



Journal *of the* American College *of* Dentists

YOUNG PRACTITIONERS'
PERSPECTIVE ON
DENTISTRY

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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.

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

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

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Correspondence relating to the *Journal* should be addressed to:

Managing Editor

Journal of the American College of Dentists

839J Quince Orchard Boulevard

Gaithersburg, MD 20878-1614

Business office of the *Journal of the American College of Dentists*:

Tel. (301) 977-3223

Fax. (301) 977-3330

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A young practitioner considers her professional future.

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FROM THE EDITOR

Police Work

The impact comes in the massive attention to character before formal education and the constant character checks that are part of practice.

Following the ACD/ADA meeting in Honolulu, my wife and I relaxed in Maui. This included a day trip to the small island of Molokai, where I spent some quality time in the police station. Of course, it was all voluntary. I had noticed on Oahu that patrolmen had a friendly, but vigilant relationship with the great diversity of people they encountered. These are professionals, trained to know all the rules and armed in a way to enforce them, spending most of their time preventing the need for enforcement by making constant, small adjustments at the margins of social relations. It seemed that their skill is substantially to guide acceptable behavior rather than to wait until the heavy hand of correction becomes necessary.

“Our authority is drawn nearly 100% from the public trust and confidence we can earn.” That is the opinion of Chief Brett Sackett of the small town of Sonoma, California, where I live. “An officer can know everything there is to know about the science of law enforcement,” says Sergeant Timothy C. Meyers, Sr., of the Molokai substation of the Maui Police Department, “and yet fail in the field. We provide a public service, not a private one.”

The police officers I speak with know in a twinkling what I am talking about when I mention professional ethics. They quote liberally from their ethics codes and volunteer copies of them. It is good stuff, although there is nothing in any I have seen about catch-

ing bad guys, punishment, cleaning up the neighborhood, or using force.

“Domestic violence is one of the most difficult situations our officers face,” reported Sergeant Meyers. “I could teach you the law and the protocol we follow. But it takes years of experience to become predictably effective in those situations.” Chief Sackett agreed, adding that these responses are often complicated by late hours, the buildup of dysfunctional interpersonal exchanges, substance abuse, interference by friends and family, and the potential for violence redirected toward those who intervene. A narrow focus on the literal law can sometimes work against any effective response, especially if the officer lacks the perspective that comes from experience. It is not police theory or kibitzing about what should have been done, but action in the heat of the moment is what counts.

“The essential thing,” Chief Sackett says, “is for officers to be able to respond to a huge range of people and situations on their level; it’s the ability to begin where the other person is. Sometimes officers, who are very skilled in other ways, just can’t quite get the knack of working within the law at the same time working with all citizens, including some very challenging ones, in the pressure of the moment. We have to

reassign these officers.” Chief Sackett smiled at this point and I had to prod him to complete this thought. “I guess doctors can’t really reassign themselves if they find it difficult to work with some patients, can they?”

I have begun to form the impression that police work is grounded on character rather than expertise. Obviously that has much to say for ethics. Ethical dilemmas and codes in dentistry lean heavily toward matters of correct technical judgment. In police work the concern is more in the direction of potential abuse of the power of the badge. In more than 40 years working with dentists, I have never heard the term “temptation” used. It is not that dentists are above temptation; it is just not the way they look at ethics.

Because character matters so much in police work, I was not surprised to find that it plays a very different role there than it does in dentistry. There is probably the same tiny fraction of didactic work devoted to ethics in police academies as there is in dental schools. The impact comes in the massive attention to character before formal education and the constant character checks that are part of practice.

Almost all police officers are hired before they attend formal training; their first job assignment is to go to school. But the process begins with interviews; tests of general knowledge and skills; background checks with banks, the IRS, or former girlfriends; polygraph tests; thorough medical examinations; and a

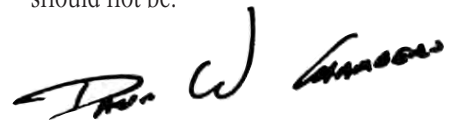
complete battery of psychological testing. No, there is no paper and pencil or OSCE-type test for ethics. The easy part is to pick out those who lack the interpersonal skills to present themselves as positive social beings. The critical part is to determine whether candidates can articulate a coherent story about who they are that is consistent with everything else that has been discovered about them in the background investigation. This is consistent with Mickey Bebeau’s work showing that dentists with disciplined licenses have a poorly developed sense of professional identity. With more than 100 applicants for every position, police departments can be very selective in whom they choose to send for training. But, note, it is the districts (the communities to be served) that do the character screening, not the schools.

The first months on the job are like the dental professional’s associateship informal residency program. New officers learn their standards by being paired with experienced officers on the job. The difference is that they spend some time working with all competent officers in a department. It would be something like a new dentist coming to a town to practice and spending two months with each of a representative handful of practitioners in the community.

Another difference is peer review. All activities involving police officers are documented in reports, much in the

manner of dental charts. The difference is that all reports are read by a minimum of two levels of reviewing officers. The duty sergeants read all officer reports, and lieutenants or chiefs review reports based on criteria such as perceived officer competence or community concern. Specialty units may also review reports for trends. Reports are automatically rolled up into summaries and predetermined trigger points, such as the number of DUIs over threshold, automatically activate response plans. (This is sort of like Evidence-based Policing, except that it is mandatory and based on actual outcomes rather than theory.)

There are differences between dentistry and police work in the way ethics is understood and implemented in the two professions. Perhaps there should not be.



LETTERS TO THE EDITOR



To the Editor:

If a dental student engages in a significant rule breaking activity, he or she may be removed from school but is not likely to go to jail because the student is only guilty of professional misconduct. If a dental student went into a store and forced the owners to hand over money, and if he or she was subsequently caught, the student would be charged with a criminal felony. When a dental student steals an exam and is caught, he or she is charged with "professional misconduct" rather than criminal theft. A student crook becomes a professional "misconductor." These are among the thoughts that occurred to me as I read the paper on "Academic Integrity in Dental School: A Call to Action" in the summer issue of the *Journal of the American College of Dentists*.

In our country, competitive people find ways to keep score in different ways. It may be how much money a ball player earns or how many second homes a CEO owns or how many expensive automobiles an entertainer has. Actually, even dental researchers keep score by the number of papers they have published. After every financial crisis or corporate fiasco, the government institutes rules and law changes that increase the cost of doing business to

prevent people from doing bad things. It never prevents new bad practices evolving.

Students today have to be very competitive to get into dental school. Those students looking ahead to post-graduate education will find ways to compete even in the presence of pass/fail grades. They will find ways to set themselves apart from the rest of the class. Some will do twice the number of prosthetic procedures needed to demonstrate that they have above average skills to gain acceptance into a prosthetic specialty program. Others may do research papers in periodontal disciplines to demonstrate above average scholarship. Changing grades to pass/fail will not, in my opinion, change the behavior of dental students in the presence of a society that has overriding societal cultural defects. When students arrive at dental school they are already jaded by the examples set by their parents and society. They harbor corrupted values, often without knowing that their values are corrupt.

Eliminating grades and replacing them with pass/fail letters will likely induce some specialty programs to develop new entrance exams, especially if National Board scores are also converted to pass/fail. It is not possible to eliminate competition by issuing a new fiat. What about the new training teachers would need to learn about criteria changes to determine if a student passes or fails? Or do they keep a secret score which will remain unknown to the students and which will be the basis for determining who passes or fails?

And if somehow we managed to significantly changing the overall culture of dental education to curtail unethical behavior, how well would the new, noncompetitive, super-ethical dentist function in the real world? Out here dentists compete with each other for patients and procedures. There are people with poor ethical values who compete using unethical or illegal maneuvers. If the grading system in dental school changes to pass/fail then the law of unintended consequences will take effect.

Perhaps a better alternative would be to spell out or list for the students which behaviors are not acceptable and what the consequences would be if violations occur. And when students develop more creative nuances of unethical behavior, the list of unacceptable activities would be expanded. There is always a fine line between unethical behavior and illegal behavior. Might it not be better to punish those who violate ethical standards while still in training? In that way they could be prevented from continuing their unethical activities after graduation.

Stanley Markman, DDS, FACD
Fort Lee, New Jersey
stano.markman@verizon.net

It is not possible to eliminate competition by issuing a new fiat.

I often get the uneasy feeling that the dentist whose work is being challenged has “done this before” and has this time been found out.

Dear Dr. Chambers,

Cheating in dental school: how dumb is that? As a former instructor in dental school, a hygiene program, and director of a dental assisting program many years ago, I was shocked as I read the article, “Academic Integrity in Dental school: A Call to Action,” which appeared in the *Journal of the American College of Dentists* issue dated Summer 2009.

What is happening to us? Yes, I know that cheating exists in society, and probably always has. But if you’re in dental school to learn how to treat all aspects of patient care, including hands-on treatment, why in the world would you not want to learn all aspects of didactic and practical treatment? How does a dental student expect to pass the board exams if that student has not studied hard with other students and practiced on mannequins until he or she “gets it right”?

Further, as an expert witness for a number of attorneys in several states, I can see a huge can of worms if students who cheat graduate from dental school, cheat on the state and national board exams, and continue cheating in practice. Place a non-precious crown and charge for gold? Only polish teeth and charge for complete Perio treatment? You take it from there...

Based on the malpractice cases I have examined over the years, I often get the uneasy feeling that the dentist whose work is being challenged has “done this before” and has this time been found out. How many other patients have been mistreated or fallen through the cracks?

Dentistry is truly a noble profession. But what has happened to society to encourage people to think that academic integrity only applies to the other person? It disturbs me even to feel the need to comment on an article such as this. But I am glad someone wrote it.

Norton Bicoll, DDS, FACD
Albuquerque, New Mexico
(505) 466-4854

DON'T JUST SIT THERE

Thomas Wickliffe, DDS, FACD

ACD PRESIDENT-ELECT'S ADDRESS

OCTOBER 1, 2009

HONOLULU, HAWAII

Fellows, spouses, and guests of the American Colleges of Dentists: good morning and welcome to this, our 89th meeting! To you new Fellows in the audience, I take my hat off to you and your accomplishments. To have been invited to Fellowship in this group means that you are a leader in our profession and your community.

When I received my invitation for Fellowship, I had only a general idea what the American College was and what it stood for. I quickly learned that within the membership were all of my heroes in dentistry. My mentors and those I respected the most were all here. WOW, what a group! I was even more impressed to learn that only about 3% of all dentists are invited to Fellowship.

As a matter of historical perspective, the American College was formed in 1920 to "cultivate and encourage the development of a higher type of professional spirit and a keener sense of social responsibility throughout the profession." As you are all well aware, that concern and need still exists today. The American College is the group that has made and will continue to make a difference for our profession, and you are the individuals that will get it done. You are truly very special people and part of a very special group. Congratulations on your past achievements. I urge you to use your leadership skills to continue to carry out the mission and goals set forth by the founders of the College.

LEADERSHIP IS ACTIVE

To quote one of my favorite philosophers, Will Rogers, "Even if you're on the right track, you'll get run over if you just sit there." I assure you that the American College of Dentists is on the right track. At the national level, thanks to a very strong and efficient Central Office and to the decades of outstanding leadership from past officers and regents, the ACD is a very proactive and effective organization. Our Executive Director, Dr. Steve Ralls, and his wonderful staff have organized a quiet revolution. They have elevated us into the computer age. Information has been organized and put into a format that is available to all of us.

Dr. Ralls has, during his excellent orientation presentation, spoken to you about what the College does. I would like to repeat a few things for emphasis.

The College has developed a series of online courses in dental ethics and professionalism. This series is available on the Internet to everyone, free of charge and for continuing education credit. This information is currently being used by several dental schools to teach ethics and professionalism to their students. A series of 52 ethical dilemmas that were first published in the *Texas Dental Journal* by the late Dr. Thomas Hasegawa have been digitized by the



Dr. Wickliffe maintains a private practice in pediatric dentistry in Billings, Montana.

Central Office and is available online for use by Sections and individuals.

A comprehensive leadership resource for dentists is also available online. This resource—which includes education, self assessment tools, and library modules—also has CE credit available. Dental History, our online multimedia dental history resource, is now available for download. For several years, this resource has been sent to all freshman dental students. If you are interested in the history of our profession, this resource will be of great value to you.

In addition to the many online resources available, the American College also distributes materials such: the Ethics Wallet Cards and *The Ethics Handbook for Dentists* to dental schools and other interested groups. My Montana Section this year used these materials to increase awareness of ethical issues in the state and to build recognition for the American College of Dentists. These were sent to all dentists in the state, both Fellows and dentists who are not Fellows.

The American College also is active in providing continuing education courses in leadership and ethical issues for its members. Some of these courses are being offered at this meeting.

The American College of Dentists actively recognizes the efforts of dental students, individual dentists, and groups that are making a difference in our profession. In addition to recognizing you new Fellows for all of your accomplish-

ments, several very special people who have made a difference to the College will be receiving awards this afternoon at our convocation ceremony.

Thanks to Dr. David Chambers, the College has an excellent journal. This journal, which is published quarterly, has a central theme for each edition. Issues are covered from a variety of angles and by a variety of experts who often have different opinions and conclusions. This approach occasionally creates controversy and always makes us think. Dr. Chambers's editorials are equally thought-provoking and analytical. Thank you, David, for a job well done!

The ACD leads the way in organizing other groups and communities of interest concerning ethical issues. The College has sponsored several Ethics Summits in the past ten years which included important and timely topics such as: Truth Claims in Dentistry, Commercialism in Dentistry, and Integrity and Ethics in Dental Education.

The current focus of the College is on a program called the Professional Ethics Initiative. The goal of this initiative is to improve the ethical climate of our profession and enhance its ethical base. It will encompass four areas of interest including: individuals, practices, organizations, and resources. The effort will be positive, striving to motivate and encourage appropriate ethical behavior. This

I urge you to get out
of your comfort zone.

The American College is the group that has made and will continue to make a difference for our profession, and you are the individuals that will get it done.

program combines many of the things that have been done in the past and places them into one organized effort with a defined focus. This initiative is being accomplished in conjunction with the ADA as well as several other interested organizations within our profession. This focused effort, like anything worthwhile, will require input and financial support from all of us.

YOUR PART

As you can see, the “mother ship” of the American College is strong and healthy and working hard to carry out our mission. We are on the right track and we are not sitting still. To be the most effective, however, the real strength must come from the Section level. Actually it is even more basic than that; the key is the individual! In my own experience as a Section Chairman for four years, a Regent for four years, and now as an Officer in the College, the thing that stands out to me is how important individual people are to the success of the organization. The Sections that are most active in sponsoring new Fellows or creating effective new projects can usually point to one person who “got the ball rolling” or “picked up the ball and ran with it.” The national organization can provide the necessary tools and ideas, but it is up to the individual to get the job done.

What a storehouse of tools and ideas we have available from the Central Office. To you Fellows who have been around for awhile, I know I’m “preaching to the choir.” You are here because you are committed to the principles and

mission of the American College. You are most likely sponsoring a new Fellow or are involved with the leadership of your Section. You know and understand that this is the group that is doing something about the ethical issues we see in our profession. To you new Fellows, I urge you to make that same commitment: become involved, ask for a job from your Section leaders and give it your best effort. Sometimes we have to move out of our comfort zones. Always keep in the back of your mind: “Even if you’re on the right track, you will get run over if you just sit there.”

My PART

To get to know me a little better, let me for a moment share some of the things that make me happy. We’ll call this my comfort zone. I very much enjoy being a pediatric dentist; I love the opportunity to interact with the children, parents, and staff in my practice. I am grateful to be a part of the dental profession and I’m grateful to be a Fellow of the American College of Dentists. I also love hunting, fishing, and backpacking; and I live in Montana, the perfect place to enjoy the peace and solitude of the great outdoors. Again I am grateful.

A couple of years ago, my wonderful life partner, Peg, who knows I love bluegrass music, gave me a banjo for Christmas. Starting from ground zero—and I mean zero—I’m very slowly learning to play. I will never be a “player,” but for me pickin’ is one of the greatest stress relievers I have found. I am grateful to Peg and her generosity and wisdom. I am also grateful to Peg for one of my greatest joys, our grandchildren. We are now up to five, and they are of course the brightest and the cutest kids in the world! I am a very lucky guy.

Another comfort in my life is cooking and eating good food and the occasional Bombay martini; I'm grateful for life's simple pleasures.

Those of you who know me are aware that I am a very shy person who is most comfortable off in a corner visiting with one or two people. Let me tell you that speaking before this group of the best of the best in our profession is as far out of my comfort zone as I can get. In spite of that fact, I promise that I will do my best to serve you and this great organization. I urge you to get out of your comfort zone and make a similar commitment. If we are going to make a difference, we need each of you.

One of the things that we as individuals can do on our own is help provide financial support for the College. We must build a foundation for the future. The American College of Dentists Foundation is the financial arm of the College, and it provides the resources necessary for the organization to carry out its mission through the many programs that were discussed previously. The system works now, however a healthy endowment is vitally important for continued success into the future. I challenge each of you to become a Gies Fellow or a Gies Benefactor. To those of you who have already made that commitment, I say "thank you."

For me, becoming a Gies Benefactor had an added benefit. I was able to create a named fund to honor a person who has had a great influence on my life. Dr. James Roche was the chairman of my pediatric dentistry graduate program at Indiana. He is my mentor and dear friend. I learned not only the excellent professional skills that the school is known for, but also ethical principles, especially concern for the welfare of our patients. Even today, he is still riding along on my shoulder and he helps me try to make the correct decision. I was very fortunate to have had this influence

in my life. As a result of this experience, I am convinced that there is no better way to learn ethics than from a mentor.

Mentoring is another focus of the American College, and it is hoped that every Section has a mentoring program as part of its list of Section projects. Mentoring is also another one of the things that we can do as individuals. Again, I call on all of you to share what you do in your practice and in your life with "the new kids on the block" in our profession. Let them see ethics in action. Your involvement will have a powerful influence. "Even if you are on the right track, you will get run over if you just sit there."

Conclusion

In conclusion, I would like to thank a few of those people who have provided encouragement and support during my tenure in the American College. Dr. Gayle Roset was Secretary-Treasurer and Newsletter Editor during my years as Section Chair. He always worked to make me look good and I often received credit for things he had done. Thank you, Gayle. I am also grateful to all of the Fellows of the Montana Section. It was a very proud and emotional moment for me when the Montana Fellows created a named fund in my name. Wow, what an honor!

My heartfelt thanks go out to all of the past Regents and Officers that I have served with during my time on the Board of Regents. This group is hard-working, committed to the mission of the College, and respectful of each others' opinions. It has been a pleasure to work with all of them. I am also grateful to the past Presidents; I have learned much

from each of them. I am confident that their influence and support will help me tremendously during the year ahead.

Our current president, Dr. Max Martin, deserves a special thank you. His professional, sincere, and thoughtful approach has proved to be very effective for both connecting with people and getting things done. He has represented us well as our President. Thank you, Max!

Our wonderful administrative staff, Dr. Steve Ralls, Karen Matthiesen, Paul Dobson, Monique Prather, Erica Royal, and Sarah Shriver also deserve recognition. This hardworking, dedicated team makes the job easier for every member of ACD.

I am grateful for the opportunity you have given to me to serve as President of the American College of Dentists. I promise you that I will do my best. Again, I congratulate all of you new Fellows. This is your day! We are here to recognize and celebrate all of your achievements. Please remember, as you continue your involvement in the College, "even if you are on the right track, you will get run over if you just sit there." ■

2009 ACD AWARDS

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 American Dental Education Association (ADEA) as the recipient of the 2009 Ethics and Professionalism Award. Accepting the award on behalf the association is Dr. Richard W. Valachovic, Executive Director.

The American Dental Education Association is the sole national organization representing academic dentistry. ADEA members are more than 16,000 students, faculty, staff, and administrators from all of the U.S. and Canadian dental schools, many allied and postdoctoral education programs, and numerous corporations working in oral health education. ADEA has made a positive and meaningful organizational commitment to ethics. Activities and accomplishments

of the ADEA in the area of ethics and professionalism are summarized below:

- Developed the ADEA Code of Professionalism in Dental Education
- Maintains standing policies that address issues related to ethics and professionalism
- Formed the ADEA Presidential Commission on the Roles of Academic Dental Institutions and Access to Care
- Created the ADEA Leadership Institute which focuses on ethics and professionalism in leadership roles
- Developed curriculum guidelines on professionalism and ethics for dentistry and dental hygiene
- Dedicated an entire three-day ADEA Dean's Meeting to ethics (fall 2007)
- Developed a Statement on Professionalism in Dental Education (2009)
- Sponsored "Assessing Professional Ethics for the Developing Dental Practitioner," a faculty development workshop for the 2008 ADEA Annual Session
- Supported the American Student Dental Association in the development of its code
- Participates actively in the Professional Ethics Initiative
- Held multiple symposia, faculty development workshops, posters, and programs at ADEA Annual Sessions
- Published multiple articles in the *Journal of Dental Education*
- Developed competencies for the general dentist
- Recognized ethics as a funding priority for the ADEA Gies Foundation

The Ethics and Professionalism Award is made possible through the generosity of The Jerome B. Miller Family Foundation, to which we are extremely grateful.

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.



DR. ROGER W. TRIFTSHAUSER

Dr. Triftshouser is recognized for his broad, exceptional, and distinguished contributions to organized dentistry, dental education, research, 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. Dr. Triftshouser is held in the highest regard not only by his colleagues but also by his friends and associates. Dr. Triftshouser's record is summarized as follows:

- President, SUNY at Buffalo Dental Alumni Association
- President, Eighth District Dental Society

- President, American College of Dentists
- Board of Governors, New York State Dental Association (1990-1996).
- Delegate, American Dental Association
- Vice Chair, ADA Council on Governmental Affairs
- Chair, ADA 2nd Trustee District ADPAC Representative
- Fellow, International College of Dentists
- Fellow, Pierre Fauchard Academy
- Diplomate, American Board of Orthodontists
- President, City of Batavia, New York, Board of Education
- Chair, Genesee County Legislature
- Governor George Pataki's Special Assistant for Intercounty Affairs
- New York State Jaycees Distinguished Service Award
- Paul Harris Fellow, Rotary Club of Batavia
- Boy Scouts of America Silver Beaver Award
- Rear Admiral, Dental Corps, U.S. Naval Reserve
- Legion of Merit, Meritorious Service Medal, two Navy Commendation Medals

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.



