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Mission

The *Journal of the American College of Dentists* shall identify and place before the Fellows, the profession, and other parties of interest those issues that affect dentistry and oral health. All readers should be challenged by the *Journal* to remain informed, inquire actively, and participate in the formulation of public policy and personal leadership to advance the purposes and objectives of the College. The *Journal* is not a political vehicle and does not intentionally promote specific views at the expense of others. The views and opinions expressed herein do not necessarily represent those of the American College of Dentists or its Fellows.

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THE AMERICAN COLLEGE OF DENTISTS, in order to promote the highest ideals in health care, advance the standards and efficiency of dentistry, develop good human relations and understanding, and extend the benefits of dental health to the greatest number, declares and adopts the following principles and ideals as ways and means for the attainment of these goals.

- A. To urge the extension and improvement of measures for the control and prevention of oral disorders;
- B. To encourage qualified persons to consider a career in dentistry so that dental health services will be available to all, and to urge broad preparation for such a career at all educational levels;
- C. To encourage graduate studies and continuing educational efforts by dentists and auxiliaries;
- D. To encourage, stimulate and promote research;
- E. To improve the public understanding and appreciation of oral health service and its importance to the optimum health of the patient;
- F. To encourage the free exchange of ideas and experiences in the interest of better service to the patient;
- G. To cooperate with other groups for the advancement of interprofessional relationships in the interest of the public;
- H. To make visible to professional persons the extent of their responsibilities to the community as well as to the field of health service and to urge the acceptance of them;
- I. To encourage individuals to further these objectives, and to recognize meritorious achievements and the potential for contributions to dental science, art, education, literature, human relations or other areas which contribute to human welfare—by conferring Fellowship in the College on those persons properly selected for such honor.

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Cover Photograph

ADA president Dr. Eugene Sekiguchi (right) works with dental student Everet Lake providing care for 12-year-old Quatrea Thomas at the Howard University College of Dentistry *Give Kids a Smile!* event.

Photo by Anna Ng Delort, courtesy ADA News. ©2004 American Dental Association.

FROM THE EDITOR

MORAL COURAGE

There is insufficient evidence to convict very many of us as possessing dangerously large amounts of moral courage.

Yogi Berra had it right: If people don't want to come, nothing can stop them! This seems to be especially true with regard to ethics.

I tried recently to write a case where an ethical dentist learned about care rendered by another dentist so abusive that the ethical dentist must respond. I failed; dentists always found some reason to excuse them from becoming involved. I have modified the case only slightly for students, replacing the question "Is there any action an ethical dentist must take?" with "Is there an ethical problem here?" Students can go on at great length about the abuses involved, naming various normative ethical principles and severely criticizing the hypothetical colleague.

It is unlikely that the different response is a result of our students being well trained in ethics—although they certainly are. If the case is modified to ask students whether they must become involved in an obvious incident of classmates cheating, stealing, or abusing clinic patients, the creative excuses reappear. Nothing seems to blunt ethics so effectively as finding out that it must be done in public. Seemingly, anonymity is a stimulus to ethical judgment.

James Rest and his colleagues have a view of ethics built on progression through stages. These include: 1) awareness of the existence of an ethical issue; 2) analysis; 3) determination of an

ethical position; and 4) action. Ethics training in dental schools—as well as editorials, workshops, and cases in journals for practitioners to read—emphasize the second and the third parts of this process. We warn people when they are about to be engaged in ethics training. Some training involves role-playing of implementation of ethical action, but this is not typical and it is still, after all, "theoretical."

Most of what we learn as professionals about identifying ethical problems and becoming involved in addressing these issues comes from observing role models and from being caught up in actual trial and error learning.

I know some people who are rich in moral wisdom. They can find the nuances in dilemmas and lay out the consequences involved. They can give theoretical positions on the matter—typically several different positions. I am much more comfortable with these people than with those who just know what is in their personal interests and label everyone else as unethical. But the people I really admire are the ones who are willing to risk something in order to promote the ethical tone of the profession. These are people who exhibit moral courage.

I am frustrated because there is not as much moral courage in the profession as I would like to see. I do not sit in judgment of my colleagues, because there isn't as much moral courage in myself as there should be either.

There has long been a debate over whether ethics can be learned at the age

when young professionals prepare themselves to start dentistry or even later if they were not exposed to ethics training in dental school. The answer is clear that ethical wisdom can be learned. Graduates of American dental schools are generally good at analyzing cases and stating positions grounded in normative principles. They are probably at least as good as their predecessors in recognizing an ethical situation when they meet one. But there is insufficient evidence to convict very many of us of possessing dangerously large amounts of moral courage.

I can think of at least three reasons for the short supply of professionals willing to take public stands on ethical grounds: lack of training, heavy personal sacrifice, and confusion over what moral courage means.

Inadequate training is unlikely to be the source of the problem. We have more of it than ever, and I think the jury is still out on whether knowing what to do automatically leads to doing it.

Personal sacrifice and the sheer size and complexity of many ethical issues are certainly significant impediments to their being addressed. Students say they will not accuse their classmates out of fear of retaliation. Practicing dentists are afraid of libel suits, rumor campaigns that ruin their reputations, and even fear of appearing to be mean-spirited. There are people who make more money by finding somebody to offend them

There are dentists who earn more each year from questionable practice than the entire enforcement budgets of most state dental boards—and they are prepared to sue to make sure that remains the case.

than by doing positive work. There are dentists who earn more each year from questionable practice than the entire enforcement budgets of most state dental boards—and they are prepared to sue to make sure that remains the case. Being the first one to take on a crusade is risky. Without confidence of being supported by like-minded colleagues, it may be foolish to be right in public.

I accept that heroism is a scarce resource and that many will prefer to remain quietly on the sidelines and cheer for the right. I am offended, though, by those who try their colleagues in absentia or in the courts of rumor. It is anything but heroic to bushwhack, to puff one's self up by talking down a colleague, or to make anonymous accusations.

This leads to the third potential reason for a lack in moral courage. It may be assumed that ethics training

and professional consensus on what is right are the foundation for moral courage. Quite possibly, however, they have the opposite effects. Having decided that one's moral position is right permits taking action only if there is pretty good reason to suspect that this righteousness will not be challenged. Some people would prefer to believe they are right and walk away rather than test their moral convictions. An honest confrontation of someone we disagree with always carries the risk that we will discover that our own views are incomplete, partially mistaken, or may not be the only valid interpretations. Moral courage requires that we face not only the external threat of sacrifice and retaliation. It also requires that we face the deeper and more dangerous internal threat of exposing our ethical positions to examination. ■



David W. Chambers, EdM, MBA, PhD, FACD
Editor

LETTERS TO THE EDITOR

**To the Editor:**

Congratulations on the excellent issue on quackery and fraud (2004, number 3). I think that it will be of considerable help to many.

Dr. Follmar's editorial leaves out what I believe is the most needed part of the solution to the problem of unscientific dentistry—the dental school curriculum must include courses dedicated to gaining an in-depth understanding of the scientific method, the evaluation of scientific articles, statistics, and the integration of that knowledge into everyday practice.

Dr. Chambers writes that “a small number of dentists abuse their patients... by practicing quackery.” There are no data on how many dentists are unscientific, but a 1995 survey reported in the *Clinical Research Associates Newsletter* said 8.7% of dentists wanted to ban amalgam use and that 14.3% were undecided about its safety. If 23% of practicing dentists do not support the use of amalgam, this reflects a very larger number who cannot or will not understand the scientific literature. And this does not take into consideration those dentists who practice other

scientifically unsupported procedures, such as cranial osteopathy, applied kinesiology, crystal therapy, fad diets, etc.

Drs. Bouquot and McMahon's article in this issue mentions Zuniga's critical article regarding neuralgia-induced cavitation osteonecrosis but fails to accurately describe his conclusions as reported in the *Journal of Oral and Maxillofacial Surgery* in 2000: “The current literature supporting the existence of NICO does not meet these criteria [for sound science] and, until these studies have been performed, the original and modern NICO concepts must be challenged.”

Drs. Bouquot and McMahon have declared that the National Council Against Health Fraud (NCAHF) is undergoing “disorganization” and will soon disappear. This is news to the members of this non-profit, all-volunteer consumer advocacy group. Bouquot and McMahon seem to be angry because the NCAHF has, for over twenty-five years, tried to deliver accurate health information to the public while adhering to the basic and well-accepted scientific rule that unless a condition is life-threatening, it is unethical to perform invasive techniques—such as those proposed by “biologic dentists”—for profit until such proofs are forthcoming and generally accepted.

I think Semmelweis would agree.

Sincerely,
John E. Dodes, DDS
President, NY Chapter of NCAHF
Forest Hills, NY

DEAR DR. CHAMBERS,

I admire the courage of the College and the considerable time and effort in bringing the position paper on quackery and fraud in dentistry to publication. Therefore, it is with the utmost respect that I submit the following comments.

Perhaps the title “quackery and fraud” does attract attention and identity to the issues, but it has a potentially disastrous downside. Within the dental profession this liability may be minimal. However, some members of the public, the media, or government could seize on the fact that a prestigious dental organization that focuses on ethics, excellence, and professionalism is acknowledging in the title of a position paper that quackery and fraud are a significant problem in dentistry, and they could attempt to use this against the profession. The profession has enough challenges to address without defending itself against charges of quackery and fraud. I realize that is far from your intent, but we must consider the opinion

of not only the profession but lay groups and special interest groups as well.

There is little to gain by directing the position paper at quacks and frauds, just as there is little to gain by directing a paper against bad drivers because very few acknowledge that they are bad drivers. Those who engage in unethical behavior seldom self-identify and probably do not regularly read this journal. The position paper is really directed toward ethical dentists. Perhaps a more effective title would have been “Identifying and addressing unethical behavior in dentistry.” Consistent with this suggestion, an effective opening might have been, “The vast majority of dental care is of high quality and the vast majority of dentists are highly ethical. However, a few individuals abuse the rights and privileges of the profession by misrepresenting the services they provide. As a self-regulatory profession, dentistry must address this small community of individuals to preserve the integrity of the entire profession.”

Thank you for considering my perspectives.

Sincere regards,
Ken Sutherland, DDS, FACD
University of Saskatchewan,
Saskatoon, SK, Canada

“...the dental school curriculum must include courses dedicated to gaining an in-depth understanding of the scientific method, the evaluation of scientific articles, statistics, and the integration of that knowledge into everyday practice.”

EDITOR'S NOTES

It has been requested that certain comments appearing in the theme issue on quackery and fraud be examined. We have not been able to verify that actions involving a dentist names Allender was actually a case in law or that Dr. Robert Baratz of Newton, Massachusetts, was cited in any way involving that action. We apologize to Dr. Baratz for whatever confusion might have arisen.

In the theme issue on the implications of the new biology, Dr. Cheryl Sheets authored a clinician's perspective, “The new dental biology—threat or opportunity?” In the biosketch accompanying the article, Dr. Sheets' faculty appointment is misstated. She is a clinical professor of restorative dentistry at the University of Southern California.

ADVANCING DENTISTS CHARITABLE DENTAL INITIATIVES— AN AMERICAN DENTAL ASSOCIATION PERSPECTIVE

Jane Forsberg Jasek, RDH, MPA
John S. Klyop, MA
Paul Landman, DDS

ABSTRACT

Volunteering to help individuals with profound need or who might not have access to oral health care is part of the ethical fabric of the dental profession. This article describes examples from the spectrum of such programs, ranging from those sponsored by national, state, and component groups in organized dentistry to faith-based groups, collaborations with other health professions, and individual practitioners. The American Dental Association serves as a catalyst, support, and clearing house for such programs.

Compassion, benevolence, and commitment have always driven dentists to serve their communities. Dentists volunteer in non-dental roles such as service groups, school activities, faith-based groups, or assisting in other organized activities. The focus of this article is to showcase examples of dental charitable programs and activities from all levels of organized dentistry. Every day individuals and societies volunteer through their professional calling and reach out to vulnerable populations to facilitate access to oral health care.

According to American Dental Association surveys, the majority of dentists very quietly provide some form of charitable care without needing or wanting recognition. American Dental Association policy support for access to oral health care spans over three decades. Currently, the Council on Access, Prevention and Interprofessional Relations supports development of resources and national partnerships to expand access to care for vulnerable population groups. Several other Association agencies, including the Board of Trustees, provide support for access to oral health care initiatives. The stories here are but a sample of the widespread altruism that exists at the national, state and local levels. Providing care to underserved groups is rewarding and can be done in a variety of settings and ways.

Ethical Basis

There is a longstanding ethical basis for dental volunteerism. Dentists who volunteer to provide charitable care serve to promote patient and public

welfare. They can use their professional knowledge, skills, and experience to improve the dental health of the public and elevate esteem for the profession. This assists in fulfilling the ethical obligation of community service as expressed in Section 3A of the ADA Principles of Ethics and Code of Professional Conduct. Moreover, charitable dental programs advance the ethical principle of justice, which in its broadest sense calls on the profession to seek allies throughout society on specific activities that will help improve access to care for all (Section 4 of the ADA Code). As they proceed through dental school, students become competent in ethical reasoning and many have service learning experiences that help them envision the part they can play in the broader community context.

