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excellence, ethics, professionalism,
and leadership in dentistry

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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.

OBJECTIVES of the AMERICAN COLLEGE of DENTISTS

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: Hidden habits that undermine professionals.

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FROM THE EDITOR

ENOUGH

Appetite was given to mankind in a time when “whatever one could get” had survival value; prudence was given to mankind to prevent obesity.

Let me introduce a humble concept: as we go through life we should take only what we need. In a word, there is a concept known as “enough,” and enough is enough.

There are two alternative positions: (a) “whatever” and (b) “there’s never enough.” There is trouble down both those roads.

Consider eating. It is the most glorious of human enterprises because, no matter how well we do it now, we have to do it all over again pretty soon. And how much should one eat? Of course, only enough. Appetite was given to mankind in a time when “whatever one could get” had survival value; prudence was given to mankind to prevent obesity.

The same is true of money. How much does one need in the end? Disregard for sufficient income is unwise. So is living one’s life with no other goal than making money—for when one never has enough, there is no escape from the tyranny of avarice. Similar logic applies to exercise, time in the sun, socializing, and praise. Aristotle called this concept the “golden mean” by which he understood that each virtue was subject to degeneration into either the vice of too much or the vice of too little.

The deceptions that “the sky is the limit” and “you deserve it all” are commercial lies recently invented by someone who wants to sell you some-

thing. Americans consumed a lot of stuff in 1985—about a quarter of everything consumed anywhere in the world. We consumed twice as much last year. I have not seen the published statistics verifying that we are twice as good as a result.

Consider these questions: How many patients should a particular dental practice have? How many MegaPascals of sheer strength should a bonding agent possess? How many hours per week should the dentist work? What is the right fee for an amalgam restoration? The answer is the same in all cases—enough (meaning sufficient to meet the needs of the circumstances). “Whatever” shows cavalier disinterest in the quality of the practice. “As much as possible” reveals weakness of understanding of how dentistry is practiced.

Gordon Christensen is fond of pointing out that God gave enamel less sheer strength than some bonding agents on the market, and the strongest agents pose significant danger of fracturing tooth structure. Certainly, twenty MPa is enough, and it would be unwise to pay for more. Curing lights that are two seconds faster than their competitors (or more often faster than the instrument the same company sold last year) are attractive to dentists who use a “never good enough” rule. How many composites, at two seconds a pop, would be required to enjoy a ball game with the kids? Ads that tout the statistical superiority of one product over another—without being clear about whether there is an actual benefit in practice—signal a bit of

contempt for the practitioner. Dentists must be cautious about the lofty-sounding language of “nothing but the best” if the best does not measure up to needs.

Too often the “whatever” and the “nothing is good enough” standards amount to the same thing: the dentist has not thought through what is actually required in the situation. After all, no one has ever responded to an ASAP request before it was possible to do so. “As soon as possible” is defined as “when one gets it.” That one should strive to do as well as he or she can is a standard that is always met, under the prevailing circumstances. Open-ended contracts and promises to oneself are unenforceable. After all, anyone who strives to get all he or she can always succeeds.

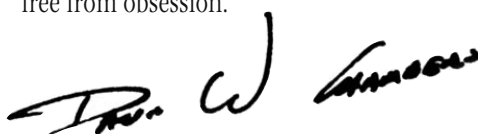
Those who might be uncomfortable with the “enough” standard still argue that the motivational impact of aiming high should not be overlooked. Should we not, they hold, always strive for perfection, or at least some stretch goal? Of course, low goals lead to low accomplishment. But individuals with concrete, attainable goals always outperform those with vague and unrealistic ones.

Actually, the relationship between goals and effort is a bit more complex. Goals have a role to play in both marshaling effort and in directing it. Those who enjoy the excitement of “there is nothing good enough” tend to frame their worlds very tightly—only a few things matter,

and they matter passionately. They have redefined “good enough” to mean better than all the rest. Thus there is no practice income that is safe enough because some guy down the street might be gaining. “Never enough” becomes a spiral trap of insecurity and invidious comparison. It is based on inadequate understanding of what is possible, on inability to control circumstances, or on both.

“Good enough” is motivating in a different fashion. When it is achieved, it releases the power of the individual to pursue other goals. It opens the world to new possibilities, and there are no limits to these.

The philosophy of “good enough” is liberating and offers the best chance of achieving excellence. It allows those who follow it to balance and enrich their lives. It is a more demanding discipline than the non-engagement of “whatever” or the fantasy obsession of “nothing is good enough.” It requires honest self-awareness and deep understanding of how things work in order to clearly define what is enough. It requires courage not to settle when things are not good enough. The ability to manage a balanced portfolio of a life that is good enough across the board is the mark of a successful life, one that is free from obsession.



Individuals with concrete, attainable goals always outperform those with vague and unrealistic ones.

WELCOME: WE HAVE SOME WORK TO DO

John M. Scarola, DDS, FACD

ACD PRESIDENT-ELECT'S ADDRESS

SEPTEMBER 27, 2007

SAN FRANCISCO, CALIFORNIA

It is an honor and privilege for me to come before you today as the incoming President of the American College of Dentists. I would like to express my sincere gratitude to the New York Section of the College for nominating me for the position of Regent in 1998 and for their continuous support and encouragement these past nine years.

THE CANDIDATE

I welcome all of you to San Francisco and extend my congratulations to our candidates for Fellowship. Today is dedicated to you, the candidates. You are being honored by the American College of Dentists for your dedication and service to the profession of dentistry and your community. However, do not take this to mean that this is the pinnacle of your professional career. Each of you has demonstrated to the Credentials Committee that you are worthy of this recognition by reason of your leadership roles in dentistry and society.

Do not for one minute think that you are receiving this honor because of the influence of your sponsor or your colleagues who are Fellows of the College. The decision of the Credentials Committee is made solely on the information from your curriculum vitae, your sponsor's support letter, and positive recommendations by consultants from your community. The names of your sponsor and consultants are not known by the committee. This is the purest

method of selection possible and is intended to guarantee that your leadership accomplishments alone are the reason for receiving this honor.

This afternoon, the College will bestow this honor on each of you in a very special ceremony. By accepting Fellowship into the American College of Dentists, you also accept the responsibilities of Fellowship. The College is not only an honorary organization, but is indeed an active organization dedicated to the advancement of the dental profession. Let me quote from a statement of the founding fathers of this College: "Some of the aims of the College are to cultivate and encourage the development of a higher type of professional spirit and a keener sense of social responsibility throughout the profession; by precept and example to inculcate higher ideals among the younger element of the profession, and hold forth its Fellowship as a reward to those who faithfully follow such ideals and to stimulate advanced work in dental art, science, and literature." As a Fellow of this College, you have the responsibility to continue to lead our profession, whether through teaching, research, literature, dental organizations, or meritorious service to the community. Each and every candidate is a leader and role model to



Dr. Scarola maintains a private practice limited to prosthodontic dentistry in New York City and teaches in the graduate prosthodontics program at the Columbia University School of Dentistry and Oral Surgery.

colleagues and thereby accepts the responsibility to conduct his or her life and work in a manner that exemplifies the highest ideals of ethics and professionalism.

THE COLLEGE

The founding of the College in 1920 occurred at a time when dentistry faced serious challenges from commercialism within the profession. There was an increasing threat from proprietary dental schools, dental journals driven by a profit motive, and deceptive advertising. I am concerned a century later that we may be facing some of the same threats to our profession. The American College of Dentists has been in the forefront in our profession to challenge these concerns by conducting four ethics summits that resulted in the development of the Ethics Alliance of Oral Health Organizations. The two most recent summits dealt with “truth claims in dentistry” and “commercialism.”

The American College of Dentists has been the leader in the advancement of ethics and professionalism in the dental profession since its founding, and the Fellows of this College play an active role in promoting and participating in ethics courses at dental schools in the United States and Canada. Our online courses in ethics are used by students, dentists, and institutions throughout the world, and our Ethics Handbook for Dentists is given to every freshman dental student in the United States and Canada.

Past Presidents McNulty, McCaslin, Haynes, and Boyd all addressed the topic of “life after Fellowship.” The thread of commonality in their presentations to the candidates for Fellowship was to continue involvement in the dental profession and to be an active Fellow and contributor in one’s ACD Section. The Sections are, truly, the lifeblood of the College. I will follow in their footsteps and challenge each of you to become an active participant in your Section. It is the aim of the Board of Regents of this College that every Section has at least one ongoing project that is beneficial to the dental profession, dental education, or society. I have two suggestions for you to bring to your Sections. One is promoting and advancing professionalism through mentoring young professionals; the second is promoting and advancing professionalism through teaching.

THE CHALLENGE

Bioethicist Jos Welie describes a profession as “a collective of expert service providers who have jointly and publicly committed to always give priority to the existential needs and interests of the public they serve above their own and who in turn are trusted by the public to do so.” This agreement is a social contract and thereby necessitates collective responsibility. The higher professions, such as medicine, dentistry,

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or as a group, promote
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Inescapably, we must
be role models.

and law, are granted by society to be self-governing. It is, therefore, the responsibility of the profession to assure society that their providers are competent to provide the services they have pledged to render. Members of the higher professions must consider their fellow providers as colleagues and not competitors. Welie states, "When professionals begin to publicly compete with one another, patients may infer that not all professionals are equally trustworthy." The erosion of trust by society and the increase in commercialism within our profession may lead society to regard us as a business and not a profession. This is a challenge that the College must accept, and we the Fellowship must engage ourselves in fostering professional behavior.

How do we as individuals, or as a group, promote professionalism? Inescapably, we must be role models.

This brings us to the concept of mentoring. Each Section of the College could become engaged in a project to share the wisdom and experience Fellows have gained over their careers with the young men and women who are following them. Mentoring should

begin in the dental schools and residency programs and then continue with the young professionals in our communities. David Chambers, in his 2006 article on mentoring in our journal, states that, "mentoring is professionally sanctioned because it leads to greater productivity and competence, enhanced commitment to the profession, and early identification and development of future leaders." This is certainly reason enough for all Sections to initiate a mentoring program.

My second challenge is for those candidates who have not yet had the opportunity to become involved in dental education. The profession is in need of teachers in our dental schools, our residency programs, and hospital programs. Volunteer a day or a half day a week to a dental school, teaching hospital, or postgraduate program in your community. Your experience, expertise, and clinical skills qualify you for the position. You, the candidate, are here today because your colleagues have identified you as an ethical professional and leader within the dental profession. You are the perfect role model for our students and young professionals. I have just completed my forty-fifth year as a part-time faculty member at the College of Dental Medicine of Columbia University, and I can assure you there is nothing more rewarding and challenging than teaching and mentoring our young colleagues.

THE ACKNOWLEDGMENTS

I am sincerely grateful to the Fellows of the American College of Dentists for giving me the opportunity to serve you as your next president. I accept this responsibility

with humility and will endeavor to lead the College with the same dedication and dignity as my predecessors.

My heartfelt thanks to President Ray Klein, the Officers, Regents, and Past Presidents for their support and encouragement over the past nine years. I ask for your continued support through the coming year so we may, together, advance the mission of the College.

I would like to thank Stephen Ralls, our Executive Director, Karen Matthiesen, Paul Dobson, and the rest of the staff for their continued advice and support throughout my years on the Board of Regents. Your dedication and unending concern for the College is an inspiration to the members of the Board of Regents. Steve, you have instilled in us a sense of collegiality that is truly inspirational.

Last, I wish to thank my loving wife, Teddie, for her sacrifices and understanding throughout my professional career. Thank you for forty-four wonderful years.

Again, I congratulate each and every candidate and ask you to accept the challenge and elevate your profession to heights never before envisioned by your predecessors. ■

WE CAN BE LEADERS IN ADDRESSING CHILDREN'S ORAL HEALTHCARE NEEDS

J. Bernard "Bernie" Machen, DDS,
MSD, EdD

CONVOCATION ADDRESS

SEPTEMBER 27, 2007
SAN FRANCISCO, CALIFORNIA

This year's meeting of the American College of Dentists is devoted to a celebration of leadership in dentistry. This is timely, because even though the profession is thriving, we need strong leadership more than ever.

Today, applications to dental schools are soaring. Dentists are busier than ever. More and more research is highlighting the relationship of oral health to overall health, research that only cements the status of dentists as valuable contributors to society.

But this golden era obscures a continuing weakness.

Poor Americans—especially, and unfortunately, underprivileged children—still have poor dental health and experience great difficulty getting dental care. In this time of our greatest strength, we are failing to serve our weakest.

The reasons for these circumstances are complex and arise out of decades of policy and practice. Each day, more and more Americans go from working class to working poor. And when they pass the threshold out of full employment, health benefits are the first to go. With no health care, seeking treatment for oral conditions comes completely off the list.

I know the American College of Dentists has raised professional standards, improved dental education, and championed strong ethics. To longstanding Fellows and to those we welcome in today's convocation, I say we must redouble our efforts at improving access to dental care for all—especially all children. I believe this goal goes to the heart of what leadership in dentistry means today.

I have three points for you:

- First, we know poor children suffer from poor dental health and poor dental care, and we know how to maintain good oral health.
- Second, while working towards that goal is worthwhile in itself, it will also help our profession.
- Last, dentists have a history of innovation and leadership in public health, one that suggests we can also make a difference in this area.

I was very disturbed in February by news of the death of Deamonte Driver, a twelve-year-old Maryland boy. Deamonte, one of five brothers in a homeless family, died after an infection from an abscessed tooth spread to his brain. Deamonte's story is complicated, and I will get into it in a moment. Let me say for now: What is surprising about this young man's death is not that it happened, but that it does not happen more often.

Tooth decay remains the most common childhood disease in America, affecting 59% of children. Yet poor children suffer twice as much decay as their better-off peers. The very young and minorities are most at risk. Nearly 30% of poor preschool children have



Dr. Machen is President, University of Florida. He was trained as a pediatric dentist.

untreated cavities, compared to 6% of the general preschool population.

We know how to prevent most dental carries and how to treat them. This is old-school, basic Dentistry 101. Yet today in America, more than two out of five poor black children and poor Mexican-American children live with untreated cavities. Despite dramatic improvements in oral health nationally in the past half century, there are a few signs to indicate that the situation is not improving. The Centers for Disease Control recently noted a 15% increase in cavities among children aged two to five.

It goes without saying that poor oral health has staggering human and economic costs. Imagine trying to concentrate in class while coping with a constant toothache. Think about the growing evidence that oral health is connected to systemic health. Also, consider the medical costs of leaving dental problems untreated until they become emergencies. In Deamonte's case, the cost of just two of his six weeks in the hospital easily topped \$200,000. So we know we have a big a problem when it comes to poor children's dental health.

What is frustrating is that we also know what needs to be done to put a healthy smile on these children. One obvious yet essential step is better promotion of preventive oral health. It is bizarre that, with the benefits of water fluoridation carved in stone, 35% of Americans still do not have adequate fluoridated water. The CDC says water fluoridation can reduce the amount of decay in children's teeth by as much as 60%. Yet in California alone, such communities as San Jose, Fresno, and Riverside do not have fluoridated water.

Too few people understand that dental caries are caused by transmissible bacteria. And too few people know about

simple preventive steps such as using fluorides, brushing, and flossing. Dental sealants are another untapped preventive tool, one especially effective for high-risk or rural kids who rely on well water.

Dentists have an illustrious history of advocating preventive care—one more impressive, it can be argued, than medical doctors. We must build on this tradition of prevention with poor children in our sights. We also need more dentists to see and care for children, especially those in vulnerable situations or communities.

I know many dentists routinely provide unpaid or low-paid assistance to needy patients. A 2000 American Dental Association survey found that nearly three quarters of the nation's dentists provide free or reduced-rate services to needy patients. I also know that organized dentistry has effective volunteer programs like the ADA's national "Give Kids A Smile" program. University dental clinics, including clinics operated by the University of Florida, also offer a valuable safety net to many poor families. More than that, they allow us to connect research and innovation to patients.

All that said, poor children should not have to depend on charity, volunteerism, or universities for basic care. Many of the country's poorest children, about twenty-two million, are on Medicaid. In theory, Medicaid includes dental benefits. But in practice, only about 30% of Medicaid children receive dental services. There are several reasons, but one is that too few dentists treat Medicaid patients.

This came through in shocking detail in Deamonte's case. Deamonte's family was enrolled in Maryland's Medicaid HealthChoice Program. The family's ordeal began not with Deamonte but with his ten-year-old brother, DaShawn, whose teeth were in even worse shape. The boys' mother and an assortment of healthcare workers and legal advocates tried for days to find a Medicaid dentist who would see DaShawn.

Public Justice Center attorney Laurie Norris told a Congressional subcommittee in hearings this spring: "It took the combined efforts of one mother, one lawyer, one helpline supervisor, and three healthcare case management professionals to make a dental appointment for a single Medicaid-insured child!" It was during this struggle that Deamonte began experiencing severe headaches. He had a tooth extraction but was eventually diagnosed with a brain infection. He died February 25, 2007.

We all know that dentists limit patients with Medicaid coverage because, in most states, Medicaid reimbursement rates either do not cover dentists' operating costs or provide only a pittance beyond cost. And dealing with the state Medicaid billing bureaucracy too often represents a monstrous ordeal. I do not think the solution is for us to endure this situation and sign up anyway. Rather, I think dentists should devote themselves and their powerful lobbying organizations to pushing for increased reimbursement rates and streamlined programs tailored to dentists' unique needs.

The evidence indicates that the higher the rates and the better managed the Medicaid programs, the more dentists participate. Studies show that Michigan and other states have seen large increases in dentists' participation after raising reimbursements.

For those of us who live elsewhere, we should be nothing less than outraged that more public dollars are not set aside for this essential care for the poorest of poor children. And we should let our representatives know. There is a lawsuit in Florida, my home state, to force the state to increase Medicaid reimbursements. Dentists should lead these kinds of efforts. We should also all make our voices heard in support of proposed federal legislation that goes a long way to addressing the problems I have

outlined. Current bills deserving our support include the Dental Health Improvement Act, Deamonte's Law, and especially the Children's Dental Health Improvement Act of 2007.

We can lend a hand in many other ways. We do not have enough pediatric dentists. And we do not have enough general practitioners dedicated to dealing with the needs of publicly funded and special needs children. The Bureau of Health Professions says at least thirty-one million people in this country live in underserved areas. I am well aware of the need to carefully monitor the number of practicing dentists in this country.

