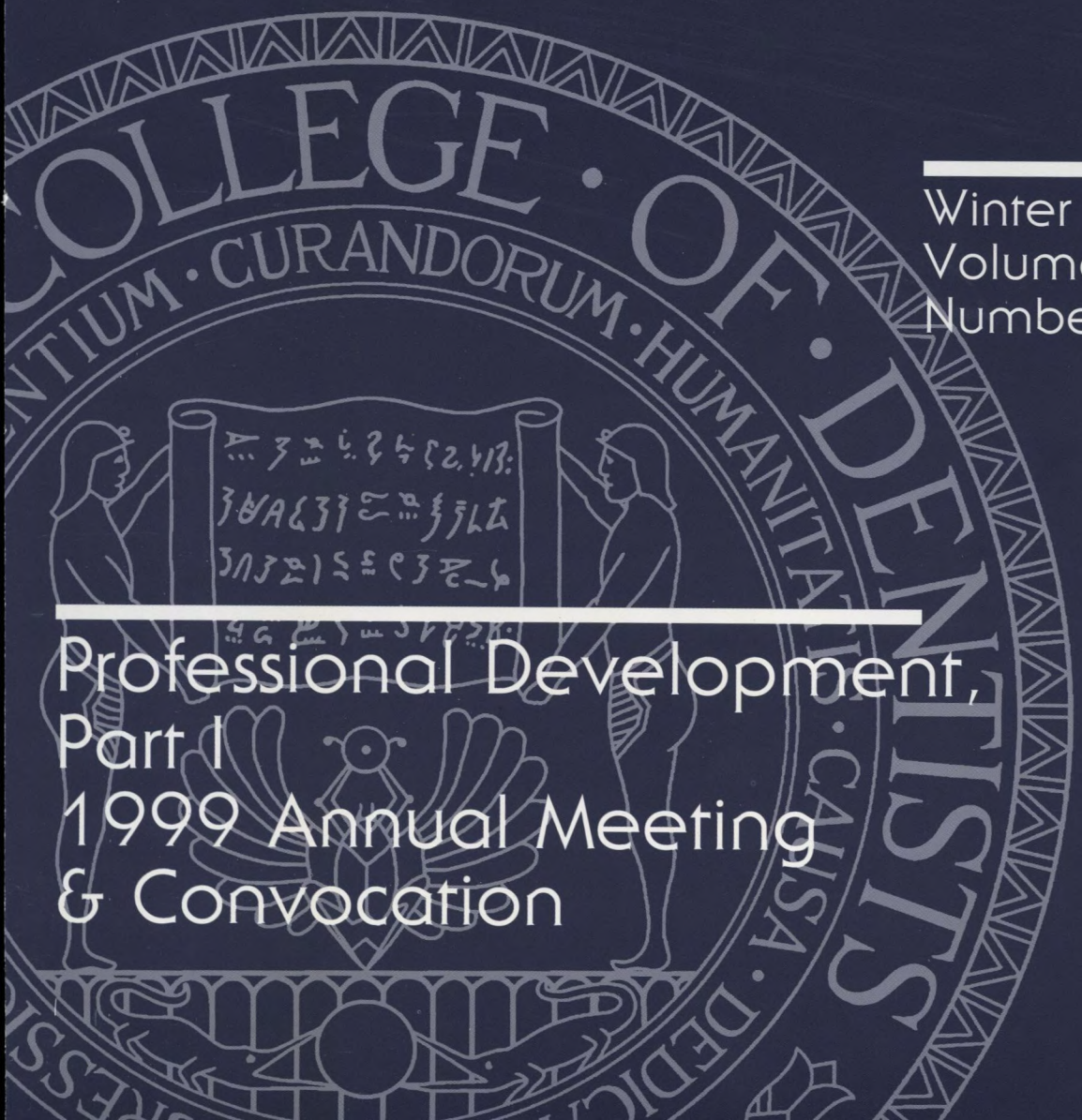
Journal of the American College of Dentists



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Professional Development, Part I
1999 Annual Meeting & Convocation

Journal of the American College of Dentists

A Publication Presenting Ideas, Advancements, and Opinions in Dentistry

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Mission

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

Objectives of the American College of Dentists

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

A. To urge the extension and improvement of measures for the control and prevention of oral disorders;

B. To encourage qualified persons to consider a career in dentistry so that dental health services will be available to all and to urge broad preparation for such a career at all educational levels;

C. To encourage graduate studies and continuing educational efforts by dentists and auxiliaries;

D. To encourage, stimulate and promote research;

E. To improve the public understanding and appreciation of oral health service and its importance to the optimum health of the patient;

F. To encourage the free exchange of ideas and experiences in the interest of better service to the patient;

G. To cooperate with other groups for the advancement of interprofessional relationships in the interest of the public;

H. To make visible to professional persons the extent of their responsibilities to the community as well as to the field of health service and to urge the acceptance of them;

I. To encourage individuals to further these objectives, and to recognize meritorious achievements and the potentials 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.p

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1999 ACD Annual Meeting

Professional Development, Part I

Departments

FROM THE EDITOR

The Viscous Attack of the Cell Phones on Civilization

I have often pondered the following scene. I was waiting to check in at a San Francisco Airport departure gate when the women in line in front of me pulled out her cell phone and engaged in this conversation: "Hi. This is [name forgotten]. I'm in the check in line at the gate now. I just thought you would like to know." [A few seconds of listening.] "Oh, it looks like two or three people. It won't be long." [A few more seconds of listening followed by what appeared to be an interruption.] "Sorry, the line is moving. Gotta run. Bye."

My fascination has been to imagine a context in which this could have been a meaningful conversation. No "I forgot to mail the mortgage." Nothing about whether the contract had been received. No "I love you" or "my hives have stopped itching." It appeared on the face of it that being fourth in line to check in for a transcontinental flight was reason enough for initiating a phone call, and that moving up to third place was enough to terminate it. I can't even imagine a context where this would be a meaningful conversation if the party the traveler was talking to was actually present in the airport.

Here is another example. Some friends were taking me to a nice restaurant in Los Angeles recently and as we walked they mentioned that it was at the corner of the block we were just traveling. A man walking in front of us whipped out his cell phone from his suit coat pocket, made a brief call and replaced the cell phone just as he walked in front of us into the restaurant. He announced quite loudly that his name was So-and-So, and that he had a reservation. Apparently, this is common bad manners in Los Angeles because the waitress announced in a voice loud enough for half the restaurant to hear, "Oh yeah, you're the guy who just phoned a minute ago." I am sorry she did that because he took his revenge by talking on his cell phone throughout lunch in a voice so loud he visibly annoyed people sitting three tables away.

As the price of talk has fallen, so has the care we give to it.

So what am I concerned about? People have always been silly and rude, and the fact they can do so electrically is hardly remarkable. Besides, instant communication must certainly have advantages. I am not, however, aware of any data supporting the claim that trauma deaths have been decreased or real estate sales increased by the use of a cell phone. My suspicion is that medical personnel have simply moved farther away from the point of patient contact and there are more real estate agents.

My beef is that we are showing every sign of flooding human affairs with palaver. It's beginning to matter less what we say and more that we are talking. Electronic communication is becoming electronic status and electronic protection against the meaningful, albeit potentially threatening, silence we need to punctuate our relationships. The results are increased cost, shifting of costs in undesirable ways, and lack of trust.

The point was made nearly four hundred years ago by Thomas Gresham. At the time, the coinage in England was being clipped. This referred to the practice of filing or sharing a sliver of metal from the edge of a coin. Because the value of coins was determined by their weight of precious metal, a "little shaver" could pass clipped coins at their face value while accumulating a cash of precious metal. The currency crisis became so significant that the government proposed to remedy this abuse by placing more

money in circulation. Gresham's Law states: "Bad money will drive out good." What Gresham prophesied, and what actually came to pass, was that individuals hoarded the new issue of coins and continued to clip and circulate the old ones. (The problem was eventually addressed by milling the edges of more valuable coins. This is the practice of placing a pattern of grooves on the edge of a coin so that clipping and filing can be readily detected.)

Gresham's Law applies to cell phones. As the price of talk has fallen, so has the care we give to it. The standards for expression on e-mail are notoriously lax. Compared to refereed publication, there are almost no standards for broadcasting information on the Internet. Agendas for meetings seem to be a vanishing ornamentation, or at best, are worked out at the last minute and faxed to people who have no time to prepare anyway. The act of talking, the right to say nothing in particular but say it nonetheless, is becoming confused with intelligent, articulate, caring communication.

On a recent trip a colleague traveling with me received a cell phone call from a lawyer who wanted to talk about a malpractice case. It was obvious from what I could hear of the conversation and from my colleague's rolling eyes that the lawyer was simply "thinking out loud" and was not gathering any useful information. Had the lawyer been sitting in his office, reading case law, studying the records or transcripts, or even thinking (silently) about legal issues, he would have been earning nothing; by doing none of these and merely rehearsing his arguments, he was able to bill his client. (My colleague, who is savvy about technology, quickly realized what was going on and interrupted to say "The transmission was breaking up" and they would have to talk some other time.)

The very notion of informed consent is in danger of being drowned in information.

This reminds me of the story told by College President Bob Ragan about a lawyer, the only one in a small Mississippi town, who was having trouble eking out a living. Two other lawyers moved to town and all three of them now are very prosperous.

I would not be inclined to make much of a fuss if the attack of electronic communication on civilization were optional and I could choose to remain silent until I had something meaningful to say. Just because the means are available, babbling for a living is now becoming the standard. The average document produced in the United States is copied nineteen times–but certainly not read that often. When I bought my first house I pretty carefully read through the two legal-sized pages of contract that I signed. In our most recent refinancing it took my wife and me half an hour to sign all of the documentation with the title agent shoving the papers in front of us as fast as she could and pointing out where our signatures or initials where required. We read none of it. But my wife, who is a banker, assures me that one of the pieces of paper we signed said we had read everything and understood it completely and that another piece of paper said if we didn't like it we could get out of it in a few days. The cost of regularity compliance in health care is substantial and rising. I personally suspect that the twenty-year pattern of higher education tuition rising at double the rate of inflation can be traced almost entirely to the "oppor-

tunity" that electronic communication makes available for demonstrating our compliance. The very notion of informed consent is in danger of being drowned in information.

Recently, my son and I arrived twenty minutes later than anticipated at my parent's house. I was surprised when my mother mentioned disapprovingly that I hadn't given her notice that I was going to be late. In the past, twenty minute's variation one way or another had been well within the range for a complicated air trip from another state. But she pointed out that my brother, the salesman with the cell phone, always calls when he is ten miles away, even though he lives nearby.

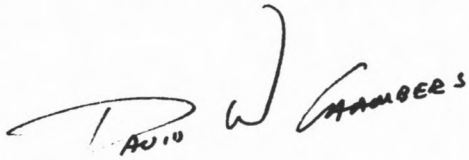
The attack of the cell phone has cheapened communication and eroded trust among people.

The attack of the cell phones has cheapened communication and eroded trust among people. It also has done little to improve our understanding of how things work. British psychologist James Reason observes that modern societies have gotten better at justifying why things go wrong or recovering from problems in their early stages, thanks, in part, to instant communication. He sees no evidence, however, that we have gotten any better at preventing problems from happening in the first place.

My final fright over the digital communication business is an economic concern. Information has no value whatsoever; knowledge, properly communicated, does. Just think what it costs to sort through and eliminate all of the unwanted mail, faxes, and e-mail messages received each day. Think of the cognitive burden necessary to find the small field on your Internet screen where what you are looking for is displayed buried in what others want you to see. For years the advocates of information technology faced a significant paradox in the market. It was easy to show that organizations investing in computers to aid the manufacturing of tangible goods were receiving returns on the order of 12% to 18% and even higher for every dollar invested in computer technology. The paradox was that similar gains could not be demonstrated in the information or service sectors of the economy. There, U.S. government estimates typically showed no return on investment in computer technology, or even small losses. To this day, even the computer industry has not been able to generate economic analyses that show a consistent, positive return on investment for digital communication in the information or service fields, including health.

A few years ago, a professor at Dartmouth College, James Brian Quinn, and his colleagues unraveled this paradox. It seems that investments in information technology do in fact increase productivity in all areas of the economy. The difference being that in manufacturing, the increased productivity is captured and sold for a profit by the manufacturing companies; in other areas the increased productivity is passed through as a non-revenue-generating benefit to customers and especially to third parties. In other words, adding information technology to education, healthcare, entertainment, or other non-manufacturing areas benefits others more than it benefits those who take the risk of such investment. A moment's reflection on the government's insatiable appetite for compliance data will reveal the sad truth of this observation. What about the cost of insurance processing? What about the documentation required for patient care, the paper work required for hospital privileges, loan applications, environmental compliance, and the astounding cost of litigation? Information technologies does add value, but often the smallest portion of that goes to dentists or patients.

Quick, grab your cell phone, fax modem, or get on the Internet and let me know whether you think civilization can stand this insult. Do we need all these new area codes? The only criteria are that your message must be well communicated, trusting and respectful, add to our understanding, and be of value to both you and me.



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

To Promote Excellence, Ethics, and Professionalism in Dentistry

ACD President-Elect's Address
October 8, 1999
Honolulu, Hawaii

Robert T. Ragan, DDS, FACD

I would like to welcome you to our 1999 Annual Meeting and Convocation, our last such meeting of the century.

Candidates, congratulations from the officers, Board of Regents, and Fellows of the College on your selection for Fellowship. In a few hours we'll be caught up in the ceremonial aspect of our Convocation, with all its pomp and tradition. You'll be able to experience first-hand the honor of Fellowship. This is an exclusive group as Fellowship is conferred on only about 3% of dentists. It is thus easy to conclude that the primary function of the College is to honor deserving dentists, such as yourselves. Yes, the conferring of Fellowship is important and is usually the highlight of a professional career. But the conferring of Fellowship certainly isn't the only thing the College does. It is the most important thing we do today, and it will probably be your most memorable link to the College. Unfortunately, many only associate the College with this one honorary aspect.

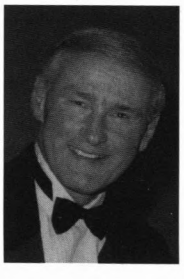
Why am I addressing this point? Simply because the single biggest problem the College faces is overcoming this perception that its role is only one of passing out honors. Nothing could be further from the truth. The more you learn about the College, the more you will come to realize that this misconception greatly minimizes the enormous contributions that this organization has made, and is making, to dentistry.

Before I leave the subject of Fellowship, I would like to make a few comments. Why do we confer Fellowship? Is it to create a "good old boys club" where we honor each other's friends? Hardly. To properly understand Fellowship, we must look at the historical perspective from which it developed. In 1920, dentistry had serious problems, particularly in research, journalism, and education. Fellowship singled out dentists who had excelled, who had high standards, and who demonstrated significant contributions to dentistry or society. Leaders thus identified served as much needed role models for dentistry. The conferring of Fellowship has from the beginning been a means of recognizing excellence. The tradition is continued today in the same way. But the mission of the College is not simply to recognize excellence through confirmation. Fellowship is extremely important, but it's just that there's more to the story.

...To Improve the Profession We Love

The College has always had projects and programs to improve dentistry. Our history is remarkable in this regard. One could argue that the College was the single most influential force shaping dentistry during its formative years. The College is out there trying to make a difference in dentistry—to improve this profession we love. In March 1999, the Board of Regents, at its Spring meeting conducted a strategic planning session. From this meeting came a revision of the mission statement of the College.