Give Kids A Smile

*Give Kids A Smile!*SM National Children's Dental Access Day was initiated by the ADA in 2002 to capitalize on the positive energy flowing from a confluence of



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John S. Klyop is director, Council on Access, Prevention and Interprofessional Relations



Paul Landman is chair, Council on Access, Prevention and Interprofessional Relations —all are at the American Dental Association.

dentistry's altruistic efforts. The ADA Board of Trustees endorsed the concept as a national day to highlight the oral health needs of underserved children and the many contributions dental professionals are making to improve the well-being of these children. Give Kids A Smile events also provide important public opportunities to educate policymakers and opinion leaders about ways to improve oral health, especially in light of funding challenges facing government-funded systems. Four corporate sponsors offered their support: Crest Healthy Smiles 2010—exclusive provider of consumer products; Sullivan-Schein—exclusive professional product distributor; DEXIS Digital X-ray Systems—providing digital X-ray systems and personnel; and Ivoclar Vivadent Inc.—donating preventive and restorative dental supplies.

As planning for Give Kids A Smile took place in 2002, Dr. Gregory Chadwick, then ADA president, addressed a U.S. Senate subcommittee on children's dental health. His testimony announced the launch of Give Kids A Smile as an ADA umbrella for charitable dental programs sponsored by individual dentists and dental societies. Dr. Chadwick emphasized such charitable efforts continue to deliver free or discounted care to underserved individuals and families to help fill in gaps left by anemically funded public health programs. The 2002 ADA House of Delegates made Give Kids A Smile an annual activity and in February 2003 the first event facilitated free dental care valued at \$100 million for an estimated one million disadvantaged children at thousands of sites throughout the country. Honors followed as the U.S. House of Representatives advanced a resolution congratulating the nation's dentists for the success of Give Kids A Smile and the American Society of Association Executives honored GKAS with its prestigious Summit Award for public service programs that "better our communities

and quality of life." The second annual Give Kids A Smile Day took place on February 6, 2004, and more than 35,000 dental professionals preregistered to participate. Stories from 2004 can be found on the ADA Web site (www.ada.org/prof/resources/pubs/adanews/gkas.asp).

OPTIONS

OPTIONS (Ohio Partnership to Improve Oral Health through access to Needed Services) is a private-public partnership between the Ohio Dental Association (ODA) and the Ohio Department of Health. The program serves low-income Ohio citizens, including senior citizens, those with complex medical conditions, and individuals with intellectual or physical disabilities. Volunteering dentists agree to treat qualified patients for reduced or donated fees and receive patients through a referral coordinator. Patients must not have any form of dental insurance or Medicaid. The dental care provided is left to the discretion of the providing dentist. During the 2002 fiscal year, 4,285 people were helped by OPTIONS, either referred to other programs because they were not eligible or matched to an OPTIONS volunteer dentist. In that same period of time, 740 dentists and 90 dental laboratories participated in OPTIONS. Dentists were matched to 1,144 people and provided \$862,011 in donated care. Dental laboratories donated \$34,271 of prostheses and dental appliances. A steering committee, with three representatives each from the ODA and ODH, determines OPTIONS policies. OPTIONS was piloted for six months in one-half of the state and went statewide July 1, 1997. "The best feature about OPTIONS is its flexibility for both providers and patients," said Dr. Sam Fick, an OPTIONS volunteer from Oregon, Ohio.

MISSIONS OF MERCY

Three state dental associations in Virginia, Texas, and Kansas have carried out a number of Missions of Mercy

(MOM) projects over the past several years. Dr. Terry Dickinson, executive director of the Virginia Dental Association, says signing up to volunteer and obtaining other MOM information is as easy as visiting the VDA Web site (www.vadental.org). Texas and Kansas dentists may also obtain MOM information from their state society Web sites (www.tda.org and www.ksdental.org). MOM clinics are typically set up with portable medical and dental equipment in a location that is easily accessible to populations within a specific geographic area. These areas are usually rural or underserved in terms of medical and dental providers. Volunteer clinicians and laypersons provide care, transportation, and other support services. Events last for two or three days, and patients are treated on a first-come, first-serve basis. Initial screening identifies urgent and requested treatment needs. Dentists are not able to address every patient requirement due to heavy demand and other factors. Post-treatment forms include local social service agencies and local dentists or clinics that have agreed to take care of emergency needs for a defined period of time. Dr. Dickinson notes that VDA members internalize a sense of community and return to their practices with a renewed enthusiasm for dentistry after volunteering at a MOM event. "It changes you forever as it demonstrates the heart and soul of this great profession," says Dr. Dickinson.

PROJECT DENTISTS CARE

In 2002, 1,256 dentists provided an estimated \$4.1 million in dental care to 18,224 Florida residents who could not otherwise access such care through Project: Dentists Care (PDC). PDC is a community of Florida Dental Association dentists who volunteer their time and services to provide dental care to disadvantaged individuals. Sites include private dental offices, health department clinics, dental school, and dental hygiene

school clinics, homeless shelters, community and migrant health centers, and other institutional clinics. PDC is part of the Florida Department of Health's Volunteer Health Care Provider Program. PDC recruits existing pro bono or reduced-fee dental access programs and places them under the statewide PDC umbrella. This allows for accounting of services provided and allows PDC sites to seek assistance for its dental programs through local fundraisers or through public funding. Volunteer healthcare workers are also provided with sovereign immunity and workers' compensation. Dr. Harold Haering, a PDC volunteer at a clinic in Fort Myers for seven years, voiced his support for the program. "We see patients referred by the Salvation Army, from homeless shelters, and those in substance abuse rehabilitation facilities. We are their safety net for dentistry, and they thank us over and over again for easing this one burden in their lives." PDC has forty-one affiliate locations throughout Florida. Dentists and local dental societies may organize an affiliate at any time. To promote volunteerism, the Florida Board of Dentistry offers continuing education credit for the pro bono services provided under PDC, up to five hours per cycle. Information is available at (www.floridadental.org).

DENTISTS IN THEIR OWN COMMUNITIES

Dr. Morris Griffin of Durham, North Carolina, cared for three political refugee families in his dental practice for many years. He volunteered to provide pro bono care through a faith-based confed-

eration that helped settle political refugees in the United States. Dr. Griffin says he was astonished at the families' intense desire to come to this free country and the overwhelming cultural barriers they faced in doing so. Dr. Griffin recalled that his patients, former Polish refugees fleeing Communist persecution, had spent several years in a Yugoslav resettlement camp before obtaining entrance to the United States. One of the children was extremely fearful due to the trauma the family experienced while in hiding. Dr. Griffin noted that short dental appointments and exhibiting a calm demeanor built a trusting relationship so dental treatment could be completed on the apprehensive child.

Four other individuals Dr. Griffin cared for were Vietnamese Montagnard tribesman, whose tribe helped U.S. troops during the Vietnam War. They had to leave following the fall of Saigon because they were threatened by the Communist regime. These families had to manage a number of critical priorities as soon as they arrived. Dr. Griffin offered to help because he knew dental care was an important part of improving their overall health. Observing the obstacles the families overcame for freedom was a meaningful experience for Dr. Griffin, who says he gets more from volunteering than he gives.

In his cosmetic dentistry practice in Chicago, Dr. Paul Landman donates his professional time and skills in several ways. He is a volunteer for the "Give Back A Smile" program sponsored by the American Academy of Cosmetic Dentistry. This program assists survivors of domestic violence by treating the dental injuries they have sustained, which helps them reclaim their smiles and their self-esteem. Dr. Landman also volunteers for the Illinois Donated Dental Services program. He recalls his first patient as a proud woman who had received high-quality dental care in the past, but who no longer could afford any care at all. She needed endodontic treatment to save a critical bridge abutment.

Her expectation from a charitable program was to lose the tooth and receive a lower-cost removable partial. Thanks to the generous contribution of services by the endodontist and the crown-and-bridge laboratory associated with Dr. Landman's practice, they were able to provide the patient with a fixed bridge. The patient was very appreciative and sent a touching note of thanks. Dr. Landman and his staff members feel very rewarded by participating in the Donated Dental Services program. "I never expected my decision to enter dental school would be the best one of my life," Dr. Landman says. "There are always tough times of getting through school, paying debts and starting a family and a dental practice at the same time." After a while, Dr. Landman reflects, things come together and then "it's time to give something back."

Dr. Robert Lauf of Mayville, North Dakota, regularly devotes time to charitable dental care in his office. He is a volunteer for the North Dakota Donated Dental Services (DDS) program. After completing comprehensive care on DDS patients, he often continues for several years to see DDS patients on a recall basis. Each year, during the Christmas holiday season, Dr. Lauf selects one family of patients challenged with long-term unemployment or catastrophic health crises and writes off the balance of their account. Dr. Lauf also provides pro bono care in several area nursing homes. He notes that he lives in a small town, sees everyone at the grocery store, and knows his neighbors and patients well. Dr. Lauf feels privileged to be in a position where he can help those who are down on their luck. "It's just good karma," he says.

About sixteen years ago, Dr. Sam Fick from Oregon, Ohio, began providing free dental care for the son of a retired police officer whom he has known since childhood. Due to disability resulting from a cerebral vascular accident, the son began using a wheelchair. Dr. Fick was consulted

There is a longstanding ethical basis for dental volunteerism. Dentists who volunteer to provide charitable care serve to promote patient and public welfare.

about sliding-fee clinics the son could access with a wheelchair. Because the family's savings had been exhausted by healthcare costs, they were concerned with being able to afford comprehensive dental care. Dr. Fick offered to see the son in his office and has provided pro bono care for the son ever since. The family is grateful for Dr. Fick's help, and has referred many family and friends to Dr. Fick's practice. Dr. Fick reports that helping this family was a heartwarming experience for him. He regularly chats with his patient on the Internet, and they have become good friends.

In Bedford, Texas Dr. Larry Spradley, an oral and maxillofacial surgeon, provides free care to residents of a local foster care home and works with referring dentists to complete pro bono surgical care in certain circumstances. Dr. Spradley has also provided free services to patients with Acquired Immune Deficiency Syndrome and Down Syndrome. He regularly participates in volunteer efforts sponsored by the Texas Dental Association, including *Give Kids A Smile* and *Missions of Mercy*.

MATTHEW 25

Since 1978 the volunteer dental component of the Matthew 25 Health Clinic has operated in Fort Wayne, Indiana. Guided by the principles of the Bible verse Matthew 25:34-40 ("For I was hungry and you fed me ..."), the clinic provides care to low-income and other vulnerable citizens. Volunteer physicians and dentists staff medical and dental clinics. Other health services include podiatry, health screening, blood pressure clinics, dietary counseling, pulmonary clinic, diabetic club, children's dental sealants, and educational classes. Members of the Isaac Knapp component of the Indiana Dental Association have volunteered since the clinic's inception, as well as dental assistants and dental

A thread of commitment and caring is woven through dentistry from individual dentists to local societies to state societies to the American Dental Association. There are thousands more untold stories of dentists' altruism and many ways to get involved.

hygienists from the local community. Allied dental students from Indiana University's Fort Wayne campus also participate as part of their educational experience. One of the dentists says she is often asked why she has provided pro bono care all these years. She answers by saying she knows she can't save the world, but she can make life a little better by helping improve the oral health of some of the less fortunate citizens of Fort Wayne.

VOLUNTEER DENTISTS PANEL

"We have been going strong since 1999 and currently have twenty-one dentist volunteers," says Dr. Richard Meltzer, who chairs the volunteer dentist panel for residents of the Hebrew Home of Greater Washington (DC). This program won the American Dental Association's Geriatric Oral Health Care Award in 2000. The Hebrew Home is a 550-bed not-for-profit nursing home in Rockville, Maryland. Almost two-thirds of its residents receive Medicaid benefits. The vast majority of residents are frail elderly, with an average age of eighty-seven, including a number of Holocaust survivors and Russian émigrés. Each of the Hebrew Home's two residential buildings contains a dental clinic. In 2003 one clinic was renovated into a state-of-the-art facility. The majority of volunteer dentists are members of the Alpha Omega Dental Fraternity, Washington Chapter. In 1999, knowing that dental care was urgently needed, they formed the volunteer dental panel so that

comprehensive care would be available to all Hebrew Home residents.

The volunteer dentists provide a full range of dental services. A full-time dental assistant employed by the Hebrew Home and a part-time volunteer dental assistant support them. Residents may pay a small appointment fee to offset the cost of the dental assistant's salary. The full-time dental assistant coordinates volunteers' schedules. Each volunteer serves approximately one-half day every month or two, so it does not take too much time from their private practices. Nursing care managers report inquiries from residents or dental problems noted by staff to the dental assistant, who then schedules an appointment. Oral surgeons, endodontists, and general dentists from the volunteer panel are on call for emergencies. The ability to chew and speak is vital to maintaining health and optimism in elderly individuals. Dr. Meltzer observed, "The residents are so happy to receive the excellent dental care that they were used to in their younger years, and the family members are gratified to see their loved ones properly cared for."

SUMMARY

A thread of commitment and caring is woven through dentistry from individual dentists to local societies to state societies to the American Dental Association. There are thousands more untold stories of dentists' altruism and the many ways they get involved. In addition to helping vulnerable individuals, charitable activities open up new and exciting opportunities to increase oral health awareness in a community or state, and they can be repeatedly leveraged to educate policymakers and other leaders.