I understand that dentistry is uniquely vulnerable to oversupply because people often pay for dental services out of pocket. I also know that dentists are independent business people who cope with high overhead and that for many years at the start of their careers, their student loan debt averages well over \$100,000. All that being the case, it is time to think more seriously about opening the doors to more dentists, particularly if we can tie loan repayment programs, tax credits, or other incentives to working in areas with shortages of dentists and health disparities in the population.

One thing is certain: With less than 5% of practicing dentists African-American or Hispanic, we desperately need more minority dentists. If we are to expect to see a diversity of patients, we must have a diversity of practitioners.

This brings me to my second point: If we do not figure out how to serve poor children better, someone else will, threatening our franchise in the process. An increasing number of states are allowing physicians to provide oral health services to very young children and to be reimbursed by Medicaid and other means. Indeed, the American Academy of

Pediatrics lists oral health as a top priority. A number of states have begun to open the doors to dental hygienists working unsupervised by practicing dentists.

Meanwhile, due to the shortage of dentists, California is now allowing dentists licensed in Mexico to practice in the Golden State. One can only imagine the complications that arise in terms of uniform educational preparation, standards of care, and the profession's commitment to protect and serve the public. There is no substitute for paying attention to these issues to preserve our autonomy. Added to these challenges, there is a misperception that dentists are more businesspeople than they are healers.

Being more receptive to the needs of the poor, and being perceived as such, will help paint a more accurate picture of dentists as the caring and giving professionals we are. With no end in sight in the debate over health care in America, some may question whether dentists can accomplish the kind of positive change I have talked about. I believe the answer is yes.

This brings me to my third and final point. We have set the standard for medicine before, and we can do it again. For example, it was a dentist, Horace Wells, who discovered and promoted the world's first anesthesia. And as I have mentioned, numerous dentists fought long and hard for fluoridation. We can honor these and other advocates by tackling this access to care challenge head on. Some of us already are.

I want to close with a few details about a dentist who has made a huge difference in his home of Ohio. He is Jack Whittaker, a pediatric dentist in Bowling Green, celebrated in the book, *Dentists Who Care: Inspiring Stories of Professional Commitment*. From the start of his practice, Jack treated Medicaid patients based only on his conviction

It is time to think more seriously about opening the doors to more dentists, particularly if we can tie loan repayment programs, tax credits, or other incentives to working in areas with shortages and health disparities.

that it was the right thing to do. After a time, these patients—who journeyed dozens of miles to see him because they had no other options—sometimes accounted for as much as half his practice.

Jack became frustrated with Medicaid and Ohio's low reimbursement rates, so he took action. He lobbied policymakers and lawmakers, eventually convincing a powerful representative to back his cause. The result was that instead of being paid 35% of their customary fees for Medicaid children, Ohio dentists began to be paid 50% to 60% of those fees. Jack could not solve this problem, but he did what he could while maintaining his practice and wound up changing the system.

To me, that is an example of leadership we can follow. Our children, and the dentists who take our place, will be the better for it. ■

2007 ACD Awards

William John Gies Award

The highest honor the College can bestow upon a Fellow is the William John Gies Award. This award recognizes Fellows who have made broad, exceptional, and distinguished contributions to the profession and society while upholding a level of leadership and professionalism that exemplifies Fellowship. The impact and magnitude of such contributions must be extraordinary. The recipient of the 2007 William John Gies Award is **Dr. Richard E. Bradley**.



Dr. Bradley is recognized for his broad, exceptional, and distinguished contributions to organized dentistry, dental education,

ethics, research, periodontics, public health, the American College of Dentists, and his community. He has been an extremely valued resource to dentistry and his country, and his record of accomplishment is broad-based and meaningful. His leadership has truly altered the course of dentistry in a positive direction. Dr. Bradley is held in highest regard, not only by his colleagues, but also by his friends and associates.

Dr. Bradley's record can be summarized as follows:

- DDS, University of Nebraska, College of Dentistry
- MS in periodontics, University of Iowa, College of Dentistry

- Chair, Department of Periodontics, University of Nebraska, College of Dentistry (initiated its first graduate program in periodontics)
- Professor and dean, University of Nebraska, College of Dentistry—responsible for initiating the merger of the college into the University of Nebraska Medical Center
- President, dean, and dean emeritus, Baylor College of Dentistry—initiated construction of \$7 million addition to enhance research and education
- Recipient of numerous research grants, NIH
- Member, NIH advisory committees
- President, American Academy of Periodontology
- President, American Academy of Periodontology Foundation
- President and trustee, American Fund for Dental Health
- President, American Association of Dental Schools
- Board of Directors, American Association of Dental Schools
- Chair, Council of Deans, American Association of Dental Schools
- Consultant, Commission on Dental Accreditation, American Dental Association
- President, American College of Dentists
- President, American College of Dentists Foundation
- Fellow, American Academy of Periodontology
- Nebraska Dental Association, Hall of Fame
- Baylor College of Dentistry, Hall of Fame

- Special citation, Pierre Fauchard Academy
- Presidential citation, American Dental Education Association

Honorary Fellowship

Honorary Fellowship is a means to bestow Fellowship on deserving non-dentists. This status is awarded to individuals who would otherwise be candidates for Fellowship by virtue of demonstrated leadership and achievements in dentistry or the community except that they are not dentists. Honorary Fellows have all the rights and privileges of Fellowship except they cannot vote or hold elected office. This year there are four recipients of Honorary Fellowship.



The first recipient of Honorary Fellowship is **Ms. Jane D. Evans**. Ms. Evans has demonstrated an exceptional record

of visionary leadership over her nearly twenty years with the Dallas County Dental Association, most recently as executive director. She has been instrumental in improving association functions, efficiency, and visibility, thus greatly benefiting society members and oral health care. Ms. Evans' record and accomplishments are summarized as follows:

- Dallas County Dental Society—Duties:
 - Executive director, Dallas County Dental Society

- Member, ADA SNIT Committee for development of TAMS software
- Member, Executive Director Advisory Committee of the ADA
- Member, Conference of Dental Meetings of the ADA
- Member of team reviewing leadership programs, ADA Trio Team
- Member of team to review process of Golden Apple Awards
- Director and Secretary, Dallas/Fort Worth Society of Association Executives
- Secretary-Treasurer, American Component Society Executives of the ADA
- President-elect, Dallas/Fort Worth Society of Association Executives
- President-elect, American Component Society Executives of the ADA
- Dallas County Dental Society—Accomplishments
 - Implemented student membership program at Baylor University
 - Directed the biggest Southwest Dental Conference in its history, broke 10,000 registrants barrier for the first time in spite of icy roads and snow
 - Managed budget of over \$1 million, with profits that allowed the society to pay off its building loan and purchase a parking lot
 - Developed relationship with Dallas Convention & Visitors' Bureau, greatly benefiting meeting schedules
 - Commitment to ethics, honesty, openness in daily operations
 - Invited speaker, Southwest Dental Conference

- Instrumental in the society becoming a pilot site for the ADA on the new TAMS software
- Implemented mobile dental van that provides care to indigents using society volunteers



The second recipient of Honorary Fellowship is **Ms. Faye K. Marley**. Ms. Marley is the executive director of the North

Carolina Dental Society and general manager of North Carolina Services for Dentistry—the for-profit subsidiary. She has been with the society for nearly thirty-nine years and over this period she has demonstrated an unwavering passion for dentistry. Her leadership and record of accomplishments are exceptional. North Carolina dentistry and the people of North Carolina have clearly benefited from Ms. Marley's diligence. Her record is summarized below:

- North Carolina Dental Society—Duties:
 - Executive director
 - Director of membership (former)
 - Managing editor, *North Carolina Dental Gazette*
 - Managing editor, *The Friday Letter*
- General manager, North Carolina Services for Dentistry, Inc.
- Member, Board of Directors, Caring Dental Professionals program
- North Carolina Dental Society—Accomplishments and Awards
 - Improved Annual Sessions, added activities for spouses and families
 - Improved the caliber and quality of scientific programs and commercial exhibits

- Helped revise organizational committee structure to be more member-driven
- Oversaw partnership with other organizations to develop Caring Dental Professionals program
- Instrumental in formation of North Carolina Dental Health Endowment, now over \$250,000
- Responsible for quality improvement of investment real estate property
- Responsible for unparalleled growth of annual session
- Special Recognition Award, North Carolina Dental Society
- Meritorious Award, North Carolina Caring Dentist Program
- Presidential Citation from ADA President



The third recipient of Honorary Fellowship is **Dr. John D. Rugh**. Dr. Rugh has an exemplary record of leadership and

achievement in dental education and research. His efforts have greatly contributed to the advancement of dental education, dentistry, orthodontics, research, and behavior-related disciplines. He is a tremendous asset to dentistry. Key events and accomplishments in the career of Dr. Rugh include:

- PhD, University of California at Santa Barbara, experimental psychology

- Four years postdoctoral training, Claremont Graduate School
- University of Texas Health Science Center at San Antonio
- Director of research
 - Chair, Department of Orthodontics Initiated Student Research Program through NIH Training Grant
 - Acting chair, Department of Community Dentistry
 - Founder and director, Facial Pain Clinic
 - Developing schoolwide comprehensive evidence-based dentistry program
- Published in areas of facial pain, bruxism, biobehavioral aspects of orthognathic surgery, oral function and aging; has edited four books and authored 17 book chapters, 110 scientific articles, and over 200 research abstracts
- Initiated research projects on adaptation of oral motor behaviors to occlusal changes
- Research has included NIH-funded Multicenter Randomized Clinical Trials and ADA-funded Science Transfer Program
- Established orthodontic residency program and nationwide orthodontic practice-based research network
- President, Neuroscience Section, IADR
- President, Biofeedback Society of America
- President, AADR
- Member, Oral Biology and Medicine Study Section, NIH
- Honorary membership in ADA, American Academy of Facial Pain, and San Antonio District Dental Society
- Harold Loe Scholar
- Distinguished Scientist Award in Behavioral Sciences and Health Service Research, IADR



The fourth recipient of Honorary Fellowship is **Dr. Thomas B. Taft**. Dr. Taft currently serves as the director of educational

development and assessment at Marquette University, School of Dentistry. Throughout his career, Dr. Taft has served dental education by upholding its highest standards. His demonstrated leadership in the field of educational development and assessment and has been invaluable to his school and the profession. He is a consummate professional, serving education with competence, diligence, and integrity. Dr. Taft's record is summarized below:

- BS, MA, Michigan State University
- PhD, University of Iowa, Educational Psychology, Measurement, and Statistics
- University of Iowa College of Dentistry
- Educational measurement specialist, two federal grants
- Marquette University, School of Dentistry
 - Director of educational resources
 - Chair, Department of Behavioral Studies and Learning Resources
 - Director of continuing dental education
 - Director of graduate studies
 - Director of educational development and assessment (currently)
 - Responsible for outcome assessment and curriculum management
 - Co-director of \$500,000 FIPSE grant
 - Assessment coordinator for R-25 NIDCR grant
 - Dissertation director for over twenty PhD candidates at School of Education
- Served on numerous committees and sections of various organizations
- Published in dental education and numerous scholarly presentations

- Member, ADA Test Construction Committee, National Boards
- Consultant, test development, Central Regional Dental Testing Service
- Presidential Citation for Leadership, ADEA

OUTSTANDING SERVICE AWARD

The Outstanding Service Award recognizes Fellows for specific efforts that embody the service ideal; emphasize compassion, beneficence, and unselfish behavior; and have significant impact on the profession, the community, or humanity.



The recipient of the Outstanding Service Award is **Dr. Emmanuel J. Rajczak**. Dr. Rajczak is recognized for his

exceptional service to dentistry, including significant contributions to the fields of prosthodontics, restorative dentistry, gnathology, and education. Dr. Rajczak also played a key role in establishing and developing the Ontario Section of the American College of Dentists. His record is summarized as follows:

- DDS, Faculty of Dentistry, University of Toronto
- Certified prosthodontist, Royal College of Dental Surgeons of Ontario
- Graduate instructor in prosthodontics, University of Toronto
- Clinical conference lecturer, University of Toronto
- Visiting lecturer and instructor, University of Western Ontario
- Chair, Advisory Council, James Sim Institute, Ontario

- Chair (founding), Ontario Section of the ACD
- Member, Council on Education, Canadian Dental Association
- President, Hamilton Academy of Dentistry
- Numerous committees, Ontario Dental Association
- Numerous committees, Royal College of Dental Surgeons of Ontario
- Member, Board of Directors, Royal College of Dental Surgeons of Ontario
- President, Association of Prosthodontists of Ontario
- President, International Dental Study Club
- President, Wisconsin Gnathological Society
- President, Canadian Academy of Prosthodontics
- President, American Academy of Restorative Dentistry (only Canadian)
- President, Canadian Academy of Restorative Dentistry
- Lectured extensively in North America and Europe
- Numerous honors and awards, including Service Award of Ontario Dental Association



Ethics and Professionalism Award

The Ethics and Professionalism Award recognizes exceptional contributions by individuals or organizations for effectively promoting ethics and professionalism in dentistry through leadership, education, training, journalism, or research. It is the highest honor given by the College in this area. The American College of Dentists recognizes **The Pankey Institute**

as the recipient of the 2007 Ethics and Professionalism Award. Accepting the award on behalf of the Institute is Dr. Irwin M. Becker, chairman emeritus. Activities and accomplishments of The Pankey Institute in the area of ethics and professionalism are summarized below:

- Vigorously championed ethical practice for thirty-five years
- Promotes ethics and professionalism to its students through its mission, curriculum, code of ethics, and modeled professionalism
- Dedicated to improving oral health care of the world's citizens
- Declines gifts from third-party vendors
- All educational programs, professional and public, are commercially unbiased
- Operates under the belief that dental education and patient care should be free from manufacturer, insurer, or other third-party bias
- Stresses the philosophy that the long-term best interests of the patient are foremost
- All courses teach and reinforce the concepts of comprehensive, values-driven, relationship-based care
- Each course spends hours on the Institute's Philosophy of Care, Principles and Practices of Optimum Care, and Professional Management and Ethical Marketing
- Carefully selects and develops faculty and mentors to represent the highest standards of professional conduct and to model the concept that patient interests come before personal gain
- Treats colleagues with respect and highest regard
- Implements evidence-based advances in treatment in a timely manner

This award is made possible through the generosity of The Jerome B. Miller Family Foundation to which the ACD is extremely grateful.

SECTION ACHIEVEMENT AWARD

The Section Achievement Award recognizes ACD Sections for effective projects and activities in areas such as professional education, public education, or community service. The **Upper Midwest Section** is the recipient of the 2007 Section Achievement Award. The Upper Midwest Section is honored for its long-standing contributions to the Program of Professional Problem Solving and Ethical Decision Making at the University of Minnesota. This ongoing effort is fully incorporated into the undergraduate curriculum as a series of seminar and assessment experiences. Numerous Fellows have volunteered their time and talents in meaningful interactions with students—both as individuals and in groups. More than 2,500 students have benefited from the Section's involvement; the response to this program has been overwhelmingly positive for all parties.

SECTION NEWSLETTER AWARD

Effective communication is a prerequisite for a healthy Section. The Section Newsletter Award is presented to an ACD Section in recognition of outstanding achievement in the publication of a Section newsletter. The award is based on overall quality, design, content, and technical excellence of the newsletter. This year's recipient is the **Southern California Section**.

2007 Fellowship Class

The Fellows of the American College of Dentists represent the creative force of today and the promise of tomorrow. They are leaders in both their profession and their communities. Welcome the 2007 Class of Fellows.