MR. C. JAY BROWN, CAE

Mr. Brown has served as the Executive Director of the District of Columbia Dental Society for the last 27 years. He has instrumentally led the society from a small local meeting to one of national recognition among the top national dental meetings in the country. His dedication, political insights, vision, and impact are noteworthy and have strongly contributed to the society's development and the positive experience of the many dentists interacting with the society. Key accomplishments and credentials in Mr. Brown's career include:

- BA in psychology, Southern Illinois University
- MPH, University of Illinois School of Public Health
- Certified Association Executive
- Licensed Life and Health Insurance Broker
- Executive Director, District of Columbia Dental Society
- Assistant Executive Director, American Association of Oral and Maxillofacial Surgeons
- Assistant Director to the Department of House Staff Activities, American Medical Association
- Immunization Director, DuPage County Health Department, Wheaton, Illinois
- Director, Department of Health Education, Tazewell County Health Department, Pekin, Illinois
- President, Society of Constituent Executives
- Financial Services Quality Team and other duties, American Dental Association
- Numerous committees and assignments, Greater Washington Society of Executives
- Secretary-Treasurer, Rock Creek Palisades Citizens Association
- Delegate, Montgomery County Civic Federation

- Member, Board of Directors, Comprehensive Mental Health Board of Central Illinois
- Award of Merit, American College of Dentists
- Honorary Member, International College of Dentists
- Honorary Member, District of Columbia Dental Society
- Israel Shulman Memorial Award, Maimonides Dental Society



MS. ROSEMARY C. FETTER

Ms. Fetter has served the Dr. Samuel D. Harris National Museum of

Dentistry as Executive Director since its opening in 1996. During this time the museum has expanded its founding roles as a tribute to the history of the dental profession to become a nationally recognized educational resource and valued cultural asset. Her record of accomplishments is summarized below:

- Bachelor of music, with distinction, Eastman School of Music
- MFA, Tulane University
- MA in management, College of Notre Dame in Maryland
- Executive Director, Dr. Samuel D. Harris National Museum of Dentistry
- Worked to have the Harris Museum become an affiliate of the Smithsonian Institution
- Oversaw designation of the Harris Museum by Congress as the official museum of the dental profession in the United States
- Led development of a popular traveling exhibition program and the MouthPower oral health education program that helps children learn about oral health

- Engaged the national dental community, raising funds to extend the museum's educational outreach
- Led establishment of an endowment of more than \$3 million
- Led the museum to achieve 66% of the Museum's Pillars Campaign goal of \$8 million to date
- Program Champion, "Give Kids a Smile" National Advisory Board
- Director, Cloisters Children's Hospital of Baltimore
- Awarded German government grant (DAAD)
- Awarded Martha Baird Rockefeller Grant
- Held academic positions at Appalachian State University and Randolph Macon Woman's College Arts Administrator, Baltimore
- Mayor's Advisory Committee on Art and Culture
- Member, Delta Mu Delta
- Member, Association of Fundraising Professionals
- Member, American Association of Museums
- Treasurer, Greater Baltimore History Alliance
- Award for Distinction in Public Service and prestigious Shils Award from the Friends of the National Institute of Dental and Craniofacial Research



MR. R. BARKLEY PAYNE

Mr. Payne is Executive Director of the ADA Foundation and he is responsible for providing oversight and direction for all administrative, fundraising, and marketing

activities of the foundation. He has been involved with nonprofit administration and development for 18 years. Mr. Payne has an exemplary record of leadership in fundraising and his efforts most emphatically benefit organized dentistry, the dental profession, and oral health care. Key events and accomplishments in the career of Mr. Payne include:

- BA in journalism, Western Kentucky University
- Executive Director, ADA Foundation
- Treasurer, American Society of Dental Foundation Executives
- Provides key direction for Dental Education: Our Legacy—Our Future and the Foundation's \$100 million campaign for innovations in dental education
- Member, Association of Fundraising Professionals
- Member, Association Foundation Group
- Member, American Society of Association Executives
- Member, Chicago Council of Planned Giving
- Member, American College of Dentists Professional Ethics Initiative Committee
- Board of Directors, National Kidney Foundation of Kentucky
- Board of Directors, Louisville Zoo Foundation
- Board of Directors, Association of the Louisville Orchestra
- Board of Directors, Cystic Fibrosis Foundation
- President's Award, National Kidney Foundation of Kentucky
- Named Young & Aspiring Association Professional, *Association Trends* magazine
- Named "Top 40 under 40," *Business-First* magazine



DR. GERALD R. WINSLOW

Dr. Winslow is a Professor of Ethics at Loma Linda University where he

teaches ethics courses to students of the health professions, including dental students. He also currently serves as Vice President for Mission and Culture. Dr. Winslow has been a major leader and contributor to dental ethics and professionalism for more than 20 years. Dr. Winslow has willingly given of himself for the betterment of others. Key accomplishments in his career are summarized below:

- BA in religion, Walla Walla College
- MA in religion, Andrews University
- PhD in social ethics, Graduate Theological Union, Berkeley, California
- Postdoctoral studies at University of Tübingen, University of Virginia, and Cambridge University
- Professor of Ethics at Loma Linda University
- Vice President for Mission and Culture, Loma Linda University
- Vice Chancellor for Spiritual Life and Dean, Faculty of Religion, Loma Linda University
- Professor of Religion, Pacific Union College
- Associate Dean of Men, Walla Walla College
- Thirty-five years of specialized teaching and writing about ethics, especially healthcare ethics
- Author of the book, *Triage and Justice: The Ethics of Rationing Life-Saving Medical Resources*
- Co-editor of the book, *Facing Limits: Ethics and Health Care for the Elderly*
- Author of numerous scholarly articles on ethics in such journals as *General Dentistry*, *Journal of the American College of Dentists*, *Western Journal of Medicine*,

Journal of Pediatrics, and *Journal of Medicine and Philosophy*

- Numerous invited presentations in North American, Australia, and Europe
- Presenter, ethics seminars for the California Dental Association, the American College of Dentists, and the Society for Health and Human Values, among many others
- President, American Society for Dental Ethics
- Alumnus of the Year, Walla Walla College
- Distinguished Teacher Award, Walla Walla College
- Zapara National Award for Teaching Excellence
- Burlington-Northern Foundation Faculty Achievement Award
- Danforth Foundation Associate
- Facilitator, Ethics Summits II and III, American College of Dentists

OUTSTANDING SERVICE AWARD

The Outstanding Service Award recognizes Fellows for specific efforts that embody the service ideal, emphasize compassion, beneficence, and unselfish behavior, and that have significant impact on the profession, the community, or humanity. The recipient of the Outstanding Service Award is Dr. Carl E. Rieder.



DR. CARL E. RIEDER

Dr. Rieder is recognized for his exceptional service to dentistry, including significant contributions to the fields of prosthodontics, restorative dentistry, implant dentistry, and temporomandibular dysfunction. Dr. Rieder also played a key role in establishing and developing the Newport Harbor Academy of Dentistry. His record of accomplishments is summarized as follows:

- Founder and Director, Newport Harbor Academy of Dentistry, since 1963

- Fred Gulick Award, Pacific Coast Society for Prosthodontics
- Charles L. Pincus Award, American Academy of Esthetic Dentistry
- President, Pacific Coast Society for Prosthodontics
- President, American Academy of Esthetic Dentistry
- President, American Equilibration Society
- Fellow, American College of Dentists
- Fellow, International College of Dentists
- Fellow, Academy of General Dentistry
- Fellow, Academy of Osseointegration
- Fellow, Pierre Fauchard Academy
- Member, Omicron Kappa Upsilon
- Life member, American Academy of Restorative Dentistry
- Life member, American Academy of Fixed Prosthodontics
- Life member, American Academy of Orofacial Pain
- Life member, American Prosthodontic Society
- Presenter of over 350 continuing education courses to international audiences
- Author of numerous articles in prosthodontic literature, primarily on the subjects of restorative dentistry, temporomandibular dysfunction, and implant prosthodontics
- Former Clinical Professor of Advanced Prosthodontic Education, University of Southern California School of Dentistry
- Private practitioner for 35 years in Newport Beach, practice limited to fixed and removable prosthodontics.

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. There is no 2009 recipient of the Section Achievement Award.

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 **Mississippi Section**.

MODEL SECTION DESIGNATION

The purpose of the Model Section program is to encourage Section improvement by recognizing Sections that meet minimum standards of performance in four areas: Membership, Section Projects, ACD Foundation Support, and Commitment and Communication. This year four Sections earned the Model Section designation: **Carolinas Section, Mississippi Section, New York Section, and Tennessee Section**.

LIFETIME ACHIEVEMENT AWARD

The Lifetime Achievement Award is presented to Fellows who have been members of the College for 50 years. This recognition is supported by the Dr. Samuel D. Harris Fund of the ACD Foundation. This year's recipients are:

Asher B. Carey, Jr.
Wesley J. Dunn
Joseph A. Gibilisco
Norman O. Harris
Leo Korchin
Stanley L. Lane
John J. Lucca
John H. Manhold
William Rakower
Wilbur O. Ramsey
Irwin B. Robinson
Guy A. Woods, Jr.

2009 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 to the 2009 Class of Fellows.

Gil A.P. Alcoforado
Lisboa, Portugal

Charles R. Anderegg
Bellevue, WA

Donald V. Anderson
Vancouver, BC

David A. Anderson
Pittsburgh, PA

David Anson
Beverly Hills, CA

Douglas A. Auld
McAlester, OK

Pamela Z. Baldassarre
Bedford, NH

Richard Bateman
Kingsport, TN

Michelle D. Bedell
Gaffney, SC

William T. Bell
Sarasota, FL

Pam Berlanga Ray
San Antonio, TX

Norton J. Bicoll
Santa Fe, NM

Laura D. Braswell
Atlanta, GA

Michelle Brichacek
Denver, CO

Todd P. Briscoe
Fort Wayne, IN

William D. Browning
Indianapolis, IN

John M. Bryan
Madera, CA

L. Stanley Brysh
Madison, WI

Philip M. Buchanan
Gilroy, CA

David W. Bull
Polson, MT

Denison E. Byrne
Baltimore, MD

Bruce A. Camp
Villa Rica, GA

Chris W. Campbell
Lexington, SC

Steve Carstensen
Bellevue, WA

Jason L. Champagne
Sparks, NV

Daniel K. Cheek
Hillsborough, NC

Regina E. Cobb
Kingman, AZ

Jeffrey M. Coil
Surrey, BC

Julie A. Connolly
New York, NY

John S. Covington
Memphis, TN

Christopher J. Cowell
DeLand, FL

Thomas B. Crump
Dallas, TX

Roland S. Davies
Austin, TX

Michael M. Day
Sparks, NV

Peter J. DeGiacomo
Thunder Bay, ON

Virginia M. Diewert
Vancouver, BC

John C. DiGrazia
Reno, NV

Thai-An Doan
Oklahoma City, OK

David L. Doerre
Burkburnett, TX

Stafford J. Duhn
San Francisco, CA

David A. Duncan
Amarillo, TX

Michael R. Favero
Sacramento, CA

Kurt Ferre
Portland, OR

Richard D. Fitzgerald
Omaha, NE

Troy A. Fox
Evergreen, CO

Edward N. Friedman <i>Brookline, MA</i>	Nora K. Harmsen <i>Honolulu, HI</i>	David A. Keller <i>Vancouver, WA</i>	Lisa A. Lear <i>Tucson, AZ</i>
Carroll S. Gallagher <i>Charleston, SC</i>	Howard D. Hill <i>Georgetown, MA</i>	Jocelyn D. Kidd <i>Lancaster, TX</i>	Natasha A. Lee <i>San Francisco, CA</i>
Joseph M. Gerlecz <i>Lynn Haven, FL</i>	James M. Hobbs <i>Plattsburg, MO</i>	Alan J. Kilstoff <i>Saskatoon, SK</i>	Michael R. Lewis <i>Rochester, NY</i>
Anthony N. Giamberardino <i>Medford, MA</i>	George Hoffmann <i>Piedmont, SC</i>	Daniel J. Klemmedson <i>Tucson, AZ</i>	James M. Lewis <i>Madison, AL</i>
William G. Glecos <i>Erie, PA</i>	Lavern J. Holyfield <i>Duncanville, TX</i>	Joseph J. Kohler <i>Erie, PA</i>	William K.B. Liang <i>Surrey, BC</i>
James G. Gray <i>Kelowna, BC</i>	Jonna E. Hongo <i>Portland, OR</i>	Peter P. Korch <i>Northern Cambria, PA</i>	Steven J. Lindauer <i>Richmond, VA</i>
Julie L. Greenlaw-O'Toole <i>Walnut Creek, CA</i>	Mark B. Hughes <i>Glendale, AZ</i>	Matthew J. Kormylo <i>Greenville, SC</i>	Pamela G. Low <i>Tulsa, OK</i>
Mark H. K. Greer <i>Honolulu, HI</i>	Jeffrey W. Hutter <i>Newton, MA</i>	Steven T. Kuhn <i>Lockport, IL</i>	Thomas S. MacKenzie <i>San Antonio, TX</i>
Gregory N. Guichet <i>Orange, CA</i>	Elizabeth A. Jabbour <i>Spartanburg, SC</i>	Gregory A. Lacy <i>Morgantown, WV</i>	Jason M. Mailhot <i>Hampton, IL</i>
Christopher N. Hacker <i>Vancouver, BC</i>	Stephen J. Jaworski <i>New Bethlehem, PA</i>	Jay C. Lamb <i>Eugene, OR</i>	Mark I. Malterud <i>St. Paul, MN</i>
LaJuan M. Hall <i>Brentwood, CA</i>	Dennis Johnson <i>Portland, OR</i>	Lewis N. Lampiris <i>Chicago, IL</i>	Thomas A. McConnell <i>Lexington, KY</i>
Robert Hallett <i>Kamloops, BC</i>	M. Kenneth Johnson <i>Charleston, SC</i>	Terry F. Lanphier <i>Omaha, NE</i>	Robert W. McDougall <i>Victoria, BC</i>
David L. Hamel <i>Marysville, KS</i>	Kimberly Johnson Genc <i>Newport Beach, CA</i>	Nita H. Largoza <i>Chula Vista, CA</i>	Edward J. Miller <i>New York, NY</i>
Douglas E. Hamilton <i>Montreal, QC</i>	Guenter J. Jonke <i>East Setauket, NY</i>	Bernard J. Larson <i>Mount Vernon, WA</i>	Janis Moriarty <i>Winchester, MA</i>
Michael D. Hanson <i>Panama City, FL</i>	Peter Y. Kawamura <i>Belmont, CA</i>	Daniel P. Lavin <i>Mililani, HI</i>	Marcus K. Muncy <i>Clarksville, AR</i>

Richard J. Nessif <i>Columbia, MD</i>	Carolyn Poon Woo <i>Toronto, ON</i>	Robert L. Smith <i>Hernando, MS</i>	Nancy C. Tilkin <i>Bethesda, MD</i>
Sheldon M. Newman <i>Centennial, CO</i>	David M. Preble <i>Chicago, IL</i>	Richard D. Smith <i>Charleston, WV</i>	Alan Y.J. Tom <i>Honolulu, HI</i>
Alastair Nicoll <i>Elkford, BC</i>	Christine L. Quinn <i>Los Angeles, CA</i>	Hilary Soller <i>Lancaster, OH</i>	Christopher M. Tota <i>Somers, NY</i>
Doug Nielsen <i>Richmond, BC</i>	Thomas H. Raddall <i>Queens County, NS</i>	Gary L. Stafford <i>Milwaukee, WI</i>	Lisa Vouras <i>Reading, MA</i>
Steven J. Niethamer <i>Palm Springs, CA</i>	Prabu Raman <i>Kansas City, MO</i>	Alan R. Stein <i>Northridge, CA</i>	Nancy A. Ward <i>Baltimore, MD</i>
Wade K. Nobuhara <i>Honolulu, HI</i>	Robert G. Ray <i>Washington, DC</i>	Jeffery Stewart <i>Portland, OR</i>	Kathy S. Warner <i>Sneads Ferry, NC</i>
Neil C. Nunokawa <i>Wailuku, HI</i>	Dennis Reed <i>Oregon City, OR</i>	Thomas E. Stone <i>Springfield, MO</i>	Carla D. Webb <i>Flowood, MS</i>
Frank L. O'Connor <i>Tucker, GA</i>	Daniel J. Reese <i>San Antonio, TX</i>	Paula S. Strange <i>Clinton, MS</i>	George A. Wessberg <i>Honolulu, HI</i>
Thomas W. Oates <i>San Antonio, TX</i>	Douglas D. Richardson <i>Xenia, OH</i>	Richard A. Sugarman <i>Atlanta, GA</i>	Trent H. Westernoff <i>Redondo Beach, CA</i>
Paul E. Obrock <i>Quincy, IL</i>	Richard J. Ringrose <i>Clearlake, CA</i>	Cliff H. Swanlund <i>Calgary, AB</i>	Charles W. Wilcox <i>Omaha, NE</i>
Randall H. Ogata <i>Seattle, WA</i>	Carlos A. Sanchez <i>Miami, FL</i>	Robert M. Taft <i>Bethesda, MD</i>	Dennis A. Zabelsky <i>Munhall, PA</i>
Glenn M. Okihiro <i>Pearl City, HI</i>	Lance V. Sanders <i>Austin, TX</i>	Robert L. Talley <i>Norman, OK</i>	Mark D. Zajkowski <i>South Portland, ME</i>
L. Stephen Ortego <i>Ball, LA</i>	Charles M. Schumacher <i>Farmington, NM</i>	Theodore A. Tanabe <i>Whittier, CA</i>	Christopher M. Zed <i>Vancouver, BC</i>
Frederic Paperth <i>Manasquan, NJ</i>	Edward H. Segal <i>Northbrook, IL</i>	Les L. Tarver <i>Monroe, LA</i>	Kenneth J. Zucker <i>St. Paul, MN</i>
William Pappas <i>Las Vegas, NV</i>	Sam N. Sgro <i>Greenfield Park, QC</i>	Keith A. Taylor <i>Chapel Hill, NC</i>	George R. Zundo <i>Danville, IL</i>
Jacinthe M. Paquette <i>Newport Beach, CA</i>	Bryan J. Shanahan <i>Flagstaff, AZ</i>	Beatriz E. Terry <i>Miami, FL</i>	
David W. Parks <i>Wenatchee, WA</i>	Rebeka Silva <i>San Francisco, CA</i>	Walter F. Thal <i>New Britain, CT</i>	

THE FUTURE AS I SEE IT

Rhett Raum, DMD

ABSTRACT

Predicting the future is always chancy, but when a young practitioner begins a career in dentistry, it is worthwhile to have some well-reasoned expectations. The critical dimensions in the next several decades in dentistry will include technology, marketing, and society.

The future of dentistry is something often talked about by those “in the know” of organized dentistry, but something that usually does not involve the input of those that will be the future. A strong background of past experiences, failures, successes, etc., helps to develop a sound vision of the future, whether it be in life, a business, or a profession. As has been the case throughout time, advances in technology, political changes, societal changes, and a few variables sprinkled in help to shape the future. In my opinion, the same will hold true for the profession of dentistry.

Before we move further along please allow me to share a little of my background so you can understand some of my visions for the future of dentistry. Dentistry came as a second career for me, after I was laid off during the telecomm bust. My undergraduate degree actually lies in the business field of human resources management. I had the privilege of serving as Speaker of the House and Vice President of the American Student Dental Association during my dental education. Upon graduation from the University of Alabama School of Dentistry in May of 2008, I purchased a practice in a rural area of Tennessee an hour or so northeast of Nashville. The practice I purchased had three computers for bookkeeping and scheduling, one dentist, one assistant (the dentist's wife), and one receptionist. The dentist had been performing his own prophylaxis cleanings for the past few years. About eight months into my practice, I had the

fortunate or unfortunate opportunity, depending on the revenue or administrative view, of purchasing a second practice as a satellite location. Now I have two hygienists, one associate dentist, three assistants, two front office employees, and my wife as the office manager with an integrated network between the two offices and computers in every operatory. My hope is that this background will help you see my vision of the future.

Technology

Technology always seems to constantly drive the shape and position of an industry or profession. Just ask anyone in the automobile or computer industries, or for that matter, any dentist who has practiced for a few, let's say 30 plus, years. New materials, techniques, and equipment will continue to emerge, changing the face of dentistry. Look at just about any dental journal and you will see an article on the benefits of cone beam computed tomography in a dental practice. While this technology is cost-prohibitive for most dental offices it will most likely become the norm in just a few short years as prices continue to drop.



Dr. Raum is a 2008 graduate of the University of Alabama who now practices in Tennessee; rhetraum@yahoo.com

For the majority of dentists, particularly ones in larger population centers, the need to market through newer technological means will drive the number of new patients they see each month in their practice.

Dentistry is definitely going digital. My wife was looking through a catalog the other day and asked me if anyone actually still used ledger cards in the age of computers. Unfortunately, some offices still do. Digital records, accounts, and communications will continue to drive dentistry to be more efficient and help reduce errors in accounts, patient records, and patient communications. Many programs are already leading the way, allowing dental offices to inform patients of upcoming appointments and promotions by email, text message, or directly to voice mail. As new communication technologies emerge dental offices will begin to communicate through those as well. Unfortunately, this will lead to less human interaction between offices and patients, reducing the human touch that is part of the healing arts.