To connect with programs or activities in your area, contact your state or local dental society or e-mail the ADA Council on Access, Prevention and Interprofessional Relations at jasekj@ada.org. ■

CREIGHTON UNIVERSITY'S INSTITUTE FOR LATIN AMERICAN CONCERN: A UNIQUE OPPORTUNITY TO PROVIDE CONTRIBUTED DENTAL CARE

Frank J. Ayers, DDS, FACD

ABSTRACT

Creighton University, a Jesuit institution of higher education, has supported a community health program in the poor and remote areas of the Dominican Republic since 1976. This program is built around multidisciplinary health teams combining undergraduate and graduate students in various health professional schools with practitioners. A permanent center in the Dominican Republic has been established for coordination and training. The program is conceived as providing participants an opportunity to reflect on their own spiritual development. The history of the program's development and its operation are described.

For almost thirty years Creighton University School of Dentistry has been sending dental students, faculty, and alumni to the Dominican Republic through Creighton's Institute for Latin American Concern (ILAC). Representatives from all of Creighton's health science schools participate in this program. The purpose of the ILAC Summer Program is to provide participants with an experience of "conscientization," or heightened sensitivity, to world reality and the individual's responsibility to this reality. This is accomplished through an immersion in the life of rural communities in a developing nation. While living with poor families in these communities, participants attempt to enhance the quality of life for as many people as possible by providing basic health care. In the process, participants are led, hopefully, to a deeper awareness of self and others and the promotion of a faith-based justice that is both Christian and Ignation-inspired (St. Ignatius is the founder of the Jesuits). Participants have included individuals from all major religions and some non-believers. Many dentists who have no formal association with Creighton have participated in the Summer Program.

The Dominican Republic is on the island of Hispaniola in the Caribbean, just east of Cuba and west of Puerto Rico. It shares the island with Haiti. Although not as poor as Haiti, it is one of the poorest nations in Latin America. ILAC now has a permanent center and year-round presence in Santiago, the second-largest city in the Dominican Republic. Since the program's beginning, ILAC healthcare

teams have worked in almost two hundred villages, primarily in the northern mountain range and along the Haitian border.

History of ILAC

Father Ernesto Travieso, SJ, is the founder of ILAC and the president of the ILAC Foundation. Travieso is a Cuban-born Jesuit priest. In 1972 he was working with young men studying for the priesthood at Regis College in Toronto, Canada. In the summer of that year, he began taking Jesuit scholastics to the Dominican Republic. The scholastics lived with families in rural villages, helped the Dominicans with chores, and encountered the problems of the poor in a developing nation. The scholastics were encouraged to reflect on their role as members of a global community and view the connection between North American affluence and the poverty found in a developing nation.

In 1976 Travieso was assigned to be the chaplain for the School of Medicine



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at Creighton University. He saw this as an opportunity for his modest summer program to grow and involve healthcare students and professionals from Creighton to join the young men studying to be Jesuits in this immersion experience. At the same time the work of healthcare teams would provide a more meaningful way to repay the Dominicans for the warm hospitality they had been providing the visitors.

Initially, ILAC had no permanent facility or year-round presence in the Dominican Republic. A two-week orientation for student participants was held at a Dominican seminary in Santiago. ILAC participants were originally individuals who showed up every summer, provided some health care, and then left. At the seminary, conditions were crowded and facilities were inadequate. As ILAC grew, leaders saw the need for a permanent facility. In 1985 plans began for ILAC to build a permanent center in Santiago. In 1991 enough of the center was completed to house the Summer Program for the first time. Since then, the ILAC Center and its programs have continued to grow. The center and its staff provide preventive health education programs to designated health promoters from the villages where ILAC has worked. It is the home for Creighton's semester-abroad program for undergraduate students. Several faculty and staff retreats have been held there. Numerous high schools and other universities have partnered with ILAC for service projects. Health care professionals from many countries have delivered health care through ILAC to poor Dominicans in programs not connected to the Summer Program. On January 6, 2004, a new four thousand square foot, state-of-the-art outpatient clinic and surgical center was dedicated at the center. This facility has examining rooms, operating rooms, a pharmacy, dental operatories, and a

The reality of poverty, even one's own personal poverty and limitation is not lost on most ILAC participants. This awareness has proven to be a life-defining experience for most of the students and professionals who have participated in the Summer Program.

reception area. Poor rural Dominicans who do not have access to hospitals and health professionals will be served there.

ILAC SUMMER PROGRAM

The ILAC Summer Program is a seven-week immersion experience for students in the Dominican Republic. Students leave in mid-June and return in early August. The program is an elective course for students beginning in their senior year. Recruitment and application begins in October of the junior year, and interviews and selection are completed by the end of November. In a typical year, eight to twelve dental students will be selected from approximately twenty applicants. In addition to a variety of information that would be part of any application, students are asked to describe in essay form their understanding of the ILAC Summer Program and their reason for applying and to briefly describe their spirituality.

The criteria for selection to the program include the following:

- Students must be in good academic standing, but overall class rank is not a consideration.
- Students must demonstrate a good understanding of the program and an openness to pursue its goals.
- Students must demonstrate a willingness to participate in group reflection, group prayer, and sharing of self.

Faculty, alumni, and at-large dentists who apply commit for a shorter period of time. They have the option to participate in the program for either a two-week or a one-month period. It is also important for the participating professionals to have a good understanding of the program and an openness to sharing. Although the main focus of this program is the students, the success of the program depends on the participation of dental professionals. The overwhelming majority of the dentists who have experienced the Summer Program report it as a growth-filled period in their lives.

Once students are selected for the program, a meeting of participants from all the health science schools is held in December. Information about fund-raising, inoculations, packing lists, etc. are provided. The cost to students who will participate in 2004 is \$2,400. A special tuition-free Spanish class is held one evening a week during the spring semester for ILAC participants.

During late March or early April, students and professionals attend a weekend retreat at the Creighton Retreat Center. ILAC staff from the Dominican Republic are on hand and to do the majority of the presentations. Students receive a history of the Dominican Republic and a description of the Dominican communities that will be served. The group of students and professionals which will serve each village is announced. Team building and some enculturation begins at this retreat.

Each summer ILAC teams work at six villages. Typical teams for each village include the following:

- Group Coordinator (usually a student who is an ILAC veteran)
- Dominican Seminarian (assists the coordinator and provides an important link to the community)

- One or two dental students and a dentist
- One or two medical students and a physician
- A pharmacy student and a pharmacist
- A nursing student and a nurse
- Two undergraduate students (assist in clinics)

When students arrive in the Dominican Republic in June, they spend the first two weeks at the ILAC Center in Santiago. They receive classes on the history and culture of the Dominican Republic, Spanish classes, and motivational talks by the ILAC staff. Teams make a weekend visit to the village where they will be working and spend their first night with their Dominican host family. Throughout these two weeks of orientation in the Dominican Republic, time is set aside for reflection and sharing of what individuals hope to learn from the immersion experience.



Above: The 2003 summer team of 46 students, 17 professionals, and staff in front of the ILAC Center. Left: Father Ernesto Travieso, SJ, the founder and president of the ILAC Foundation.

Photos courtesy of Terri Lynch, ILAC Director, Creighton University.

The actual immersion into the life of the village is for one month. It is broken into two two-week periods with a week-end break back at the ILAC Center. Different sets of professionals are usually present for each two-week session. The villages where ILAC teams work are very poor and very remote. People living there have no access to health care.

These communities have no electrical power or indoor plumbing. ILAC brings its own food and water. Participants take meals together as a group to prevent illness, but each member of the group lives with a Dominican family. Clinics are set up at one location in the village and usually operate for half a day. The remainder of the day is spent doing house visits and blending into the life of the community.

The dental clinics are very busy. Time is spent on preventive education and treating pain and infection. Because of the limits of the community, extractions are the main dental treatment provided. In recent years, gasoline-driven air compressors have been used to power dental field units. Restorative services have also been provided. The dentists both supervise students and provide treatment.

Over the years the ILAC healthcare teams have enhanced the quality of life for as many people as possible in the communities where they worked. Education and treatment are delivered with dignity and personal concern for an extremely poor segment of the Dominican population, people for whom few others have shown much concern. At the same time ILAC recognizes that it does not possess the resources to substantially affect the quality of the health care system in the Dominican Republic. Providing health care and living with the rural families allows for moments of intense interaction between Dominicans and North Americans that forge friendships and challenge awareness. The reality

Education and treatment are delivered with dignity and personal concern for an extremely poor segment of the Dominican population for whom few others have shown much concern.

of poverty, even one's own personal poverty and limitation, is not lost on most ILAC participants. This awareness has proved to be a life-defining experience for most of the students and professionals who have participated in the ILAC Summer Program. A testimony to the power of this program is the high number of individuals, whether they were initially students or professionals, who return several times to participate in it.

There are many programs, both domestic and international, that give dentists the opportunity to provide service to needy populations. The uniqueness of the ILAC Summer Program is that its primary focus is on the individual participant providing the care. Pain is relieved, preventive education is presented, and the lives of some of the world's poorest people are improved. However, in this program, this activity takes place in the context of a spiritual journey calling the individual to look at oneself, one's values, and one's relationship with humankind and the God that he or she worships. Any dentist who is interested in experiencing this unique program of service and self-growth can receive information and application from the ILAC Office. ■

VOLUNTEER SERVICES— IT'S NOT JUST THE THOUGHT THAT COUNTS

Stephen B. Corbin, DDS, MPH, FACD

ABSTRACT

Voluntary and donated oral health services are not an adequate safety net system for those in need—what must be done is vast compared to the capacity of this response. Nevertheless, the rule should be “everyone should give, and they should give enough to make a difference.” The personal rewards of voluntary service are described and nine guidelines for contributing oral health care are offered.

When is a gift truly a gift? When is a giver truly a giver? These may seem very rhetorical questions and, yet, they suggest that there is often more than meets the eye when it comes to one's charitable intentions and actions. In the healthcare field, the issue of donated healthcare services is always on the front burner. This is necessarily so because virtually everyone needs health care throughout their lives and because there is never enough health care to go around, or, at least, not enough health care resources made available to meet all needs.

In my own experience in dealing with a highly underserved population around the world, the form of healthcare system in a country does not necessarily resolve the issue of people who need care and who need help paying for care (Corbin, 2001; Horwitz, Kerker, Owens, & Zigler, 2000; U. S. Department of Health and Human Services, 2002a). Even in socialized healthcare systems, much to the dismay of proponents, there are significant gaps in access to needed healthcare services, especially by the poor and vulnerable. In market-based systems, like the U.S. or even developing countries with market-based systems, there are large numbers of people who go without routine or urgent care because they can not afford it or lack the means to get to it. In the U.S. today, more than forty-three million persons lack health insurance (Institute of Medicine, 2004) and well over one hundred million lack

dental insurance (Oral Health America, 2002; U. S. Department of Health and Human Services, 2002b). Further, for poor adults, dental services under Medicaid are quickly drying up in many states.

The roots of inadequate availability of health care go back to antiquity. In the Bible, there are references to various diseases and an apparent lack of health care experienced by at least a few individuals, a number of whom sought relief from a renowned healer on a pro bono basis. In a number of these cases, we are presented with the classically medically indigent individual. (We can't say uninsured, since this predates insurance by a long way!) Thus, we must be realistic that the need for health services beyond which people can afford to obtain out of pocket, or which are financed through a government mechanism, will persist. The poor will always be with us and thus donated healthcare services will always be needed.



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WHERE DOES THE DONATED HEALTH CARE BUCK STOP?

The real question then becomes who is responsible for providing oral health care services to those who cannot afford it. Dental education trains individuals about the art and science of dentistry, provides some exposure to how health systems operate, and deals explicitly or implicitly with professional ethics issues to varying degrees. But, by and large, there is no curriculum to address the role of philanthropy in dentistry and the individual dentist's or collective profession's roles and responsibilities.

In recent years, organized dentistry has actively encouraged and supported the provision of donated dental care through various programs, such as Donated Dental Services (DDS) and, more recently, National Give Kids A Smile Day. This *Journal* issue includes reports of a number of donated or volunteer dental care initiatives that offer a sample of what is out there. At the same time, a number of dental leaders continue to acknowledge the persistent problem of access to dental care for millions of Americans and have come to the conclusion that charity, while important, is not a health care system—not a real solution—and donated care alone will never be enough to close the gap.

All of this leaves every dental professional in the position of making a personal choice. Should I donate any of my services, or alternatively, why should I donate any of my services? The local gas station does not provide free fuel to those who need it. The grocery store is for those who wish to buy. And who expects the cable television technician to hook them up for free? Health care is clearly a commodity and



Volunteer dental professionals and Special Olympics athletes.

is subject to the rules of commodities, such as supply and demand. Still, there are rules that should apply to health care and healthcare providers that do not exactly fit the hard cold facts of commodity trading and these are what make a profession a profession and a learned individual a healer.

To the questions of who should provide free health care and how much, I would suggest that the answer to the first is essentially everyone—all practicing dentists and auxiliaries who are not legally barred from doing so. The answer to the question about how much voluntary care is appropriate, while not as clear, is something like enough to make a difference. In this case, the difference is for the people receiving the gift of care as well as the difference created in the person giving the care.