The new mission is to "To Promote Excellence, Ethics, and Professionalism in Dentistry." The College



Dr. Ragan is in the private practice of general dentistry at 216 N. Pearman Avenue, Cleveland, MS 38732.

is interested in quality, standards, professional conduct, professional development, improvement, and other similar areas—areas that lead to better dental students, better dentists, and a better profession. Just the area of ethics alone is far more important to our profession than most realize. Look at the ethical dilemmas that occur daily in our profession. A leader in dental state board examinations stated "90% of all problems we see are directly related to ethics, not incompetence by the practitioner." When ethics is viewed from this point, it takes on a new significance. The College is the champion for ethics in dentistry. It has achieved the unique position of being known as "the conscience of dentistry." The College does make a difference.

Let's review some College projects that have made a difference and are making a difference. Our recently held Ethics Summit was the first meeting of its kind in which the leadership of virtually every dental community came together to establish a baseline dialog in ethics. The leadership encompassed organizations representing general dentists, specialists, hygienists, technicians, assistants, insurers, manufacturers, suppliers, academics, research, and more. One of the outcomes of Ethics Summit I was the idea of an ethics alliance among these various communities. Pursuing this alliance will be the primary focus of Ethics Summit II which will take place next January in Nashville, Tennessee.

As another project, we give our dental student booklets, "Dentistry: A Health Profession. A Guide to Professional Conduct" to virtually every first-year student in the United States and Canada. Our ethics wallet cards are similarly distributed to senior dental students. In conjunction with the distribution of this material, several Sections give ethics lectures to dental students. This is done with the cooperation of the administration of involved schools. Next year in Chicago we will have an Ethics Facilitator Course as one of our LeaderSkills workshops. This workshop will develop ethics facilitators from Sections around the country. We are also working on an Ethics Handbook, similar in design to our dental student booklets, but intended for practicing dentists. This Ethics Handbook should be ready early next year. Also the College was instrumental in securing approval of the new ADA CERP category of "Ethics, Law, and Professionalism." This new category presents some good opportunities for our Sections to become involved with their state boards.

The Journal continues to be one of our points of light. Through the Journal, the College is able to place before the profession a scholarly discussion of those issues that affect dentistry and oral health. Our plan is to add a new Ethics in Dentistry Section to the Journal that will be done in cooperation with PEDNET, the Professional Ethics in Dentistry Network. The College continues to receive an enormous amount of recognition and visibility through the Journal and the prospects for the future are bright.

As you know, the College is composed of leaders. To this end we also have our "Outstanding Leader Award" given to senior dental students who have "demonstrated outstanding leadership, scholastic performance, and potential for impact on the profession of dentistry." We hope to have this award established soon at all dental schools.

The demographics of the profession are changing. Dentists in various ethnic and cultural groups do not appear to be joining traditional organized dentistry at the same rate we've seen in the past. We have an interest, not only because we are opposed to fragmentation of the profession, but because we require membership in the ADA. We must be proactive in our thinking and actions. A project is being tentatively planned as a summit between the different ethnic organizations and with the ADA. Dentistry is small enough as it is, we do not need to fragment it. Remember the old saying "United we stand, divided we fall."

Ensuring a Future of Leadership

The last subject I would like to mention is our Endowment and our new Gies Fellow program. As most of you are aware, the projects we undertake cannot generally be covered through your dues alone. The Endowment secures our financial future and it also ensures our ability to accomplish our mission in the years to come.

I am very excited about the establishment of the Gies Fellow category. I hope you will consider becoming a participant by contributing one thousand dollars to our Endowment. Yes, you will receive an attachment to your pin and a certificate. Yes, it will be tax deductible. But what is more important, you are providing the means for us to continue to make the difference, to be a factor, to be the best we can for the profession.

You are going to enjoy this day. You now have the opportunity to contribute as an ACD member. No one knows better than you your personal talents and abilities. Get involved in College activities in your Section. Sectional activity is the heart and soul of the College. You are what makes this College great. It has been said "You get out of an organization what you put into an organization." Take a stand! Be proud of the College! Carry on its great traditions and help us continue to be "the conscience of dentistry." I know from personal experience you will be rewarded many times over.

Please accept again my sincere congratulations. The College is proud to have you as new Fellows. Thank you very much. Aloha, enjoy the rest of the meeting.

Preserving Freedom in a Changing World

Convocation Address
October 8, 1999
Honolulu, Hawaii

Charles W. Norwood, Jr., DDS, FACD

When I decided to run for Congress in 1993 I had personal motivations for doing so—national problems that were affecting me. As a dentist and small business owner, I had seen my practice and my life change dramatically since I first went into business in 1969. I saw my future and my children and grandchildren's future changing as well. OSHA and the EPA were telling me whether or not I could give a little kid their baby tooth. They were ordering me to stick labels on the Windex bottle under the sink in the employee bathroom. They told me to buy a washer and dryer for my dental office. The managed care industry and Medicare were telling me to forget the Hippocratic Oath and instead practice dentistry under their guidelines. Taxes were taking a larger and larger share of the earnings of both me and my employees. The plans I had to leave something to my children and grandchildren were going down the drain because of rising estate and capital gains taxes. I was spending more and more time filling out forms, trying to satisfy both public and private-sector bureaucrats and less time treating patients and earning a living.

I had fire in the belly from all that. These were problems that I knew firsthand. What I didn't know at the time was that they are not unique to dentists or even small business owners in general. After serving in Congress for nearly five years, I have found that while the particulars may vary, the same story is told by our farmers, our teachers, our retailers, our manufacturers, our truckers, our bankers, our newspapers, radio, and television stations–even our military folks are dealing with the same types of problems.

I have discovered that there are fundamental changes occurring in the economic foundation of our nation and the world at large–changes that will affect every family in this country in the coming years. How those changes affect us all can be good or bad, depending on whether we have the courage to deal with them in a manner consistent with the principles on which this nation was founded–individual freedom and responsibility as guaranteed in the Bill of Rights.

What Does It Take to Be Free?

One of the requirements of freedom is the ability to earn a living and keep what you earn. Two, the ability to make your own decisions, and be free from interference and intrusion in the major activities of life.

When our founders wrote the Constitution, life was very simple. The technology for fast, worldwide transportation and information did not exist. The technology for mass production did not exist. The technology for life-saving medical procedures did not exist. The need for extensive technology education for the majority of American workers did not exist. Today we deal with all of those realities. Nationwide and world wide corporations provide most of the goods and services we use on a daily basis. Government has expanded to provide the infrastructure necessary to support these technological advances–at tremendously higher costs to the taxpayer. Our national defense

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needs have changed dramatically. Two hundred years ago we had two oceans that allowed us great insulation from international intrigues. Today we are finding ourselves drawn to one extent or another into nearly every crisis on earth.

Because of the expansion of government services, some warranted, some not, taxation has risen to the highest level in history. To support that, we have instituted an income tax system that allows government to look into every aspect of our business and personal lives. Because of the need for mass education, the federal government has become involved in education–an area that had been controlled at the state and local level. Because of technology and increased population, environmental concerns have led to regulation of every activity known to man and to federal and local controls over private property. Because we can ship goods to and from just about anywhere on earth, every business in this country is subject to worldwide competition. Because technology has allowed the growth of individual businesses to monolithic proportions, massive corporations now control most major, and even many minor enterprises.

I mentioned earlier the challenges and frustrations I faced in my small business. They are just the tip of the iceberg in our health care industry. But when I talk with our farmers, I find they are facing the same type of structural problems. They have very few places to sell their crops and livestock. They no longer deliver their goods to individuals or even businesses in their local area. Major corporate centers are their customers; and those corporations, along with the federal government, tell them how to run their farms, in much the same way that Medicare and HMOs were telling me how to run my dental practice. The bankers, teachers, and business owners in my district tell pretty much the same story.

These are the costs we pay to live in a modern world. And that modern world has some great advantages over the way the founders lived on a day-to-day basis. We can't turn back the clock–and if we weigh all the advantages over the disadvantages, I don't know how many of us would want to.

But we can fight to do a better job of making sure the intent of our constitutional freedoms is being met. And that intent is not being met as well as it should be at present.

We can fight to do a better job of making sure the intent of our constitutional freedoms is being met.

If the insurance industry wants to run the health care market–then they will have to run a free health care market. Every patient, every physician, every dentist, every hospital has to have the practical right to reject a contract and purchase or provide health care as they see fit. If insurance companies want to make medical decisions, they should abide by the same rules of responsibility as doctors. If our farmers and textile mills are expected to compete against foreign competition, that foreign competition should have to comply with every requirement placed on our farms and mills–or not sell their products here.

Competition is wonderful, as long as everybody plays by the same rules. If the federal government needs to raise massive amounts of money to fund the requirements of a modern world, there is no reason it cannot raise it without forcing all of us to jump through hoops to comply. We have for too long labored under false assumptions–that we either have to slowly relinquish our freedoms to accommodate our wealth or oppose progress altogether.

We Need a New Conservatism

We need a conservative mentality that faces the challenges of the coming century with gusto, ready to move forward, while restoring and preserving the freedoms guaranteed under the Constitution. Congress is just now beginning to deal with these issues through legislation like the Consensus Managed Care Improvement Act which restores the rights of patients in managed care plans. Congress is moving through a growing recognition that we need to enforce our trade agreements, instead of turning our backs on flagrant violations by competitors for fear of upsetting international markets. We are approaching these goals through pending legislation that will totally eliminate the income tax and the Internal Revenue Service and replace it with a simple national retail sales tax.

Competition is wonderful, as long as everybody plays by the same rules.

Never again would an average citizen have to file potentially incriminating reports with the federal government or have their income garnished from their paychecks.

We face challenges, but we also face greater opportunities than any generation in history. We have the opportunity to restore the freedoms we inherited from the founders in spite of changing markets and technology.

If we succeed, and I believe we will, we can create a new century of promise unlike any era our nation has enjoyed.

1999 Fellowship Class

The Fellows of the American College of Dentists are the leaders in dentistry and in their communities. They represent the creative force of today and the promise of tomorrow. We proudly welcome the 1999 class of Fellows...

George A. Adams
Nashville, TN

Andre Aioutz
Sion, Switzerland

Douglas R. Anderson
Columbus, OH

Niki C. Andrews
Little Rock, AR

Eugene L. Antenucci
Greenlawn, NY

David C. Averill
Burlington, VT

Lynne E. Barbour
Lancaster, MO

Dexter E. Barnes
Seattle, WA

Jeffrey A. Baumler
Niagara Falls, NY

Antonio Bello
Mexico City, Mexico

Veronica M. Bikofsky
Newark, NJ

Samuel Blum
Rockville, MD

Paul A. Bocciarelli
Rocky Hill, CT

William G. Boyd, Jr.
Ft. Walton Beach, FL

H. Reed Boyd III
Petersburg, VA

Alan H. Brodine
Rochester, NY

Ronald S. Brown
Washington, DC

Grady W. Bryan
San Angelo, TX

Robert H. Buchholz
West Chester, OH

Susan E. Calderbank
Greenville, PA

Matthew J. Campbell
Sacramento, CA

Emil G. Cappetta
Summit, NJ

Laurence Cheevers
Vancouver, British Columbia

William H. Chen
Granite City, IL

John J. Cloud
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Chester T. Coccia
West Bloomfield, MI

Ronald A. Cohen
Coral Springs, FL

Donald J. Coluzzi
Redwood City, CA

Robert L. Curry
Zanesville, OH

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Fullerton, CA

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Alan K. DerKazarian
Cambridge, MA

Peter L. DeSciscio
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Gainesville, FL

J. Kendall Dillehay
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Teresa A. Dolan
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Bloomfield Hills, MI