Digital radiography will grow to be the standard for simple imaging. This will allow general dentists and specialists to communicate more effectively in patient care, lending to a more team-oriented approach to patient care. Digital impressions are already here and they are not going away. They too will eventually become the standard in crown and bridge impressions, maybe even in removable prosthesis impressions as well.

In-office fabrication of crowns and bridges will become the norm as CAD-CAM technologies continue to be adopted in offices worldwide and as technology continues to improve. This is quite an interesting cycle of events, since most dental offices once fabricated the majority of their crowns in-office, often over lunch when fabricating gold crowns. You always hear that to predict the future you have to know your past! The use of in-office crown and bridge

fabrication technologies such as CEREC, iTero, and E4D will become the norm and not just a marketing tactic.

More and more patients are retaining their natural teeth for more of their lifetime, leading to a greater need for treatment. A subspecialty in geriatric dentistry may well develop in the coming years due to the unique needs of this patient population. There will be even greater options for tooth replacements as dentistry moves forward. I truly believe that before my career in dentistry is over there will be the ability to "grow" teeth and implant them into an edentulous site. This will be an amazing benefit to our patients, esthetically, functionally, and psychologically. Implants will continue to get even more predictable, as will root canal therapy, as we continue to expand our knowledge on these areas of practice.

The use of lasers in dentistry will continue to grow but I do not think it will ever reach the status of being the standard in dental offices unless a more robust and versatile functionality is developed and anesthetic functionality is enhanced to the point where one can prep crowns and perform RCT without the use of injected anesthetic solutions. Just like air abrasion, lasers will have certain aspects of treatment where they will be indicated.

Caries detection instruments and devices will allow us to determine the ideal width and depth of preps in order to effectively and efficiently remove all caries present. Digital radiography has already made steps toward that with the capabilities of certain imaging software, as have caries detection devices such as the Diagnodent. These types of technological advances will enable us to detect caries at a much earlier stage, allowing patients to save more sound tooth structure and maintain their teeth even longer.

MARKETING

Good or bad, marketing will become the norm for the majority of dentists throughout the nation. Most dentists do some form of marketing already, even if it is nothing more than an ad placed in the yellow pages of their local phone directory. Many dentists have already begun marketing their practices on the Internet through a variety of means. Others have resorted to billboards, bus ads, magazine ads, even ads in airline magazines. For the majority of dentists, particularly ones in larger population centers, the need to market through newer technological means will drive the number of new patients they see each month in their practice. Those dentists in more rural areas will begin to ramp up their marketing through more conventional measures as their communities begin to adopt newer technologies.

Another area that will continue to mold the profession of dentistry in the coming years is politics. Currently, our nation is in the midst of possibly significant reform in the way patients receive and pay for treatment. Dentistry and oral health have not been seriously discussed as significant components of this reform. Most dentists I have spoken with do not see this as an issue, as they expect that the inclusion of dentistry in such reform would threaten patients' and dentists' choices and freedom in treatment options. Whether you are for or against the reform under discussion, the fact that dentistry is not considered to be a part of any type of healthcare reform should startle you, given all we know as healthcare professionals regarding the links between oral and systemic health. I see this as being an important topic of discussion in the future and one in which the government will eventually try to take a larger role.

The professional identity of dentistry will continue to be challenged. Just recently in Nashville, Tennessee,

Representative Jim Cooper told a group of physicians "Medicine used to be a profession. You've lost that. Now you just want to be employees." Unfortunately, this type of mentality has the ability to expand to other professions when they are fighting for what they think is fair. The profession of dentistry will continue to be influenced by politics to some extent since the majority of state dental boards are political appointments by the states' governors. That is not to say that the board members do not have autonomy; it is simply that there is a political nature to the way dentistry is governed. If you do not believe politics play a role in dentistry or will in its future look no further than to the FDA's recent classification of amalgam as a dental material. That was a highly debated topic and one that is actually being appealed by numerous anti-amalgam groups.

SOCIETY

The third area destined to shape the future of dentistry is society as a whole. The way patients view dentists and the profession will continue to evolve and change as each patient has interactions with the profession in various forms. The way patients view dental treatment and the various ways they seek it will continue to change. Many Web sites now have rating systems that individuals can use to rate their experience with dentists. This can ultimately either turn into free marketing or become a PR nightmare. More and more patients will seek these "referrals" or "warnings" before selecting a dental home.

Patient education will continue to increase over time, hopefully resulting in an increase in the public's dental IQ.

It is always refreshing when a patient has done his or her research before the appointment and comes armed with questions regarding treatment options. This leads to the patient making a much more informed decision regarding treatment options. The number of patients who say "just pull it" will begin to decrease as the public's dental IQ rises. We will see fewer patients stating their parents had dentures in their 20s or 30s and they "just want to go ahead and get plates since they know they're going to need them." I had a 16-year-old male patient a few months ago who needed a one-surface filling tell me that he just wanted the tooth pulled because he knew he would get dentures in a few years. These kinds of statements will become a thing of the past as patients become more educated about their dental options and oral health.

The trend toward cosmetic dentistry will likely sustain itself as society as a whole continues to become more obsessed with the idea of ideal beauty over natural beauty. Patients continue to be generally more concerned with how the front six teeth look than the large carious lesion in #30 that isn't hurting them yet. This will continue to lead to larger numbers of dentists emphasizing their practice as a cosmetic dental practice instead of a general dental practice.

As mentioned earlier, elderly members of the population are retaining more teeth than ever before and that trend will continue to grow. Much more will be expected of dentists to assist

Whether you are for or against the reform under discussion, the fact that dentistry is not considered to be a part of any type of healthcare reform should startle you, given all we know as healthcare professionals regarding the links between oral and systemic health.

patients in maintaining their dentition. These patients tend to demand a more personal and social relationship in their treatment, but this aspect may diminish as future generations of the elderly become more tech savvy and not as concerned with the human touch of treatment.

Access to dental care will always be a problem. As the old adage goes, you can lead a horse to water but you can not make it drink. The same is true for patients. I have had a number of patients enrolled in the state Medicaid program who come in for a cleaning and treatment plan involving 10-20 teeth and then do not show for three consecutive appointments because they had other things to do. This was done knowing they will incur no personal costs other than getting to the appointment. There will always be people who live a significant distance from a dentist or have various reasons not to seek the care they need. However, a fair number of people considered to have an "access to care" issue are also apathetic about pursuing dental care even when it is readily made available to them.

Other variables such as third-party payers and dental auxiliaries will also contribute significantly to the future of dentistry. Insurance companies will continually try to control costs by regulating reimbursement fees for providers that accept assignment. They will also attempt to control payments to providers

under contract for non-covered items. Third-party payment decisions often affect patient decisions on treatment options. This will continue to be a trend in the future.

The role of dental auxiliaries is one which is definitely evolving. Assistants will play an even greater role in the future as dentists use their skills to a greater extent. New dental team roles are currently being developed and will be implemented shortly. The independent dental hygiene practice does not seem to be a concept that will grow in the future. It seems that the economic feasibility for such a practice would be poor.

The future of dentistry is bright for both patients and dentists. As I imagine myself looking back during my retirement, it will be quite interesting to see how dentistry has changed and evolved throughout my career. I hope to be pleased with what I am passing on to the next generation of dentists just as I have been pleased as a new dentist entering what many consider to be the "golden age" of dentistry. ■

My Vision for the Future of Dentistry

Ian Paisley, DDS

ABSTRACT

There are new ways and new places to practice the ultimately unchanging profession of addressing the oral health needs of Americans. New approaches may be needed to achieve traditional values. The rural poor cannot be put aside, corporate business models cannot be allowed to diminish the personal relationship between dentist and patient, and the social values of younger generations of practitioners do matter. They may be listening on Facebook, but they are still listening for the core values of serving patients.

It has been more than six years since I graduated from the University of the Pacific School of Dentistry but I can still remember the encouraging words of my mentors. They told me to enjoy my life in the “golden age” of dentistry. Technology was expanding the horizons in the field. Esthetic dental treatment allowed us to be the bearers of a new self-image for our patients and literally change their lives. There were very large numbers of baby boomer dentists about to retire and not nearly enough graduates to replace them, leaving my classmates and me a bounty of opportunity for success and prosperity. I have thoroughly enjoyed the first six years of my career. Not everything promised has turned out the way it was described. There are many exciting aspects to dentistry in the twenty-first century, but there are many challenges as well. I plan to consider both of these topics as I delve into this discussion of my vision for the future of dentistry.

After completing my general practice residency at the Denver Veterans Administration Medical Center, a co-resident and I opened a practice from scratch. We actually opened two, since we knew there would not be enough new patients to support a full schedule for both of us right away. One of the first orders of business was to find a dental supply company to outfit our offices with all the necessary equipment and supplies. We ventured out to the Rocky Mountain Dental Convention, and I remember feeling like I was walking into the Emerald City in far-away Oz. There were so many

beautiful displays, fascinating equipment, and knowledgeable people there to sell it. As the day went on and we attended CE classes, I was amazed by the vast amount of new technology available to be used in the modern private dental practice. I received plenty of exposure in school but this was my initial “eye opener” to what was really out there and it was exciting. From digital radiographs to CAD/CAM restoration fabrication, it seemed that the office of today was going to be a lot different than the one I watched my father practice in for the last 20 years.

GOING TO THE PATIENTS

So as you can see, I was very excited as I began my first year of private practice. Time went on, though, and I began to become aware of some alarming trends and realities that faced our profession. As I mentioned earlier, my business partner and I opened two dental practices. One was in suburban Denver and the other in rural Colorado, about 90 miles northeast of Denver. Brush, Colorado, is a small farming community with a proud tradition. There were not many dentists practicing there and as we



Dr. Paisley is a 2003 graduate of the University of the Pacific who, following his GPR, opened both a rural and a suburban practice in Colorado; ijpaisley@hotmail.com.

found out very quickly, there were plenty of patients. It was my first exposure to the problem of rural access to dental care facing our country today. For those of you who keep up with the publications of the American Dental Association, you are likely to be well-versed on this situation. We decided to accept Medicaid from the beginning and still do to this day. This is mainly because of the tremendous need that exists and what we felt was a lack of oral health education being provided to families on Medicaid. Much of our time treating these patients has been spent on prevention and the basics of a nutritional diet.

There were downsides to accepting Medicaid, including failed appointments, poor reimbursements, and the occasional lack of appreciation. But there were many patients to whom we were the only hope for receiving necessary oral health education and restorative treatment. It is those patients I think about when the discussion of access to care comes about.

I have been very lucky to serve as the 14th District Representative to the ADA Committee on the New Dentist for the last four years. Many solutions to this problem have been discussed. It is my opinion that we as a profession need to work together to find innovative solutions to address the rural access problem. Thinking outside the box is crucial and something that one of my mentors in dentistry, Art Dugoni, has tried to teach for many years. There have been many programs developed that focused on loan repayment for the young professional. Graduates are contracted to work in an underserved community designated by the state or other organization. The term of service is usually in the neighborhood

of three years and pays for a significant portion if not all of a graduate's student loan debt. I practiced in Brush for just over a year and despite the inconvenience of the drive it was a really memorable experience. It was even a bit of an adventure. It certainly was rewarding and as I look back I am glad we did it. Along with student loan repayment programs, I think there is also the need to look to the dentists at the sunset of their careers to become part of the solution. Spending a year practicing in an underserved community as one makes the transition out of full-time practice seems like a nice way to give back after enjoying the fruits of a long and successful fee-for-service career. This discussion has come up many times and is one that I want to make sure continues to come up at meetings all over organized dentistry.

Since I left my small Montana childhood hometown, I have lived in Chicago and San Francisco, until I finally settled in Denver. The big-city life is exhilarating and there are so many new things to experience. It was hard to picture myself going back to my hometown even with my father's practice waiting in the wings. I think we all can see that this is a common theme among young, new dentists. Despite the knowledge that there is great practice and financial success to be had in rural communities, graduates are simply drawn to the allure of the big city. I have witnessed this with my own eyes here in the Denver metro area. Colorado is a fun place to live. There are endless recreational opportunities just a few miles away in the Rocky Mountains. Every year I am pleased to learn that another one of my old acquaintances from ASDA or classmates from Pacific has moved out to Denver. The dental market is, as a result, very competitive. Not in a hostile sense, but simply to have enough patients for a viable full-time practice. The economic downturn after

the dot.com boom went bust left many baby boomer dentists without the kind of robust retirement they were anticipating. Many have not been able to "cut back" as they had hoped and bring on an associate. Many have simply chosen to work past the typical retirement age in order to secure a comfortable nest egg.

GOING WITH THE PERSONAL PRACTICE

This influx of new dentists and a decrease in job opportunities in metro areas has invited a new player into the dental marketplace. The corporate dental office is now securely entrenched in the mix and has changed the outlook for private practice dentistry as we know it. I want to begin by saying that this discussion is not meant in any way to vilify corporate dental offices, but simply to highlight their impact on dental practice today. Since opening my practice in Brighton, Colorado, three corporate offices have opened there as well. They fill their schedules with patients by accepting every capitation insurance plan available. They also provide job opportunities for new dentists. Opportunities for those who may not want to start a new practice or cannot find a suitable opportunity with a privately practicing dentist. The last four of my dentist friends who moved to Denver have all found themselves working, at least part-time, in a corporate dental office. It was not the first choice for any of them. As the son of a private practice dentist, as well as being one myself, I know many of the virtues of the private dental practice, especially the way every patient is treated like a member of the family.

I am saddened to hear the stories of patients who come to my practice relating the impersonality felt at a corporate dental office. They recount situations where they felt more like a

number or target on a production goal than a partner in the improvement of their oral health. This perception by the public is one of the dangers we face as a profession and we need to all work together to make sure it does not become a reality. I envision a situation in which a dentist on the verge of retirement considers not only the monetary value of his or her practice when it comes time to hang it up. I would hope retiring dentists could also consider the less obvious value of passing the torch of autonomous private practice on to the next generation of dentists. I feel this outcome secures the greatest opportunity for the public to receive the best care that can be provided by our great profession and its practitioners.

GOING TO THE NEW PRACTITIONER

The last topic I want to discuss in my vision for the future of dentistry is the role of organized dentistry. I recently served on the Strategic Planning Committee for the Metro Denver Dental Society. Included in the background information was an environmental scan highlighting trends among different age generations. The trend that stuck out for me the most was that those in generations X and Y were not “joiners.” In other words, they did not socialize in the same manner as those in older generations. They were less likely to do things because it was just what they were supposed to do. They questioned why and needed a good reason in order to initiate an action. I became a bit concerned as I applied this thinking to membership in organized dentistry. What would happen to dental societies if young members felt no reason to join? I was more concerned as I thought specifically about my experience with classmates and peers in the profession. I remember the challenges faced when trying to get students to join ASDA. Tradition was not a good enough reason; they wanted something very tangible.

This realization that new dentists are not necessarily motivated by the same social goals as their parents has emboldened me to strive to do my part in creating a modern dental society that will be attractive and valued by new dentists. Locally, the integration of social media such as Facebook and Twitter has allowed our component to reach out to our new and young members. The basic principles and benefits of organized dentistry remain the same: fellowship among members of a profession with the intention of improving themselves by communicating with and learning from others. I think this remains true across the generations. The trick is bringing people together in different ways. So I would encourage members of all generations to create a professional Facebook page and “friend” young dentists in your community or society. You may be pleasantly surprised by the response you receive.

Despite all the challenges I have mentioned, I remain very hopeful for the future of dentistry. Maintaining the fine reputation that dentistry has achieved over the years will take work. I have been happy to find, since the day I started dental school, that there are many smart, talented, and self-sacrificing individuals working as a team to make this a reality. Working together we can succeed in this endeavor. ■

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BECAUSE I HAVE A CHOICE, I Will CHOOSE TO DO THE RIGHT THING

Dusty Janssen, DDS

ABSTRACT

Leadership, in life and in dentistry, is a choice; and it should be welcomed. A dentist in his first year of practice in West Texas has chosen to center his practice on the values of involving patients in decisions about their oral health, maintaining professional integrity through ethics, and working with medical colleagues for comprehensive health.

I was not as well guided on my path to dentistry as many of my colleagues have been. I grew up around medicine and knew I wanted to enter a field where I could make a difference in peoples' lives. As I came to understand what it meant to be a physician, I realized that the practice of medicine had taken a drastic turn away from a patient-centered care to a system based on what the insurance companies had contracted to pay.

Luckily, my dentist had invited me to her office many times to observe her in everyday practice. I finally took her up on this offer and quickly realized that the practice of dentistry was still based firmly on the well-being of the patient. Although the insurance companies play a role in the care dentists are able to give, the impact is nowhere near as profound as in medicine. Because of this, I decided to enter dental school.

When I began dental school I did not fashion myself much as a leader. Much of the time I was just happy to be in a line of people that were going somewhere. However, while in dental school, due to great leaders before me and strong encouragement, I chose to step into many leadership roles. These rolls gave me an opportunity to take a unique perspective on many of the situations that are affecting dentistry today and will continue to change dentistry as we know it tomorrow. I firmly believe that for dentists to remain well-respected in the eyes of the public, we must continue to hold true many of the same principles

that we held when we entered the practice. I hope that dentistry will become more patient-centered, offering care based on scientific best practices and prevention from dentists who are ethically grounded and who communicate effectively with our medical colleagues for the betterment of our patients.

INVOLVE THE PATIENT

I have been practicing for a mere three months in the "real world" of private practice dentistry, but I have spent much of this time listening. I have been listening to the dentists around me so I can gain crucial tips and pointers to get me through the day. But most importantly, I have been listening to my patients. I think we too often see a mouth that is in utter disarray and jump straight to an extensive treatment plan that fixes every minute detail and restores it to a perfect Class I occlusion in which every tooth is as white as a toilet bowl and every smile could be used on the Got Milk ads. In West Texas, however, many of my patients are perfectly happy with their fluorosis-stained teeth and their malocclusions. They just want you to put a few back teeth in so they can enjoy a great-tasting, thick steak. If we forget about patient autonomy, ignoring patients' right to know all the options, and push treatment on them, we are no better than a used car



Dr. Janssen is a 2009 graduate practicing in Lubbock, Texas; dustyjanssen@gmail.com

salesman who persuades his customers to purchase a car they really cannot afford and quite frankly do not even like. Because in the end it does not matter how great the car drives or how perfect you made those veneers; if customers or patients do not make the decision based on their own desires, they will never be completely satisfied. My father called this predicament “post-purchase depression.” If dentists first listen, truly listen, to their patients and actually place themselves in the patients’ shoes, I feel we would gain tremendous respect and in turn be more successful, because the patients would feel more comfortable to have extensive treatment rendered.

We learned in school that G. V. Black is considered the father of modern dentistry, but many things have changed since his time. The ADA, as well as many other research organizations, have worked to stay on the cutting edge with new techniques. We have all seen that each practitioner has a special way of doing things, from how to bevel composites to how extraction sites should be grafted. I agree wholeheartedly that there are many different ways to “skin a cat,” but should not we perform procedures that are based on sound scientific foundations? If we all were able to practice with that strong grasp of actual evidenced-based dentistry, not the “evidenced-based procedures” that some insurance companies would like to push, we would become more successful with our patients and in turn help create a healthier oral cavity. In conjunction with this I would hope that we do more than fix bad teeth.

The potential exists to work with our patients to understand why they are experiencing dental decay and break the cycle of decay in their lives and in the lives of their children. If we all took a step back and got to know our patients and their habits before we ever drilled on a tooth, we would have a greater chance of understanding the basis of each individual patient’s dental decay. Only after gaining a sense of trust from our patients can we begin to ask about their personal lives and things that they might be doing that would cause them to have such poor oral health. After building this sense of trust we will be more capable of educating patients on proper hygiene and nutrition practices.

Build Trust

I hope that dentistry will continue to be led by properly trained dentists. Now more than ever there is a push toward a medical and possibly dental model in which those with the highest education act only as a safety net for the times that a less qualified individual messes up. I do not believe that this is an adequate model or even an effective model for rendering care. I do hope that there are changes to the dental team infrastructure that will allow a dentist to render care more effectively, especially in rural and poverty-stricken areas. However for any delivery model the dentist must remain the head of the team. In this area my vision is twofold. First, we as

We must not only hold ourselves to a higher standard, we must also hold our colleagues in the profession to that same standard.

A truly integrated medical and dental model would not only create earlier detection of diseases but also increase patient flow to both disciplines.

dentists must be open to change because change is imminent. Next, I hope that this integration of new dental team members will allow the practicing dentist to render more effective and efficient care to the millions who most desperately need it.

Every day in the news it seems there is a story about an individual whom many people trusted implicitly, but who turned out to have scammed the public out of hard-earned dollars. Unfortunately our profession is not immune from this epidemic of betrayed trust. Dentists are trained to make educated decisions about others' health, and for the most part, patients will never know whether the treatment rendered was necessary or even done adequately. Because of this, we must not only hold ourselves to a higher standard, we must also hold our colleagues in the profession to that same standard. It is imperative that dentists who are simply worried about their bottom line and making money take a step back and really evaluate why they entered the profession. In most instances I would be willing to wager that they entered the profession because they wanted to help people, not defraud insurance companies or little old ladies. Do we understand why they changed? Dentists and dental institutions must all work to keep our ethical standards high so that we maintain the public's trust, because we have chosen to take the moral high ground. Building trust begins with concern over one's own behavior, but it necessarily extends to helping our professional colleagues. It just takes one bad dentist to give the entire dental profession a scar that will not soon heal in the eyes of the public.

ADVANCE HEALTH

Now more than ever, our medical colleagues are discovering something that dentists have been saying for years: not only is the oral cavity directly connected to the rest of the body, but many diseases manifest themselves there first. However, due to inadequate training on both sides, dentists and physicians are not able to speak the same languages. Our coding systems do not make sense to each other and many times neither do we. As technology increases and scientists find more and more salivary markers for diseases, we as dentists must use these for the betterment of our patients. The potential is growing that dentists and physicians will work together in a more comprehensive vision of health. A truly integrated medical and dental model would not only create earlier detection of diseases but also increase patient flow to both disciplines.