Benjamin S. Adams
Greenville, SC

Timothy J. Alford
Anderson, IN

Stanley L. Allen
Greensboro, NC

Roosevelt Allen, Jr.
Hampton, VA

Ralph W. Alman, Jr.
Rockville, MD

Stephen C. Alsobrook
Memphis, TN

John A. Anderson
Daytona Beach, FL

Bryan D. Anderson
Spokane, WA

Jeffrey D. Astroth
Aurora, CO

Steven L. Atlas
Exton, PA

Gordon T. Austin
Carrollton, GA

Ernestina Avalos-Figueroa
Aliso Viejo, CA

Charles R. Babst
Duluth, MN

Paul A. Barabas
Ridgewood, NJ

Philip G. Barer
Vancouver, BC

Teri L. Barichello
Oregon City, OR

Wayne R. Barichello
Oregon City, OR

Jennifer J. Barrington
Waxahachie, TX

Irving Baum
Fishkill, NY

Darryll L. Beard
Waterloo, IL

Sean A. Benson
Baker City, OR

Tamara S. Berg
Yukon, OK

Louis H. Berman
Annapolis, MD

David F. Boden
Port St. Lucie, FL

David R. Bonnevie
Niagara Falls, NY

Thomas L. Boran
Halifax, NS

Christine Borkowski
Fidhers, IN

Maureen H. Bourgeois
St. Phillips, NF

Michael J. Boykin
Alabaster, AL

Lee Ann Brady
Key Biscayne, FL

Terry L. Brewick
Denver, CO

Leonard L. Britten
Lutz, FL

Abby J. Brodie
Fort Lauderdale, FL

Mark E. Bronson
Cincinnati, OH

Larry F. Browder
Montgomery, AL

Robert E. Butler
Webster Groves, MO

Marsha E. Butler
Long Valley, NJ

Michael L. Bydalek
Horsham, PA

Joseph M. Calabrese
Mansfield, MA

Paulo M. Camargo
Sherman Oaks, CA

Joseph E. Carlisle
Rock Hill, SC

Daniel Castro
El Paso, TX

James C. Catt
Medford, OR

Monica J. Cayouette
Charleston, SC

Jose L. Cazares, Jr.
McAllen, TX

Paul Chapnick
Toronto, ON

R.K. Chetty
Los Angeles, CA

Samuel Chiang
Vancouver, BC

Esther L. B. Childers
Washington, DC

Douglas N. Christiansen
San Diego, CA

Robert B. Churney
Clearwater, FL

Arthur E. Clark
Gainesville, FL

Blaine M. Cleghorn
Halifax, NS

Robert L. Clitheroe
Sugar Land, TX

Cameron Clokie
Toronto, ON

Richard R. Collins
Houston, TX

Paul J. Condello
Oakhurst, NJ

Linc J. Conn, Jr. <i>San Antonio, TX</i>	Michael H. Downing <i>Billing, MT</i>	Steven W. Fox <i>Akron, OH</i>	Sara C. Gordon <i>Chicago, IL</i>
John P. Conry <i>Duluth, MN</i>	Stephen C. Dulong <i>Boston, MA</i>	Charles B. Foy <i>Madisonville, LA</i>	Christopher T. Gorecki <i>Warren, MI</i>
Stephen A. Cook <i>Lafayette, IN</i>	John Dale Dumas <i>McComb, MS</i>	Kenneth L. Frangadakis <i>Cupertino, CA</i>	Leslie E. Grant <i>Glen Arm, MD</i>
Jason B. Cope <i>Dallas, TX</i>	Joel L. Dunskey <i>Brookline, MA</i>	Shelly L. Fritz <i>Albuquerque, NM</i>	Ron L. Graves <i>Ardmore, OK</i>
James W. Courrier <i>Keyser, WV</i>	Thomas R. Edmonds <i>West Columbia, SC</i>	Leonard Fuqua, Jr. <i>Kingston, TN</i>	John T. Grbic <i>Manhasset, NY</i>
Edward C. Crawford <i>Melbourne, Australia</i>	Donald C. Erbes <i>Gainesville, FL</i>	James E. Galati <i>Clifton Park, NY</i>	Bradley K. Greenway <i>Nocross, GA</i>
Randall R. Croutze <i>Edmonton, AB</i>	Douglas M. Erickson <i>Duluth, MN</i>	Jill K. Gama <i>Missoula, MT</i>	Stephen J. Griffin <i>Dallas, TX</i>
Karen E. Crowley <i>Londonderry, NH</i>	Mark C. Fagan <i>San Jose, CA</i>	D. Georgina Garcia <i>Miami Beach, FL</i>	Lisa R. Grimes <i>Enid, OK</i>
Francis M. Curd <i>Las Vegas, NV</i>	James E. Farley <i>Edmond, OK</i>	Charles E. Gaskins III <i>Richmond, VA</i>	John R. Hall <i>Richmond, IN</i>
Richard D'Innocenzo <i>Boston, MA</i>	Douglas K. Farrell <i>Ventura, CA</i>	George Gus Gatsos II <i>Aurora, CO</i>	Priscilla H. Hamilton <i>Oakton, VA</i>
Daniel G. Davidson <i>San Francisco, CA</i>	Brian N. Feldman <i>Toronto, ON</i>	Gerald Geldzahler <i>Livingston, NJ</i>	Norman J. Hammer <i>Boston, MA</i>
Gael M. Delany <i>Washington, DC</i>	Frank Feuille V <i>El Paso, TX</i>	William H. Gerlach <i>Plano, TX</i>	T. Gordon Handy, Jr. <i>Winston-Salem, NC</i>
John J. DellaCroce <i>Freeland, PA</i>	James B. Fine <i>New York, NY</i>	Daniel J. Goede <i>Sioux Falls, SD</i>	Kevin L. Haney <i>Oklahoma City, OK</i>
Francis J. Dermody <i>Vero Beach, FL</i>	Judith M. Fisch <i>Rutland, VT</i>	Alan S. Gold <i>Pittsfield, MA</i>	Guy M. Hanson <i>Boise, ID</i>
Danny H. Dickey <i>Tupelo, MS</i>	John P. Fisher <i>Marblehead, MA</i>	Marc J. Goldman <i>Millburn, NJ</i>	Willis S. Hardesty, Jr. <i>Raleigh, NC</i>
Charles L. Dolce <i>Austin, TX</i>	James W. Fisher <i>Fort Wayne, IN</i>	James P. Goldsmith <i>Laurel, MD</i>	G. Dewin Harris <i>Gresham, OR</i>
Sheri B. Doniger <i>Lincolnwood, IL</i>	Lorna G. Flamer-Caldera <i>New York, NY</i>	Barbara F. Gooch <i>Chamblee, GA</i>	Sandra G. Harris <i>Goodlettsville, TN</i>
Robert B.J. Dorion <i>Montreal, QU</i>	Diane J. Flint <i>Dallas, TX</i>	Robert A. Goodwin, Jr. <i>Brick, NJ</i>	Grant Hartup <i>Burke, VA</i>
William V. Dougherty III <i>Falls Church, VA</i>	Michael S. Fowler <i>Melbourne, FL</i>	Robert C. Gordon <i>Orangeburg, SC</i>	Holly D. Hatt <i>San Diego, CA</i>

Andrew J. Hauser <i>New York, NY</i>	William J. Jenkins <i>Toronto, ON</i>	Otto K. Klanow <i>Sterling Heights, MI</i>	Taylor L. Markle <i>Shawnee, KS</i>
Darrell L. Havener, Jr. <i>Littleton, CO</i>	Michelle Jennings <i>LaGrange, IL</i>	Jonathan B. Knapp <i>Bethel, CT</i>	William F. Martin III <i>Towson, MD</i>
K. Michael Hayes <i>Auburn, IN</i>	James D. Jensen <i>Plano, TX</i>	Shari C. Kohn <i>Hunt Valley, MD</i>	Erik C. Mathys <i>Greenwood Village, CO</i>
D. Alan Hays <i>Umatilla, FL</i>	Curtis Johnson <i>Scotland, SD</i>	Michael E. Krause <i>Ann Arbor, MI</i>	Charles B. Maxwell <i>Johnsonville, SC</i>
Otice Z. Helmer <i>Fort Worth, TX</i>	Archie A. Jones <i>Boerne, TX</i>	Joseph R. Krulewicz <i>Branchburg, NJ</i>	James P. McAndrews <i>Downey, CA</i>
Timothy J. Hempton <i>Dedham, MA</i>	Thomas Junge <i>Seattle, WA</i>	Robert E. Langsten <i>Crestview, FL</i>	John H. McClain <i>Memphis, TN</i>
Robert V. Herwig <i>Lenexa, KS</i>	Michael A. Jusseaume <i>Westport, MA</i>	Oanh Le <i>San Mateo, CA</i>	Roy A. McDonald <i>Alpharetta, GA</i>
Roger M. Higley <i>Cincinnati, OH</i>	Barbara J. Kabes <i>San Diego, CA</i>	E. Joseph LeCompte <i>Daytona Beach, FL</i>	John W. McFarland <i>Fort Lupton, CO</i>
Margaret Hill <i>Crestwood, KY</i>	Kenneth Y. Kai <i>San Jose, CA</i>	Stephen R. Lee <i>Coronado, CA</i>	Stephen W. McKenna <i>Feeding Hills, MA</i>
Julia R. Hill <i>Indianola, MS</i>	Elizabeth H. Kakales <i>Memphis, TN</i>	Marc E. Levitan <i>Mt. Pleasant, SC</i>	Michael J. Mehlbauer <i>Louisville, KY</i>
Irene V. Hilton <i>San Francisco, CA</i>	John G. Kakales <i>Memphis, TN</i>	Robert N. Lipner <i>New York, NY</i>	Jose R. Mellado <i>Coral Gables, FL</i>
N. Peter Hjorth <i>Peabody, MA</i>	Michael Kampel <i>Huntington Station, NY</i>	Lennart H. Lofstrom <i>Ann Arbor, MI</i>	Philip R. Melnick <i>Cerritos, CA</i>
E. Patrick Hoag <i>Redlands, CA</i>	Ted T. Kanamori <i>Pukalani, HI</i>	Angelina Y. Loo <i>Vancouver, BC</i>	Robert L. Merin <i>Woodland Hills, CA</i>
Timothy D Hogan <i>Fort Myers, FL</i>	Barry A. Kaplan <i>Bloomfield, NJ</i>	A. Stuart Loos <i>Canton, GA</i>	Gerald M. Middleton <i>Riverside, CA</i>
Karen E. Homitz <i>Burlington, WA</i>	James A. Karlowicz <i>Dover, OH</i>	Terence Louie <i>Walnut Creek, CA</i>	David G. Milder <i>San Diego, CA</i>
Bruce D. Horn <i>Tulsa, OK</i>	H. Michael Kaske <i>Twin Lakes, WI</i>	Craig A. Mabrito <i>Houston, TX</i>	Mark A. Miller <i>Carlton, OR</i>
Kathryn J. Hornby <i>Vancouver, BC</i>	Bryan P. Keegan <i>Bel Air, MD</i>	Jeffrey C. Mabry <i>San Antonio, TX</i>	Mark P. Miller <i>Tustin, CA</i>
Bruce A. Huberman <i>Edison, NJ</i>	Karl Keiser <i>Boerne, TX</i>	Robert MacGregor <i>Kentville, NS</i>	Kevin A. Miltko <i>Missoula, MT</i>
Amy W. Hunt <i>Rocky Mount, NC</i>	J. Branch Kennon <i>Panama City, FL</i>	Scott MacLean <i>Halifax, NS</i>	John J. Mooney <i>Putnam, CT</i>
Richard L. Jackson <i>Cincinnati, OH</i>	James C. Kessler <i>Oklahoma City, OK</i>	David M. Madorsky <i>Bloomfield Hills, MI</i>	Larry J. Moore <i>Altadena, CA</i>
Gordon H. Janke <i>Edmonton AB</i>	Brett H. Kessler <i>Denver, CO</i>	Martin J. Makowski <i>Clinton Twp., MI</i>	Regan L. Moore <i>Crestwood, KY</i>
Curtis E. Jansen <i>Monterey, CA</i>	Steven R. Kilpatrick <i>Fort Smith, AR</i>	Marshall H. Mann <i>Rome, GA</i>	Dennis Morehart <i>Enid, OK</i>
Ronald W. Jawor <i>Irvine, CA</i>	Ira R. Kirshen <i>Richmond Hill, ON</i>	Sheldon R. Mann <i>Sarasota, FL</i>	Michael L. Morgan <i>Shawnee, OK</i>

Thomas D. Moye, Jr. <i>Powell, TN</i>	Robert J. Price <i>Phoenix, AZ</i>	Steven M. Siegel <i>Glen Burnie, MD</i>	Ronald D. Venezie <i>Apex, NC</i>
Nader A. Nadershahi <i>San Anselmo, CA</i>	John C. Pritchett <i>Indianapolis, IN</i>	Tim Silegy <i>Long Beach, CA</i>	Narendra G. Vyas <i>Fontana, CA</i>
Rocky L. Napier <i>Aiken, SC</i>	Jane C. Puskas <i>Atlanta, GA</i>	Brian Silverman <i>Cranford, NJ</i>	Bruce D. Waterman <i>Brandon, FL</i>
Richard D. Nelson <i>Flagstaff, AZ</i>	Stephen T. Radack <i>Erie, PA</i>	Kevin M. Sims <i>Birmingham, AL</i>	Ronald E. Watson <i>Gainesville, FL</i>
Andrew L. Nette <i>Wolfville, NS</i>	Thomas E. Raimann <i>Hales Corner, WI</i>	G. Bennett Smith <i>Mount Airy, NC</i>	Walter G. Weber <i>Campbell, CA</i>
Roger K. Newman <i>Columbia Falls, MT</i>	Ronald J. Rainosek <i>Harker Heights, TX</i>	Lynette L. Smith <i>Mount Airy, NC</i>	Rodney B. Wentworth <i>Bellevue, WA</i>
Romer A. Ocanto <i>Fort Lauderdale, FL</i>	Jorge L. Ramirez <i>South Miami, FL</i>	Richard S. Sobel <i>Oakland, CA</i>	Edward E. White <i>Elizabethtown, PA</i>
Gilbert V. Oliver <i>Pinole, CA</i>	Gene M. Ranieri <i>Highland, IN</i>	Susana F. Socas <i>Coral Gables, FL</i>	R. Lynn White <i>Austin, TX</i>
Walter R. Owens <i>Brentwood, TN</i>	Barry D. Raphael <i>Clifton, NJ</i>	Leona A. Sperrazza <i>Philadelphia, PA</i>	DeWitt C. Wilkerson <i>St. Petersburg, FL</i>
Frank Paletta <i>Warwick, RI</i>	Robin S. Reich <i>Smyrna, GA</i>	Tanya Stavisky <i>Vineland, NJ</i>	C. Lesley Williams <i>Delta, BC</i>
Panos N. Papapanou <i>New York, NY</i>	Howard C. Richmond <i>Beverly Hills, CA</i>	Richard A. Stevenson <i>Jacksonville, FL</i>	Daniel E. Wilson <i>Aurora, CO</i>
Melanie Parker <i>San Diego, CA</i>	Randall P. Rigsby <i>Pensacola, FL</i>	Atul Suchak <i>West Covina, CA</i>	Mauricio Wiltz <i>Yonkers, NY</i>
Nancy Y. Patel <i>Mequon, WI</i>	Michelle A. Robinson <i>Birmingham, AL</i>	James E. Talbot <i>Ellijay, GA</i>	Wade G. Winker <i>Eustis, FL</i>
James D. Patterson <i>Woodstock, GA</i>	Lindsey A. Robinson <i>Grass Valley, CA</i>	Bruce J. Tandy <i>Vernon, CT</i>	Marvin R. Winter <i>Decatur, GA</i>
Thomas M. Paumier <i>Canton, OH</i>	Cliff H. Running <i>Phoenix, AZ</i>	Stephen J. Tanner <i>Alexandria, VA</i>	Eric Wong <i>Sacramento, CA</i>
Bryan S. Pearson <i>Lafayette, LA</i>	Jeanne M. Salcetti <i>Colorado Springs, CO</i>	Douglas A. Terry <i>Houston, TX</i>	Wilson Wright, Jr. <i>Birmingham, AL</i>
Mark Peppard <i>Austin, TX</i>	Harinder S. Sandhu <i>London, ON</i>	Brett S. Thomsen <i>Omaha, NE</i>	Deborah A. Zokol <i>Kelowna, BC</i>
Jorge Perdigao <i>Minneapolis, MN</i>	Dean K. Sands <i>Placerville, CA</i>	Allen L. Thomsen <i>Omaha, NE</i>	William J. Zucker <i>Sandusky, OH</i>
Gloria B. Pipkin <i>Moncks Coner, SC</i>	Mary P. Satuito <i>Rolling Hills Est., CA</i>	Brenda Thomson <i>Mississauga, ON</i>	
Peter J. Pirmann <i>Carbondale, IL</i>	William W. Schell <i>Plano, TX</i>	Larry D. Trapp <i>Loma Linda, CA</i>	
Mark L. Pitel <i>Poughkeepsie, NY</i>	Robert H. Sharp <i>Sacramento, CA</i>	Stephen C. Trawick <i>Pensacola, FL</i>	
Daniel W. Pituch <i>Jefferson Hills, PA</i>	Raymond J. Sheridan <i>S. San Francisco, CA</i>	James B. Trotter <i>Overland Park, KS</i>	
Jay C. Platt <i>Munster, IN</i>	Jack Shirley <i>San Antonio, TX</i>	Michele M. Tulak-Gorecki <i>Warren, MI</i>	

THE MIND OF THE ALCOHOLIC

James Tracey, DDS

ABSTRACT

Alcoholism and other forms of substance abuse affect between 10% and 15% of dentists, and the damage caused is well documented and understood. In the face of this, recovery rates remain below 20%. The key is in understanding the mind of the alcoholic. There are clear patterns of denial and ineffective coping that accompany the approximately ten to fifteen years over which addiction is established. Successful recovery invariably begins with a crisis that forces a change in mindset. Recovery involves mental vision of a continuous and lifelong growth process that does not involve alcohol.

It is very confusing. Alcoholism is the third leading cause of preventable death in the United States, responsible for more than 85,000 deaths annually. Between 10% and 15% of Americans will become addicted, with the normal path being first exposure during adolescence with increasing use until dependency is established in the mid-thirties. Recovering alcoholics are a protected category under the Americans with Disabilities Act. But screening for addictive habits is not always a part of routine physical examinations, and physicians are encouraged to avoid using the term "alcoholic" (individuals with alcohol dependence is the preferred term). For many in America, alcoholism is a taboo topic. For some in the law-enforcement community, it is a crime—a position reinforced by the Type 2 classification of alcoholism associated with sociopathic behavior. At the other extreme, a signature feature of Alcoholics Anonymous is describing oneself as a recovering alcoholic and repeatedly telling "one's story" and being of service to others. There are no effective lab tests for alcoholism, as there are for prostate cancer, and no surgical cures and only pharmacological adjuncts to treatment.

BECOMING AN ALCOHOLIC

The number one, essential problem with alcoholism is the way it messes with our minds.

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, identifies characteristics of alcohol dependence, predominantly in terms of behavioral responses rather than amount of consumption. There are seven characteristic signs, any three of which occurring during a twelve-month period are sufficient to indicate dependence. Let's look at these signs, not from the perspective of an outside professional, but with the mind of the alcoholic.

INCREASED TOLERANCE

As dependence on alcohol or other substances deepens, fixed amounts of the substance produce diminished effect and larger dosages are required. The case of a dentist who went from marijuana to alcohol in dental school is not untypical. He was actually proud of the fact that he cut back his alcohol consumption by balancing it with cocaine and prescription drugs. The issue in his mind was not escalating need but more effective tailoring of effects and greater range of sources.

DYSFUNCTIONAL MANAGEMENT OF WITHDRAWAL

Prolonged excessive use of alcohol causes the brain to synthesize more glutamate receptors. When alcohol is withdrawn,



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the brain becomes overexcited. Further, the euphoric effect of alcohol use through regular stimulation of neurotransmitters involved with opiates, serotonin, and dopamine establishes new baseline levels. Withdrawal triggers deprivation demand which can only be met through reprogramming the brain over months, through coping pharmacology, or most effectively and immediately by drinking. "I can remember," reported one recovering alcoholic, "being several months without a drink and going into a bar to make a phone call. The next thing I knew I had a drink in my hand. I thought, 'well I broke my promise again; but since I have already started, I might as well really have a good drunk.'"

LARGER AMOUNTS AND LONGER USE THAN INTENDED

Forty percent of American college students engage in binge drinking. Not all of them become alcoholics, but all alcoholics binge. The typical pattern is not a steady-state low-level habit, but a baseline punctuated with deep use. Sometimes extreme overuse follows periods of attempted reform; at other times, overuse is associated with periods of stress. One law school student describes heavy drinking as part of his exam preparation and boasted that he never failed a test.

PERSISTENT UNSUCCESSFUL ATTEMPTS TO REDUCE USE

All excessive alcohol users have tried to quit. The "sweet promises" they have made are astonishingly sincere and

heartfelt. But this too familiar pattern cannot be taken as evidence against alcoholics. The Romans were a superstitious society. Their daily lives were filled with propitiations to the gods and divinations. The interventions always worked; and when they did not, that was taken as evidence that the ritual was not managed properly. One dentist had been dry for four years prior to entering dental school. His fear of failing put him back on alcohol again. This was not seen as a failure of resolve to quit but rather as a sign of effective coping (after all, he graduated at the top of his class). Later he married a woman who was a professional narcotics smuggler.

