WINTER • 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.

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FROM THE EDITOR'S DESK

In Conclusion

With this issue, my 13-year term as the Editor for the ACD JOURNAL will come to an end.

I have been privileged to have served for the longest continuous term of Editor in the history of the JOURNAL, which was established in 1934 with the legendary William John Gies as its first Editor. I have been only the 7th Editor to have served the College in that 60-year span.

It has been a most rewarding experience to have had the pleasure of associating and working with many of the leaders of the dental profession during that time. Being the ACD Editor is, indeed, serving one of the most prestigious editorships in dentistry. A dental editor does not take lightly the leadership responsibilities, the rich history and the great tradition that accompanies this position.

My goals were always to emphasize the purposes and ideals of the American College of Dentists. The College's strength has been built around the strong principles and true values in life that are the basis for all ethics and professionalism in the dental profession. It is my sincere belief that the public deserves concerned care, personal integrity, high principles and professional demeanor from its health professionals.

When I first assumed the Editor's duties, it was inspiring to review the accomplishments of the Founders of the College during the early years. They set examples for leadership and

Keith P. Blair

for acting on the strength of their convictions, while holding to their ideals. They accomplished much for the dental profession then that has continued to benefit the profession for generations.

The main difference that separates a true profession from a mere trade is that a profession maintains its literature over the years. The ACD was once the undisputed leader for journalism in the dental profession and, hopefully, the College will renew its interest and concern for the important field of literature and communication within the profession in the future.

During my years as the ACD Editor, I have aimed to keep the membership informed about important issues in dentistry, to set high standards for both the content and format and to produce a professional publication that had quality, dignity and class. The ACD JOURNAL is a voice for professionalism and ethics in dentistry and represents, to its readership, the distinguished image of the College.

The Editor has a unique opportunity (the power of the pen) to influence the readership and to reflect its opinion with editorial writing. It is a challenge to every editor to do this objectively, to exercise restraint, to write constructively and to boil everything down to one page. It is also very important to present controversial subjects without being controversial in the way they are presented.

The Editor's Desk is a position that requires the assuming of an ongoing responsibility and a continuing dedication to the job. Being a dental editor is a labor of love.

During my term, we accomplished many changes in the format, style and appearance to make the JOURNAL more inviting and interesting to our readers, and we became a refereed publication. I hope that the Fellows of the College will consider that I have served the office of Editor in a satisfactory manner.

I wish to express my appreciation to the Associate Editors, to the Editorial Board of Review and to the entire JOURNAL staff for their fine cooperation and assistance over the years.

In conclusion, it has been my distinct privilege and very great honor to have been the ACD Editor.

Keith P. Blair

New Directions for the *Journal of the American College of Dentists*

1994 will bring several new directions for the Journal of the American College of Dentists (JACD). The changes that will begin next year reflect the retirement of longtime JACD editor, Keith P. Blair, and the Board of Regents approval of a plan to refocus and reformat the College's professional publication.

Dr. Blair will retire as JACD Editor on December 31, 1993 after 13 years of service. During his tenure, the JACD underwent changes in its content and format, while continuing to serve as a voice of dental professionalism. The College salutes Keith Blair for his dedicated service.

The JACD plan, adopted by the Board in November 1993, was based on comments and suggestions provided in the survey of Fellows, completed in early 1993 and a review of the scope and focus of the existing dental publications. The new directions also are intended to more closely link the JACD with the College's strategic directions. Finally, the production steps contained in the new JACD plan reflect the College's desktop publishing capabilities.

The new directions for the JACD will build upon the College's key role in ethics and professionalism. As stated in the plan, the purposes of the JACD will be "to promote the highest ideals in dentistry and health care, to inform public and professional opinion, and to enhance the quality of decision-making related to dentistry by providing a forum for discussion and debate." The Journal structure will encompass regular sections: editorial, letters to the Editor, a point/counter-point section addressing a major topic, submitted and invited articles, statistical perspectives and suggested reading. Material from the College's Annual Meeting and Convocation will be included in the first issue of each year.

The focus and directions of the JACD will emphasize publication of provocative articles addressing key issues, concerns and/or potential directions in dentistry and from areas that could affect or shape the profession. The new approach is intended to encourage Fellows involved in a wide range of professional settings to submit well-written, thought-provoking pieces. Published manuscripts may address, for example, the following perspectives:

- A summary of an major area of research in dentistry or other disciplines, with an emphasis on the implications for practice.
- Translating clinical concerns into research questions.
- Strengthening the research/clinical care interface.
- Concerns and dilemmas in dental practice.
- Factors that should be considered in the shaping of dental and/or health care policy
- Ethical dilemmas arising in dentistry today.

Beginning in 1994, the news of Sections and Fellows will be published in the ACD quarterly newsletter, News & Views. More detailed information about the content and format for submitted manuscripts will be available from the College's Executive Office in early 1994 and will be published in the first 1994 issue of the JACD. To accommodate the Journal restructuring, only two issues of the JACD will be printed in 1994. Issues will be distributed in April and October.

Search Opened for Editor,
Journal of the American College of Dentists

The American College of Dentists announces the search for Editor of the Journal of the American College of Dentists. The Editor will be responsible for developing a strong content base for the JACD that will enable this publication to serve as a premier source of professional discussion and debate; s/he also will be responsible for all aspects of content management. Specific responsibilities will include:

Planning - Develop long-range content plan and direction; develop issue themes, content plans and schedule; develop content process schedule.

Content/Manuscript Solicitation - Develop guidelines for invited and submitted material; manage process to identify, contact, negotiate with invited authors; work with authors and associate editors on content development; actively solicit submitted manuscripts; write 1-2 page editorial in each issue.

Content Review - Refine and manage review processes; assign manuscripts to appropriate associate editor(s); serve as final content reviewer, make final determination of acceptance/rejection of submitted papers; provide substantive comments to authors on all manuscripts; work with authors on making refinements/corrections to material; provide guidance during final copyedit.

Other Management - Recommend and "evaluate" associate editors; represent the JACD before other professional/scientific groups; provide assistance in efforts to secure underwriting/grant support of the JACD; provide guidance to Board on JACD and role in ACD communications.

The successful candidate will be a Fellow in good-standing with extensive and broad knowledge of the key issues in dental practice, research, education and policy, as well as knowledge of issues in related disciplines and in health policy concerns; have excellent writing skills and a distinguished publication record, excellent judgment and proven ability to work with authors to solicit, develop and refine articles. The candidate should have extensive contacts in all areas of dentistry, other related disciplines, and in policy areas and a willingness to actively solicit manuscripts from these areas. The Editor also must have proven management and leadership skills with a vision for the JACD and its role in the future of the College.

The position of Editor is a volunteer (non-staff) position. The Editor will serve as an ex-officio (non-voting) member of the Board of Regents and the Publications Advisory Committee of the College. The Editor will receive a modest honorarium and reimbursement for JACD related expenses.

Interested individuals should send a curriculum vitae or resume, the names and telephone numbers of three references, and a cover letter describing interest in this position, relevant experience and availability to perform the duties of this position, and their vision for the potential and direction of the JACD to:

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

Materials must be received no later than February 28, 1994. Selection of the Editor will be made by the Board of Regents in mid-1994, with the Editor formally assuming duties for the 1995 issues of the JACD.

Access To Oral Health Care —New Directions

INTRODUCTION

Irwin D. Mandel *

Before we begin our presentation on new directions for increasing access to oral health care, I think it would be appropriate to very briefly review some aspects of current dental health needs in the United States. The epidemiologic surveys of children in the 80's generated a period of dental euphoria—a prediction of the demise of caries—the wicked witch was dead. A closer examination of the data, however, leads to a tempering of the enthusiastic view that caries is becoming extinct. Although 50 percent of U.S. children, aged 5 to 17, are currently free of caries, there is a polarization in the pattern of incidence: 20 percent of the children have about 70 percent of the caries. The situation is similar in other developed countries. In the United Kingdom 60 percent of the caries is found in 20 percent of the children; in Australia 12 percent of the children have 50 percent of the caries. What the epidemiologic findings point up is the tyranny of the mean. One must not over-extrapolate from mean values but be cognizant as well of the range and standard deviations. It is necessary to pay attention to fringe groups in health affairs, as well as in politics. A number of studies have established that race, socioeconomic status, and behavioral patterns are major determinants of who is at risk, not only for caries but for periodontal disease as well. A recent study in Nevada, for instance, noted the decay-missing-filled (DMF) index was nearly twice as high for children in the low socioeconomic category than for children in the high socioeconomic category. In general, African-American and Hispanic children had decay rates 50 percent higher than white children. Clearly it is the have-nots who have most of the dental disease.

A very dramatic description of this state of dental affairs was recently offered by Jonathan Kozol in his book *Savage Inequalities*, which

* Irwin D. Mandel, DDS
Professor Emeritus
Columbia University

Access, Health Care Financing and Reform

Change and Continuity in Health Care in the United States:

Richard W. D'Eustachio*

The American Dental Association Task Force on Access, Health Care Financing and Reform was established in August 1991 by the Board of Trustees, responding to a proposal by Dr. Geraldine Morrow, then President-elect.

The purpose in proposing the Task Force was founded on two beliefs:

- the Association should more actively address the issues of access to health care for all and the financing of that care
- health system change may be imminent, inasmuch as the problems of health care access have become principal concerns of business, labor, health professions, advocacy groups and government.

* Richard W. D'Eustachio, DDS
Fourth District Trustee
American Dental Association

Paper presented at the 12th Annual Dunning Memorial Symposium, Columbia University, November 20, 1992

12th Annual Dunning Memorial Symposium Columbia University

compared affluent and poor school districts: "Bleeding gums, impacted teeth and rotting teeth are routine matters for the children I have interviewed in the South Bronx. Children get used to feeling constant pain. They go to sleep with it. They go to school with it. Sometimes their teachers are alarmed and try to get them to a clinic. But it is all so slow and heavily encumbered with red tape, waiting lists and missing, lost, or canceled welfare cards, that dental care is often long delayed. Children live for months with pain that grown-ups would find unendurable." Jonathan Kozol may soon replace Saint Apollonia as the patron saint of the dentally afflicted.

Oral health needs extend beyond the children. The adult survey in 1986 dramatically showed the disparity between the ages of 18 to 65 and the over-65 segment of the population. The elderly have much higher levels of oral disease and much lower rates of utilization of services than younger groups. Here, too, the minority groups are at a special disadvantage.

African-American, Hispanic and Asian adults are in a dental timewarp. Their dental care, dental awareness, and preventive practices reflect the attitudes and limitations of previous generations and, in the case of recent immigrants, places of origin. When compounded by economic difficulties, dental needs are, by necessity, given a very low priority. These needs are well known, as some objectives for dealing with them have been established by the Department of Health and Human Services in *Healthy People 2000*, the departmental blueprint for the future. The actual strategies for meeting these objectives, however, have been receiving inadequate attention.

This symposium targets current oral health problems. Access issues and possible solutions are discussed. The issue of the role of oral health care, its place in a national health strategy and financial implications are explored.

A Summary of the ADA Position Paper

The charge to the Task Force was to produce a product from which an action plan for the Association could be derived that would influence accessible, cost-effective, needed dental care for all segments of society, while maintaining dentistry's professional integrity.

The Task Force on Access, Health Care Financing and Reform undertook an examination of health care systems in selected nations and proposals for reform of the U.S. system. Its purpose was to assist the Association in developing an action plan to influence accessible, cost-effective, needed dental care for all segments of society, while maintaining dentistry's professional integrity. In this way, the Association could more actively address the issues of access to care for all and the financing of that care.

The Task Force addressed the barriers to health care experienced by all impoverished people. It endorsed reform of the Medicaid sys-

tem to include all categorically impoverished persons, to improve compensation to assure sufficient provider participation, and to adopt a standard benefit package, including dental benefits, nationwide. To advance the objective of a single system of health benefit programs for all Americans, it found preferable the transfer of the reformed Medicaid program to the private sector with coverage provided by insurance carriers and service plans.

Further, it called for a renewed commitment, supported by public policy, to health education and prevention, necessary for the improvement of general health and specifically oral health.

The Task Force identified the following major failings in the current employment-based system:

- Twenty-four million workers and their dependents without any health care benefits and, consequently, at catastrophic financial risk;
- Another 25 million seriously underinsured and at essentially the same risk;
- Inability to assure the public — even the currently insured public — that illness, combined with other unforeseen circumstances, will not eradicate life savings; and
- Inability to moderate rises in health care costs.

It noted that none of these failings applies to the delivery of dental care or to dental benefits. Accordingly, it concluded that dental benefit programs should continue to be treated separately from hospital-medical-surgical benefit programs.

To resolve the major failings in the current system, while retaining its strengths, the Task Force determined that all employers should be required to provide a basic benefit package for employees and dependents consisting of preventive services (fully covered prenatal, maternity and infant care, including immunizations) and catastrophic expense coverage (after an annual deductible equaling 10 percent of gross income is satisfied.) Small employers would be allowed five years to comply and would receive tax and other incentives to do so.

All other health benefits, including dental benefits, would remain matters for employer-employee negotiations or collective bargaining.

Related recommendations of the Task Force include support for judicial and professional liability reforms and recognition in law by all states of living wills. Such actions would moderate the overall cost of health care. The Task Force also supports federal financial incentives for health care practitioners to establish and maintain practices in less desirable, and therefore currently underserved, geographic and socioeconomic areas.

U.S. Treasury vouchers for preventive dental services should be provided to all children through age 18, not covered by Medicaid or private dental benefits. Eligibility should begin with children in lowest income families, proceeding up the family-income scale as funding availability allows. State eligibility for federal education funds should be made contingent on a commitment to achieving a goal of at least 75 percent of a state's population served by community water supplies receiving optimally fluoridated water by the year 2000. This should also be based on integrating statewide health education programs, including oral health, into school curricula.

Implementation of the provisions in these recommendations that represent either federal revenue losses or direct costs to the U.S. Treasury should be funded from revenues derived from the broadest possible taxation base.

The Task Force recognizes that these recommendations may be achievable only incrementally. It understands that some modifications may be necessary to win support in the political arena. It believes that reasonable compromise may prove to be a useful instrument for gaining acceptance of the principles presented in this paper. △

12th Annual Dunning Memorial Symposium

Health Care Reform... Practical Manifestations of Theoretical Values

David A. Nash *

The American Association of Dental Schools (AADS) represents all 55 of the nation's Colleges of Dentistry, those in Canada and Puerto Rico, and many other dental, advanced dental, and allied dental education programs. In addition, our organization has 3,500 individual members. In some of my remarks today I will speak for our Association and I will speak about our adopted position on health care reform. I do this in my role as Chair of the Association's Legislative Advisory Committee. I will not articulate all aspects of the Association's policy on health care reform for that is a matter of record and available for your reading. I will also present our Executive Committee's comment on the health care reform position of the American Dental Association. Subsequently I want to speak for myself and examine the conceptual bases that may account for whatever tensions exists between these two positions. Finally, I will conclude with my personally held view of what values should undergird health care reform: values grounded in what I understand to be the concept of a profession, specifically a health care profession.

I will move fairly quickly from the practical machinations of health care reform to the differing value theories that give rise to alternative views of reform.

I hold strongly to the intimate linkage between theory and practice. All practice is related to underlying premises and assumptions, whether identified and articulated, or not. Obviously, the better one understands one's theoretical base, the better one is able to understand what practices to advocate, and why one advocates the practices one does. In arguing for the nexus of theory and practice, I take encouragement from the celebrated American philosopher and a personal intellectual hero, John Dewey, who for many years served on this campus as a Columbia University distinguished professor; and today continues to be acknowledged as among America's most notable contributors to the funded intellectual wealth of our world. To not place my argument in a Deweyian context would be to fail to honor his spirit on this campus! Arguably, Dewey's greatest work was *The Quest for Certainty*, in which he affirmed the imperative of linking the practical and the theoretical, or of not failing to distinguish between the linking of means and ends. His constantly recurring emphasis upon the importance of an intimate, reciprocal relationship between theory and practice is one we must recur to in the context of our current discussion.[1]

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University of Kentucky

Paper presented at the 12th Dunning Memorial Symposium, Columbia University, November 20, 1992

AADS Statement on Health Care Reform

I begin by excerpting the major premises of our Association's position statement.[2]

> The American Association of Dental Schools believes that the health needs of the public require a health care system that provides access to care for all Americans and effective and therapeutic treatment at a cost that is affordable. The Association considers universal access to care a fundamental goal to be achieved in any restructuring of the health care system. We recognize that this goal may be achieved from federally-funded, federally-mandated, or private programs, and/or a combination thereof. The Association believes that federal funds must be included where no other funding is forthcoming to finance basic health care benefits.

To maintain and improve general health, oral health services must be an integral component of all health care financing and delivery systems. The development and health of the cranio-facial region has a direct bearing on general health and well-being, and is a basic element in the quality of life.

The Association strongly supports basic oral health care benefits for all persons. These benefits should include the provision of acute and primary care. Acute care is emergency care to treat pain, eliminate infection, treat life-threatening conditions like cellulitis and oral cancer, as well as to treat traumatic injuries. Primary care is diagnostic, preventive, restorative, and periodontal care. It also includes prosthodontic care to restore minimal function. The Association believes that rehabilitative care that has as its goal the enhancement of aesthetics to an otherwise functional dentition is beyond the scope of the basic benefits grouping.

