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**A publication advancing
excellence, ethics, professionalism,
and leadership in dentistry**

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

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Cover: The aspiring, ethical William J. Gies.

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From the Editor

Goldilocks and the Success Merchants

Dentistry is a wonderful profession with so many opportunities for fulfillment. It would be a shame to make the determined chase for lucre the universal standard.

A fellow from the Midwest wrote recently challenging, in a very professional way, whether the journal is really addressing the daily chairside issues dentists face in a hypercommercial world. I have to admit we have not said all that needs to be said.

The concerned fellow wanted some protection from the success gurus who have been chanting “maximize, maximize, maximize” and making dentists feel inadequate for not getting all the money they “deserve.” Wrong song on two counts. First, the best one can do may still be insufficient to meet one’s financial or human needs—ask any recent graduate. Second, the two-million-dollar practice may not satisfy the psychological needs of the superstar—ask why they are on the circuit or having difficulty selling their practice for what they think it is worth.

It is not all about money or technical wizardry or moving the needle on oral healthcare needs in America, or leadership in organized dentistry, or living in a region that affords a personally satisfying lifestyle. It is about all of these things, in the right balance. Woe to the person who says, “Of course they all matter, but one of them is the key, and when I finally have that one under control, I will start living a full life.”

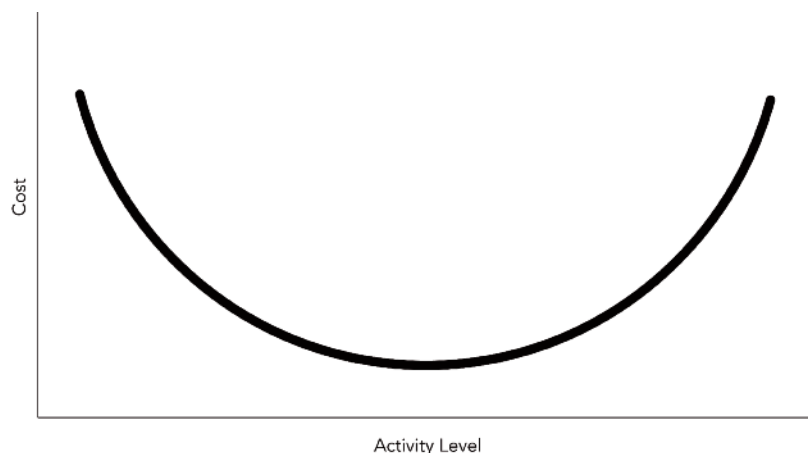
Unidirectional goals lock us into mindlessly rigid behavior. The tonically active neurons (TAN) of the caudate region of the brain monitor the outcomes of actions we initiate.

Individuals with lesions in this region suffer from obsessive compulsive disorder and cannot tell when they have cleaned their hands enough or put an item where it really belongs. Their curse is the pursuit of more. When any life goal circuit is stuck in the on position, the concept of *enough* ceases to function as a guide to life.

Let’s put these three ideas together: an ideal midpoint: too much and too little both causing misfortune, and multiple dimensions in the full life. This can be represented graphically as shown in the accompanying figure.

The example here will be how much money the office manager should get. Various dollar amounts could be shown on the horizontal axis because they are physical limits; personal value is displayed on the vertical axis as cost to the practice. The U-shaped curve represents the relationship between the objective and subjective. The bottom of the curve pinpoints the ideal of minimum cost. There is no zero; life is not free, even though many forms of it are more expensive than they need to be.

Consider possible points across the horizontal axis. If the office manager is paid a grossly insufficient amount, there will be high turnover in the position with consequent costs of replacement and retraining and disruption to the office routine. As pay increases, but remains short of ideal, staff find ways to make up the missing



The bottom of the curve pinpoints the ideal of minimum cost. There is no zero; life is not free, even though many forms of it are more expensive than they need to be.

compensation. Consistent results from equity theory research in the management literature show that employees adjust the effort/reward ratio to achieve a balance *they* consider fair.

Vitamin C is especially valuable to those with a deficiency, and almost worthless otherwise. Wanting more money that one needs can be very useful as an excuse to overlook real deficiencies while chasing imagined ones. Of course, an employee can be paid too much. There is a robust literature that shows adding extrinsic rewards, such as more pay or bonus, to a task performed for its inherent satisfaction both becomes the new expected norm and decreases intrinsic motivation and thus erodes performance. A hidden danger of overcompensation or lavishing resources beyond the ideal point is opportunity cost. What else could have been done with the extra money paid the office manager? What has been the effect on other staff members?

Dentistry is a wonderful profession with so many opportunities for fulfillment. It would be a shame to make the determined chase for lucre the universal standard. The success literature depends on a little comparative shaming. Already at about the 97th percentile of incomes among Americans, the upside for dentists generally makes sense when comparing oneself to top athletes or CEOs of large firms. Reaching for a prize so

large it will be noticed by others can have these consequences: distorted priorities or compromised moral standards; diminished overall oral health for the public; nondentists entering the profession with values other than health and service; turning patients into potentially billable units and staff and associates into productivity assets; and making it difficult for young men and women to enter this great profession. The spread between the top and bottom of dentists' incomes has grown substantially in recent years, with the superstars masking the fact that some have experienced declines in real income and hiding a fragmentation in the profession.

The focus on a single goal should not obscure the fact that practice is a multidimensional activity. Part of the mantra on the success circuit is "find your passion and dedicate yourself wholeheartedly to it." This is only true if you are grossly underperforming. Daniel Kahneman received a Nobel Prize in economics for demonstrating that the value of each gain is a diminishing function of what one already has. A dollar does not mean the same thing to a recent grad and a megapractitioner. Progress toward a goal where there is already enough has practically no value but will cost something if not channeled to a

dimension where more resources can make a difference.

Of course every cost curve is uniquely personal. The proper compensation for the office manager is different in Topeka and New York City, for the self-styled office "professional," and for the one who loves helping out folks in the community. But the shape of the curve will always have the general characteristics mentioned here. Ideal can be determined by watching to see how much cost increases as one deviated toward too much or too little. Finding the "sweet spot" can only be partially guided by expert advice from other practices. Ideal has been reached only when any change makes matters worse, all goals in professional and personal life considered.

President-elect's Address

Leadership: Past, Present, and Future

Bert W. Oettmeier, Jr., DDS, FACD

Wednesday, October 19, 2016
Denver, Colorado

I would like to begin by extending my personal congratulations to each of our candidates for Fellowship in the American College of Dentists. There is one thing I really want to emphasize: You are a part of a very select few members of our profession who are ever invited into Fellowship in the College. You were not invited into this Fellowship because of the person who nominated you; you were invited because of what you have accomplished, particularly as it relates to the mission of the College. You are here today because you have earned it!

The topic of my address to you today is "Leadership: Past, present, and future."

What is my passion? My passion is the pursuit of excellence and the quest for improvement every day. But what really excites me are those leaders who have that same passion; in other words, the people in this room! You give of yourself to make your profession, your practice, your patients, your students, and your community better, just to name a few. And for that, I thank you.

Leaders fascinate me. They come in all genders, all ages, all ethnicities, from all backgrounds, and some overcome seemingly impossible odds.

Much of what I will share with you today I will relate through my experiences in athletics, which has long been an important part of my life. On one end of the spectrum, I was given a reasonable amount of athletic ability. On the other end of the

spectrum, I was given no musical ability. My wife tells me I can't even "lip sync."

At age 14, my family moved from a small town in southwest Georgia (population 3,500) to the Kansas City area, specifically to Overland Park, Kansas. Even at that age, athletics, especially football, had become a large part of my life. And I was concerned about how that and life in general would change in the "big city."

The realtor my parents had worked with in Kansas City told them that the family directly across the street from our new home had three sons and one daughter, and that the oldest son was one year younger than me. The father of that family, I discovered, was a former football player in college and the NFL. Okay, I thought; that works for me.

Their oldest son and I immediately formed a bond. We both loved sports, were nearly the same age, went to the same church, went to the same high school, and played the same sports on our high school teams.

From dawn to dusk we played our sports: touch football in his backyard, basketball in his driveway, wiffle ball wherever we could, tennis at the courts down the street, and golf at one of the nearby public courses. When it rained, we played table tennis or shot pool in one of our basements.

Dr. Oettmeier recently retired from general practice in Leawood, Kansas: ddsk@aol.com



I still remember the basketball games we had in his driveway when his dad's former NFL friends would stop by and join us. I particularly remember frequently having to pull myself out of the cedar tree at the corner of the driveway. These former NFL players apparently had no understanding of the concept of a foul.

Although my neighbor was a very good athlete, especially a very good quarterback, he did not get the opportunity to be the starting quarterback until his senior year, the year after I graduated from high school. This was because we also had another very good quarterback in my senior class.

Our high school football coach, who was an excellent coach, was out of the same mold as former Ohio State Coach Woody Hayes (for those of you from my generation). That is, he much preferred the running game over passing. My neighbor's expertise, however, was the passing game.

My neighbor, as I said, was a very good athlete. He also was a handsome young man, a man of faith, integrity, and kindness. There was, however, one obstacle he had to deal with: he had a speech impediment, a very significant stutter. When we spoke, I would often have to help him along with the next word. Because of his stutter, he was rather shy. But he was such a kind and honorable young man, everyone respected and looked up to him.

His senior year in high school arrived, and he was the starting quarterback. Sometimes his teammates would have to call the plays for him in the huddle because of his stutter. He led his team to a very successful season that year, although he was never able to showcase his passing ability as a result of our coach's "run first" philosophy. But there was one major college that saw his potential.

My neighbor, high school teammate, and friend Neal Jeffrey, went on to become a three-year starter at quarterback for Baylor University, an All-American and Southwest Conference Player of the Year. He led Baylor to their first Southwest Conference championship in 50 years and played three years in the NFL for the San Diego Chargers.

Neal later received his divinity degree from Southwest Seminary and became an associate minister at a huge church in Dallas, Texas. If these accomplishments alone were not amazing enough, he also became a nationally-known motivational speaker, all this despite a significant stutter since childhood. He has even authored a book entitled *If I Can, Y-y-you Can*.

This should be an inspiration for all of us; I know it certainly has been for me.

We do not always know from where our leaders will come. Sometimes we are quite surprised. Some leaders are self-starters; some only need to be asked. And some have the "right stuff" but need to be encouraged and mentored.

I would like to share one other story with you. It is a story of the current head football coach at my undergraduate alma mater, Kansas State University. His name is Bill Snyder.

Coach Snyder came to Kansas State University in 1989 as a virtual unknown. But the president of K-State saw something special in him. This was his first head coaching job and has been his only coaching job. When he arrived in 1989, Kansas State University had only had two winning seasons in the past 35 years. (I'm proud to say I was part of one of those two seasons). Kansas State University had not won a game in two years when he arrived. He won just one game his first season. His closest friends urged him to leave Kansas State University before it "killed" him.

Coach Snyder told his team he would not judge them by the scoreboard, but by how much they improved as players, as persons, and as students. Three years later he had K-State ranked in the "top 20" in the country.

Coach Snyder retired at the end of the 2005 season. Over the next three years, K-State lost 19 games. Coach Snyder came out of retirement in 2009 to become the head football coach once more and had a winning season five of the next six years (the only blemish being a 6-6 record his first year back). He even had K-State ranked #1 in the country at one point in the 2012 season.

Last year, at age 76, Coach Bill Snyder became only the fourth active

coach in history to be inducted into the College Football Hall of Fame. He is generally regarded in football circles as "the architect of the greatest turnaround in college football history."

So, how did he do it? One thing was his attention to detail. Another was through his "Sixteen Goals for Success," six of which I would like to very briefly share with you.

- # 4. Improve every day
- # 6. Self-discipline: do it right; do not accept less
- #12. No self-limitations: expect more of yourself
- #14. Consistency: your very, very best every time
- #15. Leadership: everyone can set an example
- #16. Responsibility: you are responsible for your own performance

These six should come as no surprise to you. These are the same qualities you embrace. That is why you are here.

So, what is my point? My point is: we don't always know from where our leaders will come. Sometimes we are quite surprised. Some leaders are self-starters; some only need to be asked. And some have the "right stuff" but need to be encouraged and mentored. Remember Coach Snyder's Goal #12: No self-limitations.

Personally, I fit into the category of "only need to be asked." Twenty-one years ago a friend, a Fellow of the College and former ADA Trustee R. Wayne Thompson, came to me and said, "Bert, it is time for you to 'step up' and put your leadership skills to use." I knew he was right. I had been comfortably sitting back and enjoying the benefits afforded me by the actions of other leaders, but I understood his unspoken message of the importance of development of new young leaders.

Our 2017 Convocation speaker in Atlanta (and I hope you will all be able

to attend) will be General Richard B. Myers, former Chair of the Joint Chiefs of Staff from 2001-2005 under the George W. Bush administration. In that capacity, General Myers served as the principal military advisor to President Bush, the Secretary of Defense, and the National Security Council. In an interview he stated, "When I was an engineering student at Kansas State University, I often had the feeling that the professors had more faith in me than I had in myself. They were nurturing, which was really helpful and clearly carried through the rest of my life."

We need to identify and begin to nurture our future young leaders, and they are out there. I believe it is our responsibility as leaders to take an active role in finding our replacements.

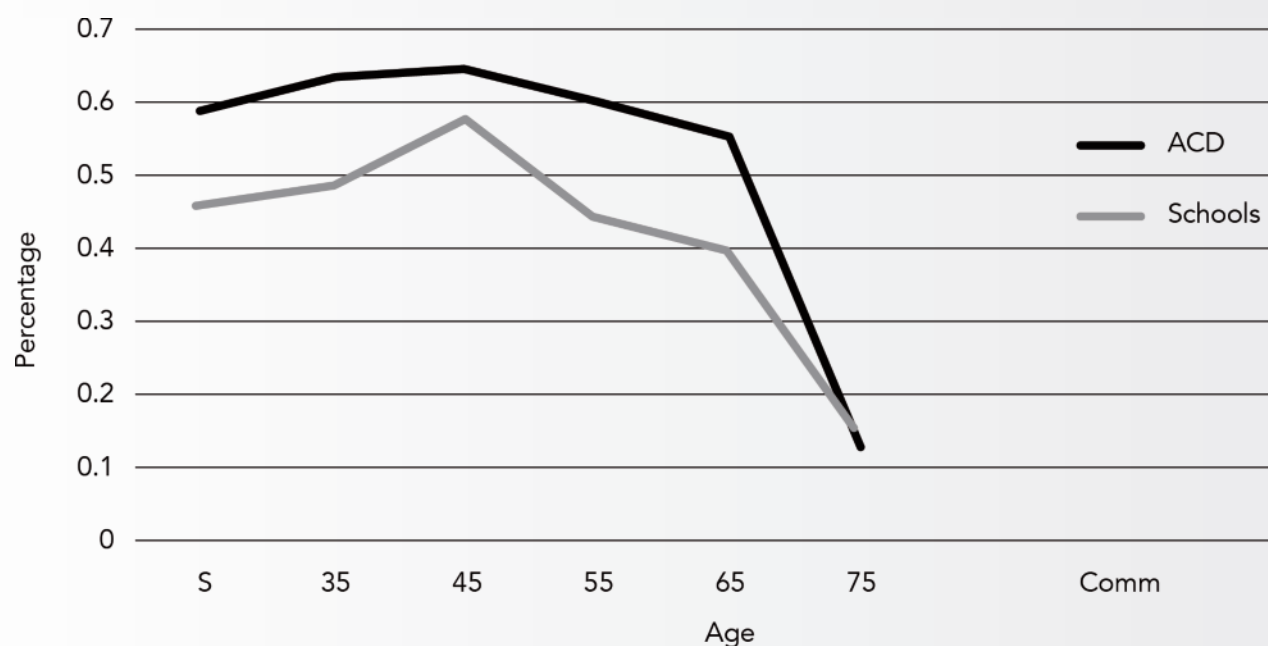
A recent study by the editor of the American College of Dentists and published in January 2016 in the *California Dental Association Journal*, looked at, among other things, leadership positions held by age for both ACD Fellows and nonACD Fellows.

What he found was that ACD Fellows hold more and higher levels of leadership positions than nonACD Fellows. No surprise there! This is part of why you all are Fellows in the ACD.

What was interesting to me was that both groups showed a gradually increasing rate of leadership beginning in dental school, peaking at about age 45, followed by a steeper decline (the decline is steeper with nonACD Fellows than with ACD Fellows), with a very sharp drop for all after age 65.

What is the significance of the results of this study? To me, the significance of this study lies in the

FIGURE 1. Percentage of any leadership participation across career segments for fellows of the American College of Dentists and for a sample of graduates from four dental schools.