A CULTURE OF GIVING

Americans are uniquely generous. We donate more of our time, talent, and treasure collectively than any other

people. Even the concept of donating resources or labor to strangers is a concept that is not known or valued in many cultures. This is a challenge for philanthropic organizations such as Special Olympics (my employer) who depend on volunteerism to bring services to needy (note that I did not say deserving) individuals. Need should be the basis for those who deserve to be able to access health care (*Oath and Prayer of Maimonides*, www.library.dal.ca/kellogg/bioethics/codes/maimonides.htm). While it is widely acknowledged that individual choices play a leading role in determining health status, there are many genetic, environmental, educational, and socioeconomic factors that contribute mightily.

Educating people about the critical role of volunteerism in creating a civil society, therefore, is a major challenge that will not be resolved overnight. The Special Olympics Healthy Athletes Program (www.specialolympics.org) currently serves 60,000 athletes per year, in forty-nine U.S. states and some fifty-eight countries. Athletes receive free health screenings, preventive services, some corrective services, education, and referral as appropriate. Over 6,000 health professionals, including more than 2,500 oral health professionals volunteered from one to several days of their time during 2003. Special Olympics provides a ready and comfortable opportunity for dental providers to gain the information and hands-on experience they need to treat the vast majority of individuals with intellectual disability. Currently underway is the development of curricula for health professions students and practicing professionals that will be made available in various languages and formats.

In the end, our society depends on role models rather than rules to guide our charitable efforts. The enlightened and visible community leader who sets a standard through personal actions, the Cub Scout collecting food for the needy, and the local dentist volunteering at the free clinic all are demonstrating the best of giving and giving back.

GIVING BACK

The giving back is what makes health care philanthropy so unique. When one writes a check to a worthy charity, there is a certain depersonalized distance in the transaction. Generally, impersonal dollars are subtracted from an impersonal account and deposited in a large, impersonal organizational account that eventually is used to support charitable organization programs and operating expenses. In any case, there is rarely a direct, person-to-person transaction between giver and receiver. In the health care scenario, however, the fruits of one's hands are literally transferred to the recipient. It is totally personal. The gift is immediate, with no intermediary. The opportunity for gratification in the giver is immediate, possibly profound, a rare moment with the potential of selflessness in a world generally oriented toward "what's in it for me?"

These profound moments are not to be taken for granted. A senior American dentist who volunteered for a Special Smiles event stated through his tears, "Now I know why I went to school all of those years and why I wanted to become a doctor in the first place." Even more poignantly, a prominent Egyptian eye surgeon, who wrote about his feelings after volunteering at the Special Olympics World Games, observed, "You have to purify your soul by sharing in the lives of these magnificent people. So, I consider myself as if I sent my soul to the laundry here in Dublin."

GUIDEPPOSTS FOR VOLUNTEER AND CHARITABLE ACTIONS IN HEALTH CARE

Following are some suggested guides for or personal philanthropy that can apply to health care services philanthropy as well. I did not invent these and I am sure that parents, role models, spiritual guides (such as Jiminy Cricket who advised in the movie *Pinocchio*, "Always let your conscience be your guide."), etc., along the way appropriately must be credited:

- Always keep your eyes open to the needs of both individuals and groups. People with needs don't want to have needs and many can not help it. Generally they lack the means and know-how to resolve the needs on their own.
- Take a good look at the power you have to make a difference in the lives of individuals and families. You are in a privileged class in that you can relieve pain, cure disease, and restore function and confidence. How many people can do that?
- Create a goal for yourself around philanthropy. At various times, your ability to impact may increase or decrease, but over the long haul, it will increase. Don't settle for giving the "widow's mite" if you are not the widow.
- Don't ever consider those whom you are serving for free as pathetic or less than you are. That destroys the beauty of the gift if not the value of the care and that can lead to serious ethical lapses.
- Instill a philanthropic attitude in your staff. You will earn immeasurable respect in their eyes. You can even build practice momentum and enthusiasm around a transparent pattern of charitable care giving.

To the questions of who should provide free care and how much, I would suggest that the answer to the first is essentially everyone—all practicing dentists and auxiliaries who are not legally barred from doing so.

- Challenge your colleagues and profession to step up and do more. In an industry that does over \$70 billion of business annually in the U.S. (American Dental Association, 2004a), even \$1 billion of charity dental care would not be that much (1.4% of the market). If everyone did a little charity care, a few donated cases per year, no one would have to do too much and much good would be accomplished (American Dental Association, 2004b). At the same time, we need to recognize that charitable care is needed year round, not just during special initiatives or promotional events.
- Never delude yourself into believing that something not intended as a gift is a gift. Thus, participating in a PPO and accepting a fee schedule below your regular fee schedule is not charity any more than a car dealer accepting less than the sticker price on a new car is donating to a community's transportation infrastructure. It is a business decision. Non-collectible debt may be a tax

Charity, while important, is not a health care system—not a real solution—and donated care alone will never be enough to close the gap.

deduction (don't rely on me for this since I am not a tax authority), but it is not philanthropy (rely on me for this as I am a self-appointed moral authority).

- Never work to be seen for your charitable acts, or use them as a means of advancing your reputation. In one ancient tradition, the greatest act of charity is one where the receiver knows not the source of the gift and the giver is not identified or celebrated. It is the act that is the perfection and not the actor. Do take pains, however, to show the effects of charitable acts, so that they will induce further charitable acts in others. This sounds like a philosophical contradiction, but it is not.
- Make sure that what you donate has legitimate value to the recipient and not just real value to the donor. A common business tactic (great from the financial perspective of the donor) is to offer merchandise or equipment of dubious or limited value to the recipient, but great financial value to

the donor compared to alternative business purposes. Expiring shelf life items (e.g., drugs, film, foods), are the classic example. Organized programs of donated exams that do not include the delivery of other needed services or reasonable referral opportunities are dubious from an ethical perspective.

- This space is reserved for you. There must be some principle you can add from your own belief system or experience that will give us a set of ten commandments for health care philanthropy.

The free giving of needed health care is important in your professional and personal life. The cost is low and the potential impact and personal rewards are high. One of the greatest rewards I experienced in my professional practice was the ability to provide care without concern about receiving payment from my patients. I worked in a government health program that did not require me to charge my patients for the care that I provided. Many difficult decisions had to be made, however, about who was next in line for health care, because there was never enough to go around. While I would have loved to have been compensated more in line with the value of health care I was providing, I never allowed myself to believe that what I was doing was charity. I feel that would have been disrespectful to my patients and disingenuous of me.

Special Olympics offers hundreds of opportunities each year for health professionals, allied health workers and health professions students to volunteer with the Healthy Athletes Program. For more information, see the Web site (www.specialolympics.org) or contact Dr. Mark Wagner at (202) 715-1148. ■

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UAB School of DENTISTRY: REACHING OUTSIDE THE WALLS

John B. Thornton, DMD, MA

ABSTRACT

Dental schools, through their service learning community outreach programs, provide both oral health services to underserved populations and experiences in service to dental students. The program at the School of Dentistry, University of Alabama is an example of such a program. The unmet needs for oral health care in the state are significant. The development of the program and its impact are described.

Access to dental care for children from low-income families or rural families has been recognized by the state government in Alabama as a real crisis.

The State of Alabama has significant unmet oral health needs. The Healthy People 2000 objectives reveal that children from poor families are more likely to have poor oral health and poor receipt of dental services. Alabama has a large population of children from low-income families reflected in the fact that 60% of our children are on reduced or free lunch programs. Alabama has one of the fastest growing Hispanic populations and has twice the number of African Americans than the national estimates for all states. Dental screenings during the 2002 to 2003 school year of 2,500 Head Start children in Alabama found a mean prevalence of 40% with untreated caries (there are about 16,000 children in our Head Start Programs). Some of the individual Health Start programs in the state had prevalence as high as 50 to 80%.

THE EXTENT OF THE NEED

In the spring of 2003, the UAB School of Dentistry, with the State Department of Public Health, screened 6,500 children for caries and sealants. Two thousand of the children were kindergartners and third graders from twenty-five schools statewide, while 4,500 children were from elementary, middle, and high schools in a rural area of South Alabama. From the statewide estimates 29% of both the K-5 and third graders had caries, and approximately 11% needed urgent dental care. Only 22% of the third graders had sealants. K-5 children were not screened for sealants because of their age. In the rural South Alabama area, 35% of the elementary children,

21% of the middle-school children, and 24% of the high school children had caries with urgent treatment needs ranging from 4 to 9%, while sealants were 9% in the elementary grades, 11% in the middle school, and 8% in the high school grades. The national goal for eight-year-olds is to have 50% of children with sealants. It was fewer than 5% for children from low income families in our Alabama survey of eight-years-olds.

Access to dental care for children from low-income families or rural families has been recognized by the state government in Alabama as a real crisis. The crisis also exists for low-income adults, who usually do not have any type of dental insurance and are not covered by Medicaid (age limit in Alabama is twenty-one years). Even though the state is aware of the dental needs of poor adults, there are no statistics on adult dental needs. The major roadblock to access is the lack of adequate numbers of dentists to meet these needs. Alabama has two-thirds the national average dentist-to-population ratio. Forty percent of Alabama counties have fewer than two general dentists. Six of the state's dental districts have fewer than three general dentists. Even though there are community health centers and public health facilities in many of the underserved areas of Alabama, there are generally no dentists at these sites even



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where there are dental facilities. This situation, however, is improving as we will discuss later in this paper, as a result of UAB's outreach program at the dental school.

DEVELOPING COLLABORATIVE PROGRAMS

In 1997, a new dean was appointed at UAB School of Dentistry. The new dean had an interest in the dental access crisis in Alabama and decided to involve the school as a possible resource for the State's access to dental care problem. She created a Division of Community Outreach within the Department of Pediatric Dentistry. Due to budget constraints, the school lost its Department of Community and Public Health Dentistry several years back. A partnership was established between the dental school and the Alabama State Department of Public Health as the initial step in getting the dental school involved in public health. The Office of Primary Care and Rural Health at the State Department of Public Health had a project called SEARCH (Student or Residents Experiences and Rotations in Community Health) funded through the National Health Service Corps, (NHSC) which supports students in health care professions (i.e. medicine, dentistry, pharmacy, optometry, and others) to work at Community Health Centers for one month during their senior year. Dentistry was not initially included in SEARCH when the partnership with the State Department of Public Health was formed, but through a joint effort funding was sought through the NHSC and a contract established to include dental students. Starting in the spring of 2000, twelve senior dental students signed up to participate in SEARCH. Twelve students were assigned to various community health centers around the state to provide dental care to children and adults in underserved and

Five of our dental school graduates, all of whom participated in SEARCH, are now practicing general dentistry at community health centers. All five are also participating in a loan repayment program sponsored by the NHSC which makes it even more attractive to go to these underserved areas.

low-income communities. Only those sites that had a full-time dentist were selected for student supervision. The UAB School of Dentistry is in the fourth year of this community outreach project.

With the success of the SEARCH program and through our partnership with the State Department of Public Health, another outreach project evolved. A small community hospital in a rural town in Alabama acquired a grant through the Department of Health Resources and Services Administration (HRSA) to place a dental clinic at a Rural Health Clinic near the hospital in Monroeville, Alabama, (city for the setting from the book *To Kill a Mockingbird*). The hospital, however, could not find a dentist to work at the clinic. The area, even though rural, had a large number of children on Medicaid, and it was difficult to access dental care for these children except for emergencies, which required driving long distances. This rural health clinic is approximately one hundred and eighty miles from UAB, but through a contractual agreement, we extended our pediatric dentistry program, for the first time in our school's history, outside of the university to a rural health site. By recruiting an additional resident to our program, we sent a resident to work at this clinic three days per week. This resident already had some advanced training in pediatric dentistry which made it an ideal arrangement. We maintained

this clinic for nearly three years, providing dental care to over five thousand children before our contract ended. Though our residents provided this care over that period, one of our former graduates drove ninety miles to serve as an attending for the resident at that clinic. A physician in the small town provided housing for our residents with the use of a log cabin on his farm. The residents especially enjoyed this aspect of the rural health clinic rotation.

In 2001, the Pediatric Dentistry Program at UAB was awarded funding through HRSA's Title VII Program, which allowed us to expand the size of our program by increasing the number of residents. The Title VII grant opened up more opportunities for the dental school to enhance outreach to children who lacked adequate access to dental care. With the expansion of our program, a partnership and contract was formed July 1, 2002 between the Department of Pediatric Dentistry and the County Health Department in the Birmingham area, which serves children and adults from the inner-city areas. Through this contract our program was able to provide pediatric dental care to children from an area Head Start Program and Medicaid recipients from the inner city. Residents worked under the supervision of public health dentists who welcomed the residents to assist with their large pediatric patient population. In addition to the rotation to the County Health Department in Birmingham, another partnership and contract was formed between our pediatric dentistry program and a school-based Title I clinic in a city approximately ninety miles from Birmingham. This is the HEALS (Health Establishments at Local Schools), Inc. which offers medical, dental, and social services to the children and their parents from the school. The children from Title I schools are on the governments reduced or free-lunch program and come from families whose

incomes are at or below the poverty level. The HEALS clinic provided these services to two inner-city elementary schools in the area. The dental clinic is funded through a Robert Wood Johnson Foundation Grant. Each resident rotates to the HEALS clinic one day every other week. Supervision is provided by local pediatric dentists who volunteer at the clinic. All attending dentists at our outreach clinics are appointed to adjunct voluntary faculty positions after proper credentialing is provided and reviewed by the university.