As I stated earlier, I was definitely not a born leader, and many times I look back and wonder how I ended up in the situations that I did. However I do believe that we all possess the ability to stand up for the profession that we have chosen. Although I am still a small fish in a big pond, I plan to first help by treating each and every patient that I see with the same kind of compassion and understanding that I would want as a patient. And in the long term, I would like to help become part of the bigger solution by continuing to advocate for the profession and set an example for generations of dentists who will come after me. So when my children are deciding on their careers, I can recommend dentistry without hesitation in much the same way my dentist did for me. ■

TECHNIQUES CHANGE, BUT QUALITY CARE DOES NOT

Lindsey Krecko, DDS

ABSTRACT

The technical tools and complexity of cases for young practitioners are not the same as those used by their predecessors, but the aim is the same: quality ethical care at the highest level. The challenges of building the ethical practice today include building trust in a world where patients have access to media depictions of a society of greed, the temptations of over-treatment, and a need for an evidence base to one's practice.

The profession I have inherited is especially significant to me because the generations of dentists like my father and my grandmother before me contributed so much to make it so. Growing up in a family of dentists made me realize there was nothing else I would rather make my life's work. It also allowed me to see firsthand how much the profession has changed in the last 50 years.

My grandmother was one of six women in her class of 250 graduates in 1956. My father had three women in his graduating class of 24 in 1980. My graduating class was almost 50% women and represented a very ethnically diverse group of students. I believe the breadth of practice of dentists of my generation is wider than it was for dentists in my father's and grandmother's generations. With residency training as a mandatory or optional path to licensure in several states, the first-year-after-graduation experience is an extension of the formal education process by at least a year. Having completed a general practice residency myself, I can attest that I performed many procedures that I never did in dental school, procedures that were mentioned but not discussed in great detail.

In my residency training, I became comfortable doing procedures that I probably would have referred out had I not completed my residency. As a new dentist without residency experience, I would have referred out every third molar extraction, every crown lengthening, and every apicoectomy. Now, I feel

confident in being able to recognize and do simple cases, and refer out the more complex, challenging ones to specialists. I also consider myself fortunate that I was able to place and restore several single tooth implants and several implant overdenture cases. Because of my residency, I completed enough IV sedation cases to be eligible for an IV sedation permit in private practice. I compare this experience with that of my grandmother, who did not have the opportunity to place implants or offer her patients IV sedation. In fact, she used belt-driven handpieces in dental school and only had the luxury of an air-driven high speed handpiece after she graduated and entered private practice.

Despite the advances in treatment options, dental materials, and digital recordkeeping, there is one aspect of dentistry that is timeless, and that is ethics. Ethics as it pertains to dentistry is an extension of the values we live by on a daily basis. One cannot adhere to a high standard of ethics in personal life but not do so in professional life, and vice versa. That is why I question the ability to truly teach ethics to dental students, or students in any health profession program. The foundation of our values is placed in infancy, shaped



Dr. Krecko is a 2007 graduate who practices and teaches in a GPR program in Chicago; ljkdss@mail.com.

as we mature, and well-rooted by the time we have reached the age at which we are enrolled in dental school. Ethical behavior should be inherent by the time dental students take the oath at their white coat ceremonies, because patient care begins earlier and earlier in the curriculum.

In some states when an ethical violation has occurred, the practitioner may face an array of disciplinary measures, which can include mandatory ethics courses. I believe this situation is counter-intuitive. Even though evidence shows that we continue to develop ethically well into our thirties, and even longer for well-educated individuals, I question what can be learned from an ethics course at a very late stage of the game, especially one that is mandated and not voluntarily attended. Is an ethics course really able to reform an individual if it is treated as a punishment?

Building Trust In A Commercial World

Trust is a critical component of the doctor-patient relationship. If we do not embody ethics, then we cannot earn the trust of a patient and the relationship is doomed to end unsatisfactorily. Failure to earn a patient's trust can present itself in myriad ways. It can subtly manifest itself in failed appointments because the patient feels uneasy, even when he or she does not verbalize these feelings. On the other hand, it may be blatant. I have experienced the difficult-to-please, difficult-to-manage patient who questioned and argued with every statement I made. Unfortunately, though it was early in my career, it was necessary for me to have "the conversation" with that patient asking him to find another practice

where he felt more comfortable. A senior dentist in my residency reminded me that it is quality, rather than quantity, of patients that is important.

Because trust is so important, I, as an individual practitioner, am always working to strengthen the trust element in each individual doctor-patient relationship. I make sure to take the time to speak to my patients honestly and educate them about their oral health, not just rush in and out of the room and forget my chairside manner. My actions let patients know I see them as people who happen to be in my office for dental care, not just a mouth full of restorative work that is going to help pay my bills. As a profession, we should be mindful of perceptions that could tarnish our public image. An excellent example is the academic misconduct in dental schools that has been reported recently; these instances threaten the public's perception of our profession, and beg questions such as, "How much cheating goes on that we never hear about?" and "If a dentist was dishonest in dental school, is he or she still dishonest in private practice?" This type of attitude jeopardizes the doctor-patient relationship, because the public projects the image of these few instances onto every member of the profession.

The concept of selling dentistry is strange to me. In fact, it might be difficult to use the words "sales pitch" and "trustworthy" in the same sentence. Either there is or there is not an indication for the treatment. Selling is basically convincing someone to get something they do not need, and it is wrong for us to perform treatment without an indication. This goes back to the trust issue. If our patients have trust in us, then they accept that the treatment plan we recommend is consistent with the diagnosis we have given them. The bottom line is that the patient must know that we are acting in the interest

of their health and have no conflicting self-serving interests of our own.

A discussion of ethics and trust is a natural segue to the discussion of over-treatment. When patients walk through the office door, they are essentially asking us, "How is my oral health?" but probably not using those exact words. Many patients are unaware of the parameters for oral health, especially since there is often no pain associated with early caries or periodontal disease. They are on a fact-finding mission, one that the patient cannot do without our help. Our mission, besides satisfying any cosmetic issues patients may have, is to identify existing progressive biological processes as well as potentially progressive biological processes. They rely on us to interpret x-rays, screen for oral cancer, measure probing depths, verify margins of crowns, and check for sticky grooves and fossae. This raw information means nothing to the patient. The moment of truth comes when the dentist, "the expert," presents the diagnosis and treatment plan to the patient. There may be two stages of the treatment plan: one to address disease processes, and one to address elective, cosmetic concerns. Acceptance of the treatment plan requires that patients put their faith in the dentist's experience and training to develop a plan that is appropriate for each individual patient. Patient acceptance is more difficult to obtain when the line is blurred between elective treatment and treatment that is absolutely necessary to eliminate disease processes.

The Temptations of Over-treatment

There is speculation in some circles that over-treatment is done mostly for economic reasons, and primarily by new dentists. It is true that the price of dental education has skyrocketed in the last 50

years. As a new dentist, I can attest that the first loan statement I received in the mail was quite intimidating as I was just beginning my career and had the entire debt burden ahead of me at the mercy of compounding interest. However, the threat of an upcoming loan payment would never inspire me to alter my treatment plan to put my finances ahead of the patient's interest. All dentists, regardless of age, aim to be part of a thriving, successful practice. Just because young dentists have student loans does not automatically make us less moral. Furthermore, as we age, it is not that we have less debt; rather, we take on different types of loans. Instead of school loans, it may be business loans, a home mortgage, or new car financing.

I believe that over-treatment occurs for two reasons. If over-treatment is purely economically driven, then one might argue that it is being done intentionally. The other type of over-treatment occurs because of a philosophy that promotes an alteration of the concept of what patients actually "need." What I consider over-treatment and wish I would only see occasionally, some practitioners consider acceptable treatment and are doing it every day. These dentists who over-treat are probably not doing it consciously; they actually believe what they are doing is beneficial to the patient's oral health, based on what some authority, academy, or institute preaches.

You can ask three dentists the same question and get four different answers. The freedom to practice and to use clinical judgment on a case-by-case basis is at the very heart of what we do. However, I disagree with practice based on false concepts. A good example of this is full mouth reconstruction or other major occlusal treatments as a therapy for temporomandibular disorder. Whereas previous concepts about TMD have emphasized occlusal disharmony, most modern authorities regard tempo-

mandibular problems as benign and reversible with simple, conservative therapy such as resting the joint, relaxing the muscles, avoiding certain pain-provoking movements and behaviors, and the use of NSAID analgesics as well as oral appliances (splints). Long-term studies have shown that 80% to 90% of TMD patients can expect good short-term results with little or no long-term problems after these simple measures. Therefore, this 80% to 90% does not fall into the category of patients who have progressive, destructive biological processes mentioned earlier (Greene, 1992). Yet I continue to see orofacial pain patients who come from other offices with an elaborate oral appliance-wearing regimen. The patients report having both a maxillary splint and a mandibular splint and wearing them together or separately at certain times of day for certain periods of time. The splint regimen is considered Phase I of treatment, and is intended to "correct the jaw-occlusal relationship," by creating changes in the occlusal relationship/jaw position and vertical dimension. Phase II of treatment is intended to stabilize the patient's jaw-occlusal relationship, and is accomplished by occlusal alteration procedures ranging from simple equilibration to full mouth reconstruction (Greene, 1992). Recently, the 2009 *Cochrane Review* published a systematic review concluding that occlusal adjustment neither treats nor prevents TMD (Koh & Robinson, 2003). If these expensive, irreversible, and invasive interventions are not indicated and patients with TMD can get well without them, then why are these treatment plans still being prescribed to patients? Though dentists who do this may believe

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The bottom line is that the patient must know that we are acting in the interest of their health and have no conflicting self-serving interests of our own.

they are simply attempting to improve the patient's health, they are unintentionally over-treating because they are following a philosophy that is not backed by scientific evidence.

There are some patients in my practice who came to the office initially in search of a second opinion. In one particular case, I did my examination and presented the patient with a treatment plan costing approximately \$8,000, consisting of some operative and two three-unit bridges. Then the patient whipped out a piece of paper from his pocket and showed me a \$24,000 treatment plan from his previous dentist which included crowns on previously uncrowned teeth, and redoing all his bridges, even those that were still clinically intact. This is a wonderful illustration of what my grandmother and father had told me all along; a conservative approach to treatment is appreciated by the majority of patients.

A NEED FOR EVIDENCE

Practice should be evidence-based, and I am encouraged to see a move in that direction recently. Earlier generations of experts relied on their reputations and personal experiences to support their positions, but this has a great potential for bias and inconsistency (Bader, 2004). In dental school and during my residency, I learned a great deal about evidence-based dentistry and the hierarchy of evidence. I began to think critically about claims made without supporting scientific evidence; and even when there was evidence, I began to consider the source and quality of the evidence. Study designs can be flawed and can bias the way the efficacy of a therapy is viewed, so we cannot rely on a single study to answer a clinical question. It is important to maintain a healthy level of skepticism and question the validity of what we

read in journals and hear at lectures (Bader, 2008). There is a difference between citing evidence in support of a position and referencing an evidence-based position. The systematic review is an excellent tool that I think will become increasingly useful to both new and established dentists as more topics in dentistry are reviewed. Systematic reviews survey all the available evidence, select papers with the least biased designs, assess the validity and strength of the conclusions, and have formal rules set for this process. The dental literature available is voluminous; even if we kept up with reading every dental journal and had no clinical practice, we still would not have the time to digest the volume of information that is generated. We must be adept at identifying which literature is free of bias, statistically significant, and clinically relevant to patient care, so that we are deserving of the trust our patients bestow upon us, and so that we can earn the trust of new patients. This is the key to being a truly ethical dentist in the twenty-first century.



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IT ALL STARTS AT THE BEGINNING

Brooke Loftis, DDS

ABSTRACT

A young dentist described her decision to join the faculty at a dental school following her General Practice Residency. Among the important considerations were having been asked and having had an opportunity to experience teaching while a resident, the excitement of being close to the emerging trends in dentistry, and a sense of the importance of the formative years of becoming a professional.

Diversity within one's scope of practice is one of the greatest attributes of dentistry. It is almost as though you can "choose your own adventure" within the profession. But this is not always an easy choice. One of the hardest decisions I made was deciding on which direction my career would take. I always knew I wanted to be a dentist, but after graduation, I was unsure how I would leave my mark in the world of dentistry. It is important for each of us to ensure that we have a positive impact, whether it is through our practice or dedication to the profession. I have many goals for my career and dreams for the profession of dentistry.

It is up to us as professionals to guide dentistry in the direction we choose together. I want to share with you just a few thoughts of where we are headed and how we can create our own destiny. The future of dentistry begins today with our dental faculty and education. The solutions we create for faculty shortages and curriculum changes will affect the future of our profession. It is imperative that we develop contemporary faculty leaders and curricula integrated with today's technology.

Dental school prepares you for your future, but when do you take ownership of your profession and career? It varies for everyone, but most agree that it takes a few years to feel comfortable within the practical world of treating patients. Dental school gave me the basics of what I needed to practice dentistry. It equipped me with the Phillips and flathead screwdrivers for my toolbox and allowed me

to fix or treat probably 70% of patients. After graduation, I completed a two-year general practice residency. With residency, I added many tools to my toolbox which allowed me to confidently treat more complex patients. I would not be able to provide my patients as many treatment options without this additional training. Residency was essential and played a vital role in my decision to become a faculty member at the Medical College of Georgia.

Nevertheless, we will all practice dentistry differently from the way we do today. Therefore, dentists must be committed to lifelong learning. Continuing your education in dentistry can be accomplished through a multitude of avenues. The need for continuing my education makes dentistry a constant challenge and will help keep my career exciting and interesting for a lifetime.

One major challenge for many dental schools is attaining new, vibrant faculty to support a cutting edge curriculum. There is wisdom in experience, and some of my greatest mentors in dental school were individuals who could bring both an educational and private practice vantage point to my clinical dental education. Unfortunately, these individuals seem to be few and far between within



Dr. Loftis is a past ASDA president and 2007 graduate who now teaches at the Medical College of Georgia; loftisb@gmail.com.

If we created a federal or state program that would offer loan repayment for faculty positions, more graduating students or residents would consider a career in academia.

the walls of a dental school. It takes a composite of faculty who have private practice experience and other faculty who are more modern and current. The challenge is finding a way to attract both types to be leaders within dental education.

We must strongly encourage new graduates to stay involved in their dental school following graduation and serve as a mentor. Also, identifying new dentists as potential faculty members is important while they are completing dental school or residency. According to the *ADA 2008 Survey of Dental Graduates*, 70% of graduating dentists the year before went directly in to private practice. Only a small fraction of students actually enter dental school with the intention of joining faculty at the end of their school or residency. We need educators and mentors to help encourage or identify those who may have not identified themselves.

CHOOSING A CAREER IN EDUCATION

Only when a mentor asked me if I had ever thought about teaching, did I actually consider it. I always envisioned myself in private practice, but through my residency I began to realize that I really enjoyed teaching others. I had the opportunity to mentor co-residents and students and began to recognize my potential as an educator. One of the many positive teaching experiences I had in residency was teaching a hands-on implant course to private practitioners from all over the nation. As a teaching resident, you diagnose, treatment plan, and present the case to implant course participants. As a teacher, you instruct and guide the practitioner placing implants in your patients. This allows residents to take ownership of their teaching and it is a great experience for the course participants. It creates a fun learning environment, focused on the teamwork approach. There are many

things that I learned as an instructor of these courses and it reinforced the education I received as a resident. If we could create this type of opportunity for dental students and residents, their potential in dental education could be realized at an earlier point in their careers. Had I not been given this opportunity, my career very well could have taken a different path and I would not be where I am today.

In order for education to attain and retain new dentists as faculty members, academic careers must become financially competitive with private practice. The financial burden of dental and undergraduate education often weighs heavily with the decision to enter private practice where the opportunity for financial success is much greater. However, the choice does not have to be focused on compensation at the salary level. There are other possibilities that have not been explored to compensate and attract new faculty. Many of my classmates chose positions at community health clinics in order to receive loan repayment or forgiveness for their dental education. I understand that this idea centers on providing care for the underserved in health professional shortage areas. We have an excellent opportunity to do just this as an educational program and many schools already have rotations through community health clinics. But through satellite educational clinics maintained and operated by universities, we can increase faculty positions at the dental school and fulfill an unmet need for patient care.

If we created a federal or state program that would offer loan repayment for faculty positions, more graduating students or residents would consider a career in academia. The loan repayment program would need to be based on need, from the amount of debt accrued during undergraduate and graduate school, not solely the background of an individual. This type of loan repayment

could help ease the burden of minimal compensation for new faculty positions. This would not only increase the number of faculty at dental schools and satellite clinics, but would also increase access to care for our nation. Another way to attract and increase the number of new, contemporary faculty members at dental schools is by creating an opportunity and experience for them in private practice. If clinics could be created as a partnership between individuals and dental schools, there would be opportunity for mainstream private practice as a faculty member. Practicing in a clinic that is associated with the school but located off campus would allow for independence of the group practice while still creating revenue for both the school and individual. This clinical practice could be teamwork oriented, with many providers practicing part-time in one location.

STAYING CLOSE TO THE TECHNOLOGY EXPLOSION

Educators are at the core of shaping the values of young professionals, and they have the most direct impact on our future leaders. However, it is important for us to ensure that the dental curriculum remains dynamic and current with emerging technology and products. Keeping education contemporary for dental students and graduates is another challenge we face in education. There have been many changes in continuing education over the past few years that have focused on keeping education current. This is also a challenge for dental institutions. There is a balance that these groups strive for. In some cases, hands-on or tactile learning cannot be traded, but there are other areas where the interactive technology we have at our finger tips can help us create a learning environment that far exceeds traditional formats. The objective of providing

quality education remains the same; however, the methods of delivery can help keep it relevant.

One very interesting program that recently was developed by the Medical College of Georgia faculty and students is the Virtual Dental Implant Training Simulation Program. By playing a video game, dental students learn how to make a diagnosis, set up a treatment plan, and place implants on a virtual patient. It allows students to put the whole process together. Players start from the beginning with the medical history of the patient and then select and use all instruments and products needed for implant placement. As they virtually place implants, students even choose the orientation of the implant. The Medical College of Georgia and Nobel Biocare developed the program with Breakaway, Ltd. It will be launched this summer at 25 universities worldwide. Dr. Cibirka, the leading developer of the program at MCG, hopes that this tool will supplement the clinical experience of students. It is just one example of a cutting edge tool in development that focuses on preparing and educating students through advanced technology.

The American Dental Association has made strides in its scientific program to provide an experience for attendees that is evidence-based and contemporary. Last year at the 149th Annual Session, the ADA launched Web-based courses. These courses, named ADA 365, allow attendees to continue the course with a virtual classroom after the didactic portion. Participants can create an interactive profile where they interact daily with one another and an instructor throughout the year. The ADA offered 43 "ADA 365" classes this year in Hawaii. This example of Web-based classes stimulates communication and networking among professionals. The challenge is encouraging participants to actually use the program and virtual classroom to ensure success of the education opportunity.

Technology continues to change the way we can serve our patients. New products and services are constantly introduced into the dental market. As with any product, the consumer must decide its usefulness in practice. Many exhibitors focus on technology to increase patient acceptance. There is value in programs that provide patient education and aid dentists in more clearly explaining treatment options available. However, you must be aware of what you are purchasing and ensure the tools you choose work well for you.

STARTING AT THE BEGINNING

When I consider what I can do for dentistry, I often reflect on those who have influenced me the most. These mentors have created a sense of pride and confidence in my education. I hope that I can emulate the colleagues who did this for me in my career. I have a strong sense of philanthropy for my patients and my dental school education. One of the greatest opportunities we have as educators is to spread that sentiment. We can help develop a sense of philanthropy within our dental students and residents at an early point in their dental careers and help develop a sense of pride within each of them. As health-care providers, we are inherently altruistic with our patients and each other. One of my favorite quotes, which I heard as a first-year dental student, is from Dr. Art Dugoni, who asked "If not you, then who?" From that point on, I decided that I would always strive to make a difference in this profession. We should all challenge ourselves and our colleagues to find the passion to become involved and create our destiny. Once you see the difference you can make in the future of this profession, it becomes an easy torch to pass on to others. ■

IT'S ALL IN THE NUMBERS

Ruchi K. Sahota, DDS

ABSTRACT

Dentistry has always been a profession of change: each generation is enriched by the values and skills of the next. Generation Next is bringing to dentistry its diversity, comfort with technology, openness to bioscience, and involvement at the local level.

Grace. Patience. Strength. My mother, and a dentist for more than 30 years, Dr. Maninder Nijjar, moved to the San Francisco Bay Area at a time when no other dentists looked like her, none talked like her, and perhaps none knew what she was doing there. There were very few like her back then. Eleanor Roosevelt said, "The future belongs to those who believe in the beauty of their dreams."

Dr. Nijjar started a practice from scratch and became the pioneer East-Indian Punjabi dentist in Northern California. Today, the Silicon Valley of California bustles with hundreds of languages, brilliant shades of skin, and lots of successful immigrant stories.

Eleanor Roosevelt ventured to look toward a future she believed in. She dedicated her life to abolishing poverty, racism, and war—at a time when it was not popular to do so. "The purpose of life is to live it, to taste experience...and to reach out eagerly and without fear for newer and richer experience." My mother, my mentor and business partner, has been an example. There is no cap, no glass ceiling, and no limit on the future of dentistry. Dentistry's present is already bright. We are stimulating innovative technology. We are recognizing diversity. We are investigating ways to reach those who are underprivileged.

And dentistry's future is already upon us. We will watch for the effects of today's technology. How will caries vaccines, regeneration modules, and other research transform our opportunities to revolutionize the treatment of dentistry? How will robotics enter our field to renovate

the administration of dentistry? The most significant question is: How will we increase the number of dentists entering the scientific research world? There is a significant lack of manpower and dollars in this field. We will entice young researchers to enter science and encourage larger contributions to entities like the Paffenberger Institute through the American Dental Association's Foundation.

