LETTERS TO THE EDITOR

The tribute to Easlick in the Winter 1980 issue elicited the most letters to the editor ever. Excerpts follow:

Words fail me to express the appreciation of Kenneth's family of the beautiful memorial accolade in the *Journal*. We do thank you for this testimonial — and for our copies.

Mercie Easlick
(Mrs. Kenneth A. Easlick)
2 Ruthven Place
Ann Arbor, MI 48104

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It was a well remembered privilege for me to have worked with Ken Easlick on the Board and to have benefited from his *work*shops. He even introduced me to that most flavorful part of prime ribs, the end cut.

Your newsy, informal elegy captures so well the humaneness that was Ken Easlick...

John K. Peterson, DDS
Director, Division of Dental Health
North Dakota State Dept. of Health
Bismarck, ND 58505

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It was very deep regret to know the death of Dr. Easlick. He was a very great teacher. We do know from Dr. Sompol that all the end of his life he still devoted all contributions to the dentistry and public health. We consider ourselves fortunate to have had the opportunity to not only be his students but also to admire him over the years. We would say here again all contributions he made will long be remembered.

On behalf of Michigan's MPH Thai dentist alumni here in the Chulalongkorn's dental school, we would express to you and please convey to Dr. Easlick's family our sincere sympathy.

With kindest regards and love.

Kalyani Amatyakul, DDS, MPH
Varaporn Buatongsri, DDS, MPH
Sompol Lekfuangfu, DDS, MPH
Dental School, Chulalongkorn University
Bangkok 5, Thailand

Your tribute to Ken Easlick in the current *Journal of Public Health Dentistry* befits the man and is a beautiful exposition of your respect and love for him . . . .

Ben D. Barker, DDS
Program Director, W. K. Kellogg Foundation
400 North Avenue
Battle Creek, MI 49016

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Your elegy to Ken Easlick was a masterpiece. Not being one of Ken's "formal" students, there were many facts about him I did not know before reading your tribute. Thanks also for the personal touches that were included.

I can attest personally to Ken's unselfish interest in others. While I was a student at the UNC School of Public Health, Ken visited our campus. I introduced myself to him and in the ensuing conversation happened to mention that I was beginning to write my dissertation. At the mention of the word "writing," he sat down with me for 30 to 45 minutes and wrote many helpful suggestions. One particularly difficult point for me to accept was: "don't expect a final product before writing at least three to four drafts."

Other opportunities to know and appreciate Ken were available in my role as Secretary-Treasurer of AAPHD. But I will always remember his concerned interest in an "unknown" graduate student in 1964.

J. Earl Williams
Chairman, Department of Community Dentistry
School of Dentistry
Medical College of Georgia
Augusta, GA 30902

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Am getting caught up with the accumulated mail and reading matter after our return from Mexico.

Last night I read your moving and sensitive elegy of Ken Easlick.

Thank you and congratulations. I am sure that everyone who was privileged to know Ken was as deeply moved in reading your elegy to Ken as I was and would want to add their heartfelt thank you.

Bob Downs
1235 S. Downing St.
Denver, CO 80210

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I was saddened to read of Ken Easlick's departure to greener pastures. I have always felt fortunate that I caught him the last year before his "retirement," and that I was privileged to be his student. Some of the things he taught me were simple and basic — how to use a library, to write a little more consciously and clearly and to accept criticism in the spirit of good intention. But what I enjoyed most about him was his unflagging enthusiasm and his sense of humor which laughed not only at the absurd human condition but at himself and us for taking it seriously . . . .

Lastly, let me compliment you on your remembrance of Ken. You caught his energy, his competence, his concern, his quixotic personality and his greatness. We need people like him and you and, I would like to think, myself to keep working and struggling to make things better in our microcosm even as the macrocosm appears in doubt.

Jay W. Friedman
403 N. Oakhurst Dr.
Beverly Hills, CA 90210

... it's even lonesome down here in Chicago knowing that Ken Easlick is gone. I doubt that I saw Ken more than a dozen times in my life, but I felt a kinship that is hard to describe. Maybe it was the sweet renegade in him that turned me on, but something did, and, while the world is a better place because of his having been here, I'm not quite willing to settle for that rationalization for having him "somewhere else" ... .

Bruce L. Douglas
Roosevelt Memorial Hospital
426 Wisconsin Street
Chicago, IL 60614

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Your tribute to Kenneth Easlick was moving and appropriate. Kenneth was one of three individuals who have had a major impact on my professional life and he was, to a great extent, the greatest of the three. My years as a member of the American Board of Dental Public Health were rewarding, discouraging, fatiguing, and exciting. Above all else, they offered the opportunity to work over a considerable span of time with Kenneth Easlick as a peer. For that I am grateful. When will another giant pass this way?