As of January 2004, our outreach program has added a new site. The new site is an indigent care clinic in a city forty-five miles from UAB. This clinic is sponsored by a local community health foundation, which provided start-up funds, and a large community hospital which provides office space for a rental fee of one dollar a year. The plan is for the clinic to be self-supporting in the future. The majority of children at this clinic are from Head Start Programs in the area and children who are Medicaid recipients. One of our residents spends one day a week at this clinic and there is an attending dentist there on that day. It is a family care clinic, and there is a general dentist who cares for the adults. Another one of our new sites reaches out to those with disabilities. This clinic opened at the United Cerebral Palsy Center of Birmingham in February, 2004. The rotation to this clinic is for one-half day a month. Its purpose is to bring dental care to the clients of the Cerebral Palsy Center because transportation and access to dental facilities are a major concern for those with disabilities.

PROGRAM IMPACT

The outreach programs sponsored by UAB School of Dentistry have had a positive effect on the dental school and the communities that we have been

involved with. Local dentists in those communities have accepted our residents and our students and have offered their help as needed. Some of the dentists have even donated dental equipment to the outreach clinics. The acceptance by local dentists is primarily due to their concern about the unmet needs of children from low-income families and the tremendous patient load that they already have in their practice. The outreach clinics by UAB are seen by the communities as a source of dental care to meet unmet dental needs at an affordable cost. Our contracts are usually calculated on how much lost income occurs when residents and dental students are out of the dental school and expenses incurred by travel, food and lodging. Generally, communities have found housing for our residents and dental students through local physicians or local leaders in the community. The benefits of outreach by the dental school is playing a major role in the access problem in Alabama and exposing dental students to diverse populations and rural health. As of this year, five of our dental school graduates, all of whom participated in SEARCH, are now practicing general dentistry at community health centers. All five are also participating in a loan repayment program sponsored by the NHSC which makes it even more attractive to go to these underserved areas.

One of our residents in pediatric dentistry who participated in our outreach was impressed by a rural community's concern for the dental needs of its children, mostly Medicaid recipients, and is working toward setting up a satellite clinic in the area when he completes our program. His primary practice will be in a large metropolitan area 80 miles from the rural site.

With careful planning, dental schools can be a valuable resource to states who are struggling to provide dental care to our most vulnerable populations (i.e. minorities, disadvantaged low-income families, and those with

disabilities). Other dental schools are also making efforts to reach out to the needy. Issues that have to be dealt with are: 1) loss of income by students being out of the school; 2) liability; 3) maintaining the school's standard of care for its students once they go outside the school; and 4) other concerns. These issues can be addressed and dealt with. At UAB, we have worked on these issues and made advances by working through each one. At the off-site clinics, the School of Dentistry has been able to acquire financial contracts to offset our losses. Generally, it is a win-win situation because the students usually bring in the income to these off-site clinics to meet the obligations of the contract. The liability concerns have been worked out by sending students or residents to sites where there are full time dentists. By appointing the dentist at these sites as voluntary adjunct faculty of the school, the off-site clinics become an extension of the school maintaining the umbrella of malpractice coverage for our students and residents. As far as keeping our standards of care at the level of the schools, we hold a workshop for all the off-site dentists with our faculty to discuss and agree on what our expectations are for our students here at the school and at the off-site clinics. Adjunct faculty must submit certain documentation (e.g., dental school degree, licenses, continuing education credits, etc.) for credentialing purposes. These issues can be worked out and should not deter us at university settings from taking advantage of this great opportunity. With the growing population, the unmet dental needs of disadvantaged populations, the loss of dentists with the growing population, and misdistribution of dentists across the U.S., this approach to dental care may be the wave of the future. Let's ride the wave. ■

A THOUSAND SMILES

Terry Tanaka, DDS, FACD

ABSTRACT

Thousand Smiles is a multidisciplinary team that has been providing cleft palate and related care in Ensenada, Mexico, for twenty-one years. This is the story of how the program began with the personal involvement of a few individuals and support from Rotary International, the structure of the care teams, and the lessons learned in conducting an international mission program. It is also the story of lives changed—patients and care givers alike.

In 1980 I met Dr. Tetsuji Tamashiro, an oral surgeon and professor at the University of Mexico, in Mexico City, Mexico. Dr. Tamashiro described how he and his team had performed hundreds of cleft lip and cleft palate procedures at the University Medical School Hospital. The following year, Dr. Tamashiro moved to Ensenada, Baja California, opened a private practice, and became the director of the local Red Cross hospital. He invited me to bring my dental team to Ensenada and start a comprehensive team in the Red Cross Hospital.

The invitation was quickly accepted and plans developed for the move to Ensenada, Baja California. There was a core of interested dentists and dental volunteers but no equipment or surgical instruments. In 1981 I presented a program about efforts to help the children in Mexico to the Rotary Club of National City, California. Following the meeting, several Rotarians stepped forward and asked how they could help with team. We submitted a request for a matching grant to the Rotary Foundation, which provides support for such projects. Together, we raised \$50,000 from barbecues and golf tournaments. We also received another \$50,000 from the Rotary Foundation.

As the Red Cross Hospital changed to a teaching hospital, the Thousand Smiles Dental Team relocated into a large warehouse and worked for several years with makeshift portable units and old dental equipment. The surgeries

were then performed at the General Hospital in Ensenada. In 1999, the Thousand Smiles Team was able to purchase a two-story building. With major renovations, a state-of-the-art clinic was constructed. The current, fully-equipped dental clinic houses eight new dental chairs, units with lights, cabinetry and state-of-the-art sterilizing equipment, as well as a well-equipped dental laboratory.

It is necessary to mention the adjustments we have had to make over the years to explain that these types of humanitarian projects are not always going to be an easy and smooth road. It would have been easy to say, "Well, we did what we could." But we persisted and no one even suggested that we throw in the towel and quit. We looked for another clinic but settled for a large warehouse in Ensenada, and operated as a "MASH" unit there for another four years. The surgeries were performed at the local general hospital.

Finally, one of the original founders of the Thousand Smiles Foundation discovered an old two-story building that we then purchased. The building was renovated by relatives of the board members and friends, and building supplies

Dr. Tanaka is a practitioner, clinical professor, and leading force in Thousand Smiles. He can be reached at ttanaka@usc.edu.

(including air conditioning units) were obtained free or at the cost of the donor. We have been in our new home, now for over two years. The building is completely paid off and we owe no one for any equipment or supplies.

THE TEAM

The mission objective is to provide free dental and surgical care for the underserved children with craniofacial deformities in Mexico and Central America. Although some adults with untreated craniofacial deformities are treated, the main focus of the group is the long-term care of the children. The Thousand Smiles Team is unique because it is one of the only comprehensive dental and surgical teams in the United States. In 1991, it was recognized by Rotary International as the best Humanitarian Team in the Northern Hemisphere. In 1991, it was also selected as one of the five most outstanding humanitarian projects in the world.

What makes it so unique is that our surgeons do more than just a weekend surgery on the lip or palate. They follow up with the multiple intricate surgeries that are required to complete the reconstruction of the face. Because ours is a dental and surgical team, these surgeries are followed by the necessary dental and orthodontic procedures that will coordinate the dental arches and the dentition, completely rehabilitating the child. These fortunate children will also have dental implants and an artificial ear made for them at these clinics.

Few other mission teams offer the services of audiologists, who perform hearing tests and place hearing aids; otologists, who place tubes and manage infections of the ear and throat; speech therapists, who examine and provide instructions for the parents and children in their own language; and general dentists, orthodontists, and prosthodontists,

who perform almost every procedure that they are able to treat in the U.S.

The Thousand Smiles Field Mission Team is made up of approximately one hundred and forty volunteers from the various disciplines of dentistry, medicine, affiliated health specialties, and lay individuals. The team is made up of two

It is necessary to mention the adjustments we have had to make over the years. These types of humanitarian projects are not always going to be an easy and smooth road.

principal groups; the first is a dental team that consists of a core of twenty or more general dentists and an equal number of assistants, three or more hygienists, and about four orthodontists and prosthodontists.

Although the team is made up primarily of U.S.-trained dentists and surgeons, surgeons and orthodontists from Mexico also play a vital role. The dental team is led by Dr. Katherine Tanaka Mits and provides comprehensive dental care for all of the children in both dental and surgical programs. This comprehensive dental care includes a prevention program, the placement of sealants, and all dental treatments, including endodontic treatment and space maintenance for involved teeth.

This is a long-term program and we have been able to follow up many of our patients for more than twenty years.

The orthodontists consult with the surgeons, general dentists, and prosthodontists regarding each patient, and realign the dental arches and provide orthodontic care for children with cleft lip and cleft palate deformities and also treat children with other genetic disorders such as hemi craniofacial microsomia and Cruzons and Treacher-Collins syndromes. The orthodontic team is led by Dr. Soona Jahina, a world-renowned expert in the diagnosis and management of craniofacial disorders. She also works as a volunteer with other surgical teams in Africa and China. The prosthodontists are led by Dr. Terry Tanaka, a clinical professor in graduate prosthodontics at the University of Southern California. They consult with the orthodontists and surgeons regarding every patient in treatment that requires orthodontic care and or surgical management. They make obturators, retainers, impressions, and molds of the face and fabricate ears and other prostheses for the young patients.

The surgical team is led by Dr. Jeffrey Moses, a recently retired oral and maxillofacial surgeon who recruits the other members of the surgical team, and Dr. Susan McCormack, the principal operating surgeon who practices in Encinitas, California.

There is a large group of medical specialists who work closely with both the surgeons and the dentists. Because the clefts are the result of problems originating from first and second branchial arch problems, the other structures that arise from these same arches are also involved. Most frequently seen are deformities of the ear and TMJ. These children usually have malformed structures of the ear and therefore are susceptible to ear infections and hearing

disorders. In addition, they frequently have no functioning condyle in the fossa and therefore suffer from facial deformities which can only be corrected with costochondral rib grafts and other creative surgical procedures. Some of these patients are brought back to San Diego and operated on at local hospitals by our surgeons.

Dr. Marc Lebovits is our principal ENT surgeon. A dedicated physician and respected San Diego specialist in head and neck surgery, he has been with the team since its inception in the early 1980s. He is the chief otologist and surgeon and places tubes in the ears of the children in addition to managing numerous ear infections and other otologic disorders. Dr. Lebovits is assisted by his wife, Cathy, another valuable volunteer.

The team also is fortunate to have the regular services of two trained Audiologists who bring their own equipment and test the children and fit hearing aids for the children. For those children who require hearing aids, they have arranged with other individual groups and U.S. companies to have refurbished hearing aids donated to them to be given to the children at no cost. Speech therapists test the children and give the children and their parents' home exercises and advice in their own language. Each specialist is assigned a volunteer who speaks fluent Spanish.

A special word of appreciation must be mentioned about the many dedicated volunteers who come from various occupations unrelated to dentistry or surgery.

These volunteers may be school teachers, school principals, landscape architects, building contractors, or even high school and college students who have the foresight to see that they can make a difference in the lives of those less fortunate. A special group that volunteers regularly is from a local high school Marine Corp Junior ROTC Program. They all speak fluent Spanish and are a great asset to the team.

FINANCES AND FUNDRAISING

It is important to emphasize that the Thousand Smiles Foundation is a non-profit organization. No one in the Thousand Smiles organization has ever received a salary or compensation for their efforts in behalf of the organization. Every cent of donations go toward the treatment of the children. This is a very important point when fundraising. Unlike the Red Cross in San Diego and in other places, we have no overhead. The members of the dental team pay all of their own travel and hotel expenses at the field clinics in Mexico.

The executive director of the Thousand Smiles Foundation is Dr. Jim Vernetti, who has refused a salary for years. Jim is an inspiration to all of us. We just celebrated his ninetieth birthday at the May clinic in Mexico.

Groups can raise funds to support their projects with a number of fundraising ideas. Our recommendations:

- Find someone to help you to write grants
- Try to find a major corporate donor such as McDonalds, Ted Turner, Pepsi Cola, or Coca Cola
- Local service groups such as Rotary Clubs and Lions Clubs have fundraising projects and are always looking for worthwhile projects.
- Golf tournaments, spaghetti dinners, and silent art auctions are a distant choice—you're better off asking your board to donate \$1000 each to start.

Currently Thousand Smiles is engaged in a campaign with a tag line of "Patients whiten their smiles while brightening the smile of a child." Dentists who wish to participate will donate proceeds from teeth whitening they offer their patients by having the patients make the check to Thousand Smiles, giving the patient a tax deduction. Ultradent is providing the whitening kits free of charge to a Thousand Smiles. We help dentists with sample letters they can send their patients telling of their participation. Checks are made to the Thousand Smiles Foundation. Patients get their teeth whitened and a tax deduction. Information is available from Dr. Carol Summerhays at carolsummerhays@hotmail.com.