Sherry R. Gwin
Pearl, MS

Larry D. Haisch
Lincoln, NE

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Charleston, WV

James M. Haney
Covina, CA

Kevin J. Hanley
Buffalo, NY

James R. Hayslett
Clearwater, FL

Van B. Haywood
Augusta, GA

Pierre Helie
Montreal, Quebec

Douglas A. Heller
Aurora, CO

Peggy Jan Henley
Knoxville, TN

Maurice B. Hill, Jr.
Brick, NJ

Dennis G. Hillenbrand
Chapel Hill, NC

Richard J. Hoard
Los Angeles, CA

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Jurgen H. Huck
Tacoma, WA

Ronald J. Hunt
Richmond, VA

Ronald K. Hunter
Camarillo, CA

Ronald I. Hutton
Winston-Salem, NC

Hilton Israelson
Richardson, TX

John William Jamerson III
Savannah, GA

Oivind E. Jensen
Naples, FL

David S. Johnson
Cape Girardeau, MO

James Michael Johnson
Owensboro, KY

Omar J. Jones III
Baltimore, MD

Divinia B. Jordan
Hauppauge, NY

David L. Kaelin
Cape Girardeau, MO

J. Steven Kahan
Chevy Chase, MD

D. Keith Keeter
Frederick, OK

John T. Kempton
East Jordan, MI

Robert D. Kiger
Loma Linda, CA

Kenneth I. Knowles
Omaha, NE

John N. Kramer
Martins Ferry, OH

Robert A. Kravecs, Jr.
Fairfield, CT

Kevin M. Laing
Van Wert, OH

Douglas L. Lambert
Edina, MN

Thomas H. Lapp
Indianapolis, IN

William E. Lee
Lexington, KY

Melvyn M. Leifert
New York, NY

Linda G. Levin
Chapel Hill, NC

Andrew M. Lewis
Beverly Hills, CA

John W. Leyman
Loma Linda, CA

Kenneth J. Linck
Florissant, MO

Jay S. Lipman
Hampton, VA

John R. Liu
Issaquah, WA

Philip W. Madden
Anacortes, WA

Charles L. Mahaffey
Springfield, MO

Murray Z. Malinoski, Jr.
Three Rivers, MI

David G. Malmberg
Lethbridge, Alberta

Susan Holtrop Maples
Holt, MI

David N. Matthews
Fort Wayne, IN

John D. McDowell
Denver, CO

Kimberly K. McFarland
Lincoln, NE

James E. Mercer
West Columbia, SC

Dorsey J. Moore
Kansas City, MO

William J. Moore
Red Bluff, CA

Thomas E. Morgan
Jacksonville, NC

Jeffrey A. Moritz
Valdosta, GA

Michael J. Mulvehill III
Arcadia, CA

Carlos A. Munoz-Viveros
Loma Linda, CA

Barry L. Musikant
New York, NY

Gayle V. Nelson
Sioux Falls, SD

Dennis E. Nilsson
Omaha, NE

Robert S. Nishikawa
Los Angeles, CA

Edward M. Norman
Lancaster, MO

Jerry M. Nossaman
Lawrence, KS

Kathleen J. Nuckles
Los Angeles, CA

Robin O'Sullivan
Cork, Ireland

Bert W. Oettmeier, Jr.
Leawood, KS

Milton M. Oshiro
Aiea, HI

Cornelis H. Pameijer
Simsbury, CT

Gordon Perlmutter
Toronto, Ontario

James A. Person
McAllen, TX

John E. Peterson
Loma Linda, CA

Mary T. Pettiette
Chapel Hill, NC

Samuel E. Pick
Las Vegas, NV

Gordon A. Pratt, Jr.
Bryan, TX

David W. Pumphrey
Atlanta, GA

Bruce D. Raibley
Evansville, IN

Michael T. Rainwater
Riverdale, GA

Allan P. Rappold
New Orleans, LA

Raymond D. Rawson
Las Vegas, NV

O. William Reeder, Jr.
Metairie, LA

Gary W. Reeves
Jackson, MS

E. Dianne Rekow
Newark, NJ

M. Elwood Rice
Mexico, MO

Neil F. Riley
Columbia, MO

Alan H. Ripps
New Orleans, LA

Michael D. Rohrer
Oklahoma City, OK

Donna Rumberger
New York, NY

Roberto Sanchez Woodworth
Mexico City, Mexico

Kathleen C. Schleif Roth
West Bend, WI

Theodore Schneider
Jacksonville, FL

L. Gregory Schneider
Pittsburgh, PA

E. Karl Schneider
Mentor, OH

Steven J. Scrivani
New York, NY

Thomas A. Seaton
San Diego, CA

Barry P. Setzer
Jacksonville, FL

James E. Sexton
Memphis, TN

Joseph F. Shea
St. Louis, MO

Roy L. Shelton, Jr.
Ashville, AL

Ronald C. Short
Klamath Falls, OR

Stanley A. Shustak
Worcester, MA

Lee H. Silverstein
Atlanta, GA

Roger B. Simonian
Fresno, CA

Bradley R. Smith
Denver, CO

Scott D. Smith
Denver, CO

Jeffery W. Smith
Sonora, CA

Marc S. Smith
Bloomington, IN

Richard A. Smith
Atlanta, GA

A.J. Smith
Salt Lake City, UT

John S. Sottosanti
La Jolla, CA

Abraham M. Speiser
Newark, NJ

Clifford B. Starr
Jacksonville, FL

Marvin G. Stephens, Jr.
Tyler, TX

Ray E. Stewart
Salinas, CA

John Thomas Streiff
Madison, WI

Michael L. Stuart
Mesquite, TX

Keith W. Suchy
Westchester, IL

Steven M. Sullivan
Oklahoma City, OK

Patrick L. Sweeney
Eastpointe, MI

Richard N. Tennenbaum
Sewell, NJ

William J. Thompson
Seattle, WA

Michael R. Thompson
Phoenix, AZ

Roger R. Throndson
Dallas, TX

Boyd J. Tomasetti
Littleton, CO

Richard D. Trushkowsky
Staten Island, NY

Barry A. Turner
Grass Valley, CA

Kathy A. Udell-Martin
New York, NY

David C. Vandersall
Indianapolis, IN

Andrew G. Vorrasi
Rochester, NY

David H. Walker
Charleston, WV

Edward J. Weisberg
Norfolk, VA

H. Warren Whitis
Osceola, AR

Fredrick W. Wicknick
Bellingham, WA

Paul H. Will
Snyder, NY

Richard M. Williams
Germantown, MD

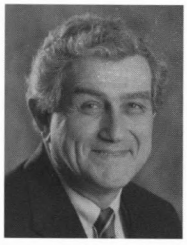
John A. Yagiela
Los Angeles, CA

Profiles in Professionalism: 1999 ACD Awardees

William John Gies Award

The William John Gies Award was established by the American College of Dentists in 1939 to recognize Fellows for outstanding service to dentistry and its allied fields. This award embodies the highest levels of professionalism, and it is the highest honor the College confers on its members.

John A. DiBiaggio, DDS, MA



The 1999 recipient of the William John Gies Award is **Dr. John A. DiBiaggio.**

Dr. DiBiaggio received his bachelor's degree from Eastern Michigan University in 1954 and his DDS degree from the University of Detroit, School of Dentistry, in 1958. He followed this in 1967 with a master's degree in university administration from the University of Michigan. Dr. DiBiaggio soon devoted his full time to the field of administration. By 1970 he was named as the Dean, School of Dentistry, Virginia Commonwealth University where he served until 1976. That year, he was named Vice President for Health Affairs and eventually President of the University of Connecticut where he stayed until 1985. Dr. DiBiaggio next was named President of Michigan State University where he served until 1992. On August 1, 1992, Dr. DiBiaggio became the eleventh president of Tufts University.

Dr. DiBiaggio has served on numerous, high-level committees and task forces including the Joint Committee on Health Policy for National Association of State Universities and Land Grant Colleges; Chair and Executive Committee, National Association of State Universities and Land Grant Colleges; Chair, Council of Presidents, Midwest Universities Consortium for International Activities; Executive Committee, Campus Compact; Board of Directors, Pew Health Professions Commission; Board of Directors, American Council on Education; Trustee, Oral Health America, and many other similar positions.

Dr. DiBiaggio's volunteer contributions have extended his effective leadership into his profession, his community, and his country. From the outset he has given generously of his time and talents to a wide range of dental, medical, and educational organizations. Through his volunteer endeavors he has supported the work of dozens of causes, including the Massachusetts National & Community Service Commission; Trustee, National 4-H Council; Trustee, American Film Institute; Board for International Food and Agricultural Development and Cooperation; Co-Chair, Fundraising Committee, United Way of Massachusetts; President, Michigan Division, American Cancer Society; and many others.

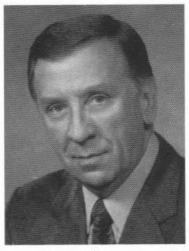
Dr. DiBiaggio has been awarded nine honorary degrees and he is the recipient of numerous honors and awards. He is a member of Phi Kappa Phi, Omicron Kappa Upsilon, Phi Beta Kappa, Beta Gamma Sigma, and Alpha Sigma Chi. He received Italy's Order of Merit award, the Pierre Fauchard Dental and Gold Medal Awards, the Fones Dental Award, among others. Dr. DiBiaggio is also widely published in the professional literature.

Dr. DiBiaggio's other interests are broad and eclectic. He is a voracious reader, a crossword aficionado, an avid skier at his Colorado home, a tennis player, and a golfer. His avocation is Packard automobiles, of which he owns two, a 1941 convertible sedan and a 1947 super custom club sedan.

Honorary Fellowship

The ACD confers Honorary Fellowship upon persons who are not members of the dental profession, but have made outstanding contributions to the advancement of the profession and its service to the public. These contributions may be in education, research, administration, public service, public health, medicine, and many other areas.

Martin F. Tansy, PhD



The 1999 recipient of Honorary Fellowship is **Dr. Martin F. Tansy**.

Dr. Tansy initially served from 1972 to 1986 in the Department of Physiology and Biophysics at Temple University, School of Dentistry, rising to Professor and Chairman. He was coordinator of the basic science departments from 1979 to 1986. Dr. Tansy played an important role in providing the basic science education to over 1,000 predoctoral dental students. Additionally, he headed development and oversight of a nationally recognized basic research program within the School of Dentistry. His research activities, which were primarily focused in the area of gastrointestinal physiology and inhalation toxicology, also included landmark work in determining toxic inhalation values for methyl methacrylate monomer vapor used in dentistry, evaluation of particulate inhalation during amalgam restoration removal, and studies on dental pulp biology. Dr. Tansy's contributions to the scientific literature include eight book chapters, four review papers, eighty-two articles, and one hundred and thirty-one research abstracts.

Dr. Tansy is Dean, Temple University, School of Dentistry. In this capacity he is the only non-dentist dean in the United States. He was a major factor in saving the School of Dentistry from closure in 1986 and leading the planning, financing, and construction of a new dental school building in 1990. Further, he initiated and oversaw the reorganization of the School's administrative/academic structure and curriculum, developed new state-of-the-art basic science research laboratories, facilitated the acquisition of new faculty and departmental leadership. The impact of Dr. Tansy's efforts as Dean is most evident by the attainment of full accreditation in 1990 and 1997.

In spite of the demands of being an accomplished dental administrator, Dr. Tansy has had time to also pursues one of the real joys in his life—going "antiquing" with his wife in Western Pennsylvania.

Award of Merit

The supporting services of dentistry are vital to the profession, providing key elements which enhance the effectiveness of dental care delivery and the growth of the profession. The ACD's Award of Merit was established by the Board of Regents in 1959 to recognize unusual contributions in dentistry and its service to humanity by persons who are not Fellows of the College.

Jeannine Jochec

The 1999 recipient of the Award of Merit is **Ms. Jeannine Jochec**.

Ms. Jochec has served the dental profession with dedication and distinction for twenty-three years with the Greater Houston Dental Society, serving the last seventeen years as executive director. As executive director, she helped establish and supervise numerous programs to benefit the membership and the public, including: planning and equipping a dental clinic for homeless adults trying to get their lives back on track; raising several thousand dollars for dental health projects through "Miles for Smiles" fun runs; producing a video to educate nursing home personnel in dental care for the elderly; and developing an anti-smokeless tobacco campaign to educate adults about the dangers of these products.

During her leadership the Greater Houston Dental Meeting grew from a small local meeting to one of the top meetings in the country. Under her guidance, the Greater Houston Dental Society received the Golden Apple Award, the ADA Society of Component Executives Award of Excellence in Programs, and an award from the American Society of Association Executives for media excellence in the production of a public service announcement.

Ms. Jochec has served as chair of the ADA Council on Dental Meetings, on several of the American Society of Association Executives Committees, and is a director for the Houston Society of Association Executives. She has been honored with the Greater Houston Dental Society President's Award, and she has been given an honorary life membership in the society.

Along with her dedication to dentistry, she has also found time to become active in numerous civic endeavors. Ms. Johec is now thoroughly enjoying retirement with her dog, Champ, at her side and her grandchildren to keep her busy—one and a half year old Will and twenty-two year old Sonia.

Service Award

This award is presented to recognize outstanding efforts of a Fellow of the American College of Dentists for exceptional and distinguished service to the College or to humanity through his or her professional service.

Chris C. Scures, DDS

The 1999 Service Award of the American College of Dentists is presented to **Dr. Chris C. Scures**.

Dr. Scures is recognized for his numerous contributions to the College, the dental profession, and his community spanning a thirty-three-year career in dentistry.

Dr. Scures has served on the Florida Board of Dentistry and the Florida Medicaid Advisory Council for the Department of Health and Rehabilitative Services. An active pediatric dentist, he was President of the Florida Society of Pediatric Dentists and President, Southeastern Society of Pediatric Dentistry. Dr. Scures has also been active with the Florida Dental Association, serving on numerous committees and delegations. He was a delegate to the American Dental Association for fifteen years.

After rising through the chairs, Dr. Scures served as President, American College of Dentists. His service on the national level also included numerous committees and task forces. For example, Dr. Scures was a member of the Special Committee to Study Establishing Standards for Teaching Professional Ethics in Dental Schools. This committee prompted the establishment of such standards in dental schools. Dr. Scures also unselfishly served as Secretary of the Florida Section for fourteen years.

Dr. Scures' hard work has been recognized through many honors and awards. He received the Leon Schwartz Lifetime Service Award from the Florida Dental Association, Dentist of the Year from the Orange County Dental Society, the Award of Excellence from the Florida Society of Dentistry for Children and the Leadership Award from the Southeastern Society of Pediatric Dentistry. Most recently, this year he was named distinguished alumnus of the year for Emory University.

Dr. Scures takes great pride in his Greek heritage and his family. He loves the outdoors, the ocean, and his garden. When not busy with his many dental activities, you will find him at the family's beach house in New Smyrna Beach.

Planning a Scientific Session

Craig S. Yarborough, DDS, MBA

Abstract

A long-time member of the California Dental Association Council on Scientific Sessions explains what goes into planning the educational program at a major scientific meeting—from the selection of speakers to on-site arrangements and the role of staff.

The applause is significant, approving, sustained, and sincere in appreciation for a presentation well done. The two and one-half hour lecture contained cutting-edge material, thoroughly researched, with visuals to match. Dr. Edwina Expert from Edmonton was everything you thought she would be when you read the course synopsis in the program. But how did she get the opportunity to present to you in Anaheim, California?

Three months before this moment, you sat in your office deciding what days, if any, of the California Dental Association's Spring Scientific Sessions you were going to attend. Thursday's schedule featured "symposiums," two and a half hour programs by speakers you were totally unfamiliar with. Friday's fare had forty presenters with names well known to you from the vast array of journals you keep up with. Saturday and Sunday's lecturers were similar to Friday's in notoriety, with some you have seen at previous Scientific Sessions.

After you outline your four-day schedule, you help attend to the needs of your staff. What subjects would best develop them? Should they attend a lecture or a hands-on workshop? You are certain to involve them in the decision to achieve a buy in on the benefit of staff attending the annual meeting.

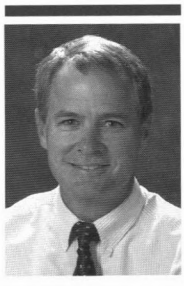
Finally, what about your significant other? Would he or she prefer a general topic lecture on nutrition or relationship building? Perhaps a guided tour of the Nixon Library or a day in Disneyland. Maybe he or she helps you purchase dental supplies and equipment, and a day on the exhibitor floor would be more productive.

Certainly a plethora of decisions for you to make, but how did you receive all of these options? That will be the subject of this article.

Finding the Talent

Let's go back even further, eighteen months to two years before Dr. Expert's outstanding presentation. The "scene" is a CDA meeting room in Sacramento. Eight council members, four consultants, and four staff members move through a full-day agenda. On the itinerary will be discussions of at least three future Sessions. The Anaheim Spring meeting in two years will need chairs for the various parts of a Session: essay, hosting, special events, table clinics, exhibitors. The Fall Scientific Session in San Francisco in eighteen months includes a deliberation on what speakers to invite.

The essay chair and vice chair will coordinate which speakers will be invited to present. Names are culled from reports from annual scouting trips each council member has made. For a speaker to be invited, a councilmember must have scouted him or her previously. Councilmembers each attend at least one major meeting a year. A "major" is loosely defined as a meeting where at least five thousand registrants will attend. A typical California meeting's registrants will consist of approximately 34% dentists, 23% dental assistants, 14% exhibitors, 9% each hygienists and guests, 8% staff, and fewer than 1% lab technicians. The significant "major" meetings include the Hinman in Atlanta, the Greater New York Dental Meeting, The Chicago Mid-Winter, the Yankee Dental Congress in Boston, both CDA Sci-



Dr. Yarborough has worked with the CDA San Francisco and Anaheim Scientific Sessions since 1972 and is Associate Dean for Institutional Advancement at the School of Dentistry, University of the Pacific in San Francisco. He can be reached at cyarborough@uop.edu.

entific Sessions in San Francisco and Anaheim, and the American Dental Association's Annual Scientific Sessions. The ADA schedules annually in large cities throughout the United States. These conventions attract fifteen to sixty thousand registrants and the best speakers in the dental world.

There are many more excellent smaller programs in the major cities across the country that are scouted also. In addition to well-known speakers, the CDA tries to find up-and-coming stars, often the local experts hoping to establish national reputations. You never know where the next Ron Jordan or Gordon Christensen will come from.

There is nothing better than to hear the applause of an audience where the speaker has met the audience's expectations...

The essay chair compiles a "wish list" of speakers for the assigned meeting. The list will fill the necessary topics each meeting must contain. The categories are common to dentistry; endodontics, periodontics, restorative dentistry, oral surgery, practice management, etc. Each specialty will be included as well as general topics, courses geared to dental auxiliaries, lab technicians, and guests. Something, we hope, for everybody.

In Anaheim, approximately forty presenters per day will be invited. Normally, four workshop courses are scheduled per day, the rest lectures. Much time and effort are devoted to inviting new, unfamiliar talent, "rising stars" to California. This raw expertise is balanced by recognized, popular speakers who may have presented for CDA before. Attempts are made not to invite the same speakers year after year.

Once the Council has finalized the wish list, the invitees are called by councilmembers. Fortunately, the opportunity to present at a major meeting appeals to most speakers. The speakers realize they will have a large audience. They also hope to have scouts from other meetings in their lecture rooms that may invite them to their meetings. Each councilmember is assigned a number of speakers to invite from the wish list. The negotiations with speakers can be delicate at times. California cannot always offer the speakers what they are worth. The CDA Scientific Sessions are unique in that none of the continuing education courses offered (excluding the hands-on workshops) are charged, ticketed, or fee presentations. They are true examples of membership benefits. CDA member dentists are not charged to attend the meeting itself or any courses they attend. A presenter, then, does not directly affect any revenues generated from the meeting. As a result, our negotiations with speakers center around their willingness receive the honor of presenting at a major meeting in front of large audiences, the opportunity to visit Anaheim and San Francisco in California, and the previously discussed exposure to scouts representing meetings from across the United States and various countries. A speaker receives an honorarium as well as a per diem and travel reimbursement.