THE DEMOGRAPHICS HAVE CHANGED

Around the corner, we will witness the changing population demographic and resonance of the nation's diversity. United States Census reports predict that minority populations will become the majority. Minority populations will account for the most of the growth in population. "Asian/Pacific Islander and Hispanic populations will double in nearly all states...by 2025 since 1995," according to a report commissioned by the Department of Commerce (1999). How will oral healthcare delivery be revised to be more culturally competent with the "new" majority in the future? How will organized dentistry change with the influx of a more diverse leadership? The bigger question is how will our access to care issues be impacted and how will the geographic distribution of underserved populations develop? One of the defining characteristics of an



Dr. Sahota practices across the bay from San Francisco and is associate editor of the California Dental Association Journal and a graduate of the University of the Pacific; ruchi.nijjar@gmail.com.

underserved population is its geographic isolation. The Surgeon General's report in 2000, *Oral Health in America*, highlighted the oral health disparities found in minority races, cultures, and ethnicities. Others have identified a history of bias, stereotyping, and beliefs about minorities being a hindrance to care (Formicola et al, 2003). We can continue to educate our profession about cultural and linguistic differences for our potential patient demographic.

We will also see a variety of systems employed to reach the underprivileged. Whether it is transportation to an office, financial fences to affording treatment, or a family's priorities other than health-care, the challenges to the underserved may only become more complex. How will we bridge the gap between the geographic distribution of dentists and patients? How will governmental health-care programs affect treatment planning and the number of dentists enrolled in the programs? The more momentous question is how will we decrease the level of oral disease in these populations? Studies show that 80% of tooth decay is concentrated in 25% of children (Mouradian, 2000) and that one of the leading causes of children missing school is dental-related illness (U.S. Department of Health and Human Services, 2000). Though there are many contributing factors, including socioeconomic conditions, we must achieve better broad-based oral health literacy.

WE ARE ENGAGED AND CONNECTED

Surveys show that Generation Next dentists will be more engaged with

politics and national affairs than the generations before them (Pew Research Center for The People and the Press, 2007). I have served on my state's Government's Affairs Council and on the American Dental Association's Political Action Committee. I see that policy can only go as far as our state and national policymakers will take it. Organized dentistry's strongest benefit is advocacy for our profession. However the personal relationships with individual voters can also affect a politician's actions. Every famous congressman or woman starts as a local guy or gal running for public office. Last year, a friend ran for our city council. We held phone banks in the office. We walked precincts. We organized local physicians and dentists to rally around her. They knew she was a friend. They knew she had the intelligence, understanding, and courage to listen. We must identify more of these people in our towns so that when policy moves through the legislature, the public's oral health is protected.

The dentists of tomorrow will look for information and use networks with their peers. The dentists of tomorrow belong to Generation Next (those born in the 1970s through the 1990s). We are accustomed to accessing news, within minutes, when we want it, on our laptops. Surveys show that the majority do not read the newspaper or keep up with everyday news in the tradition fashion. Social networking sites keep us in touch with people we have not seen in years, all on a day-to-day basis.

I see that policy can only go as far as our state and national policymakers will take it. Organized dentistry's strongest benefit is advocacy for our profession.

There will be more seats to fill than there are leaders. There will be more challenges to face than there are new dentists to create solutions.

Six months into my general practice residency, I was asked to serve as the editor of my local dental society's newsletter, the *Explorer*. The first thing I did was pen our new mission statement, "To search, to delight, to learn." We would revamp the *Explorer* publication—without boundaries and limits. It was difficult getting the Board of Directors of the component society to agree to a fresh, colorful, and face-filled magazine with stories about the inspirations of our members and profession. Our newsletter had usually been a traditional medium to inform the members of society events and relay the editor's opinions.

We showcased themes: local diversity and population demographics, marketing 101, environmental green office tools, and healthcare reform implications. We told stories: profiling local leaders and illustrating their passions and motivations. Members noticed. The new *Explorer* gave practical information we used in our offices and stirring accounts about people we knew.

The values and social habits of Generation Next will become part of the DNA of dentistry (at least until they are superseded by the next wave of young professionals). And there is much to look forward to in this development. We can energize organized dentistry at the local level through camaraderie, learning from each other, and using both to grow our profession. So the number of new dentists reaching out to serve and not simply looking on—will increase.

It's all in the numbers. In 2008, we surveyed the number of leadership positions in California and the number of new dentists fulfilling them. There were 22 new dentist volunteers fulfilling 35 leadership positions. There are simply more baby boomer generation dentists than there are new Generation X and Y dentists. There will be more seats to fill than there are leaders. There will be

more challenges to face than there are new dentists to create solutions. But it also means that there will be more opportunities for us to get involved—and more reason to get involved.

The *Explorer* experience taught me the value of forming relationships and working together for the betterment of our profession. Generation Next seeks mentors from among older friends and family members. We believe in other dentists' stories—their struggles, their victories, their lessons. And we believe in the value of coming together for a common cause—be it a national presidential election or be it organized dentistry. We believe in the strength of service. I believe we will be able to make a difference. So today I am involved: to listen, observe, and understand. We can expand upon our knowledge base and broaden the foundation of our experiences so we, today's new dentists, can make qualified decisions to move the profession. ■

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jrule0870@verizon.net

A DENTAL DEAN'S PERSPECTIVE ON ETHICAL REMEDIATION OF PRACTITIONERS

Sharon P. Turner, DDS, JD, FACD

ABSTRACT

A dental dean reviews the recently reported work of Dr. Muriel Bebeau providing an ethics remediation program for dental professionals in Minnesota who have been referred by the Board of Dentistry for disciplinary reasons. Dean Turner notes that the program is grounded in evidence, theory, practical cases, and critical thinking—all important elements on effective professional pedagogy. Issues associated with extending this approach to other states and into predoctoral education are explored. It is concluded that the documented effectiveness of the program belie claims that ethics cannot be taught.

The first article of Dr. Bebeau's two-part series described the use of a structured instructional program in ethics as a tool for a dental licensing board's management of licensees facing disciplinary action. The second provides evidence that the process is effective. Dr. Bebeau shows that her program teaches licensees referred for ethics violations to recognize potential ethical problems, and then to analyze situations appropriately so as to make ethical decisions. Dr. Bebeau's work is supported by a significant volume of literature that demonstrates the theoretical grounding of Rest's Four Component Model of Morality. The four components in this system—which are identified as sensitivity, reasoning, role concept, and ethical implementation—represent capacities that individuals must possess to practice dentistry in an ethical manner.

At present dentistry and dental education are striving to enhance their approaches to include more scientific grounding to support what is taught about clinical treatments and how it is taught in a movement that has been labeled "evidence-based dentistry." Dr. Bebeau's work takes just such an approach, as it is validated by research in fields that develop instruments used for assessments and education methodology. Additionally, her description of the theoretical underpinnings of Rest's Four Component Model of Morality successfully ties that theory to its application via customized instruction. Her instruction about Rest's components provided for licensees referred to her for violations of the Minnesota Dental Practice Act places emphasis on the specific component of relevance to each person. The framework that she has developed also has a set of assessment tools that are able to identify weaknesses in each of the four components. Moreover, her approach is individualized in that each participant in her program is given a personal assessment of his or her individual strengths and weaknesses among the four capacities recognized as necessary for forming and carrying out ethical treatment decisions in a dental setting.

Dr. Turner is Dean and Professor of Oral Health Practice, College of Dentistry, University of Kentucky; turnersp@uky.edu.

Dr. Bebeau explains that, to practice dentistry ethically, a provider must first have sensitivity to moral or ethical concerns that arise in the course of his or her work. This requires one to have the ability to identify when moral or ethical issues are presented during a patient interaction. Weaknesses in this capacity are evaluated using the Dental Ethical Sensitivity Test (DEST), which measures ability to interpret the ethical dimensions of problems that occur in the practice of dentistry. The second capacity from the Rest model is that of moral reasoning, or the ability to analyze choices for resolving a moral situation and the justification for each choice. This capacity is assessed using both the Defining Issues Test (DIT), which measures the relative importance of reasoning strategies, and the Dental Ethical Reasoning and Judgment Test (DERJT), which asks practitioners to select sound ethical choices and to provide appropriate rationale for these choices. The third ethical capacity is understanding the appropriate role concepts for professionals in society. This is measured using the Professional Role Orientation Inventory (PROI) and Role Concept Essay (RCE). Finally, ethical implementation of behavior once such behavior has been defined is also measured by the DEST, which allows the assessment evaluator to make judgments about problem-solving and interpersonal communication competencies. Dr. Bebeau contends that the deficiencies of any given practitioner from among these four essential capacities, once demonstrated via assessment by validated instruments, may be remedied by targeted instruction using a case-based Socratic type of analytic teaching methodology.

She provides outcome testimonials that show her process helps practitioners to regain a sense of professionalism and be rehabilitated to practice in an ethical manner. Her theoretical arguments are solidly based on validated research, which has been reconfirmed through her own many years of application and evaluation. I believe that this process is therefore well-grounded and sustainable as a model for both the rehabilitation of practitioners who have experienced lapses in ethical practice as well as for ethics education of professional students.

I believe this process is particularly effective in the field of dentistry because dentists and dental auxiliaries are professionals whose knowledge is grounded in science and the research that informs it as a result of their training. Thus, they respect research-based theory that can be applied in real-life situations. This respect lends credibility to the process and anticipates the positive outcomes reported. Dental practitioners are also well acquainted with the use of clinical observations and findings to formulate a diagnosis prior to performing a treatment. They should thus be able to appreciate Dr. Bebeau's assessment instruments that allow for scientific formulation of a diagnosis of the deficiencies responsible for mistakes which resulted in disciplinary action. Framing the rehabilitative process in a clinically analogous manner helps practitioners move past initial emotions of anger and embarrassment and begin to focus on their specific deficiencies as identified by the assessment instruments. The very fact that Dr. Bebeau is able to identify a "treatable problem" and then embark on targeted educational treatment to "cure" the problem allows these practitioners a way to accept this important assistance to enhancing their professionalism, as well as restoring their self-esteem.

A course of treatment in Dr. Bebeau's program begins with an interview designed to explain the process and

establish trust. The practitioner is then given the assessments and evaluated in each of the four ethical capacities to determine individual weaknesses. Actual treatment consists of multiple seminar sessions involving interactive instruction and written assignments in which practitioners are asked to analyze ethical dilemmas from real cases. The length of the course of study is determined by the scope and depth of the deficiencies identified as well as the progress made by the participants. The course finishes with a written capstone essay that presents an ethical dilemma and its resolution followed by a post-course reassessment of the capacities necessary for ethical patient treatment. Completion time is driven largely by the progress of the practitioner between instructional sessions. The cost of the program, along with the desire to regain licensure as rapidly as possible, should serve as motivation to demonstrate rapid improvement. However, time is built in between sessions for assimilation of concepts, which strikes an excellent balance and prevents "students" from completing treatment without due reflection. Moreover, I suspect that the many years that Dr. Bebeau has used a similar approach in teaching ethics and professionalism to dentists has allowed her to develop a sense of the appropriate amount of time necessary for the majority of professionals or professional students to grasp the theoretical concepts and begin applying of them to problem solving.

The approach that Dr. Bebeau has developed would seem to be one that could be applied by other state dental boards or academic dental institutions. Indeed, because it uses case-based learning, cases could be developed for relevance to ethical dilemmas in almost

any profession, and its application could be extremely widespread. All that is needed to make this instructional approach applicable to the practicing dental profession is the will of dental boards to require such an extensive and expensive program for remediation and the availability of such a course within the geographic area overseen by the board. Alternatively, to apply this conceptual framework in the context of a pre-doctoral education program for dental students, curricular time must be allocated and the material must be developed for integration within the curriculum. There also must be faculty members that are willing and competent to deliver this component of the curriculum. A potential snag in the implementation of Dr. Bebeau's course by additional state boards is that it is quite academic in structure and thus may be viewed as associated with the maligned "ivory tower" by some dental boards. Yet it is the very intellectual rigor and evidence-based approach to teaching and learning that makes this course so appealing. Additionally, the results this course has achieved as evidenced by the self-assessment material from participants and the statistical significance in assessment instrument results between pre-course and post-course testing attest to its power and effectiveness.

Given that the key to this approach to teaching ethics in the context of dental practice is the availability of knowledgeable persons to teach the material and serve as mentors in the rehabilitative or development process, it is extremely encouraging that Dr. Bebeau has found that members of the American College of Dentists volunteer to learn to teach such courses. Enthusiastic instructors who are highly regarded by practitioners or students will now be needed throughout the country for this approach to be emulated elsewhere. It is clear that the face-to-face interaction with an "expert"

in the ethics field who takes a nonjudgmental, diagnostic based approach to remediation is also a necessary element of the success of this program. Progress would be impossible if practitioners needing remediation or rehabilitation did not see their instructors as competent or of the highest integrity. Whether the use of distance learning technologies, in states that are more rural or geographically remote from available experts, would produce the same results as the in-person exchange remains to be seen. It does seem reasonable that some type of interactive video-conferencing might make this program and its process more widely available, but a cadre of well trained instructors will continue to be important to the spread of this approach.

Perhaps the most appealing part of this program for me as a longtime dental educator is the emphasis that it places on development of critical thinking skills through the application of analysis and analogy to case based material. Critical thinking is among the most important aspects of professionalism. Isolated facts must be synthesized around theoretical constructs and then applied to the conditions at hand if a dentist is to be more than a skilled technician who is proficient at psychomotor tasks. For too many years dental education has placed a vastly disproportionate share of its curricular time on fact memorization as tested via multiple-choice examinations and on psychomotor skill building. While these are, of course, important aspects of a dental student's education, they are not enough to prepare him or her for a future as an

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Perhaps the most appealing part of this program for me as a longtime dental educator is the emphasis that it places on development of critical thinking skills through the application of analysis and analogy to case based material.

independent practitioner. I believe for this reason the American Dental Education Association's Commission on Change and Innovation in Dental Education was created. This group has worked to change and enhance dental education in many ways, the most cogent of which to the subject at hand is to lead the revision of the standards for accreditation for predoctoral dental programs through the Commission on Dental Accreditation. The recommended changes in the standards call for enhancement of critical thinking skills, ethics and professionalism, and the provision of education in a humanistic environment for students and patients. These changes in dental education should help our graduates to be better equipped to deal with situations that in the past have led to disciplinary actions by dental boards. Dr. Bebeau's course is a great example of a teaching method that leads to development of critical thinking.

Finally, I believe that these articles effectively refute the age-old opinion of some that "you can't teach a dental student ethics" which, by extension, would suggest that you cannot teach a dentist ethics. Those holding this opinion would likely espouse that the rehabilitation of those who make mistakes is not possible and that efforts to do so are a waste of time and resources. Dr. Bebeau reports in her articles that she begins her assessment interview by stressing to those referred to her that everyone makes mistakes at some point in life and it is her purpose to teach her "students" what led to those mistakes and how to prevent them from recurring. Then, she carefully disaggregates ethical practice into the four components necessary to allow for the effective application of its principles to the practice of dentistry. She next provides specific instruction to raise the level of awareness of each

component to a conscious level by giving the component a name and a definition. In so doing, she makes a theoretical concept concrete and clinically relevant, which is critical to the provision of meaningful instruction.

Perhaps those who believe that ethics cannot be taught are simply not familiar with the concepts that form the building blocks of ethics or the application of terminology that describes those core values that form the criteria for ethical practice. What we cannot label or name is certainly difficult to teach, yet we see here that we can use real-life situations to demonstrate these concepts as we name these competencies "ethical sensitivity" or "implementation of ethical solutions." Thus, Dr. Bebeau's approach allows students and practitioners to understand weaknesses in their own natural tendencies and to see which tendencies must be regulated to assure ethical dental practice. Of particular interest is the portion of the course that helps students or practitioners anticipate patient requests or actions that could lead a dentist to commit ethical missteps inadvertently. The caring practitioner wants very much to help patients but must guard against actions that overstep ethical bounds. Knowing how to respond to an inappropriate request in a manner that preserves the dignity of the patient yet firmly explains the risk to the dentist is an invaluable skill. Throughout all of the phases in her program, Dr. Bebeau undeniably demonstrates that both ethical theory and its specific application in dental practice can indeed be taught to professionals and students alike. ■

REMEDIAL ETHICS PROGRAMS FOR PHYSICIANS AND DENTISTS

Joseph C. d'Oronzio, PhD, MPH

ABSTRACT

Both Bebeau's program for ethics remediation of dentists in Minnesota and ProBE, a nationwide ethics remediation program for physicians and other health professions, grew out of society's concern in the 1960s for responsibility and accountability of those in authority, including professionals. The ProBE program is described, and differences between it and Bebeau's program are highlighted. The ProBE program is a bit shorter in duration and focused on specific, individual ethical violations. It uses tensions—such as the contract between knowing what is right and doing what is wrong—to develop personal insights. A multidisciplinary team of several coaches is used in the ProBE model, and it does not depend on pre- and post-course gain scores. Bebeau's approach may be more readily adapted to predoctoral education, since it is more generic and theoretically based in the Rest model, whereas ProBE is grounded in the real and specific ethical violations of individual practitioners.

The basic premises of the 1960s rebellion of "Question Authority!" were found to be justified by Watergate at about the same time as Tuskegee's inappropriate use of prisoners as subjects in medical research. That movement soon solidified into a revolution of accountability that rippled over our mainstream cultural landscape. Just as the Watergate mentality established itself as a permanent feature of our political environment, Tuskegee found expression in health care marked by the emergence of formal research ethics, the establishment of the IRBs (Institutional Review Boards), the birth of the discipline of clinical bioethics, and a renewed interest in "professional ethics." This increased scrutiny of the behavior of the professions from external sources required a clarification of standards from within.

As a symptom of this trend, more "codes of ethics" have been devised and revised by professional societies in the last 20 years than in the previous 20 centuries. Likewise, there has never been as much systematic regulation of the professions. As a consequence, there has emerged what can only be described as a cottage industry of programs that address this combination of scrutiny and regulation with assessment, evaluation, remediation, rehabilitation, and renewal in the healthcare professions. This was the milieu within which the developmental psychologist, James Rest, developed

his Four Component Model (FCM) of morality formulation to address moral peer accountability (Bebeau, 2008).

I collapse this account of an involved and complicated trend to suggest essential background for my commentary on Muriel Bebeau's articles. She and I share this common context in our respective efforts to remediate and renew a sense of professionalism for individuals who have been identified by their licensing boards for practice act violations that involve some transgression of professional ethics. Other major initiatives in this area have been catalogued by the Federation of State Medical Boards in their "Directory of Physician Assessment and Remedial Education Programs" (www.fsmb.org/pdf/RemEdProg.pdf). In addition, there is a professional consortium of assessment and remedial education agencies called the Coalition for Physician Enhancement which was organized more recently (www.physicianenhancement.org).

Dr. d'Oronzio is Associate Clinical Professor, Department of Health Policy and Management, Mailman School of Public Health; Faculty Associate, Center for Bioethics, Columbia University; and Program Director, The ProBE Program, Center for Personalized Education for Physicians.

It is important to make explicit this communality of shared intent. The founders of the ProBE Program and Muriel Bebeau are equal innovators in an initiative that has proven to be worthwhile and supported by the community of healthcare regulators. While there are significant differences in our approaches to the task, it is important not to lose sight of the broader parallel intent to which we have been responsive.

A brief account of the ProBE Program will serve to introduce a different approach to this mutual interest and provide a preliminary basis for examination and comparison of such matters as theoretical foundation and structure of the programs, translational issues, and future directions.

THE PROBE PROGRAM

Since 1992, I have directed the ProBE Program which, like Bebeau's, was a response to our local board's request for a "course" that would provide remediation in professional ethics (d'Oronzio, 1996; 2002). ProBE is a heavily worked acronym that stands for Professional Problem-Based Ethics. From the very start, we distinguished ourselves from an ethics "course" in that we were immediately focused on a specific problem behavior, and also from a "medical ethics" or "death and dying" course in that we addressed the mores and ethos of the healthcare professions. In our initial response to the New Jersey Board of Medical Examiners, the ProBE Program accepted only New Jersey physicians (MD, DO, DPM). We expanded as a national resource in 1996 (currently 45 state boards have referred nearly 700 licensees) and since 2000 we accept

referrals from all of the healthcare professions. This includes referrals from dental boards, of which we have had 50 participants (including two hygienists and one dental assistant) from six state boards in the last decade. Since 2007, the ProBE Program has been offered under the auspices of the nonprofit Center for Personalized Education for Physicians in Denver, Colorado. A more detailed description of the ProBE Program can be found at www.cpepd.org/probe.

Individuals are referred to the ProBE Program mainly from three sources: licensing boards (as part of a consent order); legal counsel (as preemptive or anticipatory of formal legal action); and other agencies outside of the formal governmental regulatory framework, such as hospitals, professional schools, or physician health programs. Once enrolled, the participants receive a 150-page syllabus of reading materials and assignments to be completed before, during and after the ProBE sessions. These sessions enroll up to 14 participants and take place over a weekend in an intensive workshop format consisting of seven modules. Each module provides a structure within which the specific problem (infractions) of each client is reexamined and deconstructed in anticipation of the preparation of a capstone assignment (the "final essay"). This final essay provides the opportunity for the participant to demonstrate understanding of the infraction in terms of professional ethics learned in ProBE. It is the final product of the participants' work in the ProBE Program in that it is the major basis for the faculty evaluation and assessment report which is submitted to the referring agency along with a copy of the essay. The program consists of 22 hours: 14 hours of actual contact in the workshop and an additional eight hours of preparation and follow-through that is required to complete the program.

This is a modest estimation and the time from enrollment and preparation to completion and evaluation is normally seven weeks.

