HB
401

TESTIMONY OF PATRICK PLETNIKOFF ON H.B. 728
MOBILE DENTAL CLINIC
April 7, 1978

Throughout the dental feasibility study conducted by APIA for the Aleutian/Pribilof area, it was very early apparent that massive efforts were made by Public Health Dental Units to deliver service to the people of this area over the past few years. However, the records show that these efforts were often uncoordinated, equipment very often arriving days late after the professional staff had arrived and in some cases when the dentist was ready to leave or had already left. One could criticize the Public Health's efforts to deliver dental care in almost the same wording as Dr. Douglas Smole, Chief, Service Unit Dental Program used in his criticism of our plan to use mobile units combined with supervisory professionals and overwhelming numbers of volunteers who want to help free of charge. I quote him here "one shot" programs have no potential for continuing success when they deal with disease processes as multifactorial as dental diseases. Furthermore, one shot programs are usually not cost effective."

The records clearly show that the one shot approach is in fact the approach most often followed by the PHS Dental Program.

In 1974, 1975, 1976, and 1977, the records clearly indicate that the one shot a year plan was the plan used and the same plan is anticipated for 1978.

Let's explain the facts·

ATKA - Village received a total of 9 days dental service with a single dentist from 1974 through 1978 and even at that the dentist waited for his equipment to arrive and in one case decided to talk about good dental health to the children instead because he had no equipment.

FALSE PASS - Received 9 days of dental care from 1974 through 1978. The 1974 trip was aborted due to weather and another attempt was made in March of the following year.

KING COVE - From 1974 through 1978 the average days of service for dental treatment was 10 days a year for a population of over 270 people. 7 evenings were devoted to night emergency treatment of adult teeth in 1974 and the dentist was told by his superiors the program emphasis was for children's teeth, not adults. Even with this increased number of days of service the reports read (rampant cares) decay out of control, and once again the late arrival of equipment needed to treat patients.

BELKOFSKI - Children were transported to King Cove when the dentist was there for emergency care. No opportunity was available for adults or out of school youth beyond grade 8 to have dental assistance.

NIKOLSKI - From 1974 through 1978, 5' days of service was delivered to children. A planned trip for November of 1976 was attempted again the next year in May.

NELSON LAGOON - 1974 to 1978, 9 days of service. An aborted trip in November was attempted again 6 months later.

SAND POINT - 1974 to 1978, almost 20 days a year of dental service was available except for the days equipment was late in coming and the time spent trying to find a place to have a clinic. The dental staff had to clean out an old building in order to set up at all, and the portable equipment arrived 3 days later leaving 4 of the 9 days for treatment. Community response was reported as very poor. Obviously little pre-planning was done to involve the communtiy.

UNALASKA - Public Health reports a population of 104-252. The dentists say 500 year around. An average of 11 days service per year since 1974 with the usual late arrival of equipment reported by the dentists. A flouride program in the water system seems to be helping here.

A private practitioner in May of 1976 delivered emergency care for a 7 day period. The previous October, over 100 adults requested emergency treatment.

ST. PAUL - Reported population, 419. Although this community had more days care per year than all the other villages from 1974 to 1977, reports were of rampant dental disease, high sugar consumption and little or no community dental plan. Lack of coordination with school; 30 children reported as not showing for check ups in one period.

ST. GEORGE - Average of 6.4 days a year since 1974 of dental care by a dentist for a community of 154 people. Emphasis on children's teeth.

We cannot over emphasis our intention in our request for support of this program of dental care for the Aleutian/Pribilof people. We do not have as a goal the embarrassment of PHS, Indian Health Service of private practitioners. We appreciate all past efforts to check dental disease in our islands. The records clearly show that the present system is not working satisfactorily and a new approach is needed. We ask only that the new approach be given the support it deserves. The worst that can happen is the communities will get a little more dental care and the mobile unit can be used by any agency wantint to use it for delivery of service to our area.

The best that can happen is that we will have discovered and tested a new funtional,less expensive way to bring dental health care to bush Alaska and other areas will be using the money they now waste on poor programs to duplicate this method of service.

THE FOLLOWING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

South Central District Dental Society

P.O. BOX 3-487
ANCHORAGE, ALASKA 99501

March 17, 1978

Representative Alvin Osterback
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

RE: HB 728 - mobile dental clinic

Dear Representative Osterback:

The South Central District Dental Society is deeply concerned that state funds be spent for services to specific, designated, select geographic groups. This would set a precedent of legislating public tax monies to provide health care for a group limited by race and geographical location.

It appears that the Aleut-Pribilof Corporation did not assess rural area resources already available to meet the area's dental needs. Furthermore, it seems no cost effective studies were performed, nor did the Aleut-Pribilof Corp. and the Indian Health Service coordinate in planning the project referred to in the bill.

The proposal of $200,000.00 appropriates $[illegible]00,000.00 for transportation and $100,000.00 for equipment. We are concerned that no appropriations were made for manpower evaluation and licensing - or continuation of the project in successive years.

If, however, the funds are allocated, fixed facilities and equipment should be used in preference to a mobile unit. This would allow more equipment in more areas for the same dollar amount. As many as 20 communities could be served with permanent equipment.

Federal and state funds are currently being used in cost effective programs which provide services for the dentally needy, further, the continuity of licensed voluntary manpower is available within the state. Services may be provided through a multiplicity of funding sources such as: Indian Health Service, private insurance, Medicaid, General Relief Medical, and native health corporations.

In view of the above information, it seems apparent, that, in the interest of all Alaskans, the proposed legislation be further investigated. Please contact our lobbyist, Mr. Henry Pratt, for any additional information and assistance.

Sincerely,

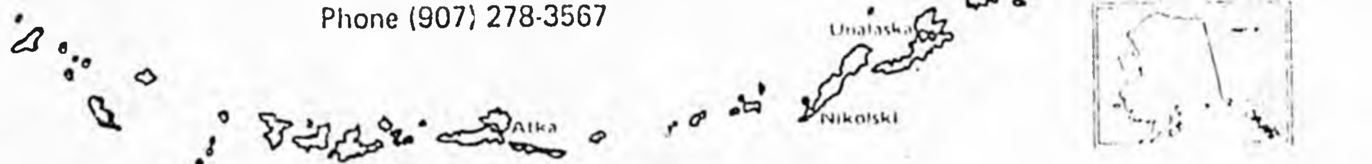
William F. Pell, D.D.S., President
South Central District Dental Society

cc: Senator Ferguson — Representative [illegible]
Senator Hackney — Representative Cooper
Senator Sackett — Mr. Henry Pratt

THE PRECEDING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

Aleutian/Pribilof Islands Association, Inc.

430 "C" Street, Suite 303
Anchorage, Alaska 99501
Phone (907) 278-3567



REPLY TO SOUTHCENTRAL DISTRICT
DENTAL SOCIETY LETTER OF 3-17-78

To: William P. Fell, DDS, President
South Central District Dental Society

The letter signed by Dr. William Fell of the South Central District Dental Society was reviewed with interest and amazement. Why should the South Central Dental Society be concerned with an area of the State they do not serve nor have any intention of serving with dental care?

The statement that this program would provide health care for a group limited by race and geographical location is indeed erroneous by design. Nowhere in the proposed bill is health care limited to any one race. When it comes to geography, of course this demonstration project is designed geographically to demonstrate a solution to a problem of geographic delivery of service. Almost every bill out of the hopper has a geographic area of service or demonstration.

The Aleutian/Pribilof Association did assess rural area resources already available to meet the area's dental needs and found all sources committed, over committed and over spent and underfunded. When it comes to cost effective studies, the Dental Association should be willing to pass over this snake pit. Private dentists from the South Central Region occasionally contracted to deliver service were so far out of reach price wise that cost effectiveness would be a joke.

For instance, one dentist billed us $30,000 for 10 days of service. That's 25% of the total PHS allotment for the entire area for a year.

The system we anticipate with this unit has proven itself over and over again as cost effective. We don't need to study the study anymore. The State of California found it so cost effective even Ronald Reagan made the support of the mobile dental units a part of the regular State budget every year to solve the dental problems of farm workers and their children.

We do not know where Dr. Fell gets his figures on cost of the unit and delivery of service. The correct figures are attached.

So far as continuation of the project over the years, we as a district have applied for self management of dental health care funds allotted to our district and have a long time commitment from the dental school to stick with us over the years ahead. We will not be returning every year for additional funding as some people have suggested.

Most of our communities lack even basic housing at this time for families. To suggest fixed facilities be built by the State for dental care is really uninformed. Does the good doctor know what it costs the State for a 900 sq. ft. building for schools in the bush? He is talking about millions, not thousands for his plan.

What does the doctor mean when he says "The continuity of licensed voluntary manpower is available within the State." Is he suggesting his organization will volunteer dental services? If so, we accept and will make the mobile dental unit available to them for that purpose.

As our program develops we will need all the help we can get and hope we will be able to count on Dr. Fell and his association for consulting and direct service.

Yours Sincerely,

ALEUTIAN/PRIBILOF ISLANDS ASSOCIATION, INC.

Patrick Pletnikoff
Executive Director

PP:alp

SPECIAL NOTE

On the strength of various legislators' commitments to this project and our own faith in the legislature, the University of California has begun work on the dental bus already, so it will be completed in time to be operational this summer. Their students picked up the shell bus in Michigan and drove it back to school on their Easter Vacation.

We are told they have over 80 volunteers wanting to serve Alaska. It would be an embarrassment to have this Bill fail.

Recommendations

It is the recommendation of this consulting agency based on the information gathered to date that there are a number of alternatives to solving the problems of delivery of dental health care to the Aleutian/Pribilof Islands.

It should be understood that this area is the most expansive geographical area in the State covering over 1,000 air miles from Kodiak Island to the Pribilofs and that, although great, efforts have been made under limited budgeting restraints by the Indian Health Service and other agencies to provide care the task was almost impossible. Without a rather dramatic community dental health education program coupled with the availability of a number of practioners, the task may never be accomplished.

Alternative I

Establish a dental unit in each of the 11 villages and bring in a dentist when needed.

Most villages have enough dental problems to require the presence of a dentist 100% of the year. The cost for such a program would be prohibitive due to State regulations and standards for building a dental health clinic coupled with the problem of getting a single dentist to work alone in one of these isolated villages as a life work.

Estimated cost of this plan would be approximately $350,000 for each of the 11 villages served or approximately $4 million without staff or equipment.

Alternative II

Fly in with 3 or 4 dentists with portable equipment, set up a clinic in the school or church and recruit students and townspeople to have their teeth repaired.

(1) Housing would be required for staff of professionals and support staff.

(2) Auxiliary x-ray developing tanks, etc. would be set up in some available building.

(3) Although the equipment for portables is good it does take up badly needed school space and it is more difficult to find things to work with under such conditions. The program is usually viewed as an intrusion because it displaces space and often staff to meet its goals as another extra in an already crowded school program.

(4) The availability of the numbers of staff necessary to complete satisfactorily the work needed is remote - other areas of the State are also in need and would suffer if staff were diverted to the Aleutian area needs.

Alternate III

Is the development of a complete mobile multi-seated and work station dental clinic completely outfitted as a large city facility not dependent on old buildings or the availability of space dedicated to the school program. Such a program has been tried previously and successfully carried out by the University of California Dental School under the direction of Dr. Stark and Dr. Solberg.

Visitation to the University of California Dental School and to its operational unit working in the Sacramento Valley fields for migrant workers' children. The willingness of the Unversity to commit for such a project as [illegible]s was explored and the possibilitie. look good for such an [illegible]rangement to be made similar to the porject now serving the migrant workers and

This program operates as follows:

1. Advance staff do surveys of the community to be served.

2. Massive school and community programs of information and education are are initiated prior to the arrival of the mobile unit. Charts, posters and public lectures and films on diet health and tooth care are conducted.

3. Dental mobile unit arrives staffed by 3 University of California staff dentists and dental graduates awaiting their final licensure. Also a part of the team are dental hygienists who assist and work wi h the unit.

4. The complete unit operates steadily often rotating in other volunteers as needed.

5. Volunteers are paid only a per diem subsistence allowance and transportation costs. They would receive additional credit for added clinical experience.

6. A periodontist would also spend time in the unit and a good possibility of a follow up prosthetic unit to work over the year on dentures [illegible] good.

At present the Aleutian people have no qualified personnel to deliver dental health needs to their people and the Public Health Service delivers only emergency type care to this area.

Due to the over 1,000 miles one must travel in order to cover the distance of the Aleutian/Pribilof area -- and the isolation of the communities -- there is not adequate space or facilities to do quality dental work and as a result very little restorative work is done. The pattern has been to extract rather than repair.

With the mobile dental unit we are designing, we will be able to move this total working clinic from one place to another and recruit quality personnel to staff it.

The Aleutian/Pribilof Islands people have no funds at this time to develop this unit and provide the service.

Unless we have these facilities we will not be able to recruit the volunteer dentists and hygienists to work on our people.

Our objectives are to design and build a mobile dental vehicle equipped with three chairs -- total service units comparable to any funds in a large city setting; to equip a step van to follow for the x-ray unit and hygienists and records; to staff the vehicles with volunteer dentists supervised by the professional staff of the University of California Dental School; to also staff the vehicles with volunteer hygienists and trained dental assistants; and to deliver full dental health service to all our people and to then make our units available to other Native groups in need in Alaska.

Methods of delivery of dental care to isolated areas have been examined throughout this country as well as in Canada and countries abroad; specialist in California and in British Columbia recommended unanimously a full mobile dental clinic which could be moved about from place to place as needed. All experts also are in agreement a short term summer program will not meet the needs of the Aleutian/Pribilof islands people. Neither the consultants nor officials from A/PIAI have ever contemplated a three to four week program as interpreted by Commissioner Helen Bierne.

Such conclusions are politically motivated and reflect a total lack of research on the part of her unit.

It is clearly the intention of A/PIAI and the volunteer dentist to develop a year round program of delivery of dental care -- beginning with clinical repair and graduating to specialized areas and ultimately using the facilities for a prosthetic follow through.

Children's rotten teeth continue to drain down their throats poisoning their systems and the older folks continue to suffer from swollen tongues and extreme malaclusion and deformity leading ultimately to warped speech patterns and systemic discord while politicians scheme out ways to protect themselves against criticism for non-delivery of service the public has been paying them to deliver.

The mobile dental system tried and tested and proven in the migrant labor areas of California and in refugee camps in Israel are not pursued with the idea of embarassing anyone. What has or

has not been done in the past is history all are willing to forget.

We want to get on with the show. Surely our legislators would not be opposed to seeking alternative methods of solving this old problem.

We are not talking about 200 million dollars worth of service.

We are talking about 200,000 which we believe will deliver 2 million dollars worth of care. Is Alaska so affluent we can afford to pass up such opportunities? We are anxous as Mrs. Bierne to see permanent dental facilities in every village in Alaska -- and some day in the future this may be possible through a subsidized program of building dental facilities in isolated areas and providing incentives to young dentists to practice in these isolated areas. Perhaps some of our young professional volunteers will want to fill these vacancies in the future after a volunteer exposure to this area.

In the meanwhile our people need dental care now.

For answers to the ill informed comments about the impossibility of moving this mobile unit from place to place in the islands one needs only to look at the equipment being moved about in the islands now and since World War II. Oil drills, heavy equipment, portable fish processing equipment and millions of barrels of fuel oil as well as prefabricated homes are moved about as easy as moving a sheel barrel and none has even suggested it was not possible.

All the Doubting Thomas' are welcome to stop by this next year, sit in our new mobile unit and have their teeth cleaned.

SOME QUESTIONS YOU MIGHT HAVE

Question

How long will the dentists use the unit?

Answer

We have a long term commitment from the University of California Mobile Dental Clinic to serve Alaska as long as we want their services.

The unit will be staffed with a dentist year round. This summer a team of three dentists, one supervising professor, two dental technicians and one x-ray technician will work for six weeks -- then throughout the year a licensed dentist will do follow up work The following summer a new team will return for another six weeks time frame.

In addition to the teams from the University of California operating their summer program we have a number of volunteer dentists from around the country who are willing to donate their time and services for two weeks to a month at a time. One association has 180 members all willing to participate.

Question

What kind of unit is it and how will it be transferred to the Chain?

Answer

The unit is a G.M.C. 26' motor home stripped. Then refitted at the University of California as a dental clinic. When completed it will be just like a three chair dental office in a large city complete with cabinetry, overhead lights, delux dental chairs and all of the support equipment needed to do a good job.

It will be transported by sea to St. Paul Islands this summer. Next summer it will be moved to the Aleutians, possibly Unalaska or Sand Point by SeaLand. At this time, moves are contemplated for Unalaska, Sand Point, and Cold Bay as needed.

Question

How will the dentists be licensed?

Answer

There are at least two ways -- (1) they can be employed by PHS for a dollar a year and assigned to the Aleutian/Pribilof Islands Association (The State law permits this); or (2) the State Department of Commerce also can license the dentists in remote areas not presently served by dentists (within a 50 mile radius).

Question

How long will the unit be in the Aleutian area?

Answer

We anticipate that after two years the unit could be moved to other remote areas of the State as requested -- we have long term consultants to staff throughout the State.

The dental program will serve anyone who is identified as in emergency need of dental care regardless of who they are. Our hygienist staff will work closely with village health aides to locate people in greatest need first and to repair on a priority basis, teeth which would be soon lost without immediate treatment.

Question

If you will primarily be serving Native Americans, why doesn't the Indian Health Service fund the program?

Answer

The primary responsibility for ensuring the protection of public health in Alaska is the State of Alaska. While this is not an overwhelming problem in the urban areas of our State where dentists establish their practices, it is almost non-existent in the rural areas.

While the Indian Health Service has a special responsibility for the health care of Native Americans, it is not capable of providing the most basic dental services to Alaska Natives.

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IPMAFUA AHB

A-035186E074 03/15/78

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MS PATRICK PLETNIKOFF

ALEUTIAN PRIBILOFF PROJECT 430 C ST

ANCHORAGE ALASKA 99501

THIS WILL CONFIRM OUR AGREEMENT SET FORTH TO NETTIE PERATROVICH

[illegible] TO ESTABLISH A MOBILE DENTAL CLINIC IN ALEUTIAN ISLANDS

THIS CLINIC WILL BE DESIGNED AND BUILT BY DR MARVIN STARK AND DR KENNETH SOELBERG OF THE UNIVERSITY OF CALIFORNIA SCHOOL OF DENTISTRY SAN FRANCISCO MEDICAL CENTER THE CLINIC WILL BE STAFFED BY PROFESSORS OF PEDIATRIC DENTISTRY AND SENIOR DENTAL STUDENTS AND HYGIENISTS. CLINIC OPERATION SAME FORMAT AS MOBILE CLINICS IN SAN FRANCISCO OPERATING FOR 10 YEARS IN MIGRANT FARM WORKER CAMPS. CLINICS WILL ALSO HAVE CAPABILITY OF HEARING TESTING AND EYE TESTING. FUNDS TO BE USED FOR TRANSPORTATION OF FACULTY AND STUDENTS PLUS PER DIEM EXPENSES. YOU HAVE OUR COMMITMENT TO PROVIDE STAFFING AND SERVICES AND COMPLETED CLINIC. CLINIC WILL BE SHIPPED AS PER DIRECTION OF ALEUTIAN PRIBILOFF PROJECT AND ESTABLISHED ON ISLANDS UNDER THEIR AEGIS. CLINIC WILL BE CONSTRUCTED UNDER THE SUPERVISION AND DIRECTION OF MARVIN M STARK RESEARCH FOUNDATION A NON-PROFIT FOUNDATION LICENSED IN STATE OF CALIFORNIA.

DR MARVIN STARK AND DR KENNETH SOELBERG

0300 EST

of ALASKA MEMORANDUM

TO Commissioner Helen Beirne
Dept. Health & Social Services
Juneau

DATE January 12, 1978

FILE NO

TELEPHONE NO 278-4668

FROM Frederick McGinnis
Deputy Commissioner
Dept. Health & Social Services
Anchorage

SUBJECT Request by Aleutian/Pribilof Islands Association, Inc.: Permit Request--Dental Services for Aleutian Chain

Consistent with numerous other recent activities on the part of the Aleutian/Pribilof Islands Association to improve health and social services to the residents of the Aleutian Islands, information was sought from my office today with regard to our Department's assistance to the citizens of the Aleutian Islands for improved dental services.

Mr. Frank Peratrovich, Deputy Director of the Association, raised the question as to whether our Department is in the position to assist consistent with the applicable Alaska Statute--AS 08.36.271, Permits for Isolated Areas. For convenience a copy of the statute is attached (Attachment No. 1).

It is my understanding that the Aleutian/Pribilof Islands Association's plan is to secure the services of dentists on a voluntary basis mostly, if not entirely, from other states to render the services. The Public Health Service will be asked by the Association to employ the dentists at a nominal salary for technical purposes. The dentists apparently will meet the Alaska statutory requirements provided in AS 08.36.110 with latest amendments (see 1976 Supplement Amendments for 08.36.110).

It is in the knowledge of the A/PIA and their legal counsel that "the Department of Health and Social Services shall designate as isolated areas those specific placesand regions remote...". (AS 08.36.271(a))

It is their impression that "the Board shall, upon recommendation of the Department of Health and Social Services, issue an annual permit authorizing...". (AS 08.36.271(b))

It is my understanding that the Association is considering requesting a slight amendment to AS 08.36.271 if necessary to accomplish certain goals but, at this time, it is not certain if such will be required.

RECOMMENDATION: It is recommended that

(1) the Department officials concerned give strongest support to the proposed plan being developed by the Aleutian/Pribilof Islands Association, Inc. in their goals of addressing this extremely long neglected need to improve the dental health of the citizens of the Aleutian Chain.

(2) the Department of Health and Social Services, after consultation with the Department of Law, release the attached suggested letter (Attachment No. 2) and the attached suggested "Designation of Isolated Areas" (Attachment No. 3).

FMcG/mg

Attachments: as indicated

cc: Catherine M. Lloyd, Deputy Commissioner

Attachment No.

gether with the registration fee. The division of occupational licensing shall, as soon as practicable, issue a registration certificate valid for the years for which issued. Each licensee shall keep the registration certificate beside or attached to his license. Failure to receive the registration form does not exempt a dentist from biennial registration. (§ 12 art III ch 186 SLA 1955; am § 9 ch 155 SLA 1968; am § 7 ch 121 SLA 1972)

Effect of amendment. — The 1972 amendment substituted "division of occupational licensing" for "central licensing section" in the first and third sentences.

Sec. 08.36.260. Branch office registration. A licensee who practices in an established office with an address other than that address for which his biennial registration certificate is issued shall obtain a branch office registration certificate for each office. (§ 13 art III ch 186 SLA 1955; am § 10 ch 155 SLA 1968)

Sec. 08.36.270. Permits for isolated areas.

Repealed by § 3 ch 26 SLA 1965; § 5 ch 93 SLA 1965.

Sec. 08.36.271. Permits for isolated areas. (a) The Department of Health and Social Services shall designate as isolated areas those specific places and regions remote from major population centers which are not served by dentists licensed under this chapter and which have a geographical location which works financial hardship, extended loss of time, or arduous and costly travel upon residents needing dental care.

(b) The board shall, upon recommendation of the Department of Health and Social Services, issue an annual permit authorizing the treatment of residents in an area designated under (a) of this section, who are not entitled to dental care by the state or federal government, by a dentist employed by the United States Public Health Service or qualified member of the armed services who serves in that area. (§ 1 ch 93 SLA 1965; am § 11 ch 155 SLA 1968; am § 6 ch 104 SLA 1971)

Sec. 08.36.280. Temporary permit. (a) The board may issue a one year temporary permit without examination to an applicant to practice dentistry in a locality requested by the applicant if the locality is of the type specified in (2) of this subsection and the applicant

(1) meets the requirements of § 110 of this chapter;

(2) desires to practice dentistry in a city or rural village which does not have a resident licensed dentist in active general practice;

(3) has a license in good standing to practice dentistry in a state, territory, district or possession of the United States;

(4) tenders and pays the fee prescribed in § 290(6) of this chapter.

STATE OF ALASKA
JAY S. HAMMOND, GOVERNOR
DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER
POUCH H 01 – JUNEAU 99811

January 16, 1978

Dental Examiners Board
937 Eighth Avenue
Fairbanks, Alaska 99701

Attention: Sydnor L. Stealey, President

Gentlemen:

Re: Designation by Department of Health and Social Services of Aleutian Islands as Isolated Area

It has recently come to the attention of the Department of Health and Social Services that, through the initiatives of certain Alaska Native organizations, improved dental services for citizens of the villages of the Aleutian Islands may be arranged. Such plans envision the utilization of dentists falling under the general coverage of AS 08.36.271(a) and (b).

Consistent with the provisions of AS 08.36.271, the Department of Health and Social Services encloses at this time the appropriate formal designation by the Department for the region involved in the emerging plans.

In line with the specific provision of AS 08.36.271(b), the Department of Health and Social Services hereby recommends to the Board the issuance of annual permits to the dentist applicants meeting the qualifications of applicants contained in AS 08.36.110, with latest amendments. The specific and individual applications related to this recommendation will be filed in accordance with your procedures.

It is our understanding that qualified applicants shall be granted annual permits under the conditions contained in the statutes and consistent with the recommendation contained herein.

Sincerely yours,

Helen Beirne
Commissioner

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

POUCH H 01 – JUNEAU 99811

January 16, 1978

DESIGNATION OF ISOLATED AREAS

by

STATE OF ALASKA, DEPARTMENT OF HEALTH AND SOCIAL SERVICES

In accordance with the provisions of Alaska Statutes 08.36.271, Permits for Isolated Areas, the Department of Health and Social Services hereby designates as isolated areas the entirety of the Aleutian Islands Chain of the state of Alaska, including any and all specific villages and communities of the Aleutian Chain.

Such designation is made solely for the purposes served by the provisions of the Alaska Statute cited above, and for dental services as provided in the cited statute.

Helen Beirne, Commissioner

Law Office of
JAMES F. VOLLINTINE
805 W. 3rd Avenue
Anchorage, Alaska 99501
Phone. 276-8144

January 11, 1978

Mr. Frank Peratrovich
Deputy Director
Aleutian/Pribilof Islands Association, Inc.
430 C Street, Suite 303
Anchorage, Alaska 99501

Dear Frank:

This responds to your request for my opinion as to whether or not A/PIA, under a contract which it has assumed from the IHS under P.L. 93-638, can employ dentists in the Aleutian area who are not licensed to practice dentistry under Alaska law. Unfortunately, at this point, the answer is not clear. Attached are copies of the relevant Alaska Statutes.

Under A.S. 08.36.271 the State Department of Health and Social Services is to designate isolated areas of the State which are not served by licensed dentists. Then, the Alaska Board of Dental Examiners shall, upon recommendation of the Department of Health and Social Services, issue an annual permit to a dentist employed by the United States Public Health Service. Hence, it appears that dentists need not be licensed to practice in Alaska if they are employed by the Public Health Service. As you suggested, perhaps there is some way that you can arrange to have the dentists under your contract employed by the Public Health Service. This would neatly solve the problem.

Another approach might be to have your dentists apply for a temporary permit from the Board of Dental Examiners to practice dentistry in Alaska. This approach is provided for in A.S. 08.36.280, a copy of which is attached. Basically, this provision provides that the Board may issue a one year temporary permit to a person not licensed in Alaska to practice dentistry in a rural area if:

> (a) the applicant is of good moral character, and is a graduate of a dental college approved by the Council on Dental Education of American Dental Association at the time of graduation, and holds a D.D.S. or D.M.D. degree, or the equivalent; and
>
> (b) the applicant has a license in good standing to practice dentisry in a State, territory, district or possession of the United States.

At first glance it would appear that your dentists could receive a temporary permit from the Board of Dental Examiners. However, I just spoke with Martha Dearborn of the Alaska Dental Society (phone 279-9144), and John Beard (phone 277-3213) who is an attorney who sits on the Board of Dental Examiners. Both persons told me that in December of 1977 the Board of Dental Examiners voted not to issue any further temporary permits. Mr. Beard stated that the Board felt that A.S. 08.36.280 was a "permissive, rather than a "mandatory" statute.

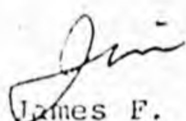
I feel that the determination by the Board of Dental Examiners not to issue temporary permits in Alaska is erroneous. In my opinion, if an applicant meets the legal requirements he is entitled to practice dentistry in Alaska under a temporary permit pursuant to A.S. 08.36.280. We could challenge the Board in Court. However, it will probably be best to have your dentists first apply to the Board of Dental Examiners for a temporary permit and obtain a formal decision from the Board. Note that the attached statute provides that the Board shall grant or deny an application for a temporary permit within sixty (60) days after it is received. After the applications are submitted we can request an oral hearing before the Board whereby we would attempt to put forward a compelling argument to pursuade them to accept the applications. They are free to reverse their December 1977 ruling to the effect that no further temporary permits will be granted in Alaska. If they do not, depending on what A/PIA wants to do, we can then take them to Court.

As you stated, another approach, and possibly the best might be for A/PIA to approach the Alaska Legislature and attempt to have the attached statutes changed. However, we do not know how long this will take. Mr. Milne has just informed me that he will send me a memorandum on what should be included in the amendment to the dentistry laws. I will then draft a proposed bill.

In summary, the quickest approach would probably be for A/PIA to have the dentists employed by the United States Public Health Service. In the alternative, the dentists could apply for a temporary permit pursuant to A.S. 08.36.280. Third, A/PIA should attempt to have the dentistry statutes amended to more realistically conform to the needs of the rural populace.

If you have any questions please do not hesitate to call.

Sincerely,



James F. Vollintine

Health and Social Services shall designate as isolated areas those specific places and regions remote from major population centers which

are not served by dentists licensed under this chapter and which have a geographical location which works financial hardship, extended loss of time, or arduous and costly travel upon residents needing dental care.

(b) The board shall, upon recommendation of the Department of Health and Social Services, issue an annual permit authorizing the treatment of residents in an area designated under (a) of this section, who are not entitled to dental care by the state or federal government, by a dentist employed by the United States Public Health Service or qualified member of the armed services who serves in that area. (§ 1 ch 93 SLA 1965; am § 11 ch 155 SLA 1968; am § 6 ch 104 SLA 1971)

Sec. 08.36.280. Temporary permit. (a) The board may issue a one year temporary permit without examination to an applicant to practice dentistry in a locality requested by the applicant if the locality is of the type specified in (2) of this subsection and the applicant

(1) meets the requirements of § 110 of this chapter; graduate of dental college; D.D.S. or D.M.D.

(2) desires to practice dentistry in a city or rural village which does not have a resident licensed dentist in active general practice;

(3) has a license in good standing to practice dentistry in a state, territory, district or possession of the United States;

(4) tenders and pays the fee prescribed in § 290 (6) of this chapter. [$25.00].

(b) The board may authorize a temporary permittee to practice dentistry in more than one city or rural village of the type specified in (a) (2) of this section.

(c) The board may annually renew a temporary permit upon written application of an applicant and upon payment of the prescribed fee if the applicant has not committed an act which is a ground for revocation in § 310 of this chapter, but in any case, within two years from issuance of his first temporary permit, the applicant must pass a board exam.

(d) A temporary permit may be revoked, suspended or annulled, or the permittee may be reprimanded, censured or disciplined by the board in the same manner and for the same cause as a licensed dentist under § 310 of this chapter.

(e) The board shall grant or deny an application for a temporary permit within 60 days after it is received. (§ 15 art III ch 186 SLA 1955; am § 4 ch 26 SLA 1965; am §§ 8, 9 ch 121 SLA 1972)

Sec. 08.36.285. Licensing a permittee.
Repealed by § 10 ch 121 SLA 1972.

Editor's note. — The repealed section derived from § 5, ch. 26, SLA 1965.

Sec. 08.36.290. Fees and penalties. The board shall impose and collect the following fees and penalties:

(1) for the issuance of an original license, $30;

(2) for the examination of an applicant, $50;

(3) for re-examination of an applicant, $50;

Sec. 08.36.271. Permits for isolated areas. (a) The Department of Health and Social Services shall designate as isolated areas those specific places and regions remote from major population centers which are not served by dentists licensed under this chapter and which have a geographical location which works financial hardship, extended loss of time, or arduous and costly travel upon residents needing dental care.

(b) The board shall, upon recommendation of the Department of Health and Social Services, issue an annual permit authorizing the treatment of residents in an area designated under (a) of this section, who are not entitled to dental care by the state or federal government, by a dentist employed by the United States Public Health Service or qualified member of the armed services who serves in that area. (§ 1 ch 93 SLA 1965; am § 11 ch 155 SLA 1968; am § 6 ch 104 SLA 1971)

Sec. 08.36.280. Temporary permit. (a) The board may issue a one year temporary permit without examination to an applicant to practice dentistry in a locality requested by the applicant if the locality is of the type specified in (2) of this subsection and the applicant

(1) meets the requirements of § 110 of this chapter;

(2) desires to practice dentistry in a city or rural village which does not have a resident licensed dentist in active general practice;

(3) has a license in good standing to practice dentistry in a state, territory, district or possession of the United States;

(4) tenders and pays the fee prescribed in § 290 (6) of this chapter.

(b) The board may authorize a temporary permittee to practice dentistry in more than one city or rural village of the type specified in (a) (2) of this section.

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(d) A temporary permit may be revoked, suspended or annulled, or the permittee may be reprimanded, censured or disciplined by the board in the same manner and for the same cause as a licensed dentist under § 310 of this chapter.

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(3) for re-examination of an applicant, $50;

Mobile dental clinics, inside full sized buses, have been bringing much needed dental care to the children of migrant farm laborers in California since 1968. In 1971 the pioneering program was expanded overseas and next month they will go to Israel, Greece, Yugoslavia and Kenya.

A Busload Of Mercy

ONE OF THE most difficult things in the world to do is to try and help people—you're immediately suspect.

But if helping people is what you want to do and your motives and intentions are honest, untinged with a personal gain or greed—then you find a way. Dr. Marvin M. Stark, a Los Altos dentist, is one of those people who finds a way.

Dr. Stark very much believes that the future of the world depends on the welfare and happiness of children. In his own way, with the help of faculty colleagues and students at the University of California, San Francisco, Dr. Stark has been eliminating needless pain in children in California and overseas for several years.

Dr. Stark's way is with a bus—a mobile dental clinic complete with four treatment chairs, the latest equipment for providing complete dental treatment, an auxiliary unit for x-ray equipment and a laboratory. Since 1968 mobile clinics have been traveling the dusty trails of the migrant farm workers, stopping wherever they did to give aid to their children. In 1971 the program was expanded overseas to Israel and then to Greece the following summer. This year it will expand even more to Yugoslavia and Kenya.

A CHILD'S visit to one of the mobile clinics is frequently also his first visit to a dentist. The friendly attitude on the part of the dental students soon allays any apprehension on the part of the children. The mobile clinic operates in each area for several days. The first day a dentist, interpreter and several assistants visit the location to orientate the children and their parents. A puppet show on dental hygiene is followed by the distribution of toothpaste, brushes and mouthwash. The mobile clinic is explained and the people are told it will be coming the following day.

When the bus arrives the children are all examined and given prophylaxis and flouride treatment. Treatments are scheduled based on priorities determined from the examinations and x-rays. If the children require additional treatment, further appointments are made. Many of the dentists participating do not speak the various languages so an interpreter explains such things as Novocain is "a medicine to make your tooth and lip go to sleep. It will go away in a couple of hours."

The story of the mobile clinics is a remarkable one in many ways. It dates back to 1965 when Drs. Stark, Ronald Nicholson, Kenneth Soelberg and Robert Weis, professors of dentistry at the University of California

By Mary Gottschalk

Medical Center in San Francisco, found themselves with a house trailer left over from a UC dental project. They gave the trailer back to UC along with the concept of converting it into a dental clinic to treat children in Head Start schools and institutions for the handicapped.

THE HOUSE trailer was a success and the idea for a mobile clinic in the form of a large bus to provide sorely needed service to the children of migrant farm laborers seemed to be the next step. The buses in California are under the sponsorship of UC and funds for their operation come from the State of California's Bureau of Community Services and Migrant Education. In its first five years of operation alone, the clinic buses, which now number three, treated upwards of 15,000 children in the agricultural valleys of California. It is an on-going program that this summer will be in Ventura, the Woodland-Davis area, and areas such as Salinas, Soledad and San Joaquin.

With such a successful program underway in California why not just sit back—why branch out? Dr. Stark sees it as a "natural offshoot" of the United States program. But more than that, it is a "20th century covered wagon" filled with pioneers who want to earn friends for their country. In Dr. Stark's own words: "There is no better way of making friends with people than by healing their children."

The first overseas bus, in 1971, went to Israel. It was a project that involved more than a year of preparatory work, not the least of which was raising the $100,000 it took to purchase and outfit the first bus and to ship it to Israel.

THE MONEY did not come from any government sources or corporations—it was money donated by individuals who shared in Dr. Stark's vision of the mobile clinic and what it could accomplish. Dr. Nicholson, a friend and faculty colleague for many years, gives the credit for the bus—the concept and the reality—to Dr. Stark.

Along with the charisma necessary to raise large sums of money, Dr. Stark has unstranded determination to see a project of this magnitude through to its fruition. He is also a man of vision. He recently found a helicopter pilot and now he is on the lookout for a helicopter to outfit as a clinic and visit remote areas that are inaccessible to motor vehicles. Some people might think "good luck," but with Dr. Stark nothing is an impossibility.

The overseas experiences are not easy to describe. Different things stand out in the minds of each participant. Gladys Stark, Dr. Stark's wife, perhaps best expresses the emotion and impressions of those who have experienced the trip first hand.

"THE CHALLENGE at first was an adventure into a new land, culture, language and people. There were many unknowns—would we be able to communicate? Where would we live (especially in a country where people wait years for a tiny apartment)? Could we adjust to new customs, new foods, extreme hot temperatures? Could we be of service? Would a war-torn people appreciate or realize we were trying to help in a new and different way by bringing dental care and education? All of these uncertainties made our first trip a very precarious one.

"Nevertheless we went and in spite of innumerable obstacles, we saw, we did, we accomplished a great deal and came home with many impressions. One in particular was our tremendous admiration for the courage and industriousness of the pioneering Israelis who but a few years ago took this impossible desert wasteland, interspersed with malaria swamplands, and transformed it into beautiful, green, fertile farmlands capable of producing the finest crops in the world.

"Another overwhelming impression was the lilliputian, tiny size of the country. As one drives the length of Israel, which can be done in six to eight hours, on either side of the road Arab lands are visible. Looking at a map the many Arab countries with their huge expanses of vast uninhabited territories which they may never use is quite apparent. However their determination to have these few square miles of land, Israel, is an obsession.

"THE REWARDS were many. We were able to communicate. English is the second language taught in the schools. The diverse cultural backgrounds of the people exposed us to a fascinating mix of customs and languages. Besides Hebrew, we heard French, Russian, Italian, German, Polish, Spanish, Arabic and Yiddish. We were able to start a worthwhile dental health program. The needs were great. Institutions for the handicapped and retarded, kibbutzim, Druze and Arab villages, deprived sectors of Tel Aviv and Jerusalem overflowed with children in need of dental care and education.

"Often the days were long and arduous, the heat unrelenting. Still the rewards predominate. We found friends everywhere—not only because of what we were doing directly, but also because we were a group who came so far specifically to give unselfishly. At first the American dental group was suspect. What were our motives? Later, as the word spread through the kibbutzim and villages, the doors opened widely and they remain open today with letters arriving daily requesting our speedy return."

For Dr. Bill Moore, who went to Israel the second year in 1972, the memories include treating a small boy one morning who had arrived at the clinic on his horse. The child spoke only Hebrew so communication was

Dr. Marvin M. Stark of Los Altos treats a woman in need of dental care at a mental institution in Israel. Dr. Stark is the single force behind the idea of a mobile dental clinic and he is the man who made it a reality for over 15,000 California children and people overseas.

A small child receives dental treatment from a senior dental student at a migrant farm workers' camp in the San Joaquin Valley. A faculty member from the University of California Medical Center supervises. Mobile dental clinics have aided over 15,000 children since they began operating.

non-verbal. At the lunch break Dr. Moore noticed the boy beckoning him to come out. He did and the boy gave him a ride on his horse to show his appreciation.

OTHER PARTICIPANTS recall their invitation to a Yemenite wedding. The wedding had over a year of preparation in it and the invitation to attend was extended to the entire group of 60 participating in the dental care program.

Dr. Weis had some apprehensions about his family which included a six-month old baby. There are no such things as disposable diapers in Israel, so the family filled their suitcases with them. They found their hosts very concerned about their comfort and welfare.

For Santa Clara dentist Dr. George Mednick, the mobile clinic experience changed his life. While participating in the Israel program the first three summers, Dr. Mednick met his wife Tamar, an Israeli living in a kibbutz. He was further influenced by the program to become a children's specialist. In addition to his private practice, Dr. Mednick is also a part-time instructor at the UC Medical Center.

Mark and Marina Bogdan of Palo Alto have also been active volunteers with the project since its inception. Mark started when he was an undergraduate at the University of Santa Clara, where many of the student volunteers come from. Marina volunteered when she was a dental hygiene student at UC. Mark and Marina were married last year and will continue their participation this summer with the program in Yugoslavia.

The mobile clinics are staffed by American students and dental instructors for only five weeks of the year, in late summer. To make sure they do not sit idle at other times, they are affiliated with institutions such as universities or municipalities. While they are there, the American group shares their methodology and skills with the dentists of the host countries. Those countries then operate it the rest of the year and it becomes a lasting goodwill project.

THE STUDENTS come from across the United States, not only from California. Participants have included students from Kentucky, Maryland, Michigan, Texas and Ohio. The host countries provide room and board and tender loving care to the participants, but no salary. Each person is responsible for raising the $1,000 it will cost them in transportation costs overseas.

The project is an expensive one, but the money involved is carefully spent. Drs. Stark and Soelberg, as well as volunteer students, spend many of their weekends at the L. W. Cross Co. in Mountain View working on the buses. Owners Dr. James Cross and Gordon Nelson allow them to store the buses there. Dr. Soelberg is the chief designer of the interiors and a minimum of 2,000 man hours goes into the outfitting of each bus. Bud Heintz and Bob Farry of University Electric in Santa Clara and Hank Heckman of Floorcraft Co. in San Jose have donated much of their time and skills in aiding the project as well.

Even now, buses are being worked on, supplies are being wrapped for shipping and money is being sought. There are still many long hours of preparation work left, to be followed by long hours of service in a foreign land. But as Gladys Stark has said, "I along with our extended family can say as Virgil's Aeneas: 'Many of these things I saw, and some of them I was.' " ◘

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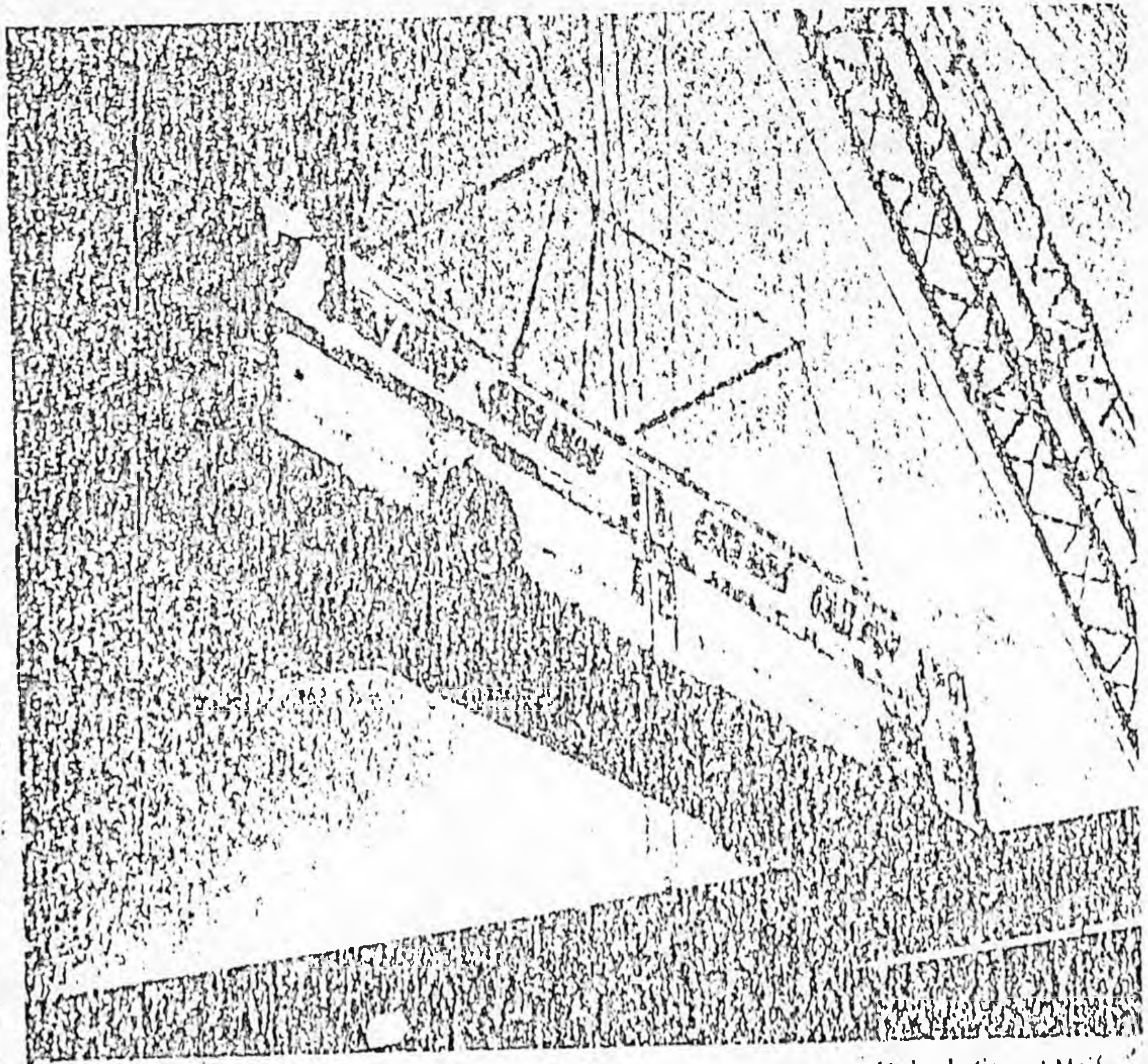
ADA News



Debarkation at Haifa

THE MOBILE CLINIC GOES INTERNATIONAL

PAGE FIVE

MARVIN H. STARK, D.D.S.
Date of Birth: March 14, 1921

PRESENT APPOINTMENTS:

Professor of Operative Dentistry and Oral Biology
University of California
School of Dentistry
San Francisco, California

Lecturer
Microbiology
University of California
School of Medicine
San Francisco, California

Consultant to Chief Health Officer, Dept. of Health, State of California.

EDUCATION:

A.B. Microbiology. University of California Los Angeles, 1948

D.D.S. University of California San Francisco, 1952

Research Fellowship, Harvard School of Dental Medicine, 1952-53

PRIVATE PRACTICE:

General Dentistry, 1954 to present

Assistant Director, Dental Clinic, Santa Clara County Hospital

Visiting Staff, O'Connor Hospital, San Jose, California

MEMBERSHIP IN:

International Association for Dental Research
Northern California Academy of Endodontists
Omicron Kappa Upsilon
Fellow, American College of Dentists
American Dental Association
American Association of Dental Schools
American Men of Science
Fellow, International College of Dentists

PAPERS PUBLISHED:

1. Stark, M. M., Kibrick, Sidney, and Weisberger, David.: "Studies on recurrent apthae: Evidence that herpes simplex is not the etiological agent, with further observations on the immune responses in herpetic infections." J. Lab. & Clinic Med. Vol. 44, No. 2, Aug. 1954.

2. Stark, M. M., and Zarka, Frank: "Gingival tumors in pregnancy." Obs. & Gyn. Vol. 8, No. 5, 1956.

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5. Nicholson, R. J., Stark, M. M., and Soelberg, K. B.: "Dissemination of mercury during preparation and trituration of amalgam." J. Pros. Dent. Vol. 20, No. 3, Sept., 1968.

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11. Stark, M. M., Nicholson, R. J., and Soelberg, K. B.: "Marginal seal afforded by n-butyl and isobutyl cyanoacrylate as cavity liners." J. Pros. Dent. Vol. 21, No. 4, April, 1969.

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13. Forsyth, R. P., Stark, M. M., Nicholson, R. J., and Peng, C. T.: "Blood pressure responses to epinephrine-treated gingival retraction strings in the rhesus monkey." J.A.D.A. Vol. 78, No. 6, June, 1969.

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26. Judes, H., Mintatos, S., Birtcil, R., Stark, M. M., and Kempler, D.: "Marginal Seal Afforded by New Cavity Varnishes." J.C.D.A. September, 1977.

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1. Laser Evaluation of Handpiece Contamination Journal of Dental Research, Feb. 1978.

2. "Human Blood Pressure Pulse Rate Responses to Racemic Epinephrine Retraction Cord." Journal Prosthetic Dentistry

Abstracts Presented at IADR Meetings

A. Philadelphia-1954: Studies on Recurrent Apthae: Evidence That Herpes Simplex is not the Etiological Agent, with Further Observations on the Immune Responses in Herpetic.

B. Los Angeles-1964: The Localization of Radioactive Calcium Hydroxide Over Exposed Pulps in Rhesus Monkey Teeth.

C. Toronto-1965: The Localization of Radioactive Calcium Hydroxide Over Exposed Pulps in Rhesus Monkey Teeth; and Hemorrhage Control in the Dental Pulp with the Use of Resorbable Oxycellulose.

D. Bal Harbour, Fla.-1966: Autoradiographic Tracings Utilizing Ca45-Labeled Ethylene Diamine Tetra-Acetic Acid; and The Effect of Topically Applied Epinephrine on Blood Pressure and Pulse Rate.

E. Washington D.C.-1967: The Measurement of Systemic Effects In Humans and Animals Following the Use of an Epinephrine Containing Gingival Retraction Agent.

F. Houston, Texas-1969: The Effects of Commonly Used Retraction Procedures on Gingival Tissue and Blood Pressure; and Marginal Seal Afforded by Polysiloxane As A Cavity Liner.