The AADS recognizes that important groups of patients require extensive care because of developmental defects and acquired anomalies impairing function, as well as chronic conditions that have oral manifestations. The Association believes that the scope of health care benefits must be sufficiently broad to provide rehabilitative benefits as part of the basic benefit package for these persons.

We believe dental education plays a pivotal role in ensuring access to effective health care through the provision of care, training, and research. Thus the Association supports the incorporation of this national resource into the nation's health care system. To this end, health care reimbursement should include compensation to health care institutions for the teaching costs associated with the provision of oral health care.

The AADS supports the provision of federal and state grants to dental education institutions to establish and enhance primary oral health care training through residency programs in general dentistry, geriatric care, pediatric dentistry, and dental public health. These residency programs provide trained oral health care professionals who are needed to ensure access in under-served areas such as rural communities, as well as to geriatric, handicapped, developmental disabled, high risk, and other medically-compromised patients. To facilitate access, the Association supports the establishment of grants to dental education institutions to offset the cost of providing to unserved and under-served groups.

Practitioners who are skilled in diagnosis, risk assessment, and treatment are essential to the provision of oral health care. The role of dental education institutions in preparing an adequate supply of practitioners who have the skills necessary to provide effective primary care is a fundamental part of the health care system. The Association, therefore, advocates grants that will enhance the educational process and improve the effectiveness of education in the health professions.

The Association believes that the number of minority graduates of dental education institutions should better reflect their representation in the population, and supports programs that will achieve that goal. Additionally, the Association endorses efforts that result in improving the health of minority and under-served persons.

The Association recognizes the important contribution that accredited programs in allied health fields of dental hygiene, dental laboratory technology, and dental assisting make to the nation's health. The AADS strongly supports initiatives that encourage enrollment, support students who are enrolled, and improve the effectiveness of dental allied health education programs.

The AADS supports programs that provide grants and low-cost need-based loans to students. In addition, the Association urges direct public support for dental education.

The retention and graduation of practitioners from disadvantaged groups as a goal is important for the public's health. The Association supports grant and loan forgiveness programs for disadvantaged persons and minorities.

Research is critical to the health of the nation. Both basic and clinical research have led to improvements in oral health. Further improvements will be the result of continued efforts to produce new knowledge in the prevention and treatment of oral diseases. The Association believes that the allocation of resources for biomedical research must receive a high priority. The Association also supports funding for educational research. Similarly, research in health services has increased the knowledge in the area of effectiveness of treatment and health care delivery. The impact of this research will contribute to cost containment, improved quality of care, as well as to an understanding of barriers to access. Therefore, the AADS supports funding for oral health services research.

With this I conclude my excerpts from the written policy of the Association of American Dental Schools.

AADS Response to the American Dental Association's Health Care Reform Policy

The AADS supports, in general, the positions taken by the American Dental Association (ADA) in their white paper on "Access, Health Care Financing, and Reform,"[3] ...those positions articulated here today by Trustee D'Eustachio. We both affirm, endorse, and support:

- Accessible, cost-effective oral health care for all Americans.
- Renewed national commitment to health education and prevention particularly among the disadvantaged.
- Medicaid reform to include comprehensive oral health care for individuals below the poverty line, and adequate compensation for health professionals.
- Oral health care for children through age 18.
- Increasing the population served by communities receiving optimal fluoridated water supplies.
- Integration of health education, including oral health, into primary and secondary schools' curricula.
- Federal incentives for health practitioners to establish and maintain practices in underserved areas.

Among the differences in the ADA and the AADS positions is that the AADS advocates for dental education's inclusion in the health care reform debate, and we do not advocate a particular model for a reformed health care system. The ADA does propose a number of reforms speaking specifically to the structure and functioning of a revised system.

As an Association, we do have concerns regarding the ADA position. One concern focuses on what appears to be an assumption of the ADA that dentistry should not necessarily be a part of a comprehensive reformed health care system in this country. In the ADA's White Paper the following two statements are made:

"The U.S. health care system's problem is essentially a matter of costs; dentistry has not contributed appreciably to the inflation in charges for health care services, therefore dentistry should be excluded from reforms of the system that would correct this problem."

"The cost-related failings of the nation's health care system are not failings of the dental care system."

These statements suggest dentistry has not been a part of the problem, and therefore, shouldn't be a part of the solution. We believe dentistry must participate vigorously in the debate concerning health care reform. We have much to teach policy makers about cost effective ways of providing ambulatory care.

The ADA Task Force recommends that dental benefit programs continue to be treated separately from other benefit programs — that they be treated as they have been since the inception of modern dental prepayment in 1954. It goes on to say: *"none of the failings (of the health care system) apply to the delivery of dental care or to dental benefits."* Accordingly dental benefit programs should continue to be treated separately from hospital-medical-surgical benefit programs.

Elsewhere in the report, dental costs are referenced as *"discretionary."* We believe it is critical to challenge this conception — that is, that oral health care is discretionary when thinking about health care generally — with the tacit assumption that it can be ignored by the public and society. The AADS believes that oral health care is an integral and essential component of health care. Enchancing the quality, utilization, availability, and affordability of oral health care benefits the public's general health and well-being. The continued fragmentation of dentistry from health care delivery and financing has neither been positive for the profession nor good for the public. It is the reason today that the acute exacerbation of an infection in the oral cavity is treated differently, that is, not paid for with general health benefits, while such an exacerbation of the large toe is!

We believe talking about dentistry in terms of *"discretionary"* undercuts the reality that the oral cavity is a part of the human body; and implies that one can be healthy with-

out oral health. To suggest that oral health is not integral to and important for health generally diminishes dentists and dentistry as a health profession. If I could appropriate a line from Linda Niessen, in her testimony at the recent Annual Session of the American Dental Association: *"I am confident that none of we dentists here who have the degree D.D.S. would ever want to have that designation identified as standing for a 'Doctor of Discretionary Services'."*[4]

Finally the ADA position states: *"The current health care and benefit system must be preserved to the fullest extent possible. Such preservation protects the interest of practitioners."* The AADS believes this could appear self-serving and inflexible to those outside the profession.

From Practice to Theory

While the American Association of Dental Schools and the American Dental Association share many common concerns in health care reform, the tensions brought out in our differences, that is, the importance of dentistry being integrated into the health care system, and dentistry not being viewed as discretionary spending; are potentially rooted in different value systems, or theoretical approaches to the ethics of health care. It is prudent that we explore these, if only briefly, in order that we can better understand why differences exist in our national debate and further understand how we might communicate more effectively in working through these differences.

At a recent Executive Committee meeting of the Kentucky Dental Association, one of my colleagues articulated an ethic common in the profession, while arguing strongly against dentistry's participation in health care reform. He said he was *"unwilling to give up the prerogatives of private practice, freedom-of-choice, fee-for-service dentistry ... free enterprise dentistry!"* This I think reflects the general culture of the profession of dentistry in America today. In such thinking, the individual and individual rights are paramount. This view is characterized in the literature and language of ethics as a libertarian theory of justice. On this view the dentist is one who, through personal initiative and discipline, has earned the right to offer dental services. Similarly, patients have a right to seek from whomever, whatever care they want ... and can afford. On this view of justice, societal benefits are distributed based on individual merit, contribution, or effort; not on the basis of need or equality. Health care will be unevenly distributed, for wealth is unevenly distributed. The preservation of the traditional prerogatives and personal autonomy of dentists (and of patients) is a principle not to be violated by society's priorities for the distribution of health care resources.

In such a *"free enterprise system,"* the business or commercial model of providing health care undermines what I will subsequently characterize as a professional model ... or a model I will want to argue is rooted in a tradition of caring. Commercialization of dental care in the United States has transformed the culture of dentistry. Dentistry has become a commodity produced and sold for a profit. The marketplace is free enterprise — therefore dental producers compete, and publicize their competitive spirit through advertising. Not only do dentists compete with one another, but they compete with their patients. The patient attempts to gain the greatest service from the dentist for the least cost, while the dentist is attempting to gain as great a net financial benefit as possible. The fiduciary relationship between dentist and patient becomes fractured. In this model, dental care becomes "discretionary spending" and is purchased in much the same manner in which a vacation is purchased ... or a new automobile. If you can afford it, you buy it. If you cannot buy it, you do without. Dental care is a commodity that dentists sell and patients buy. The dentist is a producer, the patient is a consumer, and the interaction between dentist and patient is one of many transactions in the commercial marketplace. As one leading critic has said, *"A new language has infected the culture of American health care. It is the language of the marketplace, of the tradesman, and of the cost accountant."*[5]

This libertarian theory of justice, of ethics, is challenged by both egalitarian and utilitarian views. On an egalitarian concept of justice, social and economic inequalities are not just to be accepted as the law of nature, a type of "social Darwinism" where the fittest survive; but are to be arranged, so that they are both:

- "Reasonably expected to be to everyone's advantage."
- "Attached to positions and offices open to all."

According to John Rawls,[6] the distinguished Harvard philosopher, this is the way in which we can achieve fairness in the "social contract." Fairness requires that the arrangements of a society should be

distributed in such a way that the benefits and burdens of that society are allocated irrespective of a person's position in that society. In formulating this notion of distributive justice, Rawls developed his so-called "veil of ignorance," behind which rational people would stand, not knowing what position they would occupy in a hypothetical, but just society. They could be either rich or poor, well or sick, dentist or patient. In this hypothetical situation, rational humans would design a society where the lot of the least well-off would be maximized ... since in reality that life might turn out to be their own! Thus on an egalitarian model, we acknowledged the intrinsic worth of every human and affirm that except for the natural lottery, we could be the poor individual unable to purchase oral health care for ourself or our family.

This concept of justice affirms the value and worth of every human being. It is related to Immanuel Kant's second formulation of his categorical imperative - *"act so that you treat humanity whether in your own person, or that of another, always as an end, and never as a means."*[7] People are ends in themselves ... never a means for others. Said differently, all humans are worthy of respect ... just because they are humans. It is impossible to contrast the worth of persons with the price of things. The price of a thing is a relative measure of its value in the marketplace, based on supply and demand. But human beings have a value of an entirely different order, they are priceless ... they are beyond the contingencies of the market, of supply and demand.

However, just saying that humans have infinite worth and value does not mean or imply that society should, or could afford to, provide unlimited health services to all. The egalitarian view is tempered by a utilitarian theory of justice. Society's resources are not limitless. While humans have infinite value, we can only allocate finite resources to caring for human health; there are other human goods to be cared for as well. On utilitarian moral grounds we should allocate funds based on the principle of the greatest good for the greatest number. Our resource base forces us to ask the difficult, but essential, question of costs versus benefit and value. Limited resources require that we ask the questions of what is a *"decent basic minimum,"* ... and how much can we afford.

An egalitarian view of justice is embedded in the idea of what it means to be a profession and a professional. In 1915, in a speech before the National Conference of Charities and Corrections entitled, "Is Social Work A Profession?,"[8] Abraham Flexner ... yes, the same Flexner of the Flexner Report on Medical Education published in 1910, helped establish our contemporary criteria for what constitutes a profession by identifying six cardinal characteristics of a profession. I will focus only on one. He said, *"Professions ... view themselves as organs contrived for the achievement of social ends rather than as bodies formed to stand together for the assertion of rights or the protection of interests and privileges of their members."* Professions and professionals are professions and professionals because they pursue the common good of humanity not primarily or necessarily their individual personal good. Professions and professionals are professions and professionals because they organize — not to protect their own interests (as do labor unions and trade associations), but rather to promote the common good. Professions and professionals are professions and professionals because they are committed to respecting the inherent worth, value, and good of each person ... as an end ... and not as a means. Professions and professionals serve the *"end"* of human good. Professions and professionals do not make other humans the *"means"* to their good.

Ethics in health care on a libertarian account leads to more of that which we have; an increasing gap between those who have health ... oral health, because they can afford it; and those who do not have it because they cannot afford it. Practitioners and patients being free in the market rings as hollow justification for the existence of poor oral health by the many in our society deserving of such a benefit, but who, through no fault of their own, are unable to purchase it. It's an argument that rests uncomfortably in the face of poor children who suffer from pain and infection because their parents cannot purchase care from the local proprietor of such care, while children sitting next to them in the classroom have superb oral health, not through any merit of their own, but because in the natural lottery they were born to parents of means. What price do we, as a society, pay for worshiping at the feet of this idol of individualism and autonomy?! A society that does not care for its sick is not a moral community. In fact, the moral fabric of a society is best judged by how it treats its least

advantaged citizens. The index of a nation's character is how it treats its underclasses.

The egalitarian view offers a countervailing value to the libertarian one by an ***EQUALLY*** American notion ... a ***"republican"*** tradition that stresses our obligation to rise above self-interest and to focus on the common good of the society. Republican with a little "r" is, in its etymological roots, commonweal or the common good. Health care reform must draw on this tradition to balance what has become the dominant individualist model. A call to pursue the common good is a call to pursue the good — a life of health — a life of well-being ... in common! It is a formal acknowledgement that unless we are all stakeholders in the good society and the good life, ultimately none of us will be. It is an understanding that our personal best interest is served when we, in a burst of enlightenment, affirm that other persons' interests must be served as well. It is an acknowledgement of the essential qualities of cooperation, of reciprocity, of mutuality ... in a civil society.

Conclusions

While this egalitarian idea of the common good may sound like an ethereal ideal, it is, in fact, not. In this regard I quote a noted entrepreneur of the marketplace, the Chief Executive Officer of General Motors at a time of the apogee of its success. Charles E. Wilson, in 1953, while appearing before a Congressional Committee made a comment, which is often misquoted. He is misquoted as saying what many would have expected him to say, given his business focus and leadership of America's largest corporation, "what is good for General Motors is good for the country." In fact that is ***NOT*** what he said, and he spent his entire life correcting people who misquoted him. What he said was ***"what is good for the country is good for General Motors!"***[9] What is good for the oral health of the nation's citizens is good for dentistry! However — we must be vigilant to ensure that we neither believe nor promulgate the reverse, that what is good for dentistry is good for the nation's oral health. We all acknowledge that such does not necessarily follow.

My vision is of a profession of dentistry committed to health care reform ... a profession committed to access, no matter what one's social or economic circumstance. Access to what has been called a "decent minimum" of oral health, with such a "decent minimum" being defined in a way not dissimilar to that described in the AADS's health care reform policy. My vision is of a profession of dentistry that acknowledges that the good of the profession is best achieved by vigorously pursuing the good of society. My vision is of a profession that is characterized by society as a profession of practitioners caring, compassionately caring, for the oral health of America and all Americans.

My appeal is for all of us in the profession to work together with society to pursue the common good in oral health — which is the pursuit of the good of oral health — in common!

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12th Annual Dunning Memorial Symposium

Access to Dental Care for Children

David C. Johnsen *

The extended post-election period could bring the greatest changes in health care since the era of Medicare and Medicaid. Here are only a few of the many signs. First, health care was a front-burner issue throughout the campaign and was second on a list of reasons for voters choosing Bill Clinton. From another perspective, at least six states now have class action suits at some stage against respective Medicaid departments to improve access to dental care for children. In the legislative arena, more than twenty bills on health care were considered in the last Congressional session; however, few bills included dental care in enabling legislation. The Matsui Bill, initiated by the American Academy of Pediatrics may be the only one that included dental care as a result of input from professional organizations.

Major challenges confront dentistry as it defines its new role in the political arena. There are many questions that we will deal with in an active or passive way. Is dentistry prepared to participate in the changes? What are dentistry's recommendations? How can we coordinate our efforts? With whom will we collaborate in proposing legislation? One purpose of this presentation is to explore points that may be on the minds of key players in the forthcoming "reform". It is hoped that discussions such as this Symposium will contribute to a unified effort to improve access to health care for children.

The main purpose of this presentation is to review points that can be used in developing an effective agenda. There are undoubtedly other points that can contribute to propelling a movement for better health for children.

1. The gap in the quality of oral health is widening between children able to participate in the private system and children outside the private system. The coin is bad on both sides for the "outsiders". Caries is higher and access to treatment is lower. The result is a greater occurrence of disease as well as an inability to stop its progression and prevent further disease. Dental caries is more common and more often starts early in the "outsiders". Baby Bottle Tooth Decay (BBTD) is more common in underserved groups.

Prevention and treatment of dental caries, especially BBTD, is more difficult for the "outsiders". More than 75 percent of Medicaid recipients under age 21 did not have a dental visit in 1990. This reflects a steady increase over each of the previous three years. The trend for dental access is the reverse of the trend for access to physicians; in the same report, the percentage of children not receiving a physician visit decreased to less than 28 percent in 1990. The gap in oral health indicators and in access to care for different groups may be the most academic point and the most easily agreed upon in this presentation.

2. The absence of government from dental programs is curious because dental care seems to be one field where government could accomplish a great deal. Almost all dental disease is preventable. The cost of repair is relatively high. Children entering dental care early and staying in the system enter young adulthood in excellent oral health and with a modest investment. Perhaps it is because dental disease does not make political headlines.