...and knowing the participants will go back to their practices incorporating something they learned to benefit their patients.

The size of the audience will be the result of many factors, both in and out of the speaker's control. These variables include the topic itself, the day of the lecture (in California, Friday's are the best, followed by Saturday's, both due to high staff attendance), the popularity and notoriety of the speaker, whether continuing education credit is available, relevancy of the material, and the passion of the presenter.

Setting the Stage

The councilmember who chairs hosting duties may spend the most time and effort, recruiting room hosts for each speaker. This councilmember will typically involve three or four other members of the Council, scouring CDA member lists to find volunteers capable of monitoring lecture rooms and introducing speakers. Inherent in asking a CDA member volunteer to host is the councilmember's need to inspire the volunteer to represent the CDA in the best possible light. A host is often the CDA's front line in personally facilitating the traveling needs of each speaker. A host is expected to pickup speakers flying into the meetings, offer suggestions for activities during the presenter's stay, formulate an introduction for the speaker, monitor the room during the presentation, and take the speaker back to the airport. The CDA counts on the host volunteers to provide hospitality that helps make up for our low honorariums. The CDA is fortunate these hosts volunteer year after year in exchange for a sincere "thank you" and a free lunch.

With no income generated from course fees, revenue comes almost totally from exhibitor booth costs. At the Scientific Sessions, individual booth fees range from $1,600 to $2,300. As in real estate, these fees are based on location, location, location. Prime locations are fairly obvious:

near the entrances, on the corners of the aisles, and for larger booths. Many larger exhibitors purchase blocks of booths to maximize their exposure.

At most meetings, one or more evenings of entertainment are scheduled. In California, entertainers such as Jay Leno, Bob Newhart, and Marvin Hamlisch have performed. These performances, like the dental courses provided, are no-fee membership benefits. These gala events serve many purposes. They are a way of saying thanks to our members, adding glamour to the Scientific Sessions, and they are a method to entice registrants to spend the evening in the city. It is hoped, a result will be hotel reservations by attendees. Various city Convention and Visitors Bureaus monitor reservations closely. Convention center rooms, rates, and desirable meeting dates are predicated on the number of room reservations by meeting goers.

Scientific Sessions, Meetings, Congresses, whatever the title are typically manifestations of "organized dentistry." Each program tries to appeal to a broad spectrum of the dental professional community as outlined previously. Not mentioned is the outreach to tomorrow's practitioners, the dental students. The CDA has recently begun a shadowing of councilmembers by students, a mentorship if you will, for tomorrow's program planners. Students are heavily involved in table clinics as well. The table clinics provide an opportunity for students to present their latest research verbally and visually and can be competitive. Rewards are often financial but always offer recognition for significant effort by the students.

The councilmembers are all dentist members of the CDA and volunteer their time. The support of the Council on a day-to-day basis is provided by staff employed by CDA. They are the unsung heroes working behind and in front of the scenes. Staff work directly with the convention bureaus and the exhibitors, finalize the contracts with the speakers, record the meetings, and provide a myriad of other support activities. Working hand in hand with the Council, they provide the backup and manpower that make the entire experience from the attendee's standpoint appear seamless.

The next time you attend a dental convention, perhaps you will be better able to appreciate the time and effort that went into the meeting by dedicated volunteers and staff. Their goals are very simple; to coordinate the very best meeting in the world, to support you in your effort to be a lifelong learner, to bring you together with other members of the profession to share experiences. As a program planner, there is nothing better than to hear the applause of an audience where the speaker has met the audience's expectations and knowing the participants will go back to their practices incorporating something they learned to benefit their patients.

Continuing Education– Move On or Move Out

Marcia Lambert

Abstract

One of the members of a new group of continuing education providers argues that the kind of learning dentists are interested in is what patients want and what dentists did not learn in dental school. The dual developments of new alternatives in dentistry and Baby Boomers with an appetite for appearance and money to pay for it explain why courses in aesthetic dentistry, tooth whitening, orthodontics, high-tech, and innovative marketing are so popular.

As we barrel into a new millennium, the clock seems to be ticking away with astonishing speed. The information network spawned by the computer age quickly renders current technologies obsolete, creates "new and improved" equipment and materials that promise faster and better results in every area of life, and urges a galloping society to forge ever onward. Couple that with the swelling ranks of the Baby Boomer generation, seventy-six million Americans who will turn fifty over the next thirteen years at the rate of one every seven seconds and who want to stay healthy and youthful forever. This double phenomenon has created a generation of dentists who are changing the way they do business—for them, business is *really* "Booming!" For these entrepreneurial individuals, continuing education is their key to the kingdom. Dentists nationwide who want to capitalize on this extraordinary opportunity are turning to successful practitioners who are forging trails in the field of aesthetic and space-age restorative dentistry. For them, it is their lifeline to success. Those who use these tools will be able to ride the "Age Wave" and retire with a handsome nest egg.

Never in America's history has there been a market as demanding as this one for goods and services. These individuals will inherit $10.4 *trillion* dollars from their aging parents and will spend it on themselves in their quest for the fountain of youth and for entertainment and amusements. Only a dentist can create a youthful and healthy smile. The dentists who are flocking to continuing education courses in record number are preparing to set their own sails (and sales) for a halcyon future. Or they should be, if they don't want to get trampled in the stampede. Another driving force compelling dentists to seek new ways of practicing dentistry is the attempt by insurance companies to regulate the fees of the dental profession.

In an attempt to curb the expense of dental care and subsequent payouts to its customers, insurance companies have moved into the managed care arena. Dentists who sign contracts must accept reduced payments, forcing them to treat more patients to earn the same amount of income they did in former years. This means increased personnel, longer hours, higher operational costs, and smaller profits. Few practices can balance the equation by seeing fee-for-service patients alongside the managed care group. They don't seem to be able to integrate the two well. Different procedures and materials for each group make a confusing array of procedures and protocol. In frustration, many dentists are taking early retirement, becoming employees of large dental management organizations, staying put to "see what happens," or turning to courses that will move them into the new age of dentistry. It is a good move for the future. Teeth are here to stay!

Marcia Lambert is Director of CustomCare, a marketing company that specializes in sales training and image building for dental offices. Ms. Lambert can be reached at (877) 261-4716 or marcial@mail.com.

The fact is, dentistry has changed forever. Those who still choose to live in the "find 'em, fill 'em, and bill 'em" era will not survive and prosper. Sophisticated advertising promoting a beautiful smile and healthy lifestyle has permanently altered the yardstick by which youth, beauty, and position are measured. Americans have the most beautiful smiles on the planet. Models, politicians, boardroom execs, sports celebrities, and just "regular" folks are flashing perfect smiles from magazine covers, TV, billboards, and family snapshots. They have established a new paradigm for good looks, health, and status. Youngsters and adults are wearing braces in equal numbers, dental implants finally have an audience since the Boomers are opting not to wear removable teeth, and fresh breath and tooth whitening centers are springing up in every major city in America. There is a smorgasbord of choices, and the plates are filling quickly. Better education to the public is spurring patients to ask questions and seek more modern methods of dental care.

Continuing education for the dentists is how they are acquiring that knowledge. If one wants to understand the trends in continuing education, he or she only needs to understand the way dentistry is changing. We are in an era where the public is expressing a louder voice in directing these changes and where a new breed of continuing education experts is stepping forward to help dentists respond to a broader definition of "serving the public."

The downside to this extraordinary opportunity is that some dentists view these changes as a threat to their security, rendering their techniques antiquated, and their style obsolete. Going back to the drawing board is painful, particularly for those whose schooling taught them to only repair what was broken and to shun anything that would be only aesthetic in nature. It is viewed as "unnecessary" treatment, and therefore unacceptable. They, more than the newer practitioners, are feeling uncomfortable with advertising and promoting dentistry, and are overwhelmed with the education, time, and expense moving into this arena requires. But move they must if they are to stay in the game. Insurance companies are dictating that they speed up the process.

The downside to this extraordinary opportunity is that some dentists view these changes as a threat to their security, rendering their techniques antiquated, and their style obsolete.

What are dentists choosing to learn? The spectrum is broad. Adhesive dentistry seems to be leading the parade. Patients eager for "instant" results are accepting porcelain laminates as the treatment of choice. Periodontal treatment using lasers is another topic of interest since a large number of patients, particularly the Boomers, have some degree of periodontal involvement. Laser treatment for tooth whitening and microsurgery are also very popular. Then there is instruction in the computer operation of equipment and office systems. Computer imaging is hot. Clients can now see how they will look with their new smiles. It is this promise of results that helps them accept treatment and pay for it in advance.

What are dentists choosing to learn? The spectrum is broad. Adhesive dentistry seems to be leading the parade.

Along with technical training must come practice management instruction, particularly on the topics of marketing these new and expensive services and creating optimal customer service environments. Pricetags are high and insurance coverage is minimal, if existent at all. New forms of patient financing must be acquired, and all staff members must become enthusiastic and informed proponents of treatment. Everyone in the office has usually received some form of cosmetic treatment personally and is a walking advertisement for the dentist. They are coached by dental practice management and marketing professionals in the art of outstanding customer service and are groomed to handle this aware and educated market. Many offices are initiating a "boutique" atmosphere, offering such services as aromatherapy and massage, hot compresses and cold and warm beverages. They understand that only those patients with an extraordinary experience will tell their friends about their trip to the dentist. Referrals are still the greatest source of new patient acquisition for many offices, although those who realize they are competing with the plastic surgeon, the dermatologist who does skin rejuvenation, and other elective practitioners are turning to external marketing to reach much of their clientele. External marketing runs the gamut from setting up booths at health fairs and civic functions to sending home full-color, illustrated magazines highlighting the amazing results that can be achieved with modern dentistry. Dentists realize that their time is lim-

ited, so they are hiring professionals to reach the public. The courses they take advise them of the road to follow and what other dentists are doing to successfully educate and motivate their patients to accept high-quality treatment.

This revolution is still in its infancy. The most recent polls indicate that most dentists are still relying on systems that have worked for them in the past. Most do not advertise, are still offering traditional restorative methods, and are working with minimal computer and high-tech methods of service delivery. Much like the small business owner trying to compete with the megastores like Wal-Mart and Office Depot, dentistry will see the emergence of trendy and competitive giants in the field. Among them will be:

- Tooth whitening and fresh breath clinics
- Boutique, upscale salons for adult cosmetic dentistry
- Multi-specialty practices, with "one-stop-shopping" from orthodontics to cosmetics
- Neighborhood family dentists with large staffs whose offices have all the bells and whistles in computerized and high-tech care who will market heavily and stay in the forefront of modern technology and services
- Corporately-owned practices with dentists who have become employees
- Managed care clinics

All of these successful establishments will rely heavily on continuing education courses to keep them informed and proficient in new technology and delivery methods. The truth is, there is no way to do otherwise and succeed. The aging of America and the information age accelerated by computer technology have created a "Golden Age of Dentistry." It is these catalysts that have moved dentistry into the realm of elective services and created a place for dentists among the craftsmen and artists of the medical field who keep good health and good looks alive. Those with vision, courage, and energy will reap the rewards.

The Academy of General Dentistry's Ongoing Charge for Quality Dental Education

Roger D. Winland, DDS, MS, MAGD, FACD and Marilyn Mages

Abstract

The core competency statement of the Academy of General Dentistry is "Quality of care through lifelong learning." This article traces the history of the Academy from its founding in 1952 through the development of its programs in Fellowships and Masterships, the Fellowship Exam, the American Board of General Dentistry, the National Sponsor Approval Program, and its recent efforts to reaffirm and sharpen its mission.

Prior to World War II little thought of continuing dental education occurred within dentistry. The dental study clubs at that time did not meet the needs of the greater dental population, and the American Dental Association and its component societies scheduled regular, but limited, scientific sessions that invited all members to attend.

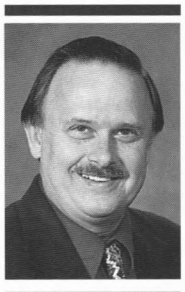
In 1951, Dr. Thaddeus V. Weclew, a general dentist in Chicago, founded the Academy of General Dentistry, recognizing the need to support general practitioners through required, ongoing dental education. His vision was that educational courses would allow dentists to keep current with new concepts.

The Academy's first organizational meeting was held on February 6, 1952, in conjunction with the Chicago Dental Society's Mid-Winter meeting. The Academy was incorporated in August of 1952 with a mission to serve as the premier resource for general dentists committed to improving patient care through lifelong learning. The first course sponsored by the Academy had twenty attendees who paid $25 each.

In the early years, the Academy's business meetings enabled the organization to develop the concept of continuing education, provide courses for its members, and foster a secondary purpose, which was to represent the general dentists' interests to government, insurance companies, and others within organized dentistry.

The original constitution and bylaws of the Academy of General Dentistry stated that "the physician's rights to perform all facets of medicine for which they have been trained and licensed should be held inviolate." This statement was adapted from the Academy of General Practice (in medicine), which shared the same visions and goals. The statement also helped to shape the Academy by opening the door to providing a strong voice for all its members, general practitioners, and organized dentistry.

At the Academy's second business meeting, members discussed the structure of the organization. The requirements for membership were rigidly set at fifty hours of school-connected courses and one hundred hours of participation in other areas, such as study clubs and dental society meetings, every three years. The Academy



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also determined that only certain courses would be authorized for membership credit—those that were connected with a school-based clinician.

Early Mission and Visions

Academy pioneers believed that in order for health professionals to stay informed of current advances, it would be necessary for them to earn continuing education credits; however, even fifteen years after incorporation of the Academy of General Dentistry, continuing dental education courses remained hard to find in many areas.

In the early 1950s, few universities offered continuing education courses, so Academy members made their own arrangements with dental schools or clinicians for course topics. Members needed to know where to find accepted courses. Dr. Weclew created a one-page bulletin, *Journal*, which in 1954 became a newsletter called *Academy Notes*, announcing this information.

In 1961, Dr. Weclew began accepting articles from contributing editors and general practitioners who were not required to be professors or have a master's degree. This redefined how dentists thought about continuing education. The magazine's name changed to the *Academy of General Dentistry Bulletin* in 1961 and included a color cover, logo, index, and photos. The name changed to *General Dentistry* in 1976, showing organized dentistry that there was a voice for general practitioners. The magazine included a calendar of major Academy events, book reviews, and increased emphasis on clinical items. The Journal began offering continuing education to readers with self-assessment quizzes in 1978 and credit for a self-instruction program in 1992.

The membership of the Academy continued to grow steadily, and increased interest in continuing education enhanced the organization's credibility. By the early 1970s, membership had grown to two thousand. In an article in November 1972, Dr. Weclew wrote, "the Academy's concept of Continuing Education is now firmly established in the dental profession. However, this recently accepted phase of graduate education, which fosters current competence for the practitioner, needs fuller recognition from the schools."

Fellowship and Mastership

As the organization grew, members made increasing demands for the quality and challenges that continuing education could provide. Ten years after the founding of the Academy, the first Fellowships were awarded to a Fellowship class of twenty-one. There was no big ceremony, but awardees were given keys and plaques. The requirements were five hundred hours of continuing education and five years of continuous membership.

Dentists become members of the Academy of General Dentistry because they want to enhance their practice and professional capabilities through continuing education.

In 1968, the Mastership program was developed to provide additional education for dentists who wanted to continue beyond Fellowship. The requirements were six hundred hours of continuing education in thirteen different disciplines. Of the required hours, four hundred need to be from participation courses.

Over the Academy's fifty years, more than eleven thousand or one-third of Academy members have earned Fellowship and fourteen hundred earned Mastership as a personal challenge and sign of achievement. They maintain a commitment to lifelong learning and quality patient care. Even members who have not earned the award view it as valuable. In a 1999 survey that was conducted by the Academy's Dental Education department, 75% of respondents commented that they planned to pursue the Fellowship award.

