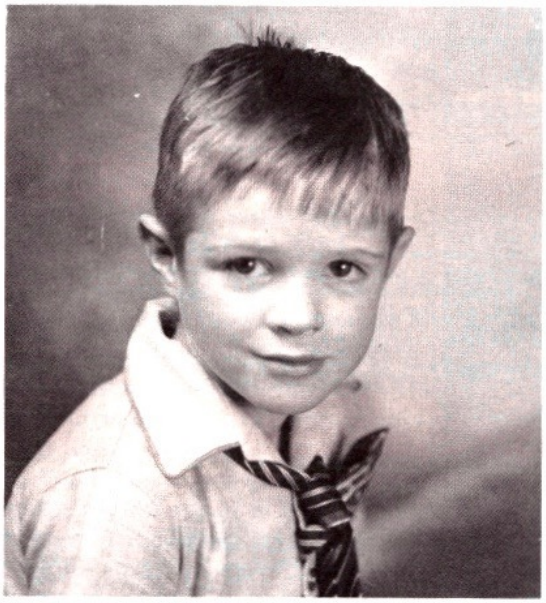
# Portrait of a professional: R. William McNeill, DDS, MS

It was 5:00 a.m. when Bill McNeill from Seattle began his solitary jogging trek across Golden Gate Bridge. The weather had been hot and cloudy the previous week, but this particular day was perfect. It was also Dr. McNeill's first day as president of the Pacific Coast Society of Orthodontists.

The characteristic discipline and ambition which Bill exhibits in his recreational, professional, and academic activities may well be credited to his parents. As young adults Bill's mother and father immigrated separately to America from Ireland. They met each other aboard ship while sailing back to their homeland to visit their families. Upon returning to the United States, they married and settled in an industrial town in New Jersey where Bill's father owned and operated a local grocery store. As a result of commitment to hard work, long hours, and honesty, the business prospered. Bill's mother had given up a blossoming career in banking in favor of marriage and now turned her energy to managing a growing family. In her soft-spoken Irish lilt, she infused Bill, his two brothers and his sister with the determination and confidence to achieve their highest academic aspirations and personal ambitions. Bill pursued a career in dentistry, as did his two brothers, one of whom settled in Princeton, NJ and the other in West Palm Beach, FL. Their sister became a registered nurse and now lives and practices in Bellingham, WA.

Bill completed undergraduate studies at the University of Delaware and in 1960 graduated from the University of Pennsylvania School of Dental Medicine.

During his years at Pennsylvania, Dr. McNeill's interest in an academic career was born through contact with Dr. Alvin Morris, a professor in Pathology and Oral Surgery and a consummate teacher. Dr. Morris' fascination with diagnostic puzzles and his principle that accurate diagnosis lies at the heart of effective health care provided Bill with a focus for additional studies. By completing the bulk of his clinical requirements early in his senior year, Dr. McNeill was able to devote a portion of his time to observation and patient care in the University of Pennsylvania Cleft Palate Clinic. These important interactions in dental school led to an internship at the Lancaster, PA Cleft Palate Clinic and an abiding interest in normal and abnormal craniofacial development.



*Dr. R. William McNeill as a child in New Jersey.*

While an intern Dr. McNeill began a research project under the tutelage of Dr. Wilton Krogman at Philadelphia Children's Hospital. An additional year was devoted to completing this project and the academic requirements for a masters' degree in physical anthropology. With the encouragement of his mentors at Lancaster and Philadelphia, Bill next applied for orthodontic graduate studies. He interviewed at several schools in the East and Midwest but found himself unable to afford a trip to Seattle for an interview with Dr. Alton Moore at the University of Washington. By happenstance Dr. Moore planned to attend a meeting in Atlantic City that year and had considered a side-trip to visit Dr. Krogman's laboratories. This fortuitously gave Bill the chance to spend a day with Dr. Moore and provided the foundation for a life-long friendship with yet another outstanding academician.

In the meantime Bill had married his college sweetheart, Yvonne Nylund, who pursued her profession as a mathematician and computer software engineer until their son Scott was born. With the coveted acceptance to the University of Washington and a National Institutes of Health post-doctoral fellowship, Bill, Vonny, and Scott moved to Seattle to begin the orthodontic graduate program. The demands of Bill's studies notwithstanding, the McNeill family, now with the addition of daughter Sandra, managed to explore the natural beauty of the Pacific Northwest by camping and hiking extensively. Their love of the outdoors and the lure of raising their children in the congenial environs of Seattle, led Bill and Vonny to consider settling in Washington despite strong family and professional ties in the East.