3. The role of organized dentistry in the design of health care legislation has not been proportional to dentistry's role in total health care. While 5 to 7 percent of the private health dollar, about $35 billion, is spent on dental care annually, only about 1 percent of the Medicaid dollar is spent on dental care, and even less of the Medicare dollar is spent on dental care. Until recently, dental organizations have not been mandated by their members to be advocates for people outside the private practice system. During the Medicare-Medicaid era, dentistry and medicine were actively uninvolved at the directive of members.

It will be important for dentistry's advocates to have a consistent, concise message for Congressional staffers on basic elements for children's oral health programs and the financing of those programs. It seems clear that one challenge lies in improving awareness of Congressional staffers drafting legislation. The next step is to identify a coalition and gain a sponsor for enabling legislation.

4. Most dentists in private practice can function outside the government system. The demand for dental care by paying patients appears to be growing steadily. A shortage of dentists is projected by the

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year 2000. Many dentists are frankly suspicious of any partnership with government as a first step in the takeover of dental care. I doubt that the government will attempt to take over a system that overall delivers high quality services, with regular participants satisfied and in good health. Another reason that the private practice system is likely to persist, regardless of the actions of Washington, is that dentistry is rarely catastrophic. Middle class people with a modest disposable income can afford most dental care; they will choose their dentist and will not submit to the directive of an outside agent.

People who have begun dental care early and have maintained a regular recall/prevention schedule enter adulthood in excellent dental health with a modest investment. The government has enough avid interest groups after them without taking on organized dentistry and medicine. Only a few of the bills presented so far discuss "single payer" financing or national health insurance. Thus, the avoidance of involvement for fear of being taken over keeps dentistry out of the legislative process.

5. The major potential player among dental organizations in the legislative process is the American Dental Association (ADA). No other dental organization is close to having the same potential. Guidelines for the Washington office of the ADA were written in the early 1970s. For every health bill in the last cycle, there was a guideline preventing ADA endorsement. The passage by the ADA House of Delegates of the "Statement on Access to Care" is a significant step in improving the advocacy role of the ADA. The ADA is currently developing an agenda. The question remains as to how much the long history of looking to Chicago for ongoing guidance will influence the Washington staff in staying flexible as the legislative winds change.

The Washington staff of the ADA has many excellent and committed people. One prediction is that the Washington office of the ADA will become more proactive. But there are limits on the ADA's influence. To put the potential impact of the ADA in some perspective, the Washington office has less than 20 people; the American Hospital Association (also based in Chicago), on the other hand, has over 100 people in its Washington office.

"The major potential player among dental organizations in the legislative process is the American Dental Association (ADA). No other dental organization is close to having the same potential."

6. Dental people in government agencies are as knowledgeable as anyone in the content of programs providing care for children. Government dental officers deal directly with the results of legislation and can best anticipate the impact of programs. The dental officers are thus a likely source for program content when people within the government are called on to assist in legislation. This group has cohesion and activity. Their recommended benefits are like that for AAPD and the American Society of Dentistry for children (ASDC). They have requested meetings with higher officials.

7. Legislation to provide basic dental services can only come about as part of health legislation for other groups (eg, children, elderly, etc). There will not be a "dental bill". An example of the inclusion of dental services into basic primary care is the Matsui Bill initiated by the American Academy of Pediatrics; dental benefits are specifically listed as part of primary care benefits. The danger of relying on inclusion as part of EPSDT is that should Medicaid be replaced, there is no specific mention of dental care.

8. The only Government program with the potential to significantly influence access to dental care for children is Medicaid. Dental services are mandated under the EPSDT section of Medicaid. Adult services are not mandated and are vulnerable to elimination. The only mandate for EPSDT relates to assuring access to care. There are no regulations on fees, paperwork simplification, etc. Will providers participate if fees meet or exceed office expenses? The "experiment" in Kentucky and West Virginia suggests that where Medicaid fees are raised above the overhead costs of a practice, more providers will participate. The results of this "experiment" are early.

Some states have had an erosion, not only in dollars for Medicaid, but also in the percentage of Medicaid dollars spent on dental care; in my state of Ohio, the percentage of Medicaid money spent on dental care

went from 1.8 percent in 1980 to 0.9 percent in 1990. The reasons for the drop are not entirely clear. It does seem clear that organized efforts to influence legislation on a state level could be considered.

The strategy to improve access to oral health care for children by improving the Medicaid system may be a fragile one. Medicaid is a nursing home program. More than half the Medicaid dollars go to nursing home care. We should at least consider the response of the nursing home industry if we try for more Medicaid dollars. That industry has a long history and experience in influencing legislation beginning in the Medicare-Medicaid era.

9. A growing number of dental organizations have made access to dental care a priority. More organizations are becoming advocates. While a collective agenda has not finalized, emerging elements include emphasis on primary care and dental care as part of primary health care. Organizations are expanding activities into the larger advocacy arena. An example is the American Association of Dental Schools (AADS); advocacy has become a major theme for AADS.

10. Dental health is perceived as an important part of general health by non dental professionals. The American Academy of Pediatrics lists dental care high on its list of recommended benefits. Migrant networks state that dental disease is the number one health problem in children ages 10-14. Head Start directors list access to dental providers as one of their leading problems. We have a story to tell and potential allies. We have not maximized natural opportunities with natural allies.

11. Dental organizations must be willing to endorse financing to be taken seriously by legislators. With the deficit, we can no longer avoid participating in cost containment and financing of programs. Three basic approaches seem to be national health insurance (or "single payer"), employer supported health insurance (eg, "pay or play"), and the status quo. Some compromise may emerge. I doubt that the "single payer" concept will have wide enough support to become the "reform". The ADA and the AAPD/ASDC have both endorsed approaches to financing. The financing choices may change as the debate unfolds, but we must enter with a willingness to talk financing.

The emerging agenda for the coming months includes development and refinement of a message followed by enrollment in a coalition with the same message and capable of getting legislation introduced. Next comes a draft of legislation and one or more Congressional sponsors. Delivery of the message to key Congressional leaders and the Administration becomes the repetitive part of the activity. The evolving message is fairly simple:

- The gap in dental health is widening between those with access to private care and those without. There is a great opportunity to have better health and lower cost when dealing with a disease that is totally preventable and expensive to repair.
- The only government program with the potential to significantly affect access (Medicaid) is reaching progressively fewer children.
- Access to primary health care for all children is the goal with dental care as part of total primary care.
- Dental health has been recognized by non-dental professionals as an integral part of total health.
- The private system works. Build on the private model to include basic dental services for all children.
- Basic preventive and restorative dental services with early entry and regular care are at the first level priority. The current EPSDT package of benefits is adequate.
- The importance of dental health as part of total health has been endorsed by major dental and non dental groups including the American Academy of Pediatrics and the American Dental Association.
- Formalized working relationships with other health groups will improve the chances for improved access to oral care for children.
- Dental organizations are willing to talk financing.
- Advocates must deliver a unified message to as many decision makers as possible. We are in a unique situation to improve oral care for children.

There may not be enough time for interested dental organizations to begin from scratch. There may compromises. The AAPD and ASDC have chosen to join the coalition that includes the American Academy of Pediatrics and the Childrens Defense Fund and have endorsed the Matsui Bill. If we stay on the sidelines as we did in the Medicare-Medicaid era, it may be another long stretch before we get another chance. By participating, we may come up empty, but if we do not participate, we will surely come up empty. △

12th Annual Dunning Memorial Symposium

Structuring Policy Options in Dentistry

Richard Adelson *

Dramatic changes have occurred since the publication of my proposal for aligning oral health services with the rest of health care.[1,2] Whereas, the prospects in 1988, and even in 1990, were gloomy for anything more than minor tinkering with publicly and privately supported health programs, the situation today is considerably brighter. The public is demanding that attention be paid to the basic structural problems in health care delivery—access, cost and quality. And government is listening. Undoubtedly, health care reform will be addressed in 1993.

Given the potential scope of the changes, it is essential that the dental profession be involved early in the ensuing debate. We must learn from dentistry's opposition to, and then, its virtual exclusion from Medicare. Failure to be involved, failure to develop approaches consistent with the emerging proposals for health care reform, may leave many Americans still unable to afford basic dental care. Lack of involvement may, by default, relinquish the design of dental benefits to those who may not fully appreciate how priorities in oral care should be assigned.

This paper will begin with the factors that are shaping the developments in health policy today. With this understanding, I will suggest a model for structuring policy options and strategies to integrate oral health care as a component of an overall health program. I will propose how oral health services can be aggregated in a manner that is consistent with other health services and which complement current thinking about meeting the public's health and social needs.

Momentum For Change

Let me begin by setting the health policy context. At no point in the last 20 years has there been as much momentum to reform the health care system. And at no time has the public been so aware and educated about the nature of the health care crisis.

Health Care Costs

Few Americans are uninformed about the escalating expenditures for health care. Expenditures exceeding 10 percent of Gross Domestic Product (GDP), unthinkable just 10 years ago, are now approaching 13 percent. Since 1970, total health expenditures increased at an annual rate of 12 percent, reaching 10.5 percent of GNP in 1984 and 11.15 in 1987.[3] At the current rate of growth, (thought by many to be unsustainable) analysts predict that we will be spending 16 percent of GDP by the year 2000 and 26 percent by 2030. The present national expenditure for health care at $643 billion is expected to reach $1.6 trillion by the end of the century.[4] Mushrooming health care costs have far exceeded the 3 percent inflation rate in the consumer price index.[5]

Among the factors fueling the increased cost is the heavy administrative burden, a direct result of the nation's complex and chaotic array of private and public programs. And the nature of this system offers few incentives to halt the rise in costs. Since most health expenditures flow through third parties, patients and providers are shielded from the full impact of health care costs. In 1987, the average citizen paid only 10 cents on every health care dollar for hospital services and 26 cents of every dollar paid for physician care, a share that has fallen steadily since.[6]

Public Disenchantment

In the eyes of most Americans, the added expenses have not brought good health or good health care. On indicators of health outcomes, such as infant mortality and longevity, America trails the other industrialized countries by significant margins.

In a Louis Harris survey of 10 industrialized countries, the U.S. showed the highest level of health care spending per person and the lowest level of satisfaction. Eighty-nine percent of Americans believed that major changes were needed in the health care system—almost 30 percent believed that it needed to be completely rebuilt.[7] In another survey, 75 percent of Americans favored a national health care program and increased government spending on medical service, even if it meant a tax increase.[8]

Traditional wisdom held that the public was dissatisfied with the health care system but happy with their own care. That is no longer true. A 1992 survey showed growing dissatisfaction with the quality of service. The percentage of Americans who reported being somewhat

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or very dissatisfied with their own health care doubled in the past five years, from 13 percent to 26 percent.[9]

Access to Care

Adding to the American disenchantment with the health care system are those who are medically disenfranchised. Close to 40 million Americans are without health insurance and that number has increased by 26 percent in the last five years. Falling outside the reach of Medicaid, three quarters of those without insurance are employed and above the poverty level.[10]

The uninsured use health services at a rate considerably lower than their insured counterparts. Freeman and colleagues (1987), comparing 1986 with 1982 data, reported signs of a deterioration of access to care by the poor, minorities and uninsured as measured by their use of health services.[11]

The health of the uninsured suffers too. A 1992 study from the state of Washington confirmed the findings of Freeman, et. al. that the uninsured have a poorer health status than the insured.[12] And they live under constant threat of the financial catastrophe that could result from a serious illness.

Health Care Reform

The call for restructuring of health care by professional groups and the public, is echoed by other sectors as well. During the last decade, in response to huge budget deficits, the federal government has shifted an increasing portion of the support for health care programs to the state level. Faced with their own budget problems, states have opted to tighten Medicaid eligibility and decrease benefits. State governments, recognizing they have reached the limits of any further growth in their share of health care funding, are turning to the federal government for assistance in addressing these issues.[13]

The cry for reform has been joined by employers, the major providers of health insurance, in an unprecedented call on the government to reign in health care costs. It is worth a note to mention the blurring of the roles of the major players in health care delivery. No longer are there clearly defined roles for providers, third party payers, and employers. Employers, faced with unmanageable costs have become their own insurers and are purchasing services directly from provider groups. Private third party payers, once content to just pay the bills for services, have become intimately involved in its actual delivery. They now review provider treatment, organize provider groups, and deliver managed care. Employers, insurance companies, and even physicians are expected to play a role in constraining costs through gatekeeping, case management and utilization review.

Over the past three years, virtually every professional group, state legislature, and think-tank has proposed a plan to reform the health care system. Yet what got the attention of Congress and the White House was Harris Wofford. Wofford a relatively unknown from Pennsylvania won a U.S. Senate seat over Richard Thornburgh in a campaign that focused on the need for national health insurance.

For evidence of government's concern, one only needs to look at the recent Presidential race. Ross Perot, delivering his economics lectures to television audiences, railed for reform, citing some of the same statistics you've just heard. Bush and Clinton debated the relative merits of their approaches to solving what has appeared to be intractable problems of limited access, high cost, and questionable quality. Now elected, Bill Clinton, promises to have a comprehensive health plan to Congress within 100 days of taking office.

Clinton's plan, as described in the *New England Journal of Medicine*, sets three goals: controlling health care costs, covering every American with at least a basic health benefits package and maintaining consumer choice in coverage and care. Quoting from that article the President-Elect plans to create a National Health Board that will "establish a core benefit package for private and public plans that will include ambulatory care, inpatient hospital care, prescription drugs, basic mental health care, and important preventive benefits such as prenatal care and screening mammography." He goes on to emphasize that "we need a health care system that stresses preventive and primary care..." and that "access to primary and preventive care will be expanded" through an increase in community centers and training support for primary care providers.[14]

The Clinton plan will be greeted in Congress by a variety of alternative approaches, mixing in different proportions: employer mandated insurance also known as "pay or play," strategies for increasing competition among health providers, government ceilings on expenditures, attempts to create coherence among existing federal and state health programs, and government support of benefits for the uninsured or uninsurable.

Although the strategies vary, there are common threads. Cost containment and access will be keynoted. All plans will have to define a basic level of service. And the bottom line will be how to raise the necessary revenues to support universal access to these basic services. Health economists see the need for considerable compromise in benefits and access, given the penchant of Congress to avoid raising the necessary taxes. And Clinton's proposal to ex-

pand health benefits is only one component of a larger agenda to revive the economy. Expecting to accomplish all of this while lowering middle class taxes would be difficult in less debt-ridden times. Given the current state of the economy, it is a mammoth undertaking.

Impact On Dentistry

Although not highlighted in the policy discussions, U.S. expenditures for dental care are considerable. The expenses appear small if you compare the $34 billion spent for dental care in 1990 to the over $600 billion expenditure for health services overall. Yet, the amount for dental services become significant when more appropriately compared to specific categories within the total health expenditure. For example, in 1990 the dollars spent for dental care was approximately two-thirds of the amount spent for drugs and for nursing home care and close to 25 percent of the bill for all physician services.[15]

Dental insurance could potentially buffer the financial impact of needed dental services. Approximately 40 percent of the population has some form of third party support for dental care. However, dental insurance, a primarily employment-related benefit, covers a relatively small proportion of workers. Of the 30 million participants covered for health services by companies with over 100 employees, only 8 million or about 25 percent had any benefits for dental treatment.[16] Given that most dental insurance is provided through the work-place, it virtually disappears for the over 65 year old.[17] Because of the high costs associated with health insurance many employers have opted to reduce or eliminate dental coverage.

Factors other than finances, such as education and attitudes toward dental care, have an impact on the utilization of dental services.[18,19] However, examination of dental utilization figures indicate that the person's ability to afford oral health care remains the dominant factor and is consistent with the lower use of health services by the poor and uninsured.[20,21] Since oral diseases are relatively non-emergent, financial decisions will relegate, to a low priority, all but critical dental problems. Given limited resources, and faced with increasing living costs (and no dental insurance) families may avoid, or delay seeking, dental services. Primary and preventive care for caries and periodontal disease will be delayed. Other aspects of care, such as orthodontics or prosthodontics, may be put-off indefinitely. Oral health is certain to suffer.

Concerns about financing dental care is occurring at a time when we may expect increasing demand for oral health services. Americans today have more of their own teeth and this trend will continue. The National Institute of Dental Research found only 4 percent of working adults and 42 percent of those over the age of 65 without teeth.[22] Studies by Douglass and others report that new cohorts of older persons will be at higher risk for oral diseases such as caries, periodontal diseases and oral cancer.[23,24] At the same time, they will have a greater personal awareness of the need for oral health care and have a history of higher utilization of dental services.

Structuring Policy Options In Dentistry

Basic Concepts

Historically, public policy discussions have all but ignored dental care. In the minds of many decision-makers, dental care is viewed as expensive and not inherently part of mainstream health care. Dentistry is viewed as primarily providing dentures or expensive crown and bridge prostheses and entailing huge and unmanageable costs. Confronted with the dilemma of containing health costs, government has been reluctant to support services that appear to be essentially cosmetic in nature, particularly in the absence of a public constituency clamoring for assistance. Recognizing these limitations, I will suggest an approach that, in the words of Uwe Reinhardt, offers "viable policy options" with "realistic policy parameters."

The argument is constructed thusly:

1. Dental services must be aggregated so that essential services, services that should be provided to all persons regardless of their ability to pay, are separated from those that are non-essential. This categorization of dental services must be consistent, both semantically and logically, with the organization and funding of other health services.