Wesley O. Young, DMD, MPH
Professor of Dentistry and
Chairman of the Department of
Community Dentistry
School of Dentistry
The University of Alabama
in Birmingham
Birmingham, AL 35294

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... I've been meaning to write you to tell you how much I liked the story you did on Ken in the *Journal of Public Health Dentistry*. It was a masterpiece, and even Ken wouldn't have found any place to use the red pencil on it. My sincere compliments, Dave. I thought the world of him, too ... .

Philip E. Blackerby
930 Don Juan Court
Punta Gorda, Florida 33950

... at last I have been able to read in detail your tribute to Ken Easlick ... .It is a superb recognition of a man who is sorely missed by many of us. What a great guy he was ... .

Dick Remington
Dean, School of Public Health
The University of Michigan
Ann Arbor, MI 48109

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To the Editor: May 4, 1980

The excellent article on "The Validity of the Radiographic Method in the Pretreatment Review of Dental Claims" by Bailit, et al. (Winter 1980, 40:26–37) correctly describes the difficulties and uncertainties ("gray zone") of dental pretreatment review. Implementation of the recommendation that "dental consultants should undergo formal training in radiographic assessment methods" would strengthen the process by reinforcing the confidence of all parties concerned that decisions are being made by competent "specialists" in this contentious area of dental practice.

Indirect radiographic review has been demonstrated to be cost-effective because it is applied most easily to bridges and crowns which represent nearly 40 percent of all expenditures. Yet, errors can be made and, according to the authors, "Twenty-eight percent of crowns could not be evaulated on the basis of radiographs alone." The solution to this problem is relatively simple. Where there is serious doubt, or in the event the attending dentist wishes to appeal a denial, study models should be provided along with the radiographs. Most attending dentists will cooperate, thus avoiding the need for a more costly — and usually unnecessary — clinical examination of the patient. These models effectively demonstrate the extent of coronal "involvement" and frequently support both the attending dentist and the consultant. As an example, if a dentist requests authorization of benefits for four or five crowns, the need for which is not evident radiographically, review of study models frequently will support the dentist's contention for one or two teeth and the consultant's denial of the others.

Another area where pretreatment review — or any review — could be effective is that of oral surgery, the removal of normal, unerupted third molars in particular. In my published study (The Case for Preservation of Third Molars, J. Calif. Dent. Assoc., 5:50–56, Feb. 1977), I pointed out that nearly two-thirds of insurance claims submitted by oral surgeons contained overcharges, most commonly teeth such as maxillary third molars which are falsely diagnosed as impactions. If we criticize general dentists for overtreatment, we should not exclude this specialty which, as a proportion of its total practice, is more abusive of dental insurance and patients than any other segment of the dental profession.

Consultants should also bear in mind that the pretreatment radiographs are also posttreatment with respect to previous restorations. Dental insurance makes possible more good as well as more bad dentistry. Where gross open margins or overhangs are observed interproximally on restorations recently done, refunds should be obtained to allow replacement at no cost to the insurance program or the patient.

It is too bad we do not have a system of graded sanctions such as fines, public notices, and other penalties to discipline the chronic offenders, a long list of which

could be provided by every dental insurance consultant. Unfortunately, organized dentistry is more concerned with protecting itself than the public. Pious platitudes notwithstanding, too little is being done to assure either quality of care or control of costs.

Jay W. Friedman, DDS MPH
403 N. Oakhurst Dr.
Beverly Hills, CA 90210

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March 17, 1980

To the Editor:

To quote directly from the concluding statement of a workshop held at the University of Michigan regarding caries prevention just two years ago:

> No preventive (dental caries control) program will work at full effectiveness or efficiency when (refined or altered) sugar is being consumed indiscriminately by the target group.

I'm extremely dismayed at the apparent lack of any strong and real effort by our profession to insist of our Federal government's elected officials that they legislate the requirement that highly sugared foods be labeled with a warning clearly stating sugar's proven etiologic relationship to dental caries.

In short, if it is logical to place a health warning on cigarette packages concerning the risks of smoking (which directly affects only one-third of the American public, and addresses health problems which do not generally appear widely until the fourth or fifth decade of human life), why are there then not similar warnings on candy bar wrappers and sugar-rich cereal boxes regarding their proven hazards to dental health when almost all American children experience rotten teeth within the first or second decade of their life?

And why doesn't the American Association of Public Health Dentists advocate such a moral objective openly within their own publication?

Rather than printing comments that reflect the divisiveness, self-interest and indifference within our profession, I think that a journal such as the one of your Association would far better concentrate its content and objectives in the direction toward reducing the unconscionable and long-standing rate of dental caries occurrence among this nation's citizenry — those the Association claims to serve.