LECTURES:

Guest Lecturer: OB-GYN Staff, O'Connor Hospital, San Jose, CA — 1961, 1962
"Dental Problems of Interest to the Obstetrician and Pediatrician"

Guest Lecturer: Naval Reserve, Oak Knoll Naval Hospital — Apr. 1960
"Current Concepts in Restorative Dentistry"
"Gingival Retraction"

Guest Lecturer: Naval Reserve, Oak Knoll Naval Hospital — Apr. 1961
"Problems Related to Amalgam Restoration"
"Cements: Their Use and Abuse"

Guest Lecturer: Naval Reserve, Oak Knoll Naval Hospital — Apr. 1962
"Varnishes, Bases, and Liners"
"Current Concepts in Restorative Dentistry"

Guest Lecturer: Naval Reserve, Oak Knoll Naval Hospital — Apr. 1963
"Gingival Re raction"
"Problems Related to Amalgam Restoration"

Lecture: Northern California Assn. of Endodontists, Statewide Meeting — Apr. 1963
"Pulp Capping and Histological Effects of Proprietary Compounds"

Guest Lecturer: Naval Reserve, Oak Knoll Naval Hospital — Apr. 1964
"Cements: Their Use and Abuse"
"Varnishes, Bases, and Liners"

Guest Lecturer: Naval Reserve, Oak Knoll Naval Hospital — Apr. 1965
"Current Concepts in Restorative Dentistry"
"Problems Related to Amalgam Restoration"

Essayist: College of Physicians & Surgeons, Annual Alumni Meeting, San Francisco, CA — 1965
"Advances in Restorative Dentistry"

Essayist: Univ. of Calif. Alumni Meeting — 1965
"Current Concepts in Restorative Dentistry"

Moderator & Participant: Dental Radio Conference, Graduate Education, Univ. of Calif. — 1965

Lecture: California Teacher's Assn., San Mateo, CA — 1965
"New Methods of Health Care Delivery"

Lecture: CAIC Meeting, Pacific Coast Academy of Restorative Dentistry — 1965
"Gingival Retraction and Related Problems"

Lecture: University of Maryland, Faculty — 1965
"Educational Problems of Interest to Restorative Dentists"
"Teaching of Operative Dentistry"

Lecture: Research Symposium, U.C.S.F. 1965
"Aerosol Hazards of Interest to the Operative Dentist"

Lecture: Mid-Peninsula Dental Society April 1965
"Epinephrine Uptake in Gingival Tissue"

Lecture: Research Symposium, U.C.S.F. 1966
"Mercury Leakage in Amalgam Capsules"

Guest Essayist: American Academy of Restorative Dentistry, Chicago. 1966
"Epinephrine Uptake in the Gingivae of Rhesus Monkeys" Film & scientific presentation.

Essayist: American Academy of Crown & Bridge Pros. 1966
"Evaluation of Cements, Bases and Liners"

Participant, Lecture and Discussion: Career Day Program, Foothill College, Los Altos, CA Feb. 1966

Lecture: Dental Society, Nassau, Bahamas Mar. 1966
"Cavity Liner, Restorative Dentistry"

Lecture: Mendel Society, Research in Dentistry University of Santa Clara. April 1966

Guest Lecturer: Naval Reserve, Oak Knoll Naval Hospital April 1966
"Gingival Retraction" and "Varnishes, Bases, Liners"

Essayist: American Assn. of Endodontists National Meeting, San Francisco April 1966
"Ca45 Labeled EDTA and Its Effects on Dentistry"

Lecture: Peninsula Component Dental Hygienists May 1966

Essayist: American Academy of Crown & Bridge Pros. 1967
"Aerosol Hazards of Interest to the Restorative Dentist"

Guest Lecturer: Naval Reserve, Oak Knoll Naval Hospital April 1967
"Cements: Their Use and Abuse" and "Problems Related to Amalgam Restoration"

Lecture: Contra Costa County Dental Society. April 1967
"Epinephrine Uptake in Gingival Tissue"

Essayist: Society de Endodontia, Bogata, Colombia. July 1967
"Pulp Capping: Clinical & Histological Discussion" and "Teaching Restorative Dentistry in the U.S."

Lecture: Foothill College, Los Altos, California Oct. 1967
"Dentists' Role in Community Service"

Lecture: Case Western University, Faculty, Students. Feb. 1968
Cleveland, Ohio.
"Teaching Restorative Dentistry" and
"Recent Advances in Restorative Dentistry"

Lecture: Peninsula Component Dental Hygienists Mar. 1968
Palo Alto, California

Guest Lecturer: Naval Reserve, Oak Knoll Naval Hospital April 1968
"Varnishes, Bases, Liners" and
"Current Concepts in Restorative Dentistry"

Lecture: Western Study Group of Combined Therapy Dec. 1968
"Pulpal Response to Operative Procedures"
Los Angeles, California

Essayist: Southern Calif. State Meeting, Los Angeles May 1968
"Advances in Restorative Dentistry. Discussion
of Pulp Protection; Bases, Varnish, Microleakage
Around Amalgam Restoration, Research and
Clinical Data"

Lecture: Southern Calif. Academy of Endodontists Dec. 1968
Los Angeles, California

Lecture: Greater New York Dental Meeting. Seminar. Dec. 1968
"Current Concepts in Restorative Dentistry"

Guest Essayist: Chicago Mid-Winter Meeting 1968
"Evaluation of Cavity Varnishes and Bases.
Their Clinical Effectiveness and Shortcomings,
Research and Clinical Data."

Guest Essayist: Chicago Mid-Winter Meeting 1969
"Recent Advances in Restorative Dentistry"

Lecture: Southern Calif. Assn. of Endodontists Feb. 1969
Los Angeles, California

Lecture: Dental Hygienists, Univ. of Calif. S.F. Mar. 1969

Lecture: Oak Knoll Naval Hospital, Oakland, Calif. April 1969

Lecture: San Gabriel Valley Dental Society, April 1969
Pasadena, California
"Current Concepts in Restorative Dentistry"

Participant and Table Clinic: Santa Clara County April 1969
Health Fair, De Anza College, San Jose, CA

Lecture: Alpha Omega Dental Alumni Chapter. L.A. April 1969
"Current Concepts in Restorative Dentistry"

Lecture: Southern Calif. Dental Assn. Los Angeles May 1969
"Current Concepts in Restorative Dentistry"

Lecture: Foothill College, Los Altos, Calif. "Role of the Hygienist in Community Service" May 1969

Lecture: University of Michigan faculty. "Current Research and Clinical Studies in Gingival Retraction" June 1969

Headline Essayist: American Academy of Pedodontists. Chicago, Illinois. "Literature Review and Research Data Related to Steroids in Dentistry" "The Pedodontist's Role in a Successful University Community Dental Program" Aug. 1969

Lecture and Clinic Demonstration: Deutche Nue Gruppe. Dusseldorf, Germany. "Crown Preparation and Gingival Retraction and Use of Hydrocolloids" Aug. 1969

Lecture: Royal Dental School, Faculty & students Copenhagen, Denmark. "Pulp Protection. Cavity Disinfection. Amalgam Restoration. Teaching of Operative Dentistry. Admission Procedures in a U.S. Dental School." Aug. 1969

Lecture: Ivoclar Company. Schaan, Liechtenstein. "Cavity Varnishes and Silicates" Aug. 1969

Lecture: L'Ecole dentiare de Paris, Paris, France. "Pulp Protection. Cavity Disinfection. Amalgam Restoration. Teaching of Operative Dentistry. Admission Procedures in a U.S. Dental School." Sept. 1969

Lecture: Northern California Dental Ass't. Assn. Sept. 1969

Lecture: Southwest Dental Assembly, San Antonio, Texas. "Recent Advances in Restorative Dentistry. Research in Varnishes and Bases. Radioactive Tracer in Varnishes." Dec. 1969

Lecture: Mexico Dental Association. Mexico City. "Recent Advances in Restorative Dentistry. Research in Varnishes and Bases. Radioactive Tracer in Varnishes." Dec. 1969

Lecture: Los Altos Rotary Club. Los Altos, Calif. "Teaching of Operative Dentistry in a Mobile Clinic. Description of a Community Program." Movies and Discussion. Dec. 1969

Lecture:	Bermuda Dental Association. Bermuda. "Recent Advances in Restorative Dentistry. Research in Varnishes and Bases. Radioactive Tracer in Varnishes."	Dec. 1969
Lecture:	University of Guadalajara, M xico. "Recent Advances in Restorative Dentistry. Community Mobile Clinic Program."	Jan. 1970
All Day Symposium:	Mid-Winter Meeting, Chicago Dental Society. "Current Research and Clinical Data Related to Gingival Retraction"	Feb. 1970
Lecture:	Northern Calif. State Dental Hygienists Assn.	Feb. 1970
Lecture:	Dental Hygienists, U.C.S.F. "Dentistry and Community Service"	Mar. 1970
Lecture:	Oak Knoll Naval Hospital, Oakland, CA "Research in Restorative Dentistry, Part I and Part II"	Apr. 9, 23, 1970
Participant and Table Clinic:	Santa Clara County Health Fair, De Anza College.	Apr. 1970
Lecture:	Rotary Club, Hayward, CA	Apr. 1970
Lecture:	Berkeley Dental Society. "Current Research and Clinical Data Related to Gingival Retraction"	May 1970
Lecture:	University of Athens, School of Dentistry	Dec. 1970
Lecture:	University of Paris, Faculty and students	Dec. 1970
Lecture:	Tel-Aviv University, Faculty of Continuing Education	Dec. 1970
Lecture:	Denver Dental Society, Denver, CO "Gingival Retraction"	Jan. 1971
Lecture:	Massachusetts Dental Society	May 1971
Postgraduate Course:	Tel-Aviv University, Faculty of Continuing Education, Tel-Aviv, Israel	Aug. 1971
Lecture:	New Orleans Dental Conference	Nov. 1971
Lecture:	University of Athens, Faculty and students	Dec. 1971
Postgraduate Course:	Ohio State University	Jan. 1972
Participant and Table Clinic:	Santa Clara County Health Fair, De Anza College	Apr. 1972

Lecture:	Oak Knoll Naval Hospital, Interns	Apr. 1972
Lecture:	American Dental Association "Sealants"	Nov. 1972
Lecture:	Mexico Dental Association	Jan. 1973
Essay:	American Dental Association, Houston, TX "Recent Advances in Restorative Dentistry"	Oct. 1973
Lecture:	Greater New York Dental Meeting "Concepts in Restorative Dentistry"	Nov. 1973
Lecture:	Oak Knoll Naval Hospital, Interns	Apr. 1974
Lecture:	Oak Knoll Naval Hospital, Interns	Apr. 1975
Mini Lecture:	Univ. of Calif. Alumni Assn. "Gingival Retraction Procedures"	Jan. 1976
Lecture:	Oak Knoll Naval Hospital, Interns	Apr. 1976
Lecture:	Oak Knoll Naval Hospital, Interns	May 1976
Mini Lecture:	American Dental Association "Gingival Retraction Procedures"	Nov. 1976
Lecture:	Brandeis University National Women's Committee, Palo Alto, CA "Mobile Clinics"	Feb. 1977
Lecture:	Oakland Naval Hospital, Interns	Apr. 1977

LECTURES AND CLINICS:

Clinical lectures and Scientific Session participant, American Dental Association annual meetings:

1.	"Pulp Protection" Los Angeles, CA	1960
2.	"Epinephrine in Gingival Retraction" Las Vegas, NV	1964
3.	"Current Restorative Dentistry Procedures" Dallas, TX	1966
4.	"Current Research in Restorative Dentistry" Washington, D.C.	1967
5.	"Clinical Data Related to Gingival Retraction" Miami, FL	1968
6.	"Current Concepts in Restorative Dentistry" New York, NY	1969
7.	"Current Concepts in Restorative Dentistry" Las Vegas, NV	1970
8.	"Current Concepts in Restorative Dentistry" Atlantic City NJ	1971
9.	"Techniques and the Result of Sealant Application" San Francisco, CA	1972

Television Presentation, American Dental Association:

1. "Gingival Retraction Procedures" New York, NY 1969

2. Chaired: Television panel on "Restorative Dentistry Procedures." Other participants: R.J. Nicholson, K.B. Soelberg, R.H. Augsburger, Vern Tueller.

Motion Picture Presentations, American Dental Association:

1.	"Abre La Boca": New York, NY	Oct. 1969
	Las Vegas, NV	1970
2.	"Las Manos Que Ayudan": Las Vegas, NV	1970
	Atlantic City, NJ	1971
3.	"Chalutz" Atlantic City, NJ	1971
4.	"Aliyah" San Francisco, CA	1972
5.	"Sights and Sounds of the International Mobile Clinic" Las Vegas, NV	1976

LECTURES AND CLINICS:

Table Clinics:

1. University of California Alumni Association: 1954, 1956, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969.

2. California Dental Association: 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970.

3. American Dental Association:

   a. "Pulp Protection" Atlantic City, NJ, 1963
   b. "Pulp Capping" Las Vegas, NV, 1965
   c. "Pulp Protection" Dallas, TX, 1966
   d. "Gingival Retraction" Washington, D.C., 1967
   e. "Pulp Capping" Miami, FL, 1968
   f. "Gingival Retraction" New York, NY, 1969
   g. "Pulp Protection" Las Vegas, NV, 1970
   h. "Pulp Protection" Chicago, IL, 1975.

4. Southern California State meetings: 1967, 1968, 1969, 1970.

5. Chicago Mid-Winter meetings: 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970.

POST GRADUATE COURSES PRESENTED:

A. University of California

1. Stark, M. M.: "Restorative Dentistry." May 1964.

2. Stark, M. M., Nicholson, R.J., and Soelberg, K.B.: "Pulp Therapy." Dec. 1964.

3. Stark, M.M., Morris, M.E., and Nicholson, R.J.: Dental Radio Conference. April, 1965.

4. Nguyen, N., Stark, M.M., and Sapone, J.: "Modern Endodontic Therapy." June, 1965.

5. Stark, M.M.: "Research Symposium." April 1966.

6. Stark, M.M., Nguyen, N., and Sapone, J.: "Modern Endodontic Therapy." Sept. 1966.

7. Stark. M.M., Nicholson, R.J., Soelberg, K.B., Christie, T.M., Morris, M.E., and Sapone, J.: "Pulp Therapy." Oct. 1966.

8. Stark, M.M., Soelberg, K.B., and Nicholson, R.J.: "The Dental Pulp---Protective Procedures." Dec. 1967.

9. Stark, M.M., Christie, T.M., Morris, M.E., Nicholson, R.J., Sapone, J., and Soelberg, KB.: "Pulp Therapy." Jan., 1968.

10. Stark, M.M., Nicholson, R.J.: "Endodontics for the Modern Practitioner." Feb., 1968.

11. Stark, M.M., Nicholson, R.J., Soelberg, K.B., and Augsburger, R.H.: Research Symposium, "Recent Advances in General Practice." June, 1969.

12. Stark, M.M., Soelberg, K.B., and Nicholson, R.J.: "The Dental Pulp--Protective Procedures" Nov., 1971.

13. Stark, M.M., Nicholson, R.J., and Soelberg, K.B.: "Save That Pulp" Jan., 1974.

14. Stark, M.M., Nicholson, R.J. Soelberg, K.B., Pelzner, R.B., Augsburger, R.H., and Barkin, P.R.: "Recent Advances in Restorative Dentistry." Nov. 1975.

15. Stark, M.M, Pelzner, R.B., Augsburger, R.A., Nicholson, R.J., Tueller, V.M., Soelberg, K.B., and Barkin, P.R.: "Mini Course in Restorative Dentistry" Jan., 1977

POST GRADUATE COURSES PRESENTED:

B. University of Southern California, Los Angeles

1. Stark, M.M., Christie, T.M., Nicholson, R.J., and Soelberg, K.B.: "Pulp Therapy." June, 1966.

2. Stark, M.M., Nicholson, R.J., Soelberg, K.B.: "The Dental Pulp--Protective Procedures." May, 1967.

3. Stark, M.M., Christie, T.M., Nicholson, R.J., Soelberg, K.B., and Weis, R.W.: "The Dental Pulp--Protective Procedures." Nov., 1968.

4. Stark, M.M., Nicholson, R.J., Augsburger, Christie, T.M., Soelberg, K.B., and Weis, R.W.: "Advanced Concepts in Restorative Dentistry." Nov., 1969.

5. Stark, M.M., Nicholson, R.J., Augsburger, R.H., Soelberg, K.B., Tueller, V.M., and Weis, R.W.: "Advanced Concepts in Restorative Dentistry." April, 1971.

Appointments

A. Visiting Professor, University of Cartegena, Colombia, South America., 1967

B. Member, Board of Director, American Cancer Society. Santa Clara Coutny, 1956-1962.

C. Pre-Dental Advisor, University of California
   1. Berkeley, 1950-1954
   2. Los Angeles, 1954-1964

D. Member, Health Advisory Committee, State Board of Education.

E. Member, Board of Director, University of California, Santa Cruz Association.

F. Consultant to:
   1. Shering Corporation, Special Seminar of Pulp Capping, 1960.
   2. Johnson & Johnson, 1964-1967
   3. Pascal Company, Seattle, Washington. 1964-present.
   4. Barnes Hind Co. Sunnyvale, Calif. 1962-present

G. Project Head Start Program and Peace Corps, July and August, 1965-66, for dental examinations.

H. Consultant, U.S. Naval Hospital Oak Knoll California.1966-67-68

I. Volunteer, S.S.HOPE Ship, Cartagena, Colombia, 1967.

J. Consultant, Tulare County School District, California Migrant Farm Children Program-Dental Project, Summer 1968

K. Chairman, California State Dental Association Research Committee, 1970 to present.

L. Member, Foothil Junior College, Dental Hygiene Advisory Committee-1970

M. Consultant, Vick Chemical Company, Mount Vernon, New York 1969-present.

N. Consultant, State of California Dept. of Education, Bureau of Community Service and Migrant Education.

O. Faculty, Postgraduate Education, University of Southern Calif.

P. Chairman, Projected Clinics in Color and Sound, U. C. Alumni meeting, January 1970.

Q. Board of Trustess, California College of Podiatric Medicine, 1970-1973

R. Visiting Professor, Tel-Aviv University, Faculty of Continuing Education, Dental Division. Tel-Aviv, Israel, 1971-7

APPOINTMENTS continued

S. Special Consultant, Ministry of Health, Israel, 1973.

T. Consultant on Scientific Material, California Dental Association, 1974-present

U. Special Consultant, Dr. Jerome Lackner, Director of Health, State of California. 1976-77

V. Personal Consultant in Dental Health to Director of Health, Jerome Lackner, State of California. 1977

W. Nominated: For Public Service Award, U.C.S.F awarded by the Chancellor for outstanding community service. 1975, 1976, 1977

COMMITTEES: University of California School of Dentistry

1. Bachelor Science Committee
2. Admissions Committee
3. Curriculum Committee
4. Building Committee
5. Chairman, Welfare and Memoriae, Academic Senate Committee
6. Director, Mobile Clinic Program, U.C. project developed to provide treatment for underprivileged children utilizing a mobile clinic staffed by faculty-supervised dental students.

PATENTS:

1. The use of acridines as caries-disclosing agents
2. Artilk, articulating paper to disclose inequalities in occlusion
3. Dental cavity liner and method of restoring carious teeth

PATENTS APPLIED FOR: 1976

1. New capsule dispenser for amalgam
2. Special digital pulp tester
3. Unique crown remover
4. Pliers for inserting pins
5. Spot-welded band kit
6. Plaque remover and interdental stimulator
7. Dental Amalgam Well; a device to reduce mercury vapor

RESEARCH IN PROGRESS: 1976

1. Evaluation of varying concentrations of epinephrine-saturated cords in the control of hemorrhage. A unique blood pressure device is being used to evaluate changes in blood pressure and heart rate.
2. Evaluation of currently used amalgams in extracted teeth. Effects of polishing and the effects of dilute acid in alkali will be determined with the scanning electron microscope.
3. Effects of finishing and polishing on composites will be evaluated utilizing radioactive materials to determine marginal leakage.
4. Evaluation of currently used die stones and their compatability with hydrocolloid impression materials.
5. Reinforced gutta percha---histological evaluation.
6. Evaluation of currently available high speed handpieces; ease of sterilization and bur removal.
7. Evaluation of mercury leakage from pre-proportioned and conventional amalgam capsules.
8. Clinical, two-year evaluation of modern amalgam and composite restorative materials in deciduous teeth.
9. Evaluation and development of new desensitizing paste.
10. Evaluation of mercury leakage around dental operatories.
11. Special testing on sterility of syringes.

PRODUCER:

1. Abre La Boca - 1969

   28 minute, color and sound, 16 mm documentary movie describing the Mobile Clinic Program in the San Joaquin Valley of California.

   Funds for the film obtained from a grant from the Vick Chemical Company.

   Purchased by the American Dental Association for their film library for national distribution.

2. Las Manos Que Ayudan - 1970

   26 minute, color and sound, 16 mm documentary which graphically portrays U.C.S.F. dental students providing dental care to migrant children, and depicts the social and educational benefits to the students and the children.

   Funds for the film obtained from a grant from the ADA.

   On file in the ADA film library for national distribution.

3. Chalutz - 1971

   15 minute, color and sound, 16 mm documentary describing the free dental care being provided to Israeli children both Arab and Jew in an effort to promote international goodwill through the medium of dentistry.

   Winner of 1971 CINE Golden Eagle Award. Entered as U.S. representative of educational films in international film festivals.

   Funds for the film obtained from grant from the California Dental Association, $8,000.

   On file in the Library of Congress.

   On file in the ADA film library for national distribution.

4. Aliyah - 1972

   10 minute, color and sound, 16 mm documentary showing dental students under faculty supervision treating Israeli children on a mobile clinic in the Gaza Strip, and in the kibbutzim and moshavim of northern Israel as well as in schools for the handicapped.

   Funds for the film were obtained from a $5,000 grant from a private individual.

   Winner of the 1972 CINE Golden Eagle Award.
   On file in the Library of Congress film library.
   On file in the ADA film library for national distribution.

MOBILE CLINICS: (California)

The following grants were obtained from the California State Department of Education to subsidize the Mobile Clinic program in California:

1969	$ 40,835
1970	210,000
1971	113,000
1972	99,000
1973	91,920
1974	98,900
1975	117,210
1976	120,053
1977	78,467

TOTAL TO DATE $969,385.

These clinics have operated in the State of California from as far north as Marysville and south to Santa Barbara.

To date approximately 25,000 children have received restorative care and instruction in prevention in these clinics. Approximately one-third of the students in the senior class serve in the these clinics each year providing dental care to the children of migratory farm workers.

These clinics have motivated a substantial number of students to proceed on to graduate work in Pedodontics.

MOBILE CLINICS: (Overseas)

A non-profit public foundation has been established which has IRS approval as a Charitable Trust 509A classification. The State of California has assigned a non-profit status to this corporation.

To date $590,000 has been contributed to this foundation from private sources during the past 5 years.

Two clinics were built by Marvin Stark and his associates and are currently operating in Israel treating both Arab and Israeli children.

One mobile clinic was established in Greece in 1971.

One mobile clinic was established in Yugoslavia in 1975.

To date approximately 100 students have served in the clinics in Israel, Greece, and Yugoslavia, and at least 3,000 children have received restorative treatment in these clinics. Dental students from the Universities of California, Michigan, Southern California, Connecticut, Maryland, Case Western, and University of the Pacific have volunteered their service and provided their own transportation. The foundation provides living accomodations for the students.

MOBILE CLINICS OVERSEAS (continued)

SPECIAL APPOINTMENT: Chief Purchasing Consultant for the Kibbutz Movement. Responsible for assisting with design and equipment for dental clinics for 275 kibbutzim in Israel.

MOBILE CLINICS:

1971: Israel

1972: Israel, Greece

1973: Israel, Greece

1974: Israel, Greece, Yugoslavia

1975: Israel, Yugoslavia

1976: Israel, Greece, Yugoslavia

1977: Israel, Greece

AWARDS:

Myrtle Wreath Award: Presented to M. Stark and family by the San Francisco Chapter of Hadassah for their humanitarian work in providing mobile dental clinics in Israel. Jan. 1977

MOBILE CLINICS: (overseas)

Future Plans

1. Plans are currently underway to develop a program for Ankara, Turkey in conjunction with UNICEF.

2. Another clinic is in the formative stages for Cebu City, Philippines.

All construction and design of the mobile clinics in California and overseas have been accomplished by Kenneth Seelberg, Ronald Nicholson, and Marvin Stark and student volunteers.

As a result of the California mobile clinic grants from the Department of Education, the Regents of the University of California currently own:

1. 40 foot General Motors transit coach outfitted as a complete 4 chair dental clinic.

2. 40 foot General Motors transit coach outfitted as a complete dental clinic.

3. 30 foot General Motors, transit coach outfitted as a complete three-chair dental clinic.

4. Four support vehicles (transport personnel and supplies)
   a. Chevrolet Carryall (2)
   b. GM Rallywagon
   c. Chevrolet Step-Van

5. X-ray equipment, and all other equipment necessary to operate 11 chairs in the field.

ADDITIONAL GRANTS:

From private industry:

1. $26,000, Johnson & Johnson, 1960.
2. $15,000, Vick Chemical Co.
   Kerr Mfg. Co.

STUDENTS SPONSORED: During the past 8 years the following students have recieved financial aid in graduate training:

1. Molly Green---University of Michigan, Pedodontics
2. Ernest Peterson---University of Indiana, Dental Materials
3. George Mednick---University of Michigan, Pedodontics
4. Michael Meyer---University of California, Orthodontics
5. Joseph Schmutz---University of California, Pedodontics
6. William Nielsen---University of California, Pedodontics
7. Ralph Zotovich---University of California, Pedodontics
8. Larry Ford ---Western Reserve University, senior student
9. Mark Bogdan---University of Detroit, dental student
10. Also sponsored---foreign students, all financial arrangements made for the student and provided for 3 years of education for the student.

FACULTY SPONSORED: The following dentists for abroad have received assistance with transportation, room and board while at U.C.S.F.

1. Ljobomir Orlic, Split, Yugoslavia
2. Daniel Kempler, one year post graduate training from Hebrew University, Jerusalem, Israel
3. Herb Judes, Head, Operative Dentistry, Tel Aviv University, Israel
4. David Assif, Tel Aviv University, Israel
5. Amos Buchner, Chairman Oral Pathology and Oral Medicine, Tel Aviv University, Israel

PUBLIC INFORMATION:

News articles related to Mobile Clinic activities have appeared in the following press releases:

1. Berkeley Gazette, June 2, 1965.
2. Synapse, U.C.S.F. campus publication, Sept. 17, 1965.
3. San Jose Mercury, Aug. 6, 1965.
4. Redwood City Tribune, Dec. 2, 1965.
5. Palo Alto Times, Aug. 3, 1966.
6. San Francisco Examiner, July 12, 1965.
7. San Jose News, July 11, 1966.
8. Redwood City Tribune, July 10, 1968.
9. Journal, American Dental Association, May 1969.
10. Journal, American Dental Association, Nov., 1969.
11. San Francisco Examiner Sunday Magazine, "California Living" May 10, 1970.
12. Congressional Record, Monday, June 1, 1970, p. E4995.
13. American Dental Association News, Sept. 14, 1970.
14. Rocky Mountain News, Denver, Colorado, Jan. 12, 1971.
15. News Letter, International College of Dentists, March 1971.
16. U.C. News (University of California Clip Sheet) April 18, 1972.
17. San Francisco Jewish Bulletin, June 30, 1972.
18. San Francisco Examiner, July 27, 1972.
19. The New York Times, Sept. 17, 1972.
20. The Campus Bulletin, (U.C.S.F. bulletin) Sept. 1972.
21. TWA Ambassador (official magazine of TWA Ambassadors Club) November 1972.
22. International College of Dentists, Scientific & Educational Journal, 1973. Vol VI, No. 2.
23. Journal American Dental Association, Feb., 1973.

PUBLIC INFORMATION: (news articles continued)

24. American Dental Association News, June 18, 1973.

25. U.C.S.F. News, June 1973.

26. California Dental Association Journal, Aug. 1973.

27. Congressional Record, June 4, 1974, Vol. 120, No. 79.

28. U.C.S.F. News, June 1974.

29. American Dental Association News, June 3, 1974.

30. Journal American Dental Association, July 1974.

31. The Hellenic Chronicle [illegible]ebruary 20, 1975

32. American Dental Association News, Oct. 11 1971

33. San Jose Mercury News Sunday Magazine, California Today, June 9, 1974.

34. Jerusalem Post, January 4, 1977. p. 5

PROFESSIONAL LICENSES:

A. Clinical Microbiologist, 1949

B. California State License Dentistry, 1952

C. National Dental Boards, 1952

D. Massachusetts License

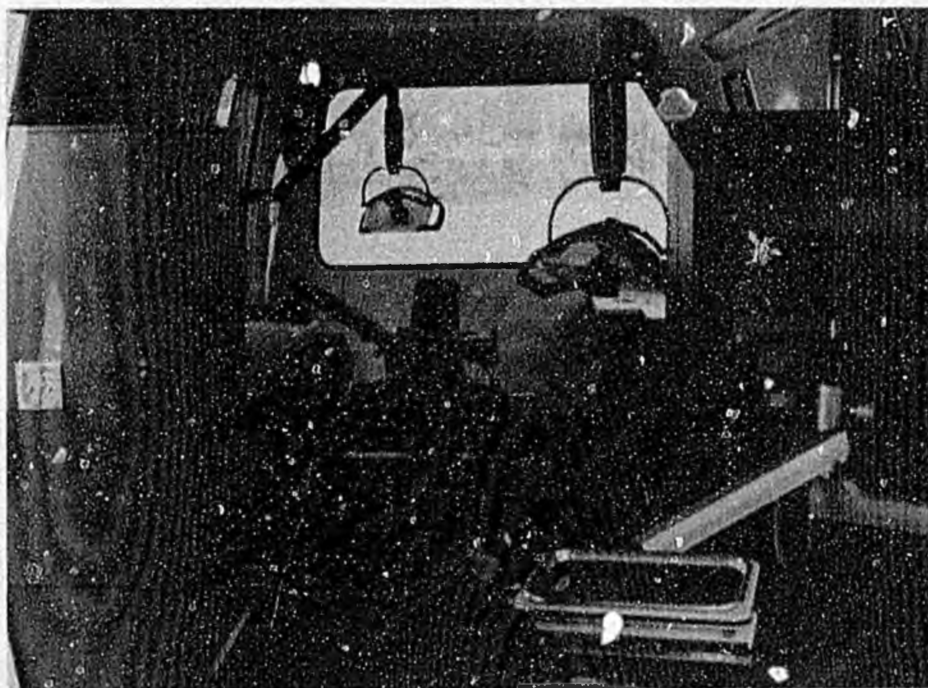
Dental Breakthrough for Bush Alaska

Senior Year dental students pose with their professors in front of the new mobile dental clinic — the first of its kind in Alaska. Paid for by the State of Alaska as the result of H.B. 728 which passed the House then cleared Senate HESS and was ultimately funded through Governor Hammond's discretionary budget.

No clinic — mobile or stationery in the world is any better equipped or more modern than the new unit.

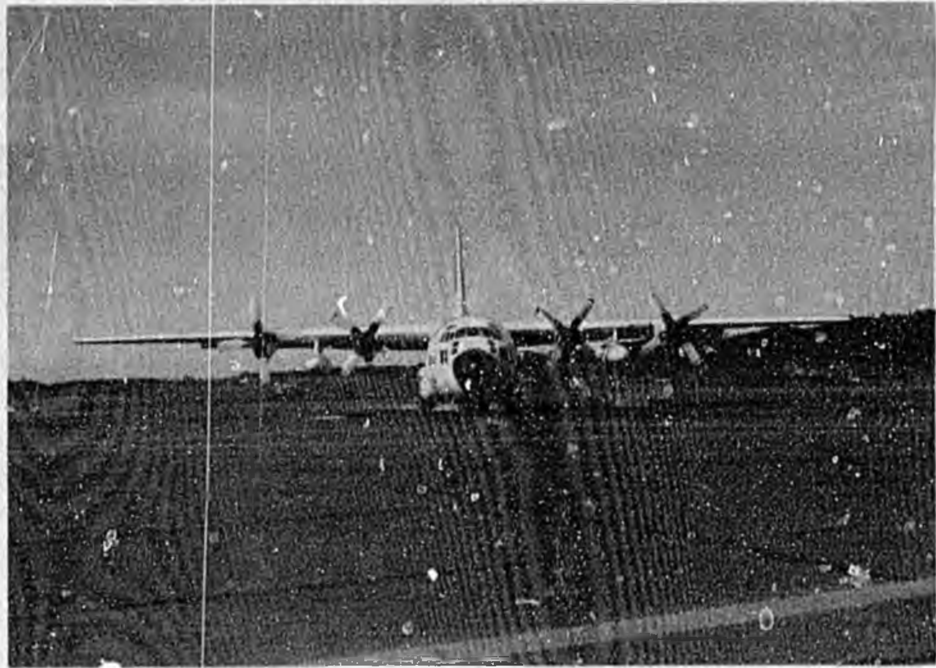
"There is no better feeling of worthwhile accomplishment than to leave a village knowing a whole lot of kids will no longer suffer from tooth aches."

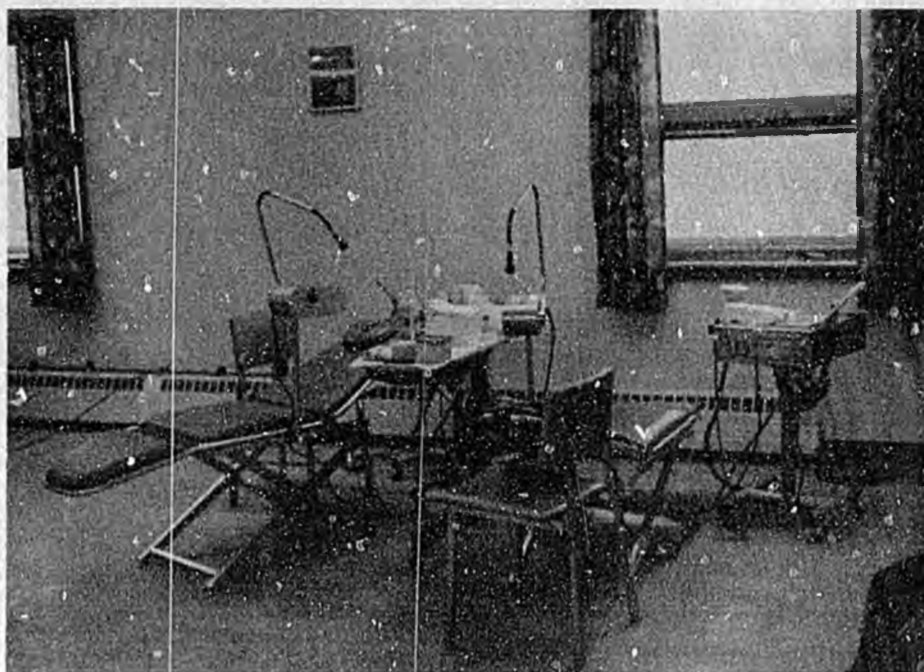
Dr. Kenneth Soelberg of the Stark Foundation joins in for the ribbon cutting ceremony, accompanied by Dr. Stolpe of PHS; Dr. Fred McGinnis, Deputy Commissioner for the State Department of Health and Social Services; Ralph Eluska, Deputy Director of APIA; and Jessie Dodson, Special Assistant to Governor Hammond.



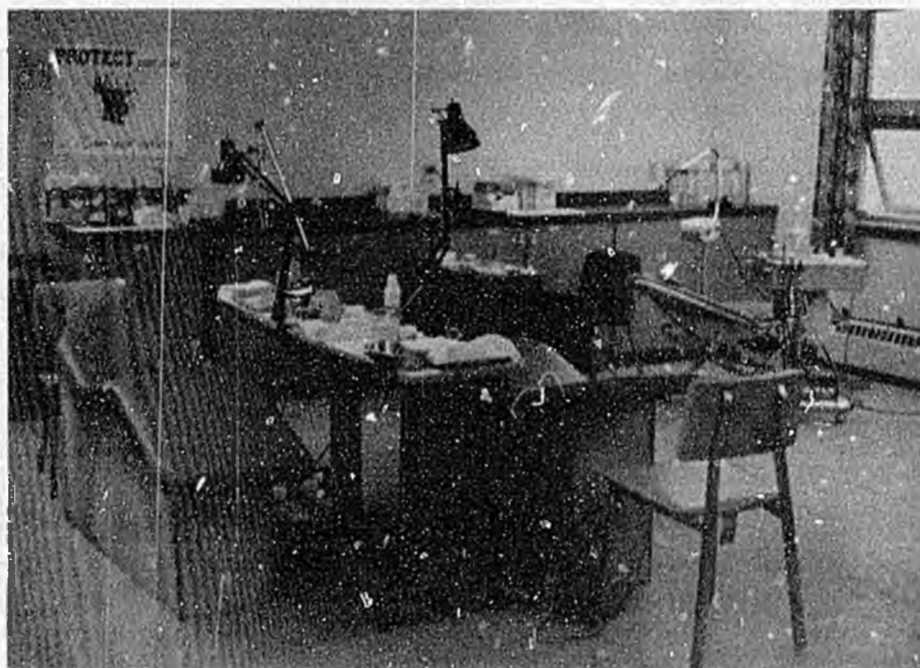
The mobile clini has every feature available for comfort and efficiency — including stereo music to listen to while being treated, air load levelers for bumpy spots in the road and heaters strategically located throughout the unit.

Pressing time and a missed barge bring the Coast Guard to the rescue. They delivered the companion support unit to St. Paul when there was no place else to turn for help.





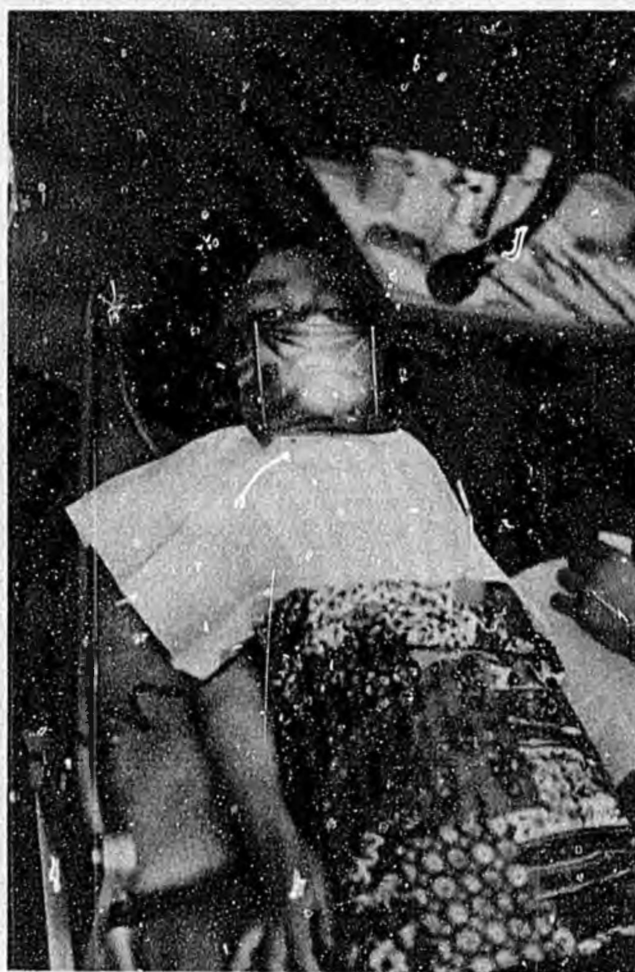
Hygienists outside working at auxilliary units cleaned teeth and did preliminary examinations and screening.



With so many volunteers we were able to set up auxilliary hygiene units outside the mobile clinic which allowed us to serve more people.

Every patient had thorough x-ray examinations so as to not miss any hidden cavities.

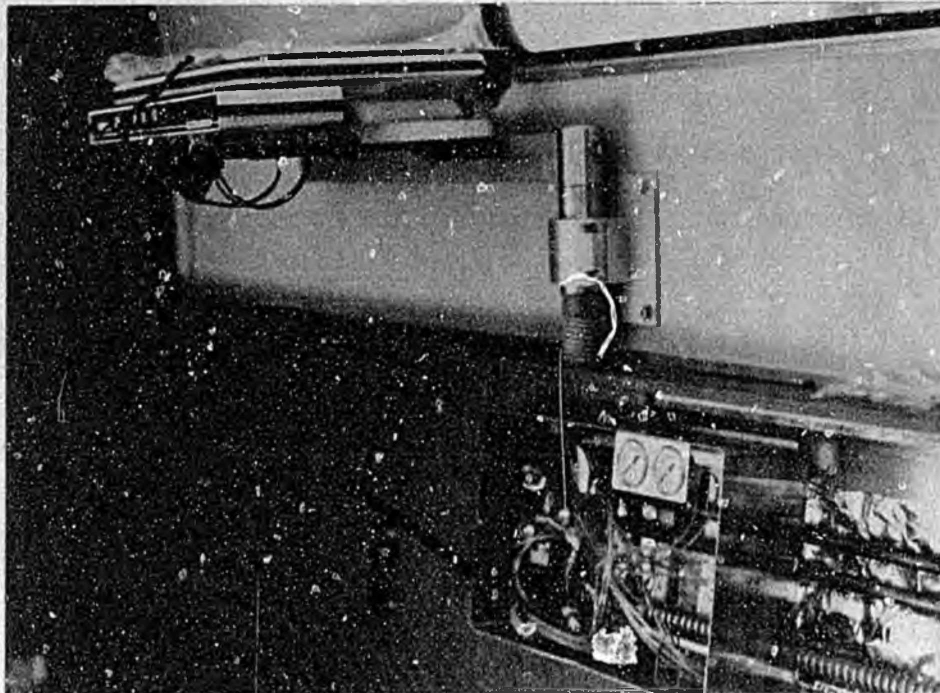
Dental Health is a Family Affair.



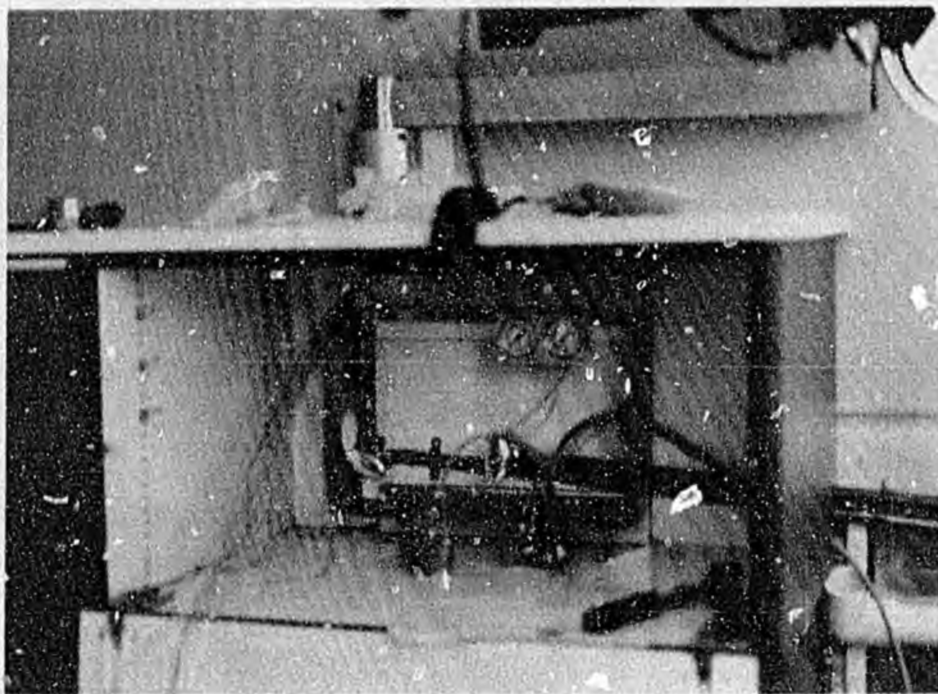
First class procedures were the watch word — full dental dams and quality techniques were applied to every patient.

Working together is the only solution to the delivery of health care services to bush Alaska.

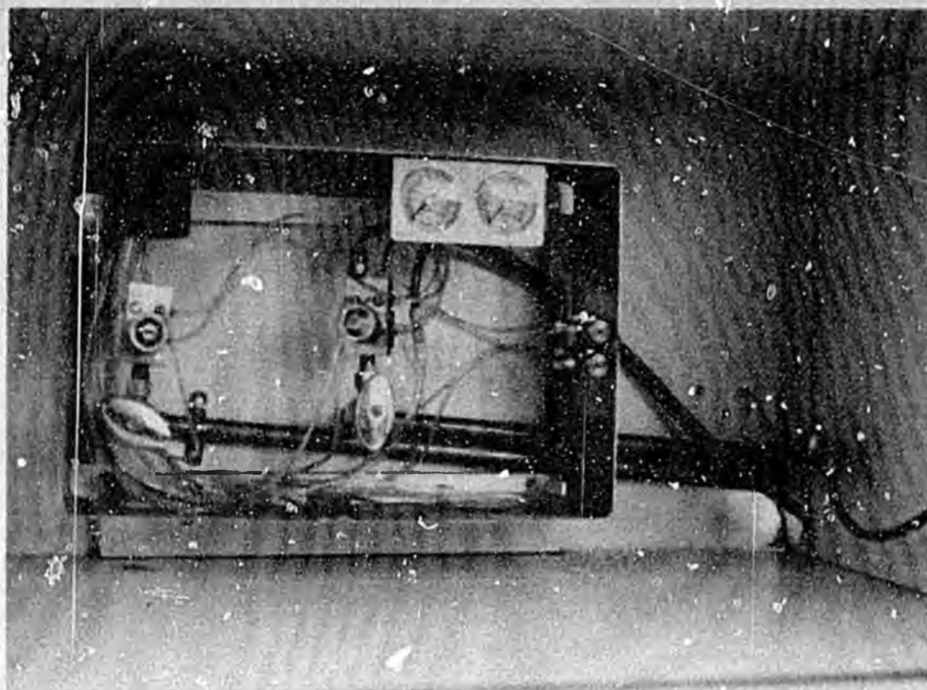
Students and professors built the unit from scratch cutting the cost by at least 25%.



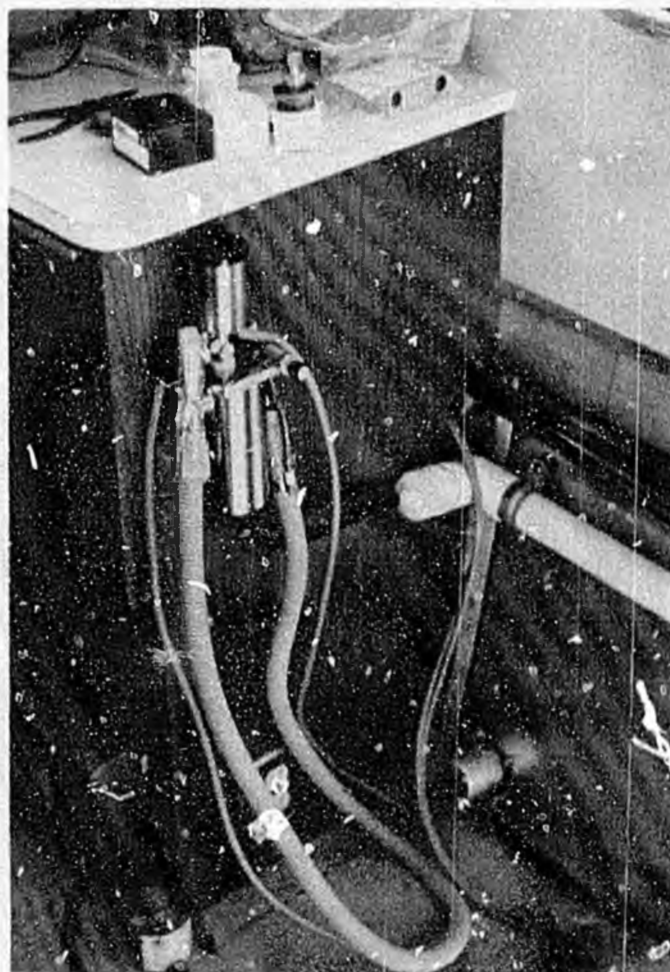
The x-ray system is wall mounted and swings out where needed.

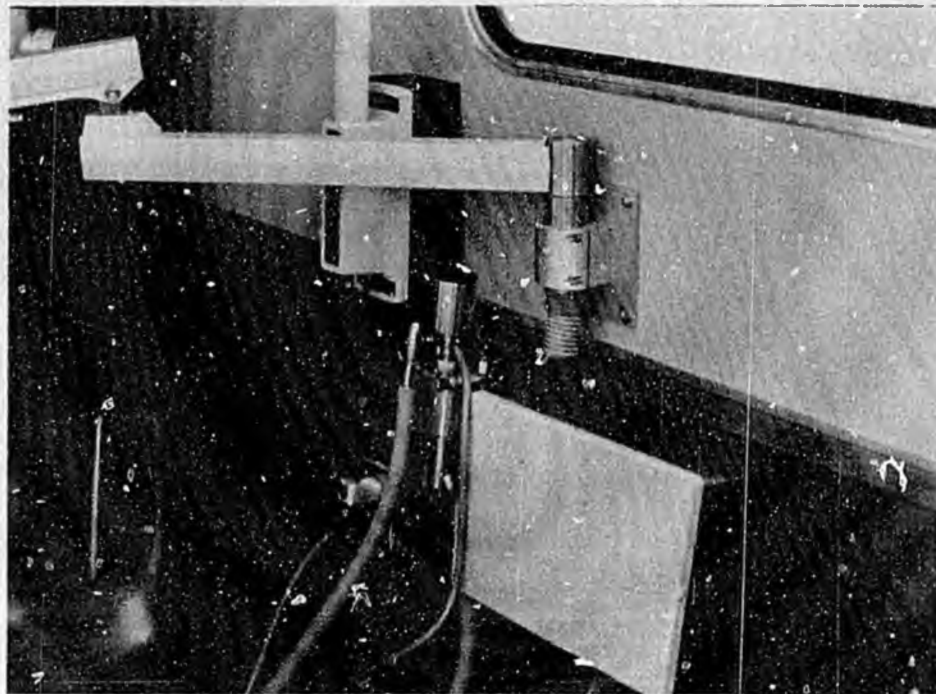


Plumbing and wiring were major undertaking for this modern unit.