2. Development of policy options must be designed to fit transparently within funding mechanisms for health care.

3. Priorities for any government supported increase in benefits must be needs-based. It would be almost unimaginable that we could expect, any time in the near future, a universal provision of dental benefits.

4. Strategies should recognize that policy development is most often incremental. We must separate short and long term goals. What may be achievable in the longer term may not be possible immediately.

Aggregation of Oral Health Services

Oral health care must be organized so that it is described in terms comparable with other health and health related services. I suggest a scheme that first creates two categories of care. It separates the treat-

ment and control of disease from the restoration of function. Dental services for the treatment and control of oral diseases is then further separated into 1) acute oral care, services that treat pain, infection and pathology and 2) primary oral care, the diagnostic, preventive, and treatment services for the infections of caries and periodontal disease. The remaining category, oral rehabilitative services, are those services designed to restore function and improve appearance. Let me describe each of these components in more detail.

Acute Oral Care

Acute oral care would be services deemed necessary to treat pain, acute infection and pathology: conditions that represent a direct threat to the patient's health and well being. Obviously, acute oral care includes treatment of existing or suspected oral malignancies and infected teeth. Moreover, the case must be made for including the care of oral problems that by themselves may not be a problem but which may complicate other health problems. Untreated oral infections may lead to a bacteremia seriously jeopardizing the patient's health. Patients with renal disease, heart conditions (particularly those requiring cardiac surgery), or requiring orthopedic surgery, should have their mouths free of infection prior and subsequent to receiving their medical treatment.

Certain care such as radiation for head and neck cancer or immunosuppressive treatment reduces the patient's ability to combat infection. Thus oral infections can produce untoward systemic effects. Patients receiving this treatment could face serious bone infection should their oral condition deteriorate. In the diabetic patient the chronic infection burden from oral problems requires increasing amounts of insulin. Oral care should also be provided when successful treatment of the patient's medical condition requires a functioning dentition.

Primary Oral Care

The primary care component of oral health services includes the diagnosis, prevention and treatment of caries and periodontal diseases. Services would include, for example, oral examinations, dental x-rays, application of preventive agents, and other procedures for treatment of these diseases. Neglected, caries and periodontal diseases can lead to acute infections requiring more serious health related interventions.

Rehabilitative Oral Care

In contrast to the disease orientation of acute and primary oral care, oral rehabilitative care relates to the restoration of oral function. Dental services would include fixed and removable prosthodontics and cosmetic dentistry. This category of dental treatment is dependent purely on the need to restore the patients functioning dentition and enhance their appearance. It does not in itself relate to improving their medical condition or even the direct medical health of the patient, as determined by their medical condition.

In promoting oral rehabilitative services, policy makers and the public need to be aware of the relationship between oral health and the patient's quality of life. The person with missing teeth is handicapped in their inability to masticate a satisfying diet. The loss of teeth will also effect their social interactions and ability to communicate and smile. Social psychology contains a considerable body of literature related to the important contribution teeth make to the attribution of "attractiveness." Attractiveness is further related to other positive characteristics, such as intelligence and competence.[25] It is, therefore, not difficult to envision the impact of oral disfigurement on the patient and the subtle effect the patients' appearance may have on their friends, family, co-workers and, for the institutionalized, their caretakers.

Policy Options

The value in untying acute, primary, and rehabilitative dental services permits the possibility of offering dental care options at different expenditure levels. By presenting funding choices independently, decision makers can judge the costs required to treat acute problems, eliminate disease, and then, the additional investment needed to maintain quality of life. Once separated, each of the components could then be more logically attached to other comparable health services.

Reinhard Priester, an ethicist from the University of Minnesota, developing a values framework for health care reform, identifies "fair access" as an essential value. He refers to these basic services as a means by which each person will receive an adequate level of care regardless of their economic level, their group or class.[26]

The categorization scheme proposed here identifies "essential dental services" —a floor of necessary oral health care. Services designed to control and treat oral disease, the acute and primary oral care described above, are inseparable from comparable health services and must be included in any package of basic care. Pain and infection in the mouth cannot be logically distinguished, for policy purposes, from pain and infection elsewhere in the body. And, no person should be denied these services based on their inability to pay.

Strategies

Dentistry has historically isolated itself from the health policy debate.

As a result, insurance coverage for oral health services is limited and relatively recent. The failure of dentistry to be forcefully involved in the ensuing health reform deliberations may result in a continuance of the inadequate and patchwork of federal benefits for dental services and limited coverage for many Americans.

Recently, the American Association of Dental Schools (AADS) has taken an active stand on redressing the limited access to oral health services. The following strategies can advance the AADS position.

Specifically, hospital or ambulatory care services should be enlarged to provide coverage for acute dental services — pain, infection, and pathology — on the same basis as the treatment of other health threatening, medically necessary conditions. Patients requiring certain procedures such as hip prostheses, renal dialysis, and coronary artery surgery, should be covered for the pre-surgical treatment of oral infections.

Planners of a benefit package for primary and preventive health services should ensure that primary oral care is also available to all children and adults through whatever mix of private or government supported coverage. Regular oral examinations should be covered on the same basis as an annual physical or breast cancer screening. Treatment of periodontal disease and dental caries should be considered a routine component of primary outpatient services.

Funding for these essential oral health care services, as part of a basic package, provides circumscribed, relatively inexpensive acute and primary care benefits consistent with other health services. At the same time, it presents a short-term political agenda for the dental profession.

Concurrent with these immediate goals, is the need to incorporate rehabilitative oral care with present efforts to expand coverage for long-term care. The restoration of function and quality of life concerns as they relate to oral health services can be tied to similar services for the impaired. The case for third-party support for the restoration of oral function can be made along with other services that relate to function, such as hearing and vision care. Rehabilitative oral care can also be justified as a component of services that provide the impaired with regular and satisfying contacts with other people. It seems unreasonable that one would provide older persons with transportation and senior centers to reduce their isolation and then not give them teeth, which help them considerably to maintain and enjoy social contacts.

Policy options that offer different levels of access, and make the distinction between essential dental services and those related to function and quality of life, open opportunities for dentistry to collaborate with other advocacy and professional groups. Collaboration would be particularly beneficial with groups such as the American Hospital Association, the American College of Physicians and the American Medical Association, all of whom are involved with developing proposals to improve access for those that are similarly excluded from the national health "safety net." Efforts should be directed to groups representing the elderly who have health policy interests, such as AARP. As noted earlier, advocates for hearing and vision care provide natural alliances as well as those organizations that lobby for broader coverage of rehabilitative services.

Coalitions with other professional and consumer groups to advocate the inclusion of oral health services in federal, state, and private financing schemes can present concerns about care decisions for the elderly being made solely on the basis of cost effectiveness. Bruce Vladek, in a recent article, argued that other issues such as quality of care, quality of life, dignity, and autonomy must enter into policy decisions.[27]

The fierce competition for admissions in today's health care market has stimulated hospitals to employ a variety of strategies to attract patients. One of these strategies is diversification which involves expanding or improving specific services, developing new referral patterns, or opening new market segments. The same arguments for packaging primary, acute, and oral rehabilitative care with other in-patient and outpatient services need to be made to these health providers. In addition, multi-hospital systems, health maintenance organizations, life care communities, home health agencies and insurance companies, to name a few, need to be aware of the market potential of including dental care as an integral component of their health services.

Dentistry must take a broader view and include advocating a range of benefits for all Americans, whether or not they include dental care. As the public, particularly those at higher risk, are protected from the actual cost or the threat of major expenditures, they will be better positioned to access needed dental care.

In all the above, a large scale education effort is needed. Dentistry must continue to educate the public about how the failure to provide coverage for dental services effects the health and well-being of society. Congress, private industry, and health providers need to be made aware of the oral health needs and the importance of viewing dental services in health and quality of life terms.

Dentistry must also direct educa-

tion efforts at health professionals. In particular, case management is becoming an important mechanism to manage and coordinate health care services. Case managers need to appreciate the importance of dentistry, to include an oral examination as part of the comprehensive assessment, to ensure that the dental services are considered and integrated as part of the total care package, and to be knowledgeable about vehicles for access and reimbursement of these oral services.

Conclusion

Policy options for dental care can be best structured by the disaggregation of this care in a way that is consistent with the funding of other health care. This paper proposes the separate consideration of primary, acute and rehabilitative oral services. Each of these can be tied to separate costing mechanisms. In addition, these options can be promoted by making the logical connection between these oral services and comparable health services. Since the person's financial status will be a major determinant of their use of dental care, policy alternatives need to support other forms of health funding, whether or not they include dental care.

The nation is about to embark upon serious discussions to design a better health care system. Dentistry must be actively involved to ensure that the provision of oral health care is transparent to approaches for overall health and is available to all Americans.

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12th Annual Dunning Memorial Symposium

Disaggregation of Oral Health Care
A Model for Defining Public and Private Responsibility

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The presidential election of 1992 established reform of the health care system as a national priority. It is anticipated that the Clinton administration will move quickly to propose a major revision of health care financing. Until now, the prevailing wisdom has been that a national health program is not politically possible; that the country cannot, or will not, commit resources to rationalize health care.

The results of the national presidential campaign reflect growing sentiment for change, from many constituencies, especially at the grass roots level. Numerous newspaper articles and TV specials over the last two years have emphasized major problems with health care in the United States. The May 1991 issues of the *Journal of the American Medical Association* [1] and ten companion specialty journals contained 52 articles dedicated to the provision of information concerning different proposals to reform the health care system. *The New England Journal of Medicine* published the health care positions of both major candidates in the presidential election[2,3] as well as editorial comment laying out the basic prerequisities for a universal health program.[4]

A variety of authors have reflected the growing discontent of the various constituents of the health care system. These constituents include hospitals, physicians, third party payers, insurance companies, businesses providing health benefits and labor unions, as well as consumers across the economic and social spectrum.[5-9] According to a poll of consumers by investigators at the Harvard School of Public Health, 89 percent of Americans feel that the health care system needs fundamental change.[10] Despite substantial differences in approaches to the problems of health care in the United States there is almost universal agreement that changes are needed that provide greater access to care and effectively control costs.

The need for "a national discussion that will end with the replacement of our present chaotic, costly, and inequitable health care system with one much closer to the ideal most critics seek" was suggested in a *New England Journal of Medicine* editorial[11] and is reinforced by editorial comment in the *Journal of the American Medical Association*[12] titled "An aura of inevitability is upon us." The editor suggests "It is no longer acceptable morally, ethically, or economically for so many of our people to be medically uninsured or underinsured." To the extent that oral health care is an essential service, this applies to dentistry as well.

One result of this dynamic rise in concern over health care is that changes in the system no longer emanate only from Washington. The states have been called the laboratory of democracy and proposals affecting the health care system have been proposed in over 25 states. Minnesota is the latest state to enact health care reform legislation,[13] joining Hawaii, Massachusetts, Vermont and Florida. Six states are proposing that employers be required to pay portions of premiums for full time employees, based on a program developed in Massachusetts. Ten other states are exploring tax incentives for employers who provide health insurance. Other states are considering subsidizing individuals without health insurance or providing compensation to hospitals for uncompensated care.[14] Twelve states, including Ohio, have introduced bills to implement a version of a single payer program (monopsonic) for health care, utilizing principles from the Canadian system.[15,16,17] Dental care (acute and primary) is included in the latest Ohio bill. The limited ability of the States to deal comprehensibly with the problem is well defined by Dukakis.[18]

At the same time, Oregon explored an explicit rationing system for Medicaid recipients, raising both legal and ethical concerns.[19] Rationing schemes, because of their wholesale inclusion or exclusion of entire categories of care, do not take into consideration needs of different groups within the population that may not fit these categories. For example, since dental care is a low priority, those at risk for oral cancer

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may be deprived of early diagnosis and treatment.

Where should public responsibility for health care end? What should be left as private responsibility? How should this division be carried out? These are the major issues to be faced in designing programs involving the financing of health care. Dental care, only partly addressed in previous public programs, is often not considered in discussions of health care reform, although these questions apply just as acutely to the provision of dental care in the United States. A major challenge for any universal program is how to include previously neglected areas, dental health, mental health and long term care, as essential elements to protect and improve the health of Americans.

The Case for Oral Health Care

Up to now dental care has been a topic conspicuous by its absence in most articles about new health care schemes. Health care analysts, when presented with a health insurance scheme that includes dental care, have two major concerns. The first is economic feasibility. Many remember that the inclusion of dental care as part of New York State's Medicaid program twenty years ago resulted in dental expenses that outstripped medical expenses in the first few years of operation,[20] due to a large backlog of unmet need.

Recent epidemiological studies conducted by the National Institute of Dental Research[21] show, however, that there is now much less unmet need. Today the need for dental care is closely related to age cohort,[22] and dentistry has shifted its emphasis from the problems of children and youth to those of adults and the elderly.[23]

A second question of concern to health care analysts is whether dental care *is* an essential part of total health care. We suggest that ample evidence is available linking the absence of oral health to morbidity and mortality, as well as to diminished quality of life.

Many oral health care services are essential, especially for those populations most at risk. Essential services include relief of the pain of toothache, improvement of the quality of life of the elderly through restoration of teeth, measures to increase the employability of those adults with unsightly dentitions, treatment of acute conditions in children and adults still at risk for dental disease and detection of life threatening illness (e.g. oral cancer, AIDS). These should be considered primary *health* care services. In addition, many individuals who are ill with severe systemic disease require dental treatment prior to or as a part of therapy. It is clear, from these few examples, that essential services provided by the dentist have great impact on an individual's health.

A recent analysis of new epidemiologic data suggests that, although the prevalence of dental disease is decreasing in younger cohorts, the number of teeth being retained as the population ages is increasing.[24] These teeth remain at risk for disease and provide the basis for assuming that there will be continuing and perhaps expanding need for dentist services. Need, however, is not demand. Demand, especially for older populations, is often linked to access and a major barrier to access to dental care in the U.S. is economic status. Many elderly lose their dental insurance upon leaving employment at retirement. Demand for dentistry remains the most price-sensitive of essential health care services due to the large out-of-pocket cost for most patients.[25] The problem of access to be faced by the health system, as a whole, has special meaning for dentistry.

Oral health needs in this society, then, are manageable, and oral health care is essential. Thus, a strategy to disaggregate dental care in order to make the inclusion of dental care in any national health care scheme practical, both in terms of finance and the control of disease, needs to be explored as a way to convert need (represented by increasing number of teeth retained by the population) to demand (represented by dentists' services).

Requirements for Inclusion in a National Health Plan

Any plan for the inclusion of dental care as part of a rationalized insurance scheme must meet several requirements. The Institute of Medicine (IOM) report, *Public Policy Options for Better Dental Health*[26], recommended that a national health program of dental insurance lead

to the availability of comprehensive dental service for all Americans. The program should include incentives to improve the oral health of the popula-

tion by fostering an emphasis on prevention and early treatment rather than expensive dental repair and reconstruction.

The IOM report goes on to emphasize the factors in dental services to be considered in designing any national dental insurance program.

First, utilization of dental services is highly correlated with income, education and occupational status. Second, more is known about the etiology of dental disease than of many medical diseases, and effective preventive measures are already developed, proved and available. Third, patterns of current use and provision of dental services indicate that many consumers are not receiving the mix of services that could be cost-effective for the individual and the nation. Fourth, although private insurance is growing rapidly, and includes some preventive services, the committee finds that the current pattern of benefit coverage encourages treatment late in the disease process, such as more expensive reconstructive services, rather than prevention or early treatment.[26]

This more than 10 year old IOM report is still an accurate summary of who is getting what oral health care in this country. Though the knowledge and capability exists to provide preventive care and early treatment, that is both effective and cost effective, not all who need care are getting it and many who do are getting it too late.

Reflecting the IOM report's emphasis on prevention, early treatment, and dental care for all, we propose the following:

1) Acute and primary oral health services should be available to all Americans, regardless of their ability to pay.

2) Since acute oral health services are an essential part of total health care, they should be treated in the same way as other acute health services with regard to access and reimbursement.

3) Preventive oral health care services should be considered as essential services.

Utilizing these principles, it is possible to construct a model for the reimbursement of dental care that separates dental services into three categories, modifying those already proposed by Adelson.[27] Adelson suggested that public policy decision makers, when presented with efforts to include oral services in health care reimbursement, should be given options that disaggregate these services into three categories—acute, primary and rehabilitative care. This organization of oral health services separates the treatment and control of disease from the restoration of function. For the purposes of reimbursement, we have adapted Adelson's model into essential and elective services, including in the essential primary care category those rehabilitative services that would be considered basic to oral function and the patient's quality of life. Clearly the final particulars of a dissagregation formula, to be put in practice, would have to be the result of broad input from the profession, consumers and those involved in economic analysis.

The categories of dental services for purposes of this reimbursement model are:

Essential Services

Acute Oral Care:

Those services needed to treat pain, infection or pathology (e.g. oral cancer, and infected teeth and/or supporting structures).

Primary Oral Care:

The diagnosis, prevention, and treatment of caries and periodontal disease. The simplest procedures required for the prevention of loss of function and the maintenance of quality of life (e.g. removeable dentures, simple restorations, single unit crowns, non-surgical periodontics).

Elective Services

Rehabilitative Oral Care:

More complex services to restore oral function (e.g. fixed bridges, surgical periodontics, orthodontics, implants). Also includes most procedures done to improve appearance. These services do not in themselves relate to the improvement of direct medical health of the patient.