The Fellowship Exam

The Fellowship Exam, introduced in 1978 to help members test their dental knowledge, became a mandatory Fellowship requirement in 1984. Until 1998, members could take the exam only one day per year with pencil and paper. To encourage more members to take the exam, the Academy made it more accessible by allowing members to take the exam on computer nearly all year at any Sylvan Prometric Center throughout the United States and Canada.

The Fellowship Exam is created with an eye toward practical general dentistry. It contains a series of questions covering sixteen dental disciplines and strongly emphasizes clinical applications of currently accepted dental knowledge, techniques, and procedures. Approximately 90% of those who attempt any given Fellowship Examination pass it.

The Exam contains three types of multiple-choice questions: simple multiple choice, multiple/multiple choice, and complex true/false. A new exam is written each year by the three Examination Committee Teams, made up of Academy Masters and Fellows. The references for the questions are current, with none being more than five years old. A bank of more than two thousand questions is evaluated, and questions are deleted as they become outdated. New questions are written by the teams each time the Exam is updated so that the pool of available questions is replenished constantly.

Team A (the first of the three exam construction teams) scores the exam after the Academy's Annual Meeting to determine the statistical reliability and difficulty of each question. The team looks at the percentage of examinees who answer each question correctly or incorrectly. If there are inconsistencies in the answers, the team evaluates the worth of that question by bringing it to the attention of the other teams. Team A also identifies questions that will be included in upcoming exams.

Team B reviews the new exam to determine if the questions are clear and checks the fairness of each question. If the team has difficulty with certain questions, it will edit the text to make it more understandable.

Team C determines whether each question in the item pool is valid and current by checking references and adding new questions to reflect the changing dental environment. This team makes any final additions or changes to questions before they can be used on the exam.

The goal of the American Board of General Dentistry is to be recognized as the premier certification for all general dentists, not just members, and by the American Dental Association.

American Board of General Dentistry

In 1981, the House of Delegates of the Academy addressed the issue of diplomate status for general dentists. The certification process was established and an independent certifying board was created to give general practitioners credentials that would be recognized by institutions and hospitals, allowing them to compete on the same level as specialists. The Certifying Board of General Dentistry was incorporated in 1984 and changed its name to the American Board of General Dentistry in 1997. Three entry points exist for a general dentist to become board certified: completion of a two-year residency program, completion of a one-year residency program and six hundred hours of continuing education, or Mastership status in the Academy of General Dentistry. Candidates must challenge a rigorous written exam and an oral exam based on case presentations. The goal of the American Board of General Dentistry is to be recognized as the premier certification for all general dentists, not just members, and by the American Dental Association.

Currently, more than three hundred general dentists are board certified. The Board has experienced an increase in members pursuing board certification and it is now looking into providing review courses to assist with the preparation.

National Sponsor Approval Program

The National Sponsor Approval Committee's mission is to evaluate the education processes used in designing, planning, and implementing continuing education. This committee reviews continuing education sponsors or providers against fourteen standards of excellence. Once approved, all continuing education provided by these sponsors is approved for Fellowship and Mastership credits. Constituent Academies also have the ability to approve a sponsor on a local level for FAGD and MAGD approved credit. The goals are to improve the educational quality and promote uniformity in identification of those continuing dental education activities that are acceptable for AGD Fellowship and Mastership.

View on Dental Education

Today's members are required to earn seventy-five hours of continuing dental education over a three-year period. The seventy-five hours for membership maintenance has been in effect for most of the Academy's existence. Until 1974, members were on an honor system to complete the membership maintenance hours. The Academy developed a strong stance on this core competency requirement and has withdrawn 4,486 members for not meeting this requirement, something no other organization has done.

The Academy's Council on Dental Education is concentrating on finding new and innovative methods to deliver courses, such as online continuing education, and has explored the need to raise its educational standards. Academy statistics indicate that its members average forty-three hours of continuing education each year, or one hundred and twenty-nine hours in each three-year period, significantly more than what is required. The organization works to balance the quality vs quantity issue by considering options that would mandate the types of courses that are taken for membership maintenance and what that impact on the organization might be.

The New Brand

During the Academy's forty-seven years, membership has grown to thirty-six thousand. The mission statement, "to serve the needs and represent the interests of general dentists and to foster their continued proficiency through quality continuing dental education in order to best serve the pubic," adopted in 1981, has built consensus and furthered the direction for the organization. In 1997, leaders believed that it was time to learn the market trends affecting the dental industry and understand the current image of the Academy of General Dentistry among both member and nonmember general dentists.

Therefore, in 1998, the Academy embarked upon a market research project which involved focus groups of

both members and nonmembers, telephone interviews with Academy leaders and rank-and file members, and an overall marketplace analysis. This research helped the Academy develop a culture statement, which helps to define the personality and character of the organization: "The AGD is an organization where one can pursue professional and educational goals in a supportive, caring atmosphere." Additionally, a core competency statement was developed to describe what distinguishes the Academy from other organizations: "Quality of care through lifelong learning."

The outcome of this research was the development of a new brand to help communicate and reflect the unified message that the Academy of General Dentistry is a dynamic, quality organization that supports and responds to the needs of its membership and general dentistry. The new Academy brand signifies the three most important facets of the Academy's mission: education, superior patient care, and representation of the general dentist.

Dentists become members of the Academy of General Dentistry because they want to enhance their practice and professional capabilities through continuing education. The Academy provides this direction through the ability to earn recognition for continuing education, earn Fellowship or Mastership, and camaraderie with other like-minded dentists. The organization also provides a strong voice for the general practitioner.

Where the Rubber Meets the Road: Contributions to Dentistry from Its Practitioners

Eric K. Curtis, DDS, FACD

Abstract

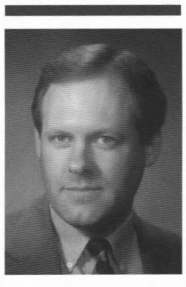
While much is made of dentists as consumers of the innovations in dentistry through continuing education, a strong case can be made for practitioners as the creators of this new knowledge. From the mechanized drill, rubber dam, and fluoridated water to compressed air, the reclining chair, and four-handed dentistry, practicing dentists are responsible for many of the profession's most important innovations.

You might expect that much of dentistry' progress should have been propelled from inside formal institutions. The mission of the university, for one, includes creating knowledge as well as disseminating it. Institutions are authoritative. They imply a meeting of minds and group consensus. Moreover, the requirement for laboratories, materials, time, and the money to deploy them would suggest that the fires of researchable ideas could be most likely fanned from the pooled resources that institutions can provide. Many of the dental profession's most transforming innovations indeed have been engineered under institutional sponsorship. In the 1950s, for example, a watershed era for dental technology, Robert Nelson developed the high-speed turbine hand piece while working at the Dental Research Unit of Washington's National Bureau of Standards. Michael Buonocore conducted his ground breaking research on enamel etching and composite resins at the Eastman Dental Center in Rochester, New York. And future dental implant icon Per-Ingvar Brånemark, leading a Lund University team in a bone repair study, found the titanium screws he implanted in rabbit thighs exceedingly difficult to remove.

Yet dentistry also honors an older model of professional and technological development, one that helped create the modern profession itself: that of the spirited, independent practitioner bent on solving a practical problem. In 1954, for instance, former Army dentist Sanford S. Golden took it upon himself to convene a group of specialists in California to develop a reclining dental chair that would allow dentists to work sitting down. His development led to the widespread use of high-speed suction and four-handed dentistry, dramatically altering dental care delivery in the decades after. Even without external funding or other institutional support, practitioners of dentistry enjoy a strong tradition of influencing and improving the profession.

The Entrepreneurial Spirit in Dentistry

Modern dentistry was born of an outside-the-system, entrepreneurial impulse. Horace Hayden and Chapin Harris, the Baltimore dentists who reinvented dentistry as a profession, left the medical school where they taught and ran the first dental school out of their hip pockets. Then, when dental education had become standardized and institutionalized in the early twentieth century, specialties emerged. But they were not imposed by university dental school departments. Rather,



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specialties sprang from the efforts of practicing dentists with a dream of better treatment for their patients. Edward Angle, the turn-of-the-twentieth-century genius who first urged dentists "regulating" teeth to dedicate themselves to that pursuit, quit his dental school position to strike out on his own. Angle's dogged blandishments—repudiating the conventional wisdom that a dentist couldn't make a living specializing—not only spurred the concept of orthodontics as a separate discipline, but showed the rest of dentistry that specialty practice could be viable.

The urge to create and improve is in our professional blood, even—or especially—for those of us in practice.

Other specialties were likewise rooted in the passion of practitioners. When Thomas Hartzell began urging a comprehensive approach to treating periodontal disease, including deep scaling and surgery, his audience was not a clutch of university professors but the dentists of the First District Dental Society of New York in 1915. And when Harry Johnston of Atlanta, decided in 1928 to concentrate his efforts on pulp treatment, he announced that his practice would be "limited to endodontics," a word he coined.

The exertions of individual dentists have even brought into being several non-dentist health care métiers. One is dental hygiene. In 1899, a dentist named Alfred Fones of Bridgeport, Connecticut, heard a lecture by a Dr. D. D. Smith of Philadelphia, who advocated periodic teeth cleanings to prevent dental problems. Fones began doing prophylaxes on his patients. In 1905, he trained his dental assistant Irene Newman to help him administer cleanings. The relationship worked well and Fones launched a training program, the Fones School of Dental Hygiene in 1913. His experiment was so successful that inquiries for hygienists flooded in from around the United States. By 1917, licensure laws were being passed to regulate dental hygienists.

A dentist in the field also helped develop facial plastic surgery. Varaztad Kazanjian, head of Harvard Dental School's Prosthetic Laboratory when World War I broke out, was named chief dental officer to a Harvard medical unit organized in 1915 to care for casualties of the British Expeditionary Forces. Kazanjian arrived in France to discover that battle-inflicted facial wounds were routinely left untreated. Combining his interest in dental and maxillofacial prosthetics with plastic and reconstructive surgery, Kazanjian began to experiment on his own with treatment methods on face wound patients in the field hospitals. He eventually treated more than three thousand cases of wounds to the face and jaws, and emerged from the war the acknowledged authority in a fledgling field. Journalists dubbed him the father of modern plastic surgery.

Even without external funding or other institutional support, practitioners of dentistry enjoy a strong tradition of influencing and improving the profession.

Virtually all nineteenth century technical improvements in dentistry came from private sources. (Some of dentistry's most fundamental improvements came from outside dentistry altogether. Charles Goodyear's vulcanized rubber was adapted and introduced to dentistry by his brother Nelson, who cleverly predicted its usefulness in denture making. Novocaine was invented by the German chemist Alfred Einhorn.) Before the word "empirical" acquired its pejorative patina, every dentist was a practical observer and researcher. From anesthesia to surgery, practitioners identified their own problems and tinkered with ways to solve them. For instance, Asa Hill of Danbury, Connecticut, introduced gutta percha for fillings about 1850. And, much as beleaguered dental students might wish to believe otherwise, rubber dams aren't the invention of punitive operative departments, but of a practitioner: In 1864, Sanford Barnum of Monticello, New York, was simply tired of getting saliva in his preps. James Beall Morrison, out of the experience of his own Ohio practice, patented the first mechanized dental drill in 1871. Even the toothpaste tube was invented in 1896 by New London, Connecticut, dentist Washington Wentworth Sheffield, who was offended by his patients' unhygienic practice of dipping brushes into porcelain toothpaste pots.

As the twentieth century approached, formal research-based, institutional science began to have a hand in dental progress. In 1890, American dentist Willoughby Miller tied dental disease to biology. Miller theorized from his experiments in the Berlin laboratories of the future Nobel Prizewinner Robert Koch that carbohydrates trapped around the teeth are

fermented by bacteria in the mouth and that the resulting acids cause tooth decay. In 1926, Columbia University chemist William J. Gies linked dentistry to universities. Gies released a Carnegie Institute-funded study that called for university-based dental education, biological sciences in the dental curriculum, and biomedical research in dentistry.

Research requires time, money, and serendipity. ("Basic research is what I am doing when I don't know what I am doing," Werner von Braun once said.) By the 1920s, partly as a result of their own inventions, dentists in practice were significantly more productive and had fewer hours to spare for home research. And few dentists had either the acumen to conduct meaningful research in a more rigorously scientific milieu or the cash to support it. Even a successful inventor could be financially ruined. A case in point was Illinois dentist William Taggart, who invented the lost-wax method for casting metal restorations. Annoyed with the laborious gold foil and inaccurate soldered inlays of his day, Taggart invested twenty years and mounds of his own money in developing the casting machine he introduced in 1907. Taggart's innovation was celebrated everywhere, but not his insistence on being paid for the right to use it. Deeply embittering the inventor, dentists simply ignored Taggart's claim to intellectual ownership and made his technique a mainstay of restorative and prosthetic practice.

Yet the private contributions to dentistry's knowledge base and technological advancement continued. Practicing dentists were too close to the problems of their patients to not be involved with the solutions. A powerhouse at Northwestern University, Greene Vardiman Black, who died in 1915, singlehandedly standardized cavity preparation and invented a clutch of machines to test alloys. Yet he was largely self-taught (the first formal lecture he heard was his own, when he was invited to teach at St. Louis's Missouri Dental College) through his practice. Much of his research was done on his own, with neither funding nor direction from an institution. Rather, his research attracted institutions.

In 1908, Colorado Springs dentist Frederick McKay set in motion waves of chemical research, social debate, and public health policy that would keep rolling throughout the century. He read a paper that year before the El Paso Odontological Society describing "Colorado stain," the brown enamel mottling he found on the children of his city. A decade later, McKay speculated that caries was inhibited by the same water that mottled enamel, a notion that led the way to H. Trendley Dean's famous Public Health Service experiment that fluoridated the water supply in Grand Rapids, Michigan.

Specialties sprang from the efforts of practicing dentists with a dream of better treatment for their patients.

The resourceful C. Edmund Kells of New Orleans was one of dentistry's most energetic geniuses. Much of current dental technology owes its development to Kells's pioneering work. As soon as he heard of Roentgen's 1896 discovery of x-radiation, for example, he assembled the equipment to build his own radiology laboratory and was soon applying x-ray diagnosis to dentistry. By the 1920s, Kells introduced compressed air into the dental office and invented the suction pump for aspiration, which was quickly adopted by not only dentistry, but all surgical disciplines where a clear, dry field is required. The first dentist in the United States to connect his dental office electrically to a central power station, Kells spruced up his office with such inventions as a thermostat and an automatic fire alarm.

Two Models for Innovation in Dentistry

The two models for dental contributions, one institutionalized, one grassroots, still coexist. Universities and other institutions have become financial and intellectual powerhouses for top-down professional change, but the wet-gloved community still contributes its fair share of ideas from the ground up. In the 1980s, for example, dentist Terry Myers of Detroit, Michigan, together with his ophthalmologist brother, developed the first dedicated dental laser. At least one practitioner has become an institution himself: In the mountains of Provo, Utah, Gordon Christensen has operated the non-profit Clinical Research Associates (CRA) for more than twenty years. Focused (in the words of its website) on "evaluating dental materials, devices and concepts for efficacy and clinical usefulness," CRA functions as the "Consumer Reports" organization of dentistry.

Whatever the source of the ideas that move the profession forward, count on two things about the next important contribution to dentistry: It won't be fast, and it won't be isolated. Progress takes years of planning, careful research, and evaluation, and there will likely be a practicing dentist or two involved somewhere along the line.