Volunteers can find information about the Thousand Smiles Foundation on our Web site (www.thousandsmiles.org). Volunteer general dentists are currently needed. They must have an active dental license in the state in which they practice. Field trips to Thousand Smiles Clinic are held on the first Friday and Saturday of the months of February, May, August, and November.

SUGGESTIONS FOR FOREIGN PROJECTS

This is a lesson for anyone thinking about this type of project: don't borrow money to put in a project like this. It's like we tell our kids, "If you can't pay cash for something, you can't afford it." If the project doesn't get off the ground, who ends up with the loan? If the idea for the project is so good, why don't the members of the board each donate \$1000 to start the project? Don't go looking for funds unless your own people

A HUMAN LIFE-SAVING MIRACLE

By Jim Verneti

Miracles do happen, even today, but too often we do not recognize them for what they are. Sometimes miracles are performed by earthly angels, and sometimes they come in bundles.

This bundle, only six days old, was brought by a desperate mother to the outpost dental clinic in Ensenada, Mexico. A severe cleft palate made the child unable to nurse or take a bottle; the lack of local health care establishments, or the money to pay for care, made it impossible for the baby to receive nourishment any other way.

Although the clinic was set up to perform palatal surgery, the infant's age and declining health made it impractical to try. But without something, the baby probably would not survive.

Enter the angels of this story: Drs. Terry Tanaka, a world-renowned prosthodontist and Soona Jahina, an orthodontist with a degree in bone physiology.

What could two dentists do to help his child? "The only possible solution is a dental obturator," said Dr. Jahina. "But how can you take an impression in the mouth of an infant this young?" asked Dr. Tanaka.

The problems were immense. There are no impression trays that small, the baby is not likely to cooperate, and what material does one use? But angels with miracles to perform do not give up easily. "We will use a teaspoon for the tray, and a silicone-type alginate, mixed to an elastic dough-like consistency," decided Dr. Jahina.

Reclining dental chairs are not common in remote clinics, and do not come infant-sized. In this case, the proper position was much more easily attained:

the baby was held upside down. This solved two problems at once: The baby's automatic response, outraged howls, opened the mouth, and the position took care of the "drip" problem.

Miracles #1 and #2: These skilled and resourceful dentists were, not to mention the clinic itself, in the right place at the right time and, against all odds, the impression was taken successfully. That afternoon and evening, the laboratory technicians used the impression to make a small plastic plate to cover the hole in the palate so the baby could eat. The next day the patient returned. The miniature appliance fit into the baby's mouth perfectly. A baby bottle of milk was offered to the baby, whose suckling instinct took over immediately.

Miracle #3: The appliance fit and worked perfectly and the baby was able to receive nourishment.

Now another problem became apparent: the baby was suckling with such vigor (a miracle in itself!) that Dr. Tanaka was concerned that the appliance might be sucked out of place and down the throat. But angels in pursuit of miracles are nothing if not resourceful. To the baby's initial dismay, Dr. Jahina removed first the bottle, then the obturator. First she drilled a small hole through the edge of the appliance. A piece of dental floss was then threaded through the hole and tied in place. Voila! Miracle #4A retrieval mechanism if the appliance loosened, .

The baby was delighted to have the bottle restored, but the joy and relief apparent on the mother's tearful face were even greater. Thanks to two dentist-angels and a bundle of miracles, her precious baby would live.

have donated first because the big boys will ask you what the board members have invested.

On the brighter side, there are plenty of people like you wanting to help. They just have to be asked, and it must be a worthwhile project that they can get involved in.

Don't attempt to do everything by yourself; there are plenty of others who have equal or better expertise. Learn to delegate. Make yourself dispensable. You must think: if something happened to me tomorrow, the program could go on easily without me.

If you plan a project in a foreign country, I would recommend that you go only at the invitation of another group such as the Red Cross or a local service group such as the Rotary Club or Chamber of Commerce.

The patients should be screened by someone from the local medical or dental society or welfare program, or the government welfare program. Be certain that you are not taking a patient away from a local dentist. If he or she complains to the local authorities you could be asked to leave.

If you elect to help a specific orphanage, you must ask the local government authorities for permission to treat these children or group of individuals. You must get all of the necessary permits to work in Mexico or another foreign country. If you do not acquire the necessary permits and a team member has an untoward result (such as uncontrolled bleeding from an extraction that requires hospitalization, or an accidental death

THOUSAND SMILES FOUNDATION: IMPRESSIONS OF MR. DAVID TANAKA

The first things you see are the children and their parents. They fill the crowded waiting room of the Ensenada Red Cross Hospital and spill outdoors, where they stand in small groups in the parking lot. Some have traveled great distances to arrive here. You can sense their fatigue, though they wait patiently.

Inside, the names of those to be treated are recorded on computers, along with case histories and other information. Volunteers squeeze through the crowded hallways, carrying boxes brimming with supplies: bandages, surgical instruments, x-ray machines, toothbrushes, and more.

All three dental chairs on the second floor are occupied. Bright lights shine into tiny mouths as English and Spanish sounds compete with the clatter of instruments and vacuums, dental drills and passing cars. Orthodontists and dental technicians mold and engineer countless retainers for patients. There is no shortage of work for these volunteers who arrived early in the morning and will continue to work nonstop until the end of the day.

Each area of the hospital facility is put to use. A converted trailer in the parking lot is the site of another dental operatory. A spare room upstairs is lightproofed to

allow x-rays to be developed. Extension cords are taped to the floor to prevent people from tripping. On a large table in a meeting room, plates of food are uncovered and coffeepots arranged. A mobile home in the clinic's parking lot distributes free lunches and clothing to the patients' families.

The clinic is transformed for these two days into a MASH unit of sorts. All three operating tables are being used downstairs: just now, two cleft palates and a cleft lip are being operated on. Surgeons, nurses, and anesthesiologists show their skills. They will work throughout the day.

Outside the OR, the recovery room begins to fill up. A mother brushes her hand through her son's hair, examining the sutures which show on the swollen upper lip as she speaks to him softly. This picture is enough to move even the most cynical of individuals.

As the fishing boats return to the port of Ensenada a few miles away, the oral surgeons, dentists, and other volunteers prepare to wrap up the day's work. There is an exhausted feeling of elation in the air. Volunteers positively glow, exchanging hugs and kisses as they pass in the hallways.

No one leaves here unchanged, especially the patients who will carry evidence of today's work in their smiles for a lifetime.

from a local anesthetic), one or all of the well-intentioned humanitarians could end up in jail for months.

The Thousand Smiles Foundation requires all dentists who treat patients in Mexico to have a valid state dental license in the U.S. The copy of the dental license must be notarized. We submit these licenses to the Mexican authorities and obtain a temporary dental license for each dentist who is going to work in the clinic. If the dentists do not get their licenses to us in time, they cannot treat patients on that weekend.

PERSONAL STORIES

There are many heartwarming stories. When someone asks, "Why do you go on these trips to Mexico?" the almost universal answer is "Because I love to see their smiling, happy faces." This answer may seem commonplace except that these are smiles from children who have been severely disfigured by congenital birth defects. What is it about their smiles that is so heartwarming? For the infants, I believe it is their innocence. They do not realize that their upper lip is severely clefted along with the hard and soft palate. Their only question is, "Why am I having difficulty swallowing my mother's milk?" For the children who are old enough to walk or run around their mother's legs and are being carried into the clinic, another surprise is visible to only those willing to look past the obvious facial deformity. It is the warm glow of love that the mother has for her child. She does not see the deformity, she only sees her beautiful child. If you look closely, you will see her hope that her child will be whole like other children. She and her child have

traveled for several days on a bus to reach the clinic in Ensenada because she has heard that there was a group of doctors who could fix her child's mouth. You realize that it can be done, and you as a team can do it. It will require more than surgery, more than obturation and perhaps, several more surgeries to make the child smile like the rest of the children, but, yes, we can do it. We have seen what hope is and, as a team, we can help make her wish come true. That's what keeps us returning year after year. I recall a personal story most vividly. It happened in Mexicali, Mexico, in 1977. A five-year-old boy with a cleft of the hard and soft palate was sent to the dental clinic by the surgeons for an impression for a palatal obturator to close the defect in the palate. He was a real screamer and put up such a fuss that I didn't think that I would be able to make an impression that day. I remember it was close to lunch time, so I told the mother to bring him back after lunch. There were some sandwiches in the next room, so I gave him half of my sandwich and said good-bye. When he returned in the afternoon, he was an absolutely different boy. He was cooperative and even allowed me to make an alginate impression without aspirating the alginate material. The next day I inserted the obturator without a fuss and as he was about to leave, his mother told him to say thank you. I recall that he not only said *gracias*, but reached into his pocket and pulled out a piece of a half-eaten cookie with lint all over it and gave it to me with a big hug. To this day, I have the memory of that

cookie to remind me of why I go on these trips to Mexico. Sometimes we do work for food, and we love every minute of it.

IMPACT

The dental and surgical field mission teams of the Thousand Smiles Foundation have been treating children with dental and craniofacial deformities for over twenty-one years. These clinics are held four weekends each year. Special cases—children that require more complex surgeries and more specialized care than can be provided in Ensenada—are brought to the U.S for special procedures, including orthognathic surgery, fabrication of fixed or removable prostheses, and special prostheses.

To date, over 200 children have received dental and medical care at each special clinic in Ensenada, Baja, California. More than 17,000 dental and orthodontic patients treated over the twenty-one years. More than 1,700 children have had surgeries performed.

For any humanitarian project of this magnitude to last twenty-one years, I believe there has to be something more than a single human being that has caused it to continue. True, there is a central core of founders, as well as other individuals, who remain and participate as actively as ever. But the enthusiasm or glue that keeps everyone together is the warm, inner feeling of being able to help someone less fortunate, and the realization that together we can make a difference, we can help many, many, children to smile again and to live normal lives. We are fortunate to be able to help them realize their wish of *Yo quiero ser como tu* (I just want to be like you).

I have every reason to believe that this program will continue for many years to come. ■

The enthusiasm that keeps everyone together is the warm, inner feeling of being able to help someone less fortunate, and the realization that together we can make a difference—we can help many, many, children to smile again and to live normal lives.

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AN EXPANDED ROLE FOR CARE ETHICS WITHIN UNITED STATES DENTISTRY

Anika Ball, RDH, BS

ABSTRACT

Care ethics is an alternative to the better known approaches based on normative principles or virtue. The care ethic is grounded in relationships intended to build others' potential. Five suggestions are offered for applying care ethics in the practice context.

Dental professionals face decisions that are of ethical significance each day of their professional lives. Every recommendation and treatment procedure has ethical substance and consequence. Each action and decision made by the dental practitioner has the potential to affect the well-being of their patients in important ways. In recognition of these ethical dilemmas, dental professionals have developed a variety of approaches to promote high standards of moral reasoning in relating to patient care.

Although dentistry is grounded in the Hippocratic tradition, its best known code of ethics, the American Dental Association's Principles of Ethics and Code of Professional Conduct, is formulated in juridical language and is based on a principled rather than a virtue-based form of reasoning. In recent years, the field of dental hygiene has established itself as an advocate for care ethics. This paper aims to identify what "care ethics" is and how it can be applied effectively in the field of oral health care.

In general terms, care ethics emphasizes that each person is part of an interdependent relationship that affects how ethical decisions are best made. Within this theory the specific situation and context in which the person is embedded becomes a part of the decision-making process. Moreover, every ethical decision may affect more than just one person. Whole families, other patients, and healthcare practitioners may also be affected. Instead of considering the consequences of our actions or our duties in the abstract, an ethic of care considers the concrete situation and its relationships, which may well involve a vulnerable, dependent, and weak person who needs the support of the community.

How would dentistry apply an ethic of care in the framework of dental practice? At the very least, this would mean integrating language within the American Dental Association's Code that better incorporates the language of care. It may also call for a restructuring of the inner framework of practice to allow



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for more time to develop and nurture relationships between patients and caregivers. An ethic of care relies on time to develop and nurture relationships. An ethic of care also focuses strongly on outreach that extends to those that are underserved. Finally, the care ethic embodies a moral and spiritual element that is continually strengthened by providing for and caring for others.

Philosophical Sources of Care Ethics

Care ethics has roots as old as the theories of virtue first proposed by Socrates and Plato. The next great Greek philosopher, Aristotle, also emphasized the development of virtues, such as friendship, prudence, wisdom, temperance, and courage—all of them viewed not only as characteristics of individuals, but also as involving important social relationships. Building on his ancient mentors, the medieval philosopher and theologian, Thomas Aquinas, formulated an ethic of altruism, a love-based ethics derived within theological virtues—faith, hope, and love.

This ancient tradition has been significantly preserved in the ethical commitments of the health professions, most notably through the influence of the Hippocratic School, whose authors wrote, in addition to the famous Oath, approximately seventy essays on health care, many of which discussed relevant character traits and virtues.

While many elements of a care ethic are in this tradition, it was not until more recent times that a care ethic came to be explicitly defined. As issues of patients' rights surfaced within American health care in the latter half of the 20th century, it became apparent the emphasis was shifting to a focus on justice, rights, and the law's focus on individual autonomy while placing less

of an emphasis upon virtues and the place of each person in relation to a community, especially in regard to the powerless and vulnerable.