Cyrus J. Stow, DDS
2195 Rockdale Drive
Conyers, GA 30207

cc: Dr. George A. Haeseler
Dr. Helyn A. Luechauer
Dr. James M. Dunning

attachment (letter to Dunning)

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March 17, 1980

Dear Dr. Dunning:

From your comments which appeared in the *Journal of Public Health Dentistry* (the Winter, 1980, issue) in response to Dr. George Haeseler's letter about the

American Dental Association, it seems to me that you may be a person who is more concerned over the issue of whether dentistry is to remain a function of the private sector or is to become more dominantly a function of our central government's bureaucracy, the issue of whether reparative dental care services will continue to be largely rendered by the dentists themselves or are to become increasingly functions delegated to auxiliary therapists, and perhaps the issue of which group of professional folks within dentistry will primarily control "the beans" than over an issue that should be considered more important: how can dentistry reduce the almost universal occurrence of rotten teeth among young children in this country that continues despite the good effects of fluoridation and oral hygiene practice?

In view of the massive and long-standing (and often quoted) collected data that reveals that (1) most American children experience tooth decay soon after age three, (2) most American children — and especially the poor — receive little or no dental care today despite the disbursement of millions of dollars through Federal health programs aimed at this problem over the past 15 years, and (3) most tooth decay is the result primarily of the excessive and frequent ingestion of sugar-rich foods — a phenomenon associated with the advance of civilization — and that it is not controlled in its entirety by either fillings, fluoridation or toothbrushing or any combination of these approaches; when is the leadership of some division of our dental profession (perhaps in education or public health) going to begin insisting that the public be warned in complete openness — and repeatedly — that eating sugar-rich foods causes dental caries?

Frankly, rather than dentistry's energies be spent chasing its own tail in circles (or that its membership waste their time gazing narcissistically into mirrors), wouldn't it be a lot more productive — and serve the public's interest more nobly — to let folks know why their teeth rot away?

Cyrus J. Stow, DDS
Conyers, GA 30207

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March 31, 1980

Dear Dr. Stow:

Thank you for your thoughtful letter of March 17th. Please believe me that nothing in my editorial was intended to discourage dental health education. I have been doing my best to educate patients about the causes of caries during 50 years of practice (yes 50!), and so have a great many other dentists. The American Dental Association itself has been doing a lot in this direction over many years. It's not a new idea. I am convinced that most thinking people know the toothbrushing-plaque control story and the sugar story already. Knowledge, however, does not automatically produce action, as we know all too well in the case of the smoking-cancer story. Nevertheless, I approve your plea (to Dr. Striffler) for conspicuous warnings on sugar-containing packages.

Since personal chairside talk on a one-to-one basis is acknowledged to be the most effective type of dental health education, I also see a real advantage in getting

more auxiliaries out in the field doing those phases of preventive dentistry that can safely be delegated to them.

James M. Dunning, DDS, MPH
Professor Emeritus
Department of Dental Care Administration
Harvard School of Dental Medicine
Boston, MA 02115

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To the Editor April 7, 1980

In reference to my plea (of March 17) regarding the labeling of highly sugared foods with a warning about their proven cariogenic potential: if the consensus among dentists and scientists does overwhelmingly support the thesis that sugar consumption plays a significant role in the widespread occurrence of dental caries, why is there not a stronger effort on the part of our profession's own leadership to share this fundamental scientific information more visibly and broadly with the American public we claim to care for?

As our nation faces increasing uncertainty on all fronts — political, economic and military — brought largely on by its declining productivity and confusion in a world where the finite limitations of resources, both raw materials and energy supplies, begin to have a real and measurable effect upon any nation that fails to confront the reality directly before it; we cannot afford any longer to ignore more cost-effective ways to reduce the burden of uncontrolled disease among our own citizens and the inescapable long-term costs that our total society bears from such hesitancy to act accordingly.

In short, if our profession does not begin to provide our Congressional health-care legislators careful advisements concerning sound and unselfish disease control measures in all areas; our common currency will become so debased and worthless from Federal over-spending as to possibly make almost all dental care seem unnecessary in contrast to being able, as a nation, to keep from essential starvation... .

Cyrus J. Stow, DDS
Conyers, GA 30207

Att: Letter to Dunning

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Dear Dr. Dunning: April 7, 1980

Thank you for your kind response in answer to my criticism of your editorial concerning Dr. Haeseler's remarks about the American Dental Association.

While there have indeed been many years of effort by the ADA to educate the American public about dental health preservation, and much effort also by other groups and individuals as well; sadly the net aggregate effort — evident in our nation's continuing pandemic of uncontrolled dental carries and widespread premature edentulousness — simply hasn't been enough to counter the marketing persistence of those who make and sell highly sugared food products with very much success.