GREAT DEAL OF TIME SPENT OBTAINING, USING, AND RECOVERING FROM EFFECTS OF ALCOHOL

Alcoholics are notorious for their ingenuity in "ensuring the stash." One would worry about finding a good hiding place for his gin in the bedroom to cover his nighttime needs. Dentists are able to manage this more easily than most because of their relatively high incomes and access to narcotics. I have heard of a dentist writing a prescription for Percodan, picking up the prescription, and then downing the entire bottle before clearing the parking lot at the pharmacy. For some "getting" becomes a game, for others an investment. Most manage the problem pretty well and do not complain about the time involved.

The number one, essential problem with alcoholism is the way it messes with our minds.

Drinking is not perceived as the problem but rather as the solution to many other problems.

IMPORTANT ACTIVITIES SACRIFICED

Alcoholics rearrange their priorities. I have never heard of a dentist or physician who stopped drinking because of concerns for his or her patients. Stories of broken families, theft from friends and the business, and rebuke of those who offer advice and help are numerous. Loss of a house or other material assets is common. Former friends who offer assistance to change or who make their friendship contingent on the alcoholic's reforming are dropped as unhelpful. Those friends and family who remain are those willing to assume a role supporting the habit—co-dependents. All of this, however, is just a matter of sorting out what matters most.

USE CONTINUES DESPITE KNOWLEDGE OF NEGATIVE CONSEQUENCES

"Things will get better" one dentist always used to say when the temporary setbacks associated with alcohol use were pointed out. A stockbroker whose alcoholism paralleled the course of the Great Depression was adamant in his view that geniuses always did their best work when drunk. Complete teetotalers and others with no known problems with drink constantly fall into the same trap of continuing ineffective behavior; in fact, it might be a requirement for those seeking political office.

The point of the preceding paragraphs is to list and discuss the signs professionals use for classifying individuals as alcohol dependent. Each of the seven tests has been presented, however, as it might appear to the alcoholic. The condition certainly does not look the same from the outside as it does from the alcoholic's perspective. Medicine sometimes observes a distinction between "disease" and "illness." The former can be found in the *DSM-V* classification system; treatment

can be pursued independently of the nature of the patient. Illness, on the other hand, is what patients have from their perspective. It is always more complicated and individual than a disease, and it cannot be cured without addressing the patient's understanding of the patient's condition.

In a fundamental sense, the mind of the alcoholic determines the character of their alcoholism. Drinking alcohol is the means for managing the problems one would not have if one were not an alcoholic. It is especially effective as a means of suppressing guilt, thoughts of failure and of having hurt others, and cancelling a sense of hopelessness. It is a self-sealing system wherein the alcoholics are unable to surrender their conception of how their lives best function, a conception that depends on the continued use of alcohol. In other words, drinking is not perceived as the problem but rather as the solution to many other problems.

THE NECESSARY CRISIS

Understanding the facts of alcoholism appears to have the same effect on changing behavior that knowledge regarding carcinogenicity of cigarettes has on stopping smoking—nil. It is not uncommon for alcoholics to be hospitalized several times or to go to driver school following DUIs and then be able to engage in detailed, accurate discussions of their conditions. They know, for example, that 7% of all deaths in America are alcohol-related, including one-third of all cirrhosis, one in five automobile accidents, a quarter of liver cancers, and more than 10% of suicides. They realize that alcohol will lead to their early death.

Johnny Cash used to start his concerts in the 1960s by announcing "I don't drink any more." After the applause had died down, he would continue "I don't drink any less either." This was followed by loud but nervous laughter. Studies place the rate of "spontaneous recovery"

Alcohol Use Disorders Identification Test (AUDIT)

AUDIT was developed by the World Health Organization. Circle the alternative that applies for each of the following ten questions.

<i>Point value per question</i>	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times/month	2 to 3 times/week	4 or more times/week
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Almost daily
How often during the past year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Almost daily
How often during the past year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Almost daily
How often during the past year have you needed a drink in the morning to get going following a drinking session?	Never	Less than monthly	Monthly	Weekly	Almost daily
How often during the past year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Almost daily
How often during the past year have you been unable to remember what happened the night before after drinking?	Never	Less than monthly	Monthly	Weekly	Almost daily
Have you or has someone else been injured as a result of your drinking?	No		Yes, not in past year		Yes, in past year
Has a relative, friend, or healthcare professional been concerned about your drinking or suggested cutting down?	No		Yes, not in past year		Yes, in past year

Scoring: A total score of eight or more suggests that a pattern of hazardous or harmful alcohol consumption exists. This is a screening questionnaire and is not diagnostic of alcohol dependence. Think about it.

from alcoholism in the neighborhood of 10%. These are individuals who answer yes to the question “If you were using alcohol to excess, have you been able to stop this practice and were you able to accomplish this without outside intervention?” This is like weight-loss claims. At any moment, dieters across America can claim to have lost ten to twenty pounds at any particular moment. Almost all of them would have to confess a few months later that they have gained back those pounds. The same is true for alcohol addiction. Stopping by sheer willpower is not the issue. Making one’s

life permanently free of alcohol and other addictive substances is.

The mind of the alcoholic makes it all but impossible to stop drinking by depending solely on one’s own resources. Consider the following very common rationalizations: “I could quit any time I really put my mind to it.” “I am ashamed to seek help.” “For the most part, I can control my use of alcohol.” “If people knew, I might lose my license, so I need to work on this problem by myself first.” The common denominator is the

The medical community and groups such as Alcoholics Anonymous have not always seen eye to eye on the best methods of recovery.

fundamental belief that the alcoholic is responsible for correcting the problem. In my experience, this mindset of the alcoholic pretending to be in charge when it is obviously not the case is the single largest barrier standing in the way of recovery. It is a mixture of guilt, pride, anger, machismo, need for control, and fear of losing one's identity.

The first step in successful recovery is to recognize that the alcoholic cannot solve his or her own problem and needs to surrender control. That runs contrary to human nature, and I have personally never seen an individual do it spontaneously. Breaking the cycle means letting others take control. And that will be precipitated by a crisis.

One dentist whose case is familiar to me will serve as an example. The senior dentist in the associateship where he was practicing confronted the addict, but the alcoholic blew him off by saying, "When you can do restorations of the quality I am capable of, then I might listen to your opinions." The senior dentist did not follow through, despite the ADA Code of Ethics, and that crisis was dodged. There were discussions of the Country Dental Societies Wellbeing Committee, but these were cast as voluntary responses and similarly ignored. Then one day in 1988, twenty-one federal agents showed up at the office and shut him down. Some pharmacists, who were recovering addicts, had turned him into the DEA. He spent forty-two days in federal prison and faced a four-year mandatory penitentiary sentence. His denial and self-control were broken, so much so that he did not even notice the physical symptoms of withdrawal. He claims that this intervention saved his life.

A crisis of a different sort was the case of a chronic alcoholic whose friend asked him one night over the dining room table to choose his own concept of God. This is not a case of religious conversion—the addict always remained distant from religion—but any answer to that question seems to require a recognition that there is some force greater than ourselves that takes a benevolent interest in our welfare. It is a realization that we are not ultimately in charge. In his precise words, "The price for recovery from alcoholism is destruction of self-centeredness."

The first step in recovery takes place in the addict's mind. It is not a change about the facts—the harm caused others, the escalating preoccupation with finding and feeding a habit, and the loss of control. Those all remain as true as they ever were. The changed mindset is, paradoxically, to realize that the alcoholic is no longer able to control his or her behavior and is willing to allow others to assume that control.

RECOVERY

It has been wisely said that the skills required to fall into a hole are different from the skills required to climb out. This too is a matter of the mind of the alcoholic. Recovery is not the same thing as cutting drinking back to what might be called social drinking, nor is it a matter of stopping altogether. It is not the former way of life without the alcohol; it is a new way of life, a separate journey.

Behavioral psychologists have accumulated overwhelming evidence that undesirable behavior cannot be managed by means of punishment. Loss of privileges, a slap on the wrist, or public ridicule do not reduce the urge to engage in undesirable behavior. They do, however, predictably drive it underground. In the case of the alcoholic, that means throwing himself or herself back on the dangerous fantasy of being in control.

The preferred alternative is known as habit substitution. B. F. Skinner, the founder of Behaviorism, was fond of saying, "If you are busy doing something appropriate in response to a stimulus, you cannot at the same time be doing something inappropriate in response to the same stimulus." There are drugs, such as Campral, Antabuse, and Naltrexone, that can be used adjunctively in recovery, but they provide alternative management for withdrawal symptoms. What is necessary is a kind of personal reprogramming away from destructive causes toward positive habits. Such programming to extinguish a negative response (the simple cessation of drinking or substance abuse) is unrealistic.

The medical community and groups such as Alcoholics Anonymous have not always seen eye to eye on the best methods of recovery. Medical practitioners generally favor permitting individuals with alcohol dependence more self-determination and favor greater reliance on pharmacological agents—or occasionally psychoanalysis—to uncover the life-altering causes of a propensity to drink. Alcoholics Anonymous requires admission of alcoholism, lifelong participation in structured support, and encouragement to gradually and continuously reform one's life around helping others.

The most effective recovery programs, such as the Physicians Health Programs, involve a ninety-day stay at a residential facility that has experience in treating healthcare professionals and is able to deal with massive issues of denial and shame that are unique to professional status. Subsequently, physicians typically resume practice. The Physicians Health Program usually requires physicians to engage in formal support groups, usually with an assigned monitor. Participants also submit to random drug and alcohol

testing for as long as five years. The essential ingredients in such programs include (a) entry into the program through intervention ("socially sanctioned coercion mechanism"), (b) frequent random drug testing, (c) tight linkage with Twelve-Step programs, (d) active management of relapses, (e) a continuing care approach over at least five years, and (f) focus on lifelong recovery.

The five-year success rate of such programs is over 90%. Statistics on success rates are notoriously slippery. Mark Twain claimed great success in quitting smoking. He was so good at it that he had done it twenty times. Every comparison among programs must be based on success rates for comparable periods of time, and the longer periods are better. Eighty percent of diagnosed alcoholics relapse within the first year. Forty percent of men who have been abstinent for two years relapse. Eight-year relapse rates are less than 10%. This is not an exercise in odds-making; the point is that recovery is an active process that continues over a very long period of time.

In the medical approach to alcohol treatment, this process is left largely undefined. In the approach used by Alcoholics Anonymous, an active structure is required and a positive approach to living with alcohol and encouraging others to do so is urged. One recovering alcoholic explained it this way: "I soon found that when all other measures failed, work with other alcoholics would save the day." Another said: "I realized that no one was going to help me just because I was in need of help and didn't ask for it. So I decided to help others. That makes me stronger every day."

Dentists, in common with other licensed professionals such as airline pilots, have a 10% to 20% better chance of successful recovery from alcohol and other addictions. The key seems to be their professional identity. Healthcare

providers will do almost anything to maintain their licenses; they realize that it is part of who they are. Fortunately, professional associations have established systems of intervention and assistance that represent alternatives to legal crisis intervention. These wellbeing committees and diversion boards are staffed with individuals, many of them recovering addicts, who understand what addiction feels like and whose goal is to promote recovery. There is a general social awareness that putting dentists in prison or watching them die in automobile accidents is not in the best interests of the public. And practice can be safe, effective, and therapeutic during recovery.

The examples and quotations used throughout this paper are known by me to be accurate. They come from two sources: my own life and "Bill's Story," found in Chapter 1 of the *Big Book of Alcoholics Anonymous*, which may be read online at www.aa.org/bigbookonline.

The positive approach to alcohol and other addictions is in the mind of the alcoholic. Unless the alcoholic/addict can envision the alternative of continued practice, with the support of available resources, as a positive recovery process, recidivism and early death are the most likely alternatives. ■

DENTISTRY: Risks for Addictive Disease

Jane Walter, LPC

ABSTRACT

Chemical dependence is chronic disease with genetic, psychosocial, and environmental contributing factors and neurological characteristics. Dentists may be at an increased risk for addiction because they are in a helping profession, work in a stressful environment in which drugs are readily available, often exhibit perfectionist personality traits, and function in isolation. Treatment can be effective, especially when provided by staff skilled in working with healthcare professionals, using the Twelve-Step approach, involving families, and addressing related dysfunctional behavior patterns and psychological issues.

I will use the terms chemical dependence, addiction, and addictive disease interchangeably. Addiction is most widely accepted among researchers and treatment professionals as being defined as a primary, chronic disease with genetic, psychosocial, and environmental factors that influence its development and manifestations. It is progressive, relapsing, and often fatal. Addiction is considered a brain disease due to the neurological changes that occur in the brain as a result of alcohol and other drug use and abuse. These changes can be irreversible, often resulting in permanent damage to varying degrees.

Over the thirty years that I have worked in the field of chemical dependence, I have termed addiction a disease of feelings, as therein lies the crux of substance use or abuse. We, as human beings (addicted or not), all drink alcohol or use other drugs for the same reason—to change the way we feel. If the chemical use did nothing to alter our mood, we would not repeat the first experience. The inability or discomfort of experiencing and resolving emotions without the use of a chemical—be it alcohol, marijuana, narcotics, cocaine, or even nicotine and caffeine—is often at the root of chemical dependence. Much has been written about the cause and course of addictive disease, but that is not my purpose here.

The American Medical Association has long classified chemical dependence

as a disease. However, in our society, it is still preferable by some to characterize it as a moral issue or one of weakness of will. The disease is certainly not a choice, but it often results from choices over which the individual has become powerless. In every case with which I am familiar, the person crosses the lines from use to abuse to dependency while losing the ability to identify the process that is occurring within himself or herself. The hallmark of addictive disease is denial. A predominant diagnostic symptom is the individual's continued chemical use despite serious, sometimes catastrophic consequences. The determining factors are not which drug is used, or when, or why, or the quantity consumed; the determining factors are loss of control of the use and consequences in any of the following life areas: health, family, legal, social, and professional. Many years ago, there was a popular poster in treatment centers that was captioned: "If you need a drink to be social, it's not social drinking."

Some sources cite the incidence of addictive disease in the United States as 10% to 20% of the population. In reality, it is probably very difficult to arrive at an accurate number due to the denial that is inherent in the individuals and



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in the families or others in the affected person's life. Many addiction professionals working in treatment centers and monitoring programs believe the incidence rate in the health professions is higher than in the general population.

ARE DENTISTS AT HIGHER RISK?

Chemical dependence is an equal opportunity disease. Unfortunately, members of some professions are afforded a bit more "opportunity" than others due to certain characteristics inherent in the profession. Dentists fit into this category because of several factors that place them at high risk for developing addictive disease.

Over the years it has been generally believed (and noted by some researchers) that dentists regularly "score" higher than other professions in the rates of alcoholism, drug addiction, divorce, depression, and suicide. This may indicate a hidden incidence of chemical dependence, because depression, divorce, and suicide are frequently residual to addictive disease.

HELPING PROFESSIONS AS A RISK FACTOR

The first high risk factor for dentists is the career choice of a helping profession. Health professionals are trained to focus on the needs of others, which in turn results in decreased focus on their own needs. In dentistry, technical education and training take predominance. In many professions, the more technical the training, usually the less attention is given to identifying and addressing the emotional needs of the trainee. Jerome

Gropper, DDS, MS, who is a leader in the field of dentistry, addiction, and recovery, describes a dentist as a professional who needs the following qualities: the eye of a sculptor, hands of a surgeon, tact of a diplomat, insight of a therapist, knowledge of a scientist, and financial acumen of a businessman. Clearly, dentistry is a profession that requires many talents and skills, often resulting in less consideration for the emotional and relational facets of life.

PHYSICAL AND MENTAL STRESS Risk FACTOR

Another risk factor is that the practice of dentistry is physically demanding; many dentists identify physical pain as the precipitating event for their first abuse of drugs. Hand, arm, neck, and shoulder pain can be easily, but not ethically, treated by the dentist self-prescribing medications. Many dentists whom I have treated identify the beginning of their disease as what initially seemed to be the fairly innocent use of a hydrocodone sample for a headache or a few breaths of nitrous oxide in order to relax prior to going home after a hard day. Nitrous oxide is viewed by many as a relatively innocuous substance; in fact, it is highly addictive. Drugs of choice for addicted dentists tend to be alcohol, opiates (particularly hydrocodone and Demerol), cocaine, and nitrous oxide.

Stress of the profession stems not only from the physical demands of dental practice. Many recovering dentists

In every case with which I am familiar, the person crosses the lines from use to abuse to dependency while losing the ability to identify the process that is occurring within himself or herself.

Update: Substance Abuse and Addiction in America

Alcohol:	18.7 million Americans abuse alcohol or are dependent
Drugs:	3.6 million Americans are drug-dependent
Tobacco:	71.5 million Americans use tobacco products
Caffeine:	80–90% of Americans are caffeine dependent

2005 National Survey on Drug Use and Health, SAMHSA (Substance Abuse and Mental Health Services Administration), Department of Health and Human Services

report the experience of stress resulting from patient demands and interactions. Often the fear of causing pain, psychologically absorbing the patient's anxiety, and dealing with patient complaints result in high stress levels for many dentists. Staff issues and relationships can be another source of stress. In many situations, the staff becomes a second or surrogate family for the dentist, resulting in blurred boundaries of roles and job descriptions. Discomfort and lack of confidence in addressing staff issues can lead to interpersonal conflicts, which further increases stress levels for everyone in the dental office. Many dentists report feeling responsible for the problems, yet feeling inadequate to resolve them.

PERSONALITY TRAITS Risk FACTOR

Another high risk factor for the development of addictive disease for dentists is

certain personality traits that appear to be prevalent in those who choose the profession. Most chemically dependent dentists with whom I have worked would score high on scales rating obsessive-compulsivity and perfectionism. (As an aside, these dentists had definite ideas regarding how their dental school training fostered and encouraged these qualities!) Obsessive-compulsive personality traits and perfectionism are set-ups for low self-esteem, as well as a host of maladaptive and self-defeating behaviors. Individuals with these qualities often feel disappointed, discouraged, and unsuccessful, as they can never meet the unrealistic standards they have set for themselves. Perfectionism is, in many ways, a rejection of one's own humanity. Low self-esteem certainly does not cause addiction, but it can be a contributing influence when combined with other risk factors.

ISOLATION Risk FACTOR

There is a final risk factor for those in the dental profession: isolation. Most dentists continue to maintain solo practices, which provide fertile ground for addictive disease to grow when "mixed" with the previously mentioned factors. As a dentist who is abusing chemicals begins to need to hide the behavior, he or she often utilizes the safe haven of the office as a private place to drink or use other drugs.