Source: Chambers, D. W. A national survey of positional leadership trajectories of U.S. dentists. *Journal of the California Dental Association*, 2016, 44 (1), 39-47. Used by permission. (S = Dental school; Comm = Community service.)

fact the average age of the incoming fellow to the American College of Dentists is 55 years old. That is a full ten years after the demonstrated peak in leadership activities. And while, yes, Fellowship in the College recognizes those for their commitment to the mission of the College, wouldn't it be nice to recognize those leaders earlier in their careers, even before they reach their peak?

This would provide the ACD with leaders who will be in their active phase longer, providing us with strong leaders to advance excellence, ethics, professionalism, and leadership in our profession. Let's bring our deserving colleagues into the ACD while they are still active, and not just to thank them for a job well done at the end of their careers.

I challenge you when you return home and to begin your search for our future leaders. Do not let age, gender, background, ethnicity, or physical obstacles bias or impair your search. You never know where you will find a superstar!

Can we really find those leaders who will become superstars? My high school friend would answer, "If I can, Y-y-you Can."

Thank you, congratulations to our new Fellows, and have a wonderful remainder of this special day! ■

2016 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 the area of ethics. The American College of Dentists recognizes the Judicial Council of the California Dental Association (CDA) the recipient of the 2016 Ethics and Professionalism Award.

The Judicial Council of the California Dental Association is the governing body composed of members of the association who are selected to lead and shape our collective futures. The Judicial Council is comprised of 11 nominated and elected members who have an interest and experience in the field of dental ethics. The mission of the council is

the promotion and maintenance of high ethical standards within the dental profession; development and uniform enforcement of a viable and legally enforceable Code of Ethics; and interpretation and enforcement of the Code of Ethics on behalf of the association, components, individual members, and the public. The council embodies CDA's culture of service to its 26,000 members by providing valuable ethics education and resources with the intention of preventing ethical or legal violations. The council has four subcommittees that are responsible for carrying out the work of the council and play an integral role in promoting ethics within the dental profession, while ensuring ethical conduct within CDA membership. The duties of the Judicial Council include:

- Exercise the powers of the CDA to discipline members
- Review and make decisions regarding membership applications referred to the council
- Consider appeals regarding membership discipline or membership denial
- Ensure development of a viable and legally enforceable Code of Ethics by participating in regular reviews and evaluations of the Code of Ethics and related sections of the Ethics Handbook
- Interpret and enforce the Code of Ethics on behalf of the association, component dental societies, and

individual members by reviewing and responding to calls, correspondence, and case referrals from component ethics committees

- Promote, through correspondence, workshops and presentations, the maintenance of high ethical standards within the dental profession, including presenting ethics education programs at local and statewide meetings
- Provide guidance to the ethics committees at the component dental societies to ensure that processes and procedures defined in the Ethics Handbook are appropriately applied and followed

Some of the key activities and accomplishments of the council are:

- **CDA Code of Ethics.** The code consists of values and behavioral principles that serve as guidelines for the ethical practice of dentistry. The code is updated, as needed, to reflect the current ethical and regulatory landscape of the dental profession. By following the Code of Ethics, dentists build public trust and maintain high ethical standards for the benefit of all.
- **Component Ethics Committees.** Each of California's 32 local dental societies has an Ethics Committee that serves as a resource to members on ethics issues. The

component ethics committees' primary role is to educate member dentists and, when necessary, investigate alleged violations of the Code of Ethics for referral to the Judicial Council.

- **Biennial Component Ethics Seminar.** The Judicial Council hosts a full-day biennial ethics seminar and invites component Ethics Committee members and staff from each of California's 32 dental societies. The component ethics seminar is designed to educate component ethics committee members and staff on their respective responsibilities in handling ethical complaints and investigations.
- **Ethics Handbook.** The Judicial Council developed an Ethics Handbook with the purpose of providing component dental societies with uniform guidelines and procedures for reviewing membership applications and investigating allegations of unethical conduct involving members. The handbook serves as a working manual that emphasizes the steps to be taken to assure fair procedures are used for every application review and member investigation. A copy of the handbook is provided to each component Ethics Committee chair and component executive director. The handbook is available in

printed and electronic format so that it will continually be a current resource on council procedures.

- **Ethics Education.** In September 2010, the council began an initiative to provide regular ethics education to CDA members, and subsequently formed the Subcommittee on Ethics Education in Dentistry (SEED) to coordinate the council's efforts in this area. SEED identified two strategies, which include writing ethics articles for distribution to members, and the creation of an Ethics Speakers Bureau to provide ethics presentations at various venues. Since the inception of SEED, the council has developed over 20 original articles that have been disseminated via various CDA publications. Additionally, the council provides ethics courses at CDA's dental convention, CDA Presents, as well as at component dental society meetings.

Accepting the award for Judicial Council of the California Dental Association is Dr. Donna Klauser.

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

Honorary Fellowship

Honorary Fellowship is a means to bestow Fellowship on deserving nondentists. 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 but cannot vote or hold elected office. This year there are four recipients of Honorary Fellowship.



Elaine L. Davis,
PhD

The first recipient of Honorary Fellowship is **Dr. Elaine L. Davis**. Dr. Davis is Professor, Department of Oral Diagnostic Sciences, University at Buffalo School of Dental Medicine. She is a former Associate Dean for Student Affairs at the dental school. Over the course of her career, Dr. Davis has distinguished herself through outstanding service in numerous positions of responsibility. She has been recognized with several high-level awards and distinctions. Specifically, her accomplishments and credentials include:

- PhD, educational psychology, State University of New York at Buffalo
- Past Associate Dean for Student Affairs, University at Buffalo School of Dental Medicine

- Professor (with tenure), Department of Oral Diagnostic Sciences, University at Buffalo School of Dental Medicine
- Chair, Council of Sections, American Dental Education Association
- Past member, American Dental Association Committee on Educational Measurements and Testing, Council on Dental Education and Licensure
- Participant in 15 international dental outreach trips to Mexico and the Dominican Republic through Buffalo Outreach and Community Assistance
- Member, University at Buffalo ad hoc Academic Integrity Committee
- Instructed formal courses in statistics to over 1,000 undergraduate and graduate students
- Served as thesis committee member for six doctoral and 40 masters degree candidates
- Fellow, American Dental Education Association Leadership Institute
- Honorary member, Omicron Kappa Upsilon
- Secretary-Treasurer, Omicron Kappa Upsilon, Lambda Lambda Chapter
- Recipient, American Student Dental Association Faculty Award, Buffalo Chapter
- Recipient, American Dental Association Geriatric Oral Health Care Award for Counseling, Advocacy, Referral, Education, and Services (CARES) program
- Author, numerous scholarly publications and presenter of numerous invited presentations



Nancy R. Honeycutt, CAE

The second recipient of Honorary Fellowship is

Ms. Nancy R. Honeycutt, CAE. Ms. Honeycutt is the Executive Director of the American Student Dental Association and has served in that capacity since 2003. Prior to this position, she served as the Executive Director for TAG International for seven years and as Executive Director for The American Group of CPA Firms for nine years before that. Ms. Honeycutt is recognized by her peers for her passion and mentorship in preparing dental students to enter the profession. Highlights of her accomplishments and credentials include:

- Executive Director, American Student Dental Association (ASDA)
- Over 35 years of experience in association management, including 30 years as an Executive Director with an extensive background in strategic planning, team building, program development, and membership recruitment and retention
- Created ASDA's first National Leadership Conference to offer a curriculum focused on developing dental student leadership skills
- Established ASDA's Wellness Initiative to educate and provide resources to dental students on balancing and addressing wellness in their lives; ASDA's Wellness Initiative was honored by the American Society of Association Executives with a silver "Power of A" Award, which recognizes the unique ability of associations to make a positive impact on peoples' lives.
- Managed a 52% growth in ASDA membership from 2003 to 2016,

with a current 93% market share of dental students; increased the budget by 181% from 2003 to 2016.

- Recipient, Inspiring Leader of the Year Award, Association Forum of Chicago
- Honorary Member, Academy of General Dentistry
- Recipient, Certified Association Executive (CAE) designation
- Member, American Society of Association Executives, Association Forum of Chicago, and Professional Convention Management Association
- Member, Board of Directors, Professional Woman's Club of Chicago
- Chair, Public Relations Committee, Professional Woman's Club of Chicago
- Cochair, American Student Dental Association National Leadership Conference



Jocelyn Johnston

The third recipient of Honorary Fellowship is

Ms. Jocelyn Johnston.

Ms. Johnston has worked in organized dentistry for 25 years. She is the first Executive Director of the British Columbia Dental Association and has served in that capacity for the last 17 years. Ms. Johnston is known for her proactive approach to the profession and to members' needs. She is highly respected by her peers and colleagues for her leadership, accomplishments, and exemplary personal standards. Ms. Johnston's record of accomplishments include:

- Executive Director, British Columbia Dental Association (BCDA); following eight years

at the College of Dental Surgeons of British Columbia and the British Columbia Federation of Dental Societies

- Initiated the Tooth Fairy Gala 16 years ago to honor BCDA award winners and raise funds for dental causes; the most recent Gala raised \$150,000 for oral cancer research
- Initiated and oversaw BCDA volunteers to provide dental assessments for over 800 government-assisted Syrian refugees from December 2015 to March 2016, which revealed that 28% of refugees were in need of urgent oral care and another 52% required necessary care
- Successfully lobbied for \$1 million in provincial government funding for a public education campaign in British Columbia, which raised awareness among the general public on early childhood caries prevention
- Introduced a province-wide X-ray inspection program, which, in addition to ensuring the safety of patients and staff, has provided a unified database that has been used for policy development and program enhancements
- Secured funding of \$1.1 million from the provincial government for the prosthodontic care of cancer survivors and children with genetic disorders to start a center of prosthodontic excellence; this is in addition to annual funding of \$100,000
- Prepared the business plan that was approved by the BCDA Board for a continuing education center providing both hands-on and online education for dentists and

staff; the education program, CE@DLC, is now a member service offering of the BCDA

- Negotiated ongoing annual government funding of \$133,000 for the BCDA to administer prosthodontic programs for patients with cleft lip and palate and complex prosthodontic needs
- Oversaw the creation of the BC Dental Trust which, through the Pacific Dental Conference, supports the BCDA and local dental organizations as well as the UBC Summer Student Practitioner Program which places fourth-year dental students in dental offices during the summer
- Initiated an annual workshop for the 20 nonprofit and institutional dental clinics from across British Columbia; the workshop brings in speakers to provide information and support to these clinics as well as providing networking opportunities
- Initiated the MLA Network in which dentists are paired with their local "member of the legislative assembly" to ensure that politicians are well-versed on issues of concern to the dental profession
- Organized two provincial Adult Dental Health Surveys in which dentists collected oral health data on their adult patients; both surveys had observations of over 10,000 patients, providing an excellent overview of oral health in British Columbia
- Member, provincial government committee to develop a universally accessible fluoride varnish program in British Columbia and awaiting ministerial approval to proceed
- Worked directly on the development and production of the annual BC Fee Guide for 25 years which is structured to balance the cost of

practice with patient accessibility to care

- Member, various national task forces related to legal expense insurance for the profession, developing practice management information and human resource planning for dentistry
- Honorary Fellow, Pierre Fauchard Academy



Dorothy A. Perry

The fourth recipient of Honorary Fellowship is **Dr. Dorothy A. Perry.**

Dr. Perry is Professor and Associate Dean for Education and Student Affairs at the University of California, San Francisco, School of Dentistry. She has spent over 40 years in dentistry covering a variety of positions and responsibilities. Dr. Perry has demonstrated leadership at all levels in numerous dental organizations. She is held in the highest regard by her peers and colleagues. Dr. Perry's record of accomplishments include:

- BSDH, MSED, PhD, University of Southern California
- Professor and Associate Dean for Education and Student Affairs, University of California, San Francisco (UCSF)
- Forty years teaching and practicing at University of California, Los Angeles (13 years) and UCSF (27 years) schools of dentistry
- Governor's appointee, Committee on Dental Auxiliaries, two terms, eight years overseeing licensing and regulation of dental assistants and dental hygienists in California

- President's Award for Outstanding Service to the Profession, California Dental Hygienists Association
- Member of the Year, San Francisco Dental Hygiene Society
- Honorary Member and Past President, Omicron Kappa Upsilon (OKU), Rho Rho Chapter at UCSF
- Led effort of OKU to donate \$10,000 to name an operatory during clinic renovation
- Recipient, Distinguished Faculty Award, American College of Dentists, Northern California Section
- Recipient, Distinguished Faculty Award, Pierre Fauchard Academy
- Recipient, Advocate Award, American Student Dental Association
- Past chair, National Planning Committee for ADEA Annual Session
- Past member and chair, University of California Board of Admissions and Relations with Schools; oversaw undergraduate admissions to all ten campuses, responded to SP1 and SP2 limiting the ways that diversity could be assured at the campuses; worked to restore diversity through improved admissions processes
- Responsible for UCSF Commission on Dental Accreditation self-studies and site visits for two cycles, both extremely successful
- Thirty years of clinical practice as a dental hygienist

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. The **Southern California Section** is the winner of the Section Newsletter Award for 2016.

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 the **Kansas Section, Kentucky Section, Northern California Section, and Oregon Section** earned the Model Section designation.

Lifetime Achievement Award

The Lifetime Achievement Award is presented to Fellows who have been a member of the College for 50 years. This recognition is supported by the Dr. Samuel D. Harris Fund of the ACD Foundation. Congratulations to the following recipients:

Sam R. Adkisson
Missouri City, TX

William N. Alexander
Pensacola, FL

Robert C. Boyd
Angels Camp, CA

Roy R. Gonzalez
San Antonio, TX

Frank L. Herbert
River Ridge, LA

Larson R. Keso
Edmond, OK

Edward S. Lane, Sr.
Germantown, TN

Paul H. Loflin
Beaver, WV

Philip J. Reiter
Portland, OR

A. Howard Sather
Sun City West, AZ

Thomas J. Zwemer
Evans, GA

Convocation Address

Be Ready to Be a Leader

Norman Y. Mineta

Wednesday, October 19, 2016
Denver, Colorado

The Honorable Norman Y. Mineta is President and CEO of Mineta and Associates, LLC and former U.S. Secretary of Commerce and U.S. Secretary of Transportation. He is well-known for his work in the areas of transportation—including aviation, surface transportation, and infrastructure—and national security. Mr. Mineta is recognized for his accomplishments in economic development, science and technology policy, foreign and domestic trade, budgetary issues, and civil rights.

Mr. Mineta's career in public service has been both distinguished and unique. For almost 30 years, he represented San Jose, California, first on the City Council, then as mayor, and later as a member of the U.S. Congress. Throughout that time, Mr. Mineta was an advocate of the burgeoning technology industry. He worked to encourage new industries, spur job growth, and supported the development of the infrastructure needed to accommodate the technology industry and its tremendous growth. Mr. Mineta served as chair of the U.S. House Committee on Public Works and Transportation from 1992 to 1994, and chaired the Subcommittees on Aviation and Surface Transportation. He was the primary author of the Intermodal Surface Transportation Efficiency Act of 1991. In 2000, President Bill Clinton appointed Mr. Mineta Secretary of Commerce.

There, he was known for his work on technology issues, achieving international cooperation, intergovernmental coordination on complex fisheries issues, and for streamlining the patent and trademark process.

President George W. Bush appointed Mr. Mineta Secretary of Transportation, where he served until 2006. Following the horrific terrorist acts of September 11, 2001, he grounded all aviation flights and then guided the creation of the Transportation Security Administration—an agency with more than 65,000 employees—marking the largest mobilization of a new federal agency since World War II. Mr. Mineta was also a vice president of Lockheed Martin, where he oversaw the first successful implementation of the EZ-Pass system in New York State.

Recognized for his leadership, Mr. Mineta has received numerous awards, including the Presidential Medal of Freedom—the highest civilian honor in the United States—and the Wright Brothers Memorial Trophy, which is awarded for significant public service of enduring value to aviation in the United States. While in Congress, he was the co-founder of the Congressional Asian Pacific American Caucus and chair

Secretary Norman Y. Mineta is introduced in full prior to his summarized remarks in this article.



of the National Civil Aviation Review Commission in 1997.

Mr. Mineta is married to Danealia (Deni) Mineta and he has two sons, David K. Mineta and Stuart S. Mineta, and two stepsons, Robert M. Brantner and Mark D. Brantner.

Summary of Secretary Mineta's Remarks

My parents had a great influence on my life. My father came to America from Japan as an unaccompanied minor at age 14 looking for work. My mother was a "picture bride." I am one of five children who grew up in San Jose, California. My father loved this new country. In my recollection there were only three times in his life when he cried.

The first was when he heard about Pearl Harbor. The family was coming home from church and turned on the radio to hear the news. "How can the land of my birth attack the land of my heart?" my father said.