How Disaggregation Could Work — an Example Using Claims Data

In order to explore the fiscal feasibility of this plan, we disaggregated dental claims data (1988) from several dental insurance programs.

We then applied the proportion of dollars spent on acute, primary and rehabilitative care to the national expenditure for dental care. Obviously, this is a very approximate approach to projecting cost under any future program, but we felt that, in the absence of rigorous research data, a rough estimate of cost distribution, utilizing numbers and reasonable assumptions for disaggregated care, could be useful to policy makers weighing the financial implications of our proposal.

The dental plans included in our data varied considerably in their encouragement or discouragement of more complex procedures, the monitoring of utilization and copayment. They included populations in three parts of the United States: the west coast, a major midwestern city and an east coast resort area. We reasoned that combining the data from these three large programs would minimize the effect of geographic differences and insurance program characteristics, since any of these variables might affect the distribution of care a-mong the three dental care categories. A total of 90,000 individuals and families are covered by these programs, with total claims of $19.4 million during a full year of experience. Since we estimate that these insurance programs cover roughly one third of the cost of the services included in rehabilitative care, we adjusted the total expenditure to reflect the other two thirds spent. As a result, the total estimated yearly expenditure for all dental services is $33.1 million.

Acute dental care (as defined in the appendix) represented 3.9 percent of the total dental care expenditures while primary care represented 33.7 percent and rehabilitative care 62.3 percent. Recent data from the American Dental Association suggests that the total expenditure for U.S. dental care in 1988 was approximately $36 billion, (HCFA's estimate is $30 billion); the 1987 ADA figure was $32.8 billion. The 1988 figure for dental Medicaid provided by the Health Care Financing Administration is $577.3 million out of a $48 billion total Medicaid expenditure. HCFA estimates that 33 percent of the national dental expenditure is covered by dental insurance and 66 percent is an out-of-pocket cost for the consumer.

Given these figures, simple arithmetic allows the calculation of the dollars needed for our categories of disaggregated dental care, based on the proportions in our claims data and a $36 billion total expenditure for dental care. These are $1.33 billion for acute care, $11.45 billion for primary care and $23.22 billion for rehabilitative care.

One third of the total dental expenditure paid as insurance claims, following HCFA's estimate, in 1988 was $12 billion. This amount was paid by insurance companies and Medicaid. It is enough to cover almost all of the acute and primary care expenditures in this model. Out-of-pocket expenditures of $24 billion covers all of the rehabilitative cost. Medicaid expenditures of $.5 billion would provide 38 percent of the estimated acute care cost. When one considers that administrative costs for dental insurance programs are estimated at 25 percent, there is probably another $4 billion in the system, some of which should be able to be realized for care with more efficient management and control of what some economists call excess profits.

This analysis of the implications of this rough model is entirely consistent with a view that virtually all acute and primary care can be covered from existing insurance funds, that primary care insurance can be required for those employed and provided for those uninsured, and that there is currently enough money in the system to do this.

Dentistry provides a good example of how public and private responsibility can be defined through disaggregation of services rather than eliminating entire categories of care. Acute dental care includes the relief of pain and suffering, the detection of more severe disease and the application of well-established preventive methodology. The success of dental preventive measures, and the pervasive availability of care for people with means, have resulted in a significant reduction in unmet need. Therefore, the problems of acute care make up the smallest segment of dental need. Assuring this minimum level of oral health can legitimately be considered a public responsibility.

The area of primary care, that is basic dentistry to control disease and provide functional integrity of the oral apparatus, can be considered either as a public responsibility or a shared public and private responsibility.

Rehabilitative care becomes

analogous to elective surgery and other health care whose function is either elective or can be provided in other ways. This area is the most likely candidate to be entirely financed through private insurance or out of pocket expenditure.

In summary, oral health care can be financed in a universal insurance program under the following scheme.

CATEGORY OF SERVICE	REQUIRED	FUNDING
Acute Oral Care	Yes	Public
Primary Oral Care	Yes	Public/Private
Rehabilitative Oral Care	No	Private

Some Dissenting Views on Disaggregation

One major objection to the disaggregation concept comes from the view that all dental care options should be provided in any required insurance scheme. Two major reasons for this position are immediately apparent. First, the decision considering the best and most comprehensive possible care for a particular patient is one to be made as part of the doctor-patient relationship, and partial coverage limits the autonomy of the practitioner in that relationship. Second, many public programs begin with very lofty goals, but subsequently are drastically restricted in order to control costs, thus affecting health and further eroding the autonomy of the practitioner.

The issue of restriction of decision-making over care is an important one. Restriction is present now with a private insurance system that reimburses only for certain services, is severely pressed to control costs, to minimize risk and to assure profit. What is covered and how much is paid certainly affects both dental and medical care decisions in everyday practice. The autonomy of the practitioner, in the dentist-patient relationship, is already eroding and this proposal will neither hasten or slow that phenomenon.

The issue concerning pressures on public programs is also a real consideration. Most programs that have been susceptible to cutbacks have been programs that cover only limited segments of the population. Medicare covers only the elderly. Medicaid, covers only the poor. Programs that provide services for everyone have large constituencies to look out for them in the democratic process. (Social Security is a good example). It seems more reasonable to have decisions concerning dental coverage as part of health care made in a public forum rather than in private, as part of a pricing program for individual insurance companies.

Dental Care - A Best Buy

Although there are certainly many ways that disaggregation of oral health care might be accomplished, the analysis presented here suggests that dental care can be included in any rationalized health insurance scheme in a fashion that is affordable, using current dollars. Any proposal which breaks down services into categories needs to be carefully discussed and formulated with input from a wide variety of professional leaders. This breakdown is presented as an example of what might be accomplished. In the past, dental care has been severely restricted or left out of rationalized health care schemes in the U.S. (Medicare and Medicaid).[28] The inclusion of this essential health service, as part of any new or revised universal health insurance program, is based on demonstrated needs of the population and benefits to patients. It is not likely, with recent disease reductions, to produce unexpected costs. Indeed, as the younger cohorts who are resistant to dental disease grow older, societal costs for acute and primary care are likely to decrease. Dental care, with its effective emphasis on prevention and the quality of life may be a "best buy," both politically as well as from a health standpoint.

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Appendix

Acute Care

Pain Relief - emergency diagnosis, infection therapy - procedures to deal with traumatic injury, denture repair, simple extractions, biopsy

Primary Care

Diagnostic services, prophylaxsis, preventive services (sealants and fluorides), simple amalgam restorations, non surgical periodontics, single unit crowns, partial dentures,

full dentures, pedodontics, surgical extractions, alveolectomies, root canals.

Rehabilitative Care

A. Functional:

Fixed bridges, precision attachments, orthodontics, surgical periodontics, surgical endodontics, implants and implant prosthesis.

B. Esthetic:

Bonding, orthodontics (esthetic), other plastic and esthetic procedures.

Hospital Based

Complex oral surgery, pedodontics under general anesthesia, TMJ surgery, orthognathic surgery, maxillofacial surgery, (including traumatic).

Treatments subject to review by hospital utilization committees, quality assurance committees or other review mechanisms. Separately reimbursed as part of hospital care.

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The three Gies Award Winning Editorials on pages 30-31-32 have been selected by the Editorial Award Judging Committee of the William J. Gies Foundation as the outstanding editorials published in 1992. Presentation of Awards was made at the Annual Meeting of the American Association of Dental Editors on November 4, 1993 in San Francisco.

Gies Award for the Outstanding Editorial Published in 1992

Taking the Teeth Out of the Boards

Victor J. Barry *

If you peruse any antique dental journal your first impression will not be how much has changed, but how much has remained the same. This, unfortunately, includes how we annually test state Board candidates. In this age of high-tech enlightenment, perhaps it's time we double-clutch our thought process and shift our paradigm to gear up for re-examining those Boards from the perspective of professional ethics.

Let's start with our state.

For the same reasons that we've replaced baboons with crash test dummies, we should relieve real patients from the risks of all clinical tests and replace them with dentoforms engineered for the task (e.g., why not add a red surprise inside?). No doubt that a lot of good dentistry is delivered during the exams, but too much is rushed botchwork on teeth which exhibit scant radiographic evidence for the need to be restored. In any other venue but the clinic floor during the Boards, so many patients would never be prematurely denied the use of so much sound enamel surrounding such tiny incipiencies. Under no other pressure-cooker conditions could a potential radiographic anomaly be so readily turned into an amalgam or inlay. In the interest of ethics we form committees to protect unsuspecting patients from impaired dentists, yet we willingly unleash on them stressed-out, paranoid board candidates who are nervous dental wrecks waiting to happen. It is a schizophrenic scandal in dental education to stress ethical treatment of patients throughout the entire curriculum except when facing that final hurdle to licensure. The desperate atmosphere for passing translates "whom are you treating?" into "what tooth are you doin'?"

What I am saying may seem harsh, but an honest look back into the dark recesses of our consciences will confirm that we have all been a guilty party—directly or indirectly—to such scenarios. No other healthcare profession tries so hard to mirror reality during an exam. That is what the undergraduate clinic is for, monitored by experienced instructors.

The system is flawed. Let's fix it.

"Because we have always done it that way" is no longer a valid reason to continue throwing dental patients into the licensure lions' den. If dentoforms were used in lieu of patients in conjunction with a comprehensive written exam, the boosts to our state Board's stature would be multiple:

- The consummate "level playing field" would be achieved. (Then crown preps and veneers could even be fair game.)
- Uncontrollable factors, such as patient absences, would be eliminated, thus keeping Murphy's law from flunking good students.
- Pass rates would increase because students could start preparing for boards during first-year operative lab.
- Unnecessary treatment and x-rays would be avoided.
- Incompetency would still be uncovered, with pass rates staying consistently higher.
- Greater accuracy could be achieved during examiners' calibration procedures.
- Students can spend more time treating patients than screening patients.
- Licensure by credentials would only be extended to candidates from those states whose ethical consideration of patients is substantively equivalent.

Professional ethics is based on a simple concept: doing what is best for the patient. Therefore, any system—in or out of school—that condones treatment planning in which the doctor's needs come before the patient's is unethical and needs righting.

Re-tuning our entire dental education and licensure system will compel dentists to put the patient first from day one in school to that final day at retirement. Taking the real teeth out of the Board exam process will not come back to bite us, but will only serve to underscore our commitment to improve the overall quality of patient care.

* Victor J. Barry, DDS, is the editor of the *Washington State Dental Association News*. This editorial appeared in the June 1992 issue.

Gies Honorable Mention Award for 1992 Editorials

Professional Responsibility for Public Protection

Daniel M. Laskin *

As members of the health care professions it is our responsibility to be concerned about the welfare of our patients and to see that they are provided the best treatment possible. To accomplish this goal, we are constantly seeking better ways to manage the many difficult therapeutic problems that patients present. New ideas come from many sources. Some come from our own creativity or that of the colleagues with whom we associate. Others come from textbooks we read, lectures we hear, or courses we attend. An even more frequent source is the professional journals to which we subscribe. The important question is, how reliable are these sources?

One needs only to peruse the pages of past issues of this journal to find many examples of treatments that were introduced with glowing reports of success but are no longer being used because the results could not be duplicated or longer follow-up showed that serious complications arose. It seems that all antibiotics since the discovery of penicillin, and even a few sulfa drugs before that time, have been placed in third molar sockets to prevent alveolar osteitis, with studies to substantiate their effectiveness. Yet, these agents are no longer used. Multiple materials, from alloplasts to autogenous bone, have been placed to augment atrophic alveolar ridges, and most of these also are no longer used. The most recent instance involves the insertion of alloplastic materials as a substitute for the intra-articular disc in the temporomandibular joint. Although initially it was claimed that they were effective, subsequent studies have shown that they can produce considerable damage. All of these examples raise serious questions about how such situations occur and, even more importantly, how they can be prevented.

Many explanations have been given for why initial clinical studies are often favorable. One would like to assume that the data are reported accurately, but even the use of peer review and statistical analysis is no guarantee of the reliability of the information. Moreover, even with properly reported data, there is still the unavoidable, and often unrecognized, influence of observer bias and placebo effects, particularly in clinical studies without proper controls. Lack of sufficient follow-up also can lead to misconceptions about efficacy. There is a frequent tendency for clinicians to seek early publication of results or to present preliminary data during lectures, and many complications do not become evident until much later.

Because of the many problems that can occur from the use of incompletely substantiated information, the responsibility for preventing such occurrences falls on many shoulders. Those who speak or write about new techniques have an obligation to temper their enthusiasm sufficiently to present an unbiased appraisal, with emphasis on negative as well as positive results. They also need to observe their patients over a sufficiently long period to ensure that the therapy is truly effective. If they subsequently recognize that their early successes become long-term failures, they need to be just as anxious to talk about or publish these findings. As Aldous Huxley once said, "Facts do not cease to exist because they are ignored."

Editors of journals also have a responsibility to protect the reader and the public and this can sometimes be a very difficult task. Although those reports with obvious inaccuracies are never published, articles with less obvious deficiencies may avoid detection, despite a careful review process, and end up on the printed page. Moreover, a decision often has to be made whether a unique procedure should be published even when there are only preliminary data to support the concept. Clearly, the editorial process also has its imperfections.

And so, the ultimate responsibility for public protection falls on the practitioners. Yet, they find themselves on the horns of a dilemma. On the one hand, they must make the final decision about therapy. On the other hand, it is unfair to expect the average clinician to make accurate judgments about the credibility of his or her peers or about the accuracy of reports already reviewed by those generally more knowledgeable in the particular subject. How, therefore, can practitioners assure the public that they are not being subjected to unsubstantiated therapy? The answer lies in a conservative approach to treatment. There are few, if any, conditions that do not have some established form of therapy already available, and none so serious that we cannot wait until all the facts are known. New techniques and technology must be carefully tested, but in selected centers rather than on the general public. By waiting until all the evidence is in, we do a service, not a disservice, for those who place their trust in our judgment.

* Daniel M. Laskin, DDS, is the Editor of the *Journal of Oral and Maxillofacial Surgery*. This editorial appeared in the October, 1992 issue.

Gies Honorable Mention Award for 1992 Editorials

Is Ethics Becoming a Luxury?

Douglas Willingham*

Some years ago, perhaps before this writer began private practice in 1981, dentistry was an autonomous, relatively unregulated profession that enjoyed a mutually-beneficial contract with the public. In exchange for absolute commitment to quality dental care and to the ethical standards of behavior long associated with dentistry, the public continued to grant the profession its powers of self-regulation and, through what were then favorable market conditions, the probability of a high standard of living for its members.

At the risk of over-simplifying this historical assessment, the contract went something like this: Students competed fiercely for seats in the freshmen dental school classes, endured the stress of professional academia and underwent the many rites of passage that are designed to instill professionalism and ethical thinking. In reward, these graduates took their diplomas and licenses to the nearest bank and obtained loans, often unsecured, to set up practices in the settings of their choice. In subsequent years, largely because of favorable supply and demand ratios, these dentists could expect to establish high standards of living for themselves and their families *provided* they worked hard, practiced ethically and nurtured that public trust.

If we accept this view, however oversimplified, of dental practice in, say, the 30 years following World War II, we can conclude that this scenario occurred often enough and long enough to become a tradition. That tradition - the expectation of achieving prosperity as part of the contract to provide quality care at fair fees in an ethical manner - seems to have less and less to do with today's reality. Of course, it is still possible for that contract to work in the traditional way (it often does) and for dentists to practice ethically in any practice setting (they often do), but there are so many new forces against that happening, especially for the new practitioner, that it is no longer an inevitability.

Bankers rarely approve unsecured practice loans any more. Too many dentists have been unable to make the old formula work. There are, in fact, too many dentists.

Suddenly, it seems, members of a trusted profession begin to seek ways to circumvent free enterprise and the laws of supply and demand in order to achieve what they understandably believe is their due for all their hard work. Enter PPOs, DMOs and other artificial mechanisms for redirecting patient flow among the all too numerous dental offices.

So what happens to ethical behavior when the rules have changed but the expectations haven't? Rules of ethics begin to bend. Unprofessional advertising, aggressive marketing and, worse still, treatment decisions based on the dictates of "managed care," begin to change the character of a dignified profession. Ethics becomes a luxury.

Will ethical behavior typified by American dentistry endure in the long haul? If the contract to provide quality care in an ethical manner no longer includes a probability of fair compensation, will the incentive to do so be diminished to the point that dentistry loses its professional identity altogether?

We should remain optimistic for the future of dentistry and be proud of what we have accomplished, but we should also be aware that now, more than ever before, with the interventions, the regulations and the oversupply of dentists which tend to lead otherwise ethical people to behave differently, we must encourage and support the study of ethics in both pre- and post-doctoral programs and re-dedicate ourselves to that which made us a profession to begin with.

* Douglas Willingham, DDS, is the Editor of the *Texas Dental Journal*. This editorial appeared in the September, 1992 issue.