Dentistry places its practitioners at a high risk for chemical dependence due to these factors: the career choice of a healthcare profession, the stress of dentistry which presents in several forms, the availability of drugs, certain personality traits that are prevalent in dentists, and the isolative nature of the profession. Do these factors constitute a higher risk for dentists than for others? I believe this is a question that will continue to be pondered.

Treatment for Addicted Dentists

Treatment for dentists and other healthcare professionals is readily available and can be very successful. Addiction, although incurable, is a highly treatable disease. It is the only potentially fatal disease I know of wherein the affected person can determine their own outcome once they have been exposed to treatment. Effective treatment for chemically dependent health professionals has become more specialized in recent years as treatment professionals and others in the field have recognized the high risk for addiction and unique treatment needs of those in healthcare careers. There are several factors necessary for effective treatment for these individuals.

It is crucial to have a treatment staff that is skilled in dealing with healthcare professionals due to the difficulty that professionals initially have in becoming patients. These are people whose work lives are spent being the caregivers and the ones in control. Treatment requires that they become patients, allowing others to give care to them—that they relinquish control and learn to accept direction and help. These are all tremendous obstacles for the healthcare professional. These obstacles are so great due to the enormous shame of admitting the problem and working through the inherent denial of addictive disease. These are people who tell themselves, "I should have known better—I'm a dentist" (or a physician, nurse, pharmacist, etc.). These are people who pride themselves on being in control, solving problems expertly, and maintaining high levels of personal privacy. Helping them accept the disease precept of addiction is absolutely essential, because shame decreases as acceptance increases. It is also important that healthcare professionals participate in

treatment with peers in order to have effective interaction, both to support and confront an emerging new identity.

The most successful treatment programs combine use of the Twelve-Step principles of Alcoholics Anonymous and Narcotics Anonymous with addiction education, spiritual re-connection, and a psychotherapeutic approach that addresses issues within the individual, the family, and work. The approach to individual issues is aimed at helping the person address the personality characteristics that have been barriers to emotional and spiritual growth due to not only to the use of the substances, but also other life experiences, including childhood events. Effective treatment engages the patient in a process wherein he or she learns to identify, experience, and resolve difficult and painful emotions without the use of mood-changing chemicals. Additionally, good treatment teaches the healthcare professional how better to identify stress in the work environment that often emanates from areas not recognized in the past. Along with identification and recognition, it is crucial for the professional to develop healthier coping skills to reduce stress in the workplace.

Effective treatment also addresses issues within interpersonal relationships, which are always damaged as a result of addiction. Involvement of the family in treatment is critical as addiction is truly a family disease, wherein everyone in the family is affected in one way or another. Much has been written about codependency and how family members become entwined in the addictive disease process. They need education and help in healing; learning how to care for themselves while the alcoholic is learning his or her own recovery process is essential. A treatment center that uses community living is most effective, as the "communities" of patients become surrogate families, providing laboratories

in which new communication skills and healthier interpersonal relationship behaviors can be practiced.

Successful treatment not only addresses addictive disease in terms of the substance abuse, but also helps the person recognize and understand the pervasive nature of the disease, which exists in many areas of his or her life. Chemical dependence is not only characterized by compulsive use of alcohol or other drugs; it always co-exists with other compulsive, self-destructive behaviors. These are individualized to the person, but often include excesses in work, spending, gambling, eating (or not eating), exercise, or sexual behavior. Effective treatment addresses all areas of an individual's life and emphasizes balance in all things.

GDA DENTAL RECOVERY NETWORK

The Dental Recovery Network of the Georgia Dental Association is committed to providing services to Georgia dentists and hygienists in these areas: (a) identification and intervention where there is a problem with substance use, abuse, or dependence; (b) recommendations for assessment and treatment; and (c) monitoring and advocacy for dental professionals in recovery. The purpose of the program is to help and support dental professionals who are suffering at any level of chemical abuse or dependence, which in turn, will protect the public whom they are licensed and privileged to serve. All participants' names are kept confidential and all of the provided information is treated carefully in strictest confidence. ■

Update: AMERICAN STUDENTS

80% of high school and 44% of middle school students report personally witnessing one or more of the following on school grounds:

- Illegal drugs used
- Illegal drugs sold
- Illegal drugs on students' person or in lockers
- Students high on drugs
- Students drunk on alcohol

August 2007 National Survey of American Attitudes on Substance Abuse XII: Teens and Parents, CASA (Center on Addiction and Substance Abuse), Columbia University

Update: AMERICAN DENTISTS

CAGE Self-Assessment Tool

(part of ADA Well-Being Survey)

- Have you ever tried to CUT DOWN on your drinking?
- Do you get ANNOYED when people talk to you about your drinking?
- Do you feel GUILTY about your drinking?
- Have you ever had an EYE-opener?

10.4% of dentists answered "yes" to 1 CAGE question; 7% answered "yes" to two questions; 4.5% answered "yes" to three questions.

2003 Dentist Well-Being Survey, Survey Center, American Dental Association

WHEN THE WALLS COME TUMBLING DOWN

Peter N. Cannon, DDS

ABSTRACT

This is a first-person narrative of a dentist's slow slide into alcohol and drug abuse, his denial in the face of a professional intervention, and his eventual acceptance of personal responsibility and recovery. There is also a discussion of the dentist diversion program in Minnesota.

I graduated from the University of Minnesota School of Dentistry in 1982. After one year of General Practice Residency, the state turned me loose to make the world safer for teeth. One of the pronounced memories that I have of dental school is all of the celebrating and partying that went on throughout the year. It was not uncommon to see classmates partake in excess alcohol consumption after exams and on weekends. I never partied or drank much in school, so that is why it was so surprising to many that I became an alcoholic and required treatment later on in the 1980s.

A Pathway to Addiction

I grew up in Duluth, Minnesota, the youngest of three brothers. I got drunk for the first time during the ninth grade, drinking cheap beer in a friend's basement. I immediately knew that I liked the experience and feeling of being drunk. I believe from that time on I was hooked.

I drank off and on somewhat sporadically during high school, college, and dental school; not very frequently, but when I did drink, it was always in excess. There was no amount of social drinking or any desire to drink at all without the goal of getting drunk.

I got married in my senior year of dental school. My wife at that time came from a family of moderately heavy drinkers, so my behavior around alcohol did not seem out of the ordinary to her. However, I do not believe she was an alcoholic.

Early on in my drinking, I never focused on any specific form of alcohol (beer, wine, or hard liquor). It was usually a combination. Then once I graduated and started practicing dentistry, I began to feel that at the end of the day I was entitled to a glass of wine with dinner. This eventually became an every-night ritual: get done with work, go home, and drink wine with dinner. On weekends, I began to feel that I had earned the right to have a drink after dinner as well as with dinner. After all, the next day I could sleep in and not have to worry about being at work by 8:00 a.m. with a hangover. The problem was that one drink usually led to two drinks. In order to make myself feel that I wasn't really drinking that much, I would still only have two drinks, but they were basically all whiskey and no mix. It is strange how the mind can convince you you're not drinking that much when you eventually start to drink straight liquor.

The next complicating factor seemed to stem from the fact that the weekend didn't just start on Friday or Thursday; it began to start on Wednesday and sometimes even on Tuesday. The thing

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that I found most disturbing about alcohol was the way it made me feel the next day. I would always have these headachy feelings and flu-like symptoms that most people associate with hangovers. I would also periodically suffer from migraines, which were at times completely debilitating. Then a colleague told me that whenever he had a headache or migraine, he would take a Tylenol 3 and it always worked to take the edge off.

We used to have a supply of narcotics such as Tylenol 3 and Empirin 3 in the office, so one time I grabbed a couple and took one. It seemed to help ease the pain of my headache. Four hours later, I took another one; and before I knew it, I wasn't having too much trouble with headaches any longer.

This was the first time in my life that I had ever taken any kind of narcotic medication. I also noted that at the time I got a kind of nice high. Somewhere the seed was planted in the back of my mind because I soon started to realize that if I supplemented my drinking with the narcotics, I didn't have a real severe hangover. This quite conveniently worked into a nice pattern. Taking a few Tylenol 3 and a little whisky gave me the same effect, if not better, and I didn't suffer from headaches the next day.

I was always able to get a supply of narcotics because we kept Tylenol 3 and Empirin 3 on hand in the office in bottles of fifty to one hundred. The ironic thing is that no patients ever seemed to get those. I would filter a few off at a time,

maybe four or five, and that would last me for the week or the weekend.

Nobody seemed to ever notice that the bottles were running low and we were always having to order more every two or three months or so.

The best thing that ever happened for me, or so I thought, was when Vicodin came on the market. Those of you who were around back then remember how easy it was to get samples. I could always spot the big box of them in the mail. I would almost always be there to greet the postman or UPS delivery guy. Then I would take the box and carry it off with what I would tell everyone was my mail, which was another stash of narcotics that I hid.

Secrecy was always key. I wanted to keep my drug habit and drinking a secret so nobody could take them away from me. I also used mostly at home. I never drank that much out in public because I had this image that I felt I had to maintain. You couldn't be the small town dentist and be seen getting intoxicated at the bars and restaurants all the time. Although I may have driven under the influence of alcohol, fortunately it wasn't very often, because I just didn't drink that much outside the home.

My wife at that time was completely unaware of my narcotic abuse, though she seemed to intimate that I was maybe drinking a little more than I should. I had always tried to rationalize that by saying, "Hey, I work hard. I'm entitled to it. I'm not an alcoholic. I don't live on a street corner or in an alley, under a

In order to make myself feel that I wasn't really drinking that much, I would still only have two drinks, but they were basically all whiskey and no mix.

freeway or in a box. I have a job. I make money. I come home every night.”

Throughout the 1980s, my routine was generally to go to work, come home, and then have two to three glasses of wine during dinner. After dinner, I would have two good, strong drinks, accompanied by a few tablets of codeine. As time went on I was requiring more and more narcotic to receive the same effect, and this required developing even more secretive behavior. Toward the end of the cycle, I was taking twelve to fifteen Vicodin tablets per night and washing those down with alcohol. My prime focus at that point in time was in getting and maintaining an adequate supply of drugs to feed my habit. I always was able to have enough whiskey on hand. I didn't want to run out, but it was a little harder and more time consuming to work at getting the Vicodin.

I never got involved with marijuana, cocaine, or any of the street drugs at that time. It may seem surprising to some people, but I rationalized that those were illegal and that I could lose my dental license if I took part in those drugs. Obviously my perception of what being a model citizen was somewhat distorted. Along with an increased tolerance for the narcotic comes an increased tolerance for alcohol, so the alcohol consumption had to increase, which unfortunately started to lead to more trouble with hangovers.

One's focus is more and more on obtaining and using drugs and alcohol. All other areas of life tend to receive less and less attention day by day. Although I never drank in the morning before work, I do not believe that my performance was up to the standard that it should

have been. I would usually show up on time, but when the hangovers would start to set in, it wasn't until I had been there at least two hours before I would even start communicating or functioning at any intelligent level whatsoever.

The relationships that I had with the staff and the patients were on a steady decline. Although you don't deliberately perform dental services in a careless manner, you may unintentionally cut corners and not give the patients the quality of attention and care that they deserve. Therefore, when you hear dentists say that they are not drinking before work and that it is not affecting their job, it is a gross misstatement.

Not only was my professional life deteriorating, my person life was on a decline as well. I ended up separating from my wife and then later going through a long, drawn-out divorce. Also, when you don't pay attention to any financial matters in your life, your financial condition deteriorates, which for me resulted in a bankruptcy. With all of these problems going on in my life, I still felt that it was everyone else's problem and not mine. It never once dawned on me that I was the common denominator in all of this chaos going on in my life.

My dental partnership started to fail rapidly as well. I was in partnership with another dentist, and he got tired of dealing with a partner who was pretty much unresponsive to the needs and activities of a dental clinic. I slowly began to realize that people were catching on to me when employees started to wonder why we were going through so many narcotics at the office. I did my best to try to stop at that time, but I would always revert to the same behavior, even though I knew the heat was on. It seemed like the world was coming to an end, and the walls finally came crashing down when I received a knock on my door March 24, 1988.

CRISIS AND RECOVERY

The knock was from a group of dentists from Dentists Concerned for Dentists (DCD), my dental partner at that time, and two other individuals. I had vaguely heard of DCD, and what I knew was that you did not want to get involved with them. What I didn't know was that what was going on was called an “intervention,” and I was the guest of honor.

What an intervention is, is a group of caring people who want an individual to get help for a specific problem, be it drinking, drugs, gambling, or any other social, physical, or emotional disorder that is going on in a person's life. It seems the most common interventions are for drugs and alcohol, and that was what was going on with me.

I knew when these people walked through the door and said who they were exactly what they were there for. From what I recall, I didn't say very much. I just sat there and listened. I was angry that they were able to walk right into my house and more or less take over. They gave me the option of either going to in-patient treatment right then and there or I would be reported to the Board of Dentistry the next day by my former dental partner, who was not a member of DCD. Dentists Concerned for Dentists does not report people to the Board of Dentistry.

I tried to rationalize and deny that there was any problem whatsoever and that I could handle everything on my own. Actually, I had been trying to handle it for some time, but I always reverted to my old behavior. After close to an hour, I finally agreed to go. I grabbed a small bag of belongings, toothbrush, wallet, change of clothes, locked my door, and we left for the treatment center. I didn't say a word the entire way there, probably from too much anger or embarrassment.

We arrived at the treatment center, which was in St. Mary's Hospital across the river from the University of Minnesota, about an hour later. I was admitted to the alcohol and drug treatment unit and was not at all happy. Understand, this is from a person who had never been to the hospital except for minor emergency visits as a kid. Here I was expected to spend the next twenty-eight days at this place I neither liked or felt I belonged.

After some basic intake assessment, I was shown to my room and was paid a visit by another resident of the center, a lawyer who was also in for drugs and alcohol. He explained to me what an intervention was and how it played a role in how I gotten there. I felt like I had been committed to an institution. I also found out that I was not required to stay there if I didn't want to, which was, in fact, true. Being the smart person I thought I was, and thinking I could handle my own problems, I decided that night that I would check out in the morning and determine my treatment plan on my own terms.

Keep in mind that at this time I was a fairly sick person. Though I later came to know this as a disease, at the time I was in complete denial that I had any problems whatsoever. I felt that I was in complete control and could handle my life better than any professional could. It was analogous to me telling a heart surgeon which type of bypass I needed or telling a neurosurgeon what type of brain surgery I needed. I was completely unqualified in determining my own fate.

The next morning, just as I had planned, I checked out. When I told the nurses I was leaving, they strongly recommended against it, but of course I knew better. When I left the center, I was able to catch a bus to downtown Minneapolis, get a handful of cash from the bank with a cash card I had, then

flag a cab and take the \$40 ride back to Stillwater where I lived.

Once I got home, I was so exhausted from the night before all I wanted to do was sleep. I knew I wasn't wanted at the dental practice anymore, so I didn't have to go to work. One thing I did do was call a psychologist I had known and seen for the marital issues which were also plaguing me at the time. I told him that I needed to get into treatment for alcohol and drug abuse, which may or may not have caught him by surprise, since he had asked me at an earlier visit if I abused either. I had, of course, denied it because I didn't think it was any of his business, nor did I think that it would have any bearing on the issues that were going on in my life at that time. He told me he would look into a few things and then would call me back later that day. I lay down to get some sleep, and when he eventually called me back, he had arranged for me to go for a chemical dependency evaluation early the following week. For some strange reason, I felt I had accomplished something and was now in control of my situation. I went back to bed and slept for the rest of the day.

At about 4:30 that same afternoon, I received a phone call from an investigator for the State Attorney General's office who worked for the Board of Dentistry. She questioned me about my alcohol and drug abuse and suggested that it would be in my best interest not to practice dentistry until the board was thoroughly able to evaluate my situation and determine the fate of my dental practice license. I reluctantly agreed at the time, but only because I had no other choice. It seemed that of all the things I had in my life that were slipping

I soon started to realize that if I supplemented my drinking with the narcotics, I didn't have a real severe hangover.

away, my dental license was the only thing that I held close. Fortunately, this was the consequence that would later force me to follow through and get help.

The next week I had my chemical dependency evaluation. Of course, since I was a drug abuser, I sugarcoated everything and expected them to tell me I really didn't have that big a problem and that I was free to go. Much to my dismay, the counselor recommended that I proceed with in-patient treatment the very next day.

In-patient treatment is where you go to a treatment center, which is usually a hospital or similar setting, and live there twenty-four hours a day to receive help, a lot of it talk therapy, for your problems. You are generally there for twenty-eight days, but often it can be longer. This is what I imagined to be a major catastrophe in my life because I simply did not want to do it, nor did I feel the need to do it.

The investigator for the Board of Dentistry called me again that day to get the details of my drug abuse. She was very sharp: she had already spoken to different sources, pharmacies, and drug companies, and pretty much had the lowdown on everything I had been doing. It was gradually occurring to me that I could not hide any further. The investigator also let me know that the board would be getting in touch with me and that it would be in my best interest to follow up with treatment as recommended by the chemical dependency evaluator.

The next day I reported to treatment, and once again I felt that I did not belong there. I did not like it, and I did not feel it was for me. There are a lot of group discussions in treatment which are led by chemical dependency counselors, trained professionals in the field of chemical abuse. In the groups are other

people who suffer from various types of substance abuse and are in different stages of recovery. The stage of recovery I was in at the time was pretty much denial. When it was my turn to talk in group and say who I was, I gave the sugarcoated version. I thought I was doing a great job being honest and the rest of the group members seemed to accept what I was saying, but I still felt doubt and displeasure in the fact they told me that I wasn't being totally honest.

During in-patient treatment, you eat, sleep, have group discussions, read, then read some more, then more group discussions, and about twice a week attend an outside Twelve-Step meeting. This process goes on week after week. It was probably in the second week, about day ten actually, when it finally hit me that the problem was actually me and not everyone else. You see, for the first ten days of treatment, I was trying to let everyone know that I had more important things to do. None of this was my problem, and if everyone else in my life would shape up, everything would be fine for me.

I did not like the idea of people telling me what to do. I could accept the fact that I was going to have to give up the drugs, but I sure did not want to give up the drinking. I felt they were two separate issues. Of course I would stop taking drugs; they were illegal. But if I wanted to drink, I should be able to drink. It finally dawned on me in a one-on-one session with a counselor when she, not in physical but in figurative terms, slapped me upside the head and said, "Come on, can't you see what's going on? It's you and not everyone else!"