Dental Economics: A Non-Subscription Dental Journal

Joseph A. Blaes, DDS

Abstract

The editor of a non-subscription publication for dentists explains the advantages of having a journal whose contents are driven by advertising revenue unrelated to products or services mentioned in the journal and free from political influence as well. The drive on the publication is reader interest rather than author or publisher philosophy, and surveys and other methods are used to stay close to the issues practicing dentists are interested in.

Dental Economics enters its ninetieth year in January 2000. This non-subscription journal can trace its roots to 1911 when it began business as a monthly magazine called *Oral Hygiene* to tell dentists about managing their practices. The name has changed, but the message has stayed the same–the use of sound business principles to help dentists keep their practices profitable and growing.

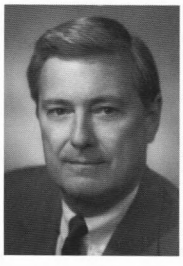
We believe that there are certain principles that all dental magazines should adhere to. It should be no surprise that the first principle should be truth. The material that appears in our magazines should be accurate in fact and in context. If we are unable to be certain that something is accurate, then we either should not publish it or make it perfectly clear by stating the source of the information.

We believe that the content of anything that purports to be journalism should be free of any motive other than informing and educating readers. In other words, it should not be motivated, for example, by the desire to curry favor with an advertiser or to advance a particular political interest. We further believe that we should hold ourselves accountable to the people we serve. We are eager to receive complaints about our work, and we will investigate complaints diligently so as to correct mistakes of fact, context, and fairness prominently and clearly.

Traditionally, dental schools have paid only lip service to the practice management curriculum. I can remember that my own exposure consisted of a one-hour class for thirteen weeks at 8:00 in the morning during my senior year. A very successful St. Louis practitioner who would regale us with stories about his boats, cars, and planes taught it. We actually learned very little about practice management. I have not done a survey, but from what I understand, this is still the standard in most dental schools. They all have great intentions, but finding the time for a non-clinical course is extremely difficult.

Dental schools are graduating future CEOs with no CEO training. Over the lifetime of their dental practices they will produce and collect millions of dollars. Dentists are generally aware of this missing component in their education and look for ways to fill this void. I believe that is the niche we serve. Our mission then is to be the business journal for dentists. We model our magazine on *Forbes*, with emphasis on columns written by proven leaders in the dental business field. Within these columns are articles that are more in-depth and stand-alone.

I was hired by PennWell three years ago to be the editor of *Dental Economics*. My publisher, Mr. Lyle Hoyt, felt that a dentist would be more likely to understand and anticipate the practice management needs of other dentists. A non-subscription magazine must have an attractive format to invite the reader in. One of the



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first things that Mr. Hoyt and I changed was the look of the inside and outside of the magazine.

This has been an exciting time of tremendous growth both in readership and advertising. I replaced some of the columnists to get some new blood into the magazine and then I began to ask the business leaders of dentistry and the business world to write articles for me. Dentists constantly give me feedback that they are reading the magazine from cover to cover.

The revenue model for *Dental Economics* is that advertising supports content. The Dentist must have a reason to read the magazine. Content is driven by the marketplace and not by any particular group view or political stand. The magazine must provide information that is of value to the dental orientated reader. The content criteria can only be determined by whether or not the dentist is actually reading the articles in the magazine and is able to put some of the information into action within the dental practice. As Editor, I am very interested in the number of advertising pages that are sold because more advertising means more content pages.

A successful dental journal can do surveys and gather statistical information that will allow the reader to tell what is missing in the content. The same information can tell the journal what material the reader is enjoying and what parts of the magazine they are not reading. The journal can quickly respond to this information unencumbered by any philosophy constraints or bureaucratic interference. Many dental publications will never publish an article that is critical of its leadership and some even promote a specific political perspective. This is a common problem for journals that are supported by membership dollars.

Some journals have tried to attract advertisers by using their content to promote certain products made by the advertisers. These magazines usually fail because dentists quickly figure out the obvious connection between the advertisers and the content. Other magazines try to attract readership by appearing to be refereed journals when in fact they are not. Dentists are pretty quick to spot that as well. One of my biggest problems is articles that are "self-serving." The majority of the articles that I reject are ones in which the author has built the article around a specific product by a specific manufacturer. Sometimes these articles can be edited if there is enough generic information.

The circulation of *Dental Economics* is qualified. In order for dentists to receive *Dental Economics* free, they must request it, in writing, and indicate that they practice at least twenty hours per week. We then can tell the advertisers that it reaches dentists who are very active and therefore likely to purchase the products that they make. Since the readers have requested the magazine, they are looking for it and are more likely to read it.

The revenue model for Dental Economics *is that advertising supports content.*

Trying to understand which topics are of current interest is both an art and a science. In addition to surveys and statistical information, we have several other ways to gather market intelligence. When a reader likes a particular article or needs more information, he or she usually will contact the authors and speak directly to them. We constantly are in contact with our authors and columnists to keep us aware of the feedback they are receiving. As editor of *Dental Economics* and author of a popular column, I am frequently asked to speak at major dental meetings, regional meetings, dental society meetings, and study clubs. At these seminars, I am able to question dentists on how we are doing in terms of meeting their needs. I also receive many unsolicited comments from dentists who seek me out at a meeting to offer their comments on the magazine.

Dental Economics exhibits at five major dental meetings each year. Being on the exhibit floor of a major meeting allows us to raise the awareness of the four magazines (*Dental Economics, RDH, Proofs*, and *Dental Equipment & Materials*) that are part of the Dental Division of PennWell. Convention booths also allow us to gather some more intelligence with dentists, hygienists, clinical assistants, and business assistants. Over the years that I was in full time practice, I became acquainted with many of the dental manufacturers because of my interest in new products and innovation. Since beginning my own "Pearls For Your Practice" column, I have met many dental industry people. Because of this close relationship, I am able to anticipate new products and techniques and how they will impact the clinical and business sides of dental practices. This keeps our magazine ahead of the curve.

I have always believed that the non-subscription magazine serves a vital purpose. During my long career in private general practice, I was an avid reader of this type of magazine because I found articles and information here that simply were not available in the peer-reviewed journals. I hope that such journalism can continue to serve the practicing dentist for many years to come.

Continued Formal Dental Education or I Would Like More

Richard G. Weaver, DDS

Abstract

Statistics are presented on recent trends in postdoctoral dental education. While enrollment in specialty and general practice residency programs has remained constant, interest in Advanced Education in General Dentistry programs has increased.

Predoctoral dental education content and structure build on the premise that the predoctoral curriculum prepares an individual to stand for licensure and entry into private practice immediately upon graduation. Postdoctoral dental education is an elective, a personal decision to pursue additional education immediately prior to entering practice or within several years after graduation. While predoctoral dental education may be considered as preparing graduates to an initial level of competence sufficient for entry into practice, almost 49% of the 1997 and 1998 dental school seniors applied to one or more programs of postdoctoral dental education (American Association of Dental Schools, 1999).

TABLE 1. PERCENT AND NUMBER OF SENIORS APPLYING TO POSTDOCTORAL DENTAL EDUCATION PROGRAMS; 1990 – 1997

	1990	1991	1992	1993	1994	1995	1996	1997	1998
Number of Graduates	4233	3995	3918	3778	3875	3908	3810	3930	4041
% Which Applied to PGD Programs	*38.1*	*39.0*	*36.9*	*40.4*	*30.8*	*30.5*	*29.5*	*33.2*	*29.4*
# Which Applied to PGD Programs	1613	1558	1446	1526	1194	1192	1124	1305	1188
% Which Applied to Specialty Programs	*21.9*	*22.8*	*22.3*	*23.3*	*19.1*	*18.0*	*18.4*	*19.7*	*20.9*
# Which Applied to Specialty Programs	927	911	874	880	740	703	701	774	845

Applicant Trends to Postdoctoral Dental Education

The Survey of Dental School Seniors, conducted annually by the American Association of Dental Schools, obtains information regarding plans to pursue accredited programs of postdoctoral dental education. These are the general practice residency (GPR) program, the program of advanced education in general dentistry (AEGD), and the eight recognized specialties of dentistry. Table 1 displays the percent and number of seniors from 1990 to 1998 who indicated they had applied to one or more postdoctoral general dentistry and/or specialty programs(American Association of Dental Schools, 1999). In 1998, 29.4% of the seniors applied to GPR and AEGD programs; and almost 21% applied to specialty programs. (About 13% applied to both GPR/AEGD and specialty programs.) Over the last four years of this period of time, there has been slight fluctuation between 29% and 33% of seniors applying to GPR and AEGD programs. Over these four years, the percent applying to specialty programs has fluctuated between 18% and 21%. The percentages between 1994 and 1998 are lower than the percentages of se-

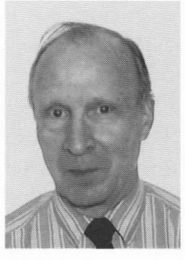

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TABLE 2. PERCENT OF APPLICATIONS TO SPECIALTY PROGRAMS

	1990	1992	1993	1994	1995	1996	1997	1998
Ortho.	28.0%	30.3%	27.1%	31.8%	30.6%	34.6%	33.3%	34.3%
OMS	23.3%	24.0%	19.4%	28.1%	23.7%	22.6%	27.4%	16.8%
Perio.	16.1%	13.5%	14.5%	13.6%	12.3%	10.9%	11.0%	10.4%
Ped. Dent.	11.6%	12.9%	19.2%	16.7%	16.4%	15.5%	20.4%	19.5%
Endo.	11.1%	10.8%	10.2%	7.1%	11.6%	9.6%	11.0%	12.5%
Prostho.	8.0%	8.4%	11.4%	4.7%	6.0%	5.0%	5.7%	4.8%
Oral Path.	0.6%	0.8%	0.7%	1.2%	0.2%	1.1%	0.8%	0.9%
Pub. Health	1.3%	1.1%	0.5%	0.6%	0.6%	0.7%	0.6%	0.8%

Note: The percentages are based on the number of applications, not the number of applicants. One applicant may apply to various specialty programs.

niors applying to GPR/AEGD and specialty programs between 1990 and 1993, when they fluctuated between 37% and 40% for the GPR and AEGD programs and 22% and 23% for the specialty programs. But the decline from the early 1990s appears to have ceased, with a rather stable 48% to 49% of seniors applying to postdoctoral dental education programs: about 29% to 30% to GPR/AEGD programs and 19% to 20% to specialty programs.

Table 2 displays the percent of applications to specialty programs, as derived from the AADS senior surveys, 1990 to 1998(American Association of Dental Schools, 1999). Orthodontics continues to be the dental specialty program most pursued by immediate graduates, with 34.3 % of the 1998 applicants for specialty training indicating they had applied to one or more orthodontic programs. There was a significant decline in the percent applying to oral and maxillofacial surgery programs in 1998, falling from 27.4% to 16.8%. Pediatric dentistry applicants have leveled off at about 20% of the specialty applicants. Endodontics continues to have a slight trend up in applicants to 12.5%, while periodontics continues a slight trend down to a current 10.4%. Prosthdontics has been at about 5% over the last several years. Oral pathology and public health dentistry each, generally, has less than one percent of the specialty applicants.

While almost 49% of the 1997 and 1998 seniors indicated they would like to immediately continue their dental education by having applied to programs of postdoctoral education, only 36% of the 1998 seniors and 37% of the 1997 seniors indicated that they had been accepted and would actually be pursuing postdoctoral education immediately upon graduation. The percent of seniors immediately pursuing postdoctoral education has risen from a little over 18% in 1980 to 36% in 1998 (American Association of Dental Schools, 1999) (Figure 1). This information from the senior surveys shows that there has been little fluctuation in the percent of seniors immediately entering postdoctoral programs over the last six years, varying between 35% and 37%.

The above information from the senior survey is closely corroborated by postdoctoral information obtained by the American Dental Association. Table 3 illustrates the number of 1997 dental graduates actually enrolled in postdoctoral dental education programs (latest year of available data) (American Dental Association, 1998). There were 3903 dental graduates in 1997. Four hundred and sixty of the graduates (11.7%) directly enrolled in postdoctoral specialty programs; 1070 (27.2%) directly enrolled in GPR and AEGD programs. Thus, 38.9% of the 1997 graduates directly entered postdoctoral dental education programs. Again, these percentages are similar to and corroborate the percentages expressed in the 1997 senior survey, such that it can be estimated that the percent of seniors immediately pursuing postdoctoral dental education has increased from about 18% to almost 40% since 1980.

Table 3 also illustrates the number of 1997 graduates immediately entering each of the specialty programs and the percent of enrollment for each specialty made up by immediate gradu-

Figure 1. U.S. Dental School Graduates' Immediate Practice Plans: 1980 - 1998

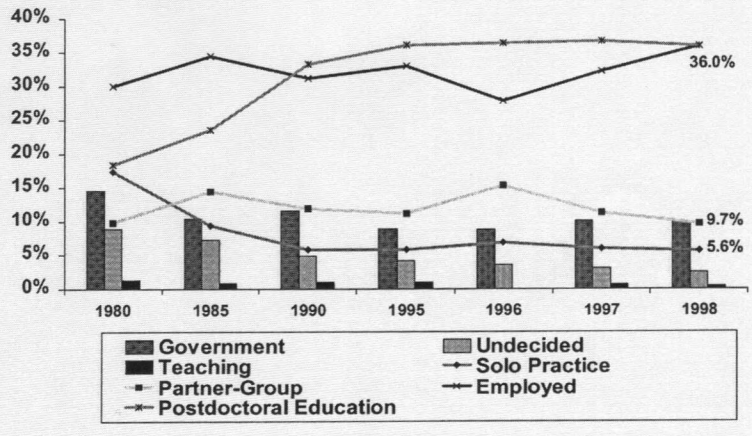
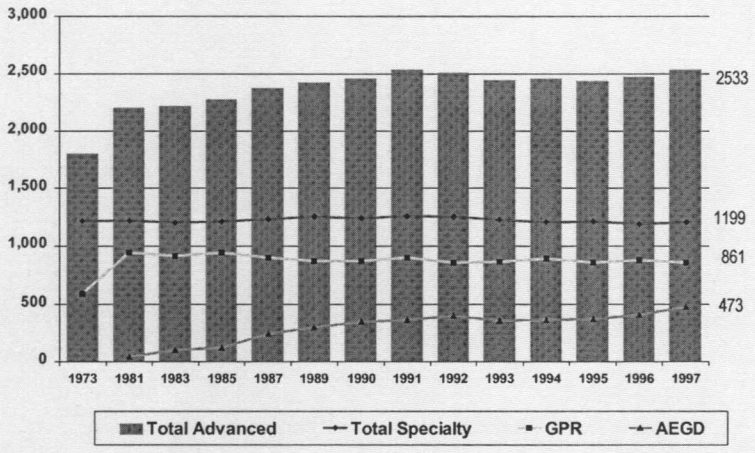


Figure 2. First-Year Enrollments in Postdoctoral Dental Education Programs: 1973, 1981 -1997



ates. Immediate graduates held a little over 38 percent of the current specialty positions. A little over 80% of the postdoctoral general dentistry positions were held by immediate graduates. The remaining 20% general dentistry and 62% specialty positions were held by prior year graduates or internationally trained dentists. Other data from the American Dental Association's report on the composition of the first-year advanced dental education enrollment (American Dental Association, 1998) indicate that only 9.6% of the specialty program positions were held by individuals who had completed a GPR or AEGD program.

In summarizing applicant trends to postdoctoral dental education by dental school seniors, currently almost 49% desire to immediately continue their education and apply to one or more programs of postdoctoral education. Approximately 36% to 39% of the seniors are selected and enrolled in postdoctoral programs; with about 27% of the seniors enrolled in GPR/AEGD programs and 12% enrolled in the dental specialty programs. It can be estimated that about 10% of the seniors have been unable to immediately pursue their interests in obtaining postdoctoral dental education. To accommodate this unmet demand, it has been estimated (Weaver, 1999) that there is, at minimum, a need to increase the number of postdoctoral dental positions by 426.