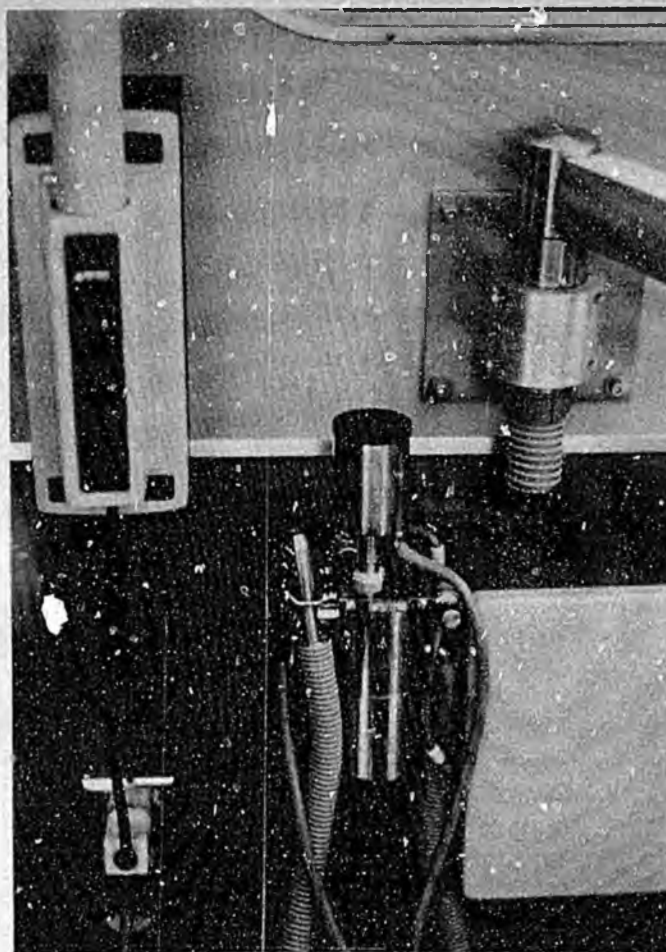


Dental Equipment hookups can be very technical — a challenge to any plumber.

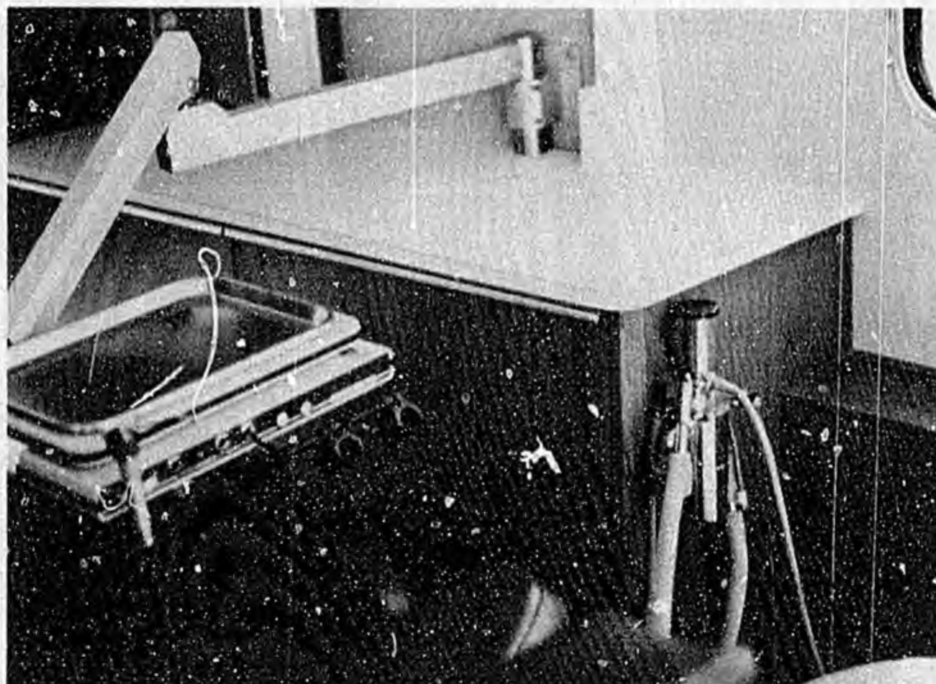




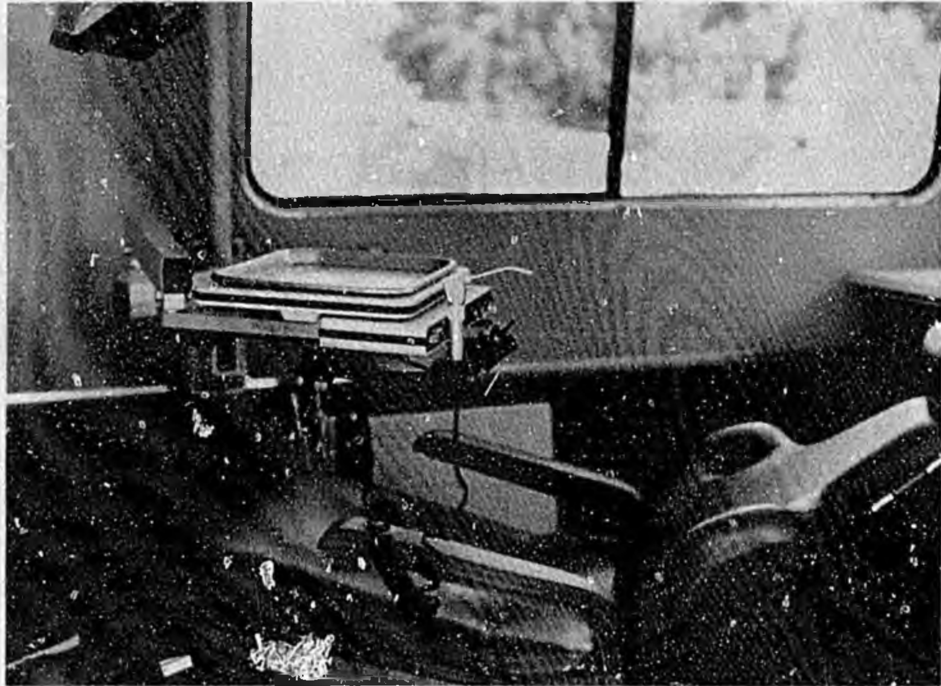
All equipment swings out and can be secured for the road.



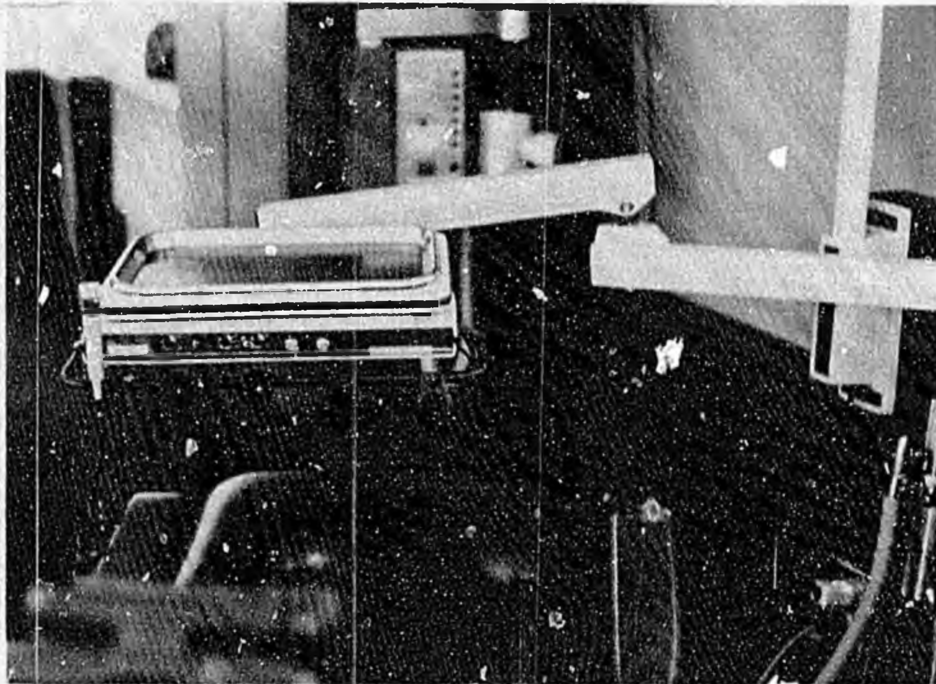
The stereo system and ear phones takes the patients mind off the drill and needles that frighten most patients. The Cukaracha Technique works well with kids.

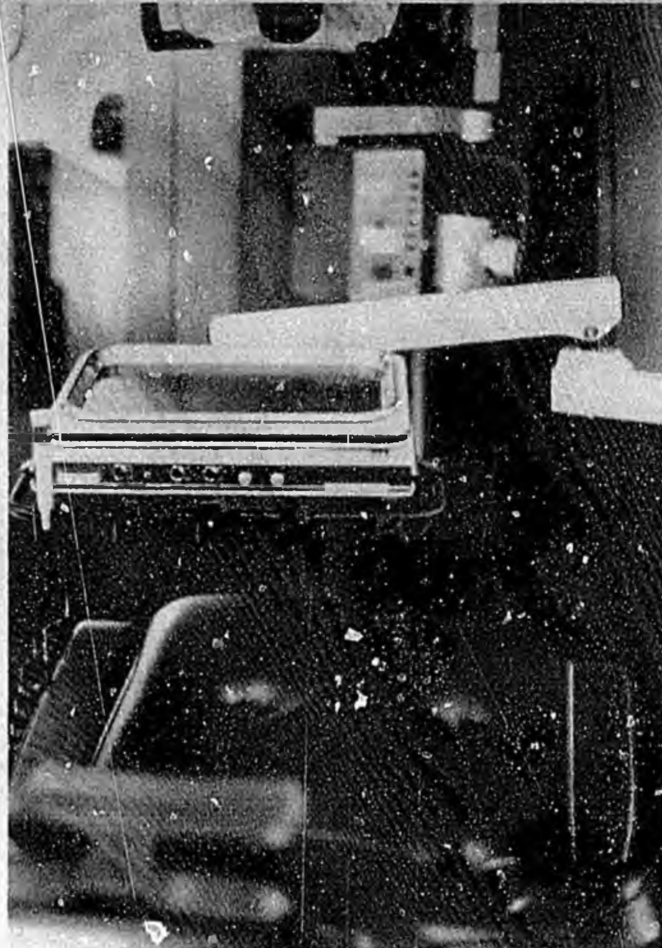


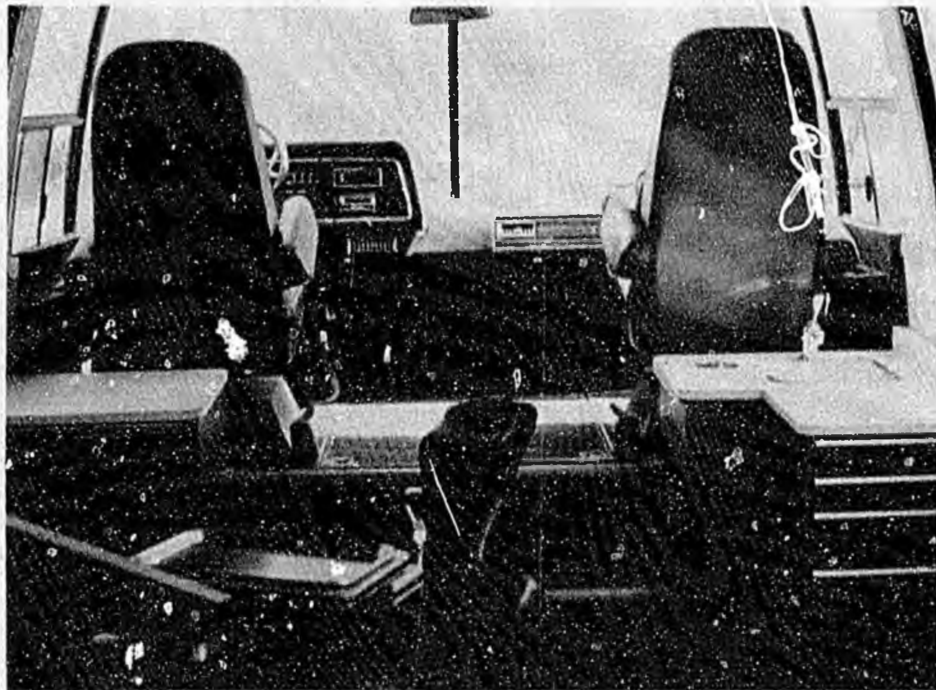
All of the equipment is the very latest and best.



These Siemens chairs are the best in the world — and better than many dental offices now have.

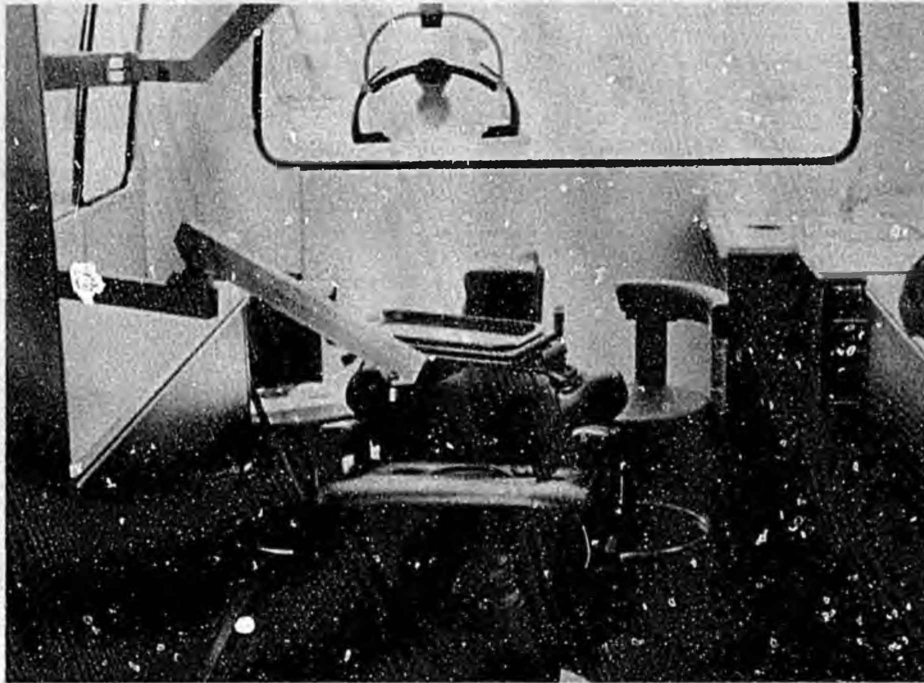






The spaciously designed drivers area allows plenty of room to operate and great viewing advantage through large picture like windows.

All equipment is designed to swing into place when and where needed.



That's it! We're all ready to go. All we need is legislation which allows Volunteer Dentists to give of their time and effort working with students of dentistry and dental hygiene fixing kids teeth in Alaska.

Your help is appreciated.

In Appreciation:

Our special thanks go to the Marvin M. Stark Research Foundation, an International organization dedicated to the health of children everywhere — for their unfailing devotion to the idea of delivery of voluntary health care to Alaska's isolated bush residents. They built the units, they drove them to Alaska and they staffed and operated the clinic as unpaid volunteers. They waded through unbelievable red tape and took a whole lot of bureaucratic abuse just so they could be of service. We apologize for the reception they got from the State Dental Board and other self serving professionals.

Pass H. B. 401
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Sane Approach to
Bush Dentistry

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02281 NL ANCHORAGE ALASKA 91 04-25 120P AST

PMS REP BILL MILES

HOUSE HESS COMMITTEE

JUNEAU AK

WE ARE AMAZED THAT NONE OF THE MATERIAL SENT YOU ON THE MOBILE DENTAL UNIT HAS FOUND ITS WAY TO THE FILES OF THE HESS COMMITTEE. WE ARE AGAIN SENDING A WHOLE PACKAGE WHICH WILL BRING EVERYONE FAIRLY AND HONESTLY UP TO DATE. PLEASE AT LEAST GIVE US THE BENEFIT OF SUBMITTING DOCUMENTATIONS TO THE COMMITTEE MEMBERS NO WONDER IT HASNT MOVED OUT OF YOUR COMMITTEE. FRIDAY WOULD BE A GOOD DATE FOR A PRESENTATION TO THE COMMITTEE BY OUR PEOPLE.

PATRICK PLETNIKOFF EXECUTIVE DIRECTOR ALEUTIAN PRIBILOF ISLANDS ASSN 1689 C ST ANCHORAGE AK 99501

TELEGRAM

RCA ALASKA COMMUNICATIONS, INC.
PHONE: 586-6142
JUNEAU, ALASKA 99802

#

02272 NL ANCHORAGE ALASKA 270 04-24 0350P AST

PMS REP BILL MILES, HOUSE HESS COMMITTEE

JUN

WHEN SOLOMON AS LEADER OF HIS PEOPLE HAD TO MAKE DECISIONS HE OFTEN LOOKED BEYOND HIS OWN PERSONAL TASTE, BEYOND HIS ENEMIES AND THE DEVISIVE INFLUENCES THAT PLAGUED HIM TO VIEW THE TRUE RECIPEINTS OF HIS ACTIONS, THE LITTLE PEOPLE WHO WOULD BARE THE BRUNT OF HIS DECISIONS. WE HAVE KIDS IN BUSH ALASKA WHO HAVE TOOTHACHES, WHO SUFFER ALL THE TIME WITH SYSTEMIC POSIONING AND MALNUTRITION BECAUSE OF DENTAL HEALTH PROBLEMS. LOOK BEYOND ALL THE RHETORIC OF THE PROFESSIONALS WHO HAVE MADE NO UNPAID EFFORT TO BRING RELIEF TO THESE PEOPLE. WHO BELIEVES THEM NOW WHEN THEY SAY THEY ARE READY TO GO TO WORK FIXING TEETH IN BUSH ELASKA, NOT I AND SURELY NOT YOU. OURS IS A VOICE CRYING OUT OF THE WILDERNESS BUT NOT BY ANY MEANS A LOST VOICE. EVERY SINGLE RURAL COMMUNITY WANTS DENTAL CARE NOW. THEY DONT CARE ABOUT OIL TAXES, FISH TAXES, D-2 OR PORK BARREL LEGISLATION WHEN THEY SUFFER WITH A TOOTH ACHE THEY WANT HELP NOW. WE HAVE A DLRS200,000 MOBILE CLINIC READY TO GO, PAID FOR WITH STATE TAX DOLLARS. IT IS INCONCEIVABLE THAT A SPECIAL INTEREST GROUP COULD BE SUCCESSFUL IN PREVENTING VOLUNTEERS FROM DELIVERING RELIEF TO THE SUFFERING SIMPLY BECAUSE THEY HAVE MONEY AND POWER. IT IS OURHOPE THT EVERY LEGISLATOR WHO VOTES OR ACTS IN OPPOSITION TO THIS EFFORT SUFFERS FROM S SEVERE TOOTH ACHE OR BREAKS HIS BRIDGE IF THE DENTISTS HAVE ALREADY GOTTEN HIS TEETH. OUR BILL IS TIED UP IN THELMA BUCHHOLDTS HESS COMMITTEE. HELP US GET IT OUT FOR A VOTE. THANKS.

PATRICK PLETNIKOFF, EXECUTIVE DIRECTOR, ALEUTIAN PRIBILOF ISLANDS ASSOCIATION 1689 C STREET ANCHORAGE ALASKA 99501

New views for Alaska television

Volume 3, Number 10 For the week of March 8-14, 1979 75 cents

ALASKA ADVOCATE

Dentists & dollars

State blocks volunteer dentists from bush practice

Examining dollars & dentists

Volunteer dentists who try to help in the bush have been blocked by rules that keep them out

by Bill Lazarus

Anchorage

While Aleuts suffer from a lack of basic dental care, state laws and the state dental board are blocking volunteer efforts to provide needed services.

Professors from reputable dental schools have volunteered to work on the Aleutian Chain for free. Fourth-year dentistry students working with the professors also have offered services, under a program developed by the Aleutian/Pribilof Islands Association.

But the program is floundering because the professors and students apparently can't get permits to practice from the Alaska Board of Dental Examiners. The dentist-dominated board is responsible for licensing dentists to work in the state.

"Professors aren't necessarily competent dentists," says Arthur Hansen, president of the dental board. He says the board is trying to protect Alaskans by insuring that only capable dentists practice in Alaska.

Officials at the Aleutian/Pribilof Islands Association, however, suspect an additional motivation: greed. They say the state board may view volunteer dentistry as undercutting private practice in the Bush.

Many private Alaska dentists contract with the U.S. Public Health Service to work in villages across Alaska. The work days tend to be long, but the pay is excellent. According to a small, random sample of 1978 health service data, individual earnings vary greatly, but on the average a dentist makes more than $1,000 a day while working in the Bush.

One health service official says that on a 10-day stay in Ft. Wainwright five years ago, Dr. Hansen earned some $22,000. Another official suggests the stay was probably 12 days.

Hansen says he doesn't recall how much he made, but he defends the figures. He says that since he worked double time in the village, he really worked about 20 normal days. That's a working month, he adds, pointing out that he makes more money in a month at his Fairbanks office. Generally, "I probably earn 25 percent less when I go to the villages than when I go to my own office," he says.

Public Health Service officials say that Bush fees are essentially the same as the office fees, except that at times money is provided to pay travel and lodging expenses.

The Public Health Service also employs its own dentists to work in the Bush. Between this and the private contracting, health service officials say, most dental needs of Bush children are met. They admit, however, that in many villages basic care for adults is not provided, because the service does not have the money.

"All we're trying to do is to get dental care out to rural Alaska where it's not being provided," says Pat Pletnikoff, executive director of the Aleutian/Pribilof Islands Association. "Right now we're just right in the middle of a pissing match. We have two people who want to come up now (the chairman and assistant chairman of the children's dentistry department at the University of California Dental School at San Francisco) ...but we can't get the permits issued for them to come and practice in Alaska."

"There is no provision in the Alaska statutes to do what they are trying to do," says Hansen. He points out that only dentists licensed in other states—and not students—are legally able to obtain special, one-year permits to work in Bush Alaska without going through the licensing procedure. (In states with dental schools, senior students are able to practice dentistry under supervision of a licensed dentist. But Alaska has no dental school and no such provision).

Besides, Hanson says, the Aleuts and their volunteers "haven't even made an attempt to apply for a permit."

The catch is that in December 1977 the board decided not to issue any more Bush permits. The one person holding a permit "had abused it," says board member John Beard. "He was practicing in an area that he wasn't supposed to be practicing in and he was doing bad work."

Other than obtaining a special permit, there are only two ways a dentist can legally practice in Alaska: he can pass an exam and gain a license from the dental board, or he can work for the Public Health Service. Federally employed dentists do not need to be licensed by the state, but they only earn $30,000 a year.

Passing the licensing exam is no easy task. Although the test is supposed to be simple, 13 of 25 people who took it last year flunked. Eighteen of the would-be Alaska dentists were already licensed in other states, but nearly half of those practicing dentists failed the clinical portion of the exam, which is judged by the dental board. This test is given only once a year.

Hansen says it's "hard to answer" questions about why so many established dentists failed. He suggests that "we have far fewer (malpractice) problems in Alaska...I think this quality has come about because our standards may be a bit higher."

A legislative audit completed earlier this year looks at the situation differently.

"Presently there is a dental manpower shortage noted in several areas of Alaska. Board policies are restricting the entry of qualified dentists and are not in the public's best interests...

"The Board's clinical examination has several deficiencies...first noted several years ago...(which) have not been corrected," the audit report says.

The report also says no instances of "deliberate grading bias" were found. It notes, however, that "a potential conflict of interest...exists when Alaska Board members who are practicing dentists grade the performance of applicants who represent potential competition."

In a written response to the audit, Hansen maintains, "There is no conflict of interest in the grading system. This is a serious charge to make especially by a lay person regarding a profession he knows little or nothing about."

He also says no shortage of dentists exists and "adequate numbers" of dentists are willing to travel to the Bush.

Only four dentists live in Alaska rural areas with a total population approaching 60,000. Alaska has 260 dentists: 200 private practitioners, 28 military dentists and 32 with the Public Health Service. Although very few dentists live in the Bush, the dentist population ratio in Alaska beats the national average of one dentist for every 2,186 people.

In its own response to the legislative audit, the House Commerce Committee voted recently to put the dental board on two years probation and urged the board to make it easier for dentists to practice in the state. The committee opted to dismantle several professional boards under Alaska's "sunset" law, but a final decision awaits a full vote of the legislature.

Despite the legislative recommendation, Hansen says he is not certain he would support legislation allowing student dentists to work under their professors in Alaska. He also says he is not sure he would support issuing permits to the

(continued on page 16)

Dentists

(continued from page 5)

dentistry professors who want to work with the Aleuts.

"I don't know whether we feel that we would have enough control over the situation...to insure quality work. In remote areas anything can go on and nobody's going to see it," he says. He adds that he is speaking for himself, not the board.

The predicament facing the Aleuts is not new. Last spring their association applied for a $200,000 state grant to buy a mobile dental clinic and to pay for the transportation and housing of volunteer dental students and professors. Representatives of the Alaska Dental Association unsuccessfully lobbied against the proposal.

Then last summer, in conjunction with the proposal, a group of four professors, six dental students and four dental hygienists came from California to work on the Pribilof Islands. But because of licensing problems, the group spent about 10 days in Anchorage doing nothing.

"They forced (the volunteer program) on people...They never cleared it through normal channels," says Hansen.

Jim Milne, a consultant through the Public Health Service after learning that the board had decided not to issue any permits. As volunteers for the federal government, the professors and students would not need approval from the state board.

Milne says the Public Health Service earlier agreed to take the volunteers under its wing, but later balked. Only after pressure was applied in Washington, D.C., he says, did the service agree to accept the volunteers, who then left Anchorage and spend about two and a half weeks treating 220 islanders.

Dr. John Stolpe, chief of dentistry for Public Health Service in Alaska, says the service did not flip-flop on the matter. He says the Aleuts approached the service about the matter only shortly before the volunteers arrived in Alaska.

Whatever the case, the health service now says it won't accept the dental volunteers.

According to Stolpe, who worked with the volunteers last summer, the problem is not the quality of the service. "From a technical standpoint, I found their services to be totally satisfactory...They are a young, enthusiastic group of people. They established a very good rapport with people in the (Pribilof) Public Health Service takes the volunteers, it will be in charge of the program. Instead, he says, it's better for the Aleutian/Pribilof Islands Association to keep control of the program and to obtain permits from the dental board.

Stolpe also says some paperwork requirements have not been met by the association and that, despite the volunteer help, the program cost more than the services provided.

Milne says the volunteer program saved money. He charges that the Public Health Service is just responding to pressures from Alaska dentists not to take the volunteers.

In light of the recent legislative recommendations, Milne says the association now will apply to the dental board for a temporary Bush permit for the volunteer dentists. He says it doesn't make sense for a dentist who might work here for only part of one summer, to go through the cost and burden of taking the licensing examination.

Even if application is made, the outlook doesn't look good for issuance of the permits.

The legislative audit itself criticizes the "double standard" of allowing unlicensed dentists to work under special permit in the Bush but not in urban areas. It recommends that either mends the permit system be eliminated. He says the board is studying the possibility of reciprocal license agreements with other states but suggests it is likely to recommend that it judge some applicants on the basis of their credentials. This would "allow for close Board scrutiny of an applicant, thus assuring the same degree of quality," he says.

Board member John F. Kobylarz, a Soldotna dentist, disagrees with the primary recommendation of the audit. "Nowhere in (Alaska law)...is the Board charged with encouraging dentists to practice in Alaska. I think the State in its powers should protect the consumer, not try to coddle the citizen from birth to death," he writes.

The dental board is made up of five dentists, one dental hygienist and one person not associated with the dental profession, a mix Hansen claims "adequately represents the public interest."

John Beard, the one public member of the board, says licensing is "protectionist" and the board ought to be dismantled. An Anchorage lawyer with Libertarian leanings, Beard suggests that judging of dentists should be left to the marketplace and that even graduation more traditional point of view. She says she understands why the public might view the dental board as protecting the state's dentists from competition. But, she insists, the state exam is necessary. "Come to the next clinical dental examination. I think you would have your eyes opened. Just having a certificate from a dental school does not mean that you are competent," she says.

Varrati questions the wisdom of allowing students and professors to practice in Alaska. "Let them come up and take the board (exam)," she says. "I don't think we have remarkably high standards...We have one of the simpler exams...I wouldn't like to see someone who fails practice in the state."

"Either something is wrong with the dental schools or we have the best dental program in the entire world. I have the feeling that (the high failure rate) is related to the economics of competition," says Bob Worl, who served as health director of the North Slope Borough for three years.

Alaska dentists, he says, have volunteered work in the Bush and "it's very tough to say it's all black or white in terms of altruism or the economics involved. It's a real mixed bag."

New views for Alaska television

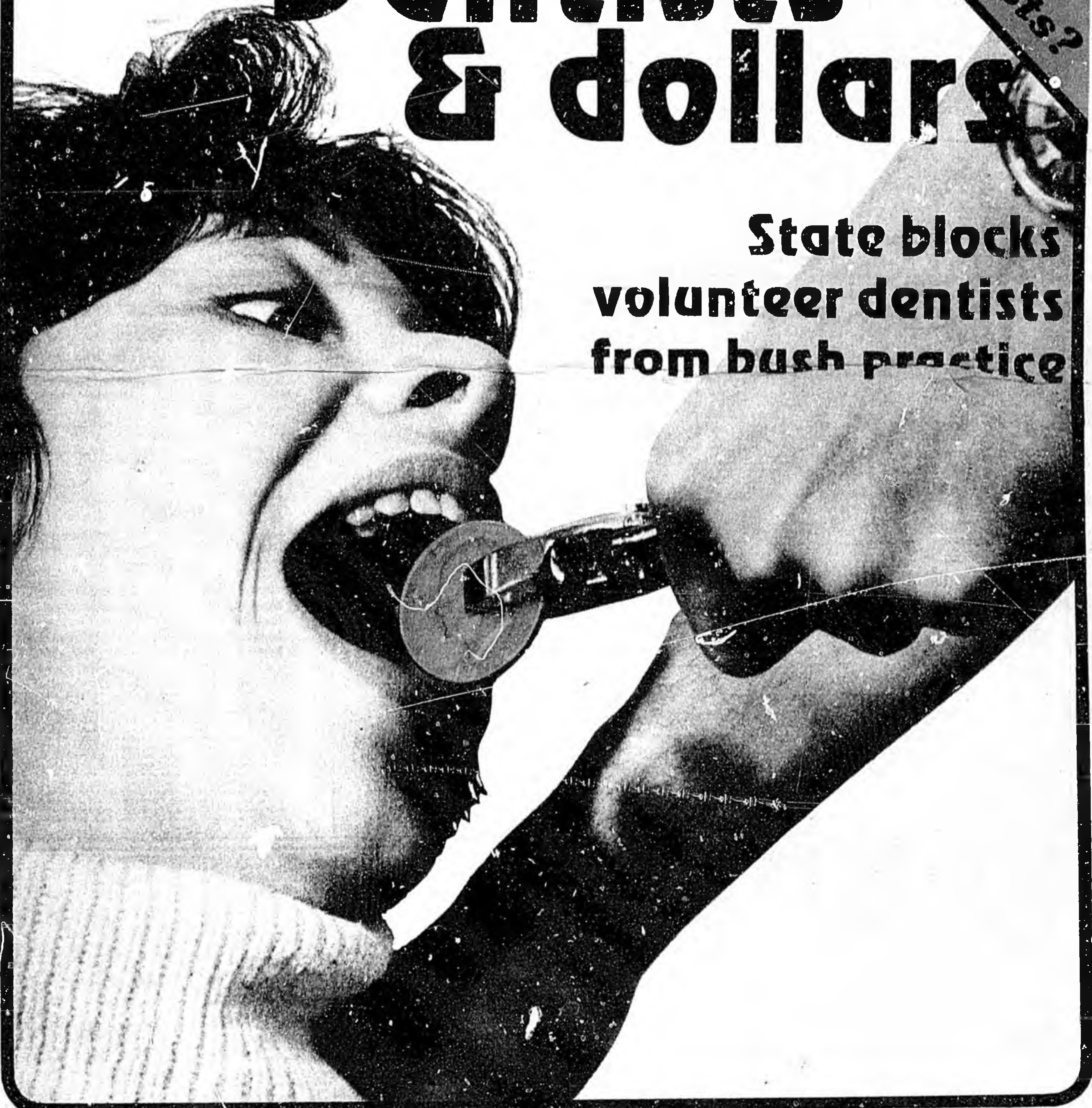
Volume 3, Number 10 For the week of March 8-14, 1979 75 cents

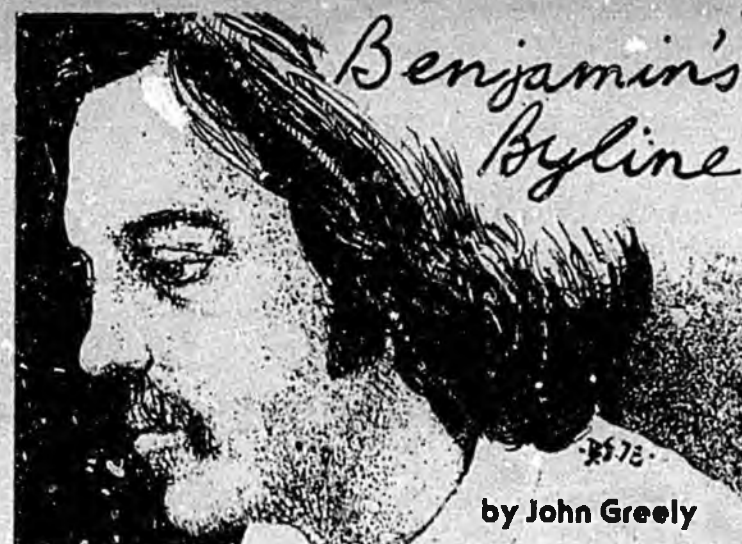
ALASKA ADVOCATE

What happens at all those wet shorts contests?

Dentists & dollars

State blocks volunteer dentists from bush practice





Benjamin's Byline

by John Greely

Juneau

Perhaps it's cabin fever. Maybe it's just a hangover from the eclipse. But a lot of people have been getting upset lately over Alaska's image.

If you've been reading *Vogue*, *Business Week* or any number of newspaper reports from Washington, D.C., you might get the idea that the composite Alaskan in 1979 drives a bulldozer to work, climbs glaciers in the nude, slays multinational oil companies in the morning and shoots wolves in the afternoon.

Now that's one heil of an image. If my folks didn't know me better, they might their their son had gone out with the sun.

So for the sake of the image-conscious (if not the relatives) let's take a few lines to examine this composite:

Bulldozers—I've always been fascinated by bulldozers, ever since they came through my childhood neighborhood to build the freeway. They returned a few years ago to make the freeway bigger and the old neighborhood smaller, but now I live in Juneau and there isn't a freeway in sight.

However, as we've been told by Rep. Morris Udall of Arizona and others, bulldozers are "poised on the border" waiting to invade the state.

Udall's right, of course, but for Alaskans living 100 miles from the nearest road, it's nothing to get hysterical about. In fact, most of the bulldozers on the border are really pointed the other way, waiting to build the gas pipeline through Canada. So, if there's anybody who should be concerned about bulldozers in Alaska, it's the Canadians.

Beating Big Oil—An image dredged up by developers to counteract the bulldozer hysteria portrays the oil industry as Alaska's whipping boy. *Business Week* magazine (Feb. 26) is the latest organ to grind out this tune.

Business Week even went so far as to suggest that because of state tax increases in recent years, the oil industry might be cool to taking on our government as a partner in some ventures. Of course, the magazine could find no one from Northwest Alaskan Pipeline Co. or the Alaska Petrochemical Corp. to back up that notion.

Northwest, for example, wants the state to cough up a bundle to help build the gas pipeline. The consortium might have found a willing partner, except state officials are holding back while they study the feasibility of the project. In turn, the feasibility of the project hinges on decisions by the gas owners, who aren't budging.

So, the question seems to be, who is whipping whom? Alaskans may take a lash to the big boys now and then, but the beating is certainly returned. Any bets that the first $1 gallon of gasoline was sold in Alaska five years ago?

Sex on Ice—A $150,000 ad placed in *Vogue Magazine* last month raised some ire because it attempted to entice tourists to Alaska with full-color shots of lots of female skin displayed in such unlikely places as Ruth Glacier ("Lovely name for an icedream.")

For state officials pondering the Northwest partnership, the *Vogue* ad might have been pause for thought: it was the product of another deal jointly financed by industry (the Alaska Visitors Association) and government.

Instead, the protests generally revolved around the idea of using sex to sell Alaska.

What these protests ignore, of course, is that the tourist industry has been using sex to sell Alaskans for years now. No, not to take off our clothes at home, but in some place like Tahiti.

So, the *Vogue* ad might be viewed as something of a boost for Alaskans to spend their vacation money in Alaska. If not, we at least will have another way to tell who the tourists are this season—they'll be the ones with no clothes on.

Wolf Killers—So much has been written about this image in the last few years that I hesitate to add any more. So whenever somebody asks me about the state's plan to knock off another 170 wolves to save the moose of Western Alaska, I just point to Gov. Jay Hammond (a veteran wolf hunter in those areas in the 1950s) and say, "Oh, that's just the start of the 1998 campaign."

To .. joke, a lot of people nod knowingly because, somehow, that's the only image that makes sense.

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ALASKA ADVOCATE

DOLLARS

State laws and the dental board are blocking efforts to bring volunteer dentists to Bush Alaska. Dental board members say they are only trying to protect the public. But some people suspect the dental board is trying to protect lucrative Bush contracts in which Alaska dentists earn more than $1,000 daily.
by Bill Lazarus
Page 5

(Cover photo by Ken Roberts)

WILD, WET & WILLING

In a unisex change of pace, several Anchorage-area clubs have begun to feature male dancers along with traditionally topless and bottomless femaies.
by Jim Erickson
Page 8

TV CHANGES

What do you want on TV tonight? Opera? Children's programming without commercials? How about Don Young, live and in color direct from Capitol Hill in Washington? All of this is possible when cable television comes to Alaska's big cities. The fast-changing medium could multiply the goodies available on the tube, but also may hurt the state's conventional TV stations and movie theaters.
by Clifford John Groh
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"THE GENERAL STORE HOBBY SHOP"

'Mikado'

[continued from page 10]

quarterfinalist competition and will be teaching music, opera specifically, when he returns to Anchorage in June to settle permanently.

Only when you have a large enough skilled musical population can you skim off a cream experienced enough to produce a good show. But enthusiasm does not automatically make quality, a fact Lee Salisbury knows. He calls it a luxury to be able to choose from many qualified singers here rather than having to work with whatever you've got.

During their own time Gilbert & Sullivan were so popular that they were always fighting "pirated" versions of their works produced without royalty or permission. To avoid this happening in the U.S., they spirited the company here secretly, complete with aliases, a midnight ship boarding, and concealment of their destination from family and friends. To prevent the rival producer from furnishing his production, they pursuaded Liberty's store not to sell Japanese silks to him, and Carte himself bought all the Japanese costumes in Paris. They succeeded in opening two days before the "pirate" and ran for 430 performances in New York City.

Gilbert and Sullivan were sometimes a reluctant team. Separately they were failures—Sullivan eternally yearning for recognition in the "serious" musical world and Gilbert never finding another partner as stimulating (or as difficult) as Sullivan. Gilbert wrote the lyrics first, giving them to Sullivan only a few months before opening date. The collaborative tradition in light operas has continued, with bread-and-butter teams like Rogers and Hammerstein, and Lerner and Lowe carrying on.

Operetta is a diminutive term and Gilbert and Sullivan light operas are not diminutive forms. They are exciting as music, captivating as social commentary, enthralling in their humanistic themes. Better yet they are simply fun. Gilbert might have been talking seriously about himself when Pooh-Bah says, "I am a particularly haughty and exclusive person, of pre-Adamite ancestral descent...I can trace my ancestry back to a protoplasmal primordial atomic globule. Consequently, my family pride is something inconceivable."

The production plays in Anchorage March 8 through 11.

Virtu

[continued from page 9]

competition will be Ella Gerber of New York. She has considerable theater experience as an actress, director and playwright, and is listed in *Who's Who in the American Theatre*.

The first festival competition in 1973 was won by the Juneau-Douglas Little Theatre for its performance of Edward Albee's "In A Chicago Abyss." The Fairbanks Drama Association won in 1975 with cuttings from a James Thurber production. In 1977 "The Audition," a play written and directed by Gerry Wilson, brought winning honors to the Kodiak Community Theatre.

Winner of the Alaska festival competition goes on to regional competition in Portland, Ore., against Washington and Oregon. Alaska has always come in second in regional competition. The regional winner goes on to Memphis, Tenn., for national competition. Both regional and national competitions are sponsored by American Community Theatre.

Each group has only two hours stage rehearsal time in Haines. This year, ASCTA requires that the competing productions be performed at least once before a local audience prior to the festival. Local arts calendars for recent months indicate the nine community theater groups are doing just that.

Only eight persons from each group are funded to participate in the festival. Half is paid by ASCA, half by theater match. Additionally, each group must sell at least a full page of advertising for the festival program.

During the festival, ASCTA's board of directors meets and elects a seven-member executive board. The 11-member general board has delegates from each of the ASCTA community theater organizations. Any adult amateur community theater, or a university or college theater with a community governing board, is eligible to join ASCTA. Actors and actresses who are active members of Actors Equity, or who receive more than half their income from acting may not participate in the festival.

If you're going to be in Haines April 25-28, take a look at what's happening at ASCTA's festival. It's a great way to see nine Alaska theater performances in short order. Since the theater holds only 200 people, I recommend contacting Mimi Gregg, Box 75, Haines 99827, phone 766-2116 (work) or 766-2425 (home) about tickets.

If you can't get to Haines, check out the local performances. But don't stop at being part of the audience...see what it's like to *participate* in community theater.

Cable

[continued from page 4]

many people assume that cable's pay-to-watch status makes advertising unnecessary, commercials will be included on at least four of the 14 channels initially planned for the Fairbanks system. A similar proportion probably will be included in the Anchorage system selected by the APUC.

By law, over-the-air commercial stations distributed by cable will run with advertising spots intact. As for programming generated specifically for cable TV, industry sources say first-run movies and entertainment specials offered as parts of extra-cost, premium packages are inviolate and will run uninterrupted.

On the basic service, cable industry sources say advertising in addition to the commercials already on the regular over-the-air stations will be light and unobtrusive.

John McCaw, vice-president of Frontier ColorCable, Inc., winner of an APUC certificate to build a Fairbanks cable system, says his company will reserve one channel for advertising that it will sell itself. Some of the prospective Anchorage operators expect to put commercials on more than one channel, but all predict the ads will be few because of little demand by advertisers.

Dark clouds have peeked over the horizon for those who oppose commericals on cable, however. A widely quoted study predicts advertisers "will start becoming interested on a broad scale" when cable reaches 30 percent of all American homes with television sets. The report says the benchmark will occur within two years (the medium already reaches 20 percent of all TV homes, or more than 18 percent of all homes).

Perhaps an ominous portent is found in the experience of actor Dan Aykroyd, who as a cast member on NBC's "Saturday Night Live" regularly parodies the hard-sell electronic huckster. Aykroyd learned his pitchman act as a real-life salesman for a cable TV station in his native Canada.

Over-the-air commercial broadcasters are concerned as well. A recent report by their national association claims cable will transmit "deceptive and irresponsible advertising" as well as "borderline pornography...subversive propaganda...the outpourings of the lunatic fringe." Broadcasters clearly are worried about loss of advertising dollars.

Recently the management of Juneau's KINY-TV, the capital city's lone commercial broadcast television station, cut back programming by 40 hours a week. KINY management cited ad revenue competition from the local cable operation as a reason for the reduction.

In Anchorage, commercial broadcasters formally opposed a 1973 bid to bring cable to town. They claimed the proposed system would duplicate their services and jeopardize free TV; the plan later died after a newspaper investigation revealed its ties to a reputed organized crime figure.

The three local TV stations also have been reluctant to sell advertising to Visions, the local pay-TV station, after it began over-the-air service in late 1977.

The local broadcasters have not come out against the new round of Anchorage cable proposals, opting instead to wait and see.

Cable industry sources insist that the new service will tend to increase all kinds of TV viewing. One local observer says the mass appeal of over-the-air broadcasting will continue to hold a large market share: "People will watch 'Laverne and Shirley' no matter what else is on." However, this experienced Anchorage broadcaster also predicts the competition provided by cable will force the commercial telecasters to improve, and in the long run could force one of the three Anchorage stations out of business.

The record shows that competition does spur the improvement of the commercial broadcasters' performance. Improvements last year in the programming and operations of the Anchorage TV stations coincided with the arrival of Visions, although several other factors probably had more impact.

Broadcasters agree that the introduction of cable TV likely will produce an intensified scramble for viewers that will further the trend toward beefed-up local programming and generally tightened operations.

Anchorage movie theaters also have been upgraded in recent months. Their traditionally poor treatment of customers seems to have run headlong into Visions' widely praised efforts in programming first-run movies.

The dominant Wometco-Lathrop chain frequently waited six months or longer after a film's initial release before putting it—sometimes in a very poor-quality copy—on one of its nine Anchorage screens. Although the company still receives complaints about its selection of films, the lag on several major releases has been eliminated.

Wometco-Lathrop vice-president Hugh McCauley of Anchorage denies that the arrival of Visions has speeded up the chain's film-buying process, saying he ordered the switch 18 months ago without knowing the pay-TV station soon would begin operations.

McCauley also dismissed as "far-fetched" any predictions that cable TV will make theaters unprofitable. A well-known study concludes that by 1985 cable and other innovations will combine to do just that. Other observers say the neighborhood movie house will survive, if only to give teenagers a place to meet and neck.

What worries broadcasters and theater operators is cable TV's capacity to entertain, but the medium is able to do much more than that. McCaw says the Fairbanks system will be capable of bi-directional cable or "two-way television." The intense competition for the right to build the Anchorage system virtually insures that the winner will boast even more state-of-the-art features.

Subscribers can use a bi-directionally equipped television to protect their residences with security systems, to purchase commodities from their living rooms and even to vote from their easy chairs—in short, to talk back to their TV sets.

An experimental system boasting all these features now operates in Columbus, Ohio.

Although the capacity for such futuristic services will be engineered into both Anchorage and Fairbanks systems, they still are at least a few years away from operation. Still farther down the road—perhaps 10 or 15 years—is direct satellite-to-home transmission by use of special antennas, which could threaten cable the way cable threatens over-the-air broadcasting.

Whatever the next stage in this technological revolution, TV's role in American life is expected to grow. The average household operates its set six hours, 17 minutes a day, the latest Nielsen survey shows, and that figure is sure to rise. Not only will people watch more television, but the expanded choice of programming probably will have them watching it alone as each viewer finds a congenial show. This implies a continuing growth in sales of TV sets as typical households buy two or three rather than one.

The future of cable TV is uncertain for more reasons than the impending advances of satellite transmission. Capital-intensive and heavily regulated, the industry is likely to be affected greatly by turns in the economy and the outcome of current congressional consideration of communications legislation. However, one bet is sure: Alaskans interested in money could do worse than to jump into the tube business.

Examining dollars & dentists

Volunteer dentists who try to help in the bush have been blocked by rules that keep them out

by Bill Lazarus

Anchorage

While Aleuts suffer from a lack of basic dental care, state laws and the state dental board are blocking volunteer efforts to provide needed services.

Professors from reputable dental schools have volunteered to work on the Aleutian Chain for free. Fourth-year dentistry students working with the professors also have offered services, under a program developed by the Aleutian/Pribilof Islands Association.

But the program is floundering because the professors and students apparently can't get permits to practice from the Alaska Board of Dental Examiners. The dentist-dominated board is responsible for licensing dentists to work in the state.

"Professors aren't necessarily competent dentists," says Arthur Hansen, president of the dental board. He says the board is trying to protect Alaskans by insuring that only capable dentists practice in Alaska.

Officials at the Aleutian/Pribilof Islands Association, however, suspect an additional motivation: greed. They say the state board may view volunteer dentistry as undercutting private practice in the Bush.

Many private Alaska dentists contract with the U.S. Public Health Service to work in villages across Alaska. The work days tend to be long, but the pay is excellent. According to a small, random sample of 1978 health service data, individual earnings vary greatly, but on the average a dentist makes more than $1,00- a day while working in the Bush.

One health service official says that on a 10-day stay in Ft. Wainwright five years ago, Dr. Hansen earned some $22,000. Another official suggests the stay was probably 12 days.

Hansen says he doesn't recall how much he made, but he defends the figures. He says that since he worked double time in the village, he really worked about 20 normal days. That's a working month, he adds, pointing out that he makes more money in a month at his Fairbanks office. Generally, "I probably earn 25 percent le s when I go to the villages than when I go to my own office," he says.

Public Health Service officials say that Bush fees are essentially the same as the office fees, except that at times money is provided to pay travel and lodging expenses.

The Public Health Service also employs its own dentists to work in the Bush. Between this and the private contracting, health service officials say, most dental needs of Bush children are met. They admit, however, that in many villages basic care for adults is not provided, because the service does not have the money.

"All we're trying to do is to get dental care out to rural Alaska where it's not being provided," says Pat Pletnikoff, executive director of the Aleutian/Pribilof Islands Association. "Right now we're just right in the middle of a pissing match. We have two people who want to come up now (the chairman and assistant chairman of the children's dentistry department at the University of California Dental School at San Francisco) ...but we can't get the permits issued for them to come and practice in Alaska."

"There is no provision in the Alaska statutes to do what they are trying to do," says Hanson. He points out that only dentists licensed in other states—and not students—are legally able to o in special, one-year permits t work in Bush Alaska without going through the licensing procedure. (In states with dental schools, senior students are able to practice dentistry under supervision of a licensed dentist. But Alaska has no dental school and no such provision).

Besides, Hansen says, the Aleuts and their volunteers "haven't even made an attempt to apply for a permit."