BOOK REVIEW

WILLIAM JOHN GIES

His Contribution to the Advancement of Dentistry

by Frank S. Orland, DDS, PhD

(Published by the Wm. J. Gies Foundation for the Advancement of Dentistry) 1992

This encyclopedia on the late William John Gies is a veritable labor of love. It is a well-deserved and unique testimonial to an American bioscientist who devoted the major portion of his life to the advancement of dentistry as an important unit of the health professions. The long-range effects of Gies' exceptional contributions to dentistry are still being experienced. His monumental study of 1926 on dental education in the U.S. and Canada, sponsored by the Carnegie Foundation for the Advancement of Teaching, remains a high point in the history of dental education. However, the rank and file of today's dental health professionals are not sufficiently enlightened about Gies' good works. Author Dr. Frank Orland has tried with great success to correct this discrepancy.

What he has done is to present the life and times of Dr. Gies in a single volume, enlivening the chronicle with interesting documents, captivating selections, historical photographs, meritorious plaques, awards, citations, testimonials, tributes, sketches, incidents and statements. This has been accomplished in 18 personalized chapters which trace the life of Gies from birth and childhood to his deification by a grateful profession. The most remarkable aspects of Gies' popularity within the profession was that he was not a dentist, and his helpful efforts occurred at a time when practicing dentists tended to be suspicious and even hostile to those considered to be non-members of the "Dental Brotherhood."

Appropriately, Gies' works on establishing the *Journal of Dental Research* and the International Association for Dental Research, together with the testimonial banquet at his retirement, occupy a significant portion of the book. In view of current emphases on the importance of research in oral disease, Gies' contributions immediately assume gigantic proportions. It is especially fitting that Orland has reproduced verbatim tributes to Gies following the latter's death at age 84. These statements from his contemporaries, all of whom were themselves dental professional luminaries, speak volumes about one of dentistry's greatest contributors.

The book is published by the William Gies Foundation for the Advancement of Dentistry, with the special assistance of the International Association for Dental Research. President Gordon Rovelstad of the Gies Foundation credits the late lamented George Paffenbarger, to whom the book is dedicated, with inspiring this biography of Gies. It was left to author Frank Orland to bring the project to life. This reviewer sincerely believes that Dr. Gies would have fully approved of this portrayal of his contributions to the progress of academic and research aspects of the profession. The book would appeal to readers interested in dental history, especially in the history of dental research. Copies of the publication may be obtained from the Gies Foundation.

Book Review by
Clifton O. Dummett, DDS
Professor Emeritus, University of Southern California
School of Dentistry

The Red Rose Ceremony

The small town of Manheim, PA was where William John Gies spent his childhood and youth and it remained his hometown. Even after he accomplished his extensive work for dentistry, as described in the Biography, Dr. Gies always came back to Manheim for visits.

The Biography's author, Dr. Frank J. Orland, had visited Manheim several times while preparing his manuscript and, through the Manheim Historical Society, became acquainted with the Committee for the Festival of the Red Rose, held at Zion Evangelical Lutheran Church each June.

The history of the Festival, which is explained in the Biography—chapter 2, pp. 14-18, is that the present church was built in 1892 (with William Gies physically assisting). The land on which the original church stood had been donated and the payment requested was one red rose from the church garden to the donor of the land. Every year thereafter, a payment of one red rose has been presented to a descendant of the original donor. Dr. Orland was asked to give the Memorial Address at this year's Red Rose Church celebration on June 13, 1993. It just happened that he was the 100th Speaker for this ceremony.

After Dr. Orland's brief recounting of William J. Gies' life in Manheim, he presented an official copy of the Biography to the Chairman of the Red Rose Committee who, in turn, presented it to the Pastor for the Church's Library. Other copies thereafter were given to the Chairman himself, to a 9th generation descendant of the donor of the deed, to the Historical Society, as well as the local Public Library and others.

It was a fitting finish to Dr. Frank Orland's long association with the life of William J. Gies, whom he had met and corresponded with almost a half-century earlier. As a final tribute, a wreath with red roses was placed on the tombstones of Dr. and Mrs. Gies by the Drs. Orland.

DECEASED FELLOWS

October 20, 1992 - October 11, 1993

* ABBOTT, THOMAS R.
Milwaukee, Wisconsin

* ADAMCHIC, JOSEPH P.
Pittsburgh, Pennsylvania

* ALEXANDER, HOMER C.
Plano, Texas

* ALLOY, JACK
Philadelphia, Pennsylvania

* ALSTADT, WILLIAM R.
Little Rock, Arkansas

* BAJUK, JOHN H.
Alameda, California

* BALSAM, MURRAY
West Orange, New Jersey

* BARTELS, JOHN C.
Portland, Oregon

* BOMER, ANCIL L.
Poplar Bluff, Missouri

* BRANSTAD, WILLIAM
Grantsburg, Wisconsin

* CALMAN, HERBERT I.
New York, New York

CARPENTER, DUDLEY, JR.
Dallas, Texas

* CARTER, JAMES E., JR.
Augusta, Georgia

* CHATALAS, GEORGE J.
Seattle, Washington

* CHERTOFF, ALEX
Bayonne, New Jersey

* CHESNEY, ALBERT
Knoxville, Tennessee

* CHRISTENSEN, RALPH O.
Pompano Beach, Florida

* CLARK, HORACE P.
Maple Glen, Pennsylvania

* CLOSSON, DONALD A.
Ocean Springs, Mississippi

* COTTRELL, IVAN R.
Rochester, New York

* CROSSWELL, HARRY A.
Pottsville, Pennsylvania

* DAHLBERG, ALBERT
Franklin Grove, Illinois

* DEWIS, G. M.
Halifax, NS Canada

* DICK, LEO G.
Keokuk, Iowa

* DOANE, HAVEN F.
Ames, Iowa

* DUNNING, JAMES M.
Boston, Massachusetts

* EHRCKE, JOHN W.
Rensselaer, New York

* EHRLICH, PAUL
Murrieta, California

* EMAN, VERNOR H.
Ann Arbor, Michigan

* EWING, JOSEPH E.
Westmont, New Jersey

* FAUBION, BERNARD H.
Tarzana, California

* FIELDS, WILLIAM H.
Louisville, Kentucky

* FOSTER, MOLLIE D.
Pittsburgh, Pennsylvania

* FRANK, CHET A.
Park Ridge, Illinois

FUJIMOTO, EDWIN N.
Hilo, Hawaii

* GALDIERI, DOMINIC
Convent Station, New Jersey

* GALLEN, LESTER C.
Glen Burnie, Maryland

* GARFIN, LAURENCE A.
Golden Valley, Minnesota

GEE, WILLIAM L.
San Francisco, California

GRAMLING, JAMES F.
Jonesboro, Arkansas

GRIEDER, ARTHUR
Ridgewood, New Jersey

* GWYNN, J. CLIFF
Tallahassee, Florida

* HALL, FRED H.
Brentwood, Tennessee

* HALVORSON, EDWIN W.
Los Angeles, California

* HARRISON, CHARLES E.
St. Petersburg, Florida

* HIATT, WILLIAM H.
Denver, Colorado

HO, GUY C.
Los Angeles, California

HOAG, PHILIP M.
Wheaton, Illinois

* HOHMAN, DANIEL L.
Hagerstown, Maryland

HOURIGAN, MATTHIAS J.
Kansas City, Missouri

* HUGHES, CHARLES M.
Camp Hill, Pennsylvania

* JENSEN, VERNON L.
Lufkin, Texas

* JONES, W. HINSON
Stuart, Florida

KERSEY, SAMUEL E.
Spokane, Washington

* LASATER, ROBERT L.
Evanston, Illinois

LATTIG, EDWARD J.
Mill Valley, California

LAWYER, HARRISON
Columbus, Indiana

* LEUNG, S. WAH
Vancouver, BC Canada

* LEVIN, MATTHEW D.
East Setauket, New York

* LEWIS, PAUL D.
Seattle, Washington

* LIFSCHUTZ, ALEX N.
Atlantic Beach, New York

* LITWILLER, OTTO B.
Peoria, Illinois

* LONG, PAUL V.
Prescott, Arizona

* LYONS, HARRY
Richmond, Virginia

MARCUS, NATHAN
Vernon, Connecticut

MARLETTE, ROBERT H.
Colorado Springs, Colorado

MASTORAKOS, LEO W.
Kirkwood, Missouri

MATTISON, GORDON D.
Gainesville, Florida

* McBRIDE, WALTER C.
Midland, Michigan

McCOLLOW, TERRENCE J.
Bloomington, Minnesota

McCONNELL, GEORGE R.
Sacramento, California

McMARTIN, ROBERT W.
Alpharetta, Georgia

* MEACHAM, FORREST
Chattanooga, Tennessee

* MILLER, GORDON L.
Vallejo, California

MOLLENKOPF, JACK P.
Lafayette, Indiana

* MONROE, WILLIAM A.
Sequim, Washington

MORENO, JUAN P.
Madrid, Spain

* MURTO, CHARLES B.
Prince Frederick, Maryland

* NIIRANEN, VICTOR J.
Honolulu, Hawaii

* NORTON, ROBERT Y.
Clareville, Australia

OVERBEY, R. MALCOLM
Memphis, Tennessee

* PARKER, WILLIAM A.
Knoxville, Tennessee

* PELKA, FRANCIS X.
Chicago, Illinois

* PENCE, JAMES H.
Omaha, Nebraska

* PEPPER, JOHN M.
Gulf Breeze, Florida

* PINCUS, CHARLES L.
Beverly Hills, California

RASKIN, ROBERT B.
Lindenhurst, New York

* REESE, HARVEY C.
Johnson City, Tennessee

RUBIN, HERMAN
Scarsdale, New York

* RUEDY, RAHN N.
San Francisco, California

* SALZMANN, JACOB A.
New York, New York

* SAPONE, JOHN
San Francisco, California

SAUNDERS, WILLIAM A.
Dallas, Texas

* SCHULSTAD, LAWRENCE M.
Bradenton, Florida

* SCOTT, OTHO E.
Evanston, Illinois

* SELIGMAN, LEON
Baltimore, Maryland

* SHAVER, GALEN R.
El Cajon, California

* SIEGEL, MARTIN T.
Poughkeepsie, New York

* SISSMAN, ISAAC
Pittsburgh, Pennsylvania

* SKUPA, ARTHUR J.
Riverside, Illinois

* SMITH, J. MELVILLE
New Orleans, Louisiana

* SMITH, WILLIAM A.
Allentown, Pennsylvania

* STEVENS, FORD W.
Langhorne, Pennsylvania

* STIBBS, GERALD D.
Seattle, Washington

* STOFFEL, WILLIAM J., SR.
Cicero, Illinois

* STREED, WARREN R.
Sun City, Illinois

* SUMMERS, FRANCIS W.
Glendale, Arizona

* SUTNICK, STANLEY
Miami Beach, Florida

* TANDIKUL, THAVIL
Bangkok, Thailand

* TAYLOR, MAURICE
Flint, Michigan

* THIERS, FREDERICK C.
St. Paul, Minnesota

TRAPP, THEODORE T.
Springfield, Virginia

* TURNER, H. ROGER
Miami, Florida

* WAITE, SHERIDAN C.
Tucson, Arizona

* WALSH, R.L.
Englewood, Colorado

* WECLEW, THADDEUS V.
Chicago, Illinois

* WEILER, LESTER
New City, New York

* WHITE, WILBUR S., JR.
Beaumont, Texas

WILLIAMS, DONALD E.
New Brunswick, Canada

* WING, JAMES C.
W. Hartford, Connecticut

* WINKELSPECHT, HAROLD J.
Delanco, New Jersey

* WORHOL, IRVIN A.
Houston, Texas

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* *Life Fellow*

The Dentist who was Dr. Albert Schweitzer's Right Hand

Malvin E. Ring*

On March 8, 1993, a prominent New York City dentist passed away. Dr. Maurice Frey's death was noted by only a few of his colleagues. Yet he was an example to all in the profession, for he had overcome extreme adversity and hardship to reach a place where he was providing outstanding service to patients from all walks of life. But more than that, he dedicated his life to helping those less fortunate, those whose suffering can hardly be appreciated by most of us in the developed countries. He also dedicated himself to teaching other dentists and physicians how to upgrade skills that had been put on hold during the black days of the second World War.

Maurice Frey was born on December 24, 1909, in Rzeszow, Poland, a bustling town of about forty thousand inhabitants on the banks of the Wislok River, about a hundred and fifty miles southeast of Warsaw. The year he was born was an auspicious year for one who was destined for a life in science. Paul Ehrlich announced that his discovery, Salvarsan, was effective in curing syphilis. T.H. Morgan began his epochal research in genetics. The first modern thermoplastic material, Bakelite, was introduced. Synthetic rubber was produced for the first time, and perhaps that was an omen, for in the same year, Henry Ford's first Model T rolled off the assembly line. And far to the north, Admiral Peary reached the iciness of the North Pole.

Maurice was one of six children born to Mayer and Helen Frey. His father was a lumber merchant who provided a satisfactory living to his family and was anxious to see them get proper educations. The early years of Maurice's life were quite uneventful, filled with the normal pursuits of a young person growing up in this rather circumscribed environment. He attended the local schools, as well as a religious school where he received a Jewish religious education. Maurice's grandfather had dreams of the boy becoming a rabbi.

Portrait of Maurice Frey at about the time he worked at the Scweitzer clinic in Africa.

However, the rabbinate wasn't appealing to the lad. Instead he became interested in the line of work carried on by his cousin, Dr. Jonathan Goldberg, a practicing dentist in the town. Maurice began working for his cousin, doing laboratory work in his office, and then decided that he, too, would become a dentist. Unfortunately, there were such stringent quotas limiting the number of Jews entering dental schools in his native Poland that it was impossible to get in. So, in 1931, he went to France where he was admitted to the dental school at Nancy. Aided by the experience he had garnered in his cousin's office, his dental school work at Nancy was outstanding, and he was graduated with honors.

Upon graduation from dental school, he moved to Paris. Because he was not a French citizen, he wasn't permitted to go into practice by himself, but instead secured a position with a French dentist. Because of his diligence and excellent ability he prospered financially. He then financed his sister, Ida's, dental education, and she began her dental training at the school at Nancy two years after him.

His parents, aware of the impending doom facing the Jews under the Nazi tyranny, prevailed upon Maurice to get his brother, Louis, who was then only 17 years old, out of Poland. Maurice was able to do this, and secured for his brother admittance into a school in Paris.

When World War II broke out, he continued to reside and work in Paris, but as the Nazi armies drew near to that city, he decided to flee rather than end up in the infamous death camps. Leaving Paris the very day Hitler's troops rolled into the city, he and his brother, Louis, made their way entirely by foot, some 1,000 miles, to Portugal, and when they crossed the border into that neutral

* Malvin E. Ring, DDS, MLS

country they finally felt safe. His sister Ida, who had settled in Marseilles after graduation from dental school, managed to survive the war and lives there today. Sadly, his mother and father were swallowed up by the Nazi juggernaut, when it overran Poland, and they perished in the Holocaust. He never saw them again.

The Frey Family's Dispersion

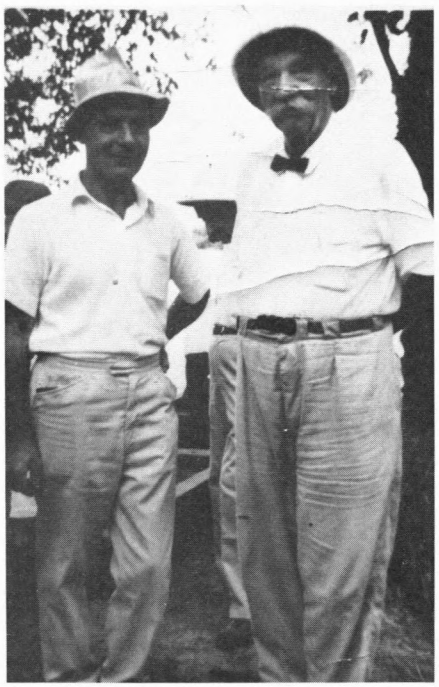
Dr. Frey's cherished hope was to leave the Europe of sadness and horror behind him and immigrate to the United States. He applied for a visa at the American embassy in Lisbon but the wait was to be a whole year. He put that year to good use by opening a dental clinic in which he treated other Polish displaced persons. Finally, in 1941, he and Louis boarded one of the last refugee ships to leave Lisbon and came to America.

The remainder of his family fared to varying degrees from the Nazi terror. His oldest sister, Matilda and her entire family were murdered in the Holocaust. When the Germans overran her country, his sister, Regina, was able to secure counterfeit papers identifying her as a Christian, and so she was able to survive the war in Poland. She ultimately came to the United States, where she now lives in Florida. Another brother, Itzak, managed to reach Israel where he became a lawyer, and was elected vice-mayor of Jerusalem. His sister, Ida, remained in Marseilles, where she practiced dentistry until 1989; she is now retired. His youngest brother, Louis, now lives in New York City, where he is in the diamond business.

Life In America

Although he had been trained at a reputable dental school in Nancy, France, and had practiced in Europe, Dr. Frey was, nevertheless, obligated by law to go back to dental school in this country in order to be licensed. In 1942 he was accepted at the School of Dental Medicine of Tufts University and was graduated from there in 1946.

He opened his first dental office in Chicopee, Massachusetts, in 1946 and was married soon thereafter. However, this marriage ended in divorce after a number of years. In 1966, he married for the second time. His new wife, Ann, had two children from an earlier marriage, Eric, who is a student at Tufts University and Karen who is a social worker in New York City. His wife, who survives him, divides her time between Southampton, on New York's Long Island, and New York City.