THEORETICAL GROUNDING AND CONCEPTUAL FRAMEWORK

The conceptual framework of the ProBE Program is pragmatic, eclectic, and explicitly focused on the offensive behavior that occasioned licensing board sanction. It is the dynamic of a ProBE Program workshop, focused as it is on the personal, specific infractions of the participants, that tends to determine applicable moral theory. Several recurrent inherent tensions of moral judgment drive this dynamic. The first is the classic cognitive dissonance of knowing "the good" but acting "the bad." This is developed in the first two assignments in which, on Friday evening, our participants present advice each might give to an aspiring student for writing a personal admissions statement that spells out the virtues of the "good doctor." This is followed, on Saturday morning, by a recitation of the details of their individual infractions. The contrast between knowing the idealized virtues and behaving in ways judged to be unprofessional creates a dramatic, dynamic tension. These "live" cases permeate the whole weekend by providing recurrent illustrations for the application of concepts of morality and professional ethics.

Similar exercises, readings, and assignments are aimed at developing other moral judgment tensions: the recognition of the difference between a boundary crossing and boundary violation in the spectrum of clinician-patient interaction; the identification of the failures of internal personal and professional self-regulation that generates legitimate mechanisms of external social accounta-

bility and state-based regulatory action; and, the reconciliation of multiple alternative ethical demands (e.g., business ethics, personal loyalty, social injustice) with the need for a prioritized singularity of an integrated professional ethic.

The systematic and confidential process of working these tensions through the several modules in a seminar of peers engenders a multidirectional nexus of direct and honest communication. This is often refreshingly novel to an isolated clientele whose contacts in the circumstance of discipline have been dominated by blame, shame, and adversarial interactions with boards and lawyers. For most participants in these groups, this dynamic is productive of insight and new understandings that each are able to articulate in the final essay, which together with their participation is evaluated by the two faculty members and assessed for the referring agency. This final assessment takes the form of a detailed letter describing the participant's performance in the workshop, an analysis of the essay, and a summary assessment of high pass, low pass, and fail. We think of our work as remediation and, in a sense, rehabilitation and thus see our judgment as that of an independent third party. In contrast with Bebeau's practice, between the referral, including provision of the consent order or other documentation of the problem, and the receipt of the assessment, there is no interaction between the referring agency and the ProBE Program. This arrangement depends on mutual trust and confidence, which we are proud to have earned from the healthcare licensing community.

It has often been said that how one frames a problem is predictive of how one solves it. This is most accurate when dealing with value-laden problems in ethics and social interactions and the central issue is of suitability. Bebeau's approach reflects her distinguished background in measurement and assessment instruments for educational psychology that she brings to the venture. The background and training of the (currently) six faculty of the ProBE Program, although commonly focused on bioethics, is multidisciplinary, drawing from the fields of medicine, psychiatry, philosophy, health law, public health, health policy, and social theory.

These differences help define significant divergence in the theoretical framing of our respective approaches. Bebeau's approach is predominantly quantitative, using no less than five instruments to provide a "diagnostic assessment" based, roughly, on Rest's FCM approach and its extrapolations. She uses test scores to identify deficiencies in judgment, and perhaps "character," and retakes are encouraged before a course design is submitted, approved by the board, and implemented.

The great potential value of this approach is that it allows for an objective pretest and posttest evaluation. The measurements that demonstrate that the educational intervention "works" depend upon the testing strategies. The great danger here is that an educational intervention so constructed will "teach to the test." This seems an especially relevant caution as there is significant and extensive three-way communication with the referring board both before the course is developed and before the client is finally evaluated. Can a client actually fail in this scheme of reiterative assessments? There is no mention of such an outcome: is this the result of good luck,

There has emerged what can only be described as a cottage industry of programs that address this combination of scrutiny and regulation with assessment, evaluation, remediation, rehabilitation and renewal in the health-care professions.

the high moral character of the 40 clients, the ability of the structure to finally elicit the “right” responses, or its inability to weed out even the most densely challenged unprofessional? Interestingly, the ProBE fail rate of 6% is about the same as Bebeau’s recidivist rate (discipline after passing the course), while the ProBE Program known recidivist rate is approximately 3/700 or .004%.

To administer before- and after-tests for ProBE Program participants would be an interesting experiment, and perhaps a helpful tool of analysis. Indeed, one of our faculty members, Catherine V. Caldicott, MD, at Syracuse Medical University, has worked with Muriel Bebeau to develop a medical version of the DERJT, called the Medical Ethical Reasoning and Judgment Test (MERJT). For ProBE purposes, this would be most effectively administered parallel to the program to see if the ProBE Program affected our clients’ ethical reasoning, judgment, and sensitivities. It would not, however, fulfill our remediative intent to gear the program itself to the pretest to posttest success. There is no assurance and scant evidence that remediation occurs as a result of the testing sequence alone, particularly if it is reiterative. The quality of the interventional education process, independent of the testing, is the key.

A SHORT NOTE ON VIOLATIONS

Definitions and categories of professional ethics violations are extremely variable. For example, a great many consent orders of ProBE participants are negotiated in lieu of, as well as adjunctive to, malpractice action. We ignore the legal liability element and address the underlying professional ethics aspect. This definitional difference makes comparisons across programs difficult. In general, however, the types of violations for which dentists have been referred to Bebeau’s course are somewhat different from those seen by the ProBE Program and vastly different when all the health-care professions are taken into account. In her typology of infractions, allowing auxiliaries to perform duties exceeding the state Dental Practice Act, insurance fraud, poor record-keeping, and complaints about competency account for 45% of the cases. For the ProBE Program dental infractions, insurance fraud and poor record-keeping are also most prevalent, but boundary violations and controlled substance diversion violations are next for ProBE, accounting for about 15% each. These latter two do not make the top 70% in Minnesota.

At risk of making too much of this difference, it is worth noting that on the spectrum of infractions, ProBE seems to see more radical or complicated departures from the norms of professional ethics. This may contribute to differences in the two frameworks in that these violations are less cognitive and more interrelational. Confronting these lapses of judgment is aided by ProBE’s open discussion within a peer contact setting in ways that have made 12-step programs successful. The group setting, the presence and facilitation of at least two faculty members, the freedom granted

by our confidentiality agreement, and our laser-beam focus on specific infractions may be traced back to the types of violations we have confronted.

TRANSLATIONAL POTENTIAL: THE NEXT GENERATION

There are two “next generation” issues for these two innovations: translation to a student population, in effect offering a preventive solution to unprofessional behavior, and extending and continuing these valuable remediative offerings into the future.

A frequent complaint of ProBE participants on Sunday afternoon is, “Why wasn’t this part of my training?” In fact, there has never been a session of ProBE that has not concluded with a general and sometimes loud and animated agreement that this program ought to be offered in medical school and residency training. The response of the faculty has been between dubious and unenthusiastic. All of us bring topics in professional ethics into our classes, conferences, and consultations, but offering of a ProBE-style program or “course” would not be effective. We understand from teaching and practicing clinical bioethics that it is best received where there are real issues or dilemmas to be addressed. It is most “teachable,” for example, to a fully trained, fully accountable attending physician caught in the vital cross-hairs of an unfamiliar conflict of values in which a well-reasoned decision must be made—carefully, competently, and, too often, quickly. ProBE is like that. It addresses a specific problem within a range of problems that are not in the imagination, much less the experience of the medical school student.

Bebeau’s course, on the other hand, seems eminently well-suited for any level of education. It frames the issues in broad terms and is driven by testing instruments that depend on a variety of moral responses to these issues. There

will always be variety and thus teachable variances in the diagnostics.

Hypothetical cases are organized within the approach defined by the instruments measuring Rest's FCM with significant effect. Indeed, case analysis is at the heart of at least three, and possibly all five of the instruments used. In addition, the FCM is extremely accessible as an intellectual construct and is broadly applicable to common life situations that tap into the student universe and are applicable to the professional life to which they aspire. In short, unlike the ProBE Program, one does not need to have been identified as having breached a professional ethic to be taught and to learn from Bebeau's model.

I suspect, however, that the main problem of translating her model to the student audience is, like using it for a professional clientele such as is seen by the ProBE Program, a practical one. It would require an allocation of course time and student attention in a curriculum that is notoriously crowded, perhaps making it prohibitive.

As to the second translational issue, replication of both of these innovations is both desirable and difficult. For the ProBE Program, this has taken the form of gradually putting a new faculty in place through a systematic training using a mentor/apprenticeship model over three years (2008–2010) and the assumption of management by the Center for Personalized Education for Physicians of Denver, Colorado. The Minnesota course would require a similar transitional training, but because of its relatively standardized educational testing format, this would seem to be a less involved process. The difficult aspect of this would be the transference of Muriel Bebeau's cumulative wisdom and experience in delivering the educational

content. A "mentor cum apprentice" process, while desirable, may be more difficult to accomplish in that she has, until now, taught alone in that important aspect of her work.

Conclusion

The shared intent of these two initiatives is best captured by the cumulative, if qualitative, research and reflection presented by Bebeau in her final sections on "Educational Significance" and her "Conclusions," which, in general, match very closely the overall experience of ProBE. We both see that it is important for licensing boards and the professions to address ethics violations with effective programs, rather than making ambiguous and unproductive gestures of punishment without remediation. The programs are different, but the ultimate message is that participants benefit from these programs and we both report that they can make a significant impact on the professionals and a new understanding of the practice of accountability. ■

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The contrast between knowing the idealized virtues and behaving in ways judged to be unprofessional creates a dramatic, dynamic tension.

A PRACTICAL PERSPECTIVE ON REMEDIAL ETHICS: MINNESOTA BOARD OF DENTISTRY

Candace Mensing, DDS, MS, and
Marshall Shragg, MPH

ABSTRACT

The President and Executive Director of the Minnesota Board of Dentistry describe how the Bebeau course in ethics, for dentists referred because of ethical lapses, is used as part of the disciplinary process in the state. It is understood that breaches of ethical standards are a complex phenomenon, often engaged in by practitioners who know that they are doing wrong but nevertheless choose to do so. Typical patterns of transgression that result in referral to Dr. Bebeau's course include inappropriate billing practices, improper relations with staff or patients, questionable advertising, substandard care, "rough behavior," and gaps in infection control.

State dental boards have the responsibility of protecting the public through the regulation, licensure, and discipline of dental professionals. The disciplinary process—investigating and resolving complaints—is managed differently by various boards. What is similar across boards, however, is that when a licensee is found to have issues that require remediation, dental boards seek to find a resolution that can directly and effectively address the identified problems. Oftentimes, those problems are ethical in nature. When the Minnesota Dental Board's complaint review committees determine that allegations include a faulty decision-making component, the committees must consider specialized assessment and remediation options. The committees select from several choices for remediation through lecture, hands-on, Web-based, and other educational programs. When the problem appears to include a licensee's inability to make correct choices when confronted with a specific set of circumstances, the board has been fortunate to have the option of referring the licensee to Dr. Mickey Bebeau's individualized ethics course through the University of Minnesota School of Dentistry.

Before this course was available to complaint review committees, there was no educationally verifiable way to assess or to teach the complexities of sound decision making for practicing dentists. Clearly, dental school education teaches standards of clinical practice. The

University of Minnesota School of Dentistry and all other U.S. dental schools also provide formal ethics courses for their students within the dental school curriculum. Nevertheless, practitioners may not recognize their own issues, may have no inclination to pursue additional education in the ethical dilemmas of dentistry, or may be uncomfortable confronting their own basis for decision making. They may not have or may not be willing to effectively develop the ability to choose between "right and wrong," between "better and best," or between "what I want versus what my patients need." When business pressures, the patient's right to informed consent through a complex discussion of treatment options—relating prognosis, benefits, risks, and alternatives—and other life stresses are added to the mix, a licensee may lose his or her ethical bearings.

Complaint review committees use the Bebeau ethics course to guide a licensee into understanding the process of sound decision making. Based upon the board's experience with the course and the evidence that referred licensees profit meaningfully from it, the hope of the committees is that learning about

Dr. Mensing is President and Mr. Shragg is Executive Director, Minnesota Board of Dentistry.

ethics and learning about one's own decision making inclinations will produce better practitioners. And when the board recognizes that a licensee lacks the skill set needed to practice in an ethical manner, then perhaps this skill set must be taught. Thus, the ethics course is a good place to begin remediation.

Several examples can be given of unethical or unprofessional conduct that would result in a referral from the Board of Dentistry to Dr. Bebeau's course. One example is a licensee who engages in inappropriate billing. Complaint review committees investigate and interview the licensee to determine if the billing problems are numerous, demonstrate a pattern, and occur over a period of time. The committees also determine whether the billing issues are inadvertent or unintentional due to poor business practices, or if they are premeditated and fraudulent. In the former case, the licensee may be referred to educational programs that help with instructing in proper billing procedures. In the latter case, the committees may refer the licensee to the ethics course (among other remedies).

A second example, seen occasionally in disciplinary cases, is the inappropriate use or treatment of employees and allied staff, and occasionally patients. The behaviors here range from verbal abuse to inappropriate sexual comments to unwanted physical contact to allowing staff to perform duties beyond the scope of practice. The committees make a referral for the ethics course in the hope

that the licensee will learn to identify the inappropriate behaviors, the causes and triggers for these behaviors, and their remedies. The only acceptable outcome is to protect the public, including employees, from unwanted, intrusive or predatory behaviors.

Another example where the Bebeau course has been useful involves the use of sedation in dental procedures without the proper monitoring of the patient's vital signs or without proper record-keeping of the monitoring process as required by the state's statutes and rules. Because committees know that these actions put the patient at great risk, the committees refer the licensee to the ethics course in the hope of determining the underlying reasons for engaging in these unnecessary and dangerous practices. This remedial ethics process should help a licensee modify behaviors from unethical, illegal, and unsafe practices to practices that ensure the safety of sedation patients and comply with existing statutes and rules.

A fourth example of potentially unethical practice relates to advertising. Some licensees claim ambiguities and inconsistencies in the laws. Some licensees find creative language in order to circumvent the law. Others claim to misunderstand the rules. Still others disagree with the rules in principle and intentionally violate the law. Yet others

A broader question is whether or not all licensees would benefit from this course, through a core competency requirement in continuing education and professional development.

Fortunately, there has been little recidivism with the individuals referred for this assessment and individually directed training.

presume that if someone else is doing it and getting away with it, it must be acceptable. Most practitioners, irrespective of their personal opinions, follow the relevant statutes and rules because it is the legal and ethical thing to do. Those who violate the law may hope to gain some economic advantage over competitors. Those who do not violate the law accept that whatever economic advantage may be gained is not as important as compliance with the law. The committees hope to help the licensee find out why he or she feels entitled to break the law. The ethics course may help some licensees see their way through this conundrum.

Providing care below the standard is another ethical concern that committees must address. One example is providing substandard periodontal diagnosis and treatment. Most licensees understand that provision of care at a certain minimum level is an essential part of complete dental care for all patients. But there are some who feel that they can neglect this care, or can provide care below the acceptable level provided by all other dentists. Flawed decision making puts the patient at risk and simultaneously puts the licensee at risk. Yet the board continues to observe this risky behavior. What cognitive processes occur within the mind of licensees that permit them to engage in substandard practice? The committees again hope, expect, and trust that licensees will discover their problems with the help of the ethics course and then proceed to improve their clinical practices and provide safe patient care.

Delivery of painful care, poor administration of local anesthesia, and gruff bedside manner are manifestations of

ethical problems for some licensees. Although this category of unethical, unprofessional care may be more subjective—and thus more difficult to define—the complaint review committees are concerned about licensees who amass several complaints of this type over time. Thus, a pattern of behavior demonstrating a lack of empathy results in a complaint committee's referral to Dr. Bebeau for ethical intervention.

A final example where ethical choices are paramount in dental practice is in regard to infection control. Most of the infection control procedures necessary to prevent the spread of infectious agents occur in the dental practice's sterilization area, out of the visual scrutiny of patients. The dentist and staff have the important role of self-regulation when it comes to proper and safe infection control procedures. If the dentist is negligent and sloppy with infection control procedures, then the staff may be as well. When compliance committees receive complaints alleging improper or substandard infection control procedures, the committees generally discover some dentists who know what should be done, but who, for some reason, do not follow through. The obvious question is why a dentist would put patients, staff members, and themselves at risk by not enthusiastically complying with OSHA and CDC rules. Again, the solution may be found in unraveling the ethical viewpoint of the dentist whose reasoning, attitude, and conduct are flawed. For answers and expected changes in behavior, the board also refers licensees with infection control infractions to Dr. Bebeau. Along with the ethics course, additional reeducation may also include infection control coursework followed by on-site office inspections. The board recognizes the multidimensional aspects involved in providing quality health services.

Throughout this discussion the phrase “the committees hope” has appeared several times. The committees “hope” to assist the licensee with ethical decision making. But the committees are also aware that a licensee’s behaviors may be like other compulsions and addictions, in which there may be some initial measurable success, but in which long-term success is much less certain. Will the unethical behaviors slowly resurface, placing the public again in harm’s way? Recidivism is the long-term challenge for the committees and the ethics course. Additionally, the board is concerned with the practical application of the ethics course. Does the licensee now have improved ethical and moral reasoning and judgment? Will these improvements protect the public? This is indeed what we hope for, and why we greatly value the work of Dr. Bebeau and her success with the dentists who are referred to her program. As demonstrated by her data and confirmed anecdotally by the board, remediated licensees have achieved the hopes of the board.

A broader question is whether or not all licensees would benefit from this course, through a core competency requirement in continuing education and professional development.

The Minnesota Board of Dentistry is pleased to see that the elements of this successful program are being shared so that its use may be continued. Dr. Bebeau’s assessment instruments and evaluation of licensees provide an important baseline by which to judge changes in how a person thinks. Fortunately, there has been little recidivism with the individuals referred for this assessment and individually directed training. Boards hope for both immediate and long-term impact of remediation. Is there the possibility of a second course to re-energize or refresh the licensees’ initial commitments to improved ethical

decision making, a course designed for follow-up evaluation and testing? Is there the possibility of (or need for) long term group therapy for those who have similar challenges, or for long term therapy for those who have ongoing issues? In the event that additional complaints occur against the same dentist, and the complaints allege similar ethical questions, is there the possibility of additional remediation focused primarily toward repeat offenders?

While most interventions are successful, some will not be, and a board needs to be prepared to place limitations on a licensee that will assure that the public is protected, and is receiving dental care only from appropriately qualified practitioners. Ultimately, a board must determine if remediation is realistic. There are other options for boards, including the loss of a dentist’s license to practice dentistry. There are many decisions that compliance committees must make in evaluating unethical practice. This ethics course is an essential, invaluable component.

When the committees receive final reports from Dr. Bebeau, she provides detailed information about conversations, debates, and outcomes. Dr. Bebeau described a particular licensee’s progress toward improved decision making through her ethics course. For example: “The most substantial growth is evident in (the dentist’s) sensitivity to ethical issues and an enhanced ability to interact effectively to reduce tension when patients react with fear, anxiety or simply the host of problems they bring with them to the care setting. [The dentist] also demonstrates real strength in better

understanding [his] role and responsibility as a healthcare provider.”

Following the ethics course in a written report to the board, a licensee stated: “I [now] incorporate the concepts of autonomy, non-maleficence, beneficence, and justice in the treatment of my patients. I have learned to use certain techniques in negotiating to arrive at a better solution for all. I have changed communication habits and incorporated certain concepts that empower the patient. I treat patients with more respect and try to show a better caring attitude, where they feel I have placed their interests above myself. I have incorporated many new ideas that apply to the practice of dentistry to my everyday life and encounters. This course has been a tremendous help and has given me a better understanding of our responsibility as individuals to our community, family, society, and profession.”

The issues that confront the profession in ethics and morality are increasingly complex. This course has made an impact on public safety by changing the lives and practices of Minnesota dentists. There is no doubt that the complaint resolution process, the profession, and the public have been enhanced by the availability of this course. ■

REMEDICATION PROGRAM FOR DENTISTS PROVIDES DATA ON MORAL DEVELOPMENT IMPORTANT TO ALL PROFESSIONS

Clark D. Cunningham, JD

ABSTRACT

A law school professor recounts the results of Dr. Bebeau's two papers, reporting on her remedial ethics program for oral health professionals who have been referred by the State Dental Board for breaches of professional conduct.

Muriel Bebeau's two-part report on the results of her remedial ethics course for dental professionals in Minnesota found to have violated the rules of professional conduct (Bebeau, 2009a, 2009b) should be of great interest to disciplines other than dentistry, not only because it describes an effective remediation program that could be adapted to other professions, but even more importantly because it provides significant evidence as to the value of empirical research in moral psychology for both designing and assessing ethical education for professionals. Bebeau has been a pioneer in applying to professional ethics the Four Component Model (FCM) of moral behavior proposed by the developmental psychologist James Rest (1979).

Because the first step for each of the 41 professionals referred to Bebeau for remedial instruction during the period covered by her report (1990–2005) was to complete an FCM-based diagnostic assessment to determine whether deficiencies in ethical competence could be identified, Bebeau was able to collect data of particular relevance in showing correlation between the ethical capacities defined by moral psychology and actual behavior found to violate professional ethics. In terms of the second FCM capacity (moral reasoning), when compared to an eight-year cohort of graduates from the University of Minnesota School of Dentistry, the remediating professionals on average scored almost 14 points lower on a general test of moral reasoning, and

more than 17 points lower on a test of ethical reasoning and judgment designed by Bebeau specifically for dental professionals (Bebeau, 2002; Bebeau & Monson, 2008).

At the time of referral, the remediating professionals also completed the Role Concept Essay (RCE), designed to elicit the participant's perception of his or her role as a professional; the resulting scores help to measure the development of the kind of professional identity which motivates commitment to ethical standards (the third FCM capacity). On a scale where the maximum possible score was 12, the average RCE score of the remediating professionals was only 3.8. In their essays, a majority of professionals failed to mention any responsibility to abide by the code of ethics, to place the interest of the patient before the self, or to engage in lifelong learning. More than a third failed to mention any social responsibility over and above serving those who can afford care.