The catch is that in December 1977 the board decided not to issue any more Bush permits. The one person holding a permit "had abused it," says board member John Beard. "He was practicing in an area that he wasn't supposed to be practicing in and he was doing bad work."

Other than obtaining a special permit, there are only two ways a dentist can legally practice in Alaska: he can pass an exam and gain a license from the dental board, or he can work for the Public Health Service. Federally employed dentists do not need to be lic sed by the state, but they c earn $30,000 a year.

Passing the licensing exam is no easy task. Although the test is supposed to be simple, 13 of 25 people who took it last year flunked. Eighteen of the would-be Alaska dentists were already licensed in other states, but nearly half of those practicing dentists failed the clinical portion of the exam, which is judged by the dental board. This test is given only once a year.

Hansen says it's "hard to answer" questions about why so many established dentists failed. He suggests that "we have far fewer (malpractice) problems in Alaska...I think this quality has come about because our standards may be a bit higher."

A legislative audit completed earlier this year looks at the situation differently.

"Presently there is a dental manpower shortage noted in several areas of Alaska. Board policies are restricting the entry of qualified dentists and are not in the public's best interests...

"The Board's clinical examination has several deficiencies...first noted several years ago...(which) have not been corrected," the audit report says.

The report also says no instances of "deliberate grading bias" were found. It notes, however, that "a potential conflict of interest...exists when Alaska Board members who are practicing dentists grade the performance of applicants who represent potential competition."

In a written response to the audit, Hansen maintains, "There is no conflict of interest in the grading system. This is a serious charge to make especially by a lay person regarding a profession he knows little or nothing about."

He also says no shortage of dentists exists and "adequate numbers" of dentists are willing to travel to the Bush.

Only four dentists live in Alaska rural areas with a total population approaching 60,000. Alaska has 260 dentists: 200 private practitioners, 28 military dentists and 32 with the Public Health Service. Although very few dentists live in the Bush, the dentist population ratio in Alaska beats the national average of one dentist for every 2,186 people.

In its own response to the legislative audit, the House Commerce Committee voted recently to put the dental board on two years probation and urged the board to make it easier for dentists to practice in the state. The committee opted to dismantle several professional boards under Alaska's "sunset" law, but a final decision awaits a full vote of the legislature.

Despite the legislative recommendation, Hansen says he is not certain he would support legislation allowing student dentists to work under their professors in Alaska. He also says he is not sure he would support issuing permits to the

[continued on page 16]

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Alaska news and tidbits from across the state

by Clifford John Groh, with staff reports

Anchorage:

Educational executives from Missoula, Miami and Buffalo are among the five finalists for the presidency of the University of Alaska.

The five were chosen from a list of 90 original candidates for a job that has turned over twice in the past two years.

Named as finalists by the university's Board of Regents were Jay Barton, vice-president and provost for academic affairs at West Virginia University; William Carlson, president of the University of Wyoming; Lawrence Pettit, former commissioner of higher education with the Montana University system; Albert Somit, executive vice-president and president of political science at State University of New York at Buffalo; and Clyde Wingfield, executive vice-president for academic affairs and provost, University of Miami.

The regents voted at a special meeting in Anchorage to bring the finalists to Alaska soon for a six-day look at the system.

UA President Foster Diebold will end his term by previous agreement early this summer.

Fairbanks:

The Fairbanks police union is suing to force reinstatement of six employees laid off by the city in an economy drive.

The Fairbanks Police Department Employees Association lawsuit charges that the layoffs of five patrolmen and a secretary violated the union's contract.

The suit, filed in state superior court, also complains that the city took the action without consulting the union or attempting to find another cost-cutting move that would avoid layoffs.

City Manager Bob Wolting said the layoffs were necessary to cut the police department's budget by $245,000, a move mandated by an ordinance passed last May that requires this year's city spending be held to last year's levels.

Wolting told the *Fairbanks Daily News-Miner* that nothing in the contract prevents reducing the police force.

Ketchikan:

The second of three unions striking the First City's pulp mill has settled on a contract and returned to work.

Members of the International Brotherhood of Electrical Workers have accepted a three-year pact with the Louisiana-Pacific mill. The new pact provides 15 members of the IBEW with terms similar to those earlier approved by the 40-member Union of Operating Engineers.

The IBEW contract provides for a 10 percent wage hike during the first year, retroactive to June 1, 1978, a 9 percent increase in the second year, and 8 percent in the third year.

Meanwhile, members of the Association of Western Pulp and Paper Workers, the 400-member union that has been striking since Sept. 15, said talks would not take place until later this month. The union said its representatives were tied up in other negotiations in Washington.

Shorts

[continued from page 8]

it all off while playing bagpipes, most participants at this Amateur Night forego any elaborate talent show. Constant cries of "Fluff that muff" from a juiced-up cross-section of GIs, tourists and run-of-the-mill locals appears to deter the nudeniks from doing much more than jiggling their flesh.

The crowds overlap at the "Wet Shorts" contest held at the other end of town, but the atmosphere is decidedly less sadistic than the scene at PJ's. Instead of a jeering, pressure-filled degradation ritual, every Monday night the Roadhouse puts on a raunchy version of a high-school popularity contest. In this "Splash for Cash" competition, well-formed young men go offstage to strip down to baby blue trunks with "WET SHORTS" imprinted on the back. (Women get their own chance for the $101 prize the next night, when the Muldoon tavern sponsors a "Wet T-Shirt" contest.)

When the men return to the dance floor that doubles as a stage, eager women with bottles of cold water spray the stretchy material until it clings tightly to the contestants' genitals.

The guys then do their stuff, dancing to the repetitive disco lyric, "Push, push in the bush." The most popular entrants are obvious—they garner not only cheers and applause, but also ice cubes and dollar bills stuffed down their flimsy undies by admiring women who approach from the audience.

Roadhouse manager Dennis Smith says the contest is judged by the announcer's reading of crowd reaction. No independent evaluators are used, he said, because, "They'd kill the judges."

Dentists

[continued from page 5]

dentistry professors who want to work with the Aleuts.

"I don't know whether we feel that we would have enough control over the situation...to insure quality work. In remote areas anything can go on and nobody's going to see it," he says. He adds that he is speaking for himself, not the board.

The predicament facing the Aleuts is not new. Last spring their association applied for a $200,000 state grant to buy a mobile dental clinic and to pay for the transportation and housing of volunteer dental students and professors. Representatives of the Alaska Dental Association unsuccessfully lobbied against the proposal.

Then last summer, in conjunction with the proposal, a group of four professors, six dental students and four dental hygienists came from California to work on the Pribilof Islands. But because of licensing problems, the group spent about 10 days in Anchorage doing nothing.

"They forced (the volunteer program) on people...They never cleared it through normal channels," says Hansen.

Jim Milne, a consultant for the Aleuts, admits the association had not applied to the dental board for special permits for the volunteers. He says the association decided to work through the Public Health Service after learning that the board had decided not to issue any permits. As volunteers for the federal government, the professors and students would not need approval from the state board.

Milne says the Public Health Service earlier agreed to take the volunteers under its wing, but later balked. Only after pressure was applied in Washington, D.C., he says, did the service agree to accept the volunteers, who then left Anchorage and spend about two and a half weeks treating 220 islanders.

Dr. John Stolpe, chief of dentistry for Public Health Service in Alaska, says the service did not flip-flop on the matter. He says the Aleuts approached the service about the matter only shortly before the volunteers arrived in Alaska.

Whatever the case, the health service now says it won't accept the dental volunteers.

According to Stolpe, who worked with the volunteers last summer, the problem is not the quality of the service. "From a technical standpoint, I found their services to be totally satisfactory...They are a young, enthusiastic group of people. They established a very good rapport with people in the (Pribilof) community...I enjoyed working with them. I thought they were sincere and worked quite hard," he says.

But Stolpe says if the Public Health Service takes the volunteers, it will be in charge of the program. Instead, he says, it's better for the Aleutian/Pribilof Islands Association to keep control of the program and to obtain permits from the dental board.

Stolpe also says some paperwork requirements have not been met by the association and that, despite the volunteer help, the program cost more than the services provided.

Milne says the volunteer program saved money. He charges that the Public Health Service is just responding to pressures from Alaska dentists not to take the volunteers.

In light of the recent legislative recommendations, Milne says the association now will apply to the dental board for a temporary Bush permit for the volunteer dentists. He says it doesn't make sense for a dentist who might work here for only part of one summer, to go through the cost and burden of taking the licensing examination.

Even if application is made, the outlook doesn't look good for issuance of the permits.

The legislative audit itself criticizes the "double standard" of allowing unlicensed dentists to work under special permit in the Bush but not in urban areas. It recommends that either the permit system be done away with (and licensing made easier) or that it be applied statewide.

In his audit response, Hansen says the dental board recommends the permit system be eliminated. He says the board is studying the possibility of reciprocal license agreements with other states but suggests it is likely to recommend that it judge some applicants on the basis of their credentials. This would "allow for close Board scrutiny of an applicant, thus assuring the same degree of quality," he says.

Board member John F. Kobylarz, a Soldotna dentist, disagrees with the primary recommendation of the audit. "Nowhere in (Alaska law)...is the Board charged with encouraging dentists to practice in Alaska. I think the State in its powers should protect the consumer, not try to coddle the citizen from birth to death," he writes.

The dental board is made up of five dentists, one dental hygienist and one person not associated with the dental profession, a mix Hansen claims "adequately represents the public interest."

John Beard, the one public member of the board, says licensing is "protectionist" and the board ought to be dismantled. An Anchorage lawyer with Libertarian leanings, Beard suggests that judging of dentists should be left to the marketplace and that even graduation from dental school should not be required to practice dentistry in Alaska.

Jana Varrati, a dental hygienist on the baord, has a more traditional point of view. She says she understands why the public might view the dental board as protecting the state's dentists from competition. But, she insists, the state exam is necessary. "Come to the next clinical dental examination. I think you would have your eyes opened. Just having a certificate from a dental school does not mean that you are competent," she says.

Varrati questions the wisdom of allowing students and professors to practice in Alaska. "Let them come up and take the board (exam)," she says. "I don't think we have remarkably high standards...We have one of the simpler exams...I wouldn't like to see someone who failed practice in the state."

"Either something is wrong with the dental schools or we have the best dental program in the entire world. I have the feeling that (the high failure rate) is related to the economics of competition," says Bob Worl, who served as health director of the North Slope Borough for three years.

Alaska dentists, he says, have volunteered work in the Bush and "it's very tough to say it's all black or white in terms of altruism or the economics involved. It's a real mixed bag."

However, taking a broad perspective, he says, "The problem is that the system is set up so that a guy is a fool if he doesn't make a killing."

ALASKA STATE LEGISLATURE

Legislative Affairs Agency
Pouch Y - State Capitol
Juneau, Alaska 99811

REGIONAL INFORMATION OFFICE
1024 West 6th Avenue
Anchorage, Alaska
99501
(907) 278-3668

Enclosed for your information and files are materials relating to the teleconference on HB 401 held March 29, 1979, including a copy of the witness and observer list.

Judy Hopkins
Anchorage Moderator

LAA 11
(Rev. 4-29-77 M)

TELECONFERENCE HEARINGS

TOPIC: HB 401 - exempting certain persons practicing dentistry and dental hygiene from licensing requirements

COMMITTEE: House HESS (Buchholdt)

DATE: Thursday, March 29, 1979 (DATE SCHEDULED: 3/28/79)

TIME: 11 - 12:30 A.S.T.

SITES PARTICIPATING: Anchorage, Fairbanks, Ketchikan, Nome

CONFERENCE MODE: audio LOCATION: LIO MODERATOR: Hopkins

NOTES:

expect: Josh Wright - Jnu
Dr. Hanson - Fbx
Dr. Redmond - Jnu

How about Jana? Claudia will advise.
Jana will be in Juneau.

PUBLICITY:

x INVITATIONAL

x Committee making contacts

___ PSAs ___ (date) ___ (quantity)

___ News release ___ (date) ___ (quantity)

___ Summary to be provided
___ Text to be provided
___ Quotes to be provided

___ Direct mail ___ (date) ___ (quantity)

___ Phone ___ (date) ___ (quantity)

x Posted at Information Office

TELECONFERENCE STARTED 11:10 am

TELECONFERENCE ENDED 1:00 pm

WITNESSES		ATTENDANCE
OBSERVERS	7	
TOTAL	7	

(2 [illegible] [illegible] to [illegible], [illegible] [illegible] [illegible] [illegible])

Legislative Information Office . 1024 West Sixth Avenue . Anchorage . phone 278-3668

Name Ralph Eluska Here to TESTIFY ____

Representing APIA Inc

Mailing Address 1689 C St Zip 99504 Here to OBSERVE ✓

Phone 276-2700

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Ralph J Eluska
(signature)

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Name Mike Delmont Here to TESTIFY ____

Representing A.P.I.A.

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Phone 276-2700

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Name GERALD M. STRANIK DDS. Here to TESTIFY

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Name Michael A. Martin Here to TESTIFY ___

Representing Aleutian/Pribilof Islands Assoc.

Mailing Address 1689 C St. Anch. Zip 99501 Here to OBSERVE X

Phone 276-2700

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Name Anthony Philemonoff Here to TESTIFY ___

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Name N. Fredenberg Here to TESTIFY X

Representing self

Mailing Address 121 W. Fireweed Zip 99503 Here to OBSERVE ____

Phone 278-4665

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N. Fredenberg
(signature)

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How did you learn about this hearing?

____

Would you have participated in this hearing if the network were not available? ____

If yes, did you use the network:
X instead of travel
__ instead of phone conversations
__ instead of mailed testimony

Date: 3/29/79 Subject: HB 401 Location: Anchorage

Name	Address	Organization	Bill No.
Pat Pietnikoff	1689 'C' St. Anch. AK	Aleutian / Pribilof Islands Assoc.	# 401
Lorsann Beecler	SRD, Box 48-A, Anchorage 99507	Alaska State Dental Hygienists Assn.	401
Jane Vassati	7030 Foothill Dr Anchorage	Alaska Health Coalition	401
Wayne Putman	RR 5 Box 5107 Juneau 99504	Alaska Board of Dental Examiners	401
Elizabeth Mekrarian	Pouch HOS	Department of Health & Social Services	130
David O. Osterback	Box 144 Sand Point, Ak	Ak Penn. Marketing Assoc.	401
Thomas. S. Redmind	3606 Rhone Cir. Anch. AK.	AK. Dental Society	401
Joshua J. Wright	3401 Denali, Anch, AK	" " "	401

Pat Pletnikoff - Ex. Director

Says the program was working last summer on Pribilof Island - was very cost effective. They took care of everyone's teeth.

Problem: they're trying to modify the regulations - change the statutes so that they can bring practitioners from out-of-state. These people are volunteers. Pat says this program has been implemented in California, Isreal & Greece. People donate their services. The Board of Examiners (dental) & local practitioners aren't going for it. They feel threatened economically.

Aleut Corp. wants 1 yr. temporary permits (would rather have permanent) so that they can continue the program.

Spec. approp. DHSS
Mobile Dental Clinic
HB-728 — SB-466

Was funded. Aleut Corp. received funds. Was put in Free Conference Committee.
Pat Pletnikoff - asked for funds.
278-3567

Dept. Health & S.S. 6-2700
Dr. Robert Fraser - Div. Public Health (3090)
Sam Granato - Div. S.S. - 3170

Lowell Swartz - 3015 acct.

$300,000 - last year
Supposed to be down Friday.
Dick Reniger — discussed matter of change in Contractional Agreement & Auditor problems.
Made Recom. to Commissioner deals w/ how to apply grant.
Intended for Capital Construction only. Used for operational activities
Negotiated contract Aug. '78 allowed only for purchase & Equipping - Want alteration of agreement.
Have equipment.

Pat { No scheduled meetings - modifications of regulations 16th Jan. Emery Johnson

H — Problem - bringing practitioners from out of state. Volunteers not being paid.

{ Ak. has no reciprocal agreement
{ 1 yr. temporary permits.

Aleutian Pribilof Island Assoc.

Jim Milme
ApIA 1689 'C' St.
Anch 99501

Al. Island Assoc.

APIE

3 Anch. Dentists

call Dr. McGinnis —
Dept H & SS All

Ralph Eluska

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

March 22, 1979

Dr. Jim Milme
APIA
1689 "C" Street
Anchorage, Alaska 99501

Dear Jim:

Enclosed you will find two copies of Rep. Osterback's bill on dentistry.

I have just spoken with Rep. Osterback and he was wondering if you were planning to come down to testify on this bill, or planning to send down any written information as back up. I told him I did not know. You might want to call him at his office: 465-3715.

Thanks for calling.

Sincerely,

Cynthia L. Hill

CYNTHIA L. HILL for
THELMA BUCHHOLDT
Chairman
House HESS Committee

Enclosure

3/8/80

HB 401

CHESTER VALLEY ANIMAL HOSPITAL
1571 MULDOON ROAD
ANCHORAGE, ALASKA 99504
(907) 333-6591

Dear Members of House HESS;

I would like to express my support for the Dental Board in their endorsement of the concept of "licensure by endorsement".

I am familiar with this type of licensure thru the veterinary licensure system. We have a similar provision in our practice act whereby a veterinarian can become licensed by providing proof of licensure in another state of the U.S. having license requirements substantially similar to the Alaska requirements, and also providing proof of having been an active practitioner for at least 5 of the last 7 years.

To me this is an effective method allowing experienced candidates to be readily licensed. To my knowledge this provision has not been abused in the veterinary field.

I think it is important that the law read "has practiced for 5 of the last 7 years." This avoids blanket licensure of candidates who have 5 years of practice time but who may not have practiced in the last 10 years and thus would be out of date.

Please let me know if I can be of service.

Sincerely,

Jon Thomas, DVM

10

MEDIOCRITY A SUBSTITUTE FOR QUALITY?*

Gentlemen, here in my hands I hold some recent news releases and editorials referring to the current problem of defective, substandard merchandise and services as well as the prevalent trend of ignoring the basic fundamental requirements for character.

Let me take time to read one or two.

Under the headline, "Apparel Industry Feeling Pinch of Defective Goods," we read that "Industry officials attribute the problem to a chain of failures that stretches from the fabric mill at one end through the dyeing and finishing industry and the garment maker to the retail shop."

Here is another. The U. S. Chamber of Commerce Chief, Winton M. Blount, warns of "A rising tide of consumer dissatisfaction with shoddy merchandise and services and with advertising and merchandising techniques will result in increasing government restraints unless businesses learn to police themselves."

From an editorial in the Texaco Star, I read the following: "Those suspected of violating the basic tenets of loyalty, honesty and ethics have been prosecuted to the fullest extent of the law." "There have been those who have criticized such a policy on the basis that 'permissiveness' is rampant in our society, and that such wrongdoing should be dismissed or treated lightly as simply a sign of the times."

We are all aware of the number of new model automobiles with defective parts that had to be recalled by the factories in the last two or three years.

Now, let me read you the conclusion of a survey made by D. L. Moore and J. L. Stewart and published in the Journal of Prosthetic Dentistry, April, 1967, under the title "Prevalence of Defective Dental Restorations."

"More than one-third of the operative effort was consumed in replacing defective restorations."

What does this mean? It means that no business today is immune to the philosophical disease of "Acceptable Mediocrity" which has us all writhing with the fear and fever of a full scale epidemic. It means that dentistry too has been caught up in the fearful tide.

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*Presented by Roy A. Fetterman, D. D. S. at the Eighty-fifth Annual Meeting of the American Association of Dental Examiners, October 25-26, 1968, Miami Beach, Florida.

It means that we, the public, which is complaining about the defective goods and below-standard services, is that same public producing the defective goods and below-standard services. It is time we the public start the cure for this debilitating disease before we become so weak we cannot stand. The prevention for this disease is no mystery. It is a three part vaccine called "Basic tenets of Loyalty, Honesty and Ethics." For some strange reason, man has, over the centuries, fought the use of this vaccine with more vigor than he has the use of fluorine in his water.

Because of the public complaints of the misuse of the fee scale by many of our profession in conjunction with a flagrant lack of ethics and poor services, the affairs of our profession and its services are gradually slipping from the hands of those most qualified with dental knowledge to handle them and into the hands and control of political arsonists. Unfortunately, the public hears little of the ethical sincere members of our profession.

> "The evil that men do lives afterthem;
> The good is oft interred with their bones;"

So said Anthony at the funeral of Caesar.

It behooves these sincere and loyal members of the profession to seriously start a cure for those among us who are affected by the disease of "Acceptable or Permissive Mediocrity." In addition, we need the development of some sound preventive program aimed at those not yet infected as well as the students soon to join our ranks.

But first, we must each put our own professional house in order lest we be not qualified to judge another.

With all honesty and sincerity, I wish to say that I consider this opportunity to speak to you today as a singular honor, for you gentlemen are looked upon by the rest of the members of the profession, as well as by a large segment of the balance of the populace, as the ultimate in dental wisdom, dental ability and dental ethics. You are the supreme court of the Dental Profession.

Upon your shoulders rests the responsibility of judging whether or not our dental schools have properly prepared a man to represent our profession. Upon your shoulders rests the responsibility of deciding whether or not these graduates will be of service to the public. You, gentlemen, are the highest tribunal of a fairly new and very necessary profession.

If I should trod upon the toes of an individual or a school, I say "If the shoe fits, put it on." I have nothing to gain politically nor financially by this appearance before you. I seek only help from the members of our profession to restrengthen the foundations upon which our profession has been based; to shore up the walls which have been weakened by the philosophies of speed and mediocrity; and restore the roof of dedication to dentistry and its service to mankind.

I feel it is reasonable to expect to find all the categories of dental education amalgamed into a harmonious and efficient medium of services offered the public by honest and enthusiastic men loyal to their profession as well as to their patients, offering the best services their ability and dental training can produce. This is our Ideal. The target is perfection which seems always just a little out of range. We must keep our sights upon it lest it slip from view over the horizon. We must keep this idea on the horizon and encourage our young people, as part of their training, to push on towards it. Enthusiasm and hope for the future will be their motivation and only we, by our example, can give them this.

I have many thoughts on the subject of our young people as who does not, so many ideas for improvements I feel could be beneficial in the teaching programs for those we are preparing to send out to practice dentistry, but of course time today does not permit me to say all I wish to say on this subject. Sufficient time will be used if I do as it was suggested that I do and give you my evaluation of the average Dental graduate in Operative Dentistry; his attitude, ability and training as based upon my experiences teaching failing senior students and men who have been unable to pass the California State Board.

Several years ago, I had the responsibility and rewarding experience of diagnosing and correcting the problems of seniors of U.S.C. Dental School who were in danger of not graduating because of their weaknesses in Operative Dentistry. It was here with my "Goon Squads " as the members affectionately called themselves, that I acquired the nickname, "Whispering Roy."

This experience became the foundation upon which I later based my instruction for the refresher course I have taught for the last nine years. This course, which is offered by the University of California Extension Division, is held twice a year for nine weeks in the spring and nine weeks in the fall, and the classes average from 10 to 20 students.

Over the last nine years, I have instructed 285 men. These men have ranged in age from 24 to 68 years and their graduating dates have ranged from 1924 to 1967. They represent 44 schools of the United States, Canada and Europe. Among them are OKU men, members of the Dean's list and of the specialities. Some have failed the California Board once, some twice, or even more. Some come for help before even attempting to take the Board.

All of these men and women, including those of my goon squads, suffered from the same thing, the lack of knowledge of the Basic Fundamental Principles of Cavity Preparation.

Those who fail the board have a long list of reasons why they failed the operative portion but not one of which even suggests that it was because of their lack of knowledge on this subject.

In 1961, I had the honor of being asked to audit the California Board and I can honestly say that the complaints of discrimination of school or race can be dismissed. I agree that a man who has been practicing one of the specialties for years and then attempts to take an operative exam is going to have difficulties and a man unaccustomed to doing foils is going to have a tough time putting in a foil, and I'll not argue that it is possible to have a bad break, a bad patient or a bad cavity, etc. on any examination, but these are the exceptions.

After observing silently, by request, for a whole day, I agree wholeheartedly with the board member who said to me, "We do not fail these men, they fail themselves." It was obvious here. So many lacking the knowledge of these important Basic Fundamentals and the ability to apply them properly.

Nine years ago, with no other magic than the desire to share the best of what I had learned in school and, in subsequent years, from men such as Ernie Jones, George Hollenbeck and Dave Shoeshone; as charter members and director of the Jones Gold Foil Study Club of U.S.C.; 25 of the last 33 years on the staff at U.S.C.; many years of association with Dr. Rex Ingraham; many years of practical experience and Rex Ingraham's Atlas of Gold Foil and Rubber Dam Procecures, I set to work. I know I had my work cut out for me because I was expected to teach these men in nine days of instruction what they had missed along the road of four years in dental school or had forgotten in years of practice. Teach them enough to enable them to pass the board.

To me, however, just trying to teach them enough to pass the board seemed as futile an effort as that made by the hunter just shooting at the spot on the

hill where the four point buck stood before he vanished over the horizon.

I'm not "Whispering Roy" any more. I'm now the "Ogre," but at the end of the course they almost all tell me they learned more in nine weeks about Operative Procedures than they did in four years of dental school. I sincerely hope I have sent each on his way with the word Operative Dentistry wrapped and tied securely with enthusiasm and quality.

Of the 17 classes, only two have passed 100% on the first try. The remaining classes have averaged about 85% passage of the board on the first try following the refresher course. Most pass it on the second try. I say most because there are some I never hear from after their completion of the course.

My first class was rather a flub since I had no one with whom to confer on a course of teaching, but it was not long before I was quite aware of the needs of these men. At the end of the class, some of the men said they did not think they had improved too much, in fact they did not think they were too bad to start with. I had to find some way to measure their improvement, so I started a procedure with the fourth class which I have continued to this time.

Each student is asked to prepare a Cl. II on the distal of the upper right second bicuspid on his typodont and bring it to class the first evening. Before I start to lecture, I collect and keep these prepared teeth until the end of the course, at which time each man makes another preparation and turns it in.

The operative shortcomings of these men I feel can pretty well represent those of many others as well and help to explain why so many of us spend a large percentage of our operative time doing over work at the expense and comfort of the patient, to say nothing of the time wasted for both dentist and patient.

No doubt you wonder why I teach only the Cl. II in a bicuspid. Nine teaching days is not enough time to make finished operators on all types of preparations. With minor modifications, the Gold Foil preparation becomes an alloy preparation. Then, too, I must remember that most of these men are primarily interested, when they come, in learning just enough to pass the board. Concentrating on one preparation seems to be the answer.

Before I show you my slides of these prepared teeth, let us refresh our memories on the definition of a cavity preparation from the book entitled

"Operative Dentistry" by G. V. Black, the acknowledged "granddad" of Operative Procedures.

"The mechanical treatment of the injuries to the teeth produced by dental caries as will best fit the remaining part of the tooth to receive a filling, restoring original form, giving it strength, and preventing recurrence of decay in the same surface."

Now let us have a little review of the seven fundamental principles that are general to the "mechanical treatment of the injuries of teeth produced by dental caries."

1. Outline Form. This may be defined as the form of the area of the tooth surface to be included within the outline or enamel margins of the finished cavity. This would include all pits and fissures on the occlusal surface.

   On proximal cavities, this means that the whole of the habitually unclean areas should be included within the outline of the cavity. This will often require that sound enamel and dentine be cut away to obtain correct outline form and is known as extension for prevention of the recurrence of the decay.

2. Resistance Form. This is that shape given to a cavity intended to afford such a seat for the filling as will best enable it to withstand the stress brought upon it by mastication. The resistance form consists of a flat seat for the filling, cut at right angles with the long axis of the tooth. In proximo-occlusal cavities the gingival wall of the proximal portion is cut flat and in the horizontal plane with definite angles. The step is also given a flat horizontal seat.

3. Retention Form. This is the provision for preventing the filling from being displaced. A large part of this is provided for by the Resistance Form, but it is further required that provision be made that will prevent the filling from being thrown out of the cavity by such lateral or tipping force as may be brought against it. This is accomplished by making the occlusal step in the form of a dove tail, and by shaping certain of the opposing walls that they will be strictly parallel or slightly undercut.

4. Convenience Form. This may require certain modifications in the general form of the cavity to render the form more convenient for placing the filling material.

   A second order of convenience form consists of sharpening the internal line and point angles. These are necessary for starting gold foil and assist in starting and securing the first portions of an alloy filling.

5. Remove remaining carious decay.

6. Finish the enamel wall.

7. Make the toilet of the cavity.

Now, let us look at the "before and after" pictures and see if you agree with me when I say the men who made the preparations did not understand the rules we just finished reviewing.

First, I will show slides of my class of November 1961 and those teeth with red dots represent the work of students who graduated from dental school in June, 1961.

(show slides)

By 1967, the California State Board approved the Cl. V restoration as an acceptable Gold Foil procedure, so now I have them cut a Cl. V as well as a Cl. II before class starts. In the fall of 1967 and the spring of 1968, I had 31 students in my two classes and there were 12 1967 graduates in this group. I would like to show you slides of the work of these 1967 graduates and see if you agree with me in my contention that they are no better operators than the 1961 students.

(show slides)

Some of you gentlemen passed these men when they took the board in your state.

Just for emphasis, let me enumerate a few of the major problems which beset these men:

1. Cutting the cavity square in the tooth.

2. Getting the gingival seats flat and at right angles to the long axis of the tooth.

3. Recognizing the proper buccal and lingual extension.

4. Recognizing decay.

5. Recognizing the difference between dentine and enamel.

6. Visualizing the finished preparation in advance.

There are other problems too, some of which are particular to individuals and others general to all.

1. Do not know how to sharpen hand instruments.

2. Lack complete knowledge of Finger Rest Position.

3. Have no understanding of the names of the hand instruments as they relate to their use.

4. One 1962 graduate had never prepared a MOD alloy. (It took him five hours to prepare and fill his first cavity for my course.)

5. Lack of knowledge of the use of and practice of using rubber dam.

6. Double jointed men have great difficulty holding and controlling handpiece and hand instruments.

7. One student had been practicing for 23 years and had never used a hand instrument.

8. One student was using the palm thumb grasp on his contra-angle trying to prepare an upper tooth.

At the opening of this paper, I made mention of a report on a survey made by D. L. Moore and J. L. Stewart on the "Prevalence of Defective Dental Restorations." In the same article was also the result of a similar survey made in 1936 by P. J. Brekhus and printed under the title, "Your Teeth" and published by the University of Minnesota Press. These two reports suggest that there has been no improvement in the failure rate of restorations in the last thirty years.

In other words, the percentage of [illegible] operators has remained about static be they past or recent graduates in spite of the high speed handpieces, visual aids, closed circuit T. V., four-handed dentistry, etc.

I believe that my findings from teaching my refresher course might well be used to contribute evidence to this fact.

Now I submit to you my evaluation of the recent graduates, as well as all the others whom I have taught the operative portion of the Refresher Course in Dentistry offered by the University of California Extension Division during the 1960-1968 period.

They are inadequately prepared with an understanding of the basic Fundamental Principles of Operative Dentistry and insufficiently trained in the application of these principles. In addition, I feel that the lack of demonstrative pride in the profession made manifest by many instructors in addition to their permissive attitude toward the students have combined with the weak training to produce too many dentists who substitute Mediocrity for Quality either by accident or intent.

Before I move on to suggested teaching procedures which I feel could help to take better advantage of the potential of each student, I wish to enumerate a few complaints of recent graduates.

1. Some schools issue hand instruments which are too large and cumbersome.

2. Students resent smart and irrelevant remarks made by instructors.

3. Several said they had received the lectures on the basic principles but no one had insisted they produce them on the clinic floor.

4. One student had been an instructor in the operative department of an Eastern school for two years and was told by the head of the department that they do not use Rex Ingraham's book because it just can't be done the way Rex says it should be done.

5. All recent graduates complain they do not get enough help from the instructors.

6. Lack of interest in the student, especially in the freshman and sophomore years. Seem to resent interruptions by students.

Would you care to guess what pertinent question is often asked me? "Can the State Board examiners do what they ask of the students?" Can you, gentlemen? Are you qualified to judge whether or not a man knows the basic principles of Operative Dentistry or are you just someone's political favorite for the appointment? These are the frank questions asked by our young people and, in many cases, for good reason.

Now that we have aired the shortcomings and complaints of the members of our profession and those about to become a part of the profession, let us turn our thoughts to how we can begin to correct these problems. How are we going to improve our service to our students so that they, upon graduation, can more efficiently fulfill their social obligations to the public?

I believe that our dental education, like the garment industry, will often find that the cause of the defective merchandise, in this case the poor dentist, began back at the "fabric mill" so to speak. Inasmuch as we cannot return the poor graduate for a refund, we are stuck with him and, only too often, his practicing of the 8th Fundamental of Cavity Preparation or the "Stickum Form" as this technique is so aptly named by my good friend and fellow teacher, Dr. Rene Eidson. In case some of you are not familiar with this form, here is the recipe. Take one large burr, use it sparingly and stickum full of filling material.

It would seem, then, that we should be more critical of our selection of students.

Right now, I wish to make it clear that I am not overlooking the fact that there are two branches of dentistry - the medical and the mechanical. In spite of the current practice of de-emphasizing the mechanics of dentistry even to the point of speaking of us as "dental physicians" just as though there is some kind of stigma connected with being a mechanic or engineer, I still say that dentistry is primarily a mechanical profession, In the same breath, I might add that I feel that a fine surgeon doing transplants is a mechanic also.

However, regardless of the present philosophy, the fact remains that most dental practitioners spend the greatest amount of their time doing Restorative Dentistry. If you remember Black says, in his definition of a Cavity Preparation, "The mechanical treatment of. . . . " etc.

So, since we now know th . the graduate dentist is going to spend most of his time doing operati , which is a mechanical procedure, then logically the candidate for dental school should be selected on his mechanical interests

and experience as well as scholastic standing. Did he ever have a Hot Rod to keep running? Has he had any art, mechanical drawing, machine shop or wood shop? I would choose a man with a lower grade average but who had enthusiasm for the profession and a background in some mechanical skills over a man with high academic scholastic record but no background of any mechanical training.

Only one man in my last class of twenty knew what I was talking about when I suggested that each one should look upon his hand and the handpiece it holds as a "milling machine."

Another point which I wish to make on the selection of these students is a closer check on the useability of the hands. Some of my students seemed to be having great difficulty in developing good control of their instruments and I discovered that these men are double jointed. Their knowledge of the subject was adequate but their attempts at applying this knowledge was very frustrating to them. I have devised a very simple test to determine whether or not this condition is present in a candidate. If it is, I feel he should be advised of it and warned of the difficulties which lie ahead. Perhaps consultation as to entering one of the less mechanical specialty fields after graduation might be considered as beneficial to the man as well as the public and the profession.

What good is the theory if you cannot put it into practice?

Another point I feel very strongly about is that teachers should have that long lost "right" to "flunk" a student restored to them. The instructor working with the student is the one most likely to know his strengths and weaknesses, not the head of the department nor the Dean. There is nothing but good to be gained by repetition of an operation, a course, a semester or a year.

The new concept of teaching operative by preparing an area in a tooth in the typodont once and then going right to the mouth of a patient is a frightening thought to me. One of the schools which teaches this theory graduated its first class this year. I have one of the students enrolled in my fall class at this moment. It will be most interesting to observe this graduate work. How will he compare with the 196[illegible] graduate who had never put in a MOD alloy? It took him five hours to make and fill his first preparation in my class.

I feel there should be a national re-evaluation of the teaching staffs of our dental schools. True, the dental education program is also suffering from

a shortage of teachers so it is than all the more important that each one be performing to his or her maximum performance. This then means teaching the teacher to teach. Faculty study groups taught by someone from another section of the nation, such as UCLA is now doing, could be a great help in standardizing the instruction in our dental schools throughout the nation.

With few exceptions, in my opinion, the average graduate student is not qualified to go right into teaching on the operative floor. He lacks the experience of solving problems that arise that do not look like those pictured in the book. An instructor should be able to quickly appraise a preparation or filling, or whatever, and aid the student in making any corrections necessary. If the instructor is a recent graduate, he is likely to teach students the same mistakes he is making, as indeed of course any other instructor is likely to do.

A teacher must be flexible, creative and enthusiastic and be aware that the methods to teach some students will not work on others. The trick is to find out why some are not doing well and correct the cause. This takes time, of course, but results are usually gratifying to student, teacher, educational institution and the public.

Too often, I have found that my students do not see or understand the relationship of an instrument to its use. For instance - the pulling action of the hoe or the chopping action of the hatchet, etc. So often we who know these things so well forget to pass these seemingly unimportant bits of information on to our students. A recent letter from my nephew who is a sophomore at one of the dental schools advises me, "the amount you taught me really put me ahead. We received an instrument case this year chucked full of stuff. They (the other students) have no idea what that stuff is. Here we are rolling into the third week and they are really having a time of it."

During the ADA meeting in Dallas, I had about a dozen senior students ask me what I mean by hollow grinding a gold knife. I reciprocated with a question. How many of them knew the difference between a splitting axe and a chopping axe. Not one did. The difference between these two axes are mechanical necessities for improving the ease and efficiency of their use for a specific job.

To know terms but not their meanings is like reciting the Lord's Prayer and not understanding the meaning of the words.

Almost all of my students have been unable to sharpen their hand instruments. If a man cannot sharpen his own insturments, I feel he is truly handicapped. How often as I work I step into my lab to sharpen up the edge of a chisel or a hoe or of what have you. You can't work with dull instruments - which brings up a point. I have found that many of my operators do not know that part of their difficulties in cavity preparation are the result of dull instruments. Some have told me they used the same instruments for the two years in school without having to sharpen them.

A real puzzler is the lack of understanding of the Finger Rest Position. Recently, I asked instructors from U.S.C., U.C.L.A. and Loma Linda if they teach Finger Rest Position, per se, and their answers were all the same. No. They say they assume that anyone who can hold a pen or a pencil can hold a handpiece. I feel that in teaching there is no room for assumption except for the assumption that the student knows nothing about the subject or portion of the subject you plan to teach him.

One day, I observed a student using the palm thumb grasp on his contra-angle handpiece preparing an upper tooth. When I suggested he try the pen grasp he said he never had. Before he completed the course, he made the change and commented on how much easier it was to use a handpiece properly. An alert and interested instructor should have corrected this for him years ago.

Unfamiliarity with the use of the rubber dam is a very serious problem. I found one of my students, a recent graduate, struggling with a rubber dam which kept buckling over the tooth he was trying to work on. He could not recognize his problem which was simply that he had put the dam to place and then turned it a quarter of a turn, thus placing the top and bottom of the dam to the sides. Try it some time. You'll have a hell-of-a-time working on the tooth.

I have been told by many of my students that they were never made to use the rubber dam.. My experiences with these students does much to substantiate a report by Dr. Robert E. Going entitled "Study Finds GP's Avoid Rubber Dam Technique." This report in turn confirms an earlier observation by Dr. Leon Ireland that "probably no other technique, treatment or instrument used in dentistry is so universally accepted and advocated by the recognized authorities and so universally ignored by the practicing dentists."

From the same article just referred to, Dr. Going states "Frequently,

the student's concepts relate entirely to the instructor's enthusiasm for or against the procedure. The quantity and quality of teaching the technique varies greatly among schools and among individual instructors within schools."

On these findings, then, we might surmise that in spite of all their weak excuses for not using rubber dam, the real reason so many men to not is becuase they were never thoroughly convinced by their instructors of the true importance of its use. This, then, brings us to one of the complaints of many of my students. They would like to have had more explanation and help from the instructors. They feel they waste time having to find out too many things by themselves. At one school, it is assumed that the seniors know all there is to know and that the instructor's role is only to act as a checker.

There is nothing that irritates an elder more than a smart-aieck younster. If you are one of these irritated elders, just don't forget that that smart-aleck youngster learned his "smartness" from some smart-aleck adult. I find that many of my students have remarked about senseless smart-remarks made by an instructor on a serious subject. The student in question asked the instructor to check his cavity preparation which the instructor did, punctuating his observation with the remark, "It looks like a chicken with its head cut off." The student said this left no doubt in his mind that the cavity was bad but he was not told how to correct it.

All I have said this afternoon adds up to a need. A need for more carefully selected students and better prepared instructors with a more uniform teaching program on a national basis. A staunch stand by our state boards against the lowering of their standards, no matter how much the political pressure piles up, is needed.

When I was going to dental school 36 years ago, all that was required for entrance was a "C" average and $300.00. In fact, the $300.00 was of more importance than the "C." U.S.C. Dental School had "Little Caesar" as we called Dean Louie Ford. We feared him, made snide remarks about him behind his back, but held him in awe and respected him as being the man at the helm. On the scene as part of his crew, either full time or part time, to prod us, coerce us and inspire us were men like Ernie Jones, George Hollenbeck, Don Smith, Jim Hickson, Doug Dyer, and others. These men were our idols and they were all men of experience and able to practice what they preached. They were unwavering in their belief in the truth of the importance of the fundamentals as the foundation for future improvements in techniques.

Most of you know I am a member of The American Academy of Gold Foil Operators and, naturally, a great advocate of foils. I am aware that the subject of Gold Foils is treated very lightly by many of the dental schools and this grieves me. I am in firm agreement with the philosophy of Ernie Jones which is that doing Gold Foil work is one of the best dental exercises there is for a dentist.

For foil to be a success, strict attention to the application of the fundamentals is an absolute must. This is not so of many other filling materials we use. It was his contention that the good habits formed in doing foil work would carry over into all other fields of the profession.

One of the currently stressed concepts of education today is that of "Continuing Education." Of course, this is nothing new but just being stressed anew. G. V. Black once said, "The professional man has no right to be other than a continuous student." Percy T. Phillips also made a similar statement when he said, "To protect the quality of dental service, the professional man must be a lifelong student of dental science and dental technology. His education must never stop."

Unfortunately, the type of continuing education in which the average dentist is most interested today is some new technique - a way to do it faster, easier, so he can make more money at it. Often the glamour of a new slant on an old subject influences us at the expense of attention to the underlying principles upon which these new concepts are based. I am in favor of continuing education 100%, but I feel we are terribly in need for some Continuing Review as a part of the program.

No matter how many new concepts there may be on the subject of castings, alloys, endontia, etc., the basic principles remain the same. For the new alloys or the improved castings to be successful, the underlying preparation of the tooth must be right. The basic concept of root canals has not changed; the opening of the canal, its reaming out, sterilization and the filling clear to the apex. The new medicaments have undoubtedly been a wonderful aid, especially to the careless operator. Without a thorough understanding of the old and proven knowledge, one cannot well understand and apply the new.

Many of these courses in new techniques in Operative presuppose that the operator knows how to make a proper cavity preparation, but from my observation of the recent graduates as well as men who have been in practice and I have taught in my refresher course, this is far from being a fact. Ask a lab man about the quality of the preparations sent to him - the finish

lines and tapers - the quality of impressions.

It grieves me greatly to see the pressures, political and otherwise, our boards are currently experiencing on the subjects of Reciprocity, changing of the Dental Practice Act, and licensing of Lesser Trained Personnel.

I feel that total reciprocity would be disastrous. No serious thought is needed to foresee what would happen if this were to take place. There would be a mad move of practitioners into the western states - the supposed land of "milk and honey," where the action and the money is, leaving less desirable areas devoid of dental care. Soon, some other kind of control or distribution of practitioners would be initiated and my guess is it would be Federal control. That would be one more step down the road away from the control of our own lives and of that of our profession.

California has been plagued with requests for Reciprocity time and time again. One of the members of the California Board recently told me that they require only the minimum to pass the board now. How far down are we supposed to go with our standards to meet those less qualified? How much better it would be to help those unqualified ones to either climb up and join the rest or be eliminated.

I see no wrong with dental teams as long as they function within the Dental Practice Act, but the suggestions that there be a change in this Act is the most frightening threat we have had yet. I fear that once we have opened the lid and released the "plagues" from the "Pandora's Box" we will close the lid and shut away forever the "hope" for quality. If we cannot turn out uniformly trained quality operators in four years of schooling, what hope do we have for those turned out in two or less?

Once again I say if a greater effort were made to properly select, train and motivate our men to produce quality restorations of maximum serviceability, we could better serve society by reducing the necessity of having to do over work improperly done and thus reduce the seeming need for Lesser Trained Personnel.

I, as a representative of the majority of the ethical Dental Practitioners of this glorious country, urge you to hold firmly to a positive line and do not let yourselves become "Permissive," taking the easy way out by allowing the few weak, incapable and incompatible ones to control the majority who are hard-working and dedicated.

While on the subject of relaxing standards, I wish to read you two letters.

One is addressed to a Dr. Rengstorff, a former student of one of my classes. It is from the House of Representatives, Alaska State Legislature. The second is Dr. Rengstorff's reply.

"Dr. P. V. Rengstorff
2321 West Lawn Avenue
Madison, Wisconsin 53711

Dear Doctor Rengstorff:

I am making a study of Professional Licensing Board procedures in support of my legislation to liberalize and simplify licensure in this state. I hope you will assist me.

It appears from the skimpy files available in the newly established central licensing section of our Department of Commerce (1966 legislation) that you applied for licensure in this state and were denied.

Please tell me your side of the story. It is my contention that the Board is limiting the number of dentists permitted to enter the state on an arbitrary basis, rather than for substantial cause. The law authorizes the Board to determine qualifications of the applicants and to pass everyone who is qualified, who in effect would not endanger the public. Under the cloak of high quality many are refused licensure we believe.

Therefore we wish to make a test case, in the courts if necessary, and to simplify and liberalize the licensing procedures. For example, the practical examination could be given by any American Dental Association approved dental school, etc.

The State Legislative Council is also studying this area. Further, more, the Department of Commerce is in the process of completing a study of its own, coupled with an audit by the Legislative Audit Committee, the results of this becoming available in January of this coming year.

Trusting you can be helpful to us in this most important work, I am

Sincerely yours,

Dr. Mike Beirne, Member
House of Representatives
Alaska State Legislature"

"Alaska State Legislature
Representative
Michael F. Beirne, M.D.
P. O. Box 4-1539
Anchorage, Alaska

Dear Doctor Beirne:

Upon graduating from Marquette School of Dentistry in 1964 I drove to Anchorage for the purpose of taking the dental board. I failed the dental board held in July of that year. In September of 1964 I joined the United States Public Health Service with which organization I served until September of 1966. In July of 1965 I failed the board for a second time. The Board advised me to take a refresher course in operative dentistry as the quality of my work fell below that of the other applicants. Many of the applicants each year come from the West Coast dental schools, e.g. Oregon, Washington, and the California dental schools. It is generally acknowledged in dentistry that the most pr ficient dental operators in the country are graduates of West Coast dental schools. These dental schools work with good equipment, hire excellent instructors, and demand their students to produce a high quality restoration. Because I was committed to PHS duties I did not at that time take the Board's advice concerning a refresher course. I took the dental board in Alaska for the third time in 1966, and again failed. In the Spring of 1967 I enrolled in a nine-week postgraduate, dental refresher course given by the University of California at Los Angeles. This course is given to help the non-West Coast dental school graduate pass the California Dental Board. In July of 1967 I took the Alaskan Dental Board for the fourth time. This time I earned by Alaskan license.

I have prefaced my remarks about the Alaskan dental board by tracing my board experiences because if anyone has a right to harbor bitterness towards the Alaskan Board it is I. But, on the contrary, I feel a deep gratitude towards the Alaskan Dental Board. They indirectly compelled me to become a competent dental operator. The nine weeks at U.C.L.A. taught me things that four years at Marquette never did.

At the beginning of the U.C.L.A. course each dentist was asked to prepare two dentiform teeth, one for placement of a gold foil and another for an amalgam. These were collected and held by the instructor. At the termination of the course we were asked to prepare two dentiform teeth again, one for a foil and one for an amalgam. We were then presented with both sets. The results of nine weeks training were remarkable. The first attempts might have been done with my pocket knife. The second preparations were beautiful.

My contention is that Marquette failed in teaching me the basic rules of operative dentistry. I don't understand why the Alaskan Dental Board should be punished for the failings of the applicant's school. Through four Alaskan dental boards I was able to compare my work with the work of graduates of other dental schools. Only this year was I able to point with pride at my gold foil, or gold inlay, or silver amalgam when a graduate of, say, Southern California or Oregon asked to see it.

The statement that the Alaskan Board limits the number of licenses on an arbitrary basis, rather than for substantial cause, simply is not true. As I recall, each year perhaps 70% of the applicants received licenses. This percentage of success compares favorably with other Western state dental boards. In fact, this year three applicants were allowed to take another one-half day to recast their faulty gold inlays, as their first casting just didn't fit. If anything, the Alaskan Board is more than fair in their examination. If the applicant can do the work he will receive a license.

Alaska is unique in that it is able to profit by the past mistakes of other states. This is true in conservation, commercial fishing and forestry as well as in dentistry. In Wisconsin and in California, both states which I have lived in and am licensed in, I have seen some horrible examples of dentistry. The people of Alaska deserve high quality dentistry. I am in full agreement with the Alaskan Board of Dental Examiner's licensing procedures. They are doing the people of Alaska a fine service. It is not the fault of the Board that Nome or Big Delta cannot retain a full time resident dentist.

The burning college liberal too often defends the status quo once he is out of school and enjoying financial solvency. Lest you might think my success in this year's board has blunted any previous crusading spirit, let me assure you this is not the case. Never after my three failures did I blame the Alaskan Board. Marquette was unable to teach me the principles of sound dentistry. Only after I was drilled in these principles last Spring was I able to pass the Alaskan Board.

In your letter you say that you are "making a study," yet as I read further it seems like your conclusions have already been established. You state in your letter you are out to abolish the Alaskan Dental Boards. I hope the time I have taken to write this letter has not been wasted, and that is used in your study, rather than dismissed. Perhaps because you lead me to doubt your objectiveness I have taken the liberty to send courtesy copies of this letter to the State Legislative Council and to the Alaskan

Board of Dental Examiners.

I thank you for allowing an expert in the field of recent Alaskan dental boards the opportunity to tell his side of the story.

Sincerely

Peter V. Rengstorff, D.D.S."