From this discussion I learned that the progression to alcohol and drug abuse started when I was young, and the abuse was only the icing on the cake. All of the behavioral, social, and mental issues that were going on in my life, even from when I was a young kid, were part of a distorted thinking process.

My whole physical and psychological makeup had been derailed at an early time in my life. It was only then that I realized how deep and serious the problem of my behavior was and how much time, hard work, and energy were going to be needed to fix the problem and get the train back on the tracks. Like I said, it was day ten and I felt that another eighteen days of treatment would not nearly be enough to get myself straightened out.

Essentially, the picture I have of treatment is taking a person apart piece by piece, examining each piece individually, and then putting the person back together again as you would an automobile engine. If you need to rebuild it, it was a deep, long, daunting task that had to be done. At this point I finally realized that my healing could begin.

While I was in treatment, I had my disciplinary hearing with the Board of Dentistry. One of their recommendations was a two-year probation period, and during this period I was not allowed to prescribe narcotics. In fact, I had to surrender my DEA license for the entire period. I was not allowed to use nitrous oxide in the office. Even though nitrous is a drug heavily abused by dentists and the dental profession, I had never partaken in its recreational use. I was also required to have random drug screening for which I could be called by the executive director of the board at any time of the day and then have one hour to get to Hennepin County Medical Center, which was about half an hour's drive from downtown Saint Paul. This would obviously cause problems in patient scheduling, but I had no choice. There were also some minor paperwork and fines, but overall these were my major stipulations. And obviously I had to successfully complete treatment with a good report from my counselors; in other words, I had to see the light and graduate.

I participated in weekly Twelve-Step meetings, a weekly after-care meeting, and periodic sessions with a psychologist. All of these people were required to submit quarterly reports on my progress. All in all, while it seemed like a lot, I had no choice, and it was a small price to pay to be able to continue practicing dentistry. Eventually graduation day came, and then I was discharged and turned loose.

Adapting to my “new” sober life had a lot of challenges. Among them was the impending drawn-out divorce that I was going through, personal financial collapse which eventually led to bankruptcy, and a change in my dental practice situation. My partner and I were splitting up our two-office practice, which turned out to be a good thing for both of us, and I was able to start rebuilding the practice that I had let go into decline.

When you first get out of treatment, you have to begin to lead a sober lifestyle, so there were a lot of things I had to relearn, such as behaviors and thought processes and ways that I managed to live my life. I had one overriding incentive to stay sober, and that was the threat of the mandatory testing. There are a lot of things that you do not understand about yourself early on in sobriety, but the fact that you have mandatory drug screening weighing over your head causes you, no matter what, to maintain your sobriety. If you get caught, you go back to ground zero as far as the board is concerned. As I said earlier, the one thing I held near and dear to my heart was my license to practice.

While this is only one person’s story, all the possible stories are similar and yet they are all different. Some people go on to lead happy, rewarding lives in their recovery; others do not make it for a variety of reasons. Relapse is a very real possibility. We all learn to live one day at a time, knowing that we are one drink away from relapse. It has been

nearly eighteen years since I completed treatment, and my life has changed in many ways, I feel all for the better. I have become more active and involved in my profession, which was long overdue. My personal life has improved, as has my financial situation. Although I did not realize it at the time, it was the call from DCD that saved my life.

How A DIVERSION GROUP Works

In the late 1970s a group of recovering Minnesota dentists formed one of the first dentist support groups in the country—Dentists Concerned for Dentists (DCD). DCD is still in existence today, dealing primarily with alcohol and drug addiction. This group not only functions as a support group and resource, but also serves to provide interventions for dentists in need of help.

DCD is mainly composed of trained volunteer dentists who supply information and resources for people in the dental community. These volunteers receive phone calls from friends and families of addicted dentists or even dentists themselves who are having problems. DCD gathers the information and then decides what level of help and support is needed. Oftentimes DCD will conduct an intervention, which helps the person gain access to treatment and recovery.

Every state operates differently and is governed by distinct laws, but Minnesota’s case is not untypical. In 1994 the state legislature mandated that a monitoring program be formed to allow healthcare professionals to get help without being reported to their state regulatory boards. The Health Professional Services Program (HPSP) was then established. HPSP serves not only dentists, physicians, and nurses, but also chiropractors, veterinarians, emergency medical technicians, nursing

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We all learn to live one day at a time, knowing that we are one drink away from relapse.

home workers, psychologists, and individuals governed by any other state licensing board that regulates healthcare providers. The funding for HPSP is provided by the various state licensing boards. The Minnesota Board of Dentistry pays for the services provided to licensed dentists, registered hygienists, and dental assistants.

It has always been felt that healthcare providers would not seek help and care for their problems because they feared repercussions from their boards. HPSP allows providers to get help and be monitored for a period of time after treatment. If the individuals successfully follow recommendations, they are not reported to the board; thus their condition would remain confidential and they would not have to face sanctions on their state license.

HPSP conducts intake evaluations, refers for appropriate care, and then follows individuals for anywhere from

one to three years as a part of their monitoring process. People are not only seen for alcohol and chemical abuse but for any physically or mentally debilitating condition. The monitoring program generally has worksite monitoring such as a co-worker or a psychologist who sees the person on a regular basis and then provides quarterly reports to the HPSP. Individuals may also be subject to random drug screenings, which are a significant part of the monitoring process. If the person continues to do well in recovery and has completed the program, his or her monitoring is discontinued. If the person fails to follow monitoring requirements, he or she can be reported to the appropriate board. People either self-report to HPSP or they can be referred by another individual.

In early 2002 the State Board of Dentistry changed the Dental Practice Act to require mandatory reporting of impaired practitioners. This change correlated more to the language that was included in most other healthcare provider acts. What this means is that if any licensed or registered dental professionals are aware of another licensed or registered professional practicing while impaired either physically, mentally, or chemically, they are required by the Dental Practice Act to report this person to the Board of Dentistry or they could face sanctions against their own licenses. This was brought about to provide leverage and consequences for people who were violating the Dental Practice Act.

It is not uncommon to know of other practitioners who have problems with drugs and alcohol but fail to act because we do not want to get involved or be the person to have to come down on a friend or colleague. This change in the Dental Practice Act gave the practitioners no choice: they had to act or they would face sanctions on their own licenses.

It was written into this law that reporting to the HPSP would fulfill the requirements for mandatory reporting to the Board of Dentistry. Since the inception of the mandatory reporting act, dentistry's participation in the HPSP has dramatically increased.

Although DCD deals mostly with alcohol and drug problems, there have also been numerous calls on other issues facing dentists. Among them can be depression, family issues, stress management, financial problems, divorce, and suicide, to name just a few. While DCD had been handling and referring these calls, it became apparent that many of these calls required more immediate response from better qualified professionals.

At about this time, the American Dental Association was recommending that the Minnesota Dental Association create more comprehensive programs for the wellness of its dental community. Four years ago the MDA formed the Minnesota Dentists Wellness Program and contracted with the Sand Creek Group, which is a nationally known assistance program headquartered in Stillwater, Minnesota. Sand Creek provides twenty-four-hour crisis phone answering and also serves as a referral contact for dentists and their immediate family members. Help is paid for by the MDA.

Sand Creek responds to a lot of the critical issues outside of alcohol and drug problems that are happening in dentistry. Sand Creek also takes calls for alcohol and drug abuse and will refer them to DCD or, in the case of multiple diagnoses, will coordinate health care for these individuals. ■

ISSUES IN DENTAL ETHICS

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ARE WE VICTIMS OF OUR OWN SUCCESS?

Mark D. Zajkowski, DDS, MD

As summer reaches its peak and the number of out-of-state license plates rises, I cannot help but reflect on how lucky we are to live and work in such a beautiful state. The way life should be, right? Absolutely, I would say in response. Most practices are thriving, and our members enjoy a nice quality of life. This quality of life is possible because many of us preserve personal or family time and are able to practice the way we want...comprehensive dental care with patients who value our care and make their health care a priority. Who would not want a practice that served affluent, well-educated, informed, and financially stable patients, right? Of course, we all strive to serve our patients well and balance life and family with the responsibilities that our profession careers. I do wonder, however, with all of our success in creating our practices, if we have become complacent in addressing the oral health needs of the underserved.

Let's start with one absolute truth. Just about everyone loves his or her own dentist, but the perception of dentistry as a whole in our state has steadily taken a beating. For years, we have been forced into a defensive mode in the press and in front of the legislature in order to preserve the continued use of certain dental materials, the scope of practice of non-dentists, Medicaid reimbursement, and countless other issues. While our thought process and rationale has

always been based on science and logic, all of these issues have taken their toll. Outsiders have been reported as viewing us as elitist, dysfunctional, turf-protecting, obstructionist, old guard, and isolationist. Fortunately, we received some compliments too, but the veracity of the negative comments was shocking to me. I hope you find it shocking as well. Being shocked enough to do something about it would be even better.

With the steady decline in our popularity among legislators came a more subtle, but much more important shift. While doing the right thing and fending off the legislative initiatives left and right, our profession has begun to cede the high ground on prevention and access for the underserved. Many groups stand willing and able to tell anyone who will listen (and there are many) that they have solutions for these problems. In the past, we have not given enough credit to these groups and often rejected concepts based on our own assumptions or traditions that have less and less relevance today. While some or many of the ideas presented by these groups are far from perfect, they present an opportunity for us to partner with them



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These editorials appeared in the *News Journal* of the Maine Dental Association.

Many groups stand willing and able to tell anyone who will listen (and there are many) that they have solutions for these problems.

and learn from each other. We may not always agree, but we can certainly listen and respect the viewpoints of other stakeholders in the discussion. This year, I fully intend to develop these relationships and nurture them for those who will follow. Solutions to our most complex problems cannot be solved in one year, but the foundation for healthy respect and collaboration has already begun to be formed.

This comes full circle to my opening comments. While dentistry has fared well in comparison to the rest of the healthcare professions, our reasons for maintaining success may ultimately doom us to irrelevance if we do not modify our current course. Why cannot we find room in our practice for one MaineCare family or child? Why cannot the patient who is not interested in a full mouth reconstruction have a flipper to replace the missing lateral incisor so he can regain some social confidence? Why should a school-age child in a first-world country miss school because of prolonged dental infections and toothaches? We know that the state system for reimbursement is woefully inadequate and will never provide real access for those most in need. When will we change our way of thinking from "It's not my problem...it's the State's problem?" We truly find ourselves at a crossroads in the debate over how dental care is delivered in Maine. One thing is certain: the individual roles on the dental team are changing, and if our association intends to lead the discussion, it is time to swallow our pride and change the way we do business in Maine. Real change is coming, and people are watching. Let's do this right, with the right attitude, and be the true leaders for meaningful change here in Maine. ■

WHAT'S WRONG WITH THESE KIDS?

Mark D. Zajkowski, DDS, MD

I heard this uttered over and over during the ADA session in San Francisco.

This came about during discussions on ethics at a meeting of the House of Delegates. In reaction to a proposal to form a task force to investigate the sudden increased prevalence in cheating among dental students, the discussion focused on why these students need to cheat and why they are being selected for dental schools in the first place. It dawned on me that perhaps the discussion was inappropriately focused on the students...maybe we should look at ourselves first. What kind of examples do we as professionals set for our future colleagues, and how do they view these examples?

Let's begin with a look at the publications that cross our desks on a daily basis. While a good many journals are peer reviewed and reputable, how many are more interested in selling a new technique to "increase our bottom line" or "increase productivity?" Do we send the wrong message to students when we recommend products or procedures solely on how they improve our business? I would never fault any of us for keeping our practices up to date, but as we choose these products and procedures, where do we draw the line

between the influence of marketing and the practice of evidence-based dentistry?

From a different angle, how do dental students view the way we serve our community? Thankfully, the vast majority of dentists in Maine give back in some way, whether through volunteer care, missions, or activism in their towns. Dentistry has always had the benefit of individual relationships with our patients and the impenetrable trust factor. Would that trust of patients be the same if we did not coach our little league teams or serve on that town committee? And speaking of trust, how do students feel about the trustworthiness of their licensed role models in treating all segments of their community? How about the kinds of patients we see? Are we only willing to see those who can pay our full fees up front, or do we accept MaineCare, or at least allow payments over time? In short, do we care for our community, or only those who can afford us?

How do students feel about how we treat each other? I am amazed how often a dentist can be criticized by a peer without a full understanding of the circumstances surrounding the care. Consider the risk of a complaint to the State Board of Dental Examiners based on a comment you may find innocuous. It is important to remember that what a patient hears is not always what is said, but the damage can be profound. Can we define ourselves as professionals without the need to criticize others unfairly? How would you like to have your care discussed by a colleague down the street?

How does it look to young professionals when we try to gain insurance coverage for a patient's treatment based on false pretenses? I recall an oral surgeon in the Mid-Atlantic who billed for "cyst removal" when removing all wisdom teeth to increase his reimbursement. The surgeon claimed that by removing the residual follicular tissue, he was treating pathology (and tripling his fees at the same time). A stain on the reputation of his colleagues nationwide was the result, and it caused untold damage to the reputation of an entire specialty. Certainly situations like this have an impact on students and how they perceive the ethics of the profession they are entering.

While these are just examples, I think it is important to remember our core mission. That mission included ethics when we were dental students, and it still applies today. Much like raising our children and setting a proper example for them to follow, perhaps we should take a moment to reflect on how we can set the path for our young and future professionals in modeling our behavior. After all, we do not really have a choice in being a role model. We are role models, and we need to live up to that standard. ■

How does it look to young professionals when we try to gain insurance coverage for a patient's treatment based on false pretenses?

A PRIMER ON DENTAL ETHICS: PART II

MORAL BEHAVIOR

David W. Chambers, EdM, MBA,
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ABSTRACT

Neither being right nor feeling certain are preconditions for moral behavior, but believing that you and others together can create a better future is. A distinction is made between the theoretical, conditional, and reversible activities of ethical analysis and the individual act of courage in committing to moral behavior. Three positions in moral behavior are considered. (a) Research reveals that moral development involves sequential stages of more complex functioning and continues into the third decade of life. Almost all individuals have a choice of several frameworks they can apply to moral problems and very few are capable of functioning at the level where philosophical discussions take place. (b) Secondly, survey and observational research among professionals shows high levels of opportunism throughout training and practice. These questionable moral habits are motley, with inconsistencies across type and time within individuals, and are heavily dependent on peer context. (c) Finally, performance language—promises that bind groups of individuals to future behavior and build moral communities—can serve as the foundation for moral behavior. Eleven specific “lessons learned about moral behavior” are identified.

Statisticians are aware of the difference between the symbols σ and SD. Both of them are used to represent standard deviation; there numerical values should always be identical in particular situations. But the Greek term sigma is understood to refer to standard deviation in the theoretical sense, in general equations and formal discussions of universal cases. The Latin term refers to specific standard deviations, ones that are calculated from concrete data in particular studies. The same pairing of Greek and Latin symbols is carried throughout statistics for averages and other parameters. This distinction helps us remember whether we are talking about theoretical situations or concrete ones.

The same distinction can be drawn between ethics and morality. Ethics, *ἠθικός*, is Greek and refers to the study of good and bad or a set of principles deriving from such a discipline. Morals, from the Latin *moralis* and *mos* for custom, means good or bad behavior. Professors of ethics could do their best work alone in an office and we would read their books to find out what they were thinking. By contrast, professors who are moral do not cheat on their spouses, shade their income taxes, or palm off heavy committee assignments on junior faculty members—regardless of what they publish. Evidence for ethics is reasonableness; evidence for morality is action.

There have been some philosophers, such as Socrates and William James, who maintained that this distinction is too thin to matter practically. For them, anyone who understands right and wrong in the ethical sense will engage in only right behavior in the moral sense. This does not square with common sense.

The connection between ethics and morality is much like the connection between σ and SD. There are many sigmas that have no realization in the actual world and figure primarily in theoretical debates among statisticians. But practical uses of standard deviations that do not conform to the principles of statistics are at risk for leading to error in inferences about research. Heavy emphasis is needed on the difference and also the relationships between ethics and morality in order to avoid the twin follies of behavior that is not grounded in ethics and trying to reason our way to good behavior. The virtues of ethics and morality are not the same: the defining characteristics of ethics are reason or wisdom; the defining characteristic of morality is courage. We need to increase the available supply of both.

In the first part of this primer, published at the end of 2006 in this journal, I presented the three major branches of ethical theory: principle and universal ethics, virtue ethics, and consequential ethics. The dissatisfaction that emerged in this discussion is that multiple patterns of behavior seem to be “justifiable” on each theory, but none had succeeded in making a lasting impact on the tone of society. Even if one theory could dominate another

(which has not happened yet), the evidence that adherents to any particular approach are in some way “more ethical” is not compelling.

So we must now pass, in the second part of this primer, to the other wing of the house and consider what lies beyond the three doors of (a) developmental moral theory, (b) descriptive morality, and (c) performance language.

DOOR #4: MORAL DEVELOPMENT

The first door into understanding good and bad behavior opens onto the exploration of how we grow morally. The way a child talks about right and wrong is different from the language and approach of an adult. We tend to prefer communities built by ethically mature individuals to honor among thieves. It may even be the case that severe forms of antisocial behavior are the result of arrested moral development.

KOHLBERG

The leading name in this approach is Lawrence Kohlberg, a Harvard professor who took his own life a few years ago. Kohlberg studied cohorts of children, almost exclusively boys, over long enough spans of years to note changes in the way they approached moral dilemmas. He observed certain regularities during this development in the way dilemmas are framed, with these developmental stages emerging in essentially the same order in each child. He divided this growth pattern into three levels: (a) preconventional, (b) conventional, and (c) postconventional moral reasoning.

He further divided each level into two patterns, making a total of six stages of moral reasoning. His primary research tool was the moral dilemma, in particular the case of Heinz, the poor man whose wife was dying of a disease for which a very expensive possible cure was available. Heinz was unable to get help raising money from his friends and the druggist wanted full payment up front, so Heinz contemplated stealing the drug. (The full dilemma appears in Part I of this pair of essays in the fourth issue of the *Journal of the American College of Dentists* for 2006.)

Participants in Kohlberg’s research were asked to explain their reasoning about moral dilemmas. We can illustrate this approach by discussing the dilemma a senior dental student faces over having only one individual in her family of patients with an “ideal Class II state board lesion.” Optimally, this particular lesion should be treated in sequence several months before the initial licensure examination, but that would leave the student with no qualifying patient for the boards in an environment where such patients are so scarce that individuals with such lesions charge thousands of dollars to sit for one-shot chances on the boards.