Snapshot taken at the hospital in Lambarene, Africa, of Dr. Frey (left) with the world renowned humanitarian, Dr. Albert Schweitzer.

Unhappy with his practice in Massachusetts, Dr. Frey decided to relocate to Manhattan. In 1947, he opened an office at 625 Park Avenue, and practiced at that location for 41 years until his retirement in 1988. Among his patients were many world-renowned diplomats, members of the diplomatic staffs of many African nations, as well as personnel of other missions to the United Nations.

His Humanitarian Efforts

He had been in practice for only two years when the International Refugee Organization of the United Nations asked him, in 1949, to go to Germany to conduct retraining courses for physicians and dentists who had been displaced by the war. Additional dentists from other member nations of the U.N. also participated in this program. It paid handsome dividends, for it allowed these retrained dentists and physicians to fill a very sorely needed deficit of medical professionals in lands that were virtually destroyed by the war. Maurice Frey put his practice on hold for these two years while he answered this important human need.

His Work With Schweitzer

Returning to New York after his stint of duty was up, Dr. Frey resumed his practice. But his strong

drive to carry out much-needed humanitarian work brought him to the decision that his skill was needed in the most distressed part of Africa, among the very poorest of the poor, and to this end he chose to serve at Lambarene in the steamy jungle of west Africa.

Albert Schweitzer, who was a theologian, philosopher, acclaimed authority on Bach and a world-renowned organist, felt that he owed still more to his fellow-man. His philosophy was that no man should be comfortable and well-fed while his fellow creatures were suffering. Accordingly, at the age of thirty he entered medical school and, in 1913, at the age of 38, armed with his new medical degree and accompanied by his new wife, a graduate nurse, he set sail for Lambarene. At that time it was French Equatorial Africa; today it is the nation of Gabon. He chose this area because the Paris Missionary Society had established a mission there in 1876, and it ultimately became the headquarters of the Protestant missions.

Lambarene was a tiny, back-water town on an island in the Ogooue River, about 100 miles upriver from where it emptied into the Atlantic Ocean, on the west coast of Africa. Surrounding it were miasmic jungles, swamps and rain forests, peopled by some of the very poorest and deprived natives of Africa. Schweitzer set to work and began building, with his own hands, and with the assistance of some natives, a simple hospital. As word of his mission spread through the jungle, ailing and undernourished natives began appearing for help. Schweitzer invited their families to come to the hospital to help care for them and to cook for them. In addition, many natives volunteered to help build additional buildings.

Over the years the hospital grew, aided by donations from individuals and charitable foundations from around the world. Schweitzer himself periodically went on world concert tours to raise money for his hospital. Today, there are 70 iron-roofed buildings housing 350 patients. There is also a leper colony with about 150 patients. The staff numbers 36, including physicians, a dentist, nurses and native aides who serve as hospital workers and farm laborers, for the hospital raises its own food. Patients come on foot from miles around seeking the help of "le grand docteur" in curing their illnesses. For his outstanding humanitarian work, Schweitzer was awarded the Nobel peace prize in 1952.

It was to assist in this difficult, but very necessary mission, that Dr. Frey decided to give up three months each year from his practice. He had the utmost admiration for Schweitzer and his work, and felt that he could do no less than help. Thus, in the years 1961, 1962 and 1963, Dr. Frey worked as the only dentist at the hospital in Lambarene. Conditions were extremely primitive. The only electric lights were in the operating rooms, with the current supplied by the hospital's own generators. The rest of the hospital got by with kerosene lamps. There were only the scantiest of supplies and instruments, but Dr. Frey made do with what he had and rendered valuable service to thousands of suffering people. It is believed that he was the only dentist in that entire nation at the time!

Schweitzer's daughter, Rhena Schweitzer Miller, who for more than 30 years called Maurice Frey a close friend, spoke highly of him in the eulogy she gave at his funeral. She recalled that, contrary to other visiting dentists, Dr. Frey never complained of the inadequate facilities and outdated equipment, and always rendered invaluable service to the many patients and their families, as well as to the native staff and expatriate professionals. She lauded him further when she said,

"We were neighbors at work, as my laboratory adjoined the dental office. I always enjoyed listening to Maurice talking to his patients and admired the way he was able to put them at ease. He adjusted to the African life, and to the people whom he had come to help, in an astonishing way. Later he continued to stay in touch with Africans in New York City, caring for many of them in his dental practice there."

"Maurice understood well the way my father operated his hospital; understood the importance of letting the patients and their families live, there, the kind of life to which they were accustomed in their villages. He felt comfortable in the midst of this black and white community, enjoyed the world my father had created in this part of Africa and naturally was deeply influenced by him. This influence lasted all the rest of his life. He responded with a profound dedication to my father, and to his ideas."

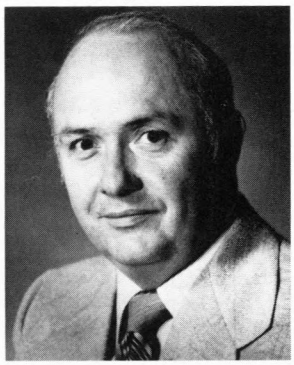
After his service in Lambarene, Dr. Frey was asked to become the Director of the Albert Schweitzer Fellowship, which fosters and supports medical training and service in Africa, and among other deprived peoples of the world. He served the Fellowship in this capacity until the very end of his life.

In this age, where the acquisition of material wealth unfortunately motivates and drives members of all professions, Dr. Maurice Frey will be remembered as one who put the welfare of his fellow-man above his own. He exemplified the best in the dental profession, which has always been a beacon of hope to suffering mankind.

Reprint requests to:
Dr. Malvin E. Ring
Two Roby Drive
Rochester, NY 14618

NEWS OF FELLOWS

Richard W. DeChamplain was recently Dean of the Medical University of South Carolina College of Dental Medicine where he had served as Interim Dean since January 1993. Earlier Dr. DeChamplain served as Chairman of Oral and Maxillofacial Surgery.



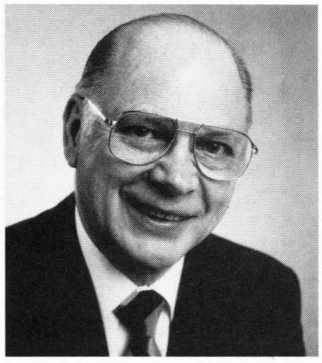
Richard W. DeChamplain

William H. DeKock was installed as President Elect of the American Association of Orthodontists. Dr. DeKock practices in Cedar Rapids, Iowa and was named the 1993 Dental Alumnus of the Year by the University of Iowa College of Dentistry.

William H. DeKock

Abram I. Chasens

W. Eugene Brain of Renton, Washington was honored by the University of Washington Dental Alumni Association with the presentation of its 1993 Distinguished Alumnus Award. Dr. Brain is a Past President of the American Association of Orthodontists.



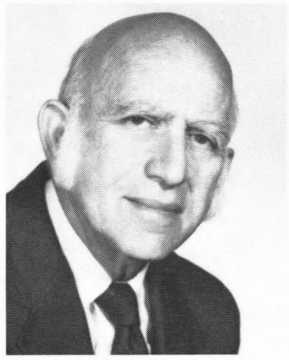
W. Eugene Brain

Ronald M. Chaput was installed as President of the Massachusetts Dental Society. Dr. Chaput practices general dentistry in Chelmsford, Massachusetts and currently chairs the National Council on Dental Practice of American Dental Association.

Ronald M. Chaput

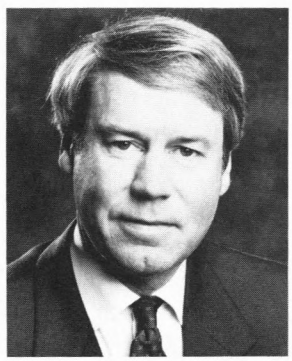
Abram I. Chasens was honored by the New Jersey Society of Periodontology as one of its founding members. Dr. Chasens established the graduate program in Periodontology at Fairleigh Dickinson University and was the recipient of the 1986 Gold Medal Award of the American Board of Periodontology.

Manuel M. Album of Jenkintown, Pennsylvania was responsible for planning the Scientific Program of the 14th Congress of the International Association of Pediatric Dentistry hosted by the American Society of Dentistry for Children recently in Chicago. Dr. Album is a Past President of the International Association of Pediatric Dentistry and of the American Society of Dentistry for Children.



Manuel M. Album

J. David Allen of Decatur, Georgia was recently installed as President of the Southeastern Society of Oral and Maxillofacial Surgeons at the society's meeting in Munich, Germany. Dr. Allen also received the National Emory Dental Alumni Association's Distinguished Service Award.



J. David Allen

Arthur A. Dugoni, Dean of the University of the Pacific School of Dentistry in San Francisco, was recently appointed to the Pew Health Professions Commission. A Past President of the American Dental Association and President Elect of the American Association of Dental Schools, Dr. Dugoni is the only dental educator appointed to this policy making group.

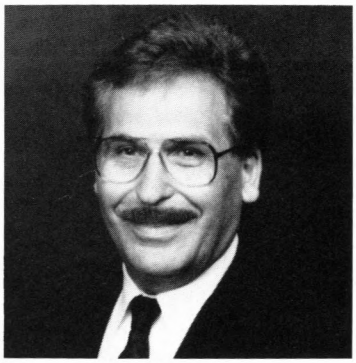
Arthur A. Dugoni

Clifton O. Dummett and his wife Lois Doyle Dummett recently published a book entitled Dental Education at Meharry Medical College: Origin and Odyssey. Dr. Dummett has served as Dean of the Meharry Medical College School of Dentistry and is a Past President of the International Association for Dental Research and the American Association of Dental Editors.

Clifton O. Dummett

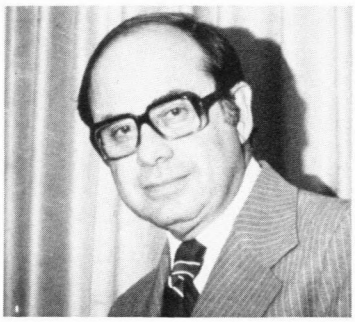
James E. Gjerset was installed as a member of the Board of Trustees of the American Association of Orthodontists. Dr. Gjerset practices in Grand Forks, North Dakota.

Ronald B. Gross of Pottstown, Pennsylvania was installed as President of the American Association of Orthodontists. Dr. Gross is currently serving as Treasurer of the Pennsylvania Dental Association.



Ronald B. Gross

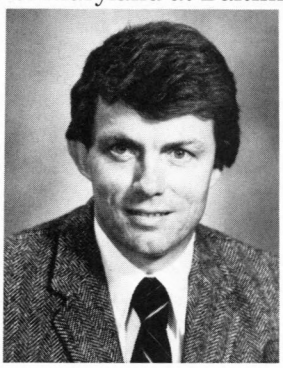
Manual I. Weisman developed the Masters Emergency Dental Service Program in conjunction with the Augusta Dental Society in 1969. This service, each year, provides emergency dental care to the large number of people attending the Masters Golf tournament. Two to three dentists are on call each day, for the entire event, and the names and addresses of the dentists are posted at the National Golf course, the Georgia and South Carolina Welcome Centers and the emergency rooms of local hospitals. Emergency treatment records are then sent to the individual's hometown dentist.



Manual I. Weisman

James E. Gjerset

Eric J. Hovland was elected as President of the American Association of Endodontists. Dr. Hovland is the Chair of the Orthodontic Department at the Baltimore College of Dental Surgery, Dental School, University of Maryland at Baltimore.

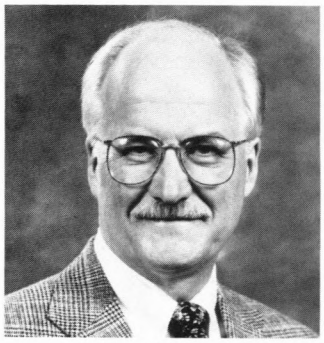


Eric J. Hovland

Robert J. Kuhn was installed President of the Pacific Coast Society of Orthodontists. Dr. Kuhn is in the private practice of Orthodontics in Santa Barbara, California.

Robert J. Kuhn

Stephen H. Leeper, Dean of the University of Nebraska Medical Center College of Dentistry, was recently elected as President of the Juvenile Diabetes Foundation International. Dr. Leeper has served as Vice President of Research for three years for the Foundation.

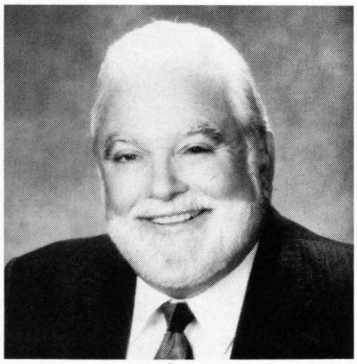


Stephen H. Leeper

Samuel D. Harris was recently honored by the New York University's College of Dentistry with the opening of the Dr. Samuel D. Harris Infant Dental Education Area (IDEA). This is the nation's first facility dedicated to oral health education for parents and caregivers of infants and preschool children.

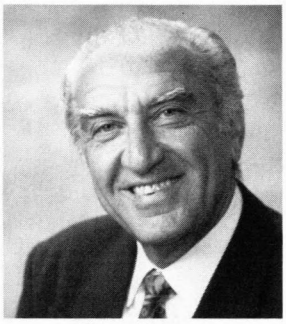
Photographed at the IDEA's opening are from the left: IDEA benefactor Dr. Samuel D. Harris, Dr. Stephen J. Moss, Chairman and Professor of Pediatric Dentistry, State Senator Nellie Santiago, State Assembly member Catherine T. Nolan and NYU College of Dentistry Dean Edward G. Kaufman.

Joseph Pinto was elected to a one year term as Vice Chairman of the Board of Directors of Delta Dental Plan of Michigan. A Past President of the Detroit District Dental Society, Dr. Pinto had practiced general dentistry in Garden City, Michigan.



Joseph Pinto

Harry Rosen of Montreal was recently honored by the Canadian Dental Association with the presentation of its Distinguished Service Award. Dr. Rosen is Professor and Director of Graduate Prosthodontics at McGill University, Faculty of Dentistry.



Harry Rosen

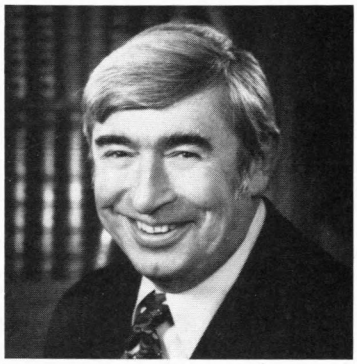
Carl L. Sebelius was the recipient of the 1993 John W. Knutson Distinguished Service Award in Dental Public Health conferred by the American Public Health Association. A former dental officer of the World Health Organization Dr. Sebelius has served as Assistant Secretary of the American Dental Association.

Carl L. Sebelius

Joseph M. Sim of Wood River, Illinois was recently installed President of the International Association for Orthodontics. Prior to his retirement, Dr. Sim served as Chair of the combined Department of Pediatric Dentistry and Orthodontics at Southern Illinois University.

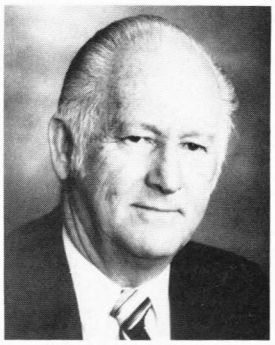
Joseph M. Sim

J. Daniel Subtelny, Professor and Chairman of the Department of Orthodontics at Eastman Dental Center in Rochester, NY, was honored with the presentation of the Louise Ada Jarabak Memorial Orthodontic Teachers and Researchers Award presented by the American Association of Orthodontists Foundation.



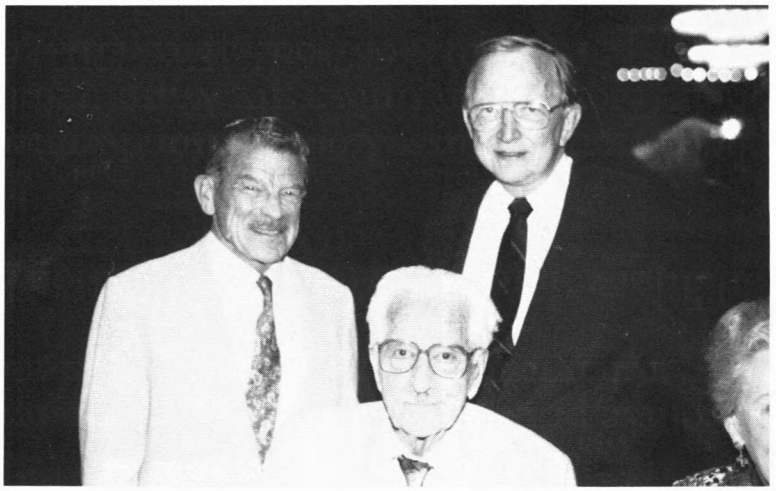
J. Daniel Subtelny

Thomas O. Sweet of North Syracuse, New York was the recipient of the University of Pennsylvania School of Dental Medicine's 1993 Alumni Award of Merit. Dr. Sweet is presently serving as Second District Trustee of the American Dental Association.