*Bill McNeill with his wife Vonny.*

Upon Bill's orthodontic certification, he was offered a position on the University of Washington faculty. This, plus a private practice association with Drs. Alton Moore and Richard Riedel provided Bill with a unique environment in which to pursue his academic interests and develop his clinical expertise. This ideal teaching/practicing arrangement unfortunately came to an abrupt halt in 1965 when Dr. McNeill was selected to serve in the United States Army. After the shock passed and the drafting was proved to be irrevocable, Bill and Vonny took a positive approach and managed to secure a post in Frankfurt, Germany.

*Dr. R. William McNeill traveling in Europe.*

In an effort to achieve maximum exposure to the German culture and society, Bill and his family chose not to reside within the American military compound, but instead became part of a Frankfurt neighborhood. Scott and Sandra attended German kindergarten and, along with their parents, mastered the German language. Bill had the responsibility for orthodontic practices in Frankfurt, Berlin, Bremerhaven, and at SHAPE headquarters near Brussels. Trips to these posts as well as ample leave time allowed the McNeills to travel extensively throughout Europe, the British Isles, and the Middle East. Bill and Vonny treasure the many personal and professional relationships that developed during their three years in Europe, and continue to expand their cultural interests through travel and international interactions.

Dr. McNeill's interest in correction of facial deformity had its seeds in his dental school and internship experiences. While in military service the dilemma of how to correctly treat a large number of orthodontic transfer cases with skeletal dysplasias and parallel exposure to management of facial traumatic injuries, stimulated Bill to become involved in the field of surgical orthodontics which was then in its infancy.

Following discharge from the Army, the McNeills returned to Seattle where Bill accepted a half-time position under Dr. Richard Riedel at the University of Washington. Dr. Riedel encouraged Bill to

*Bill McNeill enjoying a good sailing breeze out on Puget Sound.*

establish a surgical orthodontic team and to develop a teaching and research program in this area. Through initial collaboration with Dr. James Hooley and later with Dr. Roger West of the oral surgery faculty, Bill was able to achieve his goals of developing protocols for integrating orthodontic and orthognathic surgical treatment, methodologies to standardize surgical records, and systems to document treatment results. In addition to his University involvement, Bill developed a private orthodontic practice in Seattle. He and his associate, Dr. Peter Shapiro, have an active and diverse practice which emphasizes interdisciplinary patient care. Dr. McNeill's proudest academic

achievement came about in 1977, when he was appointed Professor of Orthodontics, an unprecedented accomplishment for a less-than-full-time academician.

Bill and Vonny live near the University of Washington in the Laurelhurst section of Seattle. Scott has now graduated from the University of Washington and is taking a "sabbatical" year to teach skiing, and bike through Europe with friends.

*President R. William McNeill*

Sandra has been studying at Williams College in Massachusetts and is currently spending her junior year in Madrid, Spain. Vonny, who completed a masters degree in computer science at the University of Washington several years ago is employed as an engineer at the Boeing Company. Like most Seattleites, the McNeills have a love affair with the sea and spend their leisure time sailing the coastal waters of Washington and British Columbia.

In conclusion to the interview Bill McNeill was asked to give his opinion on the following topics.

**How do you feel about the numbers of orthodontic graduate students that are being trained today?**

It appears currently that a reasonable balance exists between supply of orthodontists and demand. The reduction in new graduates realized during the last eight to ten years has been appropriate considering the decline in birth rate and the capacity of practitioners to effectively treat increasing numbers of patients.

Census figures for 1982 harbinger a population increase: more births than deaths (1.7 million), largest number of births (3.7 million) since 1970 and highest birth rate (16 per 1,000 people) since 1971. This trend will, over time, aid the re-establishment of equilibrium in those localities which now have a practitioner over-supply. In the highly probable event that population increases continue there should not be a need to revise orthodontic graduate class sizes upward. Rather, rising demand for services can be met by controlled, effective use of trained auxiliary personnel and by scientific and technical advances which will simultaneously simplify and enhance treatment capabilities.

**What will change most in the way orthodontics is practiced in the next decade?**

The orthodontist of the 1990s will have greater demands placed on his/her biologic and behavioral expertise and proportionally lower demands on technical productivity. The orthodontic specialist will be called upon increasingly to manage the more difficult problems of dento-facial physiologic and morphologic abnormality. Less complex problems will increasingly fall within the purview of the generalist or will be treated largely by trained auxilliaries under specialty supervision. Diagnosis and treatment monitoring will consume a greater

proportion of practitioner time whereas performance of repetitive mechanical procedures will receive decreasing emphasis.

This evolution will be an extension of trends already evident. The integration of facial orthopedic procedures with conventional orthodontic mechanotherapy has required the conscientious practitioner to be more discriminating in choice of treatment modality and to more assiduously monitor patient response as an indicator of treatment efficacy. The necessity to elicit high levels of patient motivation has emphasized the need for orthodontists to understand and correctly interpret behavioral attributes. Increasing involvement in interdisciplinary patient care (periodontal, restorative, orthognathic surgical) has required that the orthodontist master new or forgotten dental and medical terminology so that communication with other practitioners is facilitated and so that patient education regarding physical and psychosocial treatment aspects can be provided with confidence.