I remember when Executive Act 9066 was signed by President Roosevelt that called for Japanese, most of whom were U.S. citizens, to be rounded up and sent away. I remember that attitude of many in authority at the time: "Once a Jap always a Jap. If they attack Pearl Harbor, they will attack the West Coast." I recall the degrading posters put up around my home town of San Jose. I told my brother, "I am not an alien: I am a citizen." Our family was first sent by train to the Santa Anita

racetrack because there were stables where families could be kept. I packed my baseball hat, glove, and bat. The guard took away my bat. That was the second time my father cried. The last time was when his wife of 40-plus years died.

My father wanted to help the cause and so went to the University of Chicago to work with Special Forces, teaching them the Japanese language. My father also insisted that I learn Japanese. I wanted nothing to do with Japan, but my father insisted. He would not let bad acts distort the way we feel.

Everyone can prepare
for this kind of
leadership role; we do
it by the way we live
each day.

Fast forward to 9/11/2001. I was having breakfast with folks from the Belgium embassy. This was, like the bombing of Pearl Harbor, an event of such unanticipated magnitude, that we were forced to improvise. At first, no one knew what was happening. After three planes were seen plowing into buildings, I ordered that all commercial flights be landed. I obtained the cooperation of the Canadian airport leadership to allow planes from Asia and Europe to land in Canada. The small city of Halifax, Nova Scotia, a community of 4,000 people, opened its churches, community halls, and homes to take care of a massive influx of passengers.

The Air Force leaders realized that three incidences like this are a trend, and that Al Qaeda bragged about their intention to attack the powers of commerce (the World Trade Buildings), military (the Pentagon), and politics (the White House). When I left the breakfast meeting and drove to the White House, I saw people streaming outside. I was shown to the bunker below, which is meant to withstand a nuclear bomb.

The planes were being tracked on radar. The military was ordered to be prepared to shoot down planes, which were bombs of destruction. They were to follow Bush's instructions to avoid another December 7 Pearl Harbor. I was grasped with shock and despair as this brought back childhood memories and feelings.

The transponders of Flight 93, the plane that crashed in Shanksville, Pennsylvania, suggested that it was supposed to fly into the White House. The people on board took back the plane and crashed it. One of my wife's good friends, a fellow airline hostess, was killed. We will forever be grateful to those people who made the sacrifice of downing the plane that was bound for the White House.

Leadership is important. But sometimes events are larger and move faster than even the most thorough planning can prepare for. In those times, leadership emerges spontaneously from people of courage, from people with true values. Everyone can prepare for this kind of leadership role; we do it by the way we live each day. ■

Fellows Forum

The Imperative for Cohesion and Inclusion

David W. Chambers, EdM, MBA,
PhD, FACD, Editor of the College
and Moderator

Steven D. Chan, ODS, FACD

Daniel Hammer, DDS

Maxine Feinberg, DDS, FACD

Leo E. Rouse, DDS, FACD

Wednesday, October 19, 2016

Denver, Colorado

As the popular African saying has it: “If you want to go fast, go alone. If you want to go far, go together.” There is no doubt in my mind that dentistry is stronger with an inclusive and harmonious voice.

Inclusiveness means more than speaking on behalf of others; it means more than listening to others. It means that all affected by our actions participate in deciding how we should go and they see value in going with us.

I am troubled by signs of fragmentation in the profession. When I began teaching in dental school, more than 90% of dentists were members of organized dentistry. Today, the number is about 64% and falling at a rate of 1% per year. Specialists, educators, and new dentists are over-represented in ADA membership. Other groups are finding it more difficult to see the value. Moreover, it is not clear that all of dentistry taken together is representative of all of America.

The College would like to see the profession be more inclusive. We believe that this is healthy for the public and vital to the profession.

In the next hour you will hear from a panel of leaders who have given this matter a great deal of thought, and you will have an opportunity to provide input. The panel includes:

- **Dr. Steve Chan** is the president of the College. He has also served as president of the California Dental Association and the California Society of Pediatric Dentistry.

- **Dr. Dan Hammer** is a lieutenant in the U.S. Navy, completing his residency in oral and maxillofacial surgery. He is the regent intern of the College.
- **Dr. Maxine Feinberg** was the president of the New Jersey Dental Association and New Jersey Board of Dental Examiners before recently serving as the 151st president of the American Dental Association.
- **Dr. Leo Rouse**, a regent of the College, achieved the rank of colonel in the U.S. Army Dental Corps and served as dean of Howard University Dental School and president of the American Dental Education Association.

Each of our panelists will make opening remarks of no more than five minutes and then we will open the floor to very short questions for a total of ten minutes.

Following that I have a set of challenges for the panel. We will take on as many focused topics as possible in a format of five minutes for panel reaction, followed by five minutes of comments and queries from the floor.

Dr. Chan

In the 96-year history of ACD the faces of dentistry have changed. The faces today just look different. At the same time, the mission of the College remains unchanged. We will develop, promote, and recognize excellence,

ethics, professionalism, and leadership for the advancement of dentistry and oral health.

To the consumer, to the government, to the insurance companies, and to all forms of the media, we dentists all look the same. Yet today's dentistry is segmenting. Each part is pursuing its own self-interest.

So why is inclusion an imperative? After all, we're a pretty exclusive club. The College is about 2.8% of all active dentists. We too are self-interested. The particular "self-interest" of fellows is that we care what happens to the entire profession.

Let us reframe the question a bit. Should we see others who are not like us as "one of them," the "other?" Or should we see opportunities: "They could be one of us."

We have begun a pivot in the history of the College. In the language of my culture, "Talk does not cook the rice." We could talk and watch. Or we can act.

This year, we made our move. We sent emissaries to the National Dental Association, the Hispanic Dental Association, the Indian Dental Association, and the Academy of General Dentistry.

We are opening conversations for a brave new world. We see new conversations with even more ethnic and gender-based organizations, with the specialty organizations, with those in public health dentistry, in research, and in education. We are opening dialogue with those in industry, in the military, and in corporate dentistry. We see new conversations with those who are entering our profession.

Should we see others who are not like us as "one of them," the "other?" Or should we see opportunities: "They could be one of us."

Let's be clear: We are not sacrificing any of our standards. We are not compromising any of our criteria.

It's not enough to stand in our tent on the hill. What we gain by reaching out are new voices and freedom of action in new territories.

It is about presence, influence, and touching lives. The ancient Chinese and the ancient Romans saw a common symbol of inclusiveness. A chopstick or branch standing alone can be easily broken. Bundle many together and you cannot break us.

We begin by gathering branches. We begin by extending the hand of the College.

Dr. Hammer

I agree, that dentistry is stronger with an inclusive and harmonious voice. In addition, I agree that this is of vital importance or "imperative" as used in the title of this session.

However, in order for dentistry to truly become more inclusive, we must seek first to understand, then to be understood. This is the fifth habit of Stephen Covey's seven habits of highly successful people.

Before we can be inclusive and have our united message be understood, we must understand that inclusion has multiple definitions and constructs.

In 2015, Deloitte and the Billie Jean King Leadership Initiative collaborated to publish a report entitled, "The radical transformation of diversity and inclusion: The Millennial influence."

The study had over 3,700 responses from global professionals of all levels, ages, genders, races, and ethnicities. Those at various levels of seniority within their organizations were represented. Approximately 26% of respondents were Millennials, 47% were Generation X-ers (born 1964-79), and 27% were Baby Boomers (born 1946-63).

The hypothesis of the study was confirmed: While Millennials value the ideals of diversity and inclusion just like their generational counterparts, they fundamentally define the constructs differently, and therefore, have different expectations relating to engagement and empowerment.

Nonmillennial generations defined inclusion in terms of equity, fairness, and the integration, acceptance and tolerance of gender, racial, and ethnic diversity within the organization. "Inclusion is when everyone in the organization is given equal opportunity to work and grow without any bias regarding religion, race, and gender."

Millennials defined inclusion in terms of teamwork, valuing a culture of connectivity, and using collaborative tools to drive collaborative impact. "Inclusion is when you're a part of the process, your opinion counts, and we're working together to a common goal. It's being accountable for decisions that you are part of." "Inclusion is having an impact at all levels...and having open lines of communication, transparency, and strategic initiatives communicated to employees by executives."

Once we understand how different generations of dentists define inclusion, we can effectively communicate the value of cohesion and therefore we can be understood. If done in the reverse order or without concern for our differing paradigms, the attempt to be understood may yield little to no success. This will drive others out of the tent because they do not feel as though they belong.

A second thought comes from the book *Fuse: Making Sense of the Cogenational Workplace*. When discussing social media, the author states, “For Boomers, social media is a place and a set of tools. For Millennials, it is simply a way of everyday life.”

For most of my colleagues, we have developed our own social network or virtual reality where many draw a sense of belonging and inclusion. Unlike the nonvirtual world, on Facebook we are empowered to further manipulate this reality by deciding to “block” or unfollow individuals members. Therefore, we decide what we choose

to include in our social context and our self-selected social identity and not the reverse. We may be less interested in the digital network others created at great cost and with the help of experts because we have created and customized our own.

We have left the Information Age and are now firmly planted in the Participation Age where tools like video portals, podcasts, blogs, wikis, and discussion forums in an on-demand setting are expected. Millennials on social media do not seek acceptance into organized dentistry. They seek to participate, and organized dentistry must connect with their values and their construct of inclusion.

The next generation of leaders is ready to engage, but instead of bringing the individuals into the tent, we must bring the tent to them.

Dr. Feinberg

First, I want to say that participation among women in various organizations in dentistry is increasing, but unevenly. For example, the ADA House of Delegates contains about 21% women. Membership in the ADA by females is about 59%, compared with about 65% for males, and has been in decline and could be greater. Female deans are about 17% of the total, while females are about half of the students. It is going to take many years before parity is reached across the profession. The picture is somewhat different for applicants to dental schools.

Now the question is how women can move up in the hierarchy of organized dentistry.

First of all, we need to start thinking about this issue differently. We need to start thinking outside the box and need to approach the problem more creatively.

Maybe it makes a lot of sense for some people to work three days a

week. We should consider other forms of practice. There are other forms of practice than the traditional private practice model. We need to embrace all dentists, even those who choose to practice in modes that may be different from those familiar to most of us in this room.

So I think it is not about whether or not participation in organize dentistry in terms of members, but it is about who we include. We should not be inhibiting participation. We need to be more open about how we involve people who want to practice different ways. It is about being accepting of variety. Individuals may be different, but equally qualified for leadership in different ways.

Let's look at Federally Qualified Health Centers (FQHC). They are able to provide good services. We can work together to provide the best care for those in need. In some cases, for example, FQHCs have agreements with private offices in their areas to provide services that they cannot. We can start looking at how to get more care to more people.

The best way to increase involvement is through personal contact: Going out and meeting people. We could start involving people earlier in their careers.

We do not need to change the standard for excellence. We can change the standard by which we judge who we include.

I think we have come a long way from where we were, but there will be other forms of practice as well. There will be FQHCs or corporate models and part-time practitioners. So I think that is what we need to start thinking

While Millennials value the ideals of diversity and inclusion just like their generational counterparts, they fundamentally define the constructs differently, and therefore, have different expectations relating to engagement and empowerment.

We have to be more creative about asking people who we might not have thought about asking before. “Would you like to come to a dental meeting and meet your colleagues here in the community?” And they are touched that you would take the time to ask them.

outside the box. It is not going to be the way it was.

So I think just approaching people is the key. We have to be more creative about asking people who we might not have thought about asking before. “Would you like to come to a dental meeting and meet your colleagues here in the community?” And they are touched that you would take the time to ask them.

I think it is about being creative, thinking about involving people who have not been involved.

So it is not about whether or not the College or the workforce stands for excellence. We need to change the standard by which we judge who we include.

Leo Rouse

There are many who have much to offer the profession but may not feel fully welcome. We have heard about young dentists, men, women, and those who may not practice in traditional ways who still have genuine concerns related to diversity and inclusivity. I would like to call your attention to yet another group—our colleagues in the medical profession.

In the past few weeks, we have read about two medical doctors, both African American women, one flying as a passenger from Seattle to Hawaii and the other flying from Detroit to Texas. An announcement was made in both cases by the flight crew: “Is there a healthcare provider on this flight?” They identified themselves and said they were ready to help. In both cases their credentials were challenged—an apparent state of unconscious bias and the lack of familiarity with sincere practitioners willing to help without questioning their training based on some preconceived bias—black and a physician. The same could be true of a DMD or DDS.

In our case we will talk about the profession of dentistry and our inclusion in the healthcare system. More specifically, our role in interprofessional education and collaborative practice. Nothing is more critical than a profession that recognizes the value of diversity and inclusivity. Dentistry is a noble profession with clinicians that practice in an ethical and professional manner—the tenets of the American College of Dentistry.

As an educator, I have a commitment to ensuring that the young men and women educated in our academic dental institutions appreciate their commitment to be a pillar in their community. More specifically, the

value of mentorship and role modeling to young people in STEM subjects [science, technology, engineering, and math]. A strong dental profession has a pipeline of diverse men and women in the academic space which will represent what the profession will look like 20, 30-plus years from now. It is my hope that all of us truly understand that we as a profession must, in the words of Gandhi, become the “change that we want to see.”

Comments from Fellows

Question: My question is where is the College in considering leadership in other organizations than the ADA? Is the College open to considering other qualifications of leadership?

Dr. Chan: The College exists to recognize those who have made meritoriously contributed to the profession and society. The College exists for those who have demonstrated leadership. The reality is you do not need a title or to belong to the ADA to improve the oral health of the lives in this country. Leadership is demonstrated when a dentist mobilizes his or her contemporaries into growing segments of the population in this country untouched by the ADA. The greater question we should ask is “Shouldn’t we bring them into our tent?”

Question: With regard to Millennials, is the lower level of participation due to their fear that they will not be included or it is because they have not been made to feel welcome? How do Millennials and others look at qualifications, training, and interest?

Dr. Hammer: Millennials actually have a higher rate of membership in the ADA than do Boomers. They are active participants, but they participate in different ways. They are concerned with experience and outcomes. Leadership is less about the position one achieves. And there are ways of demonstrating participation that were not as common in years past and not identified with any single organization.

Dr. Feinberg: One of the concerns I hear from Millennials is that it takes too long to move through the formal leadership positions. I think we are going to have to realize that we need to create new opportunities for people to get where they want to be in our profession. We need to get people involved sooner.

Question: As a female, why has no one asked me what my hopes are and how I would like to contribute to the profession?

Dr. Rouse: Leaders have an ethical and mentor responsibility to communicate with everyone, including asking “what are your aspirations and professional plans in this organization and profession?” If this does not happen, apply your moral courage with integrity to facilitate a conversation about your hopes, desires, and goals for your future contributions to the profession.

Question: I have been the chair of a particular organization for quite a few years and we have reached out to young dentists in the community. Although there is some initial interest, generally they do not stay with these programs.

Dr. Hammer: I believe that is going to be more typical in the future. Millennials see a distinction between participation and joining. They value the current experience and are less likely to invest in positions that involve delayed gratification.

Question from the Moderator: Assume that we continue on our current path with the proportion outside the tent remaining similar or increasing: what would be the harm in that?

Dr. Chan. The reason for the College to exist is to raise the dignity of the profession. We exist to lift the whole profession, not just a part of it. We can ignore the change or we can engage the entire spectrum of profession.

Question from the Moderator: The path to top formal leadership in the organized profession requires many years of service. Why should those on the path step aside or shorten their tenure to make way for others? Why should others have to wait?

Dr. Rouse. I am a firm believer in legacy and succession planning. We have an obligation to prepare others, committed to values and ethics, for leadership roles of increased responsibilities. My pathway to leadership was because outstanding mentors and role models committed to assisting me in my professional development.

Dr. Chan. There were times I almost quit. There were lots of times where I was discouraged by someone higher

up in power or was isolated or just plain ignored. It didn't seem to matter that I was even here. There were times I felt “I don't belong here.” I could be spending time with my family. I could be working in my office to pay down my crushing school debt and the loan payments on my office.

But I had the great fortune in my career where many, many times someone saw something in me. Someone took me aside and said, “I believe in you.” Those powerful words changed my journey. Isn't that what we do as leaders? ■

Nothing is more critical than a profession that recognizes the value of diversity and inclusivity. Dentistry is a noble profession with clinicians that practice in an ethical and professional manner — the tenets of the American College of Dentistry.