* * * * * * * * * * *

With the support of strong young men such as Dr. Rengstorff to back me up, I say that Mediocrity is not a substitute for Quality any time nor anywhere. As the pendulum begins its swing away from the current philosophies, I would like to see dentistry as the first island of Quality rising from the modern sea of Mediocrity. I, as an individual, am trying hard to do all I can to help this come about. When the going is made difficult by those with attitudes such as that advanced by one of my students who stated that if he were to do dentistry the way I teach it he would have to double his prices or live lower on the hog. I re-read letters such as this one from Dr. Hashimoto, one of my students,

> "We really received a good stimulus to reviewing our concept of operative dentistry. I think it should be done periodically to keep us humble and alert. In this era of ultra high-speed, stress on the fundamentals is especially important and valuable before we go 'hogwild' zipping out mediocre preparations and restorations. I think your efforts were particularly meaningful to those of us going into general practice and I am sure we will pay even more attention to quality, particularly after receiving a clear insight on how to do it."

To those who have escaped that insidious disease "Acceptable Mediocrity," I say "cheers." Keep up your small preventive booster doses of that all important vaccine, the Basic Tenets of Loyalty, Honesty and Ethics, combined with continuous learning or reviewing.

To those who have willingly or unwillingly succumbed to the disease, I say "we pit you" but there is still hope for you providing you want to be healed. We need you, too, to help us shore up the sagging walls of our dental "houses."

It is never too late and it is not later than you think. Today, everyone has almost twice as much time in a lifetime to attempt to realize his desires than did those of not too long ago. For most, the drudgeries of life have been erased, sickness reduced to a minimum, and we have been given an opportunity to pick and choose from an endless number of topics about which to learn, things to do and places to go that we have become, as F. Scott Fitzgerald once said, "That most limited of all specialists, the 'well rounded man.' "

However, if you look at the philosophies on time there is much truth in these words I read some place recently:

> "If you don't have time to do it right,
> When will you have time to do it over?"

Thank you, gentlemen, for your time and respectful attention. I wish to leave you with these words of wisdom entitled "Horse Sense." This has nothing to do with dentistry but might well be applied by many of our dissenters of today; those who would willfully destroy the basic tenets of Loyalty, Honesty and Ethics rather than build upon them.

<u>Horse Sense</u>

A horse can't pull while kicking.
This fact I merely mention.
And he can't kick while pulling,
Which is my chief contention.

Let's imitate the good old horse
And lead a life that's fitting
Just pull an honest load, and then
There'll be no time for kicking.

MEDIOCRITY A SUBSTITUTE FOR QUALITY?

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FAILURES ON CLINICAL EXAMINATIONS - REMEDIATION

Roy A. Fetterman, D.D.S. F.A.C.D.
Instructor of Operative Dentistry - General Refresher Course
University of California Extension Division

Ten years ago I had the pleasure of addressing those attending the Eighty-Fifth Annual Meeting of the American Association of Dental Examiners in Miami, Florida. The title of my paper at that time was "Mediocrity, a Substitute for Quality." I have granted your association permission to reprint that paper and copies will be available [illegible] the conclusion of this session.

The substance of that paper was based [illegible] my experiences years ago while helping to correct the problems of senior students of U.S.C. Dental School who were in danger of not graduating because of their weakness in Operative Dentistry, subsequent years on the Operative Department Staff of U.S.C., and my more current experiences teaching the Operative Dentistry portion of a refresher course offered by the University of California Extension Division.

I doubt that many of you were present in the audience that day ten years ago but if you were, will you please raise your hand? I just wish to congratulate you on your continued contribution of time and energy in the interest of our profession.

This past July I addressed the meeting of the Western Conference of Dental Examiners and Dental School Deans on the subject of whether or not specialists should be required to submit to a General Dental State Board Examination for Licensure. Believe me when I say that the study involved for that paper increased my respect for, and understanding of, the problems of state boards tenfold.

I have now been teaching the Refresher Course for 18 years and in addition have tutored dentists for the states of Alaska, Nevada, and Arizona. All of these dentists were prospective clinical failures or had already achieved that status. I was once invited to audit the California State Board after which the President remarked to me, "We do not fail these men. They fail themselves."

Presented at 95th Annual Meeting of the American Association of Dental Examiners. October 19, 1978 aboard the Queen Mary Hyatt Hotel in Long Beach, California.

Since my last appearance before you, I have had the very special experience of having been a guest of the South African Prosthedontics Society with the opportunity to lecture on Operative Dentistry for a week at each of the three Dental Schools of that country. I also demonstrated the preparation and completion of a Gold Foil at two of the schools. Delivering the Fifth Fred Hossack Lecture on "Principles and Problems of Dentistry" was one of the greatest honors I have ever received. Professor Hossack has been associated with the South African Dental Schools for close to sixty years.

Speaking of honoring men from our profession, many of you have by now received your new ADA Journal and read the article which reminds us that 1978 marks the 60th year since the dedication of a statue to G. V. Black in Lincoln Park, Chicago. In South Africa I was pleasantly surprised to see Dr. Black honored with his name over the door to the Operative Clinic of the University of Witwatersrand in Johannesburg.

Last, but far from the least of my credits, is my association with the Jones Gold Foil Study Club. I am proud to remind you that I am the only remaining active Charter Member, my membership years now totaling 42. With Rex Ingraham and Jack Seymour I share the honor of teaching the club.

As you can gather from my varied experiences, I have had the opportunity to see and analyze many clinical failures.

In my 41 years as a General Practitioner and Instructor of Operative Dentistry, I note that the problems of the dentist remain the same. Namely, people still get holes in their teeth and still develop periodontal diseases. No new permanent or everlasting filling materials have as yet been developed and those materials we have are still only as good or equal to the ability and the workmanship of the dentist who prepares the cavity and places the restoration, plus the degree of care the Oral Cavity receives from the patient.

Working in close association with state boards, I am aware that the majority of the failures on the clinical examinations are those Operative procedures performed upon patients. These failing dentists often become the students I have to teach and, without exception, be they newly graduated, members of the armed forces, foreign educated, out of state educated or instructors in a dental school, they have one common problem. That is their lack of knowledge and understanding of the Basic Fundamentals of Cavity Preparation as outlined by G. V. Black.

In a few minutes I shall show you slides of Class II preparations, made by students before they had received my first lecture, and those prepared at the conclusion of the

refresher course. You will note that improvement is commensurate to each man's ability to learn and perform.

The subject of clinical failure is one of concern to many people. The failing dentist, the public, the school, the instructors, the profession, the state board and the Government. Since this is a national meeting, I assume the topic of this paper, which was suggested by B. J. Crawford, your Secretary Treasurer, is one of national concern. Articles on this subject may be found throughout the various publications of our profession but as yet no writer has printed a solution to the problem of Failures on Clinical Examinations.

I have already stated that I believe the major cause of clinical failures to be the operator's lack of knowledge of the Basic Fundamentals as well as his inability to demonstrate and use these principles. There is no doubt that there are other contributing causes for these failures as well as for the weak performances of the "near" failures.

I list six catagories which I believe are more or less contributory to failures on clinical examinations and which we might reasonably expect to alter and thus reduce the incidence of these failures.

1. Government Involvement
2. School Attitude
3. Student Selection
4. Student Attitude
5. State Boards
6. Public Attitude

Please note that I place Government Involvement in the number one position, for in recent years the dictates of the Government have really determined the attitude of the schools and the students as well as the selection of freshmen students and the performance of the State Board. The Public knows little about our profession and its problems but demands a finger in the pie because it is the Public's money which is used to educate and examine dentists. However, the Public is more concerned with possible racial discrimination and the "rights" of the candidates than with their ability or the quality of their work, thus interfering with the educational process and the true purpose of the State Board, which is to protect the people from unethical and unqualified dentists by means of "admission to licensure, renewal of licensure, and discipline."[1]

Let us just briefly study these catagories.

Government Involvement is based on money. Both State and Federal funds provide a significant portion of typical dental school finances today but with this financial aid comes a long

list of attached "strings" or controls. True, the Federal funds do aid with research grants and numerous other special programs common to dental schools, but there has also been an establishment of dictatorial "goals such as shorter (three year) programs, increased production of new dentists (larger classes), and the creation of more socially sensitive dentists (off campus training programs)." [2] These are all priorities which have been established by the Federal Government and pursued through its agencies.

There are many less obvious pressures such as affirmative action policies, the 1974 Federal "open records law," etc. No doubt many of these changes have improved the performance of some schools but they have also added administrative burdens to schools, consuming important money and time resources which I feel could be better used to improve educational programs.

Federal Legislation requires curriculum changes in all schools seeking basic grants and the selection of faculty too may be influenced by the Government, but unfortunately funds for salaries to attract experienced and qualified instructors seems not forthcoming, forcing the schools to use recent graduates or prevail upon unpaid part time instructors such as members of study clubs, etc. Just this summer members of the Jones Gold Foil Study Club gave time teaching at U.S.C.

Dental education has become so sophisticated compared to the days when I was taking my training that the schools can seemingly no longer survive on tuition and clinical income and are forced to accept the State and Federal funds with all the strings. It is very understandable that the schools often find themselves literally in "bondage" to the Government.

"As the ope of the modern dental practice changes, so does that of the schools. In recent years, schools have added time to their programs for Oral Medicine, Behavioral Sciences, Patient (and Auxiliary) Management, Hospital Dentistry, Physical Diagnosis, Periodontology, Community Dentistry, Clinical Orthodontics, Oral Biology, and many other disciplines which were not taught at all nor as extensively in the past. Naturally, these additions have almost universally produced a concomitant decrease in the percentage of time and effort allocated to the traditional dental courses." [3] Operative Dentistry and its Basic Fundamentals in particular have suffered.

In an attempt to up-grade the "image" of dentistry and remove it from the "cottage industry" catagory, some schools are stressing the medical aspect of the curriculum, also at the expense of the mechanical aspect. I think this very shortsighted philosophy on the part of those schools.

Let me quote from my paper which I delivered in South Africa. "We always have been a very important segment of the medical field entrusted with the responsibility of caring for a rather small area of the body called the Oral Cavity. We are learned in the art of prevention, healing and the relationship of the health of this cavity to the health of the whole body. We are engineers with the technical knowledge of a Civil Engineer and the Mechanical Skills of a fine Watch Maker. We are Artists able to sculpt in wax, cast in metals, and create functional appliances to replace lost natural dentition. We are salesmen teachers, educating our patients in their roll of prevention. We are researchers constantly looking for new ways to eradicate the problems of caries and periodontal involvement so as to spare man the painful dental experience."

We have truly come a great distance since powdered bones, hoofs, crabs and eggshells were mixed with honey and used as a dentifrice.

One very, very important fact to be considered in explaining clinical failures is the method of selecting freshmen students.

"Due to the lack of any better means of ranking applicants, many schools still rely far too heavily upon pre-dental grade point averages and Dental Admissions Test scores."[4] These high grade point averages may indicate that the student concentrated upon intellectual development, which is important, but dentistry is a mechanical procedure whether or not one likes the term mechanical, so, in addition to a high I.Q. and 4.0 grade point average, the dental student absolutely must have considerable mechanical skill and problem solving ability.

Regardless of what the Government says, we are not all equal in learning ability or speed or mechanical ability. How can we be when we do not even all walk, talk, or cut our teeth at the same age? A patient recently expressed "equality" in this manner: "We are all born with an equal opportunity to prove our inequality."

From an article by Dr. Robert Barkley entitled "The Dilemma of Dental School Admissions," come the following revelations. "Early indications from testing senior dental students from several schools with the new selection vehicle reveal that a sizeable percentage is below average and probably should never have been selected to study dentistry, regardless of how high their GPA was."[5] Once more from the same article: "With all of the people they have tested, four years of teachers college has never yet made an effective teacher from a freshman whose 'profile' was that of an ineffective teacher."[6]

It is reasonable to believe this would be true in the case of dental freshmen, too.

How well I remember the oft' repeated remark one of my instructors used to make: "We spoil a lot of shoe salesmen trying to make dentists of them" There is no doubt that student attitude is a contributing factor in clinical failures. However, I dislike placing the blame for this entirely upon the shoulders of the student. I recently read the following quote some place: "Members of the younger generation are alike in many disrespects."

We have been hearing complaints for many years regarding student open criticism of authority, insistance on determining curriculum, complaints about quality of instructors, lack of respect for peers, etc.

What else would one expect from a product of a permissive society which advocates base and violent entertainment, refuses to obey such a simple law as a proven safer speed limit, expects the medical profession to keep it alive for free, preserve its teeth for free, has little respect for others, lacks refinement and good manners, and generally feels that any discipline of its so-called "freedoms" is a violation of its human rights?

While lecturing on Operative Dentistry before a senior class at UCLA a few years ago, I felt that the time I took from my office to give to these students was wasted. Not only did the students show their disrespect by just sauntering in during my lecture, but they brought with them coffee and doughnuts to eat and drink while I lectured. Evidence that they really thought there was nothing more they needed to learn. Reminded me of the man who once said, "Don't bother me with the facts. My mind is already made up."

In recent years, the seniors at U.S.C. decided they had had all of the Prosthetics instruction they needed and rebelled against the remainder of the course. The sequel to this action was the failure of the Prosthetics portion of the state examination by a number of them.

Continued attitudes such as these are certainly not conducive to a professional image or production of quality clinical dentistry on either a board examination or within a practice.

No doubt you wonder why I have included the State Board in the listed categories. I feel that the boards, too, must shoulder their share of the responsibility for clinical failures.

We expect a graduate to have "gained knowledge, clinical skills, a level of professional judgment, an appreciation of the role of the dentist in the community, a concern for the oral health of all people and a level of professional maturity."[7] The only subject from this list on which the dentist will be judged by the board is Clinical Skills, and this without benefit of ever seeing the candidate at work.

Unfortunately, at this date, there has been no standardization for the teaching of clinical skills among the dental schools or for the judging on state board examinations. In other words, no agreement has ever been made within these bodies as to just what specifically constitutes a good or just acceptable preparation and completed procedure. Without a relatively standard model of the ideal to refer to either mentally or in actuality,how can one man make a fair assessment of another man's work? Only a grade of 75%, a very average grade, is required to pass a board examination, but the question is - 75% of what?

Almost all of the dentists I have worked with have passed a board examination in some state prior to their trying the California, Arizona, Nevada or Alaska examination and may take two of the western boards, thus assuring themselves more than one place to practice. These men and women, you can understand, are well qualified to make the statement that there is a difference in the quality of work accepted by the various state boards. If this is so, then this lack of standardization causes unjust criticism of the boards.

I repeatedly hear it argued that it is the responsibility of the state boards to keep the incompetent out of the profession but I disagree with this thinking. Keeping the incompetent out of the profession is the duty of the schools. It is they who decide who may graduate and receive that DDS or DMD degree. A state board can only, hopefully, keep the incompetent out of its own state.

Let me cite an example of what can happen under the present system. Several years ago, a middle-aged, out-of-state dentist took the refresher course after having failed the California board several times. He made little improvement during the course and continued to fail the board until his total was twelve. The cause of his failure was mechanical exposure. You wonder what happened to this man? I have been told he returned to the state from which he had come and continued on in practice. Are not the people of his state entitled to the same protection from practitioners such as he as are the people of California?

Actually, the responsibility of the state board today is two-fold. As already mentioned, the protection of the Public

from the incompetent and unreputable dentist, and now the protection of the dentist from the public.

I refer you to the top of the cover of the October 9th issue of People Magazine where you will read these words: "Malpractice: When and How to Sue Your Doctor."

Now, board members must be concerned about what the dentist can be held accountable for by the public. In other words, what can he be sued for? Certainly not on his knowledge of the use of Auxiliaries nor his knowledge of Patient Management, Community Dentistry and other such programs but - on his Oral Diagnosis, Treatment Planning and Clinical Skills. All the more reason why you board members must be very sure of those you pass.

In listing the six catagories referred to earlier, I had great difficulty deciding whether Government Involvement or Public Attitude should be in the #1 position. To be a "Public," and I use the word facetiously, is very confusing because each of us is a seller as well as a buyer, a plaintiff as well as a defendant, and a voter who influences the Government Policies. Are we then the cause of our own ills and seeking a cure?

Incongruous as it is, it is the Government-Public which pressures the schools to admit lesser qualified students, while in the same breath saying we are all equal; which pressures you gentlemen to drop the minimum passing grade for all of those so-called "equal" dentists and license some of them, regardless of the quality of their work, thus flooding the market and reducing dental costs. It is this same Government-Public which is so quick to accuse members of the medical profession for neglect, poor judgment, poor workmanship, and high costs yet it, itself, produces all manner of inferior services and materials under the philosophy or attitude of "It's good enough."

As the number of malpractice suits increase, there has been a corresponding increase in the use of Peer Review board effort trying to mediate between dissatisfied patients and those members of our profession who are being accused, thus reducing the number of cases reaching the courts. The malpractice lawyer responsible for the article in the October 9th issue of People Magazine states, "They (the Drs.) should police themselves."[9] We might say in return, Plumbers, mechanics, etc. police yourselves.

The public has advocated the lowering of entrance requirements to accommodate below average freshmen who graduate as below average dentists and who, more often than not, fail the state clinical examination. Eventually, these poorer students will pass a board and then the public will complain about his inferior quality of dentistry and sue him for malpractice.

The same public who joyously accepts the prepaid dental programs with its impersonal and assembly-line approach to dental programs may also be affecting clinical failures in a sense since fewer patients visit the dental school clinics and thus each student finds it more and more difficult to find patients and perfect his clinical skills.

SHOW SLIDES HERE

In remediation, I cannot pretend to give you solutions to the various influencing causes of Failures on Clinical examinations and I doubt that anyone else can either or it would have been done before now. Through lack of personal experience within the schools and boards, most of us must depend upon reading the published papers and reports of those closely involved.

I am most qualified from experience to discuss the inadequacies of clinical skills as the major cause of failures, but I have done considerable reading and given much thought to bringing you what I hope you find acceptable discussion on the six contributing catagories I have listed.

The following information from the July 1978 issue of the Journal of American College of Dentists indicates that schools, like so many businesses, seem no longer able to survive without either State of Federal financial aid.

"We have found that neither the N.Y.U. dental school nor the one at Columbia - the two under private auspices in the State - can attract adequate amounts of gifts and grants to cover operating deficits, meaning special treatment must be accorded to those institutions by the State."[10]

As we read the report on N.Y.U., etc.,we learn that U.S.C. dental school is going to receive over a million dollars less aid in the coming year. I assume this unequal distribution of funds is happening across the country. Time will soon show just how capable the administrators are at the schools which are to receive less.

It seems that less aid from the Government with a corresponding reduction of attached "strings" is our only hope to bring about the return of more of the responsibility of administration of the schools to those members of the profession, educators, state board, etc. who are familiar with the needs of the profession and the needs of dental education. These people must not compromise their principles and they must continue to try to hold the line against any increased encroachment by the Government into the territory of Dental Education.

Certainly, it is time to reverse the trend of the "permissive" attitude in all schools and the philosophy of "It's good enough." I believe that people in general yearn to be able to say "It is good" and I am sure that in their hearts most of the students wish to excel, be they able or not. The opposite of permissive is dictatorial, I am told, but there must be a workable and happy medium some place in-between where the transfer of that wonderful, indestructible and never-ending supply of knowledge from instructor to student can be accomplished with a minimum of stress and resentment.

To achieve this is, to my thinking, a mark of a good teacher.

In 1975 Dr Rex Ingraham circulated among deans, representatives of the restorative disciplies of the west coast dental schools, as well as state board members of the western states, an Opinion survey regarding clinical failures. Many of us here today have had for years the same complaints as those listed in the survey. Now that the shortcomings of the clinical training of dental students is a reality, recognized by the deans, heads of departments, etc., perhaps constructive action to correct some of the obvious problems will finally be taken.

From the Ingraham report we read the following: "Inadequate inservice training of the technique and clinical teaching staffs is probably one of the greatest failures of the undergraduate educational system." "To this date, a truly successful approach to this universal problem has not been developed by dental education."[11]

Since most instructors in the dental schools have not had any teaching training and only a DDS or DMD degree is required, I feel they should all belong to participating study clubs relative to their particular fields. G. V. Black believed that "no man has a right to be other than a continuous student."

From my paper delivered in South Africa three years ago, I quote the following taken from a report by C. C. Alpert entitled, "A Dental Examiner's View of Dental Education." "...new and very logical concepts in teaching are taking place at the University of Kentucky College of Dentistry. It is now required that all courses be reviewed periodically and that all faculty members submit to some form of evaluation."[12]

Dr. Ingraham has personally told me of the inservice training meetings he is having with his faculty members, an obvious indication of the desire of Dr. Ingraham and the faculty to provide the students of U.S.C. Dental School with the best training possible.

The schools keep trying. This phrase reminds me of my admonition to my students during their struggle to master a procedure. "Keep stirring." This refers to the story of our first astronaut to land on the moon where he was met by the beautiful Moon Maiden, etc., etc.

Since time does not allow me to read the whole report by Dr. Ingraham, I shall only read you a small portion and recommend that each of you make an effort to read the entire article which may be found in the April 1977 issue of the Journal of The American College of Dentists and is entitled "Is Clinical Preparation Adequate?"

One of the questions of this important survey asks -

"According to your observation, have there been changes between the years 1960 and 1975 in the level of competency of dental graduates in those clinical skills traditionally evaluated by state board examiners?" 83% agreed there have been changes.

Also, according to the survey, 76% agree the highest standard of performance was in the early 1960's and the lowest in 1972 to 1974. An uptrend was noted, starting in 1974, continuing into 1975.

65% of the educators polled agree there is a correlation between levels demonstrated by undergraduate students and performance of the graduates on the state boards.

In 1960 and 1962, 100% of the class from U.S.C. passed the California State Board. By the years 1972 and 1973, those passing the board totaled 90% of the classes. By 1974 an uptrend was observed and in 1975, 96% passed.

Dr. Ingraham lists the following factors which he considers to be contributory to the decline over the 15 year period just referred to, and includes the percentage of those questioned who agree.

1.	General administrative leniency	81%
2.	Lenient attitude of clinical teachers	81%
3.	Poor student attitude	90%
4.	Less clinical demonstration by highly skilled staff	63%
5.	Accelerated three year program	89%

In an article entitled, "Responsibility of Educators," S. P.Hazen questions: "Today, educators are told that our graduates are not as competent as those in the past. What standards of comparison are being used? What perspective is being taken on what a graduate should be today as compared to that of the past?"[13]

Dr. Hazen's question regarding the standard of comparison is a good one and one that I doubt anyone can answer. However, Dr. Ingraham's report certainly substantiates the current feeling that many of our graduates are not as competent as they should be and he now has statistics to prove this point.

The following is another small portion from the same survey listed under Open-ended Comments, etc. and lists reasons for clinical failures.

1. Lack of attention to detail by the daily clinical staff.
2. Lack of sufficient competent clinical staff members.
3. Younger, inexperienced clinical staff members.
4. Use of high speed; less use of hand instrumentation.
5. Lack of clinical judgment by the student.
6. Student's time divided into too many sub-requirements: team preventive dentistry, mini clinics, DAU, etc.
7. Too much emphasis on biological;not enough on clinical applications.
8. All schools seem to be in a trend to put less emphasis on clinical teaching; end result is an inferior clinical operator.
9. Lowering the student grade point admission level to accept the minority and then the faculty are requested to bring these students up to the average of the class which is next to impossible. End result - inferior training of students all the way through school and inferior practitioners after graduation.

I have a number of my own ideas for suggested changes in the school attitude within the realm of instruction, discipline having been mentioned already. That every student should have to achieve a certain level of proficiency before being allowed to graduate is, in my mind, very important. Regardless of the amount of extra time required, if the student needs it let him have it, and this does not infer that the slow learner cannot achieve. It takes him a little longer.

Two very successful dentists who were my freshmen classmates did not graduate with me. One repeated his Junior year and the other repeated every year with the exception of the senior one.

Entry to dental school at the time of my schooling required a "C" GPA and $300.00 plus one year of pre-dental training. The failure rate between the freshman and senior years was 50%. Today, the entering freshman more often than not has four years of pre-dental. He has been seasoned in the learning process, has maturity, travel experience, and a great diversity of knowledge to his credit. Note that I say knowledge and not education. I like the following quote from Ralph Waldo

Emerson: "The things taught in colleges and schools are not an education but the means of education."

Among my students I have found evidence of an abundant amount of enriching knowledge but a lack of very important information pertinent to their chosen profession, such as Finger Rest Position, Instrument and Handpiece Grasp, all of which I must correct. When inquiring of local dental schools if they teach these techniques per se, the answer has generally been "no." The men whom I questioned say they assume anyone who can hold a pen can hold a handpiece correctly, and yet we all know that the handpiece and hand instruments are not held in the same manner in which we hold a pen or pencil to write. No instructor has a right to assume anything where the student is concerned except that he comes to the school knowing nothing about dentistry.

Most of those I have taught do not understand when I say they should learn to think of their hand and handpiece as a "milling machine" as I explain the proper movement of the handpiece. They do not understand the significance of the names of their hand instruments nor the meaning of the identifying numbers of the hand instrument nor how to sharpen these instruments. In fact, most state that they were not taught how to sharpen their hand instruments and some even say they never sharpened them during four years of dental school. Some have told me they never use a hand instrument! Rather appalling revelations,don't you think? Why did these dentists fail the clinical portion of the state board? Not hard to understand.

To see Gold Foil becoming an endangered species makes me very sad as you may guess. This is due almost directly to the attitude of schools since someone decided that Gold Foil should be replaced with the easier to master and cheaper composite with its cosmetic beauty.

Dr. Ernest Jones, the first Dean of the University of Washington Dental School and former head of the Operative Department at U.S.C., was a Foil man and he made Foil men of many students during his teaching years. It was his opinion that the mastery of that procedure is the greatest disciplinary training for the dentist and he could prove that to the student. There is no cement nor any other crutch upon which to rely for the successful Foil. It all depends upon the skill of the operator.

I would like to see the Gold Foil restored to its rightful place in the dental school curriculum in place of some of the extraneous courses which might be moved to the Continuing Education Program.

Unfortunately, students are now told that the Foil is no longer a practical restoration, is too time consuming, and too difficult a procedure. It is a fact that the prepaid dental plans refuse to pay for Gold Foils because of the cost, unaware, apparently, that the properly placed and cared for Foil will outlast the alternate composite filling many times, preserve the tooth and save money. Isn't that what dentistry is all about?

Ten years ago, I made use of the following comment from a Gold Foil survey made by the Medical University of South Carolina. "The time needed to develop the necessary clinical skills and the asset of good judgment simply rules out the waste of the clinical hours required to develop a competent skill in the use of the 'least' useful of dental materials."[14]

At the death of my mother, age 88, two anterior teeth held Gold Foils placed there by a traveling dentist when she was 18 years of age. My wife has 8 clearly visible Foils in her anterior teeth, ranging in age from 12-39 years. Can you beat that for economy and service?

I have a question for you. If a traveling practitioner of so long ago with, at most, one year of dental training, could master the Basics and the use of the compacted gold filling, why should we ask any less of the student of today with his very superior pre-dental education and four times as much dental education?

Other than the reinstatement of the Gold Foil in the dental education program throughout the United States, nothing would make me happier to hear that the schools were adapting a standard of quality for a good, not just acceptable, cavity preparation and completed filling. How much easier this would make the student's lot, the instructor's teaching, and the state board's judging.

Ten years ago, I stated my thought on student selection and I have not changed my thinking on that subject. Dr. G. V. Black's definition of a Cavity Preparation begins with these words: "The mechanical treatment of ...., etc." Since the Generalist will spend most of his time doing Operative Dentistry which is a mechanical procedure, then logically the selection of the freshman should be partially predicated on his mechanical interests and experiences as well as his scholastic standing. Has he ever had a Hot Rod to keep running, or has he had any mechanical drawing, machine shop, wood shop, or art courses would be questions asked of him.

I have noticed some of my students having great difficulty developing good control of their instruments and I discovered that in some cases these men are double jointed. Usability of

the hands is vital in the selection of a freshman student. A very simple test will reveal if this condition is present and I think it should be a part of the freshman selection criteria.

Yesterday and today's dissatisfaction with the present admissions test is finally leading to new and elaborate experiments in seeking a better way of screening freshmen for entry to dental school. Dr. Ingraham tells me that U.S.C. has returned to the use of the carving test as part of the selection criteria.

If you have not read Dr. Robert Barkley's paper entitled, "The Dilemma of Dental School Admissions," you should. It may be found in the April 1976 issue of the Journal of the American College of Dentists.[15] The following quote is from that article:

> "A major breakthrough may be approaching. A handful of innovative U.S. Dental Schools are currently evaluating a revolutionary new selection process that may not only help solve the admissions dilemma, but may actually take a major step toward remaking the dental profession."

All good news and action which should in time reduce the incidence of Failures on Clinical examinations.

Every time I prepare a new paper from a requested Topic I rediscover my "inadequacies" and this paper has been no exception. As usual, my wife and I have spent many hours in discussion and analyzation of the subject matter, but this category of Student Attitude has proven to be the most demanding in thought and the most illusive in "remediation."

Just a page or two ago I read from the Ingraham report that 90% of those polled felt that Student Attitude was a contributing factor in the decline of clinical competency. Whenever, and wherever, dentists involved with education or state boards gather sooner or later the subject of student attitude and selection comes up and much time is spent in discussion and general complaints of these "misguided and mis-selected folk." These discussions so often infer that every student is obnoxious and unwilling to accept discipline, etc. This cannot be so for even in a barrel of apples there are only a very few "rotten" ones.

I asked Dr. Ingraham if he could give me an estimate of the number of disturbing students in a class. He gave an answer of 15-20%. The importance of his answer is that more than 80% are really trying to "receive" the knowledge they came to get.

Earlier, I quoted from a report on a new method for selecting students which mentioned that it had been determined

that a large number of students of a senior class tested were way below the average and should never have been selected for dental school. Could this group be part of those who cause the inharmony? Are their own inadequacies and frustrations the cause of their rebellion?

Dr. Ingraham now thinks so. He feels that the reinstating of the carving test added to other new ideas for selection of freshmen may reduce the number of poor performers and thus decrease the number of students with the so-called poor attitude.

A resentful and rebellious attitude is not the exclusive property of the undergraduate student. Many of my refresher students are lax in attendance and some are very resentful as they do not understand why, since a school did grant them degrees and a state board did issue them licenses, they cannot pass the California board examination. It is my unpleasant duty to tell them the painful truth, which is that the quality of their work does not meet the standards set by the boards of the western states. Many argue with me about the techniques I teach, telling how they were previously taught and how they would do the procedure, etc. I have a stock answer. "You have already tried your way and failed." One older man told me that if he had to practice dentistry the way I advocate he would have to double his prices or live lower on the "hog." I must add that most of those I have tutored on a private basis are usually receptive and hard working.

Over the years, my students, too, have complained of instructors they have had. So what's new? They complain about incompetent instructors, obnoxious instructors, unavailability of instructors when they are needed to help on the clinic floor plus the fact that a lecturer may advocate a certain procedure in the classroom but the same procedure may not be followed in the clinic. Now, hold onto your hats. I have even had complaints in reverse about discipline with the comment that they had heard about certain procedures but were never "made" to use them!

To my point of view, the proper "first day" could make all the difference in the world in the future attitude of a student. I asked Dr. Ingraham if U.S.C. has an orientation period for the entering freshmen and he says they do. I assume that this then is the practice of most dental schools.

My first day in dental school so many years ago is just a blur with the exception of the following statement made by Dean Ford: "Gentlemen, take a look at your neighbor because next year one of you will not be here." Attitudes were certainly formed at that moment.

Judging by the problems with students just reviewed and

the new and positive steps being taken to correct these problems, 1979 should bear witness to tremendous strides made by students in the field of clinical skills and the harmonious giving and taking of knowledge between competent instructors and eager students.

Board members will not believe how many times I have been asked if the members of the boards can produce the same quality work expected of the candidates taking the boards. How would you men and women answer that question?

Once again we come up against the Government, for, of course, members of the state board are appointed by the Governor. As in the case of one of my colleagues who is an Orthodontist, members who have not actually practiced any Operative Dentistry for years may be appointed to the board. Unfortunately, few are as conscientious as my neighbor, willing to admit their inadequacies and ask for aid. My neighbor asked me to give him some "refreshing" and I did. Now I understand that there are complaints that he is too tough a grader.

Some of the boards are taking interesting steps to improve the system of evaluating the candidates. The Nevada and Hawaii boards are considering having me give their members a participating review course in Operative Dentistry. If this comes about, the students will not have to wonder if board members can produce what they require from the board candidates.

The California Board and the Central Regional Boards have held workshops and each member has been asked to evaluate pre-prepared teeth and defend his reasoning.

It is tragic that no way has ever been devised to test a man on his ethics. One of my students once asked me, "How do you give a man a conscience?" If any of you have an answer to that question, I shall be glad to hear it.

"The measure of a man's character is what he would do if he knew he would never be found out." (Thomas MacCaulay)

From an article in the September-October CDS Newsletter comes the following: "Mr. Gilbert Laws of the United Rubber Workers stated that essentially labor wants quality dental treatment at a fair price."[16]

There is nothing new nor profound in the statement from United Rubber Workers. The desire for quality service in all realms has ever been the sentiment of us all and there is no good reason why we should not expect quality service for our money. If each of us gave quality service while earning our wages, this philosophy would travel the proverbial "full circle" and in time return quality to each of us.

It is my personal opinion that quality dentistry cannot be found in the prepaid clinic and never will be as long as "speed" is the rule and the operator required to produce 10.8 surfaces of alloy per hour and rewarded with a bonus if he does more than that. If this be the desire of the people, then perhaps we should train dentists for quality private practice and others for the prepaid clinic.

To be assured the possibility of quality dentistry, the Government-Public must learn to accept the judgment of those who are knowledgeable of and involved with the dental education process and return to them and the schools the responsibility of training dentists whom the state boards can reasonably expect to pass and license. This means, then, that the schools must be allowed to set the admissions criteria, graduation standards, etc. without public interference.

In addition, this same Government-Public must believe that the responsibility of the state board is to protect the public. It must give the boards free reign to once again pass or fail board candidates on the merit of their skill, without public intervention such as they have now.

To this date, the Government-Public's forcing of the admittance of unqualified freshmen to the schools and the school policy of "all pass" has not been a success. Once again, I refer to Dr. Ingraham's report and the statement concerning the lowering of the student GPA level to accommodate the minority student and the futile request that the faculty bring these students up to class average. "End result - inferior training of students all the way through school and inferior practitioners after graduation."[17]

These inferior practitioners have no doubt been among those who have failed the clinical examinations and their failing is due directly to the current philosophy of the public that changes the rules to accommodate everyone.

CONCLUSION

Now, in conclusion we agree that clinical failures on the state board are still an unpalatable reality. Whether or not the incidence of these failures will diminish in the future remains to be seen.

As this paper goes to print, I have received calls from two out-of-state students wishing to be tutored. One tells me that eleven graduates of one school took the California and Arizona boards and all failed but one.

It is still my opinion that the main cause of these failures is the lack of proficiency in the clinical skills. The student does not know nor does he understand the application of the Basic Fundamental Principles of Cavity Preparation.

In this paper we have explored six factors which I feel are contributory to the above stated main cause of the clinical failures, namely, Government Involvement, School Attitude, Student Selection, Student Attitude, State Board and Public Attitude, and discussed their relationship to the problem.

I think the future looks promising in its relationship to the reduction of failures on the dental state board examinations. We have learned much from our involvement with the Government. We enjoyed the money to spend but not the string attached and we found that the Government way is not the better way.

We now see some of our schools with a new attitude enthusiastically accepting the challenge of creating a better learning institution with less money to spend; the selection of students based upon their abilities as related to the needs of the dental profession in addition to their GPA; new philosophies developing pertaining to the control of students attitudes and training of instructors; state board members searching out ways to make their judging fair and protection of public and dentists effective.

Hopefully, the attitude of the Public will mellow to a less accusing, more receptive and understanding one.

May there be less need for Malpractice suits or even the enforcing of the "ordinance in South Foster, Rhode Island which provides that a dentist who extracts the wrong tooth must have a corresponding tooth pulled by the village blacksmith, or pay a fine."[17]

When all is said and done, let us remember ".... the truth is that more and better medical care is available for the sick in the United States than anywhere else in the world."[18]

And, "The fact is that for two hundred years we have had for the most part a unified profession. We have achieved the finest dental health care for most people at the most reasonable cost. The American people have the finest oral health in the world."[19]

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RURAL ALASKA
COMMUNITY ACTION PROGRAM, INC.

ROUTE SLIP

TO: JANA VERATI
AK Health Coalition

___ ACTION	___ NOTE & RETURN
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___ FILE — PER REMARKS	X FOR YOUR INFORMATION

FROM Phil Smith
RurAL CAP

REMARKS

MOORE BUSINESS FORMS, INC.

Thelma – This is a copy of the grant Aleutian-Pribilof I.A. got to lobby HB 401 through the legislature. (There is some question about the legality of Rural CAP doing this.) Irregardless, we are in favor of amending the dental statute to allow students to work outside their school setting. If this bill (401) doesn't →

12/22/78

Grant/Contract Documents:

Approval & Routing Sheet

Funding Source CSA - '79 "221" grant

Brief description of attached document HESS Dental Advocacy Contract with Aleutian/Pribilof Is. Association for $15,060

Grant/Contract # (if any)
Grant/Contract period Mar. 12, 1979 to June 30, 1979

Approval Required:

Department Head [signature] Date 3/19/79
Controller/Ch Acct [signature] Date 3/19/79
Executive Director [signature] Date 3-19-79

This form shall be completed prior to final approval by the Executive Director.

The completed form will be released to the Chief Accountant by the Dept. Head after all signatures are affixed by the Executive Director.

OBJECTIVE: Have legislation enacted which will allow for volunteer dental service in Alaska.

STRATEGY:

1. Compile and distribute at least 100 informational kits explaining the concept and advantages of the Mobile Dental Unit and utilization of qualified volunteer services. Kit to consist of pertinent documents, articles, pamphlets, photographs, etc.
2. Draft and distribute press releases based on (1) above.
3. Organize and conduct at least 8 meetings with groups involved with rural health services, i.e. - educators in health training, Native organization staffs, state employees. Show "Open Your Mouth" film and provide information on the advantages of the Mobile Dental Unit and utilization of qualified volunteers.
4. Make contact with legislators and explain need for amendments to Alaska Statutes which will enable volunteers to practice in Alaska. Testify as appropriate.

OBJECTIVE: Complete preparations for resumption of services this summer utilizing Mobile Dental Unit.

STRATEGY:

1. Travel twice to San Francisco and meet with representatives of the Stark Foundation; negotiate '79 schedule, etc. Also meet with at least one other volunteer group during these trips to ascertain if they can provide help.
2. Make detailed plans for volunteer manpower during summer '79. Seek additional private foundation funds for transportation and for per diem support of volunteers traveling to the Aleutians.
3. Coordinate plans with PHS/IHS, to include:
   a) Travel once to Washington DC to explain the program and elicit support.
   b) Advise the Anchorage IHS service unit of the ongoing status of the project.
   c) Arrange with Anchorage IHS service unit appropriate format for gathering data -- undergo orientation with PHS on forms, records, documentation so as to generate data which will facilitate proper tracking of clients.

(APPENDIX A) P. 4

4. The APIA shall organize at least one meeting involving representatives of State of Alaska-DHSS, Indian Health Service, Dental Examiners Board, and other appropriate individuals in order to refine the strategy and logistics of resuming services this summer.

12/22/78

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DENTAL SERVICES ADVOCACY PROGRAM

CONTRACT FOR SERVICES

THIS AGREEMENT made and executed the day and year hereinafter last written, by and between the RURAL ALASKA COMMUNITY ACTION PROGRAM, INC., an Alaska corporation, hereinafter called "Grantee," and Aleutian/Pribilof Islands Association, hereinafter called "Contractor," consistent with RurAL CAP Grant 00919-T-79/02 effective January 1, 1979, as modified.

W I T N E S S E T H:

The parties come in consideration of the mutual covenants herein contained agree as follows:

1. Contractor Responsibilities. The Contractor shall perform all duties and liablilties under this agreement in a satisfactory and proper manner as determined by the Grantee.

2. Board of Directors. Contractor shall maintain a Board of Directors whose members shall represent the respective communities or subregional areas from which they are elected or designated by a representative community body. The Board of Directors shall speak for and communicate with the respective communities or subregional areas they represent. Contractor agrees that it will conduct at least one full board meeting during program year 1979 (January 1, 1979 to September 30, 1979) and at least three additional meetings of either the full Board of Directors, or the Executive Board, or any combination thereof. Contractor agrees to notify Grantee in writing of all meetings of Contractors full Board of Directors at least fourteen (14) days prior to such Board meeting. Contractor further agrees to notify Grantee in writing of any and all Executive Committee meetings with said notification being provided to Grantee

at the same time as notice is provided to Executive Committee members. Minutes of all meetings of Contractor's Board and/or Executive Committee shall be submitted to Grantee not later than twenty-one (21) days after adjournment of such meeting.

3. Target Area Reports and Representation to the Grantee.

(a) Where the Bylaws of the Grantee provide for the Contractor to fill one seat on the Grantee's Board of Directors then, pursuant to Grantee's Bylaws, the Contractor shall ensure that one person (local to the region, and preferably a member of the Contractor's Board) will be designated to serve on Grantee's Board and attend Grantee's Board meetings. The Contractor shall also designate one alternate (also local to the region and preferably a member of the Contractor's Board) to fill said seat on the Grantee Board when the regular representative is unable to do so. At any regular meeting of the Grantee's Board the Contractor's representative to that Board shall be prepared to present a Target Area Report which shall, at a minimum, explain the following:

(i) The progress the Contractor is making and problems encountered in fulfilling the goals of the work program as outlined in Appendix A attached.

(ii) The progress the Contractor is making and problems encountered in fulfilling the goals of any other program Contractor is operating with Grantee funds.

(iii) Public issues which significantly affect the low-income population in the region.

The report shall be specific and shall convey a clear understanding to the Grantee's Board of the status of the Contractor's program,

with associated accomplishments and problems.

(b) The Contractor's designee to the Grantee's Board of Directors shall submit a subsequent report to the Contractor's Board of Directors and Executive Committee at the earliest available time after any meeting of the Grantee's Board of Directors. The report shall inform Contractor's Board and Executive Committee members of issues discussed and actions taken by the Grantee Board.

4. Approved Work Program and Period of Performance. Contractor shall perform all activities described in the approved work program and budget which are attached hereto and made a part hereof as Appendix A (Work Program) and Appendix B (Budget). Such activities are embodied in RurAL CAP Grant 00919-T-79/02, as modified, and shall be performed between March 12, 1979 and June 30, 1979, according to the timetable in Appendix A.

5. Payment and Reimbursement Procedure. Of the funds available for Contractor's program, Grantee shall advance to Contractor the sum of Nine thousand three hundred and xx/100 DOLLARS ($ 9,300.00), within 5 days of contract execution, which amount shall be used by Contractor to initiate the program described herein. All subsequent sums payable to Contractor shall be paid on the reimbursement method and must be substantiated by submitting the following documents:

(a) Copies of all checks disbursed for reimbursable expenses;

(b) Copies of all invoices, time sheets and other supporting documents substantiating each disbursement.

(c) Other documentation required by the Grantee or specified in the "Rural Cap/CSA Contractors Notebook.

Contractor agrees to furnish Grantee with copies of all such documents supportive of a reimbursement request on or before the 10th calendar day of each month, which documents shall reflect all costs incurred by Contractor during the preceding calendar month. Grantee shall reimburse Contractor for all allowable expenditures substantiated by the foregoing documentation within ten (10) days after receipt of such documentation from Contractor, but in no event shall Grantee pay to Contractor, during any single calendar month an amount greater than ______N/A______________________ DOLLARS ($________________________), (or _________%) of the total sum designated for Contractor's budget, unless expressly approved by Grantee's Controller.

The Grantee is not liable for Contractor incurred costs which conflict with CSA or Grantee regulations or policies. It is the responsibility of the Contractor to make obligations and spend funds consistent with such regulations and policies.

The Contractor will in no case exceed in expenditure or in commitment the total obligation dollar amount agreed upon with the Grantee, as outlined in Appendix B. The Contractor is fully responsible for any and all overexpenditures and for any disallowable and disallowed costs which it may incur.

6. Progress Reports. Contractor shall be required to prepare and submit two (2) written work program progress reports. Such reports shall detail Contractor's progress toward accomplishing the goals stated in the work program. All information contained in such reports shall be specific and will quantify data wherever possible. Reports shall be submitted according to the following schedule:

1) First Report - due May 4, 1979 — Covering period March 12 through May 4.

2) Second Report - due July 6, 1979 — Covering period May 7 through June 30.

Grantee may provide report forms to the Contractor in advance of each report due date, and if this occurs the report shall be submitted on such forms. Contractor shall maintain a filing system which contains documentation of progress made toward the accomplishment of goals stated in the work program.

7. Monitoring. It is agreed that Grantee, its agents and employees shall have the right to enter program areas and offices of Contractor at any reasonable time for the purpose of examining work in progress and administrative records in order to conduct such monitoring as is necessary for providing technical and administrative assistance and to insure compliance with this agreement. Where such monitoring by the Grantee necessitates the active involvement of the Contractor's staff, Grantee shall provide reasonable notice to the Contractor in order that the Contractor may fully participate in the monitoring activities.

8. Non-Federal Share. Contractor, its agents, or employees shall provide One thousand six hundred seventy three and xx/100 DOLLARS ($1,673) or the equivalent thereto, as its non-federal share requirement and shall document such contributions on forms approved by the Grantee. For purposes of this agreement, this non-federal share requirement shall be provided in accordance with the non-federal share budget attached hereto and incorporated herein as Appendix B.

9. Modification of Work Program and Budget.

(a) Work Program. A modification of the Contractor's work program (Appendix A) requiring written amendment is defined as any major change, including additions, deletions, or substantive rewriting of one or more goal statements. A work program amendment shall require approval by Contractor's Board or Executive Committee and submission in writing of an amended work program form to Grantee with attached narrative justification. Grantee retains the right to approve or disapprove any modification of the work program. Grantee Executive Director shall review and process any proposed work program amendment within 14 days of receipt and shall notify Contractor of said approval or disapproval. If Grantee disapproves a work program amendment, Grantee shall provide written justification for such disapproval.

(b) Budget. A budget change requiring written amendment is defined as any change which increases or decreases the amount in any cost category, as outlined in Appendix B, by an amount greater than $1,000. Grantee specifically reserves the right to render final approval of all proposed budget modifications. Grantee Executive Director shall review and process any proposed budget amendment within 14 days of receipt of such and shall notify Contractor of approval or disapproval. In the event Grantee disapproves a budget amendment, Contractor shall be provided written justification from Grantee.

(c) Fixed Budget Total. The total amount of federal funding available under this agreement is Fifteen thousand sixty and xx/100 Dollars ($15, 060). The parties to this contract understand and agree that in no case shall Contractor increase the approved total federal share, or decrease the approved total non-federal share for the budget year.

10. Delegate Agency Status. For purposes of CSA statutes, regulations, and directives the Contractor shall be considered a Delegate Agency of the Grantee as defined in CSA regulation.

11. Compliance with Approved Program and Laws. Contractor and Grantee agree to comply with all laws, rules, and regulations, federal, state and municipal, which are now, or in the future may be applicable to their businesses, equipment and employees engaged in or in any manner connected with Contractor's performance hereunder. All activities authorized by this contract shall be performed by Contractor in accordance with the approved work program (Appendix A) and approved budget (Appendix B), the Grant conditions and relevant Community Services Administration (CSA) directives.

12. Nondiscrimination. Contractor and Grantee hereby agree that no person shall, on the ground of race, color, religion, sex, age, handicap or national origin by excluded from pa ticipation in, be denied the benefits of, or be otherwise subject to discrimination in determining eligibility to participate in the program, as required by General Conditions Governing Grants under Titles II, III - B and VII of the Economic Opportunity Act of 1964, as amended.

13. Assignment or Subleasing. Contractor may not assign or sublease its interest hereunder to any other party without the prior written consent of Grantee, and Contractor agrees that any violation of this covenant will, at the option of Grantee, work immediate forfeiture of Contractor's interest hereunder.

14. Default or Termination. The Grantee may, by giving at least fifteen (15) days written notice specifying the effective date, terminate this contract in whole or in part for cause, which shall include: (1) failure, for any reason, of the Contractor to fulfill in a timely and proper manner its obligations under this contract,

including compliance with the approved program and attached conditions, and such statutes, Executive Orders, and CSA directives as may become generally applicable at any time; (2) submission by the Contractor to CSA or to the Grantee of reports that are incorrect or incomplete in any material respect; (3) ineffective because of inadequate program activity, or improper use of funds provided under this contract; and (4) suspension or termination by CSA of the grant to the Grantee under which this contract is made, or the portion thereof delegated by this contract when required by CSA direction. If the Contractor is unable or unwilling to comply with such additional conditions as may be lawfully applied by CSA to the grant or to the Grantee, the Contractor shall terminate the contract by giving reasonable written notice notice to the Grantee, signifying the effective date thereof. In such event the Grantee may require the Contractor to ensure that adequate arrangements have been made for the transfer of the delegated activities to another Contractor or to the Grantee. In the event of any termination, all property and finished or unfinished documents, data, studies, and reports purchased or prepared by the Contractor under this contract shall be disposed of according to CSA directives, and the Contractor shall be entitled to compensation for any unreimbursed expenses reasonable and necessarily incurred in satisfactory performance of the contract. Notwithstanding above, the Contractor shall not be relieved of liability to the Grantee for damages sustained by the Grantee by virtue of any breach of the contract by the Contractor and the Grantee may withhold any reimbursement to the Contractor for the purpose of set-off until such time as the exact amount of damages due the Grantee from the Contractor is agreed upon or otherwise determined.

It is further understood by the parties to this agreement that when written notification of termination for cause is given by the Grantee's Board, the Contractor shall have the opportunity, within the 15-day time limit, to take such corrective action as may be necessary. If such action that Contractor may take is deemed adequate by the Grantee for correcting the cause of termination, then the Grantee shall not terminate the agreement. It is the policy of the Grantee to terminate an agreement only as a last resort.

In the case where action to terminate this agreement occurs, the Contractor reserves the right to appeal such action, consistent with CSA Notice 6441-1.