Although a number of prior studies have reported a link between test scores for moral reasoning and actual performance (Bebeau, 2002), for those directly involved in professional education, development, and regulation, the data presented by Bebeau is particularly accessible and persuasive. Especially

Mr. Cunningham is Lee Burge Professor of Law & Ethics, College of Law, Georgia State University and Director of the National Institute for Teaching Ethics & Professionalism; cdcunningham@gsu.edu

helpful are Bebeau's detailed narratives that offer causal links between measured ethical capacities and the actual behavior of these professionals that led to their discipline. In one example, two dentists who operated a group practice with four auxiliaries were sanctioned because the auxiliaries were performing prohibited duties. The senior dentist in the practice scored very high on ethical sensitivity but very low on moral reasoning; these scores correlated with evidence that he was aware that his use of auxiliaries violated the applicable ethics code but he engaged in low-level moral reasoning to justify his behavior (e.g., others did it including, he thought, high-status members of the profession). His more junior associate—who scored very low on ethical sensitivity but high on moral reasoning—was unaware that the practices were prohibited, but when made aware of the applicable rules he was quick to see the fallacies in his partner's rationalizations. In another example, Bebeau links low moral reasoning scores with the conduct of generalists cited for providing substandard specialty care. Although all of these dentists had acceptable ethical sensitivity scores, their low moral reasoning scores helped to explain why they acceded to patient complaints about the high cost of orthodontics by taking on cases beyond their competence rather than making appropriate specialist referrals. These examples are particularly helpful in illustrating a key assertion of the FCM approach: that each of the capacities is a necessary condition for producing behavior that would be judged moral

within the relevant peer community—however, no one capacity is sufficient by itself.

The correlation documented by Bebeau between low scores for moral reasoning and role concept (and in some cases for ethical sensitivity) and documented lapses in professional conduct certainly helps make the case for trying to develop educational interventions that could address the ethical capacities measured by such scores. Bebeau's report takes us one step further by demonstrating that an educational program designed along the lines of the FCM approach can, in fact, produce measurable improvement.

After completion of Bebeau's course, professionals with low pretest scores completed posttest versions of the ethical sensitivity test and one of the moral reasoning tests, and all those who completed the course wrote new Role Concept Essays. Impressive gains in test scores were noted: average scores for both ethical sensitivity and moral reasoning increased by more than 14 points, and the Role Concept Essay scores jumped 7.5 points to a mean score of 11.2 on a scale of 12. In addition, there is the encouraging fact that only two of the remediated professionals have been subject again to discipline.

Readers will also find in Bebeau's reports evidence that the remediating professionals consciously used the FCM as a foundation for their ethical education, in particular to gain insight

That each of the capacities is a necessary condition for producing behavior that would be judged moral within the relevant peer community—however, no one capacity is sufficient by itself.

Only two of the remediated professionals have been subject again to discipline.

about their personal shortcomings in ethical abilities that contributed to their professional discipline. This evidence comes from both the participants' self-assessments and the program's capstone activity in which the professional himself or herself created an ethical dilemma that mirrored the issues for which discipline was taken and then developed a well-reasoned argument for resolving that dilemma. It appears that these capstone essays would make for compelling reading, giving us in the words of the professionals themselves both an understanding of the causal links between deficiencies in FCM capacities and unprofessional conduct and a demonstration of the effectiveness of the educational intervention. Although Bebeau's report showed appropriate concern for protecting the privacy of the professionals by removing all identifying information, it may well be that some of the professionals would consent to having their essays published.

Although Bebeau's report should encourage serious consideration of the FCM approach at all levels of professional development—particularly in professional schools—it obviously has specific relevance to how professions handle members who have violated professional norms. The law, for example, could learn a number of lessons. Whereas “professionalism enhancement programs” for lawyers are typically used only for cases of “minor misconduct,” the program Bebeau describes remediates the most serious discipline cases, those that result in license suspension. Lawyer remediation programs do not draw upon any tested theory of moral development in their design or in attempting to measure effectiveness, in contrast to Bebeau's program which is “guided by theory and grounded in evidence.”

Should the law or other professions decide to experiment with replicating aspects of Bebeau's program, two features

deserve particular attention. First, the ethical sensitivity and moral reasoning tests specifically designed for the dental profession use facts drawn from real cases, with the responses carefully validated by recognized experts. Second, the remediating professionals consistently reported that they highly valued the emphasis in the program on the fourth FCM capacity: how to actually implement a moral action—what to say to a patient or professional colleague and how to say it.

Finally, readers for whom the literature on moral psychology is unfamiliar should take comfort from Bebeau's assurance that all the measures used in her program are available for use by others and do not require special expertise to administer, and that even the measures developed specifically for dentistry have already been adapted for use in other professions. ■

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PRESERVING THE PRIVILEGE

Fred A. Bremner, DMD, FACD

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It is difficult to read a newspaper or news magazine these days without wondering whether our society is going down the tubes.

In the world of sports, Atlanta Falcons' quarterback Michael Vick and three other men were indicted recently by a federal grand jury for operating an unlawful interstate dogfighting venture (Schmidt, 2007). Former NBA referee Tim Donaghy is under federal investigation for betting on games he officiated, perhaps at the behest of organized crime (Schwartz, 2007). And, of course, Washington and Wall Street continue to make daily contributions to the Great American Scandal Machine.

EPIDEMIC OF CHEATING

Research suggests it is not just adults who are dishonest. *The Washington Post* reported in June that about half of American high school students admit to cheating. According to Donald McCabe, PhD, Professor of Organization Management at Rutgers University, students today cheat even when they do not know it. For example, surveys McCabe took from 2002 through this spring show that 40% of college students think it is okay to engage in "cut and paste" plagiarism, i.e., copying entire sections of different Web sites and putting them together for a paper. Meanwhile, 47% of high school students see nothing wrong with trying to find out what is on a test from someone who has taken it (*The Washington Post*, 2006).

Closer to home, *ADA News* recently reported on an ethical symposium on integrity and ethics in dental education at which dental educators shared their experiences with ethical breaches that involved students trading clinical procedures, using a faculty password to approve treatment, and sharing unreleased questions and answers from the National Board Dental Exam (Fox, 2007).

EARNING THE PRIVILEGE

Dentists, by and large, are an independent lot. We place a premium on our privilege to practice our profession as we deem appropriate—free from undue interference.

The key word here is "privilege." Graduation from dental school is not a sinecure; dentists must earn the privilege to govern themselves by proving to society that they are both capable and worthy of self-governance. As the preamble to *ADA's Principles of Ethics* states, we prove that worth by following "high ethical standards which have the benefit of the patient as their primary goal."

Therein lies the rub. Because self-governance is a privilege bestowed by

Dr. Bremner is the editor of *Membership Matters* and Immediate Past President of AADE; fbremner@comcast.net.

society, society can also take it away at any time—as Great Britain recently did in the wake of several notable medical and dental scandals.

CAN ETHICS BE TAUGHT?

One of the recurring debates in academe is whether ethics can be taught and, if so, whether it does any good to teach it. Bebeau and Thoma report a statistically significant difference in scores on the Defining Issues Test (a test of moral reasoning) between dental students who received ethics training and those who did not (Bebeau & Thoma, 1994). In contrast, Bertolami writes that “students take the ethics courses we offer and pass the tests we give, but no one’s behavior changes as a result” (Bertolami, 2005; Jensen, 2006). Bertolami suggests that there is a big difference between teaching ethics and teaching about ethics. He indicts the ethics curriculum for its “failure to cultivate an introspective orientation to professional life”—a failure, in other words, to connect ethical theory to the day-to-day practice of dentistry.

Even textbooks on ethics admit this lack of connection is a problem. As one widely used text puts it:

There is much encouragement for ethical conduct within the dental profession, but relatively little assistance for judging what conduct is ethically best... [F]ew would deny that they often choose a course of professional action without a sense that they have given the matter all the ethical reflection it deserved—and that they frequently do so because they have run out of ideas about how to consider it (Ozar & Sokol, 1994, p. vii).

MAKING THE ETHICAL CONNECTION

The Oregon Health Sciences University (OHSU) School of Dentistry will be taking some innovative strides toward connecting ethics and practice this fall when students, faculty, and staff will be grouped into six units that will function more like a private group practice. Giving faculty the opportunity to model ethical behaviors inside a group-practice setting has tremendous potential for teaching “applied ethics.” Oregon Dental Association (ODA) members can also help by becoming actively involved in our mentoring program, giving students the chance to discuss ethical dilemmas with dentists in practice.

Of course, all of these solutions will have little impact if we do not have ethically inclined students to start with. In this month’s Leadership Forum [in *Membership Matters*], my friend Rick Asai asks a very provocative question: How do you select individuals with high ethical and moral values for admission to dental school?

How indeed? Asai suggests one possibility is to alter admission requirements to dental school to include letters of reference for personal character as well as academic prowess. I would take it one step further and ask prospective students to respond to a series of ethical dilemmas either in an essay or, better yet, a personal interview. Such a process would at least provide a clue as to how the applicant processes ethical dilemmas. It is not a perfect solution, but it is a start.

Individual Responsibility

If we are to preserve the ability to self-regulate our profession, we must ensure it is made up of individuals of good character who have the capacity for self-governance—a mandate deeply rooted in American history. As John Adams wrote, “We have staked the future of our political institutions upon the capacity of each and all of us to govern ourselves, to

control ourselves, to sustain ourselves according to the Ten Commandments...”

From my perspective, this means that every dentist must shoulder individual responsibility for modeling ethical behaviors—and demand nothing less from colleagues. To paraphrase Adams, we cannot have professional virtue without individual virtue, and without professional virtue, we cannot survive.

If we fail to recognize and take seriously the special position of trust that society has bestowed upon us, we will have no one but ourselves to blame when self-regulation is replaced by governmental directive. ■

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BEHAVIORAL ECONOMICS

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

ABSTRACT

It is human nature to overestimate how rational we are, both in general and even when we are trying to be. Such irrationality is not random, and the search for and explanation of patterns of fuzzy thinking is the basis for a new academic discipline known as behavioral economics. Examples are given of some of the best understood of our foibles, including prospect theory, framing, anchoring, salience, confirmation bias, superstition, and ownership. Humans have two cognitive systems: one conscious, deliberate, slow, and rational; the other fast, pattern-based, emotionally tinged, and intuitive. Each is subject to its own kind of error. In the case of rational thought, we tend to exaggerate our capacity; for intuition, we fail to train it or recognize contexts where it is inappropriate. Humans are especially poor at estimating probabilities, or even understanding what they are. It is a common human failing to reason backwards from random outcomes that are favorable to beliefs about our power to predict the future. Five suggestions are offered for thinking within our means.

Let's imagine that you have a reading habit. You regularly spend between \$150 and \$200 a month buying books from Borders and Amazon. A friend offers you two "deals": (a) a free gift certificate worth \$10 off on any purchase or (b) a \$20 certificate that costs you just \$7. Which would you choose?

This study has been done many times and overwhelmingly—in 70% to 80% of the cases—respondents opt for the free card. When it is pointed out that option (a), the free card, represents a net cash benefit to the recipient of \$10 and option (b) represents a net cash benefit of \$13, respondents produce an amazing array of justifications for make the worse choice, such as "I might not always use the extra value on the card," "I may not have \$7," "I am suspicious of deals to appear too good," or "Never turn down anything that is free."

This is a classic demonstration of a blooming new field called behavioral economics. A common way of describing the discipline is to say that *homo economicus*—the rational, self-interested individual—is a fiction, or at the very best, an occasional role played under academic or post hoc circumstances. More crassly, behavioral economics has been commercialized through a stream of "airport books," cataloguing the ways human reasoning is predictably biased. A moment's reflection will confirm that, at least in the case of other folks, there sure are lots of examples of decision making that is goofy.

The serious behavioral economists do not consider such foibles as human failings but as characteristic of actual

sapient thought that can be understood through careful study. A natural consequence of behavioral economics is that decisions framed in quantitative terms—such as how many new patients per month are needed for a practice to reach its economic target or what is the optimal allocation of assets in one's investment portfolio—will almost certainly lead to incorrect answers because humans are not as good at those calculations as they believe they are. A dollar is not a dollar. We quibble about where it came from, who owns it, what else could be done with it, who is watching, and so forth. That is why most Americans would prefer the \$10 gift to an investment that guarantees a \$13 return.

REAL RATIONALITY

The kind of rationality one encounters when getting advice from investment brokers or in scientific journals is a special case of thinking where efforts are made, sometimes with hours and hours of reflection by formally schooled experts, to remove bias, rigorously define one's terms, and reduce calculations to mathematically defensible units. It is an idealization of human thought. Complete rationality is also useful as a standard against which to test the way we normally think. Human rationality is not just a randomly poor approximation of objectivity. There are systematic deviations that can be attributed to general nature, the personality of decision makers, and circumstances. The better behavioral economists are able to explain these

Homo economicus—the rational, self-interested individual—is a fiction, or at the very best, an occasional role played under academic or post hoc circumstances.

habits, the fewer surprises we will encounter when reasoning with others.

Consider an often-repeated study known as the “Divide the Dollar Game,” developed in the 1950s by John Nash, whose life was retold in the movie *A Beautiful Mind*. The rules of the game are explained to the two players: Player A will be given a dollar. He or she then proposes a sharing scheme where Player B is offered any fraction of the dollar from nothing all the way to the full dollar. Then Player B chooses to either accept or reject the offer. If the offer is accepted, the dollar is divided as proposed; if the offer is rejected, neither player receives anything. The challenge is to find the average amount accepted by Player B.

Rationally, Player B should accept any amount from one cent up. This is a choice between nothing and one cent, and if the game is played often enough at one cent, Player B can make some real money. In fact, this rational choice is always rejected. Thousands of such studies have been conducted, and Player B usually settles for something in the range of 35 cents to 45 cents. Player B is normally willing to choose nothing rather than 30 cents. An example of a useful variation on this study is to divide an average day’s wages rather than a dollar. This version of the study has been tested in various economic groups and countries. The poor in countries such as Peru will settle for 15% of a day’s wages, middle-class Americans are happy with 35%, the norm in the Middle East is 40–45%, and among liberal college students in the United States, 45% is on the low end of acceptable.

It is apparent that the Divide the Dollar Game has been reframed from “how small a gift would I accept” to “what is a fair distribution of windfalls.” But more is at stake than fairness. In a

variation of the game, Player B will often engage in revenge if given an opportunity. A deal is offered to Player B whereby he or she can reduce Player A’s reward: it costs Player B two cents to reduce Player A’s share by one cent (Player B gets no monetary benefit for such revenge). There are many takers for the revenge extension of the Divide the Dollar Game, and some players walk away satisfied to have shelled out a large sum of money rather than to have received a small gift. Much of the tragedy in marriages that have gone bad or parts of the world experiencing unending civil strife can be explained by such behavioral economics. Many dentists have encountered a few patients of this type. These situations cannot be altered by rational arguments.

Below is just a short sampling of real rationality from the perspective of behavioral economics.

Prospect Theory. Nobel Laureate in Economics Daniel Kahneman and his long-time collaborator Amos Tversky make a strong case that humans are poor at estimating potential gains and potential losses and that we value gains differently from losses. Gains have declining value as their absolute size increases. A nurse might be excited about the prospect of a raise in salary from \$51,000 to \$52,000, but an executive at Goldman Sachs would be less than enthusiastic about a nudge from \$351,000 to \$352,000. The value of \$1,000 depends on one’s vantage point. That’s why poor people play the lottery and rich people do not. The more we have the less likely we are to risk for a fixed gain. That makes physicians and dentists fiscal conservatives.

But the opposite is true for losses. We discount potential loss, but at a much higher rate. Rich folk buy product warranties, which almost never make economic sense. But we place limits on our liabilities covered by insurance. We can imagine enormous economic gain; but not losses of corresponding size. Bankruptcy places a basement on losses

while there is not ceiling on striking it rich. Such thinking was fundamental in the recent economic meltdown and will be in the next.

Framing. We have already noted the effect that our frame of reference has on bending our calculations when we considered the Divide the Dollar Game. Here is another example. *The Economist* ran ads offering three choices: (a) print version of the journal for one year at \$125, (b) on-line for \$59, and (c) both for \$125. The firm earns less from the print than the online version. When the three options were offered, 84% chose (c). The multiple-format option was really a decoy, and its price was only meant to influence the evaluation of the other choices. Virtually no one selected option (a). Did it work to throw in the decoy? When the offer was repeated with only two options (on-line for \$59 and both for \$129), sales of option (c), both formats, dropped to 32%. By putting in a misleading comparison, *The Economist* boosted sales of its higher-value offering from 32% to 84%.

In a similar example of framing, psychologist Dan Ariely offered shoppers in a mall the choice between a Lindt truffle at 15 cents and a Hershey's Kiss at one penny—both good deals. About a quarter of the shoppers selected the Kiss. He repeated the experiment, chopping a single cent from the price of each candy item. The free Kisses jumped to over two-thirds of the choices. AARP was unsuccessful when it approached the American Bar Association to create an arrangement for reduced-fee legal services. Some years later, the AARP went back to develop a pro bono program, and that has been quite effective. That is why Orville Redenbacher can brag that its popcorn is 94% fat-free, but it would be embarrassed to mention that its popcorn is 6% fat. That is also why patients will elect surgical procedures that are 90% effective and shy away from those that have a 10% chance of failure.

Anchoring. Individuals are poor judges of absolute quantities such as temperature, speed, value, and cost, or measures of association, such as correlation. But they are reasonably effective at recognizing change and making comparisons. This effect is called anchoring. We will purchase a \$1.99 jar of generic jam marked down from \$2.29 while passing by a generic jam of the same size that regularly sells for \$1.89. A well-known demonstration of this effect involves people who are not especially knowledgeable about enology bidding on French wines. In one condition, buyers simply place offers; in the other, they write down the last two digits of their social security numbers before placing a bid. The bids in the latter condition are statistically significantly more likely to resemble the last two digits of bidders' social security numbers than without invoking the (meaningless) anchor point. I have found that older practitioners express more consternation over the prices that dental practices are selling for than do young practitioners (unless, of course, they are selling). In actual fact, dental educational debt as a percentage of annual net practice income has been essentially constant for the past quarter century. Young people are used to the higher prices for everything; older ones are at least partially anchored in historical comparisons. The guidelines of the Malcolm Baldrige National Quality Award program require that all results demonstrating performance excellence be anchored, both historically against the organization's past performance and against norms for the best of current similar organizations.

Saliency. Perception in judgment is strongly biased by saliency. The concrete (actual or imaginary) is more powerful than the abstract. When the dean wants to impress the regents or potential donors, he or she shows photographs of gorgeous six-unit bridges and students on mission trips to East Africa rather than average test case scores. When a

dentist and an anti-flouridationist share the stage, woe be to the one who reels off the statistics, formulas, and logical arguments. The safe bet is a picture of dead lab rat. All the large corporations pack their financials in photographs of smiling employee volunteers. I just received a press release from Danbury (Connecticut) Hospital crowing about a meniscus transplant that made it possible for a contestant to compete in a beauty pageant. I have no idea what the hospital's HEDIS scores are or what its avoidable readmission rates are, and apparently, the hospital feels that those things should not interest me. Of course, the press release reveals a profound understanding of real human rationality.

The most famous scientific demonstration of the overemphasis we naturally place on the salient is called the Linda case. Individuals are asked to estimate the likelihood that a fictitious person named Linda who has an aptitude for numbers will be engaged in alternative situations in a few years after college graduation. Among the alternatives are writing poetry, veterinary assistant, banking, political activism, and combinations of these. An alternative form of the study provides a personal sketch of Linda, including the fact that she was involved in several small, but carefully described, political activities while a college student. With this description, where political activity is given salience, the most common projection of her future is that she is a politically active banker. This future is judged more likely than either banker or political activist. Of course, this is nonsense; it is logically impossible for the likelihood of being a politically active banker to be greater than the likelihood of being a banker.

It is just a fact that your dollar and mine are not the same size and a dollar coming and the same dollar going do not have the same significance.

Confirmation Bias. We are also strongly susceptible to confirmation bias. Liberals watch MSNBC and conservatives watch Fox, despite the research showing we appear more credible defending our biases when we are knowledgeable about opposing views. Dentists pick the speakers they want to hear at conventions based on what they want the speakers to say, and they return to their offices with stronger convictions that they were right in the first place. In the 1950s in communities north of Seattle, Washington, a story appeared in the newspaper reporting a driver finding pitting on her car window that she believed was caused by kids dropping small rocks from freeway overpasses. She had seen something suspicious. Over the next months, similar reports began to appear. Special task forces were mobilized by police departments. Finally, windows with minor pitting became so common that a researcher investigated several other communities across the nation. The Bellingham pits were exactly in line with the physical evidence in other communities that were not experiencing an “epidemic of vandalism.” An obscure Dutch anthropologist named Eugene Dubois found Java Man in 1891, but few paid attention to the discovery. The scientific community was much more interested in Charles Dawson’s Piltdown Man. A respected scientist’s finding the missing link in England (where it was supposed to be) was much more believable. It was not until the 1950s that Piltdown was unmasked as a fraud.

Superstitious Behavior. The illusion of control affects our perception of what is so. This is called superstitious behavior, and everyone does it. Estimates have been made that approximately 15% of the activities engaged in by physicians can be supported by scientific evidence. Certainly, most others would be supported

if the research were actually done, but there are likely many rituals that just happen not to be wrong very often. Las Vegas is currently struggling with its policy on slot machines. There is a core of addicts who play unrelentingly because they believe what they are wearing or their wrist action in pulling the handle really matters. A competing force is the time saved, and corresponding more frequent losses for patrons, available with electronic activation of the machine.