This shift in emphasis was particularly clear in the empirical research of Lawrence Kohlberg in the 1980s. His theory of ethical reasoning and development focused narrowly on cognitive (male) reasoning versus emotional (female) reasoning. Kohlberg's emphasis on gender and contrasting styles of ethical thinking ignited a heated debate about the relation of gender to moral reasoning.

Carol Gilligan (1982), once a student of Kohlberg's at Harvard University and now a noted psychologist in gender studies, argued that women were misrepresented within Kohlberg's research and that ethical reasoning conceived solely in terms of justice and abstract categories of duty misrepresented the moral enterprise. Gilligan offered the first explicit contemporary formulation of a care ethic in her book, *A Different Voice* (1982). According to Gilligan, women develop "an 'ethic of care' whose underlying logic...is psychological logic of relationships, which contrasts with the (generally male) formal logic of fairness that informs the justice approach."

Nell Noddings (1984) added to our understanding of the care ethic, holding that ethics is principally about particular relationships between two parties, the one "caring" and the one "cared for." Caring, she argued, is not simply a matter of feeling favorably about someone, but is about having a concrete connection with someone, an actual encounter with a specific individual. Regarding the association of caring with the feminine gender, she writes, "This does not imply that all women will accept it or that most men will reject it; indeed there is no reason why men should not embrace it. It is feminine in the deep classical sense—rooted in receptivity, relatedness, and responsiveness. It does not imply either that logic is to be discarded or that

logic is alien to women. It represents an alternative to present views, one that begins with the moral attitude or longing for goodness and not with moral reasoning."

Even though the literature on care ethics has tended to conceptually stress the feminine approach, it has increasingly moved towards viewing caring not as a feminine characteristic, but as part of the human condition. Thus James Rest (1979) and Muriel Bebeau (1984), have argued that the care ethic is not something narrowly gender-related. For example, James Rest's Defining Issues Test (DIT), which measures moral reasoning and the comprehension of moral concepts, has not found a significant difference between men and women (Bebeau & Thoma, 1994). Similarly, a study conducted by Casada, Willis, and Butters (1998) found no significant difference in value decision-making between men and women dental students.

An ethic of care encourages communication, courage, commitment, action, feeling, thinking, and reciprocity, which serves to strengthen the care we provide for our patients and ourselves.

THE MEANING OF CARE

Milton Mayerhoff (1971), who greatly influenced the writings of Noddings, describes care in these words: "To care for another person, in the most significant sense, is to help him grow and actualize himself." Applying this to ethics, Rita Manning (1992) makes a distinction between a caring moral response and a more rigid moral attitude: "An ethic of care involves a morality grounded in relationship and response... In responding, we do not appeal to abstract principles, though they may appeal to rules of thumb; rather we pay attention to the concrete other in his or her real situation. We also pay attention to the effect of our response on the networks of care that sustain us both."

Our current climate in health care tends to be increasingly pressured and limited in the development of personal relationships. Multiple environmental factors such as consumer awareness, high production costs, legalities, and time constraints add a heightened stress to the dental practice. Stress places strain upon relationships.

An ethic of care encourages communication, courage, commitment, action, feeling, thinking, and reciprocity, which serves to strengthen the care we provide for our patients and ourselves. Internal values deeply founded within the oral healthcare provider create a strong foundation in light of current challenges healthcare providers face.

Dental professionals must remember not to base their care solely upon extraneous variables but to develop a connection with the patient that allows for a deeper level of caring. A form of caring is needed that allows the dental professional to listen to the concerns

Instead of considering the consequences of our actions or our duties in the abstract, an ethic of care considers the concrete situation and its relationships, which may well involve a vulnerable, dependent, and weak person who needs the support of the community.

of the patient and enables the dental professional in turn to honestly convey his or her concerns and desires for that patient. A commitment to care must be established for each individual and caregivers should strive to know each patient past the mouth and into the mind and heart.

Moreover, "caring for" that focuses only on the individual is too narrow. Chiodo and Tolle (2001) have stated that many authors within dental ethics focus upon the individual encounter or relationship between a specific doctor or caregiver. While Chiodo and Tolle find this to be appropriate in one respect, they also stress that issues such as distributive justice may benefit from a broader social awareness. Care must also attend to the societal issues and be inclusive of these in the definition of the ethic of care. Both aspects of the healthcare professional's service to humanity are part of a care ethic.

APPLYING THE ETHIC OF CARE

How does one apply the ethic of care to dentistry? On a conceptual level it seems inspirational but is it reasonable? Does an ethic of care based upon human relations lend itself to submissiveness

and ambiguity? An ethic of care based in relationships is applied within the framework of principles. Principles remain concrete and logical but they are understood on a level deep within human emotion. Principles such as beneficence, nonmaleficence, justice, autonomy, and veracity remain the pillars of ethics. These principles define what the profession deems central to the practice of dentistry. What is gained by incorporating the language of care ethics within principles is character and value.

The American Dental Association code serves to set a standard of patient care based upon principles. Current ADA guidelines use a juridical language based upon a justice theory of ethics. The code format and language is concrete and pragmatic, which serves to "assist in harmonious living and facilitation of achievement of individual aims and desires in a socially acceptable manner." Underrepresented within the current code is a language of care, one that focuses more upon the concrete individual rather than on the abstract categories of good.

Nuala Kenny (1998), a dental ethics educator, states "rather than addressing itself to the principled resolution of moral quandaries, the perspective of care highlights the rudimentary moral skills, skills such as kindness, sensitivity, attentiveness, tact, honesty, patience, reliability, etc, that guide us in our relationships with particular others." By incorporating a language that encourages these traits and values, a more holistic approach to patient care is created.

The American Dental Hygienists Association Code of Ethics (2001) has placed patient advocacy as central to their cause. Principles such as, but not

limited to veracity, patient autonomy, and beneficence use language and formatting that relates to both clinician and patient. Core values such as patient respect, societal trust, equality, and mutuality are central elements of their code. Relationships and continued care are strongly encouraged. Dentistry would benefit by reviewing their holistic and relational language and formatting for their codes. Applying the language of care to its ethical guidelines would strengthen the ADA code.

Why change? The codes reflect the internal character and self-governing standards that dentistry adheres to. It seems that by restructuring the codes we affirm our commitment to a shared ethic of care within the dental team. We can also better equip ourselves to face ethical conflicts, thereby committing ourselves to serve the underserved, and develop our professionalism more fully together.

As ethicists Hasegawa and Welie (2001) state, codes are first and foremost aspirational. We should not limit ourselves to a language and format that does not incorporate the values of care ethics. Through expanding our ethical consciousness to include the language of care ethics, dentistry will maintain and continue to develop a higher social integrity while seeking to strengthen its team ethic of care.

Applying CARE ETHICS TO PRIVATE PRACTICE

Dentistry is about establishing relationships. As ethicist Ozar (1996) puts it, “dental professionals are, in fact, formed into a set of values, virtues, and attitudes. These have a definite place in practice.” How do we apply it to our daily routine?

First, internal value motives must be examined and continually evaluated. If we are unwilling to determine our

motives, desires, fears, and share with our co-workers and even patients, we will be unable to be genuinely honest, caring, ethical, and flexible with the needs of the patient. Authentic caring is connected to the heart and we must be able to examine our own motives honestly. In doing so, we must be willing to tell the truth and seek help from others if our ability to care is lacking. The dental practice is unique in that we are able to create team ethics and support one another in a continued pursuit for patient-centered care.

Second, develop a team care ethic within the office. Office meetings should develop and incorporate team reflection upon the needs of the patient. For instance, morning meetings could serve as a time to reflect on team goals and focus upon each patient’s perceived needs. I have found that sharing personal experiences of the day gives support to the team and serves to provide specific case scenarios within the office that can be used as an educational tool.

Third, we must structure our office practices to facilitate connecting with our patients. An ethic of care is time consuming. It takes time to nurture a relationship. At the very least, we must maintain patient care based upon the needs of the patient rather than increased production. Offices may need to increase time with patients to better facilitate personal interaction. Many offices today have decreased time spent with their patients to keep up with increased office expenses. The office must establish a commitment to the patient and follow through with his/her needs.

The layout of the office should be conducive to a private setting. Many patients state that offices do not have a comfortable and secure feel. By developing a layout that is inviting and allows for private interaction, more meaningful relationships can be established.

Fourth, commitment to the commu-

nity calls for dentistry to provide care for the underserved. Each community has its unique needs. In some areas it may be children that are underserved; in others, it may be the elderly. An ethic of care considers the vulnerable, weak, dependent person and seeks to provide them care. By becoming involved in community projects and expanding ethical values into daily living, dentistry will maintain and develop a higher social integrity.

Finally, by living our lives involved with and valuing others, we continue to

By living our lives involved with and valuing others, we continue to foster our own moral and spiritual development.

foster our own moral and spiritual development. Dental practitioners sometimes complain of workplace burnout. Caring for ourselves, as oral healthcare providers, and others can strengthen our commitment to our patients. Many who have experienced burnout have disconnected themselves from their patients. By re-connecting and valuing what our patients provide us, we limit the possibility of workplace burnout. By caring for others, we ourselves are cared for. Spiritual and moral experience manifests itself within human interaction. By valuing our relationships and emotions, dental professionals enrich

their personal lives and the lives of the people they interact with on a daily basis.

While many of us strive to work and live according to many of the core values stated above, we continue to benefit by reevaluating and consistently seeking a higher level and standard of care we provide for our patients and ourselves.

Conclusion

The interdisciplinary and interactive nature of dental practice provides an environment conducive to the ethic of care. By interacting with our patients on an ongoing, long-term basis we are able to establish a relationship embedded in an ethic of care. Patients today seek mutuality and respect. A more holistic approach to care is one that fosters relationships, communication, commitment, and honesty. Care "about" and "for" the patient is paramount within the daily workings of a dental practice. Change must be sought from within our professional associations and private offices. Without a strong commitment to care, our practice is no longer centered upon the patients' total well being. Care may then become defined by rudimentary routines and is no longer in the hands of the oral healthcare provider. ■

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JOINING

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ABSTRACT

The benefits of participating in civic and social groups extend beyond personal satisfaction. Organizations depend on the contributions of their members and societies with high participation rates are strong. The American trend in joining shows a steady increase until the 1960s and a gradual decline since. The character of joining has also changed. We are more willing to sign up without becoming personally involved. We send in our checks and let professionals handle the activities. Much of this erosion in civic participation is generational—joining is still popular among older Americans. Mobility and changing work patterns also account for some of the decline in participation, but the media, because it is passive and negative, is a major corrosive force.

Mailing lists and checkbooks are the new stuff of American civil participation.

Joining is good. There are well-documented benefits for individuals, for the groups they join, and for society as a whole. Joiners strengthen democracy, help those who are less fortunate, are better informed, and make more money than those who do not join. They are happier and live longer too. Actively participating in organizations adds about as many years to one's life as does quitting smoking (joining a group to stop smoking makes imminent sense). With the possible exception of voting, Americans lead the world in joining together for civic, philanthropic, and social purposes.

Our national character in this regard was formed in the nineteenth century, and joining increased unabated, except for the Depression years, until the 1960s. For the last forty years, we have been losing ground steadily (see accompanying table). According to Robert Putnam, a sociologist who studies these things, our social participation is eroding in both quality as well as quantity. Compared to our grandparents, Americans value the formal façade of membership more than participation, are pleased with being rabid spectators, give money instead of time, hold extreme views anonymously rather than engaging in discussion, don't trust their neighbors, are drawn to single issue drive-by causes, aspire to live in gated theme parks, and are less likely to make a full stop at stop signs.

THE TREND IN JOINING IS DOWN

The accompanying graph (Figure 2) tracks membership in the American Dental Association and the American Medical Association over the past century. Although organized dentistry's gains have been greater and its losses smaller, both trend lines mirror civic participation in this country in a general fashion.

AMOUNT OF PARTICIPATION

In 1995 ninety-three million Americans volunteered twenty billion hours of service. Most of this, however, came from retirees engaged in non-strenuous activities such as mentoring. Half of group membership, personal philanthropy, and volunteering are religious-based. As a vehicle for social solidarity, unions have gone into the tank (from a high of 33% in 1950 to under 15% in 2000). They are now largely collective bargaining agents. One-third of all employees work on a part-time or contract basis. We don't eat out much more than we did forty years ago, but the number of restaurants has been cut in half. Fast food outlets have doubled and supermarkets now sell prepared dinners that are brought home.

Perhaps no statistics better describe the changing nature of American participation in the common life than do the figures on sports and the arts. Playing a

FIGURE 1. MARKERS OF AMERICAN CIVIC PARTICIPATION

	Vietnam Era	Post Cold War Era
Meetings attended	12 per year	5 per year
"Political leaders care about me"	66%	57%
Any grassroots participation	66%	33%
Regular church attendance	45%	35%
Entertain at home	15 per year	8 per year
Family regularly eats together	50%	34%
Donations per \$2 on recreation	\$1.00	\$0.50
"Americans are basically honest"	50%	25%
Organizations with no members	125,000	6,500,000
Women working outside home	33%	66%
Daily TV watching	4.5 hours	7.0 hours
Family time: children with their parents	43%	24%

musical instrument, painting, dancing, creative arts, and participation in team sports are half as likely now as they were in the 1960s. By contrast, attendance at professional sports events and purchases of recorded music and video entertainment have more than doubled.