15. Covenant Against Contingent Fees. The Contractor warrants that no person or selling agency or other organization has been employed or retained to solicit or secure this contract upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee. For breach or violation of this warrant the Grantee shall have the right to annul this contract without liability or, in its discretion, to deduct from the contract or otherwise recover full amount of such commission, percentage, brokerage, or contingent fee, or seek such other remedies as legally may be available.

16. Waiver. The failure of either party in one or more instances to insist upon strict performance of any of the covenants or conditions of this agreement, or to exercise any privilege conferred, shall not be construed as a waiver or relinquishment of the effect of any such covenant, conditions or privilege, but the same shall be and remain in full force and effect.

17. Prior Agreement. This agreement supercedes all contracts arrangements, commitments and offers of every kind or nature, oral or written, at any time heretofore made by the parties.

18. Modification. No modification or amendment hereto shall be binding upon either of the parties unless in writing, signed by both parties.

19. Indemnification. Contractor agrees that it will save harmless and indemnify the Grantee from and against all liability and claims for damages and/or suits arising out of Contractor's performance of this agreement.

20. Applicable Laws. This agreement and the relationship of the parties hereto shall be governed by and interpreted in accordance with the laws of the State of Alaska and of the United States.

21. Status of Contractor. Contractor represents that it is a duly registered non-profit corporation incorporated under the laws of the State of Alaska and in all ways is in good standing in accordance with State law.

22. Independent Contractor. It is expressly understood that Contractor is an independent Contractor and neither it nor its agents or employees are employees of the Grantee. The actual performance and supervision of performance hereunder shall be under the control and direction of the Contractor; provided, however, that Grantee being interested in results to be obtained, is to be kept at all times fully informed of Contractor's activities in this regard. Contractor warrants that Contractor is an employer, as that term is defined in the Federal Insurance Contributions Act and the Unemployment Compensation laws of the state or states in which the work is to be performed and Contractor's identification account numbers are as follows:

Federal______________________ State________________________

23. Insurance Requirement. Contractor agrees to carry and maintain at all times during the time of this contract, general

liability insurance, in an amount not less than Three Hundred Thousand Dollars ($300,000).

24. This agreement incorporates all terms of Appendices A and B.

IN WITNESS WHEREOF, this Agreement has been executed and delivered this _____ day of __________________, 1979.

RURAL ALASKA COMMUNITY ACTION PROGRAM, INC.

By: signed 3/19

Position: ____________________

CONTRACTOR:

ALEUTIAN/PRIBILOF ISLANDS ASSOCIATION

By: signed / Pat P. 3/20

Position: ____________________

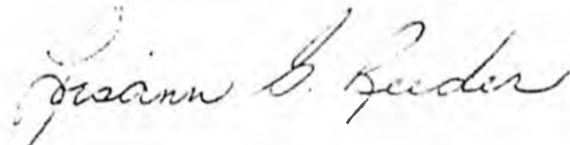
ALASKA STATE DENTAL HYGIENISTS ASSOCIATION

TESTIMONY OF LOISANN G. REEDER
Given at Legislative Hearings on HB 401
March 29, 1979

I am presenting testimony on behalf of the Alaska State Dental Hygienists' Association. My testimony pertains only to Lines 13 - 29 on Page 1, and Lines 1 - 5 on Page 2, of HB 401. This is the portion of the bill relating to dental hygiene licensing requirements. My association is aware of, and in sympathy with, the problems which have developed due to the gap in policy in the statutes which presently does not allow dental hygiene students and their supervising faculty to perform in clinical dental school study programs in remote areas of our state. As such, we are in support of HB 401, amended to read as follows:

- SEE ATTACHMENT -

Respectfully submitted,



Loisann G. Reeder, Chairperson
Legislative Committee

ALASKA STATE DENTAL HYGIENISTS' ASSOCIATION

SUGGESTED AMENDMENTS TO HB 401

Sec. 08.32.010. LICENSE REQUIRED. No person may practice, offer or attempt to practice, or advertise or announce oneself as prepared or qualified to practice dental hygiene without a license except

(1) bona fide, full-time students of dental hygiene who have completed one year of clinical study at a dental hygiene school which requires at least a two-year course and is accredited by the Commission on Accreditation of Dental and Dental Auxiliary Education Programs of the American Dental Association who are

(A) enrolled in a clinical program sponsored by, and forming a part of, the course of study at the school, and which has been registered with, and awknowledged by, the board;

(B) practicing dental hygiene in an area designated as "remote" by the Department of Health and Social Services, on an unpaid basis under the direct supervision of a dentist member of the faculty of the school, or the direct supervision of a dental hygienist member of the faculty in conjunction with the indirect supervision of a dentist member of the faculty; and

(C) (SAME - no changes)

(2) dental hygienist members of the full-time faculty at a dental hygiene school which requires at least a two-year course and is accredited by the Commission on Accreditation of Dental and Dental Auxiliary Education Programs of the American Dental Association who are

(A) engaged in a clinical program sponsored by, and forming a part of, the course of study of the college, and which has been registered with, and awknowledged by, the board; and

(B) supervising and/or practicing dental hygiene in an area designated as "remote" by the Department of Health and Social Services, on an unpaid basis under the indirect supervision of a dentist member of the faculty.

(3) A person practicing dental hygiene under the licensing exemptions as stated in (1) and (2) of this section shall be subject to all provisions of this act and other applicable laws which govern the practice of dental hygiene by licensed practitioners.

TELEGRAM

RCA ALASKA COMMUNICATIONS, INC.
PHONE: 586-5442
JUNEAU, ALASKA 99802

1979 APR 24 PM 11 39

02269 NL ANCHORAGE ALASKA 270 04-24 0350P AST

PMS THELMA BUCHHOLDT,CHAIRMAN,HOUSE HESS COMMITTEE

JUN

WHEN SOLOMON AS LEADER OF HIS PEOPLE HAD TO MAKE DECISIONS HE OFTEN LOOKED BEYOND HIS OWN PERSONAL TASTE, BEYOND HIS ENEMIES AND THE DEVISIVE INFLUENCES THAT PLAGUED HIM TO VIEW THE TRUE RECIPEINTS OF HIS ACTIONS, THE LITTLE PEOPLE WHO WOULD BARE THE BRUNT OF HIS DECISIONS. WE HAVE KIDS IN BUSH ALASKA WHO HAVE TOOTHACHES, WHO SUFFER ALL THE TIME WITH SYSTEMIC POSIONING AND MALNUTRITION BECAUSE OF DENTAL HEALTH PROBLEMS. LOOK BEYOND ALL THE RHETORIC OF THE PROFESSIONALS WHO HAVE MADE NO UNPAID EFFORT TO BRING RELIEF TO THESE PEOPLE. WHO BELIEVES THEM NOW WHEN THEY SAY THEY ARE READY TO GO TO WORK FIXING TEETH IN BUSH ALASKA, NOT I AND SURELY NOT YOU. OURS IS A VOICE CRYING OUT OF THE WILDERNESS BUT NOT BY ANY MEANS A LONE VOICE. EVERY SINGLE RURAL COMMUNITY WANTS DENTAL CARE NOW. THEY DONT CARE ABOUT OIL TAXES, FISH TAXES, D-2 OR PORK BARREL LEGISLATION WHEN THEY SUFFER WITH A TOOTH ACHE THEY WANT HELP NOW. WE HAVE A DLRS200,000 MOBILE CLINIC READY TO GO, PAID FOR WITH STATE TAX DOLLARS. IT IS INCONCEIVABLE THAT A SPECIAL INTEREST GROUP COULD BE SUCCESSFUL IN PREVENTING VOLUNTEERS FROM DELIVERING RELIEF TO THE SUFFERING SIMPLY BECAUSE THEY HAVE MONEY AND POWER. IT IS OURHOPE THT EVERY LEGISLATOR WHO VOTES OR ACTS IN OPPOSITION TO THIS EFFORT SUFFERS FROM S SEVERE TOOTH ACHE OR BREAKS HIS BRIDGE IF THE DENTISTS HAVE ALREADY GOTTEN HIS TEETH. OUR BILL IS TIED UP IN THELMA BUCHHOLDTS HESS COMMITTEE. HELP US GET IT OUT FOR A VOTE. THANKS.

PATRICK PLETNIKOFF, EXECUTIVE DIRECTOR, ALEUTIAN PRIBILOF ISLANDS ASSOCIATION 1689 C STREET ANCHORAGE ALASKA 99501

Aleutian/Pribilof Islands Association, Inc.

1689 C Street
Anchorage, Alaska 99501
Phone (907) 278-3567

February 6, 1979

Thelma Buchholdt
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Mrs. Buchholdt:

Pursuant to our discussion concerning our need for legislation to allow volunteer dentists to serve in our remote areas under permits issued by the State Department of Health and Social Services, we are sending you a packet of materials to bring you up to date and also on the cover a suggested Statute change which will take away the right to issue permits from the self serving dentists and put that authority with the Health Department instead.

Sincerely yours,

Patrick Pletnikoff
Executive Director

PP:alp
Enclosures

25% COTTON FIBER

An Act

Providing for the Practice of

Dentistry by Certain Students

Be it enacted by the Legislature of the State of Alaska,

Section 1. A.S.08.36.350 is amended by adding at the end thereof:

(7) Bona fide students of dentistry in pursuit of clinical studies as provided by A.S.08.36.275.

Section 2. Title 8, Chapter 36, of the Alaska Statutes is amended by adding thereto, the following new section:

Section 08.36.275. Practice of Dentistry by Certain Students.

A license is not required of a bona fide full time dentistry student who, during the period of his enrollment and as part of his course of study, engages in a clinical program which is:

1. Performed under the direct supervision of a:
    A. Member of the faculty of the institution offering the program who is either a professor, associate professor, assistant professor or instructor, or,
    B. A dentist holding a permit or license from the State of Alaska pursuant to A.S.08.36.220, 240, 280, or 285.
2. Sponsored by an institution which files with the board on forms to be provided for this purpose:
    A. Evidence of full insurance coverage and protection afforded all participants in the program from claims under A.S.09.55.535, et seq.

B. A waiver of venue and consent to submit to the jurisdiction of the Alaska State Courts in any suit arising from the practice of dentistry by any participant in such program.

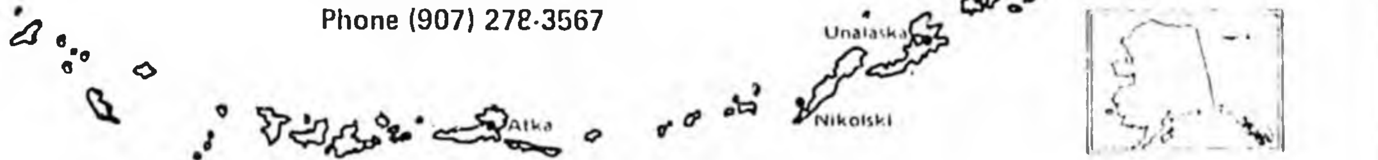
3. Offered by a dental college approved by the Council on Dental Education of the American Dental Association, and the American Association of Dental Examiners.

ok
File - Dental Files

Aleutian/Pribilof Islands Association, Inc.

St. Paul
St. George
Nelson Lagoon
Sand Point
False Pass
Belkofski
King Cove
Akutan

1689 C Street
Anchorage, Alaska 99501
Phone (907) 278-3567



November 17, 1978

Phil Smith, Executive Director
Rural Alaska Community Action Program
P. O. Box 3-3908
Anchorage, Alaska 99501

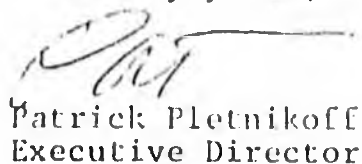
Dear Phil:

We were pleased to be invited to submit an application for an Advocacy Network Contract since we had been left out of your last funding cycle.

This dental program is really badly needed and I think we can swing it through the legislature with a little of this kind of help.

Hopefully you will be able to see your way to fund this little package.

Sincerely yours,



Patrick Pletnikoff
Executive Director

PP:alp
Enclosure

Application for a Network Advocacy
Contract for the Aleutian/Pribilof Islands Association

Anyone who has worked more than even a few weeks in rural Alaska becomes aware of the tremendous dental health problems of the people who live there. PHS and the Native Health Service are responsible only for Native dental health problems and they are unable under their present structure and budget to meet the growing need for care.

Alaska is not alone with its problems of delivery of adequate dental service to pockets of poverty - isolated communities and disadvantaged groups. Nor are they alone in their attempts to solve these problems through conventional channels only to be crushed by insecure schizophrenic professional organizations who fear public programs and volunteer services threaten their livlihood. Even Native adults living in Anchorage have a five year waiting list to sit out before they can get dental care.

Frustrated, angry and desperate for help, APIA staff began l-oking around the country to see how others were solving their rural dental health problems. The most impressive program was operated by the University of California Dental School out of San Francisco, particularly aimed at solving the dental health problems of the migrant farm laborers of California. They have an impressive record of 8 years of service and are now a permanent part of the State health budget. The program is quite simple - socially conscious dentists on staff work with students of the U of C dental school in their senior year of dental school aboard mobile clinics which bring dental health care to the people where they live and

work. It is true they had a head on collision with the dental societies of California, local, regional and state who were worried about their personal income being threatened by these units offering free services, however time and performance healed the breaches and the units continue to fill a tremendous need.

Not only does this operation not threaten private dentistry, but it complements private practice. People become more aware of dental health - prevention and care and as a result whole generations of people choose a private dentist when they can afford one and make room in their lives and budgets for dental health care services.

Hundreds of bush Alaskans are now going to a private dentist when they can as a result of the dental health awareness that has taken place over the years through the public service units like PHS and Indian Health Service.

Alaska's Rural Problems of Dental Health Care Delivery

1. The need is there and demonstrated by at least 2 organizations as intolerable: (a) APIA, (b) Cook Inlet Native Association, (c) North Slope Natives.

APIA - developed a plan with the University of California in San Francisco Dental School for delivery of health care through a mobile clinic approach. The same as was used in California. This mobile clinic became operational this summer and accomplished more than the PHS program over a 5 year period and at no cost to PHS.

Cook Inlet Native Association - hired a full time dentist right under the n[illegible] of PHS in the city of Anchorage, ordered equipment and supplies and built a dental clinic. Surely they did

not do this if there was not need for it as the dental society claims.

What are the Problems?

The problems are PHS and the Alaska Dental Society who are in bed together massaging each other's ego.

Facts

Alaska has no dental school.

Alaska has no provision for licensing or allowing volunteers in training to practice dentistry in Alaska without being in violation of the laws the Dental Society fostered.

The State Public Health Service designated the Aleutian area a distressed isolated area in order to qualify the area for issuance of emergency permits for outside dentists to practice dentistry.

The Dental Society over rode the State health services, ruling that no dentist from outside the State could practice dentistry, even free.

Federal law allowed that the APIA dental program could operate under the umbrella of the PHS or the Armed Forces, but PHS refused to allow us to operate.

This summer the dental volunteer team of 22 people arrived ready to work all summer on kids' teeth under the supervision of the U. C. Dental professors only to be told they would be arrested if they tried to deliver service. The Dental Society refused to allow temporary permits to be issued and the PHS only after pressure from Washington allowed us to operate under their wing for the limited summer program.

Facts (continued)

We have 200,000 worth of mobile dental equipment we are willing to share with the rest of rural Alaska once we get through all the legal hurdles and roadblocks put in our way by the Alaska Dental Society and the Public Health Service.

PHS dentists anticipating retirement soon from PHS intend to obtain Alaskan licenses from their cooperative bedfellows in the Dntal Society and then contract with PHS for delivery of dental services at the outrageous prices contract dentists get for their services in bush Alaska.

The head of the bush dentistry program for the State Dental Society contracted last year at Wainright, Alaska for $45,000 for two-week long sessions.

The same fellow wants to kill off our mobile dental clinic.

We need legislation now to allow volunteer licensed dentists and students supervised by their professors in quality dental schools to practice dentistry in the State of Alaska without violating any laws and without going through the self serving dental society.

We want to design such legislation, generate support for passage early in the session and get our mobile clinic back on the road fixing people's teeth this winter. We feel the $15,000 advocacy grant would be of tremendous assistance in our efforts to improve the dental health of rural Alaska.

Newwork Advocacy Program

Budget

Item	Amount
Personnel	
Primary advocate - ½ time for 3 mo.	3,500
Secretary	1,000
Travel and per diem	
Per diem - 20 days @ $50	1,000
Travel - 4 round trips to Juneau	684
Limo and cab service	250
Rental of space for advocating in an appropriate setting - 18 meetings @ 150 each	2,700
Printing, type set and production support flyers and booklet printing	2,200
Telephone	1,200
Mobile clinic pictures and replicas of units	700
	13,235
Administrative overhead	2,000
	$15,234

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

SCHOOL OF DENTISTRY
Department of Restorative

SAN FRANCISCO, CALIFORNIA 94143

October 5, 1978

Ms. Anna Philemonoff
c/o Aleutian/Pribilof Islands Association
1689 "C" Street
Anchorage, Alaska

Dear Anna,

Enclosed please find all of the addresses, phone numbers, and times at which I can be reached, as per your request.

Please feel free to call or write at any time.

Looking forward to seeing you soon.

Sincerely,

Marvin M. Stark, D.D.S.
Professor of Operative
Dentistry and Oral Biology

RECEIVED
OCT 12 1978
Aleutian/Pribilof Islands
Assn., Inc.

MMS/sf
Enc.

Marvin M. Stark, D.D.S.
Professor of Operative
Dentistry and Oral Biology
532 Parnassus St.
Room 104
San Francisco, CA 94143

(this is the address at the University)

Marvin M. Stark, D.D.S.
23480 Ravensbury
Los Altos Hills, CA 94022

(home address)

Marvin M. Stark, D.D.S.
1150 Scott Blvd
Santa Clara, CA 95050

(private practice)

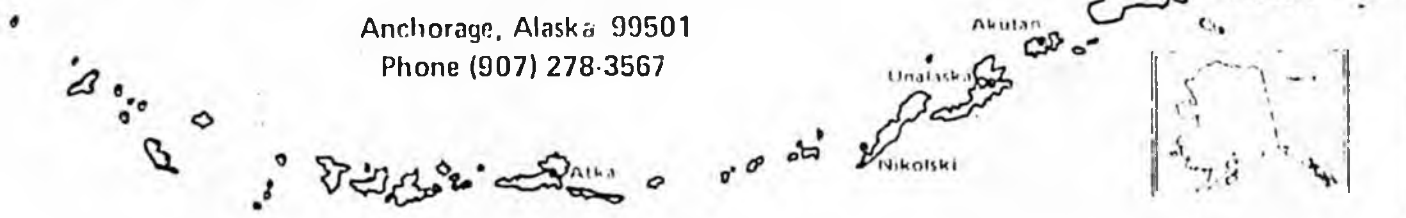
On Mondays and Fridays, Dr. Stark can be reached at the University at (415) 666-2048 or 2030, between the hours of 8:30 and 5:30.

On Tuesdays, Wednesdays, and Thursdays, Dr. Stark is at his private practice. The phone numbers are (408) 246-6588 or 243-4216

Evenings and weekends, his home phone number is (415) 948-6881 or 948-9334.

Aleutian/Pribilof Islands Association, Inc.

1689 C Street
Anchorage, Alaska 99501
Phone (907) 278-3567



September 26, 1978

Mr. Herb Rhodes, Publisher
The Great Lander
3110 Spenard Road
Anchorage, Alaska 99503

Dear Mr. Rhodes:

Your editorial outlining the abuses of the State Bid System was frankly unfair and inaccurate with reference to the Mobile Dental Lab for serving the unmet needs of the Aleutian/Pribilof area.

1. Both the House and Senate approved of the Dental Measure. You claimed they defeated the measure. The House had a floor vote in which it passed unanimously and the Senate Finance Committee gave it a "do pass" vote.

2. The money was intended by the legislature to be appropriated however more programs were approved than the Governor had money for so he was put in the position of making a choice of the best programs approved. He approved this one because it had merit and would bring to the State many times more value than the $200,000 appropriated in volunteer services helping the Native people who needed dental care the PHS was not able or willing to deliver.

3. The Mobile Dental Unit was designed by the staff of the University of California Dental School and built by them, a task only they could accomplish - no other vendor has the capability of building and delivering the unit except the Siemens Company in West Germany and their unit, not half as good as what we got, costs twice as much.

The Department of Health and Social Services did not ever order anything nine months ahead of the time money was appropriated for the unit or even afterwards. The Aleutian/Pribilof Islands

Association, Inc., a non-profit corporation, was given a contract for the development of the units and delivery of them. They made the purchase of the base unit through an Alaskan auto dealer, Alaska Sales & Service, who gave the unit to them "at cost" with no profit whatever, which could never have happened on a bid.

The size of the unit does not limit their versatility at all. They were carefully planned and are near perfect - far superior to anything ever before developed. The reason a Hercules aircraft was used to move a unit to the Pribilofs was because a jealous, hypocritical money grabbing group prevented the delivery of "free" dental services for personal reasons, refusing to issue the permit to practice causing the units to miss the pre-arranged transportation donated by SeaLand to the islands.

The staff was very adequately housed and transported as planned. AHU housed the volunteers while in Anchorage and they were efficiently delivered by Reeve Aleutian to their destination. Your reporting was prejudiced, biased and irresponsible. If you are really interested in what services are or are not provided to the Natives of this State, do a little honest research before you print. The Chairman of the Bush Dentistry Committee of the Dental Association was paid $44,000 for two stints to a bush community by the Indian Health Service last year - could this be a clue as to why they did not want to license volunteers? There is a really good story here, but you missed it completely.

As to the adequacy of dental services to bush Alaska, tell that to the toddlers, the people with swollen tongues from poor dental care and those whose decay causes drainage down their throats all their lives. Forty-five Alaskans out of 100 must conduct their business, work or study enduring dental pain or with essential teeth missing because it's cheaper to fly to Europe for dental care than to stay home and mortgage life and limb to pay for treatment.

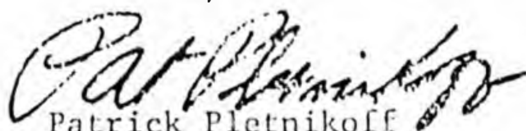
Do you think the Aleutian/Pribilof Islands Association would have sought out dental assistance from out of State if their people were receiving adequate care? Do you think for a minute the Cook Inlet Native Association would have hired their own dentist and invested in a dental office right under the nose of PHS if the service was adequate? Do you think for a moment that we would have had requests for service from our volunteer mobile unit from five areas of the State if their needs were being met? Thank God Governor Hammond is not the kind of person to give in to the political pressures that were brought to bear on him by the PHS personnel and the Alaskan Dental Association and their lobbyists in Juneau - he's got guts and our people are getting their teeth fixed. Can that garbage you are peddling and send

Mr. Herb Rhodes, Publisher
The Great Lander
September 26, 1978
Page Three

it to a more appreciative audience. You may or may not have a legitimate beef on your loss of a printing job, but attacking our dental project is sure not the way to correct it. We would give serious consideration to supporting legislation which takes government at all levels out of the printing business and puts it back with private enterprise because we feel the taxpayer should not be put in th position of competing with his own money for work.

Sincerely yours,

ALEUTIAN/PRIBILOF ISLANDS ASSOCIATION, INC.



Patrick Pletnikoff
Executive Director

PP:alp
Enclosure

cc: Governor Jay Hammond
Bob Atwood, Anchorage Times
Dr. Frederick McGinnis
Senator Glenn Hackney
Senator W. E. Bradley
Senator Ed Willis
Senator Bob Ziegler
Senator Pat Rodey
Senator John Sackett
Senator Bill Sumner
Rep. Alvin Osterback
Rep. Frank Ferguson

Alaska. By 1907, it had become a ... coal and oil center, but by the mid-forties, Katalla had become a ghost town -- a vestige of a bygone era in Alaska's history.

nboots

...d it; the kids understood ...sed it, but I sensed it was

...these people were former ...esidents of Katalla, where ...fined till the mid-thirties ... refinery burned. Now ...e just winter residents, ...the trapping. This was ...e '40's when fur trapping ...orable profession even to ...onists, with no overtones ...gered species" and all ...es, the price of fur was ... good. The permanent ...of Katalla was about two ...sen and "Wolf" Larsen. ...ther all kinds of odds and ...gathering around the big ...e at Bill Hansen's cabin. ...s gathered around the ...e very practical reason -- ...re the light was. One gas ...p hung on a nail above ...nd we all sat at the table ...d, or eat. The gas mantle ...he big round table were ..., in my opinion, that ...so close in the old days. ...of course, was the main ...the two-room cabin.

...one time, early in the ...e of the men brought in 30 ...remember my sense of ...at in the world would we ...0 ducks? But the whole ...pitched in, cleaned and ...e whole smear of them; ...roasted up and a grand ...had by all, there at that ...e in Bill Hansen's cabin. I ...he ducks were actually ...t to other households for ...and all that, I don't ...the details after all these ...I do remember sitting ...at round table eating ...d I remember the tin on

...l Hansen's cabin at one ...ass in the door but it had ...roken and been replaced ...ece of tin. Whenever ...into a bee-bee in his ...rew it against the tin --

...nda fun, and the sort of

...tinued on page 6)

The FREE Great Lander
SHOPPING NEWS & SOURDOUGH SAVER CLASSIFIEDS

Volume 10, No. 37 | Anchorage, Alaska | September 13, 1978

State Purchasing Scandal --

Tis Your Money...And Here's How the State Wastes It!

Two weeks ago the Great Lander went to war with the state of Alaska on its bid and purchase procedures. We declared that the state was ignoring the low award bid procedure as prescribed by law -- worse yet that thousands and even millions were going out with no bids at all -- many to Outside firms leaving Alaskan vendors and taxpayers holding the bag.

As one prime example, the court system admitted to 49 violations amounting to $62,000 in form buying alone. An appeal for public information has kept our telephone ringing. And we hope it continues, through the day and into the Arctic night.

Here are some of the incidents brought to light in a single week:

Radio Equipment. Fred Jones of General Electric, in Anchorage, says the state has purchased approximately $1,500,000 worth of mobile radio equipment since 1973 without bid. He says a contract held by Motorola expired that year and that pleas to Don Harris, head of state transportation, and to Mel Holverston, of the division of communications, for a bid procedure have gone unheeded. "They pay lip service to us and that is all," Jones declares. He says that the state without a bid system has been getting only a 15 percent discount from list price on the radios. Normally, a contract discount would allow 20 to 40 percent off the standard price. He estimates the state in four years has paid $300,000 more for mobile radios than it should have under a formally bid contract. He says he and other suppliers can list 53 violations of state purchasing laws that require competitive bid during the past four years.

Mailing Contract. A contract for approximately $117,000 was placed with a Hawaiian firm for the January through July period. The contract was originally placed in Seattle, but later changed to Hawaii. Bids were asked on this but Ken O'Brien of the American Mailing Equipment Co. of Anchorage says state officials felt no one in Alaska could do this work. O'Brien says his firm advised the state it could be ready in a week. When he inquired into the expiration of the Hawaiian contract, which was to end in July, state officials said a call would be made for new bids. It is now September and O'Brien reports he has never been notified by the state of a call for bids as promised.

Rehabilitation Project. A registered engineer named Louie Overstreet reports he bid $56,000 to conduct a feasibility study on rehabilitating Lynden Arms apartments for the state. He says the contract was awarded to a firm that bid $65,000 -- $8,000 more than his own bid. Overstreet was told by state officials that the other firm offered more "expertise" than his organization.

Floor Covering. Jerry Willis, who has been here since 1955, says he was the only bidder on a state contract to re-carpet the International Airport. The ... Forms, an Outside firm, who entered a higher bid.

Regular Printing. The Anchorage Printing Co. with a bid of $128,000 was low bidder on a state call to print its elections pamphlets. The state went into negotiation with Craftsmen Press of Seattle the following day and awarded that firm the job. Formal bids were never cancelled and re-advertised as required by law. Anchorage Printing was also low bidder by $9,000 on the Capital Site Commission tabloid, but the work went to Craftsmen Press after the state changed the required paper shortly before bid openings, thus eliminating sufficient time to ship the newly called for paper stock north.

School Bus Contract. Bud Goodyear of the Susitna Sentinel says that in May of this year the State Department of Education at Palmer considered accepting a school bus contract that was not the lowest offer. Goodyear reports that the Mat Su Borough officials quickly rectified the system and demanded that new bids be requested.

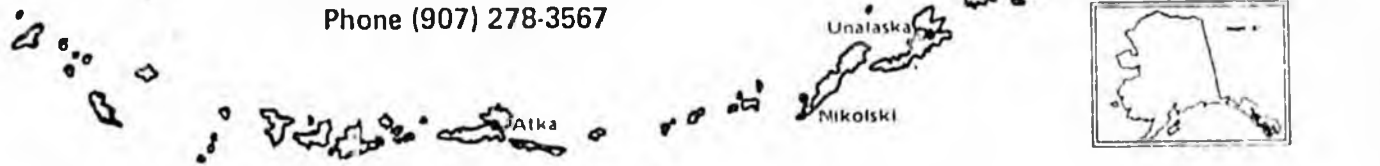
Mobile Dental Lab. When both the Senate and House defeated a measure for a $200,000 mobile dental lab for the Aleutians, the appropriation was slipped through in the governor's capital budget. The two units were purchased without bid as required by state law and are reportedly so large they can only be moved to the Aleutians in a Hercules cargo plane at $1750 an hour. Indications are the units had to be ordered by the Alaska Department of Health and Social Services at least nine months before the money was ever okayed.

The size of the units limits their versatility and insiders say dental care was already being provided Alaskan natives to the westward. No provision was made for a staff and their lodgings or transportation. A team came from the Stark Foundation in California to serve with the units, but Outside dentists are not allowed to practice in Alaska.

Form Printing. K and R Printing, now called Printmore, says it has fought the state for years to get form printing out on bid in the court system. The state ...

Aleutian/Pribilof Islands Association, Inc.

1689 C Street
Anchorage, Alaska 99501
Phone (907) 278-3567



September 20, 1978

G. H. Ivey, Director
Alaska Area Native Health Service
Anchorage, Alaska

Dear Mr. Ivey:

Thank you for your letter of September 12, 1978 in which you point out what appeared to you to be inaccuracies in my letter of August 7th.

It was our impression PHS was in some way associated with the U of A Dental Hygiene Program which was why I specifically asked how this training activity was covered legally, thinking that if they had found a way to square with the Statutes we might use the same route. I don't recall anyone at our meeting ever saying that PHS was not in fact a sponsor so I just assumed they were. I apologize for the misinterpretation. In any case, how are they covered?

The statement about covering the expenses of PHS supervisor of our program was in fact made by Dr. Smole. At least that's the way we heard it.

On Page 2 you call our attention to the fact that the Aleutian Islands area had been declared a remote area under the State Statutes and that there would be no difficulty for volunteer dentists and hygienists to receive permits to practice in Alaska. As you know that was the intention of the legislation but this intention was by-passed by the State Dental Board when their board met on December 16th and decided to stop issuing any temporary permits to practice in Alaska. We did not know of this decision by the Alaska Dental Board until May of this year and we are certain the legislators did not know of this short circuit either.

G. H. Ivey, Director
Alaska Area Native Health Service
September 20, 1978
Page Two

It is difficult to understand why the Alaska Dental Society an the Alaska State Board of Dentistry would be upset with PHS because they cooperated with us on this project. We very much appreciate your strength of conviction and dedication to servi which prompted you to help us out when we had no place else to turn.

The reason we have contacted other health organizations in rega to this project was to ascertain if there was sufficient need an interest for establishing a health support training program at AMU, since we would not alone have students in sufficient number to make up a class or a program.

We were told by the Dentist at Cook Inlet they might want to train several for their new unit, and we have also spoken with the Chugach group. There is not anything confidential or secretive about our inquiries nor has there ever been. As a matter of fact, I would think your service unit might want to be involved in not only the planning of such a program but in the hands on clinical experience as well since we expect many of those who complete the program to seek employment in the bush areas when the demand is sufficient to employ them.

As to future planning of mobile dentistry project, we are now ready to sit down and talk with you and your staff concerning where we want to function next, record keeping and cooperation. If we are to function to everyone's advantage, we will not want to be operating in competition with your schedule; rather, we would like to complement your efforts and you likewise.

As to a full time coordinator being hired this is not yet the case. However, we have asked Terry Buterin, a young Aleut man from St. Paul to spend some time with the unit, learn what he can and to then decide if he wants to pursue a training program at UCF Dental School, leading to a special certificate in mobile dentistry. He seems very excited about the potential for such a program and we will attempt to get it off the ground. It is possible at that time we might want to petition for a budgeting change to reflect this change of scope of our previously designed program and activities.

We are very pleased with your expressed willingness to work with us further this year.

Our hope is that we can move the unit from the Pribilofs this month and become operational with the following staffing by November 1st.

The UCSF Dental School has agreed to furnish us with a graduate periodontist who will supervise two dental students and a hygienist in training to be rotated each month until the summer program begins again. The cost of this phase of the program would be about $24,000 for the rest of the year including air fare and per diem.

We would appreciate having your thoughts on this and meeting with you and your staff to discuss the details at your earliest convenience.

Thanks again for your help on the Pribilofs project this summer. We look forward to meeting with you soon.

I talked with Dr. Soelberg and he says all the records were left in the stap van. If you want them sent to your office we can arrange this when we move the unit.

Sincerely yours,

ALEUTIAN/PRIBILOF ISLANDS ASSOCIATION, INC.

J. D. Milne
Consultant

JDM:alp

cc: Dr. Arthur Hansen, President, Alaska Board of Dentistry
Ms. Beverly Long, Senator Gravel's Office
Dr. Thomas Redmond, President, Alaska Dental Society
Mr. Watson, Chief, Office of Personnel, ANHS
Dr. Morrow, Director, Dental Hygiene Program, UAA
Dr. Smole, Chief, Service Unit Dental Program, ANMC
Dr. Glen Olds, President, AMU
Dr. Marvin Stark, UCSF

Dr. Smole
Chief, Service Unit Dental Program
Alaska Native Medical Center
Box 7741
Anchorage, Ak

Dr. Glen Olds
President, AMU
Grant Hall
Anchorage, Ak

Beverly Long
Fed. Building
Office of Senator Gravel
Anchorage, AK

Dr. Author Hansen
President, Ak Board of Dentistry
Alaska Dental Society
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Anchorage, Ak

Dr. Marvin Stark
Univ. of CA Dental School
Mobil Clinic
San Francisco, CA

Dr. Thomas Redmond
Pres. Alaska Dental Society
3606 Phone Circle
Anchorage, AK

Mr. Watson
Chief, Office of Personnel
ANMC
Box 7741
Anchorage, AK

Dr. Morrow
Director, Dental Hygiene Program
2651 Providence Dr. UAA
Anchorage, Ak

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

September 12, 1978

Refer to A-D (A-DE)

ALASKA AREA NATIVE HEALTH SERVICE
BOX 7-741
ANCHORAGE, ALASKA 99510

Dr. Fredrick McGinnis
Deputy Director
Alaska Department of Health
and Social Services
McKay Building
Anchorage, Alaska 99501

Dear Dr. McGinnis:

This agency has received a copy of a memorandum dated August 7, 1978, from Dr. J. D. Milne, Dental Project Consultant, Aleutian Pribilof Island, Assn. The memorandum was in relation to a meeting between Aleutian Pribilof Island, Assn., the Alaska Native Health Service and Senator Gravel's office. I would like to take the opportunity to point out to you the inaccuracy of some statements in Dr. Milne's memorandum.

The U. S. Public Health Service is not associated with the University of Alaska Dental Hygiene program, nor do the students in this program practice under the auspices or the federal government. In the past, the Alaska Native Health Service, has trained persons in dental assisting in association with Sheldon Jackson College.

Dr. Milne also stated, "they will consider allowing us to operate under this direct supervision... and added that we would have to pay for their supervision". The Alaska Native Health Service is always interested in supporting individuals and organizations committed to the improvement of the health of the Alaska Native people. We do not, nor have we in the past required payment for our support. In fact, in most instances we provide financial assistance. In this project we were not included in the planning or arrangements for what we were assured was a State of Alaska Program.

Dr. Milne implied the Alaska Native Health Service was not willing to employ volunteers. Persons providing volunteer services within the federal health system must meet all the requirements of federal employees performing the same health care. Having met those requirements, volunteer employees are entitled to all of the benefits of the federal government, save those relating to compensation (salary, retirement etc). We must accept responsibility for the individuals themselves as well as the services they provide. We cannot place individuals in "nominal employment", in order to circumvent state statutes as we were requested by Aleutian Pribilof Island, Assn.

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SEP 19 1978
Aleutian/Pribilof Islands
Assn., Inc.

Further, it was our understanding that the State Department of Health and Social Services had declared the Aleutian Pribilof Islands a remote area under State Statutes and there would be no difficulty for volunteer dentists and hygienists to receive permits to practice in Alaska. We were assured the Aleutian Pribilof Island, Assn Mobile Dental Project did not involve the Alaska Native Health Service. It was a project authorized by the legislature of the State of Alaska to be carried out under applicable state statutes and with the support of appropriate state agencies.

As you know, this did not occur. My reasons to reverse an earlier decision to not become involved and to employ the volunteers under federal regulations authorizing volunteer employment were:

1. The Alaska Native Health Service has a committment to support Alaska Native Health organizations such as the Aleutian Pribilof Island Assn.

2. We have a responsibility for the health of Alaska Native people. If this project failed because of licensing problems, the persons to suffer would be potential recipients of care..

3. Considerable State of Alaska funds had been expended for the purchase of equipment and the expenses of the several volunteers from California. If we did not employ the individuals in our program these expenditures would have been wasted entirely.

4. The dentists, dental hygienists and other volunteers were found to be well qualified, sincere and concerned individuals. Their efforts and time would have been similarily wasted.

5. The people of St. Paul and St. George supported this program and requested our assistance.

Even though my decision has resulted in a serious breach in our relations with the Alaska Dental Society and the Alaska State Board of Dentistry,

I feel the care being provided compensates for the expenditure of federal funds and the use of federal authority. It is my request that your office provide assistance to the Aleutian Pribilof Island Assn., in securing proper licensure and/or permits for volunteer personnel to practice in Alaska in the future. I would also appreciate being kept advised by your office of future plans and operations of this project.

Sincerely,

G. H. Ivey
Director
Alaska Area Native Health Service

Enclosure (1)

cc: Dr. Arthur Hansen, President, Alaska Board of Dentistry
Ms. Beverly Long, Senator Gravel's Office
Dr. Thomas Redmond, President, Alaska Dental Society
Mr. Watson, Chief, Office of Personnel, ANHS
✓Mr. Pletnikoff, Director, APIA
Dr. J. D. Milne, Consultant, APIA
Dr. Morrow, Director, Dental Hygiene Program, UAA
Dr. Smole, Chief, Service Unit Dental Program, ANMC

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SAN FRANCISCO, CALIFORNIA 941

September 11, 1978

Dr. James Milne
Aleutian/Pribilof Islands Association, Inc.
430 "C" Street
Suite 303
Anchorage, Alaska 99501

Dear Jim,

Enclosed please find brochure and price list for Siemens equipment. The items we purchased were encircled on pages 21 and 27. The price listed is retail and we get 35% discount.

The cost of the bus is approximately 150-170 thousand dollars, depending on the equipment. You will note that the chair featured in the brochure is not as new as the one we used in our bus.

I trust this is what you needed.

Best wishes.

Sincerely,

Marvin M. Stark, D.D.S.
Professor of Operative
Dentistry and Oral Biology

MMS/sf
Enc.

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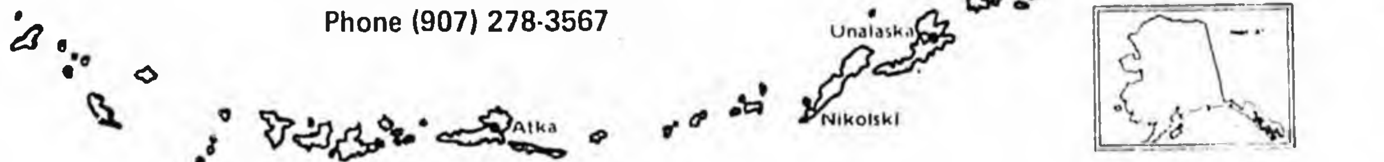
Aleutian/Pribilof Islands Association, Inc.

1689 C Street
Anchorage, Alaska 99501
Phone (907) 278-3567



September 5, 1978

Dr. Glen Olds
President
Alaska Methodist University
Anchorage, Alaska

Subject: APIA Dental Program

Dear Dr. Olds:

We would like to propose the following program be developed at AMU to serve the health support requirements of bush Alaska. We feel we could furnish a number of students from the Aleutian as well as from other native organizations such as Chugach and Cook Inlet.

Cook Inlet is planning a dental facility designed to accommodate 3 chairs with a demand for at least 2 assistants and perhaps 2 hygienists. The APIA facility could easily use 6 such persons for the summer months and one in each village during the year.

We would be happy to assist AMU in a search for funding of such a project should you be interested in pursuing it further.

Naturally, such students would need an operational facility available for training. For this purpose our mobile clinic would be available as well as the new Cook Inlet Dental Unit. Our mobile unit then would become an important element of your training program and essential to your operation. As an institution of higher learning you would be legally able to operate the mobile clinic either alone or in consort with the University of California Dental School of U.S.C. or any other school you might be comfortable with. Emery was suggested as a possibility at one time and the Stark Foundation would have no objection to this whatever.

Please find enclosed the Alaska Statutes which were obviously designed to meet the bush needs for dentistry. However, since

that time steps have been taken by the dental association and the examining board to circumvent this intention. As an example the board decided last year in its December meeting to abolish temporary permit issuance totally.

We are also sending you a fairly complete run down on what has taken place with this program and the bases touched since its inception. You will readily see that it has been an uphill vested interest battle politically as volatile as the AMN Program. It is only fitting and proper that we join forces to combat the anti social groups who are more worried about lining their pockets than delivery of service.

Sincerely yours,

ALEUTIAN/PRIBILOF ISLANDS ASSOCIATION, INC.

Patrick Pletnikoff
Executive Director

PP:alp
Enclosures

Article 3. General Provisions.

Section
190. "Board" defined

Sec. 08.32.190. "Board" defined. Board means the Board of Dental Examiners.

Chapter 36. Dentistry.

Article
1. Board of Dental Examiners (§§ 08.36.010—08.36.091)
2. Examination and Licensing (§§ 08.36.100—08.36.300)
3. Unlawful Acts (§§ 08.36.310—08.36.340)
4. General Provisions (§§ 08.36.350—08.36.360)

Article 1. Board of Dental Examiners.

Section
10. Creation and membership of board
20. Appointment and term of service of members
30. Election of officers
40. Meetings
50. Quorum
60. [Repealed]
70. General powers
80. Applicability of Administrative Procedure Act
90. [Repealed]
91. Records and reports

Sec. 08.36.010. Creation and membership of board. There is created the Board of Dental Examiners, referred to in this chapter as the board, consisting of seven members. Five members shall be qualified resident dentists who have been engaged in the practice of dentistry in the state for five years immediately preceding appointment, one member shall be a dental hygienist licensed under AS 08.32, and one member with no direct financial interest in the health care industry. (§ 1 art II ch 186 SLA 1955; am § 2 ch 155 SLA 1968; am § 8 ch 102 SLA 1976)

Effect of amendment. — The 1976 amendment substituted "seven members" for "five members" at the end of the first sentence and rewrote the second sentence.

Editor's note. — Section 1, ch. 155, SLA 1968, provides: "**Purposes.** The practice of dentistry in the state is hereby declared to affect the public health, safety and welfare and to be subject to regulation and control in the public interest. It is further declared to be a matter of public interest and concern that the dental profession merit and receive the confidence of the public and that only qualified dentists be permitted to practice dentistry in the state. All provisions of this chapter relating to the practice of dentistry and dental hygiene and to the registration of dental laboratories shall be liberally construed to carry out these objects and purposes."

Am. Jur., ALR and C.J.S. references. — 41 Am. Jur., Physicians and Surgeons, §§ 13, 23.

Dentist as within statutes pertaining to physician or surgeon, 115 ALR 261.

70 C.J.S. Physicians and Surgeons §§ 1 to 5.

Sec. 08.36.020. Appointment and term of service of members. Members of the board are appointed by the governor, subject to confirmation by the legislature in joint session. Each board member serves for a term of five years, and until his successor is appointed and qualified. The term begins on February 1. An appointment to a vacancy

is for the unexpired term. (§ 2 art II ch 186 SLA 1955; am § 1 ch 59 SLA 1964; am § 9 ch 102 SLA 1976)

Effect of amendment. — The 1976 amendment deleted "assembled" from the end of the first sentence and deleted the former fifth through eighth sentences, which related to a list of names from which appointments were to be made.

Sec. 08.36.030. Election of officers. The board shall elect a president and a secretary from among its members, each to serve for a term not to exceed two years. (§ 3 art II ch 186 SLA 1955; am § 1 ch 121 SLA 1972)

Sec. 08.36.040. Meetings. The board shall meet as often as, and at the times and places, necessary to conduct its business. (§ 3 art II ch 186 SLA 1955)

Sec. 08.36.050. Quorum. A majority of the board constitutes a quorum for the transaction of business. (§ 4 art II ch 186 SLA 1955)

Sec. 08.36.060. Expenses and salary.
Repealed by § 3 ch 59 SLA 1966.

Sec. 08.36.070. General powers. The board shall have, but not by way of limitation, the following powers and duties:
(1) to examine and issue licenses to applicants;
(2) to register licensed dentists in good standing;
(3) to submit an annual report of its proceedings to the governor and to members of the Alaska Dental Society, containing a statement of money received and disbursed;
(4) to affiliate with the American Association of Dental Examiners, and pay annual dues to the association;
(5) to hold hearings, revoke, annul, or suspend the license of a person who violates this chapter or the rules and regulations of the board;
(6) to supply forms for applications, licenses, permits, certificates, and other papers and records;
(7) to enforce the provisions of this chapter and make, alter, or amend the rules and regulations necessary or desirable to make the provisions of this chapter effective. (§ 5 art II ch 186 SLA 1955; am § 6 ch 69 SLA 1970)

Legislative committee report. — For report on ch. 69, SLA 1970 (HB 564), see 1970 House Journal Supplement No. 2, p. 7.

Sec. 08.36.080. Applicability of Administrative Procedure Act. The board shall comply with the Administrative Procedure Act (AS 44.62).

Sec. 08.36.090. Records and reports.
Repealed by § 3 ch 59 SLA 1966.

Sec. 08.36.091. Records and reports. The board shall maintain

(1) a record of its proceedings;

(2) a register containing the name, office and home addresses, and other information considered necessary by the board, of each person licensed as a dentist or dental hygienist, and a register of the licenses revoked by the board, and information on the status of each licensee. (§ 3 ch 155 SLA 1968)

Article 2. Examination and Licensing.

Section
100. License required
110. Qualifications of applicants
115. Malpractice insurance
120. Photograph and filing date of application
130. Examination
140. Out-of-state examination
150. Examination in out-of-state dental schools
160. Contents of examination
170. Partial examination
180. Re-examination
190. Grading of examination
200. Waiver of written examination
210. Waiver of examination by reciprocity
220. Issuance of license by reciprocity
230. Practice outside the state

Section
240. Issuance of license; recordation; display
244. License to practice as specialist required
246. Qualification for a specialist license
247. Limitation of special practice
248. Suspension or revocation of specialty licenses
250. Biennial registration
260. Branch office registration
270. [Repealed]
271. Permits for isolated areas
280. Temporary permit
285. [Repealed]
290. Fees and penalties
300. [Repealed]

Sec. 08.36.100. License required. No person, except those specifically exempted from the application of this chapter, may practice, or attempt to practice, dentistry without a license or permit, and a current certificate of registration. (§ 1 art III ch 186 SLA 1955; am § 4 ch 155 SLA 1968)

ALR and C.J.S. references. — Unlicensed dentist's right to recover for services, 30 ALR 860; 118 ALR 661.

Right of corporation or individual not himself licensed, to practice dentistry rough licensed employees, 103 ALR 1240.

Constitutionality and construction of statutes or regulations prohibiting one who has no license to practice dentistry from owning, maintaining, or operating an office therefor, 20 ALR2d 808.

70 C.J.S. Physicians and Surgeons §§ 6 to 24.

Sec. 08.36.110. Qualifications of applicants. An applicant for a license to practice dentistry may apply to the board for an examination and license by submitting information that he is

(1) Repealed by § 25 ch 245 SLA 1970.

(2) of good moral character;

(3) Repealed by § 10 ch 127 SLA 1974.

(4) a graduate of a dental college approved by the Council on Dental Education of the American Dental Association at the time of graduation, and holds a D.D.S. or D.M.D. degree or the equivalent;

(5) Repealed by § 1 ch 36 SLA 1970. (§ 2 art III ch 186 SLA 1955; am § 1 ch 26 SLA 1965; am § 1 ch 36 SLA 1970; am § 7 ch 69 SLA 1970; am § 25 ch 245 SLA 1970; am § 10 ch 127 SLA 1974)

Effect of amendment. — The 1974 amendment repealed paragraph (3).

Legislative committee reports. — For report on ch. 69, SLA 1970 (HB 564), see 1970 House Journal Supplement No. 2, p. 7. Chapter 245, SLA 1970 (HCSSB 399 am H), was identical to CSHB 406 (Jud.). For report on CSHB 406 (Jud.), see 1970 House Journal Supplement No. 6.

For report on ch. 127, SLA 1974 (SCSHB 817 am S), see 1974 House Journal, p. 657.