2016 Fellowship Class

Regency 1

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Marina R. Sexton
Norris Point, NF

New England Section

Brooke Blicher
White River Junction, VT

Michael A. Cooper
Hopkinton, MA

Ralph P. Ergas
Manchester, NH

Mary Jane Hanlon
Kennebunkport, ME

Zuzana Mendez
Dorchester, MA

New York Section

Babak Bina
Great Neck, NY

Joana Forsea
Roslyn Heights, NY

Edward B. Goldin
New York, NY

Shahram Shekib
Brooklyn, NY

Esperanza A. Rodriguez
Bronx, NY

Michael S. Shreck
New Hyde Park, NY

Stacy Spizuoco
New York, NY

Denise A. Trocheset
Stony Brook, NY

Quebec Section

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Hilal Sirhan
Brossard, QC

Western New York Section

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Pittsford, NY

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Joint Base Andrews, MD

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Nathan L. Fletcher
Pikesville, MD

Jay Nokkeo
Gaithersburg, MD

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Rajnikant Shah
Jeffersonville, PA

Maria Tacelosky
Nuremburg, PA

Matthew A. Zale
Dickson City, PA

Virginia Section

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Richmond, VA

Audra Jones
Richmond, VA

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Cullman, AL

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Stephen Meraw
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The ADA Has Your Back

Maxine Feinberg, DDS

Remarks at the 2015 American Student Dental Association National Leadership Conference

It is a pleasure to be here and to have the chance to speak with you this morning. I get so excited every time I'm around dental students—your energy and enthusiasm are contagious!

I want you to know how important your role as ASDA leaders is, and how important you are to the ADA. We know that this is where the leaders of the dental profession are born. Next week I will be in Washington, DC, for our annual meeting, and I know that in just a few years, it will be you sitting in that House of Delegates, leading this profession.

And I want to let you in on a secret: Dr. Summerhays and I both will be talking at length with the House next week about the important role dental students play in advancing our profession. Students have always been an important focus for the ADA, but we have kicked our engagement with students into high gear.

This year, we have invested far more in listening to you than we ever have before. And we are going to continue doing that.

I want to start by commending ASDA for partnering with us this year. Your leaders came to our retreat in February. In March, ASDA's Board of Trustees met with the ADA's Board of Trustees. The ASDA Executive

Committee and the ADA New Dentist Committee chair and vice chair met throughout the year. And together we are working on plans for further collaboration, figuring out how to create real value for dental students and meet your needs.

Dr. Summerhays and I have together visited more than 30 dental schools this year. We met students like you all across the United States. We listened, and I think we have a pretty good sense of what is on your minds.

What we heard from you is that you are excited. And you should be, because this is a remarkable profession. I cannot begin to tell you how much my career in dentistry has meant to me.

We also heard your concerns, and we know that you are concerned about a few things: Number one, dental school debt; two, initial licensure and portability of licensure; and three, finding a job.

I am thrilled that the ADA is now providing a student loan refinancing program through DRB. We launched it just last month.

After you graduate, you can apply and the program enables you to refinance at a rate that is highly competitive, because it is a program designed just for dentists. This is 100% a member benefit. And our initial research shows that this can save

Dr. Feinberg practices in Cranford, New Jersey. She served as president of the American Dental Association from 2014–2015.



students on average tens of thousands of dollars over the life of their loans.

In terms of licensure, we know this continues to be a concern. Dentists are not staying in one place anymore. Many of you might not know where you plan to practice after you graduate. And so portability is an issue we are addressing.

In March, we convened a licensure task force. In a matter of months, we partnered with ADEA, the licensing community, and students and had the first productive, collaborative discussion on this issue in years. It has been ADA policy for almost 15 years that initial licensure exams not be patient based. And if they are, that they meet certain ethical criteria. We are continuing to address that concern. But we are continuing to work on the portability issue, because the current system is not working for today's dentists.

Finally, we know you're concerned about finding jobs. Today's landscape looks very different from when I graduated from dental school. You have so many more options today, and I want you to know that no matter where you choose to practice, the ADA is here to support you. We have job postings available on our website, but the best way to start your search is to network with other dentists. You are off to a great start with ASDA. Continue to do that after you graduate, by getting involved and meeting the dentists at your local component.

We are so thankful for all you do. We look to you for your perspectives and input, and we want to help you throughout your dental careers. Even if there is something you think we need to work on, let us know—we can take it! You add an important dimension to the ADA family that allows us to assure that we are representing and meeting the needs of all dentists. Get involved, come to Washington, DC, for Lobby Day; go with your states to their Legislative Days in your state capitals. Your voices count.

Thank you for your leadership. We look forward to working with you now and in the years to come, so please stop by our booth and tell us what is on your mind. Find out what we are doing to help advocate for students and the profession in Washington, DC, and in your state. ■

Comments from ASDA Attendees

Rebecca Warnken, DDS, Bradenton, Florida; Chair, 2015 ASDA National Leadership Conference

It was truly inspiring to witness Dr. Feinberg's address at the American Student Dental Association's National Leadership Conference at the end of October. Dr. Feinberg directly addressed several of the concerns students and new dentists deal with on a daily basis. It was

This year, we have invested far more in listening to you than we ever have before. And we are going to continue doing that. We listened, and I think we have a pretty good sense of what is on your minds.

We also heard your concerns, and we know that you are concerned about a few things: Number one, dental school debt; two, initial licensure and portability of licensure; and three, finding a job.

encouraging to know the ADA is addressing student debt, licensure and mobility, and other issues that weigh heavy on our minds. She was also extremely approachable and wonderful to talk to. Her remarks offered even further confirmation that everyone in the room has made a decision to join a fantastic profession.

*Dan Hammer, Bethesda, Maryland;
ACD Regent Intern*

Like many new dentists, I became very focused on my budding career immediately after graduation and lost touch with the ADA and its mission. I was still a member, but I was slower to send in my renewal and my membership nearly lapsed. I knew the importance of the ADA, but I did not recognize my purpose in the ADA as a young dentist. I figured I would reengage once I became a more “seasoned” practitioner.

Genuine and concerned. Those are the words that best described Dr. Maxine Feinberg’s remarks. Her genuine love for the profession of dentistry and genuine concern for its future, and in turn for new dentists, was evident throughout the entire address. She was approachable and engaging. She began the address by wearing a Halloween hair band and discussing what she hands out to trick-or-treaters as though you were

sitting at home having the same conversation. She then discussed the value of ASDA, stating that, “We know this is where the leaders of the dental profession are born.” You could not help but feel that the ADA wanted to invest in our personal leadership development to advocate for the profession in the future.

Dr. Feinberg highlighted the concerns of increasing dental school debt, initial licensure, and finding a job after graduation. In addition, she emphasized tangible examples of how the ADA is working to address these real-life, omnipresent concerns for students and new dentists alike. I felt like she understood me and was invested in my future success. After her remarks I was reintroduced to the value and purpose of the ADA and the role it has in protecting my future and our profession. I called that afternoon to renew my membership for 2016.

Interim ACD Gies Ethics Project Report

Is Professionalism a Contact Sport or a Spectator Sport?

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

Abstract

This presentation is an interim report on the American College of Dentists Gies Ethics Project. Following the example of William Gies, our work has been grounded in empirical studies, with progress on the first 11 projects summarized here. The following general patterns are beginning to emerge: (a) the traditional model of individual dentists guided by abstract principles seems to exhibit some inadequacies; (b) ethical cases suggest that patients and dentists hold common views on what should be done and why in some areas but they diverge in others; (c) dentists place high value on technical excellence and income and relatively less on ethics and oral health outcomes; (d) ethics education in dental schools has not achieved the status of a discipline and is showing signs of receiving less attention than in recent years; (e) focus groups of both patients and dentists are concerned that private standards that differ across dentists as to what constitutes appropriate care are eroding trust in the profession, both among

dentists and between dentists and patients; (f) recent economic trends highlight growing fragmentation within the profession; (g) practice is losing its direct relationship with patients as it becomes more commercial; (h) dentists are confused about their role in self-regulation and thus compromising public trust; (i) dentists seem to be willing to tolerate a significant number of their colleagues cutting corners; (j) educating individual dentists about ethical theory is unlikely to be effective in bringing about needed professional behavior. Based on this preliminary evidence, it may very well be the case that the ACD Gies Ethics Projects makes recommendations such as the following: (a) improving the ethical tone of the profession will require changes at the organizational as well as the individual level; (b) standards may be more effective if shared among dentists and with the public; (c) moral leadership (helping others act more morally) is needed; and (d) it is unlikely that we will raise the tone of the profession based on saying we want or ought to—it will cost something.

Developmental psychologist Erik Erikson (1959) pointed out that becoming a mature individual involves successfully addressing a succession of life challenges. We are born dependent—so much so that humans would become extinct without the early help of those around us. The species would vanish as well if significant numbers failed to master the second challenge by becoming independent. The skills needed here are built in childhood and are normally mastered by late adolescence. The ultimate life challenge

is interdependence. Becoming productive members of communities is essential for happy marriages, running businesses, having friends, and helping others become independent. Almost every individual works out of the dependence stage, but many organizations (especially small businesses) fail. Most individuals and most organizations also grow into adulthood and interdependence.

There is a trend in privileged societies and among privileged individuals to prolong the middle, adolescent stage in a form of arrested development. The “selfie generation” is a less expensive version of the litigious society that seeks to rules to suit itself. Currently the dental profession is being pushed by forces that challenge its independence. We should carefully consider whether it is a sound strategy to double down on seeking to retain exclusive control of providing oral health care to all who need it or determine who among those receive the care. This strategy has been successful in the past, but it may place limits on the profession’s ultimately achieving the maturity of interdependence.

Garret Hardin wrote about the “tragedy of the commons” in 1968. He was referring to the early tradition of pasturing one’s livestock on the community’s shared grasslands. Individually this is eminently appropriate as the pasturage would

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This paper is an expanded version of a presentation at the 11th Congress of the International Dental Ethics and Law Society, August 6, 2016, Chicago, Illinois.

otherwise go to waste. Collectively, it is self-destructive. A single dentist might very well pretend to honor the profession's reputation for serving the public or collective monitoring and building the profession while actually pursuing personal and excessive financial goals. If organized dentistry looks the other way while this is happening it will damage the profession.

Often, ethics is seen as working up a core of principles that should bring about the world we desired if others did as we expected. The Oxford philosopher Barnard Williams (1985) makes the following observation about the field of psychology: if we work out what really makes people happy, we will have only increased the reasons why people are unhappy. Parallel reasoning applies to ethics: the longer the list of behavior expected, the more reason we will have for worrying about the unethical behavior we see around

us. Rules do not make us ethical; and our rules will likely be even less effective with others. Garret Hardin summarized this in a maxim: "Do not expect that others will solve your problems by acting against their self-interests" (1977). Said another way: debating and deciding what others should do is relatively inexpensive, while bringing about change for the better costs something. Ethics (in the sense of statements about right and wrong) is a spectator sport: morality (in the sense of making things better) is a contact sport.

The Ethical Model of Dentistry

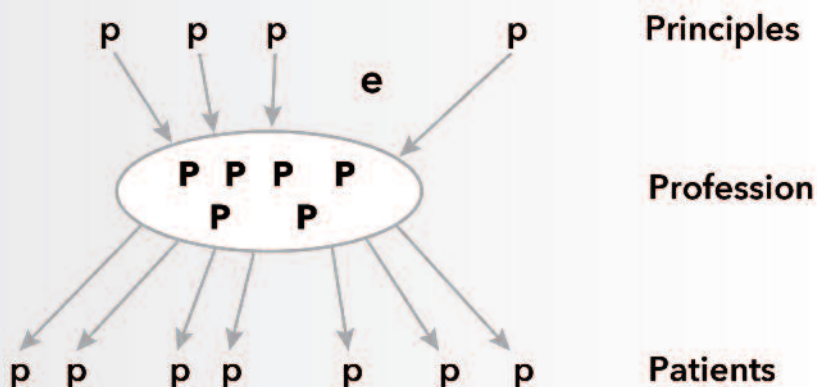
Most of us cherish a picture of ethics and dentistry something like what is shown in Figure 1. Ethical principles guide the profession, the collective group of dentists and others who serve the public. This is our social contract:

You will let us manage our affairs because we are doing so on your behalf. The symbol "e" in the diagram represents the ethicist. It is the job of ethicists to work with professionals to help them better understand the principles.

But that is an idealization. The real picture is something more like the one in Figure 2. There are principal objectives for dental practice that are not ethical principles. Practitioners are not all professionals. And if we use the rough-and-ready criterion of membership in organized dentistry, the proportion is now about 64% and falling at the rate of 1% per year. This trend is displayed in Figure 3. Further, all people with teeth are not patients. Most people are PINOHCs—Persons In Need of Oral Health Care (Chambers, 2015b). There is an increasing number of individuals who patronize dentists for smiles, Botox treatment, whitening, and other non-health services. There is also an increasing number of individuals who need oral health care but are not receiving it. We can see this in the trend line for adult dental visits shown in Figure 4. These pictures are not what we are accustomed to considering in ethics courses where we zoom in on the idealized individual at a particular point in time. When we inquire about the profession as a whole and use a longer time frame, new issues begin to emerge. Dentistry is shifting off its professional base and is moving off target.

Principles occupy a prominent position in professional ethics. It is often assumed that those who can name a set of principles will treat patients better than those who cannot. The evidence for that belief is difficult to locate. There are many outstanding dentists who think that nonmaleficence is a flower with large orange and

FIGURE 1. Idealized model for the relationships among dental ethics, professionalism, and patients.



yellow blossoms or a skin condition. Principles are often in conflict with each other, and teachers of ethics make that a virtue so they can then have discussions about dilemmas. Overtreatment, cheating, and untreated oral disease are not dilemmas. They are problems we should fix.

Dentistry has five principles. These were borrowed from Beauchamp and Childress (2009), who only had four. (Veracity, which figures very large in the ADA Code was added primarily to cover dentist-to-dentist matters such as specialty advertising). Beauchamp and Childress modeled their principles on the Belmont Report, which only had three. Hygiene has seven—better yet. Medicine has nine. There were at one time philosophers such as W. D. Ross (1930) who entertained 26. But the principles approach to ethics is not especially popular among moral philosophers today. And much more concerning is that Stanford economist Kenneth Arrow (1951) received a Nobel Prize for proving that any social welfare function about the optimal distribution of resources for the common good with more than three principles is indeterminate. That essentially means that we will be able to justify almost anything we favor based on some grounds if we have enough principles. It also means that we resolve ethical dilemmas by recourse to often unacknowledged values such as personal convenience, political power, or financial benefit.

It can be seen in Figure 2 that some of the practitioners are indicated in “scare quotes.” That is because an increasing number are not actually persons. They are legal fictions. There is also a new actor in the system in

FIGURE 2. Somewhat more realistic model of dental professionals.

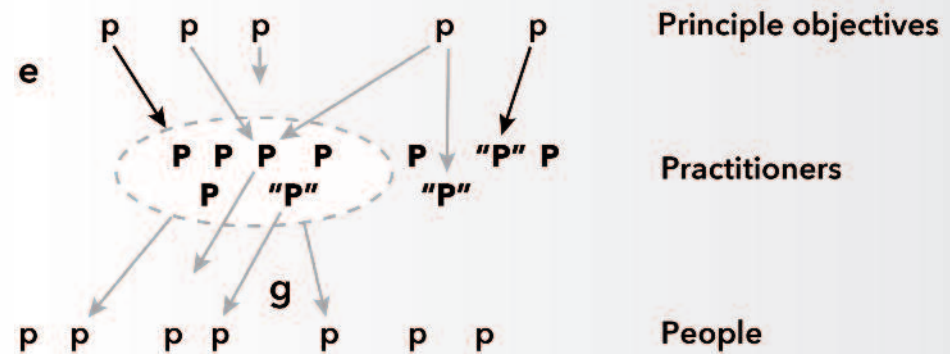


FIGURE 3. Declining ADA membership.

