one cancerous growth by implanting another in the same body.

"The pair of consultants developed a remarkable concurrence of views, both in regard to definition of the cancer problems . . . and the approaches to organize cancer control programs . . ."[1] One must hope and pray that the two nations will soon develop a similar concurrence of views toward their internal cancers which threaten the world. Irrespective of mutual distrust and differing views on other problems, there is no alternative to the US and USSR talking *to* rather than *against* one another, freezing the cancers where they stand as the first step toward their destruction. Freedom from the corruption can release enormous resources beneficial to mankind; the Commentary in this issue of the Journal is a miniscule example of what can be done. If we fail to act to control this cancer, however, the world faces disasters far worse than the wake of London fire-raids 40 years ago:

Man and woman undone,
Beginning crumbled back into darkness
Bare as the nurseries
Of the garden of wilderness.[3]

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Dentistry at the Crossroads: A Study of Professionalism

The six papers on dental care delivery that appear in this issue of the *Journal* are based on material presented at a symposium held at Columbia School of Dental and Oral Surgery in April 1981. They represent the first stage on the part of that School to make a continuing study of dental care delivery in the United States in a time of exceptionally rapid socioeconomic change.

The Wotman and Goldman paper describes some of the pressures that have recently come to bear on the private sector which comprises over 90 per cent of the personnel of the dental profession today.[1] The Rovin and Nash paper[2] and the Bailit paper[3] present factual information on a number of responses which have resulted from these pressures: department store practice, (non professional) corporation practice, franchise practice, hospital and HMO practice, competitive efforts of dental auxiliaries, and the increasing number of capitation dental health insurance programs.

The Capon[4] and the Lipscomb-Douglass[5] papers both deal with pure market theory. Capon, an economist, calls dental service an "offer" to a consumer, and deals with it as if it were a commodity of interest to a consumer under certain conditions. The dentist's chief motive is assumed to be attainment of a target income. Lipscomb and Douglass go further. They divide the dentist-providers into established dentists (EDs) and recent graduates (RGs), then study them for three variables: income, leisure time, and professional esteem. Although, for the sake of clarity, the paper omits consideration of consumer variables, the paper broadens the picture and leads one to a consideration of a crucial issue at the present time: professionalism. The Littleton paper[6] comments on the dental market theory.

The "learned professions" over the centuries have been considered as apart from the "trades" within the marketplace. Of the various characteristics of these professions, two stand out: an exceptionally large body of knowledge on the basis of which to provide quality care, and an obligation to serve the public above and beyond mere financial reward. Dentistry, as an increasingly worthy segment of medicine, has considered itself to be among the learned professions. The two characteristics just named work in conjunction with each other most of the time, but can on occasion lead in opposite directions. Just now this seems to be happening.

The quality concept is the one organized dentistry has elected to emphasize. Initially this concept led to the technical preeminence of the American dental profession. More recently the concept has become restrictive. Only the best and most sophisticated care is to be tolerated, even if the segment of the population unable to pay for this gets next to nothing. In Voltaire's phrase, the "best" has thus become "the enemy of the good." The private sector has monopolized the field; the American Dental Association has built a local-state-national hierarchy comprising over 90 per cent of practicing dentists. One result, as Lipscomb and Douglass point out, has been opposition to the entry of rivals into the field, particularly those auxiliaries who might become independent. Another result has been firm efforts to control the environment within which dentistry is practiced. Clinics, school-based and otherwise, have been discouraged, as have most programs leading to the employment of dentists on salary. Advertising has been opposed. Only the private office—typically costing some $60,000 to build, furnish, and equip (the chair alone in 1982 usually costs well over $3,000)—can really be approved as a site for practice. Only a licensed dentist should own or operate a practice. Thus a leadership cartel has arisen, and an ethic which has the effect of restricting competition. Both have resisted the forces of change—until now.

The monopoly of learning by the "learned professions"

has become a thing of the past. Extensive knowledge, and the responsibility to use it correctly, has come into the hands of many sorts of people from automobile mechanics to airplane pilots, all of whom are responsible for safeguarding human life. And then there are the consumers. Not only do many of them know a lot more science than in the past, but the bodies to be protected are theirs.

Health care begins with the consumer, and for many of them it is a long way from where they are to a conventional dental office. An extreme example is worth quoting.[7] On a farm in Alaska some 50 miles from the nearest cottage hospital and 250 miles from the nearest dental office, a child developed a toothache. She was taken on a 500-mile trip with an overnight stop. The dentist insisted on a full set of x-rays, but only extracted one deciduous tooth. The dental bill was bad enough: $68. How large was the non-dental expense this farm family had to face? Not all rural people are that far from a dental office, but large population groups even in urbanized states must overcome geographic, cultural, and economic problems of major importance before they ever get to a dental office. These problems need much further study, not even attempted in the accompanying papers.

The second major characteristic of a profession has been stated to be public service. What can the dental profession do here that it has not done? Many things. Organized dentistry is not a complete monolith. Organizations such as the American Association of Public Health Dentists and the Section on Dental Health of the American Public Health Association have been studying the problems of the underserved for years. Consumer groups are now more informed and more active than before—and should be listened to. In what directions could the dental profession move in order to serve the public as it should?

Two areas for action occur to me, both within the definition of primary care: emergency care and prevention. In both areas, semi-independent auxiliaries have a large role to play, so far denied to them in this country.

When people are in pain, palliative treatment of a first-aid type can usually precede definitive treatment. The World Health Organization[8] has suggested more than one type of auxiliary to be trained and to work in areas where there are no fully-trained dentists. In areas where there are dentists, semi-independent auxiliaries should be allowed to deliver primary dental care to school children as they do in such countries as New Zealand, Australia, and parts of Canada. Dental hygienists are now trained in the USA well beyond the duties they are allowed to perform; only minor alterations to curriculum would train them to deliver primary dental care, including the preparation and filling of simple cavities. Today, hygienists are equipped to spread a knowledge of prevention and to screen such population groups as school children and the elderly in nursing homes. They should be allowed to do so. Dentists should design their programs, lay down ground rules for them, and trust them far more than is done today. The dentists should become team leaders.

Environment also plays a part (Lipscomb and Douglass's characteristics vector C_3). Clinics, in or near public school facilities, can bring primary dental care to children, and to others as well. Utilization of comprehensive dental care by elementary school children in the countries listed above and in Scandinavia often exceeds 90 per cent, as compared with an estimated 25 per cent in this country. (Lipscomb and Douglass's figure of 59 per cent for dental visits for children does not measure comprehensive care.) School-based programs usually require public funds, and the impartial decisions of government agencies. This is where the consumers and political action must be brought into play.

A final word to the dentists of America. They have performed nobly in the preventive area through promotion of water fluoridation and other fluoride programs. Dentists will continue to be needed even where fluoridation has long been in effect, and in the other areas Wotman and Goldman mention where secular decreases in dental caries among children have occurred. Adults in these areas will increasingly keep their teeth. Periodontal and endodontic treatment, and other methods applicable to natural teeth will be more needed than ever. The prosthodontists may have to shift from removable to fixed prosthesis. In educating the adults of tomorrow to demand these services from dentists, the semi-independent auxiliaries can do (and elsewhere have done) effective work. Full dentures should be seldom needed. Adult dental care should largely replace restorative care for children.[9] The nation's total dental bill thus may not decrease very much, but the improved distribution of dental care should result in far better dental health for the public.

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