As our nation — and perhaps the whole of western civilization — continues to drift increasingly nearer the dangerous edge of real economic collapse and widespread

bankruptcy due to mounting political pressures throughout the world, the leadership of our country's productive net strength *which rests directly upon the functional health and well-being of its aggregate citizenry* cannot afford to ignore the farsighted benefits to our nation's collective endeavor to survive that depends without question on the honest, clear and widespread dissemination of proven health hazards.

Moreover, the legislative leadership of this nation cannot function with competency or purpose unless it receives the guidance it needs from the knowledgeable and trusted leadership of all the health-care professions.

I am grateful for your agreement in principle that highly sugared foods should carry a conspicuous dental health warning on their package labels. But unless admonishments toward this end are clearly, *and strongly*, given health care legislative leaders *by recognized professional individuals and professional organizations*; no change will come about, Sir.

Cyrus J. Stow, DDS
Conyers, GA 30207

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To the Editor: April 29, 1980

Having not seen his earlier complaint rendered in print, (although the editor's "shock troops", in the guise of graduate students, did pay a visit to scrutinize the complainer in his natural habitat) this curmudgeon feels the need once again to do a little judicious crabbing. First, the circumstances. Ever alert to the continuing appeals for new members, I had succeeded in interesting the director and staff of a large preventive project in joining the Association. To clinch the deal, I rushed membership applications and my brand-new copy of the Winter, 1980 issue of the *Journal* to them since I had noticed several articles concerning topics related to their project. About a week later my *Journal* was returned with the following note:

> "Dear Mr. Member of the Editorial Review Board:
>
> Thank you for providing me with a copy of your esteemed *Journal* (I think). Would you be kind enough to read the paper indicated and tell me why it was accepted... ."

The paper indicated, and heavily marked by my potential new member was "The Relation Between Dental Caries in the Primary and Permanent Dentition of the Same Individual" by Poulsen and Holm. After reading the paper, my answer to the note must be: "I don't know why it was accepted." A few readily apparent observations will suffice to explain this answer. (1) The title is a misnomer, the paper reports an attempt to identify screening criteria useful for predicting individuals who will have a high caries incidence in the permanent dentition. The relation between caries in primary and permanent dentitions is already established, as indicated in the authors' review of the literature. (2) If criteria exist to predict incidence, it seems only fair to wait until the incidence is established before testing potential criteria. In the samples of Danish children, incidence of caries in the permanent dentition was recorded at age six, a rather early stage of caries attack. An inspection of percentages of children with one or more dmfs/DMFS also indicates undue haste in evaluating caries incidence in the permanent dentition, and, at the same time, portends the results of the study. (3) In an editorial vein, the last four tables are unnecessary, and there appear to be errors in the third table since some of the row totals do not equal the percentages indicated in the second table.

Although more criticism is possible, these examples demonstrate that the paper received less than scrupulous review before acceptance for publication. Now the crabbing. Why *did* this paper get accepted? Assuming I am not alone in my criticism, something went wrong in the *Journal's* review procedures — was it inattention on the part of the reviewers, editorial prerogative, or perhaps a relaxation of the *Journal's* standards for scientific reporting? To harp upon the theme of my previous, and as yet unprinted crab, your call for recognition of dental public health specialists seems not to be justified given some of the recent emanations from the *Journal* officially representing these specialists. My potential new member may not wish to be counted among this group, and I really couldn't blame him.

James D. Bader, DDS, MPH
Associate Professor
College of Dentistry
University of Kentucky
Lexington, KY 40506

Editor's comment: Three reviewers read and commented on the paper being criticized by Bader. One, of impeccable reputation as an oral epidemiologist, recommended rejection because he felt the paper would *not* be of interest to the *Journal's* readership but he had no problems with the paper on its merits per se. In fact he stated in part: "It's well done all around." The second reviewer (a pedodontist, public health dentist, and faculty member from a British Commonwealth dental school) in two pages of comments suggested revisions, but recommended publication. The third, a public health dentist-computernik-statistical-type, had absolutely no quarrel with it (and *still* doesn't, even after reading Bader's critique and rereading the article). The article was returned with the anonymous comments of all reviewers for the authors to revise — which they did and then resubmitted. The third reviewer finds Bader's criticism of the theoretical basis for the article unconvincing. The topic considered by Poulsen and Holm, he felt, is of relevance, and it was evaluated in a reasonable and succinct manner. Of course, reasonable people will disagree on the definition of the term reasonable, but he doesn't intend to become involved in that debate, at least not here.

In regard to Bader's more substantive comments, he suggests that Bader should review the references cited by the authors and study the differences between the *dmfs* index and the hierarchical method. Such a comparison will reveal the reason why Tables II and III are unlikely to match exactly.

And your editor suggests that Bader perhaps is growing more than Kentucky Bluegrass in his glass house in Lexington.

This editor invites Poulsen and Holm to react to the Bader critique and to join the fray rather than being the passive object of it.