Figure 2 illustrates the trends in the growth of postdoctoral dental education positions (American Dental Association, 1999). The number of first-year postdoctoral positions currently stands at 2533, of which 1199 are specialty positions and 1334 are GPR and AEGD positions. There has been little change in the number of specialty positions over the last twenty-five years, fluctuating between 1199 and 1259. However, there has been a declining trend of specialty positions from the high of 1259 in 1991 to 1199 in 1997. The growth in postdoctoral dental education has come through the GPR and AEGD programs. But even here, since 1985, there has been a decline in GPR positions from 943 to a current 861 first-year positions. Over all, the growth in postdoctoral dental education since 1981 has been through the AEGD program, which now provides 473 first-year positions. To meet demands for continued education by dental school seniors, and to move toward addressing recent recommendations by the Pew Health Professions Commission (Pew Health Professions Commission, 1993; 1995) and the In-

TABLE 3. NUMBER OF 1997 GRADUATES ENTERING POSTDOCTORAL DENTAL EDUCATION PROGRAMS

Type of Postdoctoral Program	Program Enrollment	Number and Percent of Enrollment by 1997 Graduates	
Specialty Programs			
Dental Public. Health	34	1	2.9%
Endodontics	181	36	19.9%
Oral/Max-Facial Pathology	12	3	25.0%
Oral/Max-facial Surgery	192	91	47.4%
Orthodontics	286	144	50.4%
Pediatric Dentistry	180	78	43.3%
Periodontics	162	66	40.7%
Prosthodontics	150	39	26.0%
Combined Programs	2	2	100.0%
Total Specialty	1199	460	38.4%
Postdoc. General Dentistry			
GPR	861	749	87.0%
AEGD	473	321	67.9%
Total Postdoc. Gen. Dentistry	1334	1070	80.2%
Total Postdoctoral Programs	2533	1530	60.4%

TABLE 4. PERCENT RESPONSES TO FACTORS INFLUENCING PLANS TO PURSUE POSTDOCTORAL DENTAL EDUCATION

Decision Factors	First Choice	Second Choice	Third Choice
1. Need additional experience	24.6%	12.4%	11.9%
2. Expand scope of knowledge/skills	32.8%	29.9%	8.9%
3. Additional specialty training	30.0%	15.1%	15.7%
4. Transitional experience	5.6%	16.4%	24.7%
5. Anxiety of entering practice	0.3%	0.8%	2.9%
6. High level of debt	1.1%	2.9%	5.6%
7. Availability of stipends	0.3%	2.9%	5.0%
8. Higher income potential/prestige	1.9%	15.7%	15.6%
9 Influence of family/friends	0.9%	2.5%	6.7%
10. Other	2.6%	1.3%	3.1%

stitute of Medicine (Fields, 1995) for dental education, there is need to increase the number of positions in advanced general dentistry.

Factors Influencing Plans for Postdoctoral Dental Education

Respondents to the 1996 American Association of Dental Schools Survey of Dental School Seniors were asked to indicate factors that most influenced their decision to pursue or not pursue postdoctoral dental education. Those pursuing postdoctoral education chose from the following factors: (1) need additional clinical experience prior to entering practice, (2) want to expand current scope of general dentistry knowledge and skills, (3) want additional education in a particular dental discipline, (4) desire a transitional experience between education and practice, (5) anxious about entering practice, (6) high level of indebtedness, (7) availability of stipends, (8) higher income potential/professional prestige, and (9) influence of family and/or friends. Table 4 presents the percent responses to these influencing factors as first, second, and third choice.

The most influential of these factors, as indicated by first choice responses, were factors 2 (32.8%), 3 (30.8%) and 1 (24.6%). The next highest first choice factor was 4 (5.6%). Factors 5 through 9 each had less than 2% of the responses. As a second choice of influencing factors, 4 further emerged as an important decision factor (16.4%), along with 8 (15.7%). Among seniors indicating a third influencing factor, 4 received 24.7% of the responses, 3 received 15.7%, and 8 received 15.6%. Factors 5, 6, 7, and 9 each had less than 7%, even as third choice factors. Anxiety about entering practice, educational debt, availability of a stipend, and the influence of family and/or friends did not appear to be significant decision factors to individuals pursuing postdoctoral education.

Individuals who responded in the 1996 Senior Survey that they had no plans to pursue postdoctoral education were requested to indicate why they were not. Their response choices were (1) no interest at this time, (2) immediate practice opportunity, (3) not feasible due to level of indebtedness, and (4) may not be able to successfully compete for a training position. Table 5 presents the percent responses to these factors.

As the most influencing decision factor, 1 received the most responses (43.8%) followed by 2 (32.7%), and 3 (11.2%). Inability to compete for a training position received 1.6% of the responses. Level of debt emerged as more of a significant factor among second choices, with 24% of the responses. It further increased as a third choice response at 29.4%. It is apparent that level of debt was a contributing factor to individuals choosing not to pursue postdoctoral education.

Respondents to the 1997 and 1998 Senior Survey were asked to indicate factors that influenced their immediate plans following graduation. Respondents chose from the following factors: (1) high level of educational debt, (2) eager to begin practice, (3) no interest in obtaining advanced education, (4) may not be able to successfully compete for an advanced education position, want to expand dental knowledge and skills prior to entry into practice, (6) influence of family and/or friends, (7) higher income potential/professional prestige, (8) desire a transitional experience between education and practice, (9) interests with dental/non-dental activities outside of clinical practice, and (10) other. Respondents were asked to choose up to four factors, in priority order. Table 6 presents the percent first choice responses to these influencing factors for the 1998 seniors pursuing private practice and postdoctoral dental education. The percent responses for the 1997 seniors were most similar to the 1998 responses for all factors.

TABLE 5. PERCENT RESPONSES TO FACTORS INFLUENCING PLANS NOT TO PURSUE POSTDOCTORAL DENTAL EDUCATION

Decision Factor	First Choice	Second Choice	Third Choice
1. No interest at this time	43.8%	31.7%	25.1%
2. Immediate practice opportunity	32.7%	32.2%	13.7%
3. Not feasible due to high debt	11.2%	24.0%	29.4%
4. Perceived inability to compete	1.6%	4.3%	13.3%
5. Other	10.7%	7.7%	18.5%

TABLE 6. PERCENT RESPONSES TO FACTORS INFLUENCING PLANS TO IMMEDIATELY ENTER PRIVATE PRACTICE OR PURSUE POSTDOCTORAL EDUCATION

INFLUENCING FACTORS	Private Practice	Postdoc. Education
1. High Level of Debt	28.9%	3.6%
2. Eager to Begin Practice	40.4%	-
3. Not Interested in Advanced Dental Education	4.1%	-
4. Unable to Compete for Advanced Education Position	1.5%	-
5. Expand Dental Knowledge and Skills Prior to Practice	-	65.7%
6. Influence of Family and/or Friends	3.9%	1.8%
7. Higher Income Potential/Professional Prestige	3.2%	11.0%
8. Desire a Transition Between Education and Practice	-	6.9%
9. Interests Now Lie Outside of Clinical Practice	-	2.3%
10. Other	2.5%	8.7%

For respondents with plans to immediately enter private practice, "eager to begin practice" was the factor with the highest percent of responses (40.4%), followed by "high level of debt" (28.9%). For respondents with plans to immediately pursue postdoctoral education, expanding dental knowledge and skills prior to practice received the highest percent of responses (65.7%), whereas debt was indicated as the most important influencing factor by only 3.6% of these respondents.

These responses to the 1997 and 1998 Senior Survey parallel the responses to the 1996 Senior Survey. For individuals pursuing postdoctoral education, debt was not a significant decision factor. But for individuals not pursuing postdoctoral education, debt was a contributing and often significant factor in making that decision. Those pursuing postdoctoral education did so irrespective of their various debt levels, as individuals with high debt pursued postdoctoral education at a rate similar to those with no or low debt (American Association of Dental Schools, 1999).

Discussion

It is apparent that almost one-half of the dental school seniors are considering postdoctoral dental education an essential component of their education prior to entry into practice. About 20% percent want to immediately pursue one of the dental specialty programs. About 30% want to pursue programs of postdoctoral general dentistry (GPR/AEGD). Dental educators must begin to acknowledge and help resolve implications resulting from one-half of the seniors wanting more knowledge, skills, and clinical experience prior to entering practice. It is time to review the place of postdoctoral dental education in the "life-long learning" requirements of dentistry.

Commitment must extend beyond creative programming and funding by which to increase the number of postdoctoral positions so as to meet the demand for such education. Three immediate educational issues arise. Pre- and postdoctoral education must collaborate to assure an integrated continuum of curricular and educational experiences. In particular, postdoctoral general dentistry competencies must extend the competencies, knowledge, and skills of the new graduate; as well as provide opportunities to increase proficiency in the competencies of the new dentist (American Association of Dental Schools, 1997).

Second, dental schools must be ready to accept greater accountability for the competence of their graduates and their readiness for postdoctoral education and practice. If 50% of the seniors indicate they want more before entering practice, what specifically is it they want and how is it to be provided? And if a senior is unable to meet selection criteria for postdoctoral dental education programs, how well qualified or ready is this person for entry into practice?

And third. Postdoctoral education is an elective. It is generally accepted the programs select their residents and trainees from the "most qualified" of their applicants. A broader range of graduates will have to be accommodated. Postdoctoral programs must accept the challenge of working with the broader academic range of residents and trainees.

As almost 50% of seniors apply to postdoctoral programs and consider the immediate pursuit of such education essential to their education prior to entering practice, dental educators have extensive challenges and opportunities before them as they review the place of postdoctoral dental education in the continuum of dental education.

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Credibility

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

Abstract

The believability of a message is grounded in almost everything except the content of the message—there is no self-warranted truth. Credibility is based on the believer's assessment of the form of the message, its source, and especially by triangulation with a reference point. The most common group of reference points are compatibility, authority, collegiality, and performance

Who are you going to believe? There are more ways to do dentistry than ever before—new materials, new equipment, new financial relationships, new patient values, and diverse professional aspirations. There are certainly are a lot of claims being made by means of cheap media, self-appointed experts, almost as many scientific journals in the world than there are dentists in the United States, journals that publish reviews of the scientific journals, CE speakers who reveal what the reviews really mean, and even newsletters that rate the CE speakers. And all of this is taking place in a regulated and litigious environment and one that seems to be increasingly so. Who is the person to believe?

Self-Evident Truth

It would be convenient if every statement where required to carry with it a certificate of its authenticity; something that could be inspected when necessary to show that we would be safe in believing the statement. These things only exist in the dreams of gullible men and women. (I am excluding here tautologies such as "We were out numbered because the other side had more warriors" and "This should be greatly appreciated by those who like this sort of thing." Such statements tell us about what words mean but not about the world.)

Revelation is certainly a powerful way to receive a message. It comes close to being self-evident truth, but only in the sense of seeing no need for external authentication. It is bigger on the self-evident side than on the side of truth. How, for example do we decide between contradictory revelations? False prophets have been a concern since true ones started the self-evident truth business. For the most part what makes a prophet false is the fact the people don't believe him or her anymore. The impossibility of self-evident truth is contained in the classic Greek paradox of several hundred years BC: "Epimenides the Cretan says that Cretans always lie."

Nonetheless, there are certain kinds of statements that tend to be believed regardless of who says them or what circumstances exists. Sloppy or inconsistent messages are discredited. As Mark Twain observed, "When the clock strikes thirteen, it tends to cast doubt on the hour and on all twelve that preceded it." Balanced arguments

The credibility of messages comes from their reference points.

are given more credit than one-sided ones. It seems that pushing too much on one side of an issue prompts a defensive search on the listener's part for the speaker's hidden motives. There is also a very powerful pull to believe messages that are consistent with what we already hold to be true. If an advocate for fee-for-service and an advo-

cate for capitation share a platform in front of a mixed audience, the fee-for-service proponent will be judge credible by those in the audience who favor this form of reimbursement and the speaker presenting the capitation point of view will be judged as credible by those with a leaning towards such programs. This is such a powerful influence that one's opponent can speak volumes of truth and one's champion can mouth mostly nonsense before the effect is overcome.

The fourth characteristic of messages that make them believable in a general sort of way is what they demand of the audience. Asking too little and asking too much reduce the persuasive power of a message. This finding was discovered by Yale psychologist Irving Janis almost half a century ago by studying the impact of oral hygiene messages. When junior high school children were exposed to oral health care messages and asked to brush to reduce the consequences of oral disease, it was discovered that the relationship between persuasive pressure and compliance was not simple. A mild message with pictures of healthy dentitions and a suggestion that brushing would be helpful to maintain such an attractive appearance produced almost no change in attitudes or brushing behavior. Pictures and explanations of moderate complications were reasonably effective in changing attitudes and behavior. But pictures of "bombed out" mouths and predictions of dire consequences produced attitude and behavioral changes much like the benign message. It appears that when we ask nothing we get it and when ask too much you get nothing as well. People seem to have a built in protection against messages that are too frightening or too demanding to be comfortable.

Finding the right amount of edge to put on a message to make it believable can be summarized in the Rule of the Reasonable Reach. A message that repeats what the audience already knows is disregarded and one that is threatening or makes large jumps over what the audience already knows provokes a defensive reaction. Notice that the Rule of the Reasonable Reach refers to the believability of messages and the criterion is in the relationship between what is said and what the audience already believes; it has nothing to do with the relationship between what is said and what is true. A bogus message that stretches what the audience already knows in a comfortable way is more credible than a true message that is frightening when there is no external standard for comparison. One of the ways to tell which areas have too many players on the CE circuit is to look at the matter of reach. As a field becomes saturated, the messages become more exaggerated as each speaker attempts to differentiate his or her message from the pack. As the reach gets longer, credibility diminishes in a nice self-limiting way.

Journals bestow authority through the peer review process—although some confusion remains whether reviewers are peers of the authors or peers of the readers.

Consistency Theory

The credibility of messages comes from their reference points. Believability is a triangulation process involving the message, the believer, and a reference point. The basic system is displayed in the accompanying Figure. Consider a somewhat unusual claim made about a new adhesive dentistry product in a respectable, peer-reviewed journal such as the *Journal of Dental Research* and the same claim made in a newsletter published by an individual with a reputation for bending the truth towards commercial interests. The first case is shown on the left. The believer has a positive impression of the respected journal and perceives a positive association between the journal and the message. In order to balance the triangle (avoiding a single negative relationship), the believer credits the message. The same sort of "arithmetic of credibility" exists in the second case, shown in the center. The same positive relationship is perceived to exist between the message and the reference point (the pro-

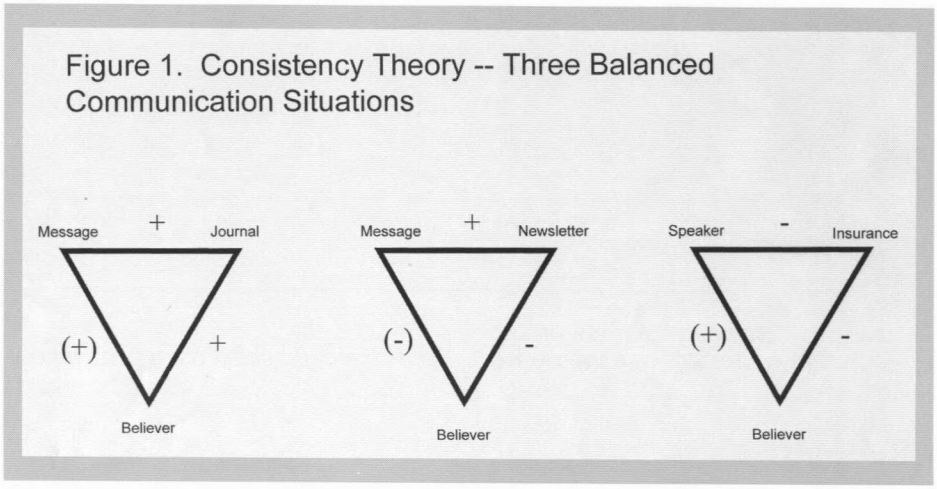

Figure 1. Consistency Theory -- Three Balanced Communication Situations

prietary newsletter advocates the product), but now there is a negative assessment of the reference point (the reader is suspicious of the newsletter). In order to avoid a situation with a single negative association on the triangle the believer must discredit the message, thus producing two negative associations.