At the preconventional level, the dental student would frame the problem in tightly personal terms of reward and punishment. At Stage 1, the following theme might be running through the student’s head: “I know Dr. Boxhider will

Evidence for ethics is reasonableness; evidence for morality is action.

find out about this. He is a tyrant, and if he discovers my hoarding this lesion, he would ruin my career." Punishment is assumed to be an inevitable consequence of detected transgressions. At Stage 2, the fear of punishment is not as concrete and literal, but self-interest is still the underlying force. "This patient doesn't understand optimally sequenced care and was responsible for letting the caries get out of control in the first place. If I have to postpone the boards or run the risk of showing up with a questionable patient, I can kiss that associateship at the Wonderful Dental Care Group goodbye." Stage 2 moral thinkers are literal loophole lovers.

Conventional in Kohlberg's terminology means with reference to the norms of groups to which the individual belongs and whose interests should be considered when deliberating ethical choices. A Stage 3 dental student would rehearse thoughts like these in the dilemma of reserving a Class II lesion for initial licensure examination: "My friends would consider me naive to treat the patient now; everybody hoards patients. The clinic director would be unsympathetic to giving me more patients, particularly such scarce ones when other students don't have anything like a qualifying patient in their pools." Also at the conventional level of moral reasoning, but of a more global or societal nature and somewhat more abstract, the Stage 4 student would reason differently. The ADA Code of Ethics says "The most important aspect of this obligation [Code Section 3: Beneficence] is the competent and timely delivery of dental care within the bounds of clinical circumstances presented by the patient,

with due consideration being given to the needs, desires, and values of the patient." Issues of competence, the meaning of timeliness, and the patient's not having said anything about the matter must be interpreted as part of applying this stage of moral reasoning.

The highest level, postconventional moral reasoning, is a bit more vague. Individuals at this level move to abstract considerations of principles of right and wrong beyond their own self-interests or the interests of significant reference groups. They create individual codes of ethics that could be defended as correct and appropriate in some universal sense. The individual at Stage 5 is a delight to ethicists and will always get an A in the ethics class. He or she is aware of and can counterpose a full range of ethical considerations. Our hypothetical student would identify all of the arguments presented so far and add others. "There is an issue of fairness here; am I obliged to follow the rules of a system that itself subordinates patient health to other considerations? Aren't I considering making a decision for my patient without informing her or finding out her wishes? Circumstances have placed me in this unfortunate position, but my overall performance as an emerging professional is consistent with the highest ethical standards; it is the pattern that matters, not the exceptions." Kohlberg admits that Stage 6 is idealistic. Comprehensive, universal ethical positions are rare—except among philosophers. If the student with the precious Class II lesion could unify or clearly prioritize the blizzard of alternative considerations into a unified whole, he or she would score at the highest level.

Kohlberg's research, and a fair bit of subsequent work, has demonstrated that these levels emerge in sequence: preconventional reasoning comes before conventional reasoning, and then postconventional reasoning follows. In

fact, however, the levels telescope: individuals who are capable of conventional reasoning are also capable of preconventional reasoning (but not vice versa). The stages are only capabilities, not typical behavior patterns, and individuals who could operate at the postconventional level often function at the preconventional level, especially under stressful circumstances.

The possibility of advanced stages of moral reasoning is age-related. Conventional reasoning is rarely seen before adolescence; postconventional reasoning begins to emerge in late adolescence, and certainly continues to evolve beyond the time most dentists have settled their practice habits. Kohlberg presents evidence that the possibility of higher stage reasoning continues to increase at least as far as age forty and that it is associated with both IQ and with completing higher education. This appears to be a clear positive answer to the question whether dental students can learn moral behavior in dental school. (The first conversion from preconventional to conventional levels among young boys seems to be a function of the socioeconomic status of parents, but not the later changes.) Almost all individuals studied by Kohlberg were at Stage 3 and Stage 4; the highest level encountered in most groups is Stage 4/5.

Kohlberg's theory concerns itself with moral reasoning, not moral behavior. He is explaining to us what individuals typically are capable of doing when asked to discuss moral choices. There is no way to tell with certainty, for example, what the dental student will do with the Class II lesion. We only know what he or she would be able to justify doing.

PIAGET, REST, AND GILLIGAN

A rich picture of developmental approaches to moral reasoning requires discussion of the contributions of Jean Piaget, James Rest, and Carol Gilligan.

Kohlberg was an admirer of the Swiss psychologist Piaget and built on his work. Beginning in the 1930s, Piaget engaged in systematic observation of children in natural settings. His working idea was that children are not just little or incomplete adults; they exhibit age-specific patterns of behavior in their cognitive, social, and moral behavior. Each of these stages is internally consistent, but with age, the more crude systems are replaced, in an order that is the same for each child, with more complex and serviceable mental structures.

Piaget has his own theory of moral development, but perhaps his major contribution (judging from today's perspective) was in noting that cognitive, social, and moral development evolve in parallel with each other. Clearly, Kohlberg's conventional level of moral reasoning is linked to the child's ability to function as part of a social group and his view of postconventional reasoning requires advanced cognitive skills. Piaget noted that the ability to consider hypothetical situations (what if), the ability to mentally reverse situations, and the capacity to take the perspective of others are all involved in advanced reasoning. They also play a critical role in teamwork, delayed gratification, and ethical deliberation. Recent research on the physiology of the brain reveals that myelination of the frontal lobes and their integration with other regions of the brain is delayed significantly compared to development of the cognitive cortex or the areas responsible for long-term memory. The frontal region is concerned with short-term memory (which permits comparisons of alternatives), the capacity for counterfactual reasoning (solving complex hypothetical problems), and

acts of will such as choosing to sacrifice now for a greater good later. Damage to the frontal lobes is associated with antisocial behavior. It appears that Piaget's observations that cognitive, social, and moral behavior are interconnected and emerge in stages has a physiological foundation.

James Rest and the center he founded at the University of Minnesota are characterized as Neo-Kohlbergian. The Defining Issues Test is the most commonly used test now for measuring individuals' moral reasoning development, which is reported as three types: personal interest, maintaining norms, and post-conventional schema. In the tradition of Kohlberg, five dilemmas are used to evaluate the thinking of individuals confronted with moral choices.

But Rest also proposed that moral judgment could be understood as more than reasoning independent of moral action. He developed a four-component model for morality. (a) Moral sensitivity or awareness comes first; we must recognize that we are in an ethical situation before we can respond to it. Perhaps some people are especially sensitive and others a bit oafish in knowing what is going on around them and whether it matters. (b) The second part of the model is selecting an appropriate course of action. This is the step of ethical analysis; of considering alternatives and prioritizing and articulating reasons justifying potential behavior. This is what ethics books are about and what is taught in ethics courses. (c) Motivation to act ethically is the third step, and Rest lays out the possibility that an individual could have been a star at step two (ethical analysis) and then fold his or her tent and go no further. Rest also acknowledges the possibility of doubling back in this process. For example, a

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sound ethical analysis at the second step might be reframed if the moral action at the third step appeared inconvenient. (d) Finally, there is the matter of implementation, which involves persistence, ego strength, and interpersonal skills. Again, allowing that the steps in Rest's model are independent, we can have a sensitive individual at the highest level of sophistication in ethical analysis, and highly compassionate to engage in moral behavior who, nonetheless, makes a botch of the intervention for lack of communication skills, understanding of organizational dynamics, or even because he or she is the wrong person (as an alcoholic father advising his son on drinking). Rest places less emphasis on the linear ordering of levels and sequence in moral reasoning than did Kohlberg. There has been too little work

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extending and strengthening Rest's work of the four steps in moral behavior.

Carol Gilligan, a research associate of Kohlberg's, noticed that few of the boys in his studies reached the higher levels of moral development. She also thought that women might frame the dilemmas used in the research in different terms. She became a pioneer in the field of women's studies with her interviews of professionally oriented graduate students and women who were facing decisions about abortions. The women's voice when looking at their own issues was certainly more complex and nuanced than the voice used by boys to describe moral reasoning for hypothetical cases. Gilligan described this voice as one of "care." By this she did not mean nurturing as in the traditional female role of caring for others. Instead, her axis of moral development runs from simple

acceptance of socially or group-defined roles (which she calls separation from self) to a personal sensitivity to the full range of individuals affected by a moral action, including the woman herself (which she calls identity). The morally mature woman cares what might happen to herself and others and orients toward avoiding actions where anyone might be hurt.

WHAT WE FOUND BEHIND DOOR #4

The developmental approach to morals calls into question some naïve assumptions about good and bad people.

- a. The metaphor that pictures individuals as containers of moral virtue, to be filled by education or other means, does not seem appropriate. Very likely there is something called the capacity for morality, but the capacity grows over the first ten to forty years of life. Although the growth may be in some invariant sequence, it is not at the same pace for all, and the process is subject to premature truncation. Muriel Bebeau, an Honorary Fellow of the College, has demonstrated that ethics training can advance individuals to higher levels of reasoning. David Ozar, another Honorary Fellow, has developed a hierarchy of moral action that represents higher-level moral reasoning. Nevertheless, it is apparent that education (in the sense of filling up the student with knowledge) is an incomplete view of moral development.
- b. Individuals do not always use all of their moral capacity. One could be capable of the highest flights of ethical theory but choose—for reasons that we have not studied—to act in certain situations, or even generally, on a conventional or even preconventional basis. We need to understand better why some individuals in some situations fail to live up to their full moral potential.

- c. Everyone is not capable of functioning at the highest moral level. Children certainly cannot manage ethical challenges the same way adults do; even late adolescents may not have reached their stride. If we take Kohlberg seriously, very few of us ever reach the level where we incorporate anything like the ethical theory of philosophers into our moral behavior. Quite literally, there is a serious risk of disconnect between ethical theorizing and practicing good and bad behavior, and better theories will not do much to bridge that gap.
- d. Framing morality as rule-following represents a low-level approach to ethical matters.

DOOR #5: DESCRIPTIVE ETHICS

Eighty years ago Hartshorne and May (1928-1930) set out to identify children who had a propensity for defective moral character. They studied eleven thousand children in school, home, and athletic contexts where lying, cheating, and stealing might be possible and captured the children's perceptions, reporting their findings in three volumes. The dominant insight: there is no such thing as a moral type of child. Virtually all children were flawed, but not in any consistent pattern. Some would steal but not lie; some would cheat on an arithmetic test but not a geography test. Moral behavior appears to be largely situation specific.

Men are more likely to admit to cheating than are women, and students with low overall academic performance say they cheat more often (Cizek, 1999; Stern, 2006). Nath and colleagues (2006) report differences between medical, dental, nursing, pharmacy, and allied health programs on what constitutes

professional behavior. Donald McCabe, the current leading researcher on lack of academic integrity (2005; 2006), finds that 66% of college students self-reported cheating in 1993; thirty years previously this figure stood at 65%. However, self-reported cheating is higher in professional schools: 72% in engineering schools and 84% in business schools. A preliminary report by McCabe at the 2007 meeting of the deans sponsored by the American Association of Dental Education suggested that the number in dental schools may be even higher. Andrews and her colleagues (2007) report that 75% of U.S. and Canadian dental students self-report that they have cheated on examinations (23% very often) and 58% say they have cheated on preclinical assignments. A 2000 paper (Beemsterboer, et al) reported that 83% of dental schools had experienced cases of ethics allegations involving copying on tests. The proportion of schools with allegations of altered clinical records was 52%, 26% for taking credit for clinical work that was not one's own, and 21% for stealing.

Lapses of integrity are more difficult to study among practicing professionals because cohort samples are more difficult to assemble, although it may be assumed that all of them were once students. Serious breaches were reported by Steneck (2006) in the practicing science and engineering communities. Reid, Mueller, and Barnes (2007) found that 81% of surveyed dentists saw no ethical issue involved in accepting gifts from patients. Nearly fifty years ago McCluggage (1960) found that unprofessional behavior in practice was associated with questionable behavior in school, and Masella (2007) recently explored the concern over eroding professionalism in dentistry. In the Harvard study of professional ethics (Fischman, et al,

2004), the first years of practice for journalists, actors, and genetics researcher scientists were decisive in creating a "professionalism of expediency." My own research (Chambers, et al, 2002) found that practice profiles among young dentists that exhibited a tendency to engage in unusually procedures was unrelated to educational debt, but associated to a small degree with borrowing to establish a practice.

The evidence on professional cynicism is consistent, but difficult to interpret. In dentistry (Hutton, 1968) and other professions (Goldie, 2004; Pascarella & Terenzini, 2005), a consistent pattern is noted of students increasing in cynicism as they enter the clinical phase of their professional educations. By contrast, the findings are equally clear that humanitarian and service motives rise noticeably in college and the first years of professional education. The American Association of Dental Schools' annual Survey of Seniors for the Class of 2006 (Chmar, et al, 2007) lists the motives of service to others receiving a 50% rating in the "very high" category; income potential and working with hands each received 41% "very high" ratings.

There is also research on factors associated with lapses of integrity. Jones (1991) proposes a general model involving the interplay between individuals and the organizational contexts in which they find themselves. Perceived probability of detection, temporal immediacy, concentration of effect (dramatic nature of acts), proximity of those involved, and prevailing social consensus all play a role. Surveillance and availability of collaborators also seem to matter. Jones is particularly concerned over asymmetries in status such as those that exist between a lawyer or business executive and their clients; and he suggests that professionals—because they work in contexts where there is no immediate check on their work—are especially prone to moral challenges. McCabe

(2001) found that college students called before an ethics board but not disciplined were likely to be repeat offenders. The most definitive research on factors that contribute to moral gaps in the academic setting is summarized by McCabe, Butterfield, and Treviño (2006). Incidence of self-reported cheating is related to perceived likelihood of being reported, personal acceptance of academic policies, and estimates of how widespread cheating is among classmates. There seems, however, to be no significant association between cheating and perceptions regarding the severity of possible penalties.

The view of morality from the perspective of peer networks seems to be useful (Brass, et al, 1998). Zey-Ferrell and Ferrell (1982) found that beliefs by employees in organizations about how strongly they felt their colleagues valued corporate norms was a better predictor of their self-reported ethical lapses than the employees' own personal beliefs. Sheehan and others (1990) and Silver and Glick (1990) report that medical students and residents reflect, in their own moral frameworks, the abuse they receive during training. McCabe (2006) summarizes this view: "Observed peer behavior was the most important of the influences studied for all of the graduate students" (p. 300). This should be obvious in the case of collusion and other forms of collaborative dishonesty, such as fee-splitting. But it raises a challenge to understanding how to intervene to reverse the direction of moral decay. If, as Habermas (1990), Rest

(1986), and other moral philosophers suggest, moral failure is defined as action that damages those around us, how, at the same time, can the morals of those around us be the driving force for elevating our level of morality?

The power of the cultural context in moral matters affects both whether or not morality will be preserved and what will be done, or not done, when breaches occur. As a student wrote recently in the *Journal of Dental Education* (Koerber, et al, 2005), "Most people understand they are doing something wrong, but they don't understand the consequences of behaving unethically" (p. 214). There seems to be evidence (Andrews, et al, 2007) for the oft-told concern of students that faculty members overlook breaches of integrity. Only 63% of the surveyed dental students (and 42% of the faculty members) claim they support the academic integrity policies in place in their schools; fewer, 38%, believe these policies are effective in managing cheating. (To be fair to faculty members, they blame the administration, and the administration blames society.) McCabe (2005) expresses the problem in these terms: "Each campus constituency tends to shift the 'blame' for cheating elsewhere" (p. 28). A faculty member at Rutgers (Puka, 2005) recently had the courage to defend in writing his view that the system is so broken that students should be allowed to cheat if they want to.

Whistle-blowing is a mixed virtue. Trevino and Victor (1992) found that business school students viewed colleagues

who report cheating as ethically ideal but disliked. In the study by Andrews and colleagues (2007), only 47% of students agreed with the statement that "students should be held responsible for monitoring other students." The analogy would be that audible flatulence in church is impolite; but it is a worse offense to point it out. Schrader (1999) notes that "most students resolve dilemmas by letting the issue drop, by doing nothing, by going along with the situation or with others in it, and by letting the problem resolve itself" (p. 48). We have already considered Carol Gilligan's work with women where identifying and validating the concerns of those who might be hurt in a moral crisis is considered by many to be the purpose, the final resolution, of moral issues.

The final piece of data comes from a dental school study where the question was asked "Why do you believe your classmates cheat?" Fourteen percent said it was to get ahead, improve class rank, etc. About a quarter each attributed cheating to fear of failure and physical opportunities being made available. Not being prepared, needing to catch up, and being pressured were mentioned by about four in ten students. The most common motive for academic dishonesty, mentioned by 51% of the dental students, was lack of respect for the system. This is the cultural context argument blown up to rather large proportions. Students seemed to be saying "A system that I regard as being questionable has only weak claims on my behavior when there is so much at stake." Students felt that 94% of their classmates were engaged in cheating. This study was conducted thirty years ago (Fuller and Killip, 1979) and the respondents are now entering the prime years of their practices. Similar findings emerged twenty years earlier in the study conducted by Douglas More and commissioned by the American College of Dentists.

WHAT WE FOUND BEHIND DOOR #5

What can be learned in a general way about morality by looking at research on how professionals actually behave?

- e. Perhaps the most meaningful lesson is that people are not all good or all bad; in fact, they may not even be consistent across opportunities or across times. Our understanding of moral action is enhanced if we also know the context in which the person is behaving. Perception of peer values and organizational norms are powerful stabilizers of moral activity. Our attention is thus drawn to the entire peer group and we should begin to inquire into the potential for moral behavior generally in a community. The "bad apple argument" is too limited; we must at least be willing to consider a few "bad barrels" as well.
- f. The realization is inescapable that moral integrity is a porous concept. Opportunistic behavior is arguably the norm among professionals. Most of us are facile at rationalization. It is unlikely that we will be able to address moral weakness as long as we continue to think of it as being clear-cut, localized, and only needing spot attention to address unambiguous violations.
- g. While we are fixated on the fact that professional behavior is opportunity in a situation-specific fashion, a new issue begins to take shape in the background: why is such widespread moral weakness accepted? Equivocation is the dominant response to being confronted with concrete instances of moral lapses or with wholesale characterizations of professional culture as being morally soft. It seems to be easier to agree on ethical theory than to take moral action.