Sec. 08.36.115. Malpractice insurance. If medical malpractice insurance for dentists becomes unavailable on the voluntary market and the director of insurance finds, after public hearing, that the unavailability is impairing the delivery of dental services to the public, the director of insurance may require all persons licensed under this chapter to carry medical malpractice insurance and to purchase their insurance from the Medical Indemnity Corporation of Alaska established under AS 21.88. If a finding of unavailability of insurance on the voluntary market and impairment of services has been made under this section, purchase of medical malpractice insurance from the Medical Indemnity Corporation of Alaska is a condition of licensure under this chapter. The provisions of this section are statisfied if the licensee's employer maintains insurance for him from the Medical Indemnity Corporation of Alaska. (§ 10 ch 102 SLA 1976)

Sec. 08.36.120. Photograph and filing date of application. Each applicant shall submit a recent unmounted, autographed photograph of himself. Applications shall be filed at least 30 days before the date scheduled for an examination. (§ 2 art III ch 186 SLA 1955)

Sec. 08.36.130. Examination. An examination shall be given at times and places determined by the board to be convenient and economical for the applicants and the state. At least once each year the board shall appoint from its membership an examination committee of at least three persons. The examination committee shall conduct an examination at least once a year and report the results to the board for official action. (§ 3 art III ch 186 SLA 1955; am § 5 ch 155 SLA 1968)

Sec. 08.36.140. Out-of-state examination. If an applicant requests the board to hold an examination outside the state, the board may require the applicant to pay the transportation costs to the members of the committee conducting the examination. (§ 3 art III ch 186 SLA 1955)

Sec. 08.36.150. Examination in out-of-state dental schools. The examination committee, with the approval of the board, may conduct an examination in the clinic of an approved dental school within the continental limits of the United States and admit to the examination a dental student in his last year of school who would otherwise be eligible

for admission to examination and licensing in the state upon completion of his education. (§ 3 art III ch 186 SLA 1955)

Sec. 08.36.160. Contents of examination. The examination shall be clinical and written and of such a character as to test in a satisfactory manner the qualifications of the applicant to practice dentistry. The examination shall consist of the following:

(1) The subjects of the written examination shall be selected in accordance with the trend of dental education as determined by the Council of Dental Education of the American Dental Association.

(2) The applicant shall give demonstration of his skill in operative and the prosthetic dentistry or any procedures as recommended by the American Association of Dental Examiners. (§ 4 art III ch 186 SLA 1955; am § 6 ch 155 SLA 1968)

Sec. 08.36.170. Partial examination. A student at least 19 years of age who has satisfactorily completed regular courses of instruction in dentistry in at least two different school years at an approved dental school, and who is certified by the dean of the college as having satisfactorily completed the subjects included in section I of the examination may take section I of the examination. If the student passes section I and subsequently takes the full examination, the requirements of section I are waived. (§ 5 art III ch 186 SLA 1955)

Sec. 08.36.180. Re-examination. An applicant shall pass each subject of each section of the examination with a score of at least 75 per cent. If an applicant fails in one subject in each section, he may be re-examined in that subject. If an applicant fails in more than one subject in any section, he shall be re-examined in the whole section. If an applicant fails the examination or any section of it on two separate occasions, the board shall refuse to examine him further until he produces evidence satisfactory to the board that he has pursued further study in preparation for the examination. (§ 6 art III ch 186 SLA 1955)

Sec. 08.36.190. Grading of examination. Upon the conclusion of the written examination and as soon as practicable, the papers shall be rated by an examiner. The examiner shall prepare a report in duplicate on each written examination and a report in duplicate on each practical examination. The examiner shall forward one copy of each report on each candidate to the secretary of the board and one copy to the division of occupational licensing. The secretary shall prepare a composite report on each applicant and file one copy of his report with the division of occupational licensing. As soon as practicable the division of occupational licensing shall notify each candidate of the results of the examination. (§ 7 art III ch 186 SLA 1955; am § 2 ch 121 SLA 1972)

Sec. 08.36.200. Waiver of written examination. The board may waive the requirement for written examination for an applicant who holds a certificate from the National Board of Dental Examiners that

he has passed the theoretical or written examination given by the national board. (§ 8(a) art III ch 186 SLA 1955)

Sec. 08.36.210. Waiver of examination by reciprocity. The board may waive the requirement for written examination for a graduate of an approved dental school who has been licensed, and has been in legal and reputable practice of dentistry in a state, territory, district or possession of the United States which has requirements for licensing, and give reciprocal rights, equivalent to those of this state, if the applicant meets the requirements of § 110 of this chapter. (§ 8(b) art III ch 186 SLA 1955; am § 3 ch 121 SLA 1972)

Sec. 08.36.220. Issuance of license by reciprocity. If an applicant having the qualifications contained in §§ 110 and 210 of this chapter has been engaged in the practice of dentistry for a period of five years in the state, territory, district or possession of the United States, immediately preceding his application to practice in the state, the board may license the applicant without examination. (§ 9 art III ch 186 SLA 1955; am § 2 ch 26 SLA 1965; am § 7 ch 155 SLA 1968; am § 4 ch 121 SLA 1972)

Sec. 08.36.230. Practice outside the state. A dentist licensed to practice in this state and residing and practicing dentistry outside of this state, may maintain his eligibility to practice in this state by biennially registering his name and place of residence with the division of occupational licensing. If the dentist fails to register, the board may reinstate his license without examination upon payment of a penalty of $25, payment of all delinquent registration fees, and presentation of proof of active practice at his place of residence, certified by the dental board having jurisdiction at his place of residence, or, if there is no board, by evidence satisfactory to the board. (§ 10 art III ch 186 SLA 1955; am § 5 ch 121 SLA 1972)

Sec. 08.36.240. Issuance of license; recordation; display. The board shall issue a license to each successful applicant who has paid the required fees. The holder of a license shall register it in the office of the clerk of the superior court in the judicial district of his place of residence. The licensee shall display the license in a conspicuous place where he practices. (§ 11 art III ch 186 SLA 1955; am § 6 ch 121 SLA 1972)

Sec. 08.36.244. License to practice as specialist required. No licensed dentist may hold himself out to the public as being especially qualified in a branch of dentistry by announcing through the press, sign, card, letterhead or printed matter, or any means of public advertising, using such terms as "specialist," or inserting the name of the specialty, or using other phrases customarily used by qualified specialists that would imply to the public that he is so qualified, without first securing a specialist's license as provided in this chapter. (§ 8 ch 155 SLA 1968)

Sec. 08.36.246. Qua cation for a specialist license. (An applicant for a specialty license must

(1) possess a license to practice dentistry in the state, and

(2) have completed two or more academic years of advanced education in the specialty.

(b) The provision of (a) (2) of this section does not apply to dentists who have limited their practice exclusively and who ethically announced limitation of practice in accordance with American Dental Association policy before July 23, 1968. (§ 8 ch 155 SLA 1968)

Sec. 08.36.247. Limitation of special practice. (a) No specialty license may be issued unless the applicant presents proof satisfactory to the board that he is qualified to practice that specialty.

(b) This section may not be construed as limiting or preventing a licensed and qualified dentist from performing, without a specialty license, dental acts or services to the public in any of the branches of dentistry, except that no dentist may administer a general anesthetic to a patient without a valid permit as required by regulations of the dental examiners board. (§ 8 ch 155 SLA 1968)

Sec. 08.36.248. Suspension or revocation of specialty licenses. The board may suspend or revoke a specialty license upon any grounds set out in § 310 of this chapter, and the procedure for suspensions and revocations shall be the same as for the revocation or suspension of a regular license to practice dentistry. (§ 8 ch 155 SLA 1968)

Sec. 08.36.250. Biennial registration. At least 60 days before January 1 of every other year, the division of occupational licensing shall mail a form for biennial registration to each licensed dentist. Each licensee shall complete the form and return it together with the registration fee. The division of occupational licensing shall, as soon as practicable, issue a registration certificate valid for the years for which issued. Each licensee shall keep the registration certificate beside or attached to his license. Failure to receive the registration form does not exempt a dentist from biennial registration. (§ 12 art III ch 186 SLA 1955; am § 9 ch 155 SLA 1968; am § 7 ch 121 SLA 1972)

Sec. 08.36.260. Branch office registration. A licensee who practices in an established office with an address other than that address for which his biennial registration certificate is issued shall obtain a branch office registration certificate for each office. (§ 13 art III ch 186 SLA 1955; am § 10 ch 155 SLA 1968)

Sec. 08.36.270. Permits for isolated areas.
Repealed by § 3 ch 26 SLA 1965; § 5 ch 93 SLA 1965.

Sec. 08.36.271. Permits for isolated areas. (a) The Department of Health and Social Services shall designate as isolated areas those specific places and regions remote from major population centers which

are not served by dentists licensed under this chapter and which have a geographical location which works financial hardship, extended loss of time, or arduous and costly travel upon residents needing dental care.

(b) The board shall, upon recommendation of the Department of Health and Social Services, issue an annual permit authorizing the treatment of residents in an area designated under (a) of this section, who are not entitled to dental care by the state or federal government, by a dentist employed by the United States Public Health Service or qualified member of the armed services who serves in that area. (§ 1 ch 93 SLA 1965; am § 11 ch 155 SLA 1968; am § 6 ch 104 SLA 1971)

Sec. 08.36.280. Temporary permit. (a) The board may issue a one year temporary permit without examination to an applicant to practice dentistry in a locality requested by the applicant if the locality is of the type specified in (2) of this subsection and the applicant

(1) meets the requirements of § 110 of this chapter;

(2) desires to practice dentistry in a city or rural village which does not have a resident licensed dentist in active general practice;

✓(3) has a license in good standing to practice dentistry in a state, territory, district or possession of the United States;

(4) tenders and pays the fee prescribed in § 290 (6) of this chapter.

(b) The board may authorize a temporary permittee to practice dentistry in more than one city or rural village of the type specified in (a) (2) of this section.

(c) The board may annually renew a temporary permit upon written application of an applicant and upon payment of the prescribed fee if the applicant has not committed an act which is a ground for revocation in § 310 of this chapter, but in any case, within two years from issuance of his first temporary permit, the applicant must pass a board exam.

(d) A temporary permit may be revoked, suspended or annulled, or the permittee may be reprimanded, censured or disciplined by the board in the same manner and for the same cause as a licensed dentist under § 310 of this chapter.

(e) The board shall grant or deny an application for a temporary permit within 60 days after it is received. (§ 15 art III ch 186 SLA 1955; am § 4 ch 26 SLA 1965; am §§ 8, 9 ch 121 SLA 1972)

Sec. 08.36.285. Licensing a permittee.
Repealed by § 10 ch 121 SLA 1972.

Editor's note. — The repealed section derived from § 5, ch. 26, SLA 1965.

Sec. 08.36.290. Fees and penalties. The board shall impose and collect the following fees and penalties:

(1) for the issuance of an original license, $30;

(2) for the examination of an applicant, $50;

(3) for re-examination of an applicant, $50;

(4) for biennial registration, $40;
(5) for each branch office biennial registration, $40;
(6) for a temporary permit, $25;
(7) Repealed by § 7 ch 94 SLA 1968.
(8) for re-instatement as provided in § 230 of this chapter a penalty of $10;
(9) for a specialty license, $30;
(10) for a duplicate license, $10. (§ 16 art III ch 186 SLA 1955; am § 7 ch 94 SLA 1968; am § 12 ch 155 SLA 1968)

For history of taxation of profession of dentistry, see United States v. Dasher, 9 Alaska 719 (1940).

C.J.S. references. — 53 C.J.S. Licenses § 34; 70 C.J.S. Physicians and Surgeons §§ 2 to 4, 6 to 8.

Sec. 08.36.300. Deposit of fees and payment of expenses. Repealed by § 3 ch 59 SLA 1966.

Article 3. Unlawful Acts.

Section
310. Grounds for revocation of license
320. Order of reprimand, suspension and revocation
325. Limits or conditions on license; discipline

Section
330. Injunction
340. Penalties

Sec. 08.36.310. Grounds for revocation of license. A license and registration may be revoked, suspended, or annulled, or the licensee may be reprimanded, censured, or disciplined by the board after hearing when he

(1) secures a license through deceit, fraud, or wilful misrepresentation of a material fact;
(2) is convicted of a crime involving moral turpitude;
(3) has a chronic or persistent inebriety or addiction to habit-forming drugs which renders him incompetent to continue the practice of dentistry;
(4) commits wilful or gross malpractice or wilful or gross neglect in the practice of dentistry;
(5) hires, supervises, permits or aids unlicensed persons to practice dentistry;
(6) is insane or has a contagious or infectious disease making him an improper person to continue in the practice of dentistry;
(7) practices or offers to practice dentistry under a name other than the name in which the license is issued;
(8) uses the name of a company, association, corporation, trade name, dental clinic, or business name in connection with the practice of dentistry;
(9) knowingly practices in the employment of or in association with a person who is practicing in an unlawful manner;

(10) uses an advertising solicitor or free-publicity press agent;

(11) wilfully deceives or attempts to deceive the board with reference to any matter under investigation by it;

(12) advertises professional superiority;

(13) advertises free dental work or free examination;

(14) advertises prices for professional service;

(15) advertises to perform any dental operation painlessly;

(16) advertises by means of a large display, glaring light sign, or sign containing as a part of it the representation of a tooth, bridgework, or any portion of the human head;

(17) advertises by a medium other than the carrying or publishing of a modest professional card or the display of a modest window or street sign at the licensee's office containing the name, address, profession, office hours, telephone number and specialty;

(18). permits the use of his name as a dentist by others in the sale or advertisement of products;

(19) violates a provision of this chapter or a regulation of the board promulgated under authority of this chapter;

(20) advertises as a specialist in any branch of dentistry, unless he devotes a major portion of his practice to that branch;

(21) engages in the practice of fee-splitting;

(22) engages in unprofessional conduct;

(23) obtains a fee by fraud;

(24) directly or indirectly advertises or solicits for dental hygiene business;

(25) advertises as a specialist in a branch of dentistry without first obtaining a specialty license;

(26) fails to report a death that occurred on premises used for the practice of dentistry to the office of the secretary-treasurer of the board within 72 hours;

(27) administers a general anesthetic without a valid permit required by regulations of the dental board. (§ 1 art IV ch 186 SLA 1955; am §§ 13—15 ch 155 SLA 1968)

Cross reference. — As to malpractice actions, see AS 09.55.530—09.55.560.

ALR references. — Ground for revocation, 54 ALR 1504; 82 ALR 1181.

What amounts to conviction within statute making conviction ground for cancelling license, 113 ALR 1179.

Revocability of license for fraud or other misconduct before or at the time of its issuance, 165 ALR 1138.

Admissibility and necessity of expert evidence in proceeding for revocation of license, 6 ALR2d 675.

Sec. 08.36.320. Order of reprimand, suspension and revocation. The board may, by a majority vote, evidenced by the signatures of the members on the order, reprimand a licensee or revoke or suspend a license. (§ 5 art IV ch 186 SLA 1955)

Sec. 08.36.325. Limits or conditions on license; discipline. (a) In addition to actions under §§ 310 and 320 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health, the authority to practice dentistry should be limited or conditioned or the practitioner disciplined, the board may censure, place on probation, restrict practice by specialty, procedure or facility, require additional education or training, or revoke or suspend a license.

(b) The Administrative Procedure Act (AS 44.62) applies to any action take by the board under this section. (§ 10 ch 102 SLA 1976)

Sec. 08.36.330. Injunction. The board may sue in its own name in a competent court to enjoin any person from doing an act consituting a violation of this chapter. (§ 7 art IV ch 186 SLA 1955)

Sec. 08.36.340. Penalties. A person who violates any provision of this chapter for which no specific penalty is provided, is guilty of a misdemeanor and is punishable by a fine of not more than $500, or by imprisonment for not more than six months, or by both. (§ 8 art IV ch 186 SLA 1955)

Article 4. General Provisions.

Section
350. Application of chapter
360. Practice of dentistry defined

Sec. 08.36.350. Application of chapter. This chapter applies to a person who practices, offers or attempts to practice dentistry in the state except

(1) dental surgeons or dentists in the military service in the discharge of official duties;

(2) licensed dental hygienists in the performance of duties authorized by law;

(3) dentists in the employ of the United States Public Health Service, United States Veterans' Administration, Alaska Native Service, or Department of Health and Social Services, in the discharge of official duties;

(4) clinicians demonstrating at meetings of dentists approved by the board;

(5) physicians and surgeons;

(6) dentists in the employ of the United States Public Health Service providing care by authority of a permit issued under § 271 of this chapter. (§ 2 art I ch 186 SLA 1955; am § 2 ch 93 SLA 1965; am § 6 ch 104 SLA 1971)

Sec. 08.36.360. Practice of dentistry defined. A person engages in the practice of dentistry who

(1) performs or holds himself out to the public as being able to perform dental operations;

(2) diagnoses, treats, operates on, corrects or attempts to correct, or prescribes for, a disease, lesion, pain, injury, deficiency, deformity, or physical condition, malocclusion or malposition of the human teeth, alveolar process, gums or jaws and adjacent tissues;

(3) performs or attempts to perform an operation incident to the replacement of teeth;

(4) furnishes, supplies, constructs, reproduces, or repairs prosthetic dentures, bridges, appliances or other structures to be used and worn as substitutes for natural teeth, except on prescription of a duly licensed and registered dentist and by the use of impressions or casts made by a duly licensed and registered dentist;

(5) uses the word "dentist" or "dental surgeon" or the letters D.D.S. or D.M.D. or other letter or title which represents him as engaging in the practice of dentistry;

(6) extracts or attempts to extract human teeth;

(7) owns, manages or operates a place where the acts and things described in this section are performed or done. (§ 1 art I ch 186 SLA 1955)

Chapter 40. Electrical Administrators.

Article
1. Board of Electrical Examiners (§§ 08.40.005—08.40.080)
2. Licensing (§§ 08.40.090—08.40.180)
3. General Provisions (§§ 08.40.190—08.40.200)

Cross reference. — As to electrical contractors, see AS 08.18.026.

Article 1. Board of Electrical Examiners.

Section
05. Purpose of chapter
10. Creation and membership of board
20. Appointment and term of office
30. Chairman of board
40. Board meetings
45. Categories of licenses
50. Regulations
60. Examinations
70. Inspection or investigation by board
80. Compensation of board members

Sec. 08.40.005. Purpose of chapter. The purpose of this chapter is to protect the safety of people and property in the state from the danger of improperly installed electrical wiring and equipment, by providing a procedure to assure

(1) the public that persons responsible for making electrical installations in this state are qualified; and

(2) a sufficient number of persons are so qualified. (§ 2 ch 53 SLA 1977)

Sec. 08.40.010. Creation and membership of board. There is hereby created a Board of Electrical Examiners consisting of three members

STATE
of ALASKA

MEMORANDUM

TO: Commissioner Helen Beirne
Dept. Health & Social Services
Juneau

DATE: January 12, 1978

FILE NO:

TELEPHONE NO: 278-4668

FROM: Frederick McGinnis
Deputy Commissioner
Dept. Health & Social Services
Anchorage

SUBJECT: Request by Aleutian/Pribilof Islands Association, Inc.: Permit Request--Dental Services for Aleutian Chain

Consistent with numerous other recent activities on the part of the Aleutian/Pribilof Islands Association to improve health and social services to the residents of the Aleutian Islands, information was sought from my office today with regard to our Department's assistance to the citizens of the Aleutian Islands for improved dental services.

Mr. Frank Peratrovich, Deputy Director of the Association, raised the question as to whether our Department is in the position to assist consistent with the applicable Alaska Statute--AS 08.36.271, Permits for Isolated Areas. For convenience a copy of the statute is attached (Attachment No: 1).

It is my understanding that the Aleutian/Pribilof Islands Association's plan is to secure the services of dentists on a voluntary basis mostly, if not entirely, from other states to render the services. The Public Health Service will be asked by the Association to employ the dentists at a nominal salary for technical purposes. The dentists apparently will meet the Alaska statutory requirements provided in AS 08.36.110 with latest amendments (see 1976 Supplement Amendments for 08.36.110).

It is in the knowledge of the A/PIA and their legal counsel that "the Department of Health and Social Services shall designate as isolated areas those specific places and regions remote...". (AS 08.36.271(a))

It is their impression that "the Board shall, upon recommendation of the Department of Health and Social Services, issue an annual permit authorizing...". (AS 08.36.271(b))

It is my understanding that the Association is considering requesting a slight amendment to AS 08.36.271 if necessary to accomplish certain goals but, at this time, it is not certain if such will be required.

RECOMMENDATION: It is recommended that

(1) the Department officials concerned give strongest support to the proposed plan being developed by the Aleutian/Pribilof Islands Association, Inc. in their goals of addressing this extremely long neglected need to improve the dental health of the citizens of the Aleutian Chain.

(2) the Department of Health and Social Services, after consultation with the Department of Law, release the attached suggested letter (Attachment No. 2) and the attached suggested "Designation of Isolated Areas" (Attachment No. 3).

EMcG/mag

Attachments: as indicated

cc: Catherine M. Lloyd, Deputy Commissioner

STATE OF ALASKA
DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER
JAY S. HAMMOND, GOVERNOR
POUCH H 01 – JUNEAU 99811

January 16, 1978

Dental Examiners Board
937 Eighth Avenue
Fairbanks, Alaska 99701

Attention: Sydnor L. Stealey, President

Gentlemen:

Re: Designation by Department of Health and Social Services of Aleutian Islands as Isolated Area

It has recently come to the attention of the Department of Health and Social Services that, through the initiatives of certain Alaska Native organizations, improved dental services for citizens of the villages of the Aleutian Islands may be arranged. Such plans envision the utilization of dentists falling under the general coverage of AS 08.36.271(a) and (b).

Consistent with the provisions of AS 08.36.271, the Department of Health and Social Services encloses at this time the appropriate formal designation by the Department for the region involved in the emerging plans.

In line with the specific provision of AS 08.36.271(b), the Department of Health and Social Services hereby recommends to the Board the issuance of annual permits to the dentist applicants meeting the qualifications of applicants contained in AS 08.36.110, with latest amendments. The specific and individual applications related to this recommendation will be filed in accordance with your procedures.

It is our understanding that qualified applicants shall be granted annual permits under the conditions contained in the statutes and consistent with the recommendation contained herein.

Sincerely yours,

Helen Beirne
Commissioner

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

POUCH H 01 – JUNEAU 99811

January 16, 1978

DESIGNATION OF ISOLATED AREAS

by

STATE OF ALASKA, DEPARTMENT OF HEALTH AND SOCIAL SERVICES

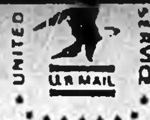
In accordance with the provisions of Alaska Statutes 08.36.271, Permits for Isolated Areas, the Department of Health and Social Serv' .s hereby designates as isolated areas the entirety of the Aleutian Islands Chain of the state of Alaska, including any and all specific villages and communities of the Aleutian Chain.

Such designation is made solely for the purposes served by the provisions of the Alaska Statute cited above, and for dental services as provided in the cited statute.

Helen Beirne, Commissioner

MIDDLETOWN, VA. 22645

RCA Mailgram



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PAT PLETNIKOFF
CARE ALEUTION PRIBOFF ISLAND ASSN
430 C ST
ANKORAGE AK 99500

WAS PLEASED TO LEARN OF YOUR ACQUISITION OF A MOBILE DENTAL UNIT. PEDODONTIC SPECIALTY TRAINING PROGRAM AT UCSF AND USC HAVE BEEN LOOKING FOR SUCH A FACILITY TO STAFF WITH SPECIALTY STUDENTS AND INSTRUCTORS ON A ROTATING BASIS. WOULD LIKE TO DISCUSS THIS WITH YOU.

MERLE E MORRIS, DDS PROFESSOR AND HEAD PEDODONTICS
DEPT OF GROWTH AND DEVELOPMENT
UNIVERSITY OF CALIFORNIA AT SAN FRANCISCO
SAN FRANCISCO CA 94143

1634 EST

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AUG 30

Aleutian/Pribilof Islands
Assn., Inc.

University of California - San Francisco

Ray Wong	Dental student
Dan Fong	Dental student
Glenda Fong	Dental Assistant
Diane Perez	Dental Assistant
Carolyn Stark	Dental Assistant
Evon Mitchell	Dental Hygienist
Sandro Fong	Dental Hygienist
Carmen Romo	Dental Hygienist
Sigrid Jennings	Coordinator
Kenneth Moore	Coordinator/student
Dr. K. Solberg	Dentist
Dr. R. Pelznen	Dentist
Dr. Marvin Stark	Director, Mobile Dentistry

Univeristy of Southern California

Tony Perez	Dental student
Tami Haroldson	Dental Hygienist Student
Judy Salter	Dental Hygienist Student
Dr. Chris Thanos	Faculty Member

UCLA

Dave Kolegraff	Dental Assistant

San Francisco State University

Debbie Jacobson	Dental Assistant

Mr. Bob Singke
Area Executive Officer
Alaska Area Native Health Service
P. O. Box 7-741
Anchorage, Alaska 99510

TELEGRAM

THE RESIDENTS OF ST. PAUL ISLAND HAVE A DESIRE TO RECEIVE DENTAL TREATMENT AS PROVIDED BY THE ALEUTIAN PRIBILOF ISLANDS MOBILE DENTAL UNIT AND THE UNIVERSITY OF CALIFORNIA SCHOOL OF DENTISTRY, DENTAL STUDENTS IN THEIR LAST CLINICAL YEAR UNDER THE DIRECT SUPERVISION OF THE PROFESSORS OF DENTISTRY.

WE APPRECIATE THE COOPERATION OF THE PUBLIC HEALTH SERVICE IN WORKING WITH THE ALEUTIAN PRIBILOF ISLANDS ASSOCIATION IN MAKING THIS PROGRAM POSSIBLE AND PERHAPS RELIEVING SOMEWHAT THE PRESSURE FOR SERVICE.

MICHAEL ZACHAROF, PRESIDENT
TANADGUSIX CORPORATION

8/16/78 called in by J. Linda Merculief

NIGHTLETTER - May 4, 1978

Sent to:

Glen Hackney, Chairman, Senate HESS Committee
Rep. Alvin Osterback
Rep. Frank Ferguson

PLEASE BE ADVISED THAT ALL OPPOSITION TO OUR DENTAL PROJECT, H.B. 728 HAS BEEN WITHDRAWN BY THE ALASKA NATIVE HEALTH SERVICES. FOLLOWING IS A COPY OF THEIR LETTER:

Dear Mr. Pletinkoff:

The project description of your Mobile Dental Project has been received and reviewed by the Alaska Native Health Service. The review was done by four experienced professionals within and without the dental field. Upon completion of the individual reviews, an Ad Hoc Committee of Area Office and Service Unit personnel considered carefully all of the information available about your project. It is our conclusion the Aleutian Pribilof Island Association Mobile Dental Project does not constitute a project proposal for Alaska Native Health Service participation. At the present time the Aleutian Pribilof Island Association Mobile Dental Project involves only the State of Alaska and the U. S. Bureau of Indian Affairs.

As an Indian Health agency, I would be remiss in not supporting a program aimed at the improvement of the general health and dental health of the Alaska Native people. The Aleutian Pribilof Island Association Mobile Dental Project has my support subject to the following conditions and recommendations:

1. My support does not constitute any future commitment by the Alaska Native Health Service for additional expenditures of funds or personnel.

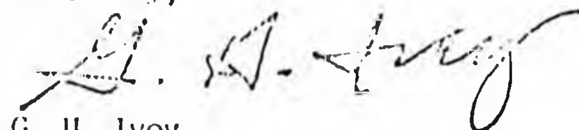
2. The medical (or dental) services provided carries no threat of detriment to the health of the recipients of care.

3. The project is accepted and desired by the people in the communities of the Aleutian chain and the Pribilof Islands.

4. The Aleutian Pribilof Island Association coordinate the services provided by this project with the dental program of the Anchorage Service Unit.

It is my sincere wish that this project will result in improved dental care to the Alaska Native people in the Aleutian Pribilof Region. I urge you to take advant: e of the experience and knowledge of members of my staff in completing the planning of the project and your dental feasibility sutdy. I will look forward to a successful cooperative program.

Sincerely,



G. H. Ivey
Director
Alaska Area Native Health Service

UNITED STATES GOVERNMENT

memorandum

DATE: March 17, 1978

REPLY TO ATTN OF: Chief, Service Unit Dental Program - ANMC

SUBJECT: APIA Dental Feasibility Studies

TO: Community Relations Officer, ANMC

The attached information should enable you to answer APIA questions about dental activities in this Service Unit.

1. COSTS: (Attachments # 1)

a) Costs of field trips, by village, are listed. This includes dates, duration of trip, costs of freight and names of dental personnel traveling. This should serve to show typical costs of Aleutian trips.

b) In a usual fiscal year our dental teams have been providing 29-32 team weeks in the APIA region including overtime. An exception to this was F.Y. 1977. Less time was spent as a result of two mid-year dentist resignations resulting in trip delays to bring replacements on duty. Copies of our F.Y. 1978 field trip schedules have been provided APIA previously. A revised version is attached. See attachment # 2.

c) Teams traveling usually consist of a Commissioned Officer grade O-4 and a dental assistant GS-4. The APIA proportion can be calculated from team work weeks spent in the APIA region and the following information. Average Annual Salaries for those IHS dental team employees including Base Pay, COLA, SHA, incentive pay, quarters and subsistence are :

CO-4- $25,750
GS-4- $14,645

Overtime costs are currently averaging $6.89/hr for the dental assistants. No overtime is paid to salaried Commissioned Officers. Current overtime experience averages 16 hours per field trip week for each team member.

d) The Anchorage Service Unit dental supply budget for F.Y. 1978 is $29,600 . We have no way of identifying what portion of that amount is used in the Aleutian-Pribilof region. Based upon a porportion population a "guesstimate" would be in the $1500-$2000 range.

e) Our teams use portable field equipment that costs about $4500 per set-up at Gov. prices. Portable x-ray units, when available, in safe portable form, cost another $2000-$3000. Hand instruments cost another estimated $1000 per portable unit. This equipment weighs about 700 lbs and does not include lab support equipment and complete instrumentation and supply for specialty services.

Buy U.S. Savings Bonds Regularly on the Payroll Savings Plan

OPTIONAL FORM NO. 10
(REV. 7-76)
GSA FPMR (41 CFR) 101-11.6
5010-112

2. The level of care provided and frequency of visits by dental teams for the past three years are shown on attachment # 3. These data also include references to level of specific preventive programs, community efforts, travel difficulties etc.

   Basic care consists of routine services with the exception of specialty care like prosthetics and orthodontics and periodontal surgery. Examinations, fluoride treatments, prophylaxsis and oral hygiene instructions, fillings, stainless steel crowns, extractions, pulpotomies, minor surgical procedures and palliative treatments make up the bulk of basic care provided.

3. All age groups are treated. The main emphasis is on pre-schoolers and students. In some instances available dental-team time has exceeded adult demand for care. Complete prosthetic and orthodontic treatment of high quality cannot be provided during visits of short duration due to lack of lab support, time and equipment. Considerable prosthetic care has been provided however during longer trips such as to St. Paul and St. George. More manpower to allow more frequent visits by the same dentist would be desirable.

   Computer printouts are attached which show services provided by age group and village during Fiscal Years 76 and 77. F.Y. 77 printouts for King Cove, Nikolski, False Pass and Belkofski are missing. A retabulation and separate computer run has been requested to recapture that data. Individual patient exam records could be used as an interim source of information. I'll be available to explain the printouts if necessary.

   Computer printouts are also available that reflect epidemiological data and services required by patients examined. It is important to note that these data are probably under-reported since the large sample of examinations are for younger age groups. In addition clinicians tend to under-report specialty service requirements that they are unable to provide in portable-intermittant clinics. The net result in my opinion is that the report of level of services required is not 100% accurate for older age groups. Disease rates and services requirements of patients seen at ANMC may provide a more accurate picture. This is because a larger sample of adult patients is seen and a broader scope of services is provided at the ANMC fixed facility. Such information can be duplicated from printouts or microfiche. I believe that personal explanation of the data would be beneficial and less confusing.

4. Other sources of funding would include :

   a) Dental benefits for those under age 21 in families who are eligible for Medicaide.

   b) Employees benefit plans that include dental coverage, ~~Dental~~ Delta Dental Plan etc.

   c) Veterans benefit for those who have been recently discharged or who have service connected disabilites.

   d) Personal dental insurance coverage.

   e) Private funds.

   f) Corporation funds for contract dental care.

   g) State grants for community programs, such as H_2O Fluoridation.

   h) Grants from private foundations.

   i) Volunteer programs.

   j) National Health Service Corps. ✓

5. The greatest un-met dental needs are :

   a) The need for consistent effective community involvement in meaningful preventive programs such as :

      - Community H_2O fluoridation.

      - School centered fluoride rinse and fluoride tablet programs.

      - Periodic topical fluoride gel programs by Health Aides et.als.

      - Community and family attention to nutrition and limitation of refined carbohydrate consumption.

      - Continuing integration of dental health information into school curriculum.

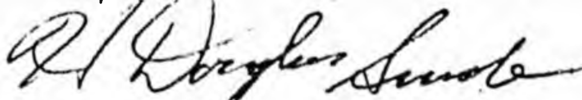
   b) Increased corrective services for adults especially in larger villages.

   c) Increased specialty services for younger patients.

d) Continuing evaluation of quality of care at clinical and community levels.

6. To accomplish the above the expertise and resources of several agencies need to be coordinated. The needs can be best met by co-operative efforts to overcome travel obstacles and the lack of adequate facilities and manpower. The more frequent presence of familiar dental personnel, working in facilities equipped to provide a broader range of service, has the greatest potential for overcoming disease backlogs and most importantly has the best chance of getting communities involved in preventing disease. One shot programs have no potential for continuing success when they deal with disease processess as multifactorial as dental disease. Furthermore one shot programs are usually not cost effective.

I hope these thoughts contribute to the APIA efforts. I look forward to cooperative efforts toward total program improvement.



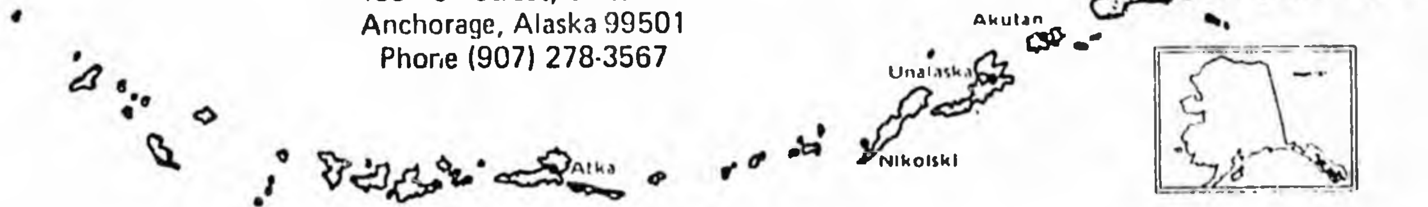
H. Douglas Smole, DDS

CC: ANC-ACH
C,ADSB

Attachments (4)

Aleutian/Pribilof Islands Association, Inc.

430 "C" Street, Suite 303
Anchorage, Alaska 99501
Phone (907) 278-3567



Memorandum

To: Dental Feasibility File

From: Patrick Pletnikoff, Executive Director

Date: April 10, 1978

Subject: Meeting with IHS Personnel Regarding Dental Project

A meeting was held this date with the following to discuss the Dental Project:

1. Dr. Nielsen
2. Dr. Douglas Smole
3. Dr. John Stope
4. Mr. Ken Isaac
5. Mr. Elmo Strickland
6. Mr. Jeff Trenton
7. Mr. Perry Smith, BIA Area Office

The purpose of this meeting was to discuss the problems, concerns, and progress made to date regarding our dental feasibility study as well as our proposed programs in the dental field. We also discussed the lack of information being provided IHS in the total project. Mr. Perry Smith represented the Area Office of the BIA and discussed the proposal we submitted requesting funding from BIA.

In essence, BIA will fund our proposal request when IHS does the following:

1. Agree to monitor and provide technical assistance to our dental project.

2. Agree with the scope of work that we propose in our mobile dental project.

Information is being provided IHS to Dr. Smole for review concerning our mobile dental program. We have set a date of 4/18/78 as a final review date. At this time, IHS should provide a letter to BIA indicating that they will support our program in all aspects.

The meeting ended with all agreeing to support a program we wish to develop and implement.

Information will be provided IHS this date to Dr. Smole.

PP:alp

TESTIMONY IN SUPPORT OF THE MOBILE DENTAL HEALTH SERVICE FOR THE ALEUTIAN/PRIBILOF AREA OF ALASKA PRESENTED BY PATRICK PLETNIKOFF, EXECUTIVE DIRECTOR

When I was a child and my father before me, statistical surveys were being conducted concerning the conditions of the children's teeth. The studies go on and the teeth fall out before the final report is in. Last year's cavities are this year's candidates for false teeth. We don't want money for another study of what needs to be done. Anyone living in bush Alaska knows the deplorable conditions of the dental health of these people. Many people find it less expensive to fly to Switzerland to have their teeth fixed and easier than getting care at home. Unfortunately, most of us are not able to afford the trip or to be away from our families long enough to get our teeth fixed in that way.

One thing we don't want this project to be is a threat or an attack on any one group of professionals. We know most everyone is doing the best they can with what they have to work with given the vast area they must serve. What we do want to do is provide a pilot project demonstration of still another way of dealing with the problem. It has worked in other places and we believe it will work here. Once we have things under control in the Aleutian/ Pribilof area we will be happy to move the equipment to other parts of the State where the need is great -- we have that kind of long term commitment also from Dr. Stark and the University of California Dental School in San Francisco.

At present the Aleutian people have no qualified personnel to deliver dental health needs to their people and the Public Health Service delivers only emergency type care to this area.

Due to the over 1,000 miles one must travel in order to cover the distance of the Aleutian/Pribilof area -- and the isolation of the communities -- there is not adequate space or facilities to do quality dental work and as a result very little restorative work is done. The pattern has been to extract rather than repair.

With the mobile dental unit we are designing, we will be able to move this total working clinic from one place to another and recruit quality personnel to staff it.

The Aleutian/Pribilof Islands people have no funds at this time to develop this unit and provide the service.

Unless we have these facilities we will not be able to recruit the volunteer dentists and hygienists to work on our people.

Our objectives are to design and build a mobile dental vehicle equipped with three chairs -- total service units comparable to any funds in a large city setting; to equip a step van to follow for the x-ray unit and hygienists and records; to staff the vehicles with volunteer dentists supervised by the professional staff of the University of California Dental School; to also staff the vehicles with volunteer hygienists and trained dental assistants; and to deliver full dental health service to all our people and to then make our units available to other Native groups in need in Alaska.

Methods of delivery of dental care to isolated areas have been examined throughout this country as well as in Canada and countries abroad; specialist in California and in British Columbia recommended unanimously a full mobile dental clinic which could be moved about from place to place as needed. All experts also are in agreement a short term summer program will not meet the needs of the Aleutian/Pribilof islands people. Neither the consultants nor officials from A/PIAI have ever contemplated a three to four week program as interpreted by Commissioner Helen Bierne.

Such conclusions are politically motivated and reflect a total lack of research on the part of her unit.

It is clearly the intention of A/PIAI and the volunteer dentist to develop a year round program of delivery of dental care -- beginning with clinical repair and graduating to specialized areas and ultimately using the facilities for a prosthetic follow through.

Children's rotten teeth continue to drain down their throats poisoning their systems and the older folks continue to suffer from swollen tongues and extreme malaclusion and deformity leading ultimately to warped speech patterns and systemic discord while politicians scheme out ways to protect themselves against criticism for non-delivery of service the public has been paying them to deliver.

The mobile dental system tried and tested and proven in the migrant labor areas of California and in refugee camps in Israel are not pursued with the idea of embarassing anyone. What has or

has not been done in the past is history all are willing to forget.

We want to get on with the show. Surely our legislators would not be opposed to seeking alternative methods of solving this old problem.

We are not talking about 200 million dollars worth of service.

We are talking about 200,000 which we believe will deliver 2 million dollars worth of care. Is Alaska so affluent we can afford to pass up such opportunities? We are anxous as Mrs. Bierne to see permanent dental facilities in every village in Alaska -- and some day in the future this may be possible through a subsidized program of building dental facilities in isolated areas and providing incentives to young dentists to practice in these isolated areas. Perhaps some of our young professional volunteers will want to fill these vacancies in the future after a volunteer exposure to this area.

In the meanwhile our people need dental care now.

For answers to the ill informed comments about the impossibility of moving this mobile unit from place to place in the islands one needs only to look at the equipment being moved about in the islands now and since World War II. Oil drills, heavy equipment, portable fish processing equipment and millions of barrels of fuel oil as well as prefabricated homes are moved about as easy as moving a sheel barrel and none has even suggested it was not possible.

All the Doubting Thomas' are welcome to stop by this next year, sit in our new mobile unit and have their teeth cleaned.

SOME QUESTIONS YOU MIGHT HAVE

Question

How long will the dentists use the unit?

Answer

We have a long term commitment from the University of California Mobile Dental Clinic to serve Alaska as long as we want their services.

The unit will be staffed with a dentist year round. This summer a team of three dentists, one supervising professor, two dental technicians and one x-ray technician will work for six weeks -- then throughout the year a licensed dentist will do follow up work. The following summer a new team will return for another six weeks time frame.

In addition to the teams from the University of California operating their summer program we have a number of volunteer dentists from around the country who are willing to donate their time and services for two weeks to a month at a time. One association has 180 members all willing to participate.

Question

What kind of unit is it and how will it be transferred to the Chain?

Answer

The unit is a G.M.C. 26' motor home stripped. Then refitted at the University of California as a dental clinic. When completed it will be just like a three chair dental office in a large city complete with cabinetry, overhead lights, delux dental chairs and all of the support equipment needed to do a good job.

It will be transported by sea to St. Paul Islands this summer. Next summer it will be moved to the Aleutians, possibly Unalaska or Sand Point by SeaLand. At this time, moves are contemplated for Unalaska, Sand Point, and Cold Bay as needed.

Question

How will the dentists be licensed?

Answer

There are at least two ways -- (1) they can be employed by PHS for a dollar a year and assigned to the Aleutian/Pribilof Islands Association (The State law permits this); or (2) the State Department of Commerce also can license the dentists in remote areas not presently served by dentists (within a 50 mile radius).

Question

How long will the unit be in the Aleutian area?

Answer

We anticipate that after two years the unit could be moved to other remote areas of the State as requested -- we have long term consultants to staff throughout the State.

The dental program will serve anyone who is identified as in emergency need of dental care regardless of who they are. Our hygienist staff will work closely with village health aides to locate people in greatest need first and to repair on a priority basis, teeth which would be soon lost without immediate treatment.

Question

If you will primarily be serving Native Americans, why doesn't the Indian Health Service fund the program?

Answer

The primary responsibility for ensuring the protection of public health in Alaska is the State of Alaska. While this is not an overwhelming problem in the urban areas of our State where dentists establish their practices, it is almost non-existent in the rural areas.

While the Indian Health Service has a special responsibility for the health care of Native Americans, it is not capable of providing the most basic dental services to Alaska Natives.

Law Office of
JAMES F. VOLLINTINE
805 W. 3rd Avenue
Anchorage, Alaska 99501
Phone: 276-8144

January 11, 1978

Mr. Frank Peratrovich
Deputy Director
Aleutian/Pribilof Islands Association, Inc.
430 C Street, Suite 303
Anchorage, Alaska 99501

Dear Frank:

This responds to your request for my opinion as to whether or not A/PIA, under a contract which it has assumed from the IHS under P.L. 93-638, can employ dentists in the Aleutian area who are not licensed to practice dentistry under Alaska law. Unfortunately, at this point, the answer is not clear. Attached are copies of the relevant Alaska Statutes.

Under A.S. 08.36.271 the State Department of Health and Social Services is to designate isolated areas of the State which are not served by licensed dentists. Then, the Alaska Board of Dental Examiners <u>shall</u>, upon recommendation of the Department of Health and Social Services, issue an annual permit to a dentist employed by the United States Public Health Service. Hence, it appears that dentists need not be licensed to practice in Alaska if they are employed by the Public Health Service. As you suggested, perhaps there is some way that you can arrange to have the dentists under your contract employed by the Public Health Service. This would neatly solve the problem.

Another approach might be to have your dentists apply for a temporary permit from the Board of Dental Examiners to practice dentistry in Alaska. This approach is provided for in A.S. 08.36.280, a copy of which is attached. Basically, this provision provides that the Board <u>may</u> issue a one year temporary permit to a person not licensed in Alaska to practice dentistry in a rural area if:

> (a) the applicant is of good moral character, and is a graduate of a dental college approved by the Council on Dental Education of American Dental Association at the time of graduation, and holds a D.D.S. or D.M.D. degree, or the equivalent; and
>
> (b) the applicant has a license in good standing to practice dentisry in a State, territory, district or possession of the United States.

At first glance it would appear that your dentists could receive a temporary permit from the Board of Dental Examiners. However, I just spoke with Martha Dearborn of the Alaska Dental Society (phone 279-9144), and John Beard (phone 277-3213) who is an attorney who sits on the Board of Dental Examiners. Both persons told me that in December of 1977 the Board of Dental Examiners voted not to issue any further temporary permits. Mr. Beard stated that the Board felt that A.S. 08.36.280 was a "permissive, rather than a "mandatory" statute.

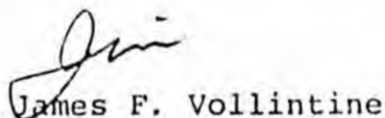
I feel that the determination by the Board of Dental Examiners not to issue temporary permits in Alaska is erroneous. In my opinion, if an applicant meets the legal requirements he is entitled to practice dentistry in Alaska under a temporary permit pursuant to A.S. 08.36.280. We could challenge the Board in Court. However, it will probably be best to have your dentists first apply to the Board of Dental Examiners for a temporary permit and obtain a formal decision from the Board. Note that the attached statute provides that the Board shall grant or deny an application for a temporary permit within sixty (60) days after it is received. After the applications are submitted we can request an oral hearing before the Board whereby we would attempt to put forward a compelling argument to pursuade them to accept the applications. They are free to reverse their December 1977 ruling to the effect that no further temporary permits will be granted in Alaska. If they do not, depending on what A/PIA wants to do, we can then take them to Court.

As you stated, another approach, and possibly the best might be for A/PIA to approach the Alaska Legislature and attempt to have the attached statutes changed. However, we do not know how long this will take. Mr. Milne has just informed me that he will send me a memorandum on what should be included in the amendment to the dentistry laws. I will then draft a proposed bill.

In summary, the quickest approach would probably be for A/PIA to have the dentists employed by the United States Public Health Service. In the alternative, the dentists could apply for a temporary permit pursuant to A.S. 08.36.280. Third, A/PIA should attempt to have the dentistry statutes amended to more realistically conform to the needs of the rural populace.

If you have any questions please do not hesitate to call.

Sincerely,



James F. Vollintine

REPORT OF NATIVE EDUCATION CONSULTING & TRAINING ASSOCIATE ON DENTAL FEASIBILITY STUDY FOR THE ALEUTIAN/PRIBILOF AREA

Consultants for the Aleutian/Pribilof Islands Association have spent many hours visiting with dentists interested in donating some of their valuable time to work with the people of the Aleutian/Pribilof Islands on their dental problems.

One particular group visited and planned with is the University of California Dental School at San Francisco - Mobile Dental Lab Unit headed by Dr. Marvin Stark and by Dr. Kenneth Soelberg his associate.

Films on the entire mobile dental program were reviewed and an on site visit to a migratory farm workers camp where children were being treated was made. Particularly impressive was the quality of care delivered. No Park Avenue Dental office would be more conscientious, kind and caring no matter what was paid yet their volunteer dentists, hygienist and support staff worked deligently and painstakingly with no payment whatsoever. Full dental dams were used, full sterile technique and leaded aprons for X-ray for both patients and operator were mandatory and every child was treated with flouride. The hygienists gave instructions concerning dental health, tooth care and diet.

After several days of exploring the needs of the Aleutian/ Pribilof Islands and the Dr. Stark Mobile Dental Program, we finally arrived at a consensus.

1. The dental team agreed to serve the Aleutian/Pribilof Islands area. Three senior staff dentists expressed a willingness to be a part of the project - supervising graduate and senior year dental students as they volunteered services to the people of the Aleutians area.

2. An examination of the area to be served resulted in our selecting St. Paul and St. George as our first target area. The units would start there and spend the entire summer bringing the entire community up to standard care level. It was planned to do follow up on this period with a periodontics and a prosthetic unit which would take care of the prosthetic needs identified by the clinic team. While the clinic was operational the local health aides would be given comprehensive instruction by the dental hygienists on tooth and mouth care and help them design a year round dental health program for the schools.

Both St. Paul and St. George would be treated in St. Paul. St. George people would be transported to St. Paul for ease of delivery of service.

3. Prior to clinic time publicity would go out to the communities to be served. Plenty of notice would be available in order to give people time to plan and be ready for treatment. When the unit arrives people will be examined and given prophylaxis and flouride treatment. Treatments are scheduled based on priorities determined from examinations and X-rays. For those requiring additional treatment, further appointments are made.

4. If proper arrangements can be made a follow up periodontist (child specialist) will spend 3-6 months at the unit along with a crew of prosthetic technicians who will manufacture teeth prescribed by the clinic team.

Housing

Housing and board will need to be furnished for the entire team (usually seven at a time).

Transportation

All volunteers would be furnished round trip transportation and a per diem payment large enough to cover food and living expenses.

Facilities

It is possible to set up an entire unit in a school room, hall or church but it would be far batter to have a mobile unit much like the bus they have been working with since it is compact and so efficient to work with. The recommendation made by the team is that we purchase a G.M.C. motorhome unit stripped - which the team will equip themselves with special chairs, suction, X-ray, lights, etc. Cabinet work would be done under their supervision in Palo Alto. When the entire unit is complete it will be shipped to our summer clinic site at St. Paul in the Pribilof Islands.

It is our recommendation the unit be moved next to Sand Point and then to Cold Bay and Unalaska and the patients be transported

to the central site for treatment.

Once the Aleutian/Pribilof Islands have been worked thoroughly, the unit could be made available for other parts of the State where needed.

IN THE HOUSE

HOUSE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "A mobile dental clinic for isolated Alaskans."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

Section 1. The sum of $200,000 is appropriated from the general fund to the Department of Health and Social Services to be allocated as follows:

FY 78 (1) To the Aleutian/Pribilof Islands Assoc., Inc., for purchase of a mobile dental clinic (a GMC motor home ,equipped with three complete dental work units - cabinets and fixtures) $100,000

(2) Funding for supplies movement and operation of the dental unit for a period of one (1) year $100,000

Said dental unit to be made available to other areas of the State through the Aleutian/Pribilof Islands Association, Inc., as it becomes available after meeting the crisis need of the Aleutian/Pribilof area.

Section 2. The unexpended and unobligated portion of this appropriation lapses into the general fund June 30, 1979.

Section 3. This act takes effect immediately in accordance with AS-01-10-070(c).