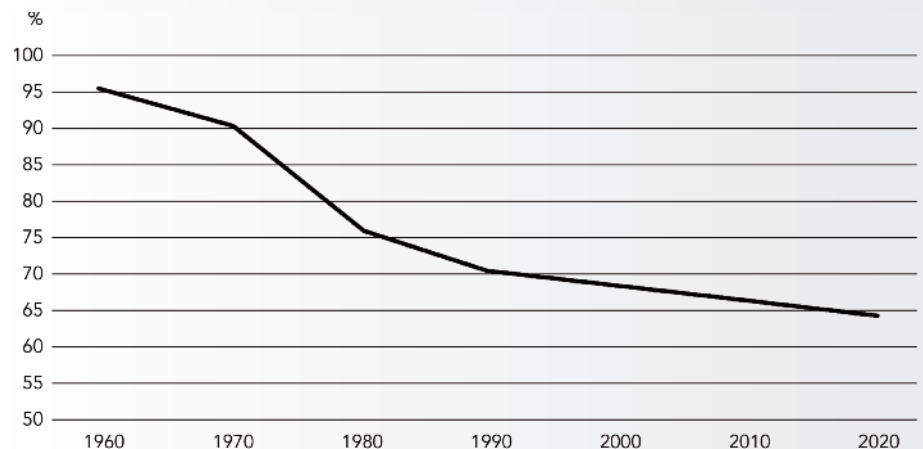
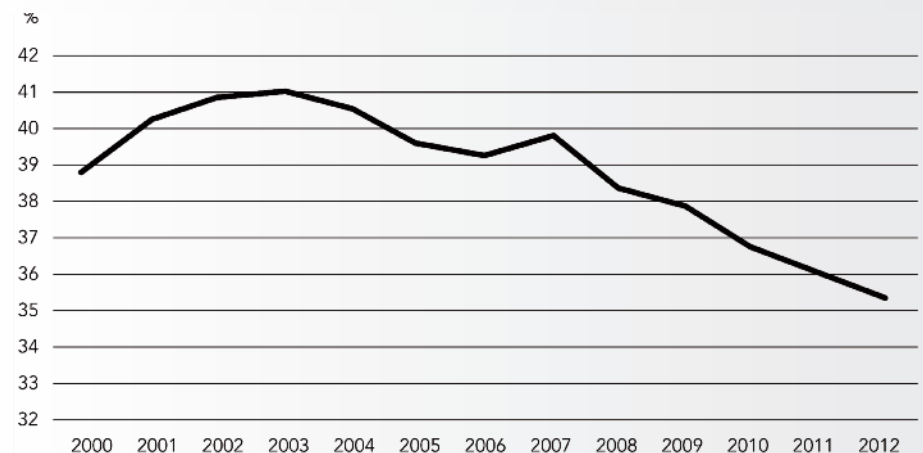


FIGURE 4. Adults with dental visit in past year.



Source: AHRQ Medical Expenses Panel.

recent times. I have labeled these folks “g,” and that stands for all those who offer their services to practices to show them how to achieve their principal objectives. These include web designers and PR consultants, practice management gurus, DSOs, and others who may infect the profession with standards that are not traditional in a healthcare profession.

The ACD Gies Ethics Project

The American College of Dentists has a historic concern for the ethics of dentistry. The *Journal* is the major venue in the United States and Canada for publishing papers in dental ethics. We have sponsored courses in ethics that have reached thousands in the past few years, including about ten intensive all-day workshops, three ethics summits, and as many white papers. Through the College, practitioners are financially supported to take online courses at bioethics programs or to earn advanced degrees to strengthen their foundations in ethics. Our online resources include AGD-approved CE programs that have now been completed for credit by about 90,000 individuals. We have an online ethics textbook, ethics cases with feedback, and a 50-hour intensive self-study program for entire offices. One of the sections of the College is the American Society for Dental Ethics. We are in a trial arrangement for section status with the Student

Professionalism and Ethics Association. Each of these connections guarantees the autonomous integrity of both organizations while taking advantage of common goals and sharing resources.

All of this can be accessed at www.dentaethics.org. There is no reason not to go there. It is all free. Who would charge for ethics?

About a year ago, the Board of Regents of the College approved a major project on ethics. We also managed to raise a multimillion-dollar bequest to support this effort. It is called the ACD Gies Ethics Project. This will be a three- or four-year project modeled after the work William Gies, a biochemist, did for the Carnegie Foundation for the Advancement of Teaching almost 50 years ago and on what Abraham Flexner had done for medicine two decades previously. Gies recommended that dentistry be a profession distinct from medicine but of equal stature. The latter, he argues, could best be achieved by moving dental education into research-intensive universities and by making prevention the highest goal of the profession. Most dental visits today are for preventative services.

The focus of the American College of Dentists is different than what animated Gies. We are concerned with the ethical foundations of the profession rather than the role of education. We are identifying our project with the name of Gies because of the unique method he used in his study. Over a period of several years he visited every dental school in the United States and Canada. His 500-plus-page book, *Carnegie Bulletin #19*, released in 1926, is very rich in factual descriptions and very short on recommendations.

Early Evidence

We intend to follow the Gies model and ground our work in empirical findings. Some of the early results are summarized here.

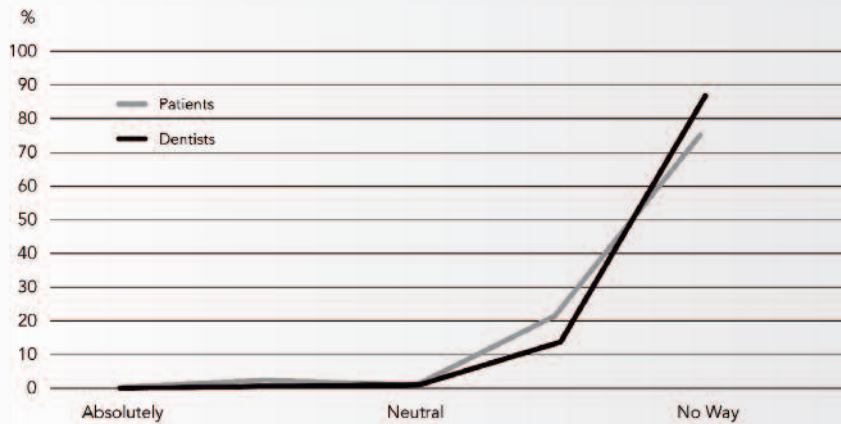
Cases

When dental students discuss particular cases in seminars, they have the advantage of getting feedback from colleagues. The American College of Dentists wanted to make this kind of experience available to practicing dentists. But the challenge is how to provide feedback without a face-to-face presence. The solution was to present cases to a representative sample of fellow dentists and a sample of patients—91 of the former and 54 of the latter. There are eight such interactive cases online at www.dental.ethics.org. They cover such topics as informed consent, charity care, patients who skip out on payments, and “selling dentistry.” They are available in both written and video format, thanks to the outstanding work of Larry Garetto at Indiana.

Figure 5 is an example comparing dentists’ and patients’ perceptions about the necessity of a dentist intervening on behalf of a staff member who is being harassed by a patient. It is hardly a dilemma; in fact this is essentially a legal matter of a hostile workplace environment. And this is about as close to consensus as one could expect: there is one right thing to do and both dentists and patients see it clearly. There are many among the almost 100 actions and reason explored in the study that clearly signal what would be expected of a practitioner.

It will be useful to come back to this study shortly. But there were some general findings that will help prepare our minds for what is coming

FIGURE 5. Patient and Dentist Responses: Dentist is justified in overlooking harassment of employee as this is a private matter.



(Chambers, 2015a). First, there was absolutely no relationship among responses by dentists or patients between actions and reasons offered in justification. An ethical principle could be clutched while favoring one course of action, ignored by others, and even used to defend different and quite inconsistent actions. Or a favored response could be defended on several principles. As William Jennings Bryan was fond of saying, “It is a poor mind that can’t think up some reason for doing whatever one wants to.” Copies of Enron’s code of ethics, which is an outstanding example of a code, were being sold on eBay in October of 2001. M. C. Matthews noted in 1988 that organizations with codes of ethics are more likely to be indicted for fraud than were those that have none.

Both dentists and patients in our eight-cases study organized their responses around dignity. Dentists felt better about paternalism than did

patients. But the leading motive for dentists was a blend of technical and business efficiency. The leading motive for patients was oral health outcomes. They are not the same thing. Think sealants or veneers and implants. There is no dental procedure that has a stronger foundation in evidence than the prophylactic use of sealants. It remains a substantially underutilized procedure. So much for evidence-based dentistry.

Do Dentists Care About Ethics?

It would be futile to ask dentists whether they valued ethics or thought of themselves as ethical. This is not because the answer is unimportant, but because one is unlikely to get any range of answers. It would be like asking folks in a room raise their hand if they cheat on their income taxes. As David Callahan notes in his book, *The Cheating Culture* (2004), almost all immoral behavior is committed by individuals who regard themselves as ethical, or at least would indicate that

they are ethical if asked. The IRS knows that one in seven Americans allow themselves a little slack on their tax returns (about \$3,000 on average). Those with large incomes are slightly more likely to cheat.

But how can we measure what dentists value rather than what they say they value? The answer may come from considering how they spend their time since we know they value that. Those who plan dental conventions understand this implicitly, and that is why it would be very difficult to get 50 hours of ethics CE.

The ACD Gies Ethics Project has been using a technique based on how one would allocate resources that has a respectable pedigree in social psychology (Ross & Nisbett, 1991). Imagine that one wanted to determine whether an individual favored Hillary Clinton or Donald Trump but was suspicious that the report would be hedged. A common technique is to show a small news clip with a headline that slams Clinton and another that dumps on Trump. There are plenty of each. If one consistently spent more time viewing the anti-Trump pieces, it is reasonable to bet that the individual favors Clinton. The process can be reversed and headlines that strongly favor Trump and strongly favor Clinton are presented and relative interest is measured. Again it is reasonable to infer preferences based on what information one pays attention to. Our values determine how we spend our scarce time seeking information or avoiding things we find unpleasant.

We have been gathering data using a little eight-item survey asking how likely dentists are to read various fictitious journal articles. These are described as being very thorough and appearing in reputable journals. Two each, one positive and one negative, promise information about ethics in practice. Two suggest information about business success, one suggesting a rosy picture and one a gloomy one. Similarly there are two for oral health outcomes and two for promising new technology.

The outcome of interest is the relative difference in attention between the positive and negative stories. Table 1 shows preliminary results from about 100 dentists. The differences are highly significant. Making money is not the top priority outcome of dentists. Neither is ethics the least valued of the motives studied so far. Dentists identify themselves with technical expertise and relish the opportunity to shine at it. It is an obvious, but often overlooked, fact that most dentists really enjoy performing dentistry and, in particular, relish doing the very best technical work possible. The smallest interest is in the overall level of oral health in America that results from that work or as a consequence of striving for technical excellence on a select group of PINOHCs. True financial success is a highly valued motive and ethics much less so.

This squares exactly with the finding in the study using cases described a moment ago. It is also, according to some thinkers, the future of the professions. In the first ten years of this century, the Carnegie Foundation for the Advancement of

TABLE 1. Value determination from “Would you read this” exercise.

Means and (standard deviations) for difference of interest in reading a positive minus a negative article.

Technical	Financial	Ethical	Oral Health
.833 (1.17)	.325 (1.39)	-.0625 (1.44)	-.708 (1.37)

Teaching undertook comprehensive studies of the professions of medicine, nursing, law, engineering, and the ministry. These are the same folks who brought us the Flexner report in medicine, the Reed report in law, and the Gies report in dentistry.

According to William Sullivan (2005), who coordinated these studies, the driving force in the professions is no longer service or even a special discipline or control of practice. It is mastery of specialized technology. If one has doubts about this, look at any professional journal in dentistry to see how much technology can be purchased. By contrast, how many journals, or even how many articles are there devoted to the possibility that the difference in the skill or service motive one experiences in a dental chair is due to differences between dentists? The current interest in EBD has almost entirely collapsed into thumping on dentists for not paying enough attention to what clinical researchers are doing with technique and the downplaying of practitioners’ experience and PINOHC’s values. Sullivan notes that hitching one’s star to technical advances is the best way for computer professionals, physical fitness professionals, professional hairdressers,

and public safety professionals to distinguish themselves and reduce competition. He refers to this as “the hubris of professional technology.” The distribution of clock hours in dental school between technique and the rest of becoming a professional offers no ground for optimism that this is a misleading concern.

Dental Ethics Education

Dental school has potential for being formative in an emerging professional’s life. Of course it is a slightly artificial environment, where the moral models include peers and faculty and smaller numbers of patients and full-time practicing dentists. But the interactions with licensed dentists one enjoys in practice is arm’s-length and relatively less frequent.

Ten years ago, Marylyn Lantz, Mickey Bebeau, and Pam Zarkowski (2011) conducted an excellent study of the contents of dental ethics education curricula. They found that dental schools have an average of 26.5 formal clock hours in lecture and seminars that most often stress ethical principles and addressing dilemmas dentists

would face with patients once they enter practice. That coverage is to be expected as dental schools accreditation requires that graduate be able to identify principles and engage in theoretical reflection. There is no accreditation requirement that graduates act morally.

The ACD Gies Ethics Project is in the process of gathering information from dental educators about ethics. Our work will supplement the earlier study by focusing on the dental educators themselves, the ethical organizational climate in schools, and the evidence that these curricula make a difference. The results to date are tentative, but clear patterns are beginning to appear.

First, there are no full-time dentist ethicists. The average time devoted to teaching dental ethics is about 15%. There are two general arrangements: About one in eight dental ethics educators are full-time ethicists who have other appointments outside the dental school, most often in medical schools or hospitals or schools of public policy. The rest are predominantly full-time in the dental school, but only devote half a day to a full day on average to teaching ethics. For the most part, dental ethics educators come to the field out of a personal conviction and are self-taught, picking up a course here and there and borrowing material from various sources. In the period since beginning this study, most deans have not been able to identify a specific person responsible for the ethics program in their schools. The most common outcome measure of the success of these programs is a class assignment requiring that students demonstrate ethical reflection on a case either given by the instructor or identified out of the student's experience. There is no

evidence that having an ethics curriculum impacts the overall moral climate of schools. The principal complaint of dental ethics educators is that their programs are isolated and that clinical faculty unwittingly undermine the efforts of the ethics presentations by modeling "how things are in the real world."

With the more than 20 scholarly journals in professional ethics in fields such as medicine, nursing, law, business, and bioethics generally, there is only one dental ethics journal. The *Journal of Dental Ethics* is published in India. Dentistry appears unique among the professions in having a very slender platform for building a cumulative field of dental ethics. One reason may be that dentistry, in contrast to professions that have a scholarship of ethics, is practiced in isolation from one's peers. Recall the previously mentioned impossibility of reaching consensus on the social welfare equation that Kenneth Arrow proved. There is an exception that Arrow and others acknowledge: when one only need satisfy oneself about what is good or right, it is easy to avoid conflicts. Another reason it is possible that other professions have a robust cadre of ethicists is that they can bill for their services. They do so through hospitals. Dentistry is a bit unusual in insisting that only dentists can be remunerated directly by patients for their oral health services.

Focus Groups of Patients

A key activity in our project is to listen to small groups of patients and dentists in unstructured situations. This is being done in four representative states: California, Ohio, Oklahoma, and North Carolina. We are focusing at the state level because that is where the action is about appropriate behavior is located.

States write their own practice acts regarding scope of practice, use of auxiliaries, and practice locations and business practices, and insurance carriers differ by state. Dentists' socializing, CE participation, and informal exchange of ideas is mostly local. Anyone who believes that dentistry is the same everywhere needs to travel more. There is currently no national code of ethics for Canadian dentistry—it is managed at the provincial level.

Five patient focus groups have been conducted so far. We are being assisted in this effort by the Citizen Advocacy Center, a Washington, DC, nonprofit that serves licensing and certifying organizations in all the health professions.

Pain and fear are not the major concerns of patients regarding dentistry. Cost is, and that holds across all income levels. Another factor that is always mentioned and mentioned frequently is that each dentist seems to have something different to say. This is the *Reader's Digest* goblin all over again (Ecenbarger, 1997). Patients distrust dentists because they hear different stories. Although this has been widely decried by the profession, it is thoroughly documented by clinical researchers (Bader & Shugars, 1992).

It is too early to craft an overriding generalization about patients' attitude toward dentistry, but perhaps it might eventually be something along these lines. "Patients do not like dealing with dentists." Contrast this with the experience of buying furniture, eating

at a restaurant, or working out at a fitness center. All, including dentistry, are costly and involve effort. But shoppers, diners, and fitness folks generally want to be there to get the service. Of course dentists want patients in the chair, but patients would rather be elsewhere. Quoting one focus group member, “I think several dentists have been trying to sell me more treatment than I need. Even when they overcharge me, I just will not hassle with them. I prefer to do without or try to find another dentist.”

Focus Groups of Dentists

We have conducted six focus group meetings with dentists in four states so far. This includes members of leadership and practitioners. About two-thirds of the participants have been members of organized dentistry. The same three questions are always asked: What, in your opinion, are the greatest current ethical issues (a) between dentists and other dentists, (b) between dentists and patients, and (c) between dentists and organizations?

The results to date could be summarized as follows: The overarching theme for tensions between dentists is that individual dentists set personal standards, often with commercial intent, rather than seeking common professional norms. The big problem with patients is that dentists are not working from a common service motive and many are becoming more commercial. With respect to organizations, the center of professionals acting with a common

purpose is giving way. The very notion of a professional identity appears to be in question. If each practitioner defines the goal of practice, the right treatment plan for a patient, or even whether a margin is intact based on a personal and individual standard, the profession will lose its integrity. If dentists define themselves based on technical dimensions, the center of attention will shift away from the patient. There seem to be an increasing number of pushy folks willing to help dentists succeed by some standards that are different from the professional values of service that prevailed in dentistry just a few decades ago.