- h. Finally, professional amorality begins to look less and less like a matter of finding and punishing individual transgressors. Have we not overlooked chances to raise the level of concern for our fellows, contribute to the common good, and build communities where we can all thrive? Morality has become a question of how far down will we allow individuals to go (negative morality) rather than how far up we can rise as a community (positive morality).

DOOR #6: PERFORMANCE LANGUAGE

True philosophers get heartburn over the descriptive morality of the previous section. “How,” they ask, “can various descriptions of what people do be used as a basis for deciding what they should be doing? Just because people act a certain way does not mean that is the right way to act.” In fact, this mistaking what is for what ought to be has a special name: the “naturalistic fallacy.”

We saw behind the first door in the previous essay (principles approaches to ethics) that given situations are open to multiple interpretations, some of them leading to conflicting courses of action. There is also the problem that clear ethical understanding does not necessarily lead to behavior that is consistent with that insight. But the wobble between ethical theory and moral behavior is even greater than that. The deontological ethicists, those who hold that good intentions are the basis for ethics—duty ethics and casuistry—face the problem of uncovering the true motivation for behavior. William Jennings Bryan noted that “it is a very poor mind that cannot think of a good reason to do what it wants.” Good lawyers and press agents can be hired if extra help is needed.

Even those who act from the purest of motives cannot be distinguished with any certainty from those with a clever justification, thus making each individual the only true judge of ethics on the ethics-as-duty view, and then only for himself or herself. Of course, this is an unacceptable position, and we have to find some way to protect ourselves from it.

Here is the problem expressed as a little story. The instructor stood in front of a philosophy class I was taking many years ago. I thought he had a bit of a smirk on his face as he gestured toward the blackboard and asked in a challenging way, “What is this? It is right in front of you. Just tell me what it is.” He was pointing toward something that looked like a straight vertical line followed by, but slightly detached from, something that looked a bit like a three. Finally he said he would give us a hint. Evenly spaced in front of the ambiguous figure he clearly made an 11 and a 12; then to the right, again evenly spaced, he made a distinct C followed by a D. Soon the game lost its interest. In triumph, the professor announced that the “it” he was pointing to was a blackboard. He might as well have said “this” is a figure, a game, a gesture, the end of my finger, or even “this is not a hippopotamus.” All of these descriptions are equally correct in theoretical terms, and some sort of context might be cooked up to make many of them reasonable. This is called the problem of indeterminacy of designation. That is a fancy way of noting that there is no one-to-one correspondence between the real world and our interpretation of it. Every description is not meaningful—the professor could not have convinced us that he was pointing to a hippopotamus—but there remains a very large, if not infinite, number of plausible interpretations for any given situation.

The definition of immoral does not mean ungrounded in ethical principles; it means failure to make or follow through on promises that build community.

MORAL CONSCIOUSNESS AND MORAL COMMITMENT

This matters a lot in the relationship between ethics and morality. The “it” we are interested in might just be somebody’s conception of an ethical ideal, as in “it’s just the right thing to do.” The way the problem is framed makes a difference in how it is approached. Ethical disagreements that arise so often when considering dilemmas are likely to be traceable to individuals who agree substantially on their ethical positions but interpret the case differently. Alternatively, individuals may agree on the ethical principles involved in a case, but only one of them will act based on those principles. How can we bridge the gap between ethics and morality?

Sometimes it happens that the situation can be reframed to ensure an ethical interpretation that justifies a predetermined favored course of action—or most often principled prevarication. This is called an ethical rationalization. Carol Gilligan's famous case study of women facing decisions on abortion illustrates the tenuous relationship between ethical interpretation and moral action. The stories are heart wrenching for the complex tossing and turning the women engage in. The common denominator in the ethical resolutions is distress over realizing that there is no solution that avoids having to hurt someone (but only in one of the cases Gilligan reported was the fetus mentioned). Five of the eleven cases described in detail were women who were choosing a second or third abortion or who had subsequent abortions. It appears that an individual can be deeply, totally engaged in an ethical decision, and even do things, without there being a clear sense of moral action.

A parallel situation exists in dentistry. As part of the initiative of the American College of Dentists to raise awareness of the damage caused by fraud and quackery, a colleague and I crafted a case where a dentist recognizes gross and continued negligence in the care rendered by a colleague. The case was engaging in the traditional sense that students and dentists could recognize principles such as nonmaleficence and fiduciary responsibilities to patients. But problems arose when the same case was presented in terms of moral action. We asked what the ethical dentist should do in this case. Many said some action was necessary, but the natural of the actions tended to be vague. There were always some practicing dentists who felt that the

ethical dentists should avoid taking any action. Because this was puzzling, we asked the “no action justified” dentists, who included officers in organized dentistry, to explain their framing of the issue. “You can't tell if the patient is lying” and “perhaps there is something going on in the referring dentist's life” were examples of ethic reframing. We incorporated each of these objections into new versions of the cases. For example, multiple sources of the complaint were introduced, each from personal friends of the ethical dentist who were upstanding members of the community, emphasizing the repeated nature of the abuses. This did not do the trick—even when the cases were presented to the objecting dentists in versions that specifically addressed their objections. Some people are just not going to take moral action—regardless of how fully their conscience is filled with ethical conviction.

This does not amount to nihilism—“there is no rational order in the world, so who cares.” Nor do we have to put up with ethical relativism—“each person is his or her own ethical standard.” We are, however, pretty much locked into pluralism. Ethical pluralism is the position that, for each situation, some interpretations are untenable, but there may be more than one acceptable alternative. Moral pluralism defines a moral space, ruling out many unacceptable courses of action, but leaving in one or more morally required courses of action. Additionally, the moral space has fuzzy borders and sometimes an ambiguous relationship with ethical theory. But there is a bridge, and we turn to that now.

MORAL PROMISES

A remark that sounds very much like Lewis Carroll is “I don't know what I mean because I haven't said it yet.” Language is the key to grounding moral behavior in ethical theory. It is the bridge we have been looking for. Sometimes,

language is used to describe the situation as it is seen. The dentist says, “I see a little spot on this radiograph.” (Actually, the dental assistant could say this as well and may be the one who draws it to the attention of a dentist who has overlooked it.) The dentist can also say, “This is caries and your insurance company will pay a certain amount as reimbursement for repair if I tell them it is.” (The assistant certainly cannot say that.) The first example is descriptive language; the latter is performance language. Performance language actually does something. It creates actionable categories that change someone's or something's status; it commits the speaker to a course of action.

The difference between descriptive and performance language can be seen in the analysis of ethical dilemmas that are used in teaching situations. Those discussing the case in class may bring up alternative analyses and demonstrate good knowledge of ethical principles. When asked to switch roles from an abstract observer to take a position within the case (for example, “What would you actually say to the patient if you were the dentist in this case?”), some participants can make this role change while others cannot. Some will say, “Mr. Black, I recognize your desire to have these teeth removed based on what happened to your parents. But those teeth are sound, and as a professional I value preserving health. I would be happy to work with you so you have the strongest teeth and healthiest mouth possible, if that is what you would like.” Others dodge the issue, saying, “I would want the patient to understand that my own autonomy has to be part of the solution too. But I don't want to say anything that would offend the patient because he might just go to a cheapo clinic and get them all out.” The first

response is “in the case,” the second is “about the case.”

There are three important differences between descriptive and performance language. First, descriptive language is theoretical, reversible, and conditional. Its truth or utility depend on perspective and that is open to interpretation. Multiple interpretations of the context are possible, so several descriptions are plausible, as in the illustration of the professor and the blackboard. Inconsistent potential actions can be countenanced simultaneously. In the example above, the dentist wants both to decline the patient’s wishes and at the same time avoid “losing” the patient. These inconsistent hopes can be maintained as long as the case is being “described.” By contrast, performance language represents an actual and irreversible behavior. After having told the patient that the dentist will not extract vital teeth, he or she could not very well say, “That was only a theoretical statement and now we can talk about other possibilities.” Descriptive statements could happen; performance ones happen as soon as they are stated. That is why some of those considering ethical dilemmas prefer to remain at the theoretical level, or may even be incapable of actually taking a moral stance.

The second difference concerns perspective and responsibility. Descriptive statements are true or false based on conformance to abstract and general standards. “Failure to obtain informed consent is a breach of patient autonomy no matter what the circumstances or the parties involved.” One would always be correct in making that comment, in a general sort of way, even if it had no bearing on whether or not a particular dentist should obtain informed consent in a specific case. Moral claims must be personally redeemed. In performance language, one only and always speaks for himself or herself. What makes the

moral claim “I should ensure informed consent” true or not is no longer the ADA Code of Ethics but the speaker’s behavior. Taking a moral position through performance language makes the speaker responsible. That is why some of those considering ethical dilemmas prefer to remain at the theoretical level, or may even be incapable of actually taking a moral stance.

The third difference between descriptive and performance statements concerns relationships. Descriptions interpret what appears to be going on between individuals; performance language creates relationships. Descriptive language talks about a slice of the present as a specimen. When we listen to discussions of ethical cases conducted at this level, we draw conclusions about the speakers, such as, “Boy, she sure knows the codes and ethical principles,” or, “I feel uncomfortable with his view of the world,” or, in the case mentioned above regarding extractions, “The speaker seems to be waffling because there is no way to have it all.” Ethical analysis provokes judgments about the speaker. By contrast, performance language creates expectations about mutual futures—without being judgmental. The dentist who engages the patient who wants to have all his or her teeth removed by offering to work together is making a commitment to future actions that involve both parties. It is a promise that the person to whom the performance language is expressed can count on certain behavior now and to come. On this line of reasoning, the definition of immoral does not mean ungrounded in ethical principles; it means failure to make or follow through on promises that build community when they are needed. That is why some of those considering ethical dilemmas prefer to

Descriptive statements could happen; performance ones happen as soon as they are stated.

remain at the theoretical level, or may even be incapable of actually taking a moral stance.

Moral behavior includes physical acts such as charity dental care and establishing office hours that are convenient for working single mothers. These may not be performance language in the conventional sense of making speeches, but they carry the same impact of responsible communication intended to make a better community. The phrase “to take a stand” derives from the practice of standing up to be counted as taking a position. Serving on a peer review committee, questioning a colleague about his or her practice seeming to move away from traditional health values, or speaking at a White Coat Ceremony are moral acts. So is writing an editorial. Any pronouncement intended to build a moral community that publically commits the speaker to a positive role in that community is a moral act. Analyzing an ethics case or developing a personal philosophy is not.

The universal moral question sounds something like this: "I would like to talk with you about what I see as an opportunity for you and me to work together for a future that benefits all of us."

The moral question and the ethical one are different. Ethics is the study of right and wrong and the job is finished when a correct sorting of possible positions has been made and, even better, when some rules have been framed that facilitate this kind of sorting. If done well, there should be an element of certainty in this work. Moral positions are anything but certain; they are based on faith and courage that a process should be followed—a tool rather than a rule. The moral question is, "How can I get into a conversation about improving community?"

The universal moral question sounds something like this: "I would like to talk with you about what I see as an opportunity for you and me to work together for a future that benefits all of us." Note that this statement does not presuppose a correct position, although it makes the speaker responsible and implies that a better condition (not the perfect one) would involve several people. Note also that the speaker is not required to assume an ethically complete or superior posture. Taking moral positions always makes one vulnerable. One need not be a philosopher or even a saint to engage in moral action; but it sure helps to have courage.

WHAT WE FOUND BEHIND DOOR #6

Language approaches to ethics are new philosophical methods. It may seem paradoxical that talking is the bridge between realizing what is right and behaving morally. What are some of the conclusions that can be drawn from this distinction?

- i. Ethical analysis is certainly not a moral behavior. When philosophers do it, it is an academic discipline.

When students do it in an ethics course, an interview, or any other artificial situation where they are describing what is happening, they are engaged in school work. When we point out the ethical lapses of others or propose changes that we would like to see others bring about, that is homiletics or moralizing. When we rehearse ethical justifications for actions we have already taken or would like to take in order to clothe our actions in respectability, that is faux ethics.

- j. True moral behavior is making promises or letting others believe that we have made them. Sometimes this involves specific language, but more commonly we use acts or assume roles that de facto carry legitimate expectations. Whenever others can reasonably be expected to count on us in the future to redeem these promises for the mutual benefit of all concerned, we have made a promise and have acted morally. When there is uncertainty about this kind of understanding, we need to talk about it. But in all cases, we speak in the first-person singular. There is no morality without an "I": there is no safe, universal perspective.
- k. Because morality is about relationships and about the future, there can be no certainty. Courage is required. One of the surest signs that one is not behaving morally is to approach others with a precondition that you will be right. The proper attitude is that you are willing to work with others to try to make things better; time and your joint efforts will tell. This is not ethical judgment (the application of right and wrong) but moral engagement (the discovery and creation of better communities).



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RECOMMENDED READING



Summaries are available for the recommended readings marked by asterisks. Each is about eight 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 donation to the ACD Foundation of \$15 is suggested for the set of summaries on moral action; a donation of \$50 would bring you summaries for all the 2007 leadership topics.

Austin, J. L. (1962).

How to do things with words.

New York, NY: Oxford University Press.

Austin argues that certain types of statements “do” something rather than merely describe. “I offer to pay \$1M for the house” or “The jury finds you guilty” are examples. The book is an analysis and classification of such statements, which Austin calls performatives. The meaning of performatives is in their impact on listeners, not in their being true or false.

Donaldson, T., & Dunfee, T. W. (1999).

Ties that bind: A social contracts approach to business ethics.*

Boston, MA: Harvard Business School Press. ISBN 0-87584-727-7; 306 pages; about \$30.

This theory of business ethics is based on an assumption of a growing consensus around hypernorms that all would agree to (although the authors do not identify these norms). Under these hypernorms is “moral free space” in which we are at liberty to make private arrangements within moral communities (such as firms). These norms are authentic when approved by a majority of members but are binding on all. The two major protections for members of communities is voice (freedom to speak up) and exit. There are suggestions for resolving various types of conflict. The program is called Integrative Social Contracts Theory (ISCT). “Business ethics, we assert, is more a bundle of

shared understandings than a set of fixed pronouncements. It exists as a rich and at times even internally inconsistent mosaic. Business ethics should be viewed more as a story in the process of being written than as a moral code like the Ten Commandments” (viii).

Gilligan, C. (1982).

In a different voice: Psychological theory and women’s development.

Cambridge, MA: Harvard University Press.

Detailed reporting on studies of women making decisions regarding abortions and analyzing hypothetical ethical dilemmas intertwined with commentary from one of the founders of critical theory from the women’s perspective.

Habermas, J (1984).

The theory of communicative action.

Boston, MA: Beacon Press.

This is an application of performance language to social and political institutions, with a very high standard that all those affected by moral decisions should have an opportunity to participate in discussions about what counts as good. This is tough reading: two volumes translated from the German and extremely wide-ranging.

MacIntyre, A. (1966).

A short history of ethics.*

London, UK: Routledge.

ISBN 0-415-28749-9; 273 pages; about \$15.

This is not a summary of various ethical theories; it is an exposition and critique of major and minor positions that reveals shifts over the centuries in the framing of ethical problems.

- a) Tribal Greek (900 BC)—ethical as fulfilling one's role in tribe;
- b) Socrates and Plato (450 BC)—unsuccessful search for an abstract sense of the good;
- c) Aristotle (350 BC)—virtue consisted of fitting in with the upper class in a closed society;
- d) Christianity (until 1500)—loyalty to unjustified principles in a world that was dangerous and offered no opportunity for success;
- e) Luther, Hobbes, Spinoza (1550)—individual emerges as owing allegiance of faith to God and political allegiance to ruler;
- f) Age of Reason (1600s)—rise of science and beginning of middle class give rise to notion of natural rights of man, beginnings of ideal of liberty;
- g) British Enlightenment (1700s)—men can decide what is right as part of their civil government;
- h) French Enlightenment—men can create moral societies;
- i) Kant (1780)—ethics can be defined as a rational abstraction;
- j) German Idealism (early 1800s)—the state becomes or can become the dominant moral agent;

- k) late German Idealism (late 1980s)—individual moral life becomes meaningless;
- l) English nineteenth century—dominated by social reform programs with moral underpinnings such as utilitarianism (the greatest good for the greatest number); and
- m) modern English thought focuses on reforming the moral question and trying to get precise about the language used without taking positions about how individuals or groups should behave.

Reimer, J., Paolitto, D. P., & Hersh, R. H. (1982).

Promoting moral growth: From Piaget to Kohlberg (2nd Ed).*

Long Grove, IL: Waveland Press.

ISBN 0-88133-570-3; 285 pages; about \$20.

Kohlberg used observations of psychological development of boys and young men to develop a theory that the cognitive capacity to reason about moral issues develops through two stages at the preconventional level (rewards and punishments) to two stages of a conventional level where morality is considered in light of social norms. He also suggests two additional stages at the postconventional level based in philosophical reasoning, although there is little evidence that this is obtained by many individuals. The authors began working with Kohlberg in 1976 teaching moral development.

2007 MANUSCRIPT REVIEW PROCESS

Nine unsolicited manuscripts were considered for possible publication in the *Journal of the American College of Dentistry* during 2007. Four manuscripts were returned to their authors as being inappropriate in topic or format for the journal. Of the five sent for full review, two were accepted for publication, one following extensive revision. Twenty-five reviews were received for the reviewed manuscripts, an average of 5.0 per manuscript. Consistency of reviews was determined using Cramer's V statistic, a measure of association between review recommendations and the ultimate publication decision. The Cramer value was .764, where 0.00 represents chance agreement and 1.00 represents perfect agreement. The College feels that authors are entitled to know the consistency of the review process. The Editor also follows the practice of sharing all reviews among the reviewers as a means of improving calibration.

The Editor is aware of six requests to reprint articles appearing in the journal and eight requests to copy articles for educational use received and granted during the year. There were two requests for summaries of recommended readings associated with Leadership Essays.

In collaboration with the American Association of Dental Editors, the College sponsors a prize for a publication in any format presented in an AADE journal that promotes excellence, ethics, and professionalism in dentistry. Nineteen manuscripts were nominated for consideration. The winner was a discussion regarding "Blurring the lines between

general dentistry and dental specialties" written by Dr. Eric Curtis and appearing in the July 2007 issue of *AGD Impact*. Fifteen judges participated in the review process. Their names are listed among the *Journal* reviewers below. The Cronbach alpha for consistency among the judges was .862.

The College thanks the following professionals for their contributions, sometimes multiple efforts, to the dental literature as reviewers for the *Journal of the American College of Dentists* during 2007.

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