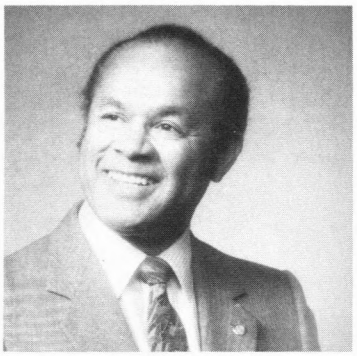
Thomas O. Sweet

Collister M. Wheeler of Portland, Oregon was recently honored when 300 friends and guests gathered to celebrate his 100th birthday. Dr. Wheeler is a retired Captain of the United States Navy Dental Corps and served for many years as Secretary/Treasurer of the Oregon State Board of Dental Examiners.



Photographed with Dr. Wheeler are, on the left, former Dean of the University of Texas Health Science Center at San Antonio Philip F. Boyne and ACD Regency 8 Regent Walter N. Johnson.

Richard Carlos Tatum of Columbia, Maryland recently received a Masters in Public Health (Magna Cum Laude) degree from Loma Linda University with a major in Health Education and Promotion.



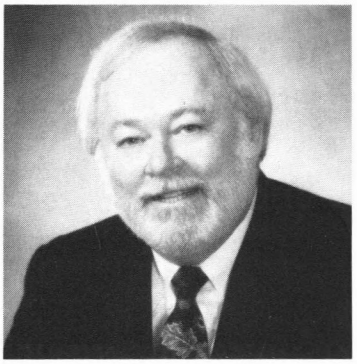
Richard Carlos Tatum

Raymond D. Wenn of Charlotte Town, Prince Edward Island was appointed President of the Canadian Dental Association. Dr. Wenn assumed the office during the Association's annual meeting in Ottawa September 10 and 11.

Raymond D. Wenn

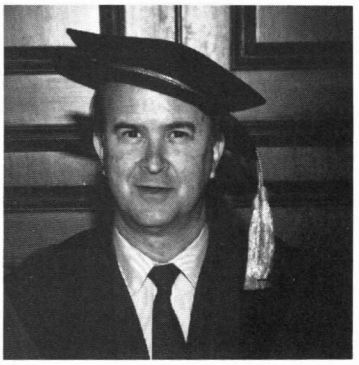
ACD President Albert Wasserman attended the British Dental Association's Annual Conference in Bournemouth, England.

Dwight R. Weathers recently completed his term as President of the American Academy of Oral Pathology. Dr. Weathers served as the Dean of the Emory University School of Dentistry from 1985 until its closure in 1992. He is currently Professor and Vice Chairman of Oral Pathology at Emory University School of Medicine.



Dwight R. Weathers

George A. Zarb was awarded the degree of Doctor of Laws Honoris Causa by the Dalhousie University, Halifax, Nova Scotia. Dr. Zarb is Professor and Chairman of the Department of Prosthodontics, Department of Dentistry, University of Toronto.



George A. Zarb

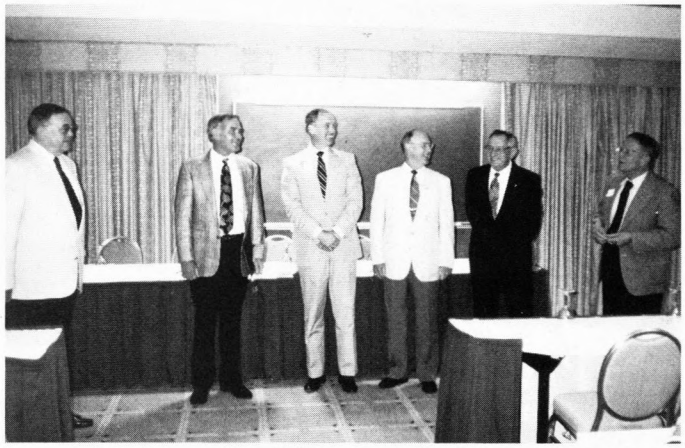
Photographed at the British Dental Association Annual Conference are, from the left, ACD President Albert Wasserman, British Dental Association President Margaret Seward and the Lord Major of Bournemouth, Ron Whittaker.

SECTION ACTIVITIES

Florida

The Florida Section held its annual business session, scientific meeting and dinner September 11 - 12 at the Marriott World Center in Orlando. The Section's business meeting was Chaired by Dr. José Medina and ACD President-Elect Chris Scures announced the names of the 13 dentists from Florida to be inducted into the College in San Francisco.

Former ACD President Charles W. Fain, Jr. installed the following new officers of the Section: Chairman William Blosser, Chairman Elect, Edward Gronsky, Vice Chairman Carlton J. McLeod and Secretary/Treasurer Chris C. Scures. The Florida Section voted to continue the support of the University of Florida School of Dentistry as well as student and faculty awards. The Section also voted to contribute to the American College of Dentists Foundation and to make a donation to a fund established to assist those dental students of the University of Florida who suffered loss as a result of the financial collapse of the supplier of student instrument kits. The Florida Section also voted to write to the Chairman of the Florida Board of Dentistry requesting that a course in ethics be included as a part of the annual continuing education requirement for relicensure.



Photographed at the Florida Section's meeting are from the left: ACD Past President Charles W. Fain, Jr. installing section officers Chairman William Blosser, Chairman Elect Edward Gronsky, Vice Chairman Carlton J. McLeod and Past Chairman José Medina.

Metropolitan - Washington Section

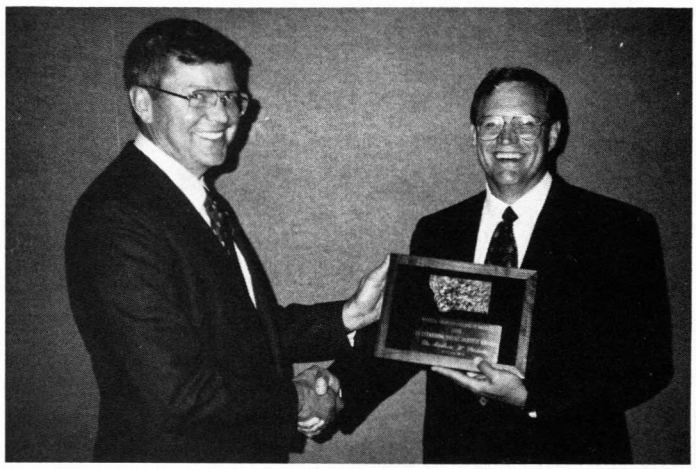
The Metropolitan-Washington honored Dr. Gordon H. Rovelstad upon his retirement as Executive Director of the American College of Dentists.

Photographed at the Section's meeting are Dr. Gordon H. Rovelstad and Dr. Aida A. Chohayeb.

Montana

The Montana Section recently held its annual meeting presided by Chairman Frank V. Searl, Jr. The other officers of the Section are Vice Chairman Christopher J. McDonald and Secretary/Treasurer Stephen Dailey.

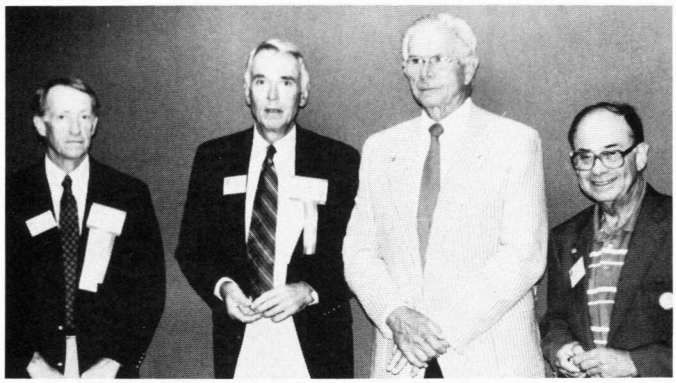
Section Chairman Frank V. Searl, Jr. photographed presenting the First Annual Outstanding Young Dentist Award to Dr. Andrew W. Pickens.



Georgia

The Georgia Section conducted its annual meeting August 7 in Asheville, NC in conjunction with the Georgia Dental Association's Annual Session. The meeting was attended by 50 Fellows and was addressed by ADA President Jack H. Harris, 5th District Trustee Heber S. Simmons, Jr. and Candidate for ADA President-Elect Jack V. Hintermann. The Georgia Section presented a $1000 check to Dr. Heber S. Simmons, Jr. for the ADA Emergency Flood Relief Fund. Twelve new Fellows to be inducted in 1993 were introduced and 25 and 15 year Fellowship Awards were presented.

Photographed at the Georgia Section's meeting are, from the left: ADA President Jack S. Harris, Dr. Jack V. Hinterman and ADA 5th District Trustee Heber S. Simmons, Jr.



Georgia Section Vice Chairman Larry C. Miller, on the left, photographed presenting the 25 and 15 year pin awards to Drs. Jo H. Stegall, Jr., T. Earl Taylor and Manuel I. Weisman.

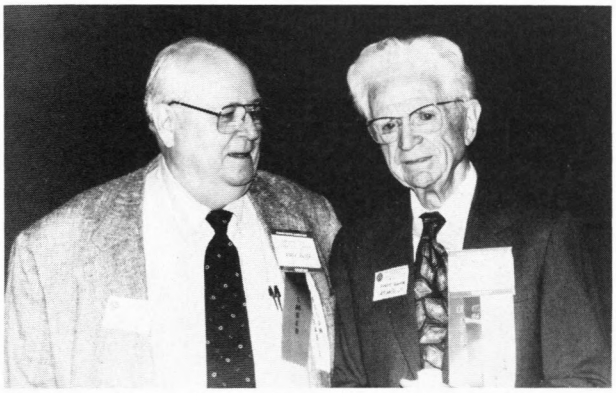
Photographed, from the left, are: Drs. Barrett Trotter, Carole Hanes and Wally Edwards, Associate Dean, Medical College of Georgia, School of Dentistry.

Washington

The Washington Section recently held its annual dinner meeting in Seattle in conjunction with the Washington State Dental Association Scientific Session. Chairman Stan Sapkos presented two $1000 scholarships to students from the University of Washington School of Dentistry for outstanding achievement in Restorative Dentistry (the Ferrier Memorial Award) and Periodontics.

Dr. J. Harvey Losh was elected Chairman and Dr. Tom O. Conlon was elected Vice Chairman of the Section.

Photographed at the Washington Section's meeting are from the left: Section Chairman J. Harvey Losh, Scholarship recipients Steven Machida and Eugene Tynes, Past Chairman Stan W. Sapkos and Vice Chairman Tom O. Conlon.



Dr. Robert A. Ranier, Jr. introduced Dr. Robert D. Robinson who is 93 years of age and has not missed a Georgia Section meeting or an Annual Session meeting of the Georgia Dental Association for 71 years.

Georgia Section Chairman Gerrit Hagman presented a check for $1000 for the ADA Emergency Flood Relief Fund to Dr. Heber S. Simmons, Jr. ADA 5th District Trustee.

Mississippi

The Mississippi Section held its annual meeting in Biloxi with Chairman Peter B. Perkins presiding. The Section presented an Outstanding Student Award, as well as an Outstanding Faculty Award which was received by ACD Fellow Sigurds O. Krolls. Dr. Robert T. Ragan addressed the meeting and 25 years pins were awarded to Drs. David M. Miller, Jr., Dewey M. Metts, Jr., Harry D. Halliwell, Jr., Samuel G. Sanders and James W. Wooten. Dr. Lloyd W. Rose, Chairman of the Ethics Committee, reported that the committee will give a short program on ethics at each state district dental meeting. The following Section Officers were elected: Chairman Donald B. Hall, Chairman Elect William Martin and Secretary/Treasurer Lloyd W. Rose.

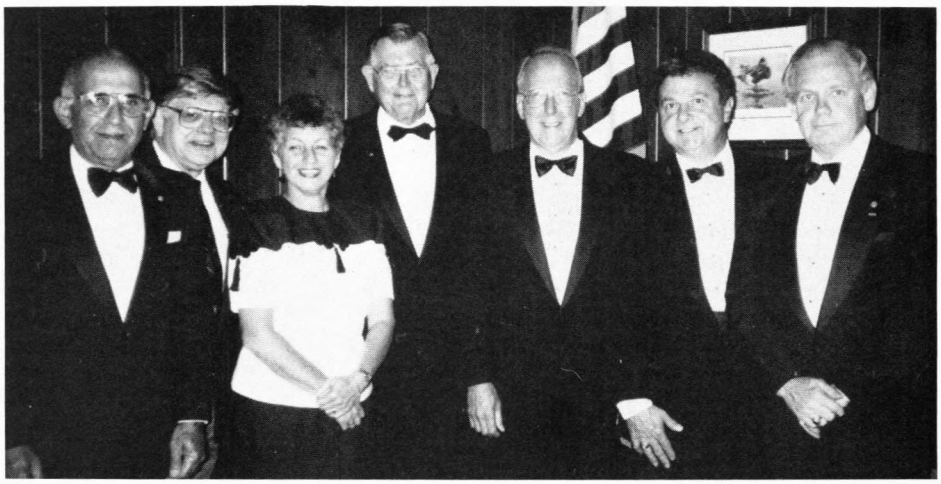
Photographed, from the left, are: Section Officers Secretary/Treasurer Lloyd W. Rose, Chairman Donald B. Hall and Chairman Elect William Martin.

Dr. Sigurds O. Krolls receives the Outstanding Faculty Award from Section Chairman Peter B. Perkins, on the right.

Wisconsin

The Wisconsin Section held its Annual Meeting recently in Milwaukee. The meeting was attended and addressed by ACD Regency 5 Regent Richard E. Bradley. The Section elected the following officers for the 1993-94 year: Chairman Elise Sampson, Vice Chairman Donald F. Pricco, Secretary/Treasurer Robert J. Karczewski and Editor George E. Rooney, Jr.

Dr. Richard E. Bradley, ACD Regency 5 Regent addressed the Wisconsin Section meeting.



Photographed at the Wisconsin Section meeting are, from the left: ACD Vice President nominee Prem S. Sharma, Section Secretary/Treasurer Robert J. Karczewski, Chairman Elise Sampson, ACD Regent Richard E. Bradley, Section Past Chairman Russell T. Kittleson, Vice Chairman Donald F. Pricco and Editor George E. Rooney, Jr

STATEMENT OF OWNERSHIP AND CIRCULATION

THE JOURNAL OF THE AMERICAN COLLEGE OF DENTISTS is published by the American College of Dentists, 839 Quince Orchard Blvd., Suite J, Gaithersburg, MD 20878-1603. Editor: Keith P. Blair, D.D.S., Managing Editor: Sherry Keramidas, Ph.D., CAE.

The American College of Dentists is a non-profit organization with no capital stock and no known bondholders, mortgages or other security holders. The average number of readers of each issue produced during the past twelve months was 5,289, none sold through dealers or carriers, street vendors or counter sales; 4,806 copies distributed through mail subscriptions; 4,806 total paid circulation; 483 distributed as complimentary copies. For the Summer/Fall 1993 issue the actual number of copies printed was 5,165; none sold through dealers, etc.; 4,583 distributed through mail subscriptions; 4,583 total paid circulation, 503 distributed as complimentary copies; 5,165 copies distributed in total. Statement filed with the U.S. Postal Service, September 22, 1993.

INFORMATION FOR AUTHORS

INTRODUCTION

The Journal of the American College of Dentists is published 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, authories 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.

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

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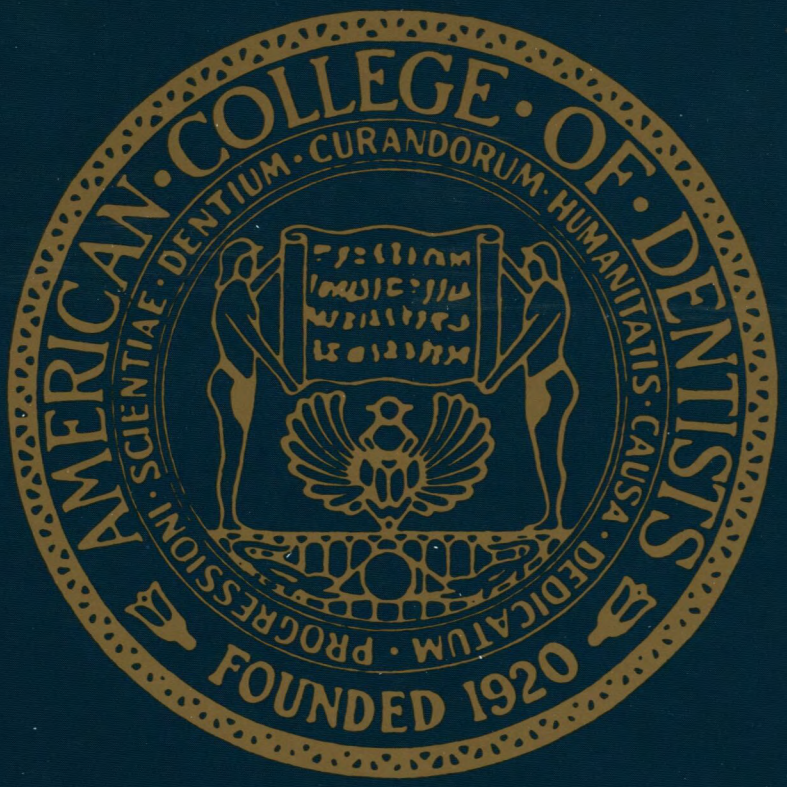

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