The Economic Picture

Here is one illustration of the fragmentation that is beginning to appear in the profession. Figure 6 shows inflation-adjusted financial data for the past 30 years. Note that the income of the typical American family has been remarkably flat. There is anger in this country over that fact. Second is the handsome increase in general practitioners’ net incomes, bringing them into the top 3% or higher of earners in America. That was the case until about 2006, several years before the general economic downturn, when market forces such as declining demand for care and an increasing ratio of dentists to patients began to take effect. Third, student dental school debt has risen as a constant rate over the past quarter century compared with average practice incomes. The reason it has become a concern only in the past few years is likely due to the fact that it has now exceeded one year of average income of practitioners because of the downturn in practitioner’s incomes and because senior dentists are finding it more difficult to sell their practices.

Finally, and this is the most important trend in the figure, the two thin lines above and below the trend line for practice income of general practitioners begins to fan out. These lines represent the standard deviation of general practitioner’s earnings. About 16% of general dentists earn above the top line. That is over four and a half times the median household income in America. But about 16% earn below the bottom line. Some dentists are moving backwards in real dollars. The concern is the growing spread within the profession. This gap argues for a divergence in values that can damage the profession’s ability to share common goals or speak with a single voice.

The Yellow Pages Study

One of the problems with opinion and related research is sampling bias. Who will tell you, even anonymously, about their unsavory habits? As a result, much of our information about dentists is likely on the rosy side. To mitigate this a study was conducted tracking down almost every dentist in the San Francisco Yellow Pages (Chambers, 2010). Information on practices was cross-referenced with the database from the California Department of Consumer Affairs. There were about 1200 dentists identified as practicing in the county. The data confirmed the known fact that young dentists and dental educators are significantly more likely to be members of organized dentistry and that large ads and the presence of websites are unrelated to age.

Figure 2, introduced earlier as an approximation of the current model of practice, contained some practices depicted in “scare quotes” to represent

the fact that they were economic fictions. Rather than providing a direct contact between the dentist and the patient, some are placing a screen between themselves and those they serve. Ten percent of the practices in San Francisco were operated under a fictitious business name. Of these, only 54% were registered with the state board and county, as required by law. The fact that receptionists hung up or refused to disclose the names of the practice owners when asked suggests that there is some defensiveness about this arrangement. Effort was made in these cases to visit the offices directly, but some did not even exist at the advertised location. Fourteen dentists advertising their services were not registered as having a license in the state. What is of interest to us here is that dentists practicing under a fictitious name were more likely to have multiple offices, to have larger ads, and to advertise prices. They were also more likely to have disciplined licenses and they were older than their colleagues.

Suggested Modifications in the Model of the Profession

There is more research to present, but it may be prudent to pause and summarize at this point. That will provide a richer context for what follows. A plausible hypothesis here is that the center of the profession is not holding. Dentists are increasingly using their own interpretations of excellence in the privacy of their own offices. They are turning more often to technical or financial criteria for defining professional identity. They are increasingly seeking the help of outside interests in this effort and falling away from organized dentistry.

The traditional ethical foundation of professionalism based on principles is no longer sufficient to hold us

together. Some philosophers, such as David Hume (1777), writing at the time of American Independence, said as much: “Nature is always too strong for principles.” The remainder of this paper proceeds on the assumption that we can safely ignore principles altogether and should concentrate on what dentists, patients, and others do instead to bring about improvements in total oral health. This is not an argument for anarchy that some believe is the only alternative to an aspirational or enforceable code.

The alternative is to build moral communities, and that is accomplished by strengthening relationships between dentists and among dentists and anyone else affected by what dentists do. Communities are built on relationships, and relationships are built on treating others as moral agents.

The critical relationship is that between moral Leaders and moral Neutrals. A tiny change there can bring the number of Detractors down much more dramatically than can anything Enforcers, codes, or education can do.

FIGURE 6. Economic stress on the integrity of the profession.

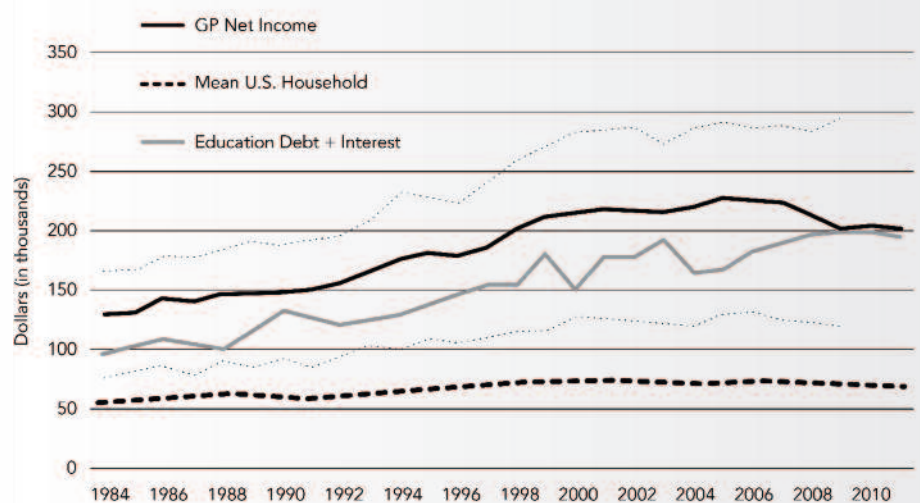
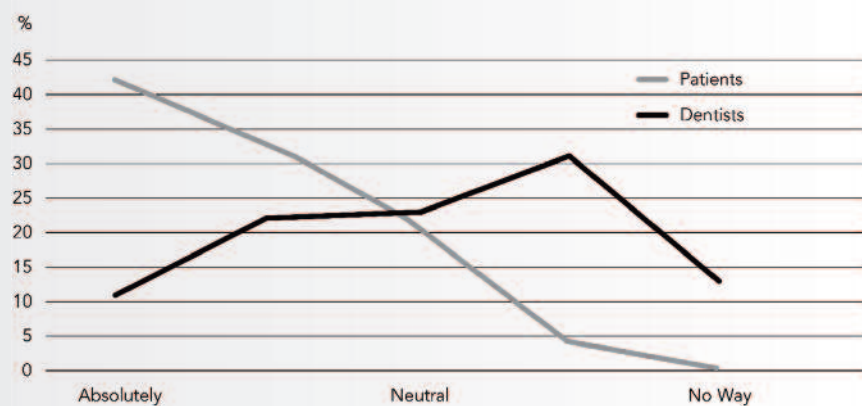


FIGURE 7. Patient and dentist responses: Involve component society with evidence of dentist not treating to Standard of Care.



There is a sharp and important distinction between morality and ethics. Morality is what people do together to make the world better. Ethics is what people say about that. Most teaching and most meetings are concerned with ethics and they often produce disappointing results. One of the experiments in the ACD Gies Ethics Project reaffirmed the result reported in the literature that professionals assembled at a meeting to talk ethics scored higher on commitment to be moral than these same individuals did when they returned to their dental offices (Chambers, 2016b). Context matters and committees are not representative of moral contexts in dentistry.

A detailed and formal plea for the difference between spectator ethics and moral contact is made in the forthcoming book *Building the Moral Community: Radical Naturalism and Emergence* (Chambers, 2016a). This is about how moral agents build

communities based on the way they treat each other.

The theses is that organizations come into existence or lose membership and influence based on the way individuals treat each other, rather than on their aspirations. Every interaction among moral agents leaves a residue that bends the future.

Further Evidence

There are two more sets of evidence to be considered in support of the view that dental ethics as the voluntary and occasional application of principles by one practitioner at a time will no longer do the work required to hold the profession together. Instead we need relationships between moral agents building moral communities by the relationships they forge with others.

Justifiable Criticism

It is often said that there is a social contract between the professions and the public. The public allows professions collectively to control membership and discipline their members in

exchange for dedication to serving the public's needs. But there is growing confusion over what turns out to actually be two contracts. One is codified in state regulations and symbolized by licensure. It is a commercial contract, enforceable in court. The other is an implied contract among professionals who pledge to police each other so that the commercial contract would be unnecessary.

The fourth century BCE Greek Aristippus proposed a test for identifying true philosophers. He said that when all the perfect laws have been written and enforced to make us good and right, the philosophers would be the ones whose behavior did not change. A colleague who is a member of a Judicial Council in a state visited as part of this project said recently, "The problem we face is that we know who the bad actors are, but the state is too slow and timid to take action against them." From a spectator's point of view both contracts are failing. But why should the professional look to the commercial interests of the state to enforce a professional contract? The recent U.S. Supreme Court decision on tooth whitening demonstrated that professionals often do not recognize the difference between the professional and the commercial contracts.

Earlier, the eight-case study of dentists and patients regarding actions and justifications in various problematic situations was sketched. There was almost perfect consensus on what should be done about hostile workplace environments. Figure 7 shows an altogether different situation from the same study. The question

is whether a dentist should take any action when it is recognized that a patient has experienced gross or continuous faulty treatment at the hands of a colleague. Aside from the obvious fact that dentists are divided on this matter, it is also clear that whatever the typical dentist does will be at odds with almost all patients and almost all of his or her colleagues. The profession is fragmenting over a basic matter such as enforcement of the professional social contract.

Section 4.C of the ADA Code of Professional Conduct states: "Dentists shall be obliged to report to the appropriate agency as determined by the local component or constituent society instances of gross or continual faulty treatment by other dentists. Patients should be informed of their present oral health status without disparaging comment about prior services." This is often read as "Say nothing because you were not there." The advisory opinion adds, among other things, "This may involve

consultation with the previous treating dentist."

As part of this project justifiable criticism has been investigated for about four years. Data have been collected from several surveys, judgments of actual treatment images such as radiographs, and over 100 pages of transcription from videotapes of dentists working through cases. The results are still preliminary, but here are some highlights that are beginning to emerge.

Whether action is taken to discover the circumstances surrounding suspected faulty treatment or to respond to confirmed cases is almost entirely a matter of personal choice among dentists. Is not that exactly the issue that the focus groups of both patients and dentists have been waving their arms about? Some would go to the state board over a couple of overly large endo accesses while others would overlook an endo file in the sinus that the patient had not been told about. Practices would be ignored in veteran

and beginning practitioners alike that would be automatic failures on one-shot initial licensure examinations. This is shown in Figure 8 where O is the proportion of variance explained by the dentist making the decision, M is the type of fault committed by a referring dentist, and P is the years of experience of the referring dentist. The concept of a pattern of faulty treatment is difficult to detect.

Quoting one transcript: [Experimenter] "You have seen several cases now, and a number of them suggested that Dr. X has technical difficulties." [Dentist] "I don't think one can identify a pattern until there are several, maybe four or five bad outcomes." [Experimenter] "You have just said that there were six of them in a row." [Dentist] "Well, I certainly wouldn't take any action based on that number of cases. One can never be sure of the circumstances." As this session continued, several more faulty outcomes appeared, but the dentist said on each occasion "perhaps the next one will reverse the trend."

There were a number of dentists, perhaps a third, who would not take action even after half an hour of one bad outcome after another from the same dentist. Never was it mentioned that it is professional policy or personal conviction to refuse to engage in justifiable criticism. Every dentist said in general that he or she would do it under the appropriate circumstances. In particular, however, some dentists consistently failed to find circumstances that matched in principle the general requirement.

This led to the hypothesis that dentists choose their justification to rationalize the actions they want to

FIGURE 8. Justifiable criticism: Proportion of variance explained by dentist making judgment, age of dentist being judged, and severity of flawed work.

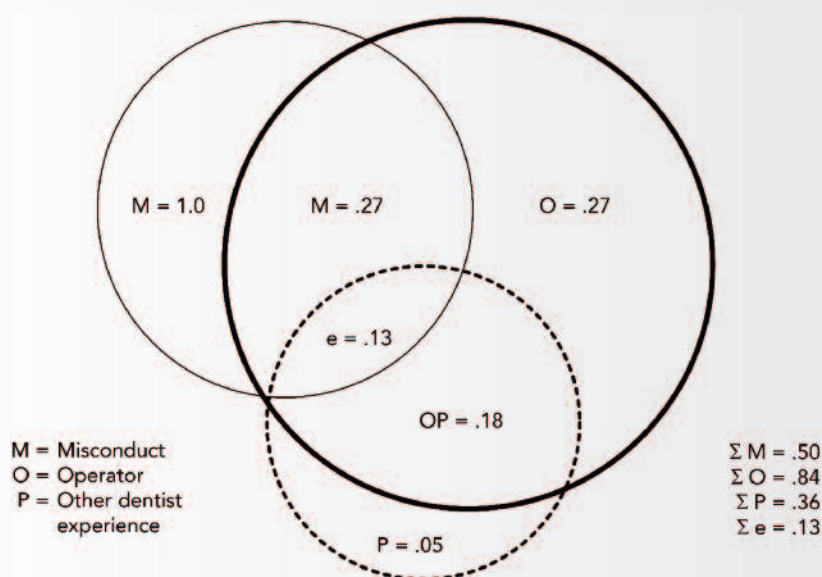
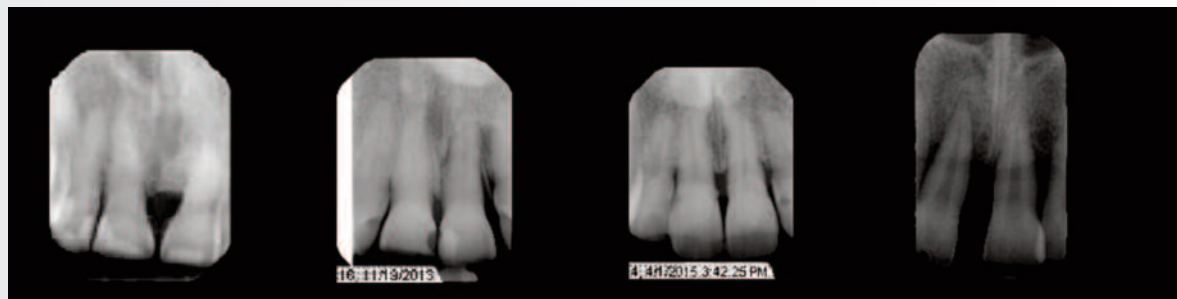


FIGURE 9. Extent of periodontal involvement in teeth targets for veneers.



follow. There seems to be some evidence for this notion. In one scenario, Dr. X intends to immediately put veneers on upper incisors with heavy periodontal involvement. Some practitioners would bring this to the attention of Dr. X, colleagues, or even licensure bodies; others would refrain from becoming involved. After the decision about action had been taken, participants were shown the four radiographs appearing in Figure 9. Those who took action said they had understood the case to be toward the right on this series. Those who ducked the issue thought the case was more toward the left. Not only do principles have an imprecise effect on action (as demonstrated in the eight-cases exercise), we can retrospectively interpret the world to suit the needs of the moral behavior we feel comfortable with.

Bad Apples and Bad Barrels

One final example will be given of the fact that we do not really understand how individuals behave until we know the context as they define it. The number one reason people give

for cheating is that others are cheating. A moment's reflection will show that we cannot fix this problem with principles, by education, or one individual at a time.

This last example is about how we can analyze moral behavior as it changes over time and in context; it describes how moral communities develop (Chambers, 2014). The project started by asking a distinguished group of dental leaders how many "detractor" dentists there are, defining that in terms of overtreatment, lack of informed consent, mooching their colleagues' patients, and so forth. They said 20%: a rather dark number.

We can imagine a simplified world where there are four types of agents or four behavior patterns one might characteristically observe. First would be those who drain the common good—the Detractors. Another would be the ethically Neutral practitioner whose distinguishing characteristic is not breaking the rules. The third type of dentist, the Leader, is a net moral positive for the profession. Among other attributes, they are willing to call out the detractors when necessary. The fourth agent in this model is an Enforcer, such as state boards, who are indemnified for trying to keep down the bad actors.

To illustrate these differences, imaging a conversation around a

posting on a chatroom discussing ways to increase insurance reimbursements using difficult-to-detect and perhaps fraudulent reporting. Such conversation threads appear with embarrassing frequency. The folks who promote the devious practice and contribute additional "creative" schemes and justifications about how insurance companies are ripping off the dentist go in the Detractor category. Neutrals would walk away shaking their heads and congratulating themselves on being so ethical. The moral Leader would say something like this: "I believe what you are doing is wrong. You are discrediting the profession. Insurance companies are likely aware of what you are advocating and will take steps to curb the practice, most likely by adding onerous paperwork that will have to be borne by all dentists, ethical or not. You are damaging the profession and I want to see you stop."

Individuals are changed by the history of their interactions with others. When a Detractor and a Neutral interact, it is very good for the bad actor who borrows the good dentist's reputation and perhaps just a little unfortunate for the Neutral dentist. But when Detractors and moral Leaders meet it is difficult for

both of them. When Detractors encounter Enforcers, Enforcers get a little positive bump and Detractors take a major hit. In this fashion, it is possible to characterize a moral community entirely in terms of the effects each agent has on others over time. In harmonious moral communities, there is convergence on a stable population of each kind of agent. In other cases, the relationships among agents is not strong enough to keep the community together and it fragments.