Active participation in a random event increases participation. We scratch for winning numbers, send in coupons, and go through strange behavior at fundraising events. A recent winner in the Spanish National Lottery was asked about his winning pick of the number 48. He attributed it to cleverly realizing that dreaming of the number seven for seven nights in a row meant something. Stock traders in London were given an opportunity to experiment with a computer system advertised to have the potential for a small and random capacity to enhance accuracy of stock projections by manipulation of several function keys. Some traders used the keys frequently, others less so. Of course there were no differences in outcomes because the keys were bogus. Those who used the keys the most gave themselves higher success scores on the random task. The performance of the traders in the actual market over the following months was tracked, and those who engaged in superstitious behavior experienced worse outcomes.

Ownership. One more among the many systematic distortions of perception that have been identified and documented: ownership. My toothache hurts more than others’. We become invested in those things we spend time with, especially those we work on. Ask any teenager what the car he and his father rebuilt from scratch is worth compared with the teenager who was gifted a similar car by his parents. Ownership bias is at the heart of disagreements

between sellers and purchasers of dental practices. But the mere fact of possession can matter regardless of sweat equity. The classic experiment here was conducted at the University of Washington, where students in the union were asked to price several objects of small value. A U-Dub coffee mug received an average value of \$1.45. A comparable group of students was gifted several items, including the U-Dub mug. The second group was asked the same question, “What are these items worth?” The mug was now valued at \$7.40. In neither case was there a question of students paying or receiving money, and thus there was no expectation of profit from trading. It is just a fact that your dollar and mine are not the same size and a dollar coming and the same dollar going do not have the same significance.

BEING OF TWO MINDS

Functional magnetic resonance imaging has become a powerful tool in behavioral economics research. It is argued that calculated self-interest is different from the absence of altruism, that security from threat is not the same thing as being satisfied, and that intuitive judgment and calculated reasoning are distinct processes. In each case, there is evidence that different areas of the brain are activated. There is also pretty good behavioral data supporting the idea that there are two ways of reasoning.

It has long been known that chess masters and computers play the game differently. The computer projects huge numbers of potential sequences of moves and picks the one that yields the best payoff. It is sometimes mistakenly assumed that chess masters always do the same. In some situations, they do generate short scenarios of “thinking ahead” moves. But their dominant strategy, and what distinguished the

best from the good, is their capacity to recognize commonly occurring, key patterns with known consequences. It is quite possible that dentists, physicians, engineers, and even politicians depend on the same pattern-matching schemes instead of logical cognition.

Some patterns are easy to detect and some are not. In many cases, differences are based on naturally occurring neural structures common to everyone, and sometimes they are personal modifications resulting from life experiences and training. The Stroop Test is a good example of the former. We naturally recognize words more quickly than colors (sorry, right-brain enthusiasts!). Given a list of words for colors printed in various colors, subjects can more quickly name the word than the color it is written in. And when confronted with the word “green” written in blue letters, reaction time slows perceptibly and the most common response is the word and not the color. We are just wired that way.

This technique of inferring mental structure from reaction patterns can be used to uncover subtle reasoning structures that might differ from one individual to another based on learning and life experiences. In a procedure called the Implicit Association Test, subjects are presented with a list of names and asked to quickly sort each item into one of two categories. For example, Mary, Leonard, Mike, and Latisha are grouped as either male or female. This task comes off very quickly. A more complex test is to sort the list into complex categories that are pairs such as “male or dentist” and “female or patient.” Now we slow down, but more so for some pairings. Those combinations that occur naturally in our mind are managed automatically; those that are strange or uncomfortable to us take a fraction of second longer—even when we are absolutely certain that we have made the correct choice and others would agree with us. Delayed reactions reveal

inadequacies in the deep structure of our cognitive networks. Individuals who have no rational trace of racism or sexism in their public lives and honestly believe themselves free of prejudice have trouble with the compound list above. Female and African American dentists just do not come as readily to mind as male, Anglo ones do. The best-selling author Malcolm Gladwell, who is Haitian and who describes this effect in his book *Blink*, confesses to having the same difficulty.

Our rational and intuitive thinking systems are not always in harmony. The intuitive system is rapid, effortless, automatic, emotional, concrete, context specific, and highly personal. Our rational system is slow, deliberate, abstract, justifiable, theoretical, and self-conscious. There are strange relationships between these two systems. Our rational system is the one we use to describe what our intuitive system is doing; but our intuitive system is what we use to determine whether we need to activate the rational system. This leads to the unreliability of experts as teachers: they often just invent plausible verbiage for intuitive processes they have mastered and made subconscious. Ironically, most of our decision making takes place with the help of the intuitive system. It is the default mode, and rational thinking is called on more often when our intuitive system is malfunctioning due to altered context, when we are called upon to justify our actions, or in highly artificial environments such as academics or reading professional journals. Research has established that perfectly sound intuitive judgments are distorted when we anticipate that we will have to give rational justifications for them. This may explain some of the high rhetoric of debates about evidence-based dentistry. As Canadian psychologist Steven Pinker notes, “Our brains are made for fitness, not for truth.”

Haven't we managed to do just fine thinking with our gut while pretending to think flawlessly with our heads? Haven't we been well served in believing our random successes are evidence of our superior insight?

Our intuitive "thinking" is intrinsically neither good nor bad. Its fitness depends on whether our mental patterns match the circumstances. Professional education is essentially the process of developing a repertoire of such intuitive patterns that have "cash value" in the most common conditions, or alternatively, sticking to situations where effective patterns already exist and avoiding learning opportunities that challenge or supplement existing patterns. The training soldiers undergo is designed so they develop habits of instant response with high survival value. Sometimes these habits of response fail to match the circumstances, resulting in tragedy, such as the death of civilians. Such unfortunate events are exaggerated by post hoc postmortems that are grounded in rational hindsight. Rational reconstructions of intuitive responses lead to strange analyses. The same disconnect can be observed in bad clinical outcomes and malpractice suits.

The correct role of a rational review of unfortunate outcomes from the application of intuitive thinking is to challenge the rational foundations which preceded the action and upon which intuition was based. Negligence is a matter of poor training, inadequate protocol, and recovery systems, and general personal habits such as greed or ambition. Rational second thought is ineffective in preventing miscarriages of intuition; it is valuable for altering the circumstances leading up to intuitive error.

We tend to overestimate the value of rational thinking because we have to resort to this approach when there are differences of opinion. Most of us are completely convinced by the validity of our own intuitive thinking, not so much by what appears to be the intuitive thinking of others. When differences of opinion arise, we have to resort to our rational system. We keep rolling out

deeper systems of rational structure in search of common ground. The other guy is called "irrational" if we stop searching before we reach common ground.

CHANCE AND PREDICTION

Human beings are not superstars when it comes to predicting which events are likely and which are not. We are not even particularly good at giving cogent explanations for what has already happened (backward prediction), although we are much more willing to attempt this than predicting the future. A professor once asked her students to write about the imagined experiences of a fictitious colleague who had taken a sabbatical in Paris (no other information was provided). Typical responses were several hundred words in length and contained imaginative detail. The assignment was repeated in another class, changing only the description that the colleague was going to take a sabbatical in the future. There was little difference in the types of events imagined in the future, but detail was diminished and the narratives were much shorter. Even in our imaginations, the past is richer than the future.

Behavioral economists have extensively studied how individuals conform their actions to the predictions they make about future events. Players in the stock market are the favorite target of researchers who collect and categorize the bumbling of those who believe they are more rational than their colleagues. To a lesser extent, many of the remarks below would apply to dentists making diagnoses based on clinical evidence, choosing materials or equipment, making a business plan, or (of course) investing for retirement.

Probability is one of the most familiar and misunderstood of all concepts. This is illustrated by the joke about one old codger who phones the TV station to complain, "What do you mean, 'A 20% chance of showers?' It's raining where I

am for certain.” This is followed by another cranky call: “You’re both goofy. There’s no rain at all here.” Both callers have a point: it is either raining or it is not. Probabilities exist in a theoretical, rational world but not in the real one. They are the subjective estimates we are prepared to use in our rational calculations, and as such, they are always personal forecasts that may or may not be borne out in reality. We have grown up with the notion that probabilities can be determined with some degree of precision by measuring the ratio of successful trials to the total number of trials. For example, over the long run, every dollar wagered in Las Vegas returns 84 cents—a known fact, but a historical one. If we played long enough, that is the way it would come out. But there is no single wager that will turn out to confirm or confound that value. Imagine a dentist telling a patient that research shows that an endodontic procedure performed under prevailing circumstances will work 84 times out of 100. The first question the patient will want answered is whether they are in the 84 or the 16 group. Think of probability as the confidence one has that the future will resemble the past enough to bet on a particular course of action.

The reason for digging a little deeper than is customary into probability is to force a wedge between predicting the past (where probability can be calculated as the proportion of successes over trials) and predicting the future (where it certainly cannot). Those who have had some success understanding the past have a right to believe they will be good at predicting the future. But the evidence is overwhelming that it is human nature to be overconfident. As Nassim Taleb puts it, “The lucky fool fails to realize that he is both lucky and a fool.” Economist John Kenneth Galbraith was only a bit kinder: “When it comes to the stock market, there are two kinds of investors. Those who

don’t know where the market is going and those who don’t know that they don’t know where the market is going.”

Of course, there are many folks who accept that this view is correct, but only for others. They have a track record of beating the odds; they are smarter than the rest. At any moment in time there are in fact a predictable number of people who are doing better than average based on predicting probability. But that only proves that events that are based on chance produce a random distribution that includes about an equal number of lucky winners and unlucky losers. Regardless of how smart we are, chance still plays its role. The fact that we confuse smarts and luck is inherent in human nature. It is called the fundamental attribution fallacy: we claim that success is the result of skill and failure the result of luck.

University of Chicago economist Eugene Fama has worked out the view that markets are intrinsically systems that automatically adjust to new and relevant information. It is the function of markets to establish value based on public information. Theoretically, if everyone has the same information at the same time, there would be no way to beat the market. This is known as the theory of random walks of the stock market. There are two exceptions: insider information that allows some to get the jump on the self-correction of the market (which is illegal) and the general, long-term increase in real value in markets that floats everyone’s boats. All the rest is random luck. This year’s Nobel Laureate in economics, Oliver Williamson, developed the theory that organizations, such as insurance companies, dental offices, and the ADA, come into existence precisely because markets are too blunt to align interests of those who provide and receive services in a rational fashion.

Why do we persist in believing the myth of the shrewd speculator who possesses an esoteric system for predicting the future that is better than everyone else? The answer is known as survivor

bias (an understandable rational error). Those who are lucky get to tell their story, at least for as long as they remain lucky. Besides, it is human nature to be optimistic. Nassim Taleb argues that rewarding (very handsomely indeed) CEOs for having been right on big bets in the past is bankrupting this country. We have no way of recovering the gigantic losses they must, per chance, eventually occur. His heroes are those who work for their living by discovering ways of creating predictable value. The prototype of Taleb’s wise man uncompromised by randomness is the dentist (no kidding).

Before passing on from the subject of confusing prediction of the past with prediction of the future, a few words of encouragement can be given. When predicting the past (giving explanations or understanding trends), rigorous mathematical models do work, although there are diminishing returns, with each new factor in the explanation adding less precision than previously understood factors. Such sophisticated models are fine as long as the world remains constant. The last time I looked, there is enough change to make this a risky assumption.

A different approach is suggested for predicting the future. This system involves picking only a few, perhaps two to four key indicators, and sticking with them for awhile, even if they do not always work perfectly. An improvement on this system is to have several simple prediction systems and then taking the average of their projections. A variety of experts and resources makes this system even better.

We love the illusion of choice as much as the illusion of control. We are so clear on the notion that restriction of alternatives is undesirable that we fall into the trap of believing that more choice is automatically desirable. This is a key argument in keeping healthcare

financing private, and in nudging up its cost. Patients are willing to pay well for choice, even choice they do not use. When asked whether they would prefer to make their own decisions about cancer treatment or follow the direction of their physician, 70% of Americans who are cancer free proudly stand by their personal freedom. Actually, 90% of patients turn this choice over to their care providers. Duke psychologist Dan Ariely performed experiments where subjects were rewarded for making correct choices in a computer maze. Subjects were allowed to either proceed based on previous choices or permitted to backtrack. Those who backtracked (preserved their freedom of choice) performed consistently worse than those who adopted a general strategy and stuck with it, regardless of minor disappointments.

Nobel Laureate in economics Herbert Simon distinguished between individuals who attempt to optimize their predictions (maximizers) and those who set targets based on what is needed and then seek means of satisfying these needs (satisficers). Surprisingly to some, satisficers actually do better than maximizers. They are also happier, healthier, and live longer.

SO WHAT?

Behavioral economics is fashionable. There is a good industry in turning out bestsellers. But are the cute little lab studies that poke fun at the gaffs that seem to be part of the makeup of human nature really anything more than parlor games? Haven't we managed to do just fine thinking with our gut while pretending to think flawlessly with our heads? Haven't we been well-served in believing our random successes are evidence of our superior insight?

I will leave it up to each reader to decide personally whether he or she cares how marketers manipulate them, whether false dreams are frustrating, and whether it matters that patients make choices that are surprising to the dentist but seemingly rational to themselves. Certainly the three economics Nobel Laureates cited in this essay see something of a substantial concern in our fooling ourselves about how rational we are.

If we intended to take seriously the possibility that we could benefit by adjusting our habits of mind to accommodate known, systematic problems with snap decisions and tortured logic, I would suggest that we look to the following:

1. Our intuitions are educable: we can train to respond instantly and naturally to commonly occurring circumstances. The time to get good at ethics is not when confronted by temptation, but by systematically reviewing all office policy this Thursday to identify structural ethical traps. The same is true for CPR. This is habit training.
2. Our intuitions are context specific. The major issue with intuition is relying on the same habits when the context has changed. Those who eat with others consume 35% more food, and if the group contains four or more people, food consumption is up 75%. The strategy is to note that new context creates surprises and then jump to a rational override rather than follow intuitive behavior.
3. Make the wise choice the default. Thirty percent of employees who are eligible for employer-matching 401(k) plans fail to sign up. Permission to be an organ donor requires effort. The general rule should be to require opt-out for desirable behavior and opt-in for risky behavior. Choice is preserved, but people will be

nudged in the right direction. Very careful consideration should be given to this principle in treatment plan presentations to patients.

4. Avoid both too much and too little choice. Don't hoard more choice than is useful. It is wrong to assume that the dissatisfaction occasioned by few choices can automatically be fixed by providing unlimited or even a very large number of choices. Consumer research on sales of jam in supermarkets produces a nice inverted-U curve. Few choices, few sales; a huge array of choices, few sales. Goldilocks had the right idea. Research on happiness quotients across various countries shows that once the basic needs are met, more does not contribute to happiness. We Americans are not the happiest of nations.
5. Give up the illusion of being able to completely predict or control the future. Some degree of control is possible, and the use of a few key predictors and averaging across multiple perspectives will be serviceable to a certain degree in many cases. The big mistake is to think that we can do better than that. It is foolish to over-steer, chasing more precision than is characteristic of the situation. We waste resources and opportunities, annoy our friends, and engage in superstitious behavior when we pretend or "demand" that nature behave less randomly than it intends to. ■

RECOMMENDED READING



There is a rapidly growing, popular literature on behavioral economics. Summaries are available for the seven recommended readings with asterisks. Each is about four pages long and conveys both the tone and content of the original source through extensive quotations. These summaries are designed for busy readers who want the essence of these references in 20 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 behavioral economics; a donation of \$50 will bring you summaries for all the 2009 leadership topics.

Ariely, Dan (2009).
***Predictably Irrational:
The Hidden Forces that Shape
Our Decisions****

New York, NY: HarperCollins.
ISBN 978-0-06-185454-5;
368 pages; about \$28.

“Wouldn’t economics make a lot more sense if it were based on how people actually behave, instead of how they should behave?” “Each of the chapters in this book describes a force (emotions, relativity, social norms, etc.) that influences our behavior. And while these influences exert a lot of power over our behavior, our natural tendency is to vastly underestimate or completely ignore this power.” “Somehow, the basic ideas of economics and the belief in overarching rationality have become so ingrained in our understanding of the social world around us that people from all walks of life seemed to accept them as basic laws of nature.” Competition, arbitrage, full information, etc. have not optimized the world. “In theory, there is no difference between theory and practice, but in practice there is a great deal of difference.”

Brafman, Ori and Brafman, Rom (2008).
***Sway: The Irresistible Pull of
Irrational Behavior****

New York: Doubleday.
ISBN 978-0-385-53060-6;
206 pages; about \$14.

An MBA and psychologist pair of brothers present an extremely light and readable summary of some social psychology experiments and personal experiences showing that we tend to be “swayed” by irrational forces such as aversion to loss, diagnostic biases that

lead us to confirm previously made decisions, commitment to previous positions, judging based on reputation rather than the facts, and anchoring our judgments in personal norms. We would do well, they urge, to build in opportunities for someone to challenge or check our work.

Gladwell, Malcolm (2005).
***Blink: The Power of Thinking
Without Thinking****

New York, NY: Back Bay Books.
ISBN 978-0-316-01066-5;
320 pages; about \$16.

Our brains use two different strategies to make sense of situations: one is nearly instantaneous and works with patterns, the other is logical and takes longer. If we can control the environment in which rapid cognition takes place, we can control rapid cognition. On straightforward choices, deliberate analysis is best. When questions of analysis and personal choice start to get complicated—when we have to juggle many different variables—then our unconscious thought process may be superior.

Lambert, Craig (2006).
The marketplace of perceptions.
Harvard Magazine.

March-April, 50-57, 93-95.

Very readable summary of behavioral economics and selection of research being conducted by various Harvard faculty members.

*(Recommended Reading continued
on next page.)*

RECOMMENDED READING

Makridakis, Spyros, Hogarth, Robin, and Gaba, Anil (2009).

Dance with Chance: Making Luck Work for You*

Oxford, UK: Oneworld.
ISBN 978-1-85168-679-7;
287 pages; about \$23.

We suffer from an “illusion of control” that fools us into thinking the future is more predictable and less uncertain than it really is. Or worse, we believe we can influence chanced events through our own actions. The reason for widespread belief in superstition is that it holds out the promise that we can do something to affect chance. The paradox of control is that we gain greater influence over our futures by recognizing what we cannot control.

Schwartz, Barry (2004).

The Paradox of Choice: Why More Is Less*

New York, NY: Harper Perennial.
ISBN 978-0-06-000569-6;
265 pages; about \$16.

Schwartz sets out to explore the “darker side of freedom.” Having no choice and having too much are both worse than having sufficient alternatives. “I believe that we make the most of our freedoms by learning to make good choices about the things that matter, while at the same time unburdening ourselves from too much concern about the things that don’t.”

Taleb, Nassim Nicholas (2004).

Foiled by Randomness: The Hidden Role of Chance in Life and in the Markets*

New York, NY: Random House.
ISBN 978-1-4000-6793-0;
316 pages; about \$27.

Taleb is a trader whose goal in life is to avoid “blowing up”—losing more than one can afford—and to use his free time to read and reflect on the meaning of life. His message is that randomness is a characteristic of all human activity and that it is wrong to “bet” on winning big; in fact it is wrong to be guided by chasing outcomes at all; sound processes are what pay off in the end. “This book is about luck disguised and perceived as nonluck (that is, skills) and, more generally, randomness disguised and perceived as non-randomness (that is, determinism).”

Thaler, Richard H., and Sunstein, Cass R. (2008).

Nudge: Improving Decisions About Health, Wealth, and Happiness*

New Haven, CT: Yale University Press.
ISBN 978-0-300-12223-7;
293 pages; about \$26.

Humans are known to use inefficient intuitive reasoning most of the time and are often incapable of and seldom make rational decisions. Without taking away freedom of choice, systems should be designed with “nudges” to encourage people to make decisions that they would make if they were operating completely rationally. These nudge mechanism include incentives, understanding the mapping between choice and outcomes, defaults, feedback, appreciation for expected error, and structuring complex decisions. The system is called libertarian paternalism. Examples are given in the areas of retirement savings, investing, credit cards, privatization of Social Security, prescription drug plans, organ donation, ecology, school choice programs, no-malpractice health care, and privatization of marriage.

2009 MANUSCRIPT REVIEW PROCESS

Four unsolicited manuscripts were received for possible publication in the *Journal of the American College of Dentistry* during 2009. Two manuscripts were accepted for publication following peer review and two were declined. Nine reviews were received for these manuscripts, and average of 2.25 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 .912, 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. One manuscript accepted in 2008 contingent upon satisfactory revisions in response to reviewers' comments was withdrawn by the authors who declined to make the suggested revisions.

The Editor is aware of three requests to reprint articles appearing in the *Journal* and six requests to copy articles for educational use received and granted during the year. There was one request for summaries of recommended reading 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 ethics, excellence, professionalism, and leadership in dentistry. Eleven manuscripts were nominated for consideration. The winner was an essay by a student, now Dr. Michael Meru, entitled "Following your moral compass" which appeared in the Spring 2008 issue of *Mouth*, the publication of the American Student Dental Association. Eleven judges participated in the review process. Their names are listed among the *Journal* reviewers below. The Cronbach alpha for consistency among the judges was .952.

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 2009.

Norman Becker, DDS
Shirley, MA

Fred Bremner, DMD
Milwaukie, OR

Roland W. Hansen, DDS
Palm Desert, CA

Donna B. Hurowitz, DDS, FACD
San Francisco, CA

Jennifer King, BBD, LLD
London, England

Michael Maihofer, DDS
Roseville, MI

Michael Meru, DDS
Los Angeles, CA

Frank J. Miranda, DDS, MEd, MBA
Oklahoma City, OK

Detlef B. Moore
Milwaukee, WI

Laura Neumann, DDS
Chicago, IL

Linda Niessen, DMD, MPH, MPP, FACD
Dallas, TX

Marsha Pyle, DDS, FACD
Kansas City, MO

Steve Ralls, DDS, FACD
Gaithersburg, MD

Cherilyn Sheets, DDS, FACD
Newport Beach, CA

Philip E. Smith, DMD
Lexington, SC

Scott L. Tomar, DMD, DrPH
Gainesville, FL

Thomas F. Winkler III, DMD, FACD
Wellesley, MA

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