Academic institutions have, in many cases, led in developing these extensions of orthodontic practice. Thus, the newly graduated practitioner may in some respects have an edge on more experienced orthodontists. For the young specialist who intends to extend his basic education as well as the established practitioner who is committed to staying current, continuing education and professional development will assume increasing importance.

In the next decade one will not be able to assume the attitude of a specialist merely by virtue of training and credentials. Rather, one will be required by professional and societal pressures to demonstrate a capacity to competently manage complex treatment problems and to respond with enthusiasm and confidence to such challenges.

**Do you believe that the recent nationwide and local institutional advertising campaigns have been worthwhile?**

Yes, in my view the orthodontic public information programs have been very effective. Awareness of the positive benefits of quality orthodontic health care has been substantially increased. In my own practice I find that new patients have an improved understanding of the potential physical and psychosocial benefits of malocclusion correction even before my staff and I interact with them.

The public image of orthodontics and orthodontists has been enhanced. We are consulted with increasing frequency as resources for health care information rather than strictly as technicians or cosmeticians. Even if we cannot objectively credit the public information programs with initiating a specific number of patient contacts, the public preceptual improvement has, in my mind, entirely justified the program costs.

Of particular importance are those aspects of the program which emphasize the special education and training which distinguish the fully qualified orthodontic specialist from the nonspecialist. It is our responsibility to make this distinction clear as we rely increasingly on direct patient referrals rather than on referrals from other practitioners. It is essential that we capitalize on every opportunity to use the media as a public educational tool.

In spite of my positive endorsement of our advertising efforts to date, I feel strongly that the programs must continue to evolve. The responsible AAO officers and council members have the obligation to our membership to continually evaluate the advertising program direction to be certain that the proper issues are being addressed and that the most effective media outlets are being utilized.

**What are your opinions about specialty licensure as it relates to orthodontists?**

Specialty licensure for orthodontists and for all dental specialists is, I believe, in the best interest of the public. By requiring evidence of specialty education and demonstration of specialty skills, state and provincial governments could alleviate to some extent, the public confusion concerning specialty qualification. In addition, such a system of licensure would provide the bodies charged with control of professional ethics (Peer Review Committees, Dental Disciplinary Boards, etc.) clear jurisdictional guidelines. It would eliminate the subjectivity which now so often leads to inaction or inappropriate action on the part of these bodies when they are called upon to judge practitioner performance.

A further benefit of specialty licensure would be the elimination of state board requirements concentrating on restorative dentistry procedures. Access to specialty examinations for state and provincial licensure would remove some of the existing barriers to practitioner mobility. Specialists in some localities may feel threatened by such changes since they envision an uncontrollable influx of new graduates or semi-retired practitioners. Economic factors would, however, ultimately prevail. In my view, such natural supply and demand control would be both philosophically and operationally superior to our current system.

One note of caution is, however, in order. Efforts are being made at the ADA level to dilute the formal requirements for specialty education. The Commission on Dental Accreditation recently approved a revision of the Requirements for Advanced Specialty Education Programs to permit part-time enrollment. Moves continue to be made to recognize credits for continuing dental education participation as equivalent to formal graduate training. The AAO Trustees have registered opposition to such changes in educational criteria. As specialty licensure is considered it is essential that our constituent and component leadership be involved in establishing eligibility criteria so that only fully qualified practitioners achieve specialty recognition.

**How do you see the "yellow page listing" vote going at the next AAO House of Delegates meeting?**

I am certain that this will again be a hotly contested issue. The protagonists ("It's-too-expensive-for-the-young-guys" versus "It's-an-essential-adjunct-to-our-advertising-efforts") were distinctly divided on a geographic basis. The PCSO delegation voted unanimously in favor and will in all likelihood come out of caucus again in support of the national yellow pages listing program.

This position is in keeping with the trend for block directory listing in all health care fields. Identification with the AAO logo and certification of national specialty affiliation is one more way in which we can assist the public in distinguishing the qualified orthodontic specialist from the generalist who offers orthodontic care.

Health care professionals have traditionally allocated only minimal resources to advertising and promotion. A 1982 accounting summary for 135 dental general and specialty practitioners in the State of Washington showed less than 1.2% of gross expended for promotion and entertainment. This contrasts sharply with the average small business allocation of 3%.

Orthodontics is a profession, but the orthodontic practice is a business. As a business it will respond increasingly to forces in the marketplace. As business managers, orthodontic practitioners have the option of controlling the direction of that response by their level of financial commitment to such things as yellow pages listing. It is my hope that the 1984 AAO House of Delegates will vote in favor of this program.

PCSO Staff