Let's see how this might work. The panel of dental leaders also provided what they felt would happen in each of the possible types of encounters among the four types of moral agents. This information was programmed this into a computer simulation. Technically, this is known as a Markov replicator model, and is strongly Darwinian in concept. Disregarding the advice of the experts, the model was seeded with a very low one-tenth of one percent of Detractor dentists and Leaders were laid on lavishly. This is shown in the initial positions on the left in Figure 10.

Various combinations of initial proportions and effects of interactions among the agent types were tried. The computer was allowed to perform about 50,000 iterations under various combinations of assumptions, although a stable relationship typically emerged within the first 1,000 iterations. These are encounters where the effect of interactions based on relationships among agents changes the distribution of future agents and how they interact in the future. This is a model of the dynamics inherent in human relationship among individuals who have various moral dispositions.

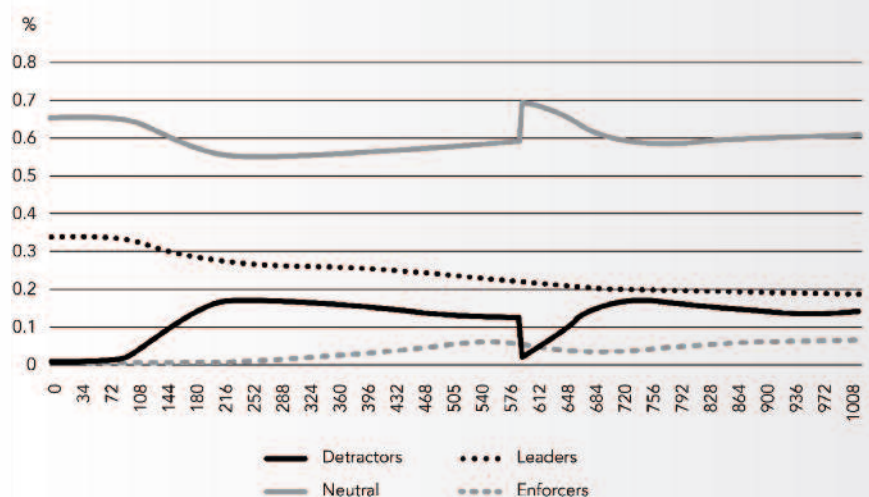
It is a simulation of building a moral community.

The diagram of changes in the moral character of a community, based only on the nature of the relationships among the agents in the community, reveals the following: (a) the proportion of Detractors rose to a stable level; (b) Enforcers also increased as a proportion of the population (Detractors spawn Enforcers more than Enforcers reduce Detractors); (c) the proportion of Neutrals remained essentially constant; and (d) the share of moral Leaders declined. What is happening is that Neutrals drift into the bad actor category until that group can absorb no more. The system has a "capacity" for immoral actors that is defined by the relationships among all agents in the system. Leaders are not supported and they lapse into neutrality. In the end, the panel of experts was correct that the proportion of Detractors in dentistry, defined as has been done here, is about 20%. Such a system is in balance and there is unlikely to be a loud cry over what appears to be a

discouraging proportion of Detractors because the Neutrals, the largest proportion in the mix, are able to maintain their customary level of fitness. Such simulations demonstrate the commonplace known to all management teachers that organizations are perfectly designed to achieve the level of bad outcomes they are willing to tolerate.

There is a small spike in the middle of the graph that requires explanation. This is the "miracle of CE." The computer model was jiggered so that on one particular day all Detractor dentists would take a CE course in ethics. Very optimistically it was guaranteed that 80% of them would be completely converted to become ethical Neutrals. They had no natural inclination to break any of the rules and they embraced beneficence, veracity, and the like. That would be a monumental, almost Sisyphean, task, but one it makes no sense to attempt. It would be a waste to dust up and outfit dental students or dentists to act morally in an environment that does

FIGURE 10. Simulation of the evolution of a moral community over time.



not support that behavior. The term “support” is not meant to denote ethical aspirational pronouncements: the driving force is conditions where desired behavior contributes to moral agents thriving.

This is only a dark picture if one continues to start at the traditional place without taking full account of the system we operate in. It is self-congratulatory and magical thinking to crank harder on the wrong handle. We need to look to see where the real levers of moral change are. There is a method computer modelers use to identify the key elements in a complex system. It is known as sensitivity analysis and it involves making multiple minor adjustments in various elements in the system to see which ones result in the largest changes in overall outcome. In this case, the critical relationship is that between moral Leaders and moral Neutrals. A tiny change there can bring the number of Detractors down much more dramatically than can anything Enforcers, codes, or education can do.

The core of the profession is the relationship between the Leaders and the Neutrals. It may have been overlooked because the relationships that matter are often casual remarks and small efforts to clear up problems before they become public. The challenge we face is that Neutrals do quite well in communities that have more Detractors than Leaders. There is not a deafening clamor in the profession for toning up our morals. Unjustifiable criticism is hardly justifiable. The most precious missing ingredient is Leadership of the direct personal contact type.

How We Might Move Forward from Here

The data collected so far on the ACD Gies Ethics Project suggest that it will be a limp approach to call ever more loudly that “someone” needs to fix things so that we can achieve “professionalism as we have known it.” We need a model that shows how the parts of the moral community are connected to each other and who counts as partners in the community. We can then debate alternatives and determine how much moral improvement we are willing to work toward.

As a very tentative first draft, but one based on a range of research, something like the model shown in Figure 11 is worth considering. The big differences between this model and what was looked at in the beginning is that all the Ps have been replaced and all the principles have been scrubbed out. Moral agency (MA) involves the double relationships of taking action to make a better world recognizing (a) that the success of our efforts also depend to some extent on what others do and (b) that those we interact with have exactly the same moral status we have in the sense that they are seeking to make the world better by their efforts, but in full recognition that their success depends on what we do. That is why the arrows connecting moral agents are bidirectional arrows. In Figure 11, some of the moral agents are dentists. But moral agency is not conferred by license or title; it is earned by the way we treat each other. A moral agent is anyone who is recognized and treated as having the same uncoerced capacity to influence your future as you have to influence theirs. There is no such thing as a morally superior position. Doctors become moral agents when they take off their white coats.

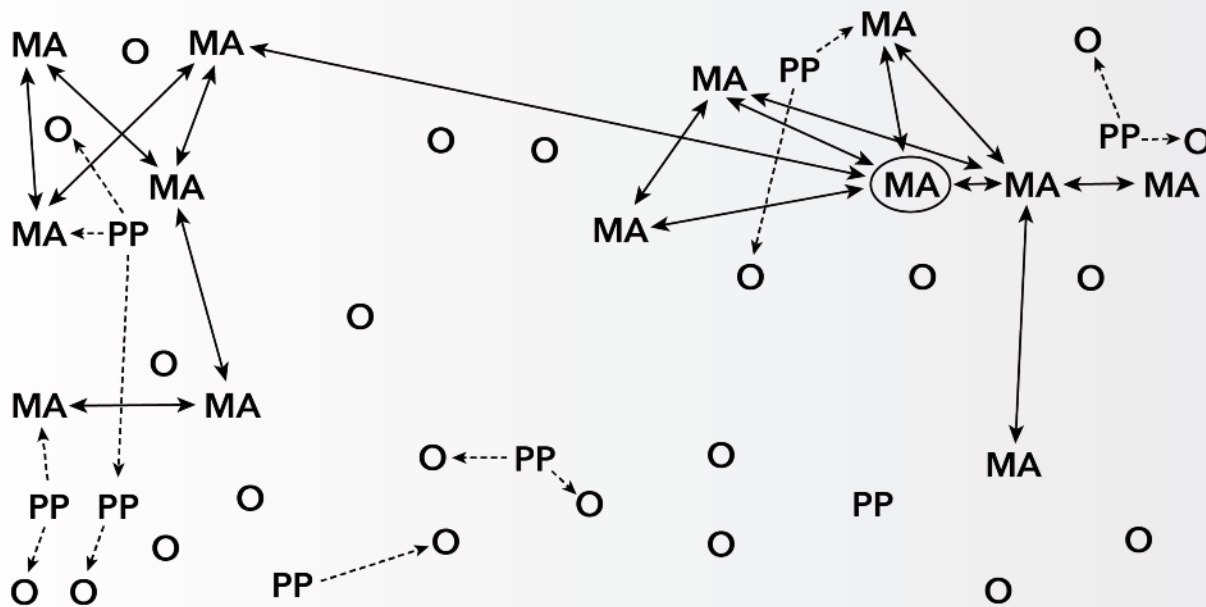
Some moral agents are patients or PINOHCs: those, for example, who have the capacity to influence what dentists value through choosing the conditions of treatment or even whether to seek and accept treatment. Third parties are often moral agents. PPs are principled persons; those whose primary relationships is with a principle and who treat others as objects according to their understanding of what the principle dictates. The arrows connecting principled persons are unidirectional because there is no reciprocity of moral agency.

There is, in some sense, an ethically superior position; and that has caused a lot of mischief. When one gives charity or good but paternalistic care or treats patients fairly in the commercial sense, others are reduced to moral objects. One should get some credit for that; it is certainly to be preferred to bad dealing. It is what the moral Neutral does. A moral object is any other who is treated with dignity but denied the reciprocal agency of being recognized as having equal moral standing and the real opportunity to affect us just as freely and without coercion as we expect to affect them. The environment, children, people lacking competency, and some prisoners are natural moral objects. Patients, PINOHCs, government regulators, colleagues, insurance companies, industry representatives, and young dentists should not be so treated.

Morality is about moral agents who enjoy reciprocal, uncoerced influence on each other. Ethics is about treating others according to one’s own principles. Morality is the contact sport that changes both those we come into contact with and us in the process. Consider the hot rock. Held

FIGURE 11. **New model for the moral community.**

MA = Moral Agent; PP = Principled Person; O = Object



over a swimming pool (as one might do with ethical principles) it has little effect. When dropped into the water, it raises the temperature of the nearby water slightly. The water lowers the temperature of the rock. The only effect on water at the other end of the pool is caused by contact with water that has been heated by the rock. Sometimes those who favor ethics think they can get it on the cheap. The attitude is “shouldn’t it be sufficient for me to point out bad behavior?” or “Surely all costs associated with getting the moral community I favor should be borne by those who detract from it?” If morality is worth having, it is worth the cost of getting it. Think moral Leaders.

The new diagram is not based on principles. The function of harmonizing action for the common good and thus building the moral

community is performed by mutual relationships among moral agents. When we work together for common thriving, we are acting morally. But we can go farther. Communities need no longer be defined in terms of membership dues. They are the relatively stable patterns of relationships among those working together. There are certainly dentists who are more truly members or even leaders in organized dentistry than are those who write their annual check and nothing more.

Most individuals intuitively recognize different kinds of clusters or communities in Figure 11. The network in the upper left is typical of a club. It has lots of mutual interactions. The cluster in the lower left is much like the picture of the profession

described earlier. It is vertical, with numerous objects, dominant one-way influence, and weak connections with other groups. Even without much explanation, people feel most positive about the cluster in the upper right. It looks richer and healthier: it is, in fact, more moral. We want to be part of a mutually supportive group, rich in connections, both internally and at longer distances. Such communities arise and retain their form by repeated interactions among constituent members and those around them, as illustrated in the computer modeling described above. They have been studied extensively by experts such as Ronald Burt (1995). Incidentally, no

one would be surprised to learn that the moral agent circled near the top center is the key individual. Research as shown that agents of this type (in this relationship) enjoy the most freedom and influence and earn the highest incomes based primarily on their position in the moral community.

The view offered by the ACD Gies Ethics Project, at this point approximately one year into the process, is simply that we should join hands to move the oral health care profession in the direction of becoming a strong moral community. Some of the specific steps might include:

- Recognize, engage, and support moral leaders—especially among the young and ethnically diverse. This is not a reference to the person who is chairing a committee and is ethical by virtue of not wasting water in a drought. The reference is to those who lead by calling out the best in others.
- Recognize that every dentist practices on his or her license and his or her colleagues' reputation. We are responsible for our fellow dentists' behavior, even when it costs just a little to keep it spiffy. Each is not entitled to a private standard, regardless of how it is justified.
- Organizations are best built on rich networks of relationships that are mutual and embrace all those who have the capacity to affect our futures. This includes acknowledging that the very important people in our lives include all who need oral health care, diverse practitioners, insurance companies, the government, and corporate and other

commercial entities. These people should be at the table with us, and they should be sitting on the same side of the table.

- Oral health care is not a spectator sport; it is a contact sport. We cannot be ethical based only on what we think or say or even who we fervently root for. If we were on trial, accused of being moral, there should be sufficiently clear and compelling evidence to guarantee a conviction?

We are all angels and ready to soar, but we only have one wing. ■

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The Dangerous Specter of Addiction

A Cautionary Tale

American Society for Dental Ethics

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Abstract

The literature is equivocal: dentists are either as susceptible to substance abuse or somewhat more susceptible than the general public. Most of us have suspected at one time that a colleague was troubled by excessive alcohol consumption or prescription pain medications. We often sit on the sidelines, waiting for an ideal opportunity to help, wary about offering unsolicited advice or invading the privacy of a colleague. When the problem is confronted and intervention begins, we hold our breath, yearning for a healthy outcome but dreading the worst. This brief memoir describes the first author's real-life attempts to support a colleague (with the help of a psychologist, the second author) at various intersections of treatment. The moral challenge of professional confrontation is explored. Suggestions on how to intervene with friends, colleagues, and loved ones are offered.

Dr. Yarborough is a faculty member and administrator; **Dr. Peltier** is Professor of Psychology and Ethics; and **Dr. Huston** is an Adjunct Associate Professor. All are at the University of the Pacific Dugoni School of Dentistry; bpeltier@pacific.edu.

The authors wish to thank Dr. Curtis Vixie for his help and wisdom in preparing this manuscript.

Information regarding the prevalence of substance abuse by dentists is confusing for several reasons. Examples include currency of information, folklore, and shame-based underreporting. Current reliable information suggests that 6 to 10% of dentists have displayed signs of chemical dependency, about the same as the general public (Kenna & Wood, 2005). This means anywhere from one in ten to one in 16 dentists have had "issues." It also means that we all personally know these individuals, are friends with them, and often work and practice with them. When their dependency becomes apparent, we tend to rationalize it away, or we feel too inhibited to confront the individual.

When asked to write about his own personal experience in this area, the first author collected stories from friends and other professionals as well as personal experience to chronologically outline a typical pattern in dealing with a fellow professional or friend. The goal is to walk the reader along such a pathway in an attempt to prevent colleagues from facing devastating outcomes. At each crossroad, questions are posed and the reactions of a psychologist-coauthor are provided in response. It is our hope

Rather than getting better, the situation seems to be getting worse. According to a recent CDC Morbidity and Mortality Report, “The rate of drug overdose deaths involving synthetic opioids nearly doubled between 2013 and 2014.”

that this retrospective will help steer any reader who finds him or herself in similar situations in the future.

Dentist: The story begins in Anytown, USA, where you (a dentist facing a hypothetical composite issue) practice in a small, tight-knit community of fellow dentists. You are at the local hardware store and happen to cross paths with a pharmacist friend who offhandedly asks, pleasantly enough, if another dentist in your complex has been extracting more teeth than normal. It is a nice way of saying your friend has been ordering large prescriptions (50 to 100 tablets) of Vicodin for his office in the past month or so. This event happens at a time when small-town professionals are still inclined to speak informally about their work with each other in good faith, without worrying too much about the problem of formal confiden-

tiality or HIPAA, for that matter. The pharmacist also says that he still receives the same number of prescriptions from your friend’s patients.

You answer, “No, not that I am aware of.” Although you are only dimly aware at the time, this is the first of many red flags, and you are surprised and confused. This dentist is a colleague you like and trust. Intuition told you that something is wrong, but you are not clear at all about what. You wonder silently: What should you do? What is the best way to approach your colleague? Do you have any obligations or responsibilities to the profession, legally or ethically? Do you need to do anything to protect his practice, his patients, or his family?

Psychologist: The good news is that the culture of healthcare has changed significantly in the past decade or so, with more awareness, the advent of computerized drug monitoring, and vigilant pharmacists. That said, addiction is cunning, as they say in treatment, and addicts are notoriously and self-destructively clever. I have known dentists who practiced while under the influence of 30 standard dose Vicodin per day (or more). Humans can adapt—temporarily—to astonishing amounts of alcohol and drugs. This kind of problem is more common than most people think, and it is typically kept secret, albeit sometimes an open secret.