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

SCHOOL OF DENTISTRY
Department of Growth and Development

SAN FRANCISCO, CALIFORNIA 94143

August 23, 1978

Pat Pletnikoff
Alention Priboff Island Association
430 C Street
Anchorage, Alaska

Dear Pat:

I was very pleased to learn of your acquisition of a mobile dental unit. The pedodontic specialty training programs at U.C.S.F. and U.S.C. have been looking for such a facility to staff with specialty students and instructors on a rotating basis. I would like to discuss this with you.

Sincerely,

Merle E. Morris

Merle E. Morris, D.D.S., M.S.
Professor & Head of Pedodontics
Department of Growth & Development

MEM/jag

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

August 10, 1978

ALASKA AREA NATIVE HEALTH SERVICE
BOX 7-741
ANCHORAGE, ALASKA 99510

Refer to A-DE

Mr. Ralph Eluska
Deputy Director
Aleutian Pribilof Island, Assn.
430 C Street Suite 303
Anchorage, Alaska 99510

Dear Mr. Eluska:

The purpose of this letter is to report to you the substance and conclusions of the meeting held on Monday, August 7, 1978. In addition, I will list for your information the conditions of Alaska Native Health Service participation in health corporation health care programs. Participating in the meeting were:

Representing Aleutian Pribilof Island, Association:

Mr. Ralph Eluska, Deputy Director
Dr. James Milne, Consultant to APIA

Representing Senator Gravel's office:

Ms. Beverly Long, Special Assistant

Representing the Alaska Native Health Service:

Mr. Robert Singyke, Executive Officer
Mr. Charles Watson, Chief, Office of Personnel
Dr. John Stolpe, Chief, Area Dental Services Branch
Dr. David Jones, Ass't Chief, Area Dental Services Branch
Dr. Douglas Smole, Chief, Service Unit Dental Program, Anchorage

The request to nominally "hire" Aleutian Pribilof Island, Assn., volunteer personnel to staff a Mobile Dental project presented to the Alaska Native Health Service by Mr. Marc Grober on June 5, 1978, was not accepted. The reasons for this decision were presented and are the subject of a separate letter to Aleutian Pribilof Island, Assn., dated August 4, 1978. Briefly the reasons can be stated as follows:

1. The government must assume liability for the acts of its employees including employees under a Volunteer Service Agreement. In order to assume this liability, day to day supervision must exist.

2. Volunteers are considered employees of the Federal government

for the purposes of the benefits provided by 5 U.S.C 8101, for work related injuries and diseases.

3. Volunteers are covered by the Tort Claims provisions of Title 23 U.S.C.

4. The circumstances proposed by Aleutian Pribilof Island, Assn., do not meet the definition of a Federal employee.

5. "Nominal hire", by the government would result in circumvention of the Alaska statutes relating to the licensing and dental practice.

6. The coordination and personnel workload required to qualify and place on volunteer agreements as many as 25 - 40 individual volunteers would be unreasonable.

The Alaska Native Health Service would be remiss in not supporting a dental program aimed at the improvement of the general health of the Alaska Native people. In a previous letter to Aleutian Pribilof Island, Assn., based upon the circumstances outlined in the information provided in your proposal titled, Aleutian Pribilof Islands, Association Mobile Dental Project, it was concluded the project does not constitute a project for our participation. Health care programs must meet specific conditions to assure the support and participation of the Indian Health Service. These conditions can be summarized as general conditions and personnel requirements. These conditions and requirements are found in Federal laws, Federal regulations and Indian Health Service policies and are listed below:

General Conditions:

1. Support of a program by the Alaska Native Health Service does not constitute any future committment of additional expenditures of funds or personnel.

2. Medical (or dental) services provided carries no threat or detriment to the health of the recipients of care.

3. The project is accepted and desired by the people in the communities involved. Evidence of this acceptance must be provided in writing from the appropriate village council or governing body.

4. The services are planned and coordinated with the dental program in the Service Unit having responsibility for the health of the community.

5. Where specific Service Unit resources are requested, the program

be approved by resolution of the Service Unit Health Board and/or Regional Health Corporation Board of Directors.

6. The personnel appointed as Federal employees meet the definition of a government employee which includes:

   a. Intent to become a Federal employee.
   b. Work under the direct supervision and control of Department (HEW) officials.
   c. Work under a formal appointment.
   d. Work in a Department facility.
   e. Volunteers may supplement, but not take the place of personnel employed through usual procedures.
   f. In accordance with the provision of an established volunteer service program.
   g. Selection of individual volunteers will be the responsibility of Department officials.
   h. Records of actual service performed by each volunteer must be maintained.

Personnel Requirements for Appointment: In general the personnel requirements for the appointment of a volunteer employee are similar to those for permanent employment, and are:

1. U.S. citizenship, volunteers are not required to be U.S. citizens.

2. Dentists must be graduates of an accredited dental school and submit evidence of graduation.

3. Dentists must be licensed in one of the states or District of Columbia and submit evidence of licensure.

4. The individual must intend to become a Federal employee.

5. An application or request should be submitted.

6. A resume' of training and experience is required.

7. Evidence of satisfactory medical condition may be required.

8. The term of appointment must be determined.

Aleutian Pribilof Island Assn., representatives stated that the immediate problem they face is the fact that the Mobile Dental Unit will be arriving in Alaska on or about August 14, 1978. Volunteer dentists and

students from the University of California San Francisco School of Dentistry will arrive with the unit. A method must be sought which will allow them to work for the period August 15 to September 30, 1978.

In summary, the recommendations agreed upon at the meeting, in general, encompassed both the long range solution to the problems of licensing and a short range solution to the immediate problem.

1. The Aleutian Pribilof Island Assn., will arrange a meeting with the Alaska Board of Dental Examiners and IHS representatives to explore the possibility of receiving some type of licensure by the State of Alaska for the dental personnel of the Aleutian Pribilof Island Assn. project.

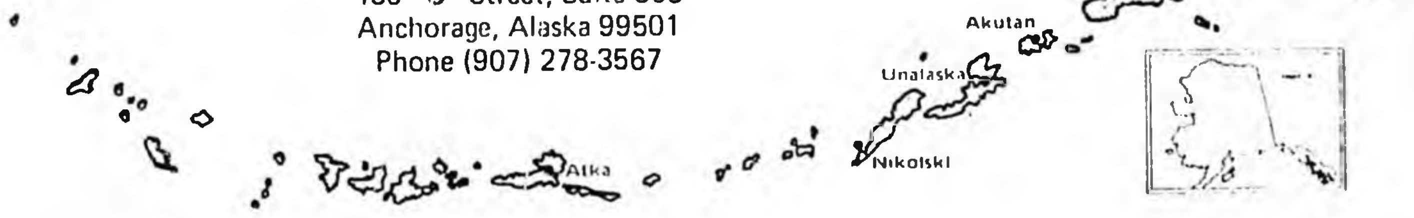
2. Depending on the results of the above meeting, IHS will attempt to provide support for the immediate operation of the Aleutian Pribilof Island Assn. project as available personnel and scheduled activities permit.

3. The Alaska State Board of Dental Examiners and Alaska Dental Society shall be made aware of any arrangements which IHS makes to provide interim supervision of the Aleutian Pribilof Island Assn. project.

Sincerely,

John R. Stolpe, D. D. S. M. P. H.
Chief, Area Dental Services Branch

cc: Dr. Milne, APIA Dental Consultant
Ms. Long, Special Ass't, Senator Gravel
Mr. Singyke, Area Executive Officer
Mr. Watson, Chief, Area Personnel
Dr. Jones, Ass't Ch, Area Dental
Dr. Smole, Ch, ANMC Dental
Dr. Hansen, President, Alaska State Board of Dental Examiners



Aleutian/Pribilof Islands Association, Inc.

430 "C" Street, Suite 303
Anchorage, Alaska 99501
Phone (907) 278-3567

June 5, 1978

David Jones, DDS
Assistant Chief
Area Dental Services Branch
Box 7-741
Anchorage, Alaska 99510

Dear Dr. Jones:

As you are aware, we are now approaching the fruition of a dream I think we all share, intensive remedial and prophylactic dental care in the Aleutians, through the use of our mobile dental unit.

In our earlier discussions you offered that IHS might consider "hiring" our instructor and student dentists so that they might be able to practice in the bush.

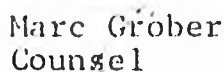
To my knowledge, the best way in which these personnel can practice with the mobile dental unit project, under the current statutes, is to be in the employ of IHS (see AS 08.36.350.(3)). Though we have prepared legislation to alter the statutory scheme, enactment is far beyond the time at which the project will be ready to roll.

We are asking that you nominally "hire" our personnel for the term of their tour of duty with the unit. As I am sure there is a maze of paper work that would be required before we could begin such a program, I'd like you to put me in touch with the proper person to work out the necessary details. I, of course, am at your disposal.

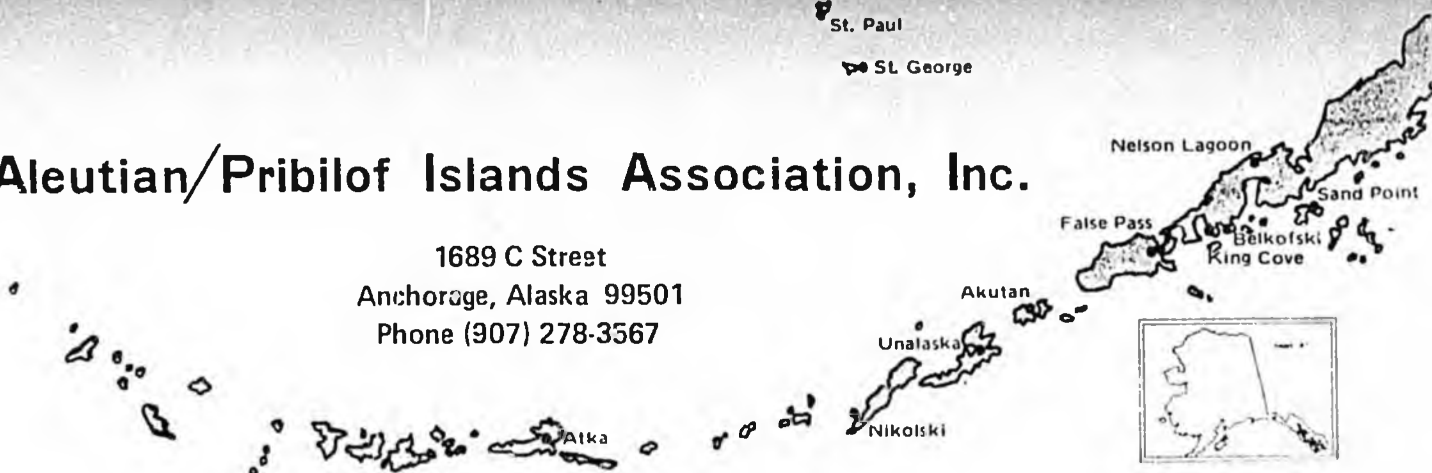
I hope in this way we can provide "dentists" to bush communities at no cost to IHS or ANS. As I think that is a common goal I look forward to your affirmative response.

Please, let's get together at your earliest convenience.

Sincerely yours,



Marc Grober
Counsel



Aleutian/Pribilof Islands Association, Inc.

1689 C Street
Anchorage, Alaska 99501
Phone (907) 278-3567

To: Gerald H. Ivey, Director
Alaska Area Native Health Services

From: Patrick Pletnikoff, Executive Director

Date: February 6, 1979

Subject: Letter of Commitment to Plan

This is a letter of commitment to plan and implement any future operations of the mobile dental clinic with the Service Unit Director of the Anchorage Service Unit of IHS.

This letter will serve to inform you that we are ready and waiting to talk to you and your staff about our plans for use of the dental clinic in the months ahead. We really should have a meeting soon to discover what areas of coverage need immediate attention and what our priorities will be.

Although efforts will be made to obtain licensure through the State Legislature we want to be sure our people will be allowed to work this summer.

An early meeting would be appropriate for all concerned.

PP:alp

St. Paul
St. George

Aleutian/Pribilof Islands Association, Inc.

Nelson Lagoon
Sand Point
False Pass
Belkofski
King Cove
Akutan
Unalaska
Nikolski
Atka

1689 C Street
Anchorage, Alaska 99501
Phone (907) 278-3567

April 11, 1979

Thelma Buchholdt
Pouch V
Juneau, Alaska 99811

Subject: Support H.B. 401

Dear Ms. Buchholdt:

You may already be aware of the efforts of the Aleutian/Pribilof Island Association to bring adequate dental health care to the people of the Aleutian Islands, but we want you to know more about our mobile dental clinic and the problems we have had in getting authorization from the State Dental Board needed to allow our volunteer dentists and dental students in training to offer their services in Alaska. The Dental Board wants no permits to practice issued even though the present law specifies they are to issue permits - as a matter of fact, they refuse to issue any permits at all.

Last summer we had 22 volunteers standing by waiting to get permission to volunteer their services - we finally ran the program through the United States Public Health Service. The present law and contrived conditions which exist in Alaska prevent any volunteer who would fix kids teeth without charge from practicing.

Representative Osterback has submitted a bill this session which will exempt volunteer dental personnel from permit requirements thus paving the way for a new summer program of dental health care aboard the mobile unit. Your support of H.B. 401 is essential to the health care of all bush Alaskans. Your Yes vote on this measure is essential this session.

Thousands of Alaskans go to work every day of their lives with a tooth ache or in need of dental care because the cost of dentistry is prohibitive. Some fly to Europe for dental work because it's cheaper than staying home and having the work done by an Alaskan dentist.

Eventually of course, over pricing, indifference and greed will move the citizenry to action - and dentistry will become a publicly supported element of our society. In the meanwhile we need your support now of H.B. 401 so we can bring in the sensitive socially conscious volunteers who want to come to Alaska for a few weeks to improve the overall dental health of our people.

Sincerely yours,

Patrick Pletnikoff

Patrick Pletnikoff
Executive Director

alp

Aleutian/Pribilof Islands Association, Inc.

1689 C Street
Anchorage, Alaska 99501
Phone (907) 278-3567

September 26, 1978

Mr. Herb Rhodes, Publisher
The Great Lander
3110 Spenard Road
Anchorage, Alaska 99503

Dear Mr. Rhodes:

Your editorial outlining the abuses of the State Bid System was frankly unfair and inaccurate with reference to the Mobile Dental Lab for serving the unmet needs of the Aleutian/Pribilof area.

1. Both the House and Senate approved of the Dental Measure. You claimed they defeated the measure. The House had a floor vote in which it passed unanimously and the Senate Finance Committee gave it a "do pass" vote.

2. The money was intended by the legislature to be appropriated however more programs were approved than the Governor had money for so he was put in the position of making a choice of the best programs approved. He approved this one because it had merit and would bring to the State many times more value than the $200,000 appropriated in volunteer services helping the Native people who needed dental care the PHS was not able or willing to deliver.

3. The Mobile Dental Unit was designed by the staff of the University of California Dental School and built by them, a task only they could accomplish - no other vendor has the capability of building and delivering the unit except the Siemens Company in West Germany and their unit, not half as good as what we got, costs twice as much.

The Department of Health and Social Services did not ever order anything nine months ahead of the time money was appropriated for the unit or even afterwards. The Aleutian/Pribilof Islands

Association, Inc., a non-profit corporation, was given a contract for the development of the units and delivery of them. They made the purchase of the base unit through an Alaskan auto dealer, Alaska Sales & Service, who gave the unit to them "at cost" with no profit whatever, which could never have happened on a bid.

The size of the unit does not limit their versatility at all. They were carefully planned and are near perfect - far superior to anything ever before developed. The reason a Hercules aircraft was used to move a unit to the Pribilofs was because a jealous, hypocritical money grabbing group prevented the delivery of "free" dental services for personal reasons, refusing to issue the permit to practice causing the units to miss the pre-arranged transportation donated by SeaLand to the islands.

The staff was very adequately housed and transported as planned. AMU housed the volunteers while in Anchorage and they were efficiently delivered by Reeve Aleutian to their destination. Your reporting was prejudiced, biased and irresponsible. If you are really interested in what services are or are not provided to the Natives of this State, do a little honest research before you print. The Chairman of the Bush Dentistry Committee of the Dental Association was paid $44,000 for two stints to a bush community by the Indian Health Service last year - could this be a clue as to why they did not want to license volunteers? There is a really good story here, but you missed it completely.

As to the adequacy of dental services to bush Alaska, tell that to the toddlers, the people with swollen tongues from poor dental care and those whose decay causes drainage down their throats all their lives. Forty-five Alaskans out of 100 must conduct their business, work or study enduring dental pain or with essential teeth missing because it's cheaper to fly to Europe for dental care than to stay home and mortgage life and limb to pay for treatment.

Do you think the Aleutian/Pribilof Islands Association would have sought out dental assistance from out of State if their people were receiving adequate care? Do you think for a minute the Cook Inlet Native Association would have hired their own dentist and invested in a dental office right under the nose of PHS if the service was adequate? Do you think for a moment that we would have had requests for service from our volunteer mobile unit from five areas of the State if their needs were being met? Thank God Governor Hammond is not the kind of person to give in to the political pressures that were brought to bear on him by the PHS personnel and the Alaskan Dental Association and their lobbyists in Juneau - he's got guts and our people are getting their teeth fixed. Can that garbage you are peddling and send

Mr. Herb Rhodes, Publisher
The Great Lander
September 26, 1978
Page Three

it to a more appreciative audience. You may or may not have a legitimate beef on your loss of a printing job, but attacking our dental project is sure not the way to correct it. We would give serious consideration to supporting legislation which takes government at all levels out of the printing business and puts it back with private enterprise because we feel the taxpayer should not be put in the position of competing with his own money for work.

Sincerely yours,

ALEUTIAN/PRIBILOF ISLANDS ASSOCIATION, INC.

Patrick Pletnikoff
Executive Director

PP:alp
Enclosure

cc: Governor Jay Hammond
Bob Atwood, Anchorage Times
Dr. Frederick McGinnis
Senator Glenn Hackney
Senator W. E. Bradley
Senator Ed Willis
Senator Bob Ziegler
Senator Pat Rodey
Senator John Sackett
Senator Bill Sumner
Rep. Alvin Osterback
Rep. Frank Ferguson

Katalla, Alaska. By 1907, it had become a coal and oil center, but by the mid-forties, Katalla had become a ghost town -- a vestige of a bygone era in Alaska's history.

...nboots

...d it; the kids understood ...sed it, but I sensed it was

...these people were former ...esidents of Katalla, where ...fined till the mid thirties ... refinery burned. Now ... just winter residents, ... the trapping. This was ... '40's when fur trapping ...orable profession even to ...onists, with no overtones ...gered species" and all ...les, the price of fur was ... good. The permanent ... of Katalla was about two ...sen and "Wolf" Larsen. ...ber all kinds of odds and ... gathering around the big ... at Bill Hansen's cabin. ...s gathered around the ...e very practical reason ... ...re the light was. One gas ...p hung on a nail above ...nd we all sat at the table ...d, or eat. The gas mantle ...he big round table were ..., in my opinion, that ... so close in the old days. ... of course, was the main ... the two room cabin.

... one time, early in the ... of the men brought in 30 ... remember my ...ense of ...t in the world would we ...0 ducks? But the whole ... pitched in, cleaned and ...e whole smear of them; ... roasted up and a grand ... had by all, there at that ... in Bill Hansen's cabin. I ...he ducks were actually

Volume 10, No. 37 | Anchorage, Alaska | September 13, 1978

State Purchasing Scandal --

Tis Your Money...And Here's How the State Wastes It!

Two weeks ago the Great Lander went to war with the state of Alaska on its bid and purchase procedures. We declared that the state was ignoring the low award bid procedure as prescribed by law -- worse yet that thousands and even millions were going out with no bids at all -- many to Outside firms leaving Alaskan vendors and taxpayers holding the bag.

As one prime example, the court system admitted to 49 violations amounting to $62,000 in form buying alone. An appeal for public information has kept our telephone ringing. And we hope it continues, through the day and into the Arctic night.

Here are some of the incidents brought to light in a single week:

Radio Equipment. Fred Jones of General Electric, in Anchorage, says the state has purchased approximately $1,500,000 worth of mobile radio equipment since 1973 without bid. He says a contract held by Motorola expired that year and that pleas to Don Harris, head of state transportation, and to Mel Holverston, of the division of communications, for a bid procedure have gone unheeded. "They pay lip

... Forms, an Outside firm, who entered a higher bid.

Regular Printing. The Anchorage Printing Co. with a bid of $128,000 was low bidder on a state call to print its elections pamphlets. The state went into negotiation with Craftsmen Press of Seattle the following day and awarded that firm the job. Formal bids were never cancelled and re-advertised as required by law.

Aleutian/Pribilof Islands Association, Inc.

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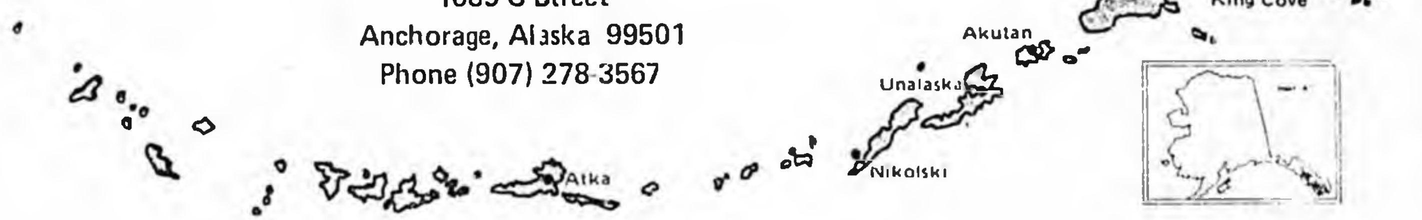

QUESTIONS AND HONEST ANSWERS ON THE MOBILE CLINIC

1. Why was the unit stuck out on St. Paul all winter?

   Answer Because we were told by the State enforcement people we would be arrested if we operated it. They took down the license number of the vehicles and names and addressed of all volunteers then threatened them with arrest.

2. Why was most of the work done outside the Van?

   Answer It was not. Though large numbers were examined outside the parent van, some cleaning was also done in this manner on portable units which were an integral part of an operating system. Without the parent operative units outside van service would not have been practical. Our system allowed 7 chairs to operate all at the same time saving time and allowing for a flow of screened patients to the operative unit.

3. Was the mobile concept cost effective?

   Answer No it was not because we had to feed and house all of the volunteers for 14 days while we went through all the red tape getting started.

   As it turned out we accomplished over $100,000 worth of dental services. It could have been $200,000 without all the interference.

4. Did APIA apply for licenses or permits?

   Answer We were prevented from applying for anything by the dental board. We were informed that there was no application procedure or way to apply since the board had met in December and decided not to issue any permits to anyone no matter what the legislation says.

   Dr. Hanson and Dr. Wright re-stated this information in the APIA offices. Dr. Hanson said there would never be any permits issued to anyone as long as he had anything to say about

it no matter what the Legislature decided nor how the present law read.

5. Is there any other way to qualify?

   Answer No!

6. How do the present hygienists in training qualify for permits?

   Answer They do not qualify. They operate illegally but are not bothered by the dental board for some unknown reason.

7. Is there a record of what was accomplished before the unit arrived in St. Paul?

   Answer Yes there is. It was a buck shot hit and miss attempt.

   St. Paul: Reported population of 419. Although this community had more dental days care per year than all the other villages from 1974 - 1977, reports from visiting dentists were of rampant dental disease, high suger consumption and little or no community dental plan. Lack of coordination with the school program. 30 children reported as not showing for check ups in one period. Floridation system broken down for 3 years.

   St. George: Average of 6.4 days of care a year since 1974. For a community of 154 people - emphasis on children's teeth only.

AFTER THE UNIT OPERATED

1. New health attitude about dental care. Everyone in town was served. Mothers brought their children. Relatives brought their friends. The floridation unit was repaired. A total community dental health program was started. All examinations were documented together with x-rays and completed charts furnished by the PHS Dental Service Unit. Records left behind for the next visiting PHS dentist were so complete the next group of PHS dentists were able to pick up where the volunteers left off. This was indeed a good demonstration of how effective the 2 agencies could work together without the outside interference of the Dental Union and the State Dental Board. As a result of this joint venture, St. Paul has the best dental health in all of bush Alaska.

With the elimination of red tape, delays and political pressures, every $20,000 spent for transportation and room and board for volunteers will produce $100,000 worth of excellent dental treatment and care.

We cannot over emphasize our intention in our request for support of this program of dental care for the Aleutian/Pribilof people. We do not have as a goal the embarassment of PHS, Indian Health Service or private practitioners. We appreciate all past efforts to check dental disease in our islands. The records clearly show that the present system is not working satisfactorily and a new approach is needed. We ask only that the new approach be given the support it deserves. The worst that can happen is the communities will get a little more dental care and the mobile unit can be used by any agency wanting to use it for delivery of service to our area.

The best that can happen is that we will have discovered and tested a new functional, less expensive way to bring dental health care to bush Alaska and other areas will be using the money they now waste on poor programs to duplicate this method of service.

When the units were here for inspection by the dentists, Dr. Hanson walked right past the units refusing to even look inside. Let's not depend on this kind of open mind to make a decision on this service.

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The Myth of Professional Licensing

STANLEY J. GROSS *Indiana State University*

ABSTRACT: *The public and most professionals believe that occupational licensing protects service consumers against charlatans and incompetents. This review of historical, economic, and sociological research indicates a specious association between licensing and the competence of practitioners. Rather, the evidence reveals licensing to be a mystifying arrangement that promises protection of the public but that actually institutionalizes a lack of accountability to the public. The collusion between the state and the professions is maintained by myth. Acknowledging the failure of licensing is preparatory to defining the problem of how to protect the public.*

Licensing is presently a "hot" issue for psychologists, social workers, and counselors (Forster, 1977; Hardcastle 1977; Matarazzo, 1977; Prest, 1976; Swain, 1975). The helping professions are following in the footsteps of the health and legal professions in attempting to gain legal sanction for autonomous practice, expecting to gain similar status for these professions as well as the approval of third-party payers. Though the several helping professions are at different points in their progress from registration to certification to licensing[1] in each of the 50 states, there is an almost universal assumption that licensing is a "good thing." This myth is most often expressed as a belief that "licensing protects the public against incompetent practitioners." This largely uncritical stance appears to be the attitude of the vast majority of the public and professionals alike. Even highly critical consumer-oriented groups (Adams, 1975) appear mystified by the licensing notion, believing it to be an initial screening device for determining quality service.

This article examines the research and scholarly opinion related to the incredibly varied licensing system that results from the collaboration between the state and the professions. Licensing is used in the literature to refer both to the arrangement whereby practice is restricted as well as to all collaboration between a state and a profession, including registration and title certifications. This article is not concerned with professionally controlled credentialing arrangements that do not benefit from association with restrictive legislation. It focuses on those occupations that have gained autonomy as the result of licensing statutes. Excluded from this analysis are occupations for which autonomy is precluded either by statutes that write in a subservient role for the professional (e.g., as in nursing) or by institutions that maintain control of the service setting (e.g., as in school teaching).

A great deal of the research on which this article is based focuses on the medical profession, but this is appropriate. Medical licensure is the model that other professions aspire to, so experience with that model is instructive. Unfortunately, there is little research referring specifically to psychologists or other helping professionals, the history of such arrangements being so recent. It is possible, though not likely, that some of the conclusions might be different for them.

The history of licensing in the health professions centers on the attempts of special interests to impose or to sabotage a monopoly on the practice of healing. Licensing has been the instrument used to restrict practice to professionals, who have claimed it was in the public interest to do so. There is no good evidence to support these claims. Of the evidence found, some is inconclusive or insufficient on some points, but mainly the research refutes the claim that licensing protects the public. This knowledge is crucial to the current debate yet

Requests for reprints should be sent to Stanley J. Gross, Graduate Studies in Education, Indiana State University, Terre Haute, Indiana 47809.

[1] Friedman (1962) defines them as follows: *Registration*—"individuals are required to list their names in some official register if they engage in certain kinds of activities. There is no provision for denying the right to engage in the activity to anyone who is willing to list his name" (p. 144). *Certification*—"the governmental agency may certify that an individual has certain skills but may not prevent, in any way, the practice of an occupation using these skills by people who do not have such a certificate" (p. 144). *Licensing*—"requires some demonstration of competence . . . and anyone who does not have a license is not authorized to practice and is subject to a fine or a jail sentence if he does engage in practice" (p. 145).

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0003-066X/78/3311-1009$00.75

is almost completely ignored outside of the scholarly disciplines used in this investigation which are devoted to the study of such phenomena.

Though reference is made in this article to professional self-interest and lack of accountability to the public, no implication that individual practitioners or professional associations are deliberately or intentionally self-serving is intended. In fact, one reason for this article is that practitioners as well as the public are mystified, such mystification being an important contribution to and evidence for the existence of a system of thinking, feeling, and behaving that maintains licensing. The difference between what people believe to be true about licensing and what is cited in this article indicates that the belief is maintained by myth and argues for the necessity of the consciousness raising attempted herein. The article reviews the historical antecedents of current licensing arrangements, relates the guild-like structure of professions to the licensing charter, examines the effectiveness of state licensing boards—particularly their actions to maintain professional self-interest, considers the centrality of the license to the entire system, and explores the supposed link between licensing and quality service.

Historical Antecedents

In the 13th century, Frederick II, Emperor of the Holy Roman Empire, wrote the first medical practice law. Its provisions included (a) examination by a teacher of medicine, (b) punishment for offenders by confiscation of goods and a year in prison, (c) three years devoted to the study of logic, (d) one year of practice under the direction of an experienced physician after five years of study, (e) the setting of fees, (f) free care of the poor, and (g) a prohibition on a physician owning an apothecary shop (Derbyshire, 1969).

Krause (1977) points to a pattern, dating from ancient Egypt and Greece, of a medical practice hierarchy that differentiated the curers of the masses and the curers of the elite. At the top of this hierarchy was temple medicine with its priests serving the aristocracy. At the next level were the community practitioners who practiced a fee-for-service medicine for those who could afford it, which served as the model for practice today. At the bottom was folk medicine practiced in an oral tradition, often by women. Ehrenreich and English (1973) described these practitioners:

> Women have always been healers. They were the unlicensed doctors and anatomists of western history. They were abortionists, nurses and counsellors. They were pharmacists, cultivating healing herbs and exchanging the secrets of their uses. They were midwives, travelling from home to home and village to village. For centuries women were doctors without degrees, barred from books and lectures, learning from each other, and passing on experience from neighbor to neighbor and mother to daughter. They were called "wise women" by the people, witches or charlatans by the authorities. (p. 3)

Ehrenreich and English (1973) also noted the dichotomy in medical practice that emerged in 13th-century Europe, where "witches" practiced among the people while the ruling classes were served by university-trained physicians. Licensing laws came into vogue as the means "to prohibit all but university-trained doctors from practice" (Ehrenreich & English, 1973, p. 17). Though the effectiveness of these laws was limited because of the great need for service and the inability and unwillingness of university-trained physicians to serve the masses, it is important to note this early reliance on the authority of the state to legitimate an occupation. This attempt to monopolize medical practice in situations of imbalance between need and available service was unrealistic given the large number of unlicensed medical advisors and would eventually lead to a temporary abandonment of licensing in the 19th century in the United States (Kett, 1968).

Licensing laws were used as an exclusionary technique in France during the 14th century (Ehrenreich & English, 1973). As the result of the requirement for university training, the practice of healing was restricted to the upper classes, to men, and to those in the favor of the Church (which controlled the universities), most of whom were ecclesiastics (Spector & Frederick, 1952). By the 16th century as the universities became more secularized, the university-trained professionals no longer were compelled to take religious orders. Emerging from the grip of the church, the associations of physicians became similar to craft guilds. These, however, were not destroyed by the impact of commercialism, centralized governments, and laissez-faire economics, as the craft guilds and the feudal system were to be (Spector & Frederick, 1952).

As occupations, professions were a special case, first in serving the social elite and later in being populated by the elite. Professions, like land, broke the direct connection between work and income for the English gentleman, permitting him to make a considerable sum of money without engaging in a "despised" trade. Gerstle and Jacobs (1976) concluded, "One could carry on commerce

by sleight of hand while donning the vestments of professional altruism" (p. 3).

In the United States, a flood of legislation prior to 1800 gave the power to regulate medical practice to the guildlike associations of professionals, the state medical societies (Spector & Frederick, 1952). The development of medical schools at about the same time instituted a two-tiered hierarchy of regular medical practice that included those trained through apprenticeship only and those who added medical school to their qualifications. Both categories were licensed, though Shryock (1967) has observed that legislatures were more impressed with the latter group. Three parallels with the present day were evident prior to the 19th century. First, licensing was associated with the interests of the dominant elite--the Church and aristocracy in Europe and the commercial class in America (Reiff, 1974). Second, sanctioning power was given to guildlike professional organizations as the means by which these interests were to be maintained. Third, admission to the guild maintained the profession's upper-class identification by requiring where it could and otherwise preferring a period of prolonged university training unavailable to the lower classes.

The second quarter of the 19th century brought about surprising changes in these developments in the United States. In response to the egalitarian sentiment of the times, there was a wholesale deregulation of the professions of law and medicine. By the time of the Civil War, "no effective state licensing system was in operation" (Spector & Frederick, 1952, p. 19). The popular rhetoric explaining this eventuality has a modern sound. It included complaints that the professions (a) made things so complicated that intelligent persons who ordinarily could be expected to take responsibility for themselves could not argue in a court of law or obtain the information needed to properly take care of themselves, (b) were monopolies in restraint of trade, (c) maintained a subordinating class system that hoarded privileges and blocked the entry of the lower classes, and (d) retarded developments and blocked talent in nonorthodox realms of practice (Tabachnik, 1976). More fundamentally, the demands of a growing population and an expanding frontier ushered in a wave of democracy and individualism (Spector & Frederick, 1952) and a popular health movement (Ehrenreich & English, 1973) that upset the machinery by which professional practice was controlled. The professions then became more socially inclusive as the society became more egalitarian.

Beginning in the 1870s, however, the bar associations and the medical societies began promoting a relationship between competence and licensing that culminated in our present complex system (Tabachnik, 1976). In effect, the professions, no longer able to call upon the class system to maintain their privileged status, turned toward government to secure public confidence and a monopoly of skill (Gerstle & Jacobs, 1976). In the 20th century, the trends have been (a) for licensing to include an ever greater number of occupations, (b) for the type of licensing to go from title certifications to compulsory licensing of practice, and (c) for the raising and tightening of standards--including moving from an apprentice system to one centering training in educational institutions, lengthening the period of training, and adding internships after training (Spector & Frederick, 1952). Though there have been some reactions to professional dominance expressed during the last decade by client revolts and by pressures toward community control, the present strength of professional power makes "threats to established patterns of dominance appear minimal" (Gerstle & Jacobs, 1976, p. 18).

Profession as Guild

Gerstle and Jacobs (1976) described a craft guild as follows:

> They restricted competition, set prices, defined the quality of raw materials and craftsmanship, controlled entrance and training, and gradually developed ordinances touching on the guildsman's relations with fellow members, nonmembers, members of other guilds, future members, dependent workers, and consumers. (p. 2)

Though professionals may wish to deny any similarity between their associations and guilds because of the class commercialism or the association with unionism suggested by the guild label, the analogy is helpful in understanding the centrality of licensing to professional practice. The charter of autonomy is given to the professional via the licensing arrangement on the basis of public acceptance of the idea of professional expertise and altruism (Haug & Sussman, 1969). The charter is essential. Without it, professionals would not be able to control the potentially sharable knowledge that is the basis of their expertise, nor would they bother to guide practitioners to make the costly pretense of the altruism ideal (Haug & Sussman, 1969; Reiff, 1974). To maintain the charter,

the professional must mystify the public by making the service appear to be expert and altruistic.

Modern professionals conceal their commercial interests, but these are nonetheless apparent in professional procedures. Reiff (1974) describes the professional as an entrepreneur dealing with knowledge as a commodity, "supplying and withholding for a price service as a form of labor" (p. 455). According to Krause (1977), for physicians "the key variable is power gained through possession of the medical skill. The power is legitimized—made official—through licensing laws which prohibit others from practicing medicine" (p. 35). Controlling the knowledge, making it a commodity, creates a scarcity economy over which the professionals have monopolistic control. Though there is talk about a free market, "Health care providers themselves are not responsive to market pressures exerted by consumers, because demand levels are not determined by consumers but by physicians" (Carlson, 1970, p. 857). By having absolute control over the spigot, professionals can arrange things so that they themselves are benefited rather than their clients. For example, Carlson (1970) points to the choice of a fee-for-service system as opposed to a prepayment system. In a fee-for-service system, services, "the need for which is determined by the providers of those services, are continuously bought by users" (p. 858). According to Carlson (1970), this induces inelasticity in demand by restricting user choice and leads to increases in costs. The alternative, prepayment, gives providers and consumers a common goal—maintenance of health. Krause (1977) points out that in a fee-for-service system it is to the physicians' economic advantage to overdefine who is ill, while in a prepayment system it is advantageous to underdefine this group.

The charter of autonomy includes the necessity to define the terms of practice and "a legal, moral, and intellectual mandate to determine for the individual and society at large what is healthy, moral, ethical, deviant, normal, or abnormal" (Reiff, 1974, p. 452). Thus, a system of logic and perception may be erected which organizes ethics and rationalization to protect professionals from the effects of their decisions. Those dependent on them suffer from their mistakes, ignorance, self-deception, and bias, since professionals have the right (indeed the mandate) to define when a mistake has been made. In this way a situation is created in which feedback from experience is so limited that self-corrective action is unlikely. These trappings of power led Gerstle and Jacobs (1976) to observe the "shift of emphasis on the part of professionals from control over the quality of the product or service to control of price" (p. 9). Such power is widely emulated, so much so that many want their occupations to become professions. Gerstle and Jacobs (1976) observed that the mystique of the professional is considered so socially useful for so many purposes that there is no consideration that it could be a liability.

The Boards

The mechanism by which monopolistic control is maintained is the state licensing board. The charter is, in effect, given to a public body by a state legislature, and its members are generally appointed by the state's governor. On the surface it appears that these boards would act in the public interest, but in fact, they are "captured" by the profession they are supposed to regulate. In most cases, particular professions proposed the licensing law establishing the board, their representatives negotiated with the legislators during its passage, and their representatives fill a majority, if not all, of the seats on the board (Cohen, 1975). Shimberg (1976), in reviewing the effect of "sunset" laws, indicates that even when public members are included they often become coopted. Using "umbrella" agencies to supervise a number of professional boards in a state has not made these boards more accountable. Pfeffer (1974) also found inclusion of the lay public on boards to have little discernable effect on their accountability.

If there is a tie between competence and licensing, there ought to be some evidence of that tie in the work of licensing boards. Unfortunately, there is not. As Cohen and Miike (1974) have suggested, in addition to assessing initial competence, the boards should monitor continuing competence and should discipline errant practitioners. A related public interest matter is the availability of licensed professionals. Boards ought to be active, according to Cohen and Miike (1974), in affecting the redistribution of practitioners and in developing new patterns of utilization of related professionals. Referring to health care personnel supply and demand, Krause (1977) concludes, "Self-interest of the crudest sort still plays a role in the way these issues are handled. As usual, the needs of the consumer are pushed aside" (p. 193). Licensing boards do very little in these areas and instead restrict themselves to the administration of

entry examinations. Even in this role they do poorly, measuring minimal competence only (Cohen & Miike, 1974).

So, what do licensing boards do? Pfeffer (1974), reviewing the limited research, concluded, "Occupational licensing operates to restrict entry and enhance occupational incomes" (p. 104). He reported observed relationships (a) between the enactment of licensing laws and the decline in the numbers of training institutions and trainees, (b) between the control of competitive behavior among professionals and an oversupply of professionals (to maintain the illusion of professional dominance), and (c) between the restrictiveness of a profession and its independence from local economic conditions. In this regard, Krause (1977) reports that the number of medical school graduates was held constant from the 1930s to the 1960s despite rapid population growth. Moore (1961) found that restrictions on entry benefit the practitioners in the field at the time the restrictions are imposed. He reported the imposition of citizenship requirements for regulated occupations in Illinois in 1939, at a time when there was a large influx of trained practitioners from Europe.

The particular means of controlling entry is the manipulation of the examination pass rate. Maurizi's (1974) study of 18 occupations indicated that

> a 10 percent increase in excess demand (applications) generates a decrease in the pass rate varying primarily from 1 percent to 10 percent depending on the occupation, and that a 10 percent increase in average practitioner incomes produces up to a 10 percent decrease in the pass rate . . . . The power of the licensing boards is often used to prolong the period of higher incomes resulting from increases in excess demand for the services of the occupation in question. (p. 412)

Maurizi (1974) suggested that over the long run the increase in income at the time restrictions were imposed would attract more new entrants, which in turn would result in a decline in income for members of a profession *if* entry restrictions were not manipulated. The relationship between restriction imposition and income is apparently not all that certain. Maurizi (1974) said his data had no power to explain the relationship for half of the occupations he studied. Pfeffer (1974), studying three occupations, found no evidence of a relationship between the licensing of an occupation per se and the incomes of its practitioners. He did find, however, a relationship between examination failure rates and incomes—the higher the proportion of successful applicants, the lower the income (Pfeffer, 1974). Cohen and Miike (1974) and Krause (1977) report the practice of permitting foreign physicians to practice in chronic-disease hospitals and mental hospitals—either ignoring citizenship requirements or lowering passing examination grades for those who will work in less desirable settings or in geographical areas of high need.

Licensing Is the Key

It has been observed that licensing has rarely been sought by the public; rather, it has been sought by the professionals who wished to be licensed (Cohen, 1975; Friedman, 1962). In effect, the legal mechanisms of the state legitimize the occupation. Freidson (1970) observed,

> The foundation on which the analysis of a profession must be based is its relationship to the ultimate source of power and authority in modern society—the state. In the case of medicine, much, though by no means all, of the profession's strength is based on legally supported monopoly over practice. This monopoly operates through a system of licensing that bears on the privilege to hospitalize patients and the right to prescribe drugs and order laboratory procedures that are otherwise virtually inaccessible. (p. 83)

Hardcastle (1977) calls the need for legal protection an "expedient of an occupation on the make" (p. 14). The occupation becomes "made," ironically, as a profession through the use of public institutions and in opposition to the public interest. Friedman (1962) called the results of licensing "unendurable" even in medicine where the case for licensing was the strongest.

Though there is no evidence of any relationship whatsoever between licensing and the quality of care, the likelihood of licensing laws being removed is remote. Carlson (1970) describes licensing as going from a presumed remedy to a problem: "Licensure would likely fall of its own weight except for a reverence for professionalism" (p. 860). Licensure statutes are defended vigorously because their loss to the professions means (a) the loss of a captured board that acts in their interest free of the influence of outsiders and (b) the loss of the power given to the profession as the result of making the violation of the professional monopoly punishable as a crime (Pfeffer, 1974). So licensure is terribly important to the professionals, and yet the public is gullible (Moore, 1961), loosely organized, and lacking expertise when compared to the highly motivated trade and professional groups (Shimberg, 1976). The result is the maintenance of self-serving licensing systems regardless of their justice or usefulness.

The existence of licensing laws indicates a shift of opinion in the last century from the notion that people know what is best for themselves to the notion that "society" is the best judge (Moore, 1961). In this regard, Krause (1977) observes that the public does not judge expertise. Technically incompetent general practitioners have as many patients as competent ones. The conclusion is thus made by many that the public cannot protect itself and that licensing is, therefore, a necessity. However, the control of information by professionals does not permit a testing of the capacity of consumers to take care of themselves. The belief that information is the key to quality care is supported by the necessity, even with licensing statutes, for individuals to gain a considerable amount of information in order to effectively choose a therapist (Gross, 1977).

This complex structure surrounding licensing permits professionals to hide from the public's view their dependence on the licensing statute. Fortunately, it isn't really that necessary for the integrity of the profession, but it is for monopolistic economic control. There are several professions (e.g., university professors, dietitians, librarians, engineers) that are generally unlicensed partly because they practice in institutions. Goode (1960) suggests that pressure for licensing is greatest for occupations that deal with clients as individuals and where competence cannot be easily demonstrated. Reviews of licensing suggest that certification and registration arrangements would accomplish the protection of the public as well as the compulsory licensing of practice would (Friedman, 1962; Moore, 1961). Professional associations credential practitioners and accredit training programs without dependence on state law. More than 100 years ago it was recognized that the licensing laws had provided the professions with their power, so it was these laws that became the target for attack (Tabachnik, 1976). This may not happen in this century, but it is useful and important to note that the problem of licensing is brought about through the complicity of state governments (Gerstle & Jacobs, 1976; Tabachnik, 1976).

There is a rather strong push currently to reform licensing laws (e.g., national credentialing, institutional licensure; Cohen, 1976; Roemer, 1973). Though it is appealing to believe that there is hope for the system, the fact that professionals would remain in control in the alternatives suggested is discouraging. The crucial aspects of the problem, the absence of accountability and the maintenance of the monopoly, would not change (Illich, 1976). Further, the underlying reason for reform is obscured by the hope of reform. According to Krause (1977), the grip of physicians on maintaining control of their work is weakening under pressure from new technology and new specialty occupations. The old craft-guild model is not up to controlling it all without some help from the state legislature. The help might follow the pattern of nurse licensing laws in which the nurse's subservience to the physician is written into the law (Krause, 1977), or new laws may be suggested that institutionalize the physician as the manager of a system of health service delivery. In these ways, then, "reform" aids the physician to adapt to the problem of role obsolescence. Still, licensing is the key.

Licensing and Quality

The link between licensing and competence is the basis for societal support for licensing arrangements. I have questioned that link. It is instructive to add the evidence that licensing does not seem to be effective in preventing incompetent practice, and in the specific case of medicine with which we are most concerned, there isn't much interest in the discipline of incompetent practitioners. Derbyshire (1969), a former president of the Federation of State Medical Boards, intensively studied the problem of discipline and estimated that 5% of America's doctors are unfit to practice. He also reported that 38 states do not even specify professional incompetence as a reason for disciplinary action.

The political nature of this problem is revealed by the contrasting views of the action of the state boards in the area of discipline. Derbyshire (1969) apparently conducted two studies of state board disciplinary actions. Referring to the first study, he is vague about the number of incompetents, but of the 1,000 disciplinary actions taken over a 5-year period, he says *many* were because of incompetence. He goes on to say,

> Critics have said this is not a significantly high number. But if one makes a modest estimate that each of these physicians treats an average of 800 new patients every year, this means that 800,000 people have fallen into the hands of unscrupulous or incompetent physicians during the five year period. Viewed in this light the "insignificant" figure assumes important proportions. (Derbyshire, 1969, p. vii)

Shryock (1967), also referring to the first study,

thinks the number is *not large* and wonders how effective the board actions were but concludes that "the medical members of the boards were making *some* effort at professional self-discipline in the public interest" (p. 114; emphasis added). Cohen (1973), on the other hand, referring to Derbyshire's (1969) later study of 938 board actions over a 4-year period says "*only* 400 were based upon some form of incompetence" (p. 3; emphasis added). Krause (1977), having reviewed studies of discipline, is not specific, but he takes a stronger stand: "The most striking finding of all studies is the near total avoidance of any policing of peers by the licensing board members even in cases of extreme malfeasance" (p. 284). Since physicians are autonomous, they can and do determine the extent to which professional incompetence is defined as a social problem. The lack of action on this problem indicates that it is to their self-interest to obscure the problem.

Board staffs, according to Cohen (1973), are inadequate to carry out investigations, and the statutory provisions for such investigations are marked by ambiguity and a lack of precision. Malpractice suits appear to be the only effective feedback technique available that is likely to affect the physicians' willingness to consult and to refrain from procedures for which they are unqualified (Klaw, 1975). Krause (1977) reports that one half of all surgical operations are performed by physicians untrained or inadequately trained in surgery. Since physicians are permitted under licensing laws to use procedures for which they have not been trained, the likelihood is that economic motives (earning higher fees, losing a patient to another doctor) will maintain the threat posed by the incompetent physician. Federally mandated Peers Standards Review Organizations pose more problems than prospects for change (Laptzin, 1974; Newman & Luft, 1974; Zitrin & Klein, 1976). Israel (1973) has commented, "Among the features hindering effective implementation (of the review process) is the tradition of autonomy in private practice, and the associated reluctance of physicians to interfere in each others' practices and to be publicly critical of each other" (p. 130).

There are some who see licensing as the determiner of incompetence. Illich (1975, 1976) has been articulate about health delivery systems creating dependency on physicians. This dependency, which reduces the ability of people to care for themselves, is joined with a mystification by which people ignore the possibility that they could care for themselves. This mystifying dependency is a major factor in iatrogenic (physician-caused) illness, which is variously estimated (a) to include from 50% of all illness (Illich, 1976) to 20% of medical patients (Stuart, 1970), (b) to jeopardize one third of hospitalized patients (Walker, 1973), and (c) to more than double the length of hospital stays (Stuart, 1970). Those who want to see licensing laws changed to permit "paraprofessionals" to perform licensed medical functions describe licensing laws as restricting the productivity of personnel (Roemer, 1973), locking practitioners into activities prescribed by statute which are not in accord with their abilities (paraprofessionals can do many tasks better than physicians but are not permitted to), and escalating health care costs (Carlson, 1970).

The experience with deprofessionalization in the second quarter of the 19th century is viewed differently in different quarters. Tabachnik (1976) reports that in America, deprofessionalization stimulated the growth of medical schools, increased the number of doctors, raised average standards, and was not as bad as the then-leaders of American medicine expected it to be. Shryock (1967), on the other hand, treats it as a calamity—a time of rampant quackery and deterioration in the quality of practice. It is never clear in his analysis if quality is related to incompetence or to the social class and educational background of the physicians.

In summary, licensing arrangements do not seem to be providing the structure for effective solutions to the problems of delivering quality care in the health and helping services. Instead, the evidence overwhelmingly supports the conclusion that licensing maintains a structure that is in the self-interest of the service giver and in opposition to the public interest. Licensing actually results in the institutionalization of a lack of accountability to the public. This information may cause some to question a collusion between the state and the professions which is justified in altruistic terms but which appears not to merit public confidence. This information has not been introduced into any of the debates about licensing in the professional literature. Acknowledging this information can be the first step toward a clearer definition of the problem of how to protect the public and maintain professional integrity.

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