NATURE OF PARTICIPATION

There are one and a half million registered nonprofit organizations in America. But more than half of the groups listed in the *Encyclopedia of Associations* actually have no members. Mailing lists and checkbooks are the new stuff of American civil participation. Here's just one example. About twenty years ago Greenpeace was a major consumer of forest products to drive their massive environmental reform efforts. Recognizing the conflict in their position, they stopped the bulk mailings, and within one year had lost 85% of their membership.

Such organizations where membership is an honorific rhetorical device for fundraising and political lobbying clout are now fifty times as numerous as they were five decades ago. On average, such organizations spend between 20-30% of their budget on fundraising, experience a 30% annual turnover in membership, and are largely overlapping with similar groups because they share mailing lists. The net effects of burgeoning vicarious organizations have been to concentrate money in the hands of a small number of lobbyists, decrease grassroots participation, and Balkanize the civil landscape into multiple, extreme, single-issue groups.

According to Peter Frumkin of the Kennedy School of Government at Harvard, "In recent decades, one of the most pronounced trends in the nonprofit and voluntary sector has been the push to professionalize large parts of the work force." Frumkin does not use the term "professional" in the sense that would be applied to dentists who have specialized knowledge and work from public trust. Instead he means one who acts in the

name of others who are excluded from direct participation and from seeing what is being done with their money. Almost 10% of federal programs are now administered through nonprofit organizations. But we are not talking about Rotary or the community church. Pass-throughs and issue-oriented lobbying groups are a major industry in the United States. Salaried, career specialists staff them. Some individuals earn their livings writing grants for community health centers. The American Society of Association Executives is a thriving new professional group, complete with a CAE title. In the past thirty years the number of lawyers in this country has increased at three times the rate of increase for all professions taken together.

Temporary, spectator associations are replacing the face-to-face meetings where members worked out their differences in order to achieve a common good. As Putnam styles it, "Come if you have time. Talk if you feel like it. Respect everyone's opinions. Never criticize. Leave quietly if you become dissatisfied."

REASONS FOR DECLINING JOINING

Americans are certainly busier than we used to be and that leaves less time to get together. On average, only 10% of those we count as friends are work colleagues. The nature of getting to work is also different. Only 4% of us work at home or within walking distance of home. The commute from the suburbs to the city common a quarter of a century ago has been replaced with a triangular commute involving work, home, and the shopping mall or gym. On average we spend an hour and a quarter each day driving.

A major corrosive force on joining has been the media. Not only do television, the Internet, cellphones, and the video world compete for time with participatory group activities or individual

reflection time, they also alter the way we view the world. Televisions are on an average of seven hours per day in American homes. Most children have them in their bedrooms, and two-thirds of meals are eaten to the accompaniment of television. Forty percent of Americans' free time is spent with the television set.

But television and the Internet do not engage us the same way our family members or others in groups might do. The new media are passive, private, and judgmental. Only 7% of Americans consider television as a source of news; it is generally regarded as entertainment. Television makes no demands on us to accommodate our views in ways that can be checked by others. With multiple channels and numerous web pages, we tend to seek what is familiar and comfortable rather than what is challenging. Until the Watergate era, the media reported what politicians said and did; now they comment on it. For each minute our politicians speak on the record, television personalities provide six minutes of analysis. The bias in the media is probably not so much liberal as it is negative. The format of television

is unrealistic. On the one hand, there are guaranteed happy solutions in a one-hour time frame, while on the other, news coverage is an endless succession of tragedies and scandals that can only be accepted if we distance ourselves from the content. It is no accident that there is appeal in the notion of "reality" television. The Internet further removes its users from the real world by allowing us to select narrow focuses of interest, to pretend that we are someone other than who we really are, and simply to disconnect if we find things disagreeable.

According to some analyses, much of the transition from participation to being a spectator can be explained in generational terms. Those who are volunteering and still joining are the generation that fought the World War II and the Korean War. Baby boomers, who make up most of the American population, tend to be self-preoccupied and to have internalized the cynicism of Vietnam and Watergate. The small Generation X is not as cynical, but is still somewhat self-absorbed. The "millennium generation" is socially quite aware and concerned. The problem is that they are

comfortable with computers and other virtual participation, highly mobile, and are quick to move from one issue to another at a superficial level.

SOCIAL CAPITAL AND TRUST

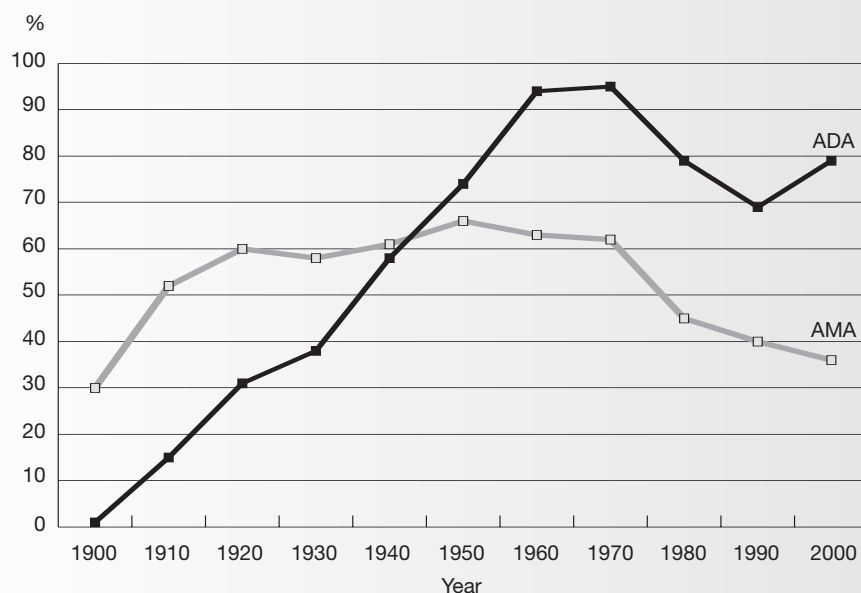
So far it has been demonstrated that the American landscape for voluntary and nonprofit organizations has changed. We are joining less and participating vicariously instead of personally. Is this something to be worried about? Have we lost something worthwhile or is this just the new and appropriate way people should relate to each other?

The argument in favor of social capital goes well beyond individuals having a good time in the bowling league or enhancing their self-image delivering Meals on Wheels. There is considerable evidence showing that people who relate to each other generally, as opposed to episodically in spot transactions, are able to advance both mutual and personal interests. Groups, even those as large as countries, show a direct relationship between joining and participation on the one hand and democracy, mutual support, and economic development on the other.

THE VALUE OF TRUST

Social capital is the accumulation of generalized trust. Trust means willingness to act on assurances others give regarding their intended responses. Generalized trust is a disposition to extend trust in a general way. This kind of trust is characteristic of stable societies, well-educated individuals, and repeated interactions in a variety of non-business situations. I have always thought I could tell more about individuals in five minutes on the basketball court with them than I could by reading a CV or checking references. Generalized trust is exactly what

FIGURE 2. MEMBERSHIP IN ORGANIZED DENTISTRY AND MEDICINE



accumulates when individuals join and participate in face-to-face relationships with others over time and over multiple activities. Generalized trust is not naiveté. Research studies show that those who are trusting of others are less likely to be fooled or betrayed than those who are suspicious. Groups and societies that value trust build social capital and reduce disappointments.

The argument for social capital built through trust is that the costs of doing business are reduced because there is less need to investigate others' motives or to protect against betrayal, that predictability permits creation of long-term realistic planning, and that experimentation and creativity are promoted.

In his best seller, *Bowling Alone*, Robert Putnam presents compelling evidence for the value of social capital. Among others studies reported, Putnam summarizes a project in which he calculated a social capital index for each of the fifty United States based on club membership, volunteering, donations, public office-holding, etc. He also calculated a variety of indexes within each state for socially desirable outcomes. Putnam found that as social capital increases within each state so does child welfare, neighborhood safety, economic prosperity, physical health, longevity, ratings of personal happiness and optimism, and democracy. Clearly, joining matters and America is loosing the benefits of general trust in each other.

Other authors have looked at reduced joining as a triumph of cynicism. It has been argued that the declining trust of Americans in government and profession-

als is a result of personal preoccupation with individuality, increased access to the negative media, a history of betrayal (especially by government and big business), and increasing personal expectations resulting from a long history of prosperity.

PROFESSIONALS vs. INSURANCE

The sociologist Carol Heimer puts it this way: "The historical trend towards reducing vulnerability through insurance may reduce the pressure to motivate

Groups, even those as large as countries, show a direct relationship between joining and participation on the one hand, and democracy, mutual support, and economic development on the other.

trustworthy behavior, thus reducing total societal trust and the social capital trustworthiness it creates." Professionals and insurance are both in the trust and confidence game, but they play on opposite sides of the table. Every relationship and every activity contains risk for betrayal and for unwanted outcomes. It has always been human nature to reduce social risk. But there are two ways to manage this. The professional says, "Trust me because I have knowledge and skills to help you and I have your best interests in mind." This is managing

others' trust by reducing the uncertainty in the relationship and its expected positive outcomes. It is the historical foundation for medicine, law, and the ministry, and it is certainly a part of the proud heritage of dentistry.

The other approach to managing trust is to focus on vulnerability. The argument runs something like this, "Trust me because I know the approximate odds of success and failure and will partially compensate you for losses." This insurance approach to trust is a cynical argument that does not depend on interpersonal relations, social capital, or the benefits of joining. It depends on impersonal averages. Here is a list of some of the tactics used to reduce vulnerability (some of which dentists or patients may recognize from their dealings with the insurance industry): offering compensation, spreading risk across individuals, increasing the costs of finding alternatives, creating confusion, establishing penalty clauses, bundling services, and refusing to negotiate.

Generalized trust is valuable to the fabric of society. It promotes those things we value most. America has been losing social capital through declining participation in groups where trust grows. We have been delegating our participation to others and assuming the role of spectator. We have been sliding into an insurance mentality where active trust and engagement are being replaced by guarantees and entitlement. ■

RECOMMENDED READING



*Cook, Karen S. (Ed.) (2001).

Trust in Society

New York, NY: Russell Sage Foundation. ISBN 0-87154-248X; 403 pages; price unknown.

This book is a collection of lengthy academic papers that explore the meaning of trust and its application in contexts ranging from artificial two-person games to organizations and societies at large. Trust is defined as a willingness to act on the assurances given by others about their intended responses. Generalized trust is a disposition to trust others (a characteristic of the person who trusts). Social capital is collective trust behavior in a group, and is thought to have positive benefits for members directly and to reduce the “costs of doing business.” Interesting essays are included on strategies for reducing uncertainty and vulnerability, interpretation of signals of trustworthiness, and demonstrations under those circumstances where trust pays.

De Tocqueville, A. (1966).

Democracy in America.

New York, NY: Mayer & Lerner.

A French nobleman visited Jacksonian America and wrote this classic commentary on the American character. Among other characteristics, de Tocqueville noted our tendency to join in groups. He viewed this as a mixed blessing, with the potential to undermine both government as the overarching collective and individual action, a concern that was shared by Madison, Washington, and John Jay.

*Frumkin, Peter (2002).

On Being Nonprofit: A Conceptual and Policy Primer

Cambridge, MA: Harvard University Press. ISBN 0-674-00768-9; 213 pages; price unknown.

A broad treatment of nonprofit and voluntary organizations seen as addressing civic and political concerns, delivering services to those in need, expressing the values of donors to influence society, and as an entrepreneurial opportunity. Increasing professionalization and commercialization are just two of the potential forces that can cause imbalance and loss of identity in this segment that plays an important alternative to government and business.

Patterson, T. E. (2003).

The Vanishing Voter

New York: Vintage.

Voting among Americans, especially the educationally and financially marginalized, continues to decline. Patterson sees this as primarily a generational issue related to rising cynicism. His proposals for addressing this problem smack of expediency—on-the-spot registration, longer poll hours, and making voting days national holidays.

*Putnam, Robert D. (2000).

Bowling Alone: The Collapse and Revival of American Community

New York, NY: Simon & Schuster. ISBN 0-7432-0304-6; 541 pages; about \$16.

Americans' participation in civic life has been on a steady decline from almost half a century. This loss of social capital has negative consequences for political engagement, quality of life, health, and economic strength. Causes include generational succession (replacement of the engaged generations who preceded the baby boomers by less involved generations), television (as both a time thief and a personalizing influence), increasing work hours, and sprawl.

****Editor's Note***

Summaries are available for the three recommended readings preceded by asterisks. Each summary is about four pages long and conveys both the tone and content of the original source through extensive quotations. These summaries are designed for busy readers who want the essence of these references in fifteen minutes rather than five hours. Summaries are available from the ACD Executive Offices in Gaithersburg. A \$15 donation to the ACD Foundation is suggested for the set of summaries on joining; a donation of \$50 brings you summaries of all the 2003 leadership topics.



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