According to the Centers for Disease Control, “overdoses involving prescription painkillers are at epidemic levels and now kill more Americans than heroin and cocaine combined.”¹ The CDC also notes that, “Past misuse of prescription opioids is the strongest risk factor for heroin initiation and use, specifically among persons who report past-year

dependence or abuse” (CDC, 2015). Rather than getting better, the situation seems to be getting worse. According to a recent CDC Morbidity and Mortality Report, “The rate of drug overdose deaths involving synthetic opioids nearly doubled between 2013 and 2014” (CDC, 2016).

As noted, epidemiological data about dentists and addiction vary somewhat, but it is fair to say that between 6% and 10% of practicing dentists have experienced a significant “problem” with drugs or alcohol at some point in their lives. According to the *DSM-5* (APA, 2015), the 12-month prevalence rate of alcohol use disorder is 8.5% (12% among adult males), and the rate of opioid abuse is nearly 1% among adults. Do the math: As an example, if there are 33,000 active dentists in California,² it is reasonable to believe that 3,000 dentists will be practicing while impaired in some way during their career in California alone.

Dentist: After some reflection, you decide to ask your colleague about the prescriptions outlined by the pharmacist. He tells you that he had been providing the analgesics in-office to patients after procedures. Previously he had been writing prescriptions for pain medication that patients had to fill themselves. You do not question his response then, and are naïvely hoping that your discussion would put your colleague “on notice” and somehow (magically) end such prescription practices.

Later, team members from his practice approach you with concerns that your colleague is drinking

“socially” beyond norms and displaying behaviors of intoxication at work. He is clear-headed and professional with his patient care, but does not seem quite as focused or consistent as he had been in the past. Dental team members are genuinely concerned and worried. Now what do you do and say?

Psychologist: Team members see it all. Dentists forget that nearly everything they do is witnessed by staff. If you want to know what is really going on in a dental practice, ask them. They often observe dysfunction, but feel powerless to intervene. A truly healthy practice keeps channels of communication open so that corrosive secrets cannot thrive. In a healthy practice culture, assistants can influence dentists. Useful corrective feedback is welcome in such settings. Unhealthy practices stifle such a feedback loop.

At this point you have more than your intuition to go on. You have a clear professional responsibility to take some action at this point. Many people would still be tempted to try to shield and “protect” their colleague, but that strategy sets one up as an “enabler,” someone who helps the addict stay the same. You must not allow yourself to become (or remain) allied with the “sick” or addicted behavior of your friend. This does more harm than good, even though it is surprisingly tempting in real life. Feelings of loyalty and avoidance of conflict or embarrassment are a powerful enemy at this point.

Dentist: As “evidence” of a substance abuse problem mounts, you sit down with your friend to voice your

concerns for him as a friend and colleague. You mention his social drinking behavior and voice your concerns over the number of prescriptions that continue to come from his office. He eventually admits to using the pain medications for himself, asserting that it helps relieve his back pain. He insists that he does not have an addiction problem and that he never drinks or takes medications during the day while working on patients. You now reflect on more red flags, and your intuition gnaws at you full time. With this new information, what do you do now?

Psychologist: The notion that a dentist could use dental practice drugs to self-medicate for back pain is not only criminal, it is crazy, and must be confronted right away—in compassionate but direct terms.

These kinds of conversations are extremely difficult, no matter how strongly we urge them in an essay such as this. But, they must be had, as lives are often at stake. There is help available, through professional organizations, the state board, and other local venues. You do not have to go it alone. Example contact and referral information is posted at the end of this article.

Dentist: Soon thereafter, his spouse calls you. She, too, is concerned about the changes in her husband’s behavior, and her concerns are so significant that she urged him to seek a rehab program. You agree with her, and wonder if and how you could reinforce her recommendation.

Psychologist: Sometimes it is possible to put on a “full court press,” where many important members of an addict’s life lean on him or her in a consistent way with a consistent

message. This, of course requires that you engage in a conspiracy with third parties, which can create uncomfortable feelings of betrayal. After all, you will be talking extensively behind your colleague’s back to his spouse. Once again, secrets can be toxic, and a secret relationship with the spouse can create a dangerous triangulation. Be prepared to openly acknowledge that you have had these discussions to your friend at the earliest feasible time. Keep your purpose clearly in mind: to help your friend get effective help. This may be a good time to engage the assistance of an addiction specialist.

Dentist: Soon, you are pleasantly surprised when your addicted colleague calls you on his way to rehab, while being driven there by another concerned friend. You feel relieved and hopeful for the first time. You figure that he will have a life-changing experience, and that the rehab will work. In that phone call he says some of the right things: He was doing this for his wife, their children, his practice, although he does not, personally, think that he needs treatment.

Psychologist: This is obviously great news, and it represents a good start. But it is only a start. The return from addiction to health (and hopefully permanent abstinence) is almost always punctuated with false-starts, set-backs, and misadventures. Your job now is to encourage him, express support and admiration for his courage and good judgment. Then you fasten your seatbelt and prepare yourself for the rocky path ahead. You are correct, though. He did not say all of the right things. He

auspiciously left himself off of the list of people he was going to rehab for.

Dentist: Your optimism takes a serious hit when he leaves the program early, saying he had gotten everything he needed out of it, and was a changed individual. This is very new territory. You guess (and hope) that since he was in treatment, everything would be okay. Your intuition tells you that completing the program would have been better, an acknowledgment that he was trying to do whatever it takes. You do not know what to make of it all, and are not sure what to say.

Psychologist: This is a common form of magical thinking: If we can just get the addict into treatment, everything will be fine. Sadly, it rarely works that way. It's the same genre of thinking that dental patients use when they assume that dentists are the ones that take care of their teeth. Patients have to do the hard work of daily care; dentists earnestly and mightily offer their best treatments to repair the damage and stem the losses. You also work hard to establish effective self-care.

However, our methods are relatively limited compared to the power of addiction. We have improved immensely in the past 20 years, but we still cannot produce magic. Abstinence and recovery are extremely difficult challenges for most addicts. You are correct, of course—completion of the treatment program would have been a much better outcome. Premature

departure is a bad sign, but it happens all the time. In fact, it can be expected.

It is best to take the long view. This first experience with rehab is best viewed as a first move in a long game, not a failure. There is much to be learned from it. Help engage your colleague in this kind of thinking. He is still plagued by “stinking thinking,” and this is a regular part of the process. Normalize it without giving in to his logic. Remain a consistent force for health and sanity, whatever that requires. He has already demonstrated that he might endanger patients, but you must consider the idea that he has an illness or disability rather than just bad behavior. (This gets complicated. You might even consult with your state dental association or an attorney about the fine difference between medical disability and bad behavior, especially if he returns to practice.) Expect him to squeal mightily about your unwillingness to agree with him and his pathological thinking. He will call your stance unfair, mean, and even a betrayal of friendship. He will try to manipulate others so that he can get his old life and situation back while remaining an addict. He might even threaten legal action. He wants to stay the same but with different consequences.

Dentist: Unfortunately, your intuition is correct. Fortunately, he does not return to his practice, so his patients are never in jeopardy of care under the influence. Another dentist maintained his practice with the hope that he would return after a “medical leave.” Your friend then relapses to his previous behavior of substance abuse, returning for multiple truncated rehab attempts. You never really knew what to say or how to support him after each unsuccessful visit. You continue to ask yourself: What, if anything, could I have said or done?

Psychologist: His practice dodged a bullet. But, that doesn't help him. He is doing what addicts do. You must not self-flagellate. Do not go back and second-guess what you have done, unless you are trying to learn about this process in case it happens again in the future. In dealing with addiction it is important to be clear about responsibility. You do not have responsibility for his use, his rehab, his relapses, or his behavior. Your responsibility is to be the best colleague and friend possible. This means that you continue to support him in healthy ways and continue to maintain healthy boundaries and limits.

While you never really know what is going to happen, this situation is starting to look ominous.

Dentist: Your friend is very good at telling you what you want to hear—almost. He takes “full responsibility” for his current state of affairs, something you figured is important in recovery. His relapses are always due to someone else though, due to their transgressions or affronts to him. Again, he claims he had fully recovered and is ready to move forward. Your gut feel says otherwise. Perhaps that just “one false move” from his spouse, a friend, or his children will trigger a relapse. But what do you know?

Psychologist: You seem to know quite a bit. Your intuition has served you well all along the way, even though there has not been much that you could do. This pattern is typical enough to be a sad and tragic stereotype. Relapses, while not inevitable, are so common that they are considered to be an expected component of addictive disorders (or as some say, a component of the

disease process). You plan for relapses in treatment. Be careful about the “one false move” pattern. It’s a method that addicts use to avoid responsibility and to freeze and manipulate others so that they, the addict, can stay the same. You must develop a thicker skin. It is hard for nonaddicts to imagine what it is like to be an addict and to think like one. Remember what healthy relationships and interactions are like, and keep them in the front of your mind. Hopefully, his spouse and kids are involved in some kind of supportive situation such as family therapy or Al-Anon, a self-help organization for family and friends of addicts. You might want to catch a couple of meetings yourself. It’s a very interesting scene.

Dentist: Your colleague claims he is also ready to return to dentistry. You are in a position to advocate for him, possibly even secure him a job. Of course, this would put your reputation and credibility on the line (as well as patient safety), especially when you are not totally convinced he has turned a big enough corner. How can you help him with a job and be certain that he was ready to return to work?

Psychologist: Just because you are “in a position to advocate for him” does not mean that you must or should. You and he need to have a straightforward conversation about all of this before you act. You should stay in touch with how you feel throughout. Listen to your intuition now. If you decide to go out on a bit of a limb to help an old friend, make certain that any messages you send to third parties are measured and totally honest and complete. If this is not okay with your addicted friend, withdraw the offer. With your partner’s consent, consider a consultation with

The notion that a dentist could use dental practice drugs to self-medicate for back pain is not only criminal, it is crazy, and must be confronted right away—in compassionate but direct terms.

therapists from his last rehab attempt. Once again, do not enable an addict’s efforts to stay the same. And do not risk your good reputation to do so.

Dentist: Your response then, with the help of a psychologist, is to require regular random drug testing for six months before you will be willing to vouch for him. Then you could feel at least somewhat confident in advocating for him. He listens but never really makes this commitment. Your meetings became farther apart and eventually cease. You hear through friends that he is having trouble staying sober. You feel, perhaps even know, that a future call awaits you that your colleague has been “found unresponsive” by paramedics. Is there something, even at that late stage, you can do?

Psychologist: Who knows? Probably not. It is natural to wonder about such things, especially in such a devastating situation. Addiction is immensely powerful and is sometimes deadly, even with the best treatment and in

spite of wonderful, well-meaning family and friends. The death of an addict typically leaves others confused, with many strange and conflicted feelings (in addition to grief), such as frustration, remorse, guilt, and even anger. It is crucial for survivors to do what it takes to resolve those feelings as best they can. This can take time. Everyone wonders what they could have done differently...in retrospect.

Dentist: The call does come, and while expected, is still shocking. At that time, you go back over each red flag, each crossroad where perhaps you could have made a difference. Once more you ask the big question for a psychologist to answer “What more could we have done?”

Psychologist: The problem of addiction is real, devastating, and current. The nature of a profession requires its members to self-regulate to protect the public, because the public is not in a good position to protect itself in this kind of a situation. Patients do not know this kind of thing goes on, so we have to intervene assertively. You did the right things. Do not second guess yourself at this time, rather learn from it, read articles like this and be prepared to care for the next friend, colleague, or family member who will have the same fight. Sadly, you have little or no control over the eventual outcome. Nonetheless, it’s usually worth an intervention. You never know...

There is help available, through professional organizations, the state board, and other local venues. You do not have to go it alone.

Your job now is to encourage him, express support and admiration for his courage and good judgment. Then you fasten your seatbelt and prepare yourself for the rocky path ahead.

Summary

There are many effective resources available to help in situations like the one described above. Typically, one set of resources is needed to break through denial and resistance, to label and establish a preliminary diagnosis, and to start the healing process by motivating the addict to accept an appropriate referral for treatment. Diversion programs are available for dentists to allow them to seek and receive treatment while maintaining their license to practice (with mechanisms in place to assure patient safety). Dental boards and state associations both offer confidential diversion treatment programs. While you can reach out to either organization for help (both programs accept self-referrals), if the state board contacts an addict, mandates treatment to keep one's license, and offers diversion, one typically must participate in the board's program. If one reaches out for help prior to any board involvement, one can usually participate in a dental association's program. Typically it is not necessary to be a member of organized dentistry to take advantage of these programs. Clients who complete these programs in California have a very high success rate (90%+) as defined by long-term sobriety.

Here are California websites that describe example programs and ways to contact them. Most states provide similar programs and resources:

- CDA Well-Being Program:
www.cda.org/Portals/0/pdfs/cda_wellbeing_brochure.pdf
- CDA Well-Being Contact Info and FAQ: www.cda.org/Portals/0/pdfs/cda_wellbeing_faq.pdf

- Dental Board of California Diversion Program:
www.dbc.ca.gov/licensees/diversion.shtml

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Online Sources

- ¹ www.cdc.gov/media/releases/2011/p1101_flu_pain_killer_overdose.html
- ² <http://kff.org/other/state-indicator/total-dentists/?currentTimeframe=0>

2016 Manuscript Review Process

In addition to the 20 published theme papers and one article reviewed by the American Society for Dental Ethics, nine unsolicited manuscripts were considered for possible publication in the *Journal of the American College of Dentists* during 2016. Two of these manuscripts were accepted for publication with minor revisions. One remains under review. Six were determined by the reviewers as not meeting publication standards, three without detailed review because the content did not match the mission of the *Journal*.

Sixteen reviews were received for the four manuscripts for which full reviews have been complete, for an average of 4.0 reviews per manuscript. Consistency of reviews was determined using the phi coefficient, a measure of association between review recommendations and the ultimate publication decision. The phi was 0.500, 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.

Instructions for authors and instructions for reviewers can be found on the ACD website. *Journal* reviewers are encouraged to use a sequential set of standards in evaluating manuscripts. The first concern is that the manuscript presents a topic of significant interest to our readers. Those that meet this criterion are evaluated for absence of bias in the presentation. The third standard is clarity of presentation.

The editor is aware of two requests from others to republish articles appearing in the *Journal* received and granted during the year. This is a 10% republication rate.

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 2016.

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Submitting Manuscripts for Potential Publication in JACD

Manuscripts for potential publication in the *Journal of the American College of Dentists* should be sent as attachments via e-mail to the editor, Dr. David W. Chambers, at dchambers@pacific.edu. The transmittal message should affirm that the manuscript or substantial portions of it or prior analyses of the data upon which it is based have not been previously published and that the manuscript is not currently under review by any other journal.

Authors are strongly urged to review several recent volumes of *JACD*. These can be found on the ACD web page under “publications.” In conducting this review, authors should pay particular attention to the type of paper we focus on. For example, we normally do not publish clinical case reports or articles that describe dental techniques. The communication policy of the College is to “identify and place before the Fellows, the profession, and other parties of interest those issues that affect dentistry and oral health.

The goal is to stimulate this community to remain informed, inquire actively, and participate in the formation of public policy and personal leadership to advance the purpose and objectives of the College.”

There is no style sheet for the *Journal of the American College of Dentists*. Authors are expected to be familiar with previously published material and to model the style of former publications as nearly as possible.

A “desk review” is normally provided within one week of receiving a manuscript to determine whether it suits the general content and quality criteria for publication. Papers that hold potential are often sent directly for peer review. Usually there are six anonymous reviewers, representing subject matter experts, boards of the College, and typical readers. In certain cases, a manuscript will be returned to the authors with suggestions for improvements and directions about conformity with the style of work published in this journal. The peer-review process typically takes four to five weeks.

Authors whose submissions are peer-reviewed receive feedback from this process. A copy of the guidelines used by reviewers is found on the ACD website under “How to Review a Manuscript for the *Journal of the American College of Dentists*.”

An annual report of the peer review process for *JACD* is printed in the fourth issue of each volume. Typically, this journal accepts about a quarter of the manuscripts reviewed and the consistency of the reviewers is in the phi = .60 to .80 range.

Letters from readers concerning any material appearing in this journal are welcome at dchambers@pacific.edu. They should be no longer than 500 words and will not be considered after other letters have already been published on the same topic. [The editor reserves the right to refer submitted letters to the editorial board for review.] Where letter a to the editor refers specifically to authors of previously-published material or other specific individuals, they are given an opportunity to reply.

This journal has a regular section devoted to papers in ethical aspects of dentistry. Manuscripts with this focus may be sent directly to Dr. Bruce Peltier, the editor of the Issues in Dental Ethics section of *JACD*, at bpeltier@pacific.edu. If it is not clear whether a manuscript best fits the criteria of Issues in Dental Ethics, it should be sent to Dr. Chambers at the e-mail address given above and a determination will be made.

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