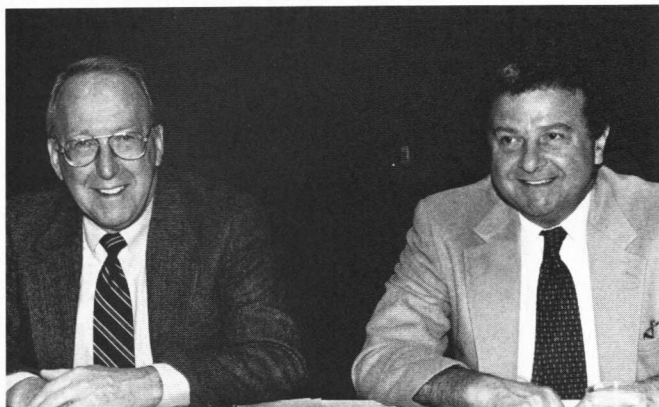
Photographed at the Oklahoma Section meeting are, from the left: Immediate Past Chairman of the Oklahoma Section W. Scott Waugh, ACD Regency 5 Regent Richard E. Bradley, Section Chairman James S. Torchia and Section Secretary-Treasurer James B. Roane.



Fellows of the Oklahoma Section photographed at the annual meeting.

Wisconsin

The Wisconsin Section held its spring meeting on April 2 in Milwaukee and hosted the Second Annual Dr. Henry L. Banzhaff Memorial Lecture. Dr. Banzhaff was a pioneer in dental education and served as the Dean of Marquette University School of Dentistry. He was also the President of the American Dental Association, the



Wisconsin Section Chairman Russell T. Kittleson, left, and Secretary-Treasurer Donald F. Pricco.



Wisconsin Section Chairman Russell T. Kittleson, on the left, presents an Award of Recognition to Dr. Prem S. Sharma.



From the left are Edward W. Rogers, Cornelius T. Geary and Robert H. Peterson.

American College of Dentists and the American Association of Dental Schools. The memorial lecture to Section Fellows and dental students was delivered by Dr. Michael A. Heuer, Senior Associate Dean at the Northwestern University Dental School.



From the left, Timothy J. McNamara and George E. Rooney, Jr.



ACD Vice President Juliann S. Bluit addressed the business meeting of the Section.



From the left are Nancy S. Barton, Jon G. Scrabeck and Donald J. Ferguson.

NOMINATION FORM REQUEST

Name _____ F.A.C.D.
 Address _____
 City _____ State _____ Zip _____

 Signature _____

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

January 15 — Closing Date for Nominations. Send the form to the American College of Dentists, 839 Quince Orchard Blvd., Suite J, Gaithersburg, MD 20878-1603

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.

EDITORIAL POLICY

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

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

PREPARATION OF MANUSCRIPTS

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

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

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

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

Dorlands' 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

Address all manuscripts and related correspondence to: The editor, JOURNAL OF THE AMERICAN COLLEGE OF DENTISTS, 839 Quince Orchard Blvd., Suite J, Gaithersburg, MD 20878-1603.

REFERENCES

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

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

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

REPRINTS

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

COPYRIGHT POLICY

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

American College of Dentists

1993 Annual Meeting & Convocation

November 4 - 5

**San Francisco Marriott
San Francisco, California**

Thursday, November 4

Noon - 7:30 p.m.

Registration of Candidates & Sponsors

1:00 - 5:30 p.m.

Section Representatives Assembly

Building a Partnership

National/Section/Regency Conference

Friday, November 5

9:00 - 11:45 a.m.

Expanding Our Vision: Becoming More Effective in a World of Health Care Reform

Improving Quality and Accessibility of Our Health Care System: Cost Effective Controls in a Reformed System

Donald Steinwachs, Ph.D., Director
Health Services Research and Development Center
The Johns Hopkins University

The Specific Challenges for Dentistry in Health Care Reform

William E. Allen, D.D.S., Consultant to the Executive Director
American Dental Association

Ethical Concerns and Implications of Health Care Reform

Barbara Koenig, Ph.D., Executive Director
Center for Biomedical Ethics
Stanford University

3:00 - 5:00 p.m.

Convocation

Reaching For a Higher Standard

John C. Greene, D.M.D., M.P.H., Dean
University of California at San Francisco
Dental School

7:00 - 11:00 p.m.

Reception & Dinner Dance

OFFICERS

President

ALBERT WASSERMAN
410 North San Mateo Drive
San Mateo, CA 94401

President-Elect

CHRIS C. SCURES
2122 E. Robinson St.
Orlando, FL 32803

Vice President

JULIANN S. BLUITT
NUDS, 240 East Huron St.
Chicago, IL 60611

Treasurer

CHARLES V. FARRELL
1800 C Street, Ste. 223
Bellingham, WA 98225

Immediate Past President

THOMAS W. SLACK
3015 Jet Wing Drive
Colorado Springs, CO 80916

Editor

KEITH P. BLAIR
4403 Marlborough Avenue
San Diego, California 92116

Executive Director

SHERRY KERAMIDAS
839 Quince Orchard Blvd., Suite J
Gaithersburg, MD 20878-1603

REGENTS

Regency 1

EDWARD C. McNULTY
608 Fifth Avenue, Suite 808
New York, NY 10020

Atlantic Provinces, Connecticut, Maine, Massachusetts, New Hampshire, New York, Quebec, Rhode Island, Vermont

Regency 5

RICHARD E. BRADLEY
6424 Crooked Creek Drive
Lincoln, NE 68516

Alberta, Iowa, Kansas, Manitoba, Michigan, Minnesota, Nebraska, North Dakota, Oklahoma, Ontario, Saskatchewan, South Dakota, Wisconsin

Regency 2

JAMES L. PALMISANO
3 Bay Point Drive
Toms River, NJ 08753

Delaware, District of Columbia, Europe, Maryland, New Jersey, Pennsylvania, Puerto Rico

Regency 6

RICHARD J. HAFFNER
11810 Gravois
St. Louis, MO 63127

Arkansas, Louisiana, Mississippi, Missouri, Tennessee, Texas

Regency 3

ALSTON J. McCASLIN, V
211 East 31st Street
Savannah, GA 31401

Alabama, Florida, Georgia, North Carolina, South Carolina, Virginia

Regency 7

RICHARD B. HANCOCK
4808 Clairemont Mesa Blvd.
San Diego, CA 92117

Arizona, Colorado, Nevada, New Mexico, Southern California, Utah, Wyoming

Regency 4

JAMES T. FANNO
4811 Munson St., NW
Canton, OH 44718

Illinois, Indiana, Kentucky, Ohio, West Virginia

Regency 8

WALTER N. JOHNSON
12 Hilltop Drive
Seaside, OR 97138

Alaska, British Columbia, Hawaii, Idaho, Montana, Northern California, Oregon, Washington

American College of Dentists
839 Quince Orchard Blvd., Suite J
Gaithersburg, MD 20878-1603

Return Postage Guaranteed

Second Class Postage
PAID
at Gaithersburg, MD
and Additional Mailing Office



Dental Health Care: Yesterday, Today and Tomorrow

New National ACD Office Dedicated

Professional Role Orientation Inventory