Consistency theory, as this approach is called, can also be used to show how negative reference can add credibility to messages. The figure on the right illustrates the currently fashionable practice of CE speakers to establish their credibility by running down dental insurance. In an audience where the association between the listeners and insurance is negative and the speaker portrays a similar negative association with insurance, believers balance the triangle by assuming a positive relationship between speaker and whatever the message is.

Messages are not self-warranting. They are evaluated by triangulation on a reference point and the rule is: all three relationships positive or any two relationships negative is a comfortable position for the believer. A single negative among any of the relationships is uncomfortable. Examples might include a respected friend criticizing an aspect of your practice you feel proud of, a world authority tauting a practice you disapprove of, or someone you dislike taking a position similar to your own on an issue. In these circumstances, the believer is uncomfortable and will engage in some combination of the following: seek additional information, change one of the perceived relationships, invent a different reference point that explains the situation (such as "he was only fooling"), bracket the experience as unexplained, or forget the matter entirely. In terms of probability these strategies are listed in order from the least likely to occur to the most likely. Although consistency theory works well to explain which messages are likely to be believable and which ones are likely to trigger uncomfortable responses, considerably leeway remains in determining which messages different people will find credible. The reason is that a given message can have multiple reference points. For example a reasonable and moderate spokesperson for a view one finds repugnant might publish in a respectable journal and advance a position that has both attractive and disquieting consequences. It may take some time, but most readers will find a way of disbelieving the message. As a general rule, human nature is flexible enough to find a reference point to justify any belief we want to maintain.

Table 1. The Common Bases of Credibility

The Message
- Free from sloppiness and inconsistency
- Consistent with present beliefs of audience
- Balanced arguments, appearance of fairness
- Asks audience to make "reasonable reach"

The Presenter
- Titles, presumed expertise
- Men
- First impressions dominate subsequent ones
- Presented confidently
- In good form

Reference Points for Consistency
- Compatibility
- Authority
- Collegiality
- Performance

Four Common Reference Points

Before discussing compatibility, sponsorship, collegiality, and performance as major groups of reference points, something must be said about universals. The accompanying table lists several reference points that always seem to work. For example, people with titles or people who have been introduced as being experts in a field get a credibility advantage to begin with. Similarly, for non-gender-related topics, men are given more credibility than are women, even when the message is identical as in the case of written reports signed either John Smith or Jane Smith. People who have been credible in the past continue to enjoy

that advantage while people who have been incredible before must struggle to overcome a prejudice. The power of first impressions—called the "primacy effect"—is so great that a person you think is intelligent who spills coffee on himself is thought to be "just human"; while a person who spills coffee on himself the first time you meet him and then says something profound is often judge to be eccentric. Confident people have the benefit of credibility extended to them. Finally, the marks of good communication reflect on the message. A journal article announcing a true scientific break through may tend to be discredited for its use of non-professional jargon or poor spelling. This is an especially likely response from those individuals who lack a reference point to judge the content of the message.

We want to believe people whom we feel are like ourselves.

Prophets are often argued as a special case. Prophets earn credibility by either predicting future events or by providing plausible interpretations for ambiguous ones. Researchers are the prophets of science. When they report that a particular result has a p-value of .05, what they are saying is something like "If one hundred researchers did tomorrow the same thing I did, I am predicting that no more than five of them would find contradictory results." Scientific theory is also used as a form of explanation for observed events.

Of the many ways that sources of credibility could be grouped, I have picked four for special attention here: compatibility, authority, collegiality, and performance.

Compatibility: Other things being equal we give more credence to messages from people with whom we identify. Women believe women, republicans believe republicans, teachers believe teachers, and golf players believe other golf players—or at least they are expected to make a show of it. The art of believability is to some extent a search for common bonds. The friendly chat of a car salesman is both for the purpose of relaxing the customer and for finding common ground—perhaps having lived in a common community, a hobby, a former occupation, or a mutual friend. Compatibility strengthens the positive bond between the speaker and the message in the triangle.

Every good CE speaker knows that the first few minutes of presentation are for establishing rapport rather than presenting the message. To be absolutely honest about it, compatibility is not based on similarities between ourselves and those we listen to. Instead it is a matter of similarity between the image projected by the speaker and the kind of person we believe ourselves to be. It is the stock and trade of sales people to flatter their customers. The people we see on television—from actors in advertisements to weather reporters—are all believably enhanced images of ourselves. A CE speaker gets few credibility points for citing the research literature, and may actually lose a point if the references are too numerous or too "scientific." A much safer approach is to claim to be "just a plain ol' working, wet-gloved dentist," to show a picture of an attractive office and to suggest that he or she is making quite a bit of money. Since making a lot of money may jar the professional self image of some dentists, the code language "my family enjoys the lifestyle they deserve" is often used as a substitute.

Civilization would be intolerable brutish and awkward if every claim made by a speaker where challenged or if a requirement existed to supply proof.

Authority: The word authoritative is commonly used as a synonym for believable. Authority refers to the privilege of using the resources of an organization or group, including the public trust. Authority can be earned, bestowed, or purchased.

When audiences resist what is being presented, the problem is often one of whether the speaker is authorized the give the message rather a difficulty with the message itself. It is common practice in public hearings for individuals approaching the microphone to state their name and identify their authority for speaking. In congress this formula is still retained when the floor is given to "the Representative from the state of Georgia" rather than to a named individual. Similarly at the local level the chair calls for the "treasurer's report." The introduction of a speaker at a continuing education course or any other public situation would hardly count as an introduction unless it enumerated the speaker's claims to authority. It is also becoming appropriate practice to require that CE speakers and journal authors disclose any interests that might conflict with their status as an independent authority on the topic—"a kind of compromised authority."

Authority can be earned by experience and expertise, as for example by respected clinicians or researchers, or by senior statesmen in the political arena. Authority can also be bestowed for defined periods of time such as ad-

junct faculty appointments or election to an office in an organization. Every president understands that his or her views carry more weight when in office then they did before or do after. Universities must be careful in bestowing authority on adjunct faculty because the status can become diluted; and adjunct faculty must be ethical in publicizing their authority, especially when it has terminated. Scientific organizations bestow limited authority by inviting speakers and by sponsoring juried presentations. Journals bestow authority through the peer review process—although some confusion remains whether reviewers are peers of the authors or peers of the readers.

Authority can be "purchased" in the sense of being acquired by the efforts of the speaker that are unrelated to his or her qualifications to speak.

Finally, authority can be "purchased" in the sense of being acquired by the efforts of the speaker that are unrelated to his or her qualifications to speak. Who's Who, self publication, and membership in academies whose purpose it is to elevate the interests of members are among the most conspicuous of examples. Subtle efforts to "borrow" authority include dressing, acting, and inquiring the personal artifacts of authoritative individuals. There is always tension between those who have earned authority are those who have it to bestow and those who seek to borrow it. Advertising is just such an example. Patients and the public at large seem to have little problem with professional advertising. The objection comes from professionals themselves and the realizations that professionals who purchase authority through advertising erode the professional hierarchy of earned authority and the control the organized profession has over its members through its ability to bestow authority.

Collegiality: There is an important association between credibility and collegiality—we want to believe people whom we feel are like ourselves. Colleagues are individuals engaged in parallel performance; they share the same goals and the same methods of accomplishing them even though they do not work together directly as a team. The rules for communication among colleagues are primarily a matter of identifying a group of individuals who are trustworthy.

There is a ritual that can be observed when colleagues who are strangers meet each other. It is a strange mix of professional courtesy and cynical references to those who are not present. In dentistry there is a little testing on managed care, some controversial figures on the CE circuit, maybe some discussion of practice style, and if the potential colleague still seems to have the proper values, a little testing on controversial legislation or philosophies of practice. We don't trust those who skip the social hour and arrive just as the meeting starts and thus deprive us of the chance to conduct our probing. Colleagues are very conscience of the line between "us and them."

Audiences implicitly understand that every speaker has feet of clay; they expect, however, speakers to wear polished shoes.

The relationship between an actor and the audience is heavily dependent on whether the audience contains colleagues or not. In order to maintain credibility with a non-colleague audience, speakers repeat their performance frequently before different audiences. They are reluctant to give the same performance over again to the same group. Professionals in serving their clients, customer, and patients demonstrate this principle. Colleagues speaking to non-colleagues also frequently pick their audience and prefer situations where the audience cannot respond. Nurses prefer to work with children or in the operating room for this reason. Pseudo-professionals such as real estate agents and accountants strive for professional recognition because this status permits them to claim an exclusive right that only they can judge the performance of their colleagues. The device for bringing dinner from the kitchen to the dinning room known as a dumb waiter was invented in the nineteenth century to relieve the upper crust of society from the burden of having to guard their language in front of their domestic service. The word "dumb" is not a reference to intelligence but marks instead an inability to speak.

Issues of credibility among colleagues are more sensitive than problems of believability generally. Group membership based on a common future and common methods is considered sufficient warrant for the veracity of most colleagues' statements. The confidence man, the colleague who sells out, the one who reveals the secrets of the profession to patients or the public, the one who plays by a personal sense of integrity rather than agreed professional ethics are large threats. It is not so much a matter that they have fooled their colleagues into believing something the colleagues

later found unbelievable, it is that they have shown that collegiality itself can be counterfeited. It is for this reason that colleagues are often tested and teased, probed to see if they can stand up under pressures and probed to see if they will take the professional line over other reasonable interpretations. Perhaps, initial licensure examinations are just such a form of hazing. The breaking of collegiality is also behind the strong reaction of organized dentistry to publication in *Readers' Digest* of a few cases of wide variation in treatment planning among dentists when equally wide variation has been published in the scientific dental literature for years before.

Performance: My college graduation speaker was Adlai Stevenson. The opening remarks of his address went something like this: "On this important occasion, we are each expected to perform a prescribed role. My job is to speak; and yours is to listen. I hope we each finish our work at approximately at the same time."

There is a school of thought, which might be labeled the dramatological approach to credibility, that grounds believability in the joint performance of the speaker and the listener. There are rules for communication situations such as always stay in character, make it easy for the audience to play its part, slightly exaggerate formality, and even smile and be somewhat ambiguous when making a claim that could be challenged. A fundamental rule in this approach is that civilization would be intolerable, brutish, and cold if every claim made by a speaker where challenged or if a requirement existed to supply proof. To get on with our social life we make an agreement that individuals will be credited as being whomever they say they are unless there is dramatic proof to the contrary. "Dramatic" in this sense means that they are bad actors and violate the conventions of communication situations. When this occurs it is not so much a matter of disbelief in what the speaker says but a disqualification of the speaker from representing himself or herself as an authority on the subject.

Future examples of such dramatological rules include the obligation to inform the audience, or in some cases negotiate with the audiences, a common understanding of the meeting. Another is the agreement that what goes on behind the scenes, the "backstage" actions will not be allowed to intrude in the performance. Yet another requirement is that the actor cannot simultaneously represent two groups. This is part of what lies behind the ethical issues of disclosure of self interests or conflict of interest. Actors are expected to create an appropriate distance between themselves and their audiences. Even one's best friend is expected to assume some formality when giving a presentation at a component dental society meeting for example. Symbols of office, titles, physical separation in a group, and limited contact are all part of this process of establishing credibility. In addition to this mystification, believable speakers are expected to idealize their performance. Some of the common techniques expected include conveying a sense of duty as the reason for speaking and concealing any personal satisfaction one may get, creating a sense of infallibility or perfection by removing all errors prior to the performance and then removing all evidence that the errors had been corrected, presenting only the polished results of work rather than the trial and error that went into producing it, hiding any signs that the work reported involved unpleasant or semi-illegal or degrading activities, and finally, concealing the need to make any trade-offs. In both mystification and idealization the sin is failing to learn and meet the expectations of the audience. Audiences implicitly understand that every speaker has feet of clay; they expect, however, speakers to wear polished shoes. These expectations hold for both speakers of questionable repute and motive and for the most revered and professional presenters. Lost of credibility is a matter of being a "bad actor" in both the literal as well as the figurative sense of that phrase.

Loss of credibility is a matter of being a "bad actor" in both the literal as well as the figurative sense of that phrase.

A case in point is the famous Dr. Fox lectures. Years ago, a Hollywood actor was coached to present a continuing education program for physicians. He was judged more creditable than his counterpart, a true expert. In a second experiment the dramatologically correct but content thin Dr. Fox turned out to be a more effective communicator than the expert based on tests of factual knowledge given to the audience following both presentations.

There is something even deeper at stake than believability in the performance approach being discussed here. The word "person" comes from the same root as the word for mask. In a very real sense, our personality is defined by the relationships we have with others. We are whomever we want to be as long as others will accept us at "face value."

Recommended Reading

Brown, R. (1965). Social Psychology. *New York: The Free Press.*

Fine summary of social psychology from the academic point of view. Chapter 11 is entitled "The Principle of Consistency in Attitude Change."

Festinger, L. (1957). A theory of cognitive dissonance. *New York, NY: Row, Peterson.*

Classic summary of research showing that our beliefs and behavior are constantly being reconciled, dissonance is being resolved, to protect our image of ourselves from the discomfort of inconsistency.

** Goffman, Erving (1959).* The presentation of self in everyday life. *Garden City, NY: Doubleday Anchor. 260 pages; $2.50 at time of publication in paper.*

Human interaction is governed by rules that relate the performer or the performing team to the audience. In addition to the content of performances there is a context that must be managed, often through the mutual good intentions of both audience and performer. Discussed are the rules of creating an impression, interactions among members of a team making a presentation, the different rules for the "front"—where the performance is presented—and the "back"—where it is prepared, role expectations and conflict, what happens when someone is "out of character," and the management of impressions to remain in role. Goffman argues in the end that the "self" we work so hard to present is as real as the self we think wears the mask.

Janis, I. L. & Feshbach, S. (1954). Effects of fear-arousing communications. Journal of Abnormal and Social Psychology, 48, *78.*

Both high fear-arousing and low fear-arousing messages about oral hygiene produced small behavioral and attitude change among adolescents compared to a mildly fear-arousing message. It is believed that the high fear message exceeded the Rule of the Reasonable Reach while the low stress message did not call for any reach.

Naftulin, D. H., Ware, J. E., & Donnelly, F. A. (1973). The Doctor Fox lecture: a paradigm of educational seduction. Journal of Medical Education, 48, *630-635.*

A Hollywood actor was coached in a medical topic about which he knew nothing and compared to a true subject expert when presenting a CE course. The actor was judged more authoritative and credible. Subsequent research by the same authors revealed that the actor also produced larger gain scores in knowledge among the audience.

** Nierenberg, Gerard I. (1975)* How to give and receive advice. *New York, NY: Pocket Book. ISBN 671-80204-6; 192 pages; price unknown.*

Less a book about how to give advice than one that shares the personal wisdom of the author. Mostly stories and jokes that illustrate general points. Nierenberg is a lawyer and author.

** Tannen, Deborah (1990).* You just don't understand: Women and men in conversation. *New York, NY: Ballantine. ISBN 0-345-37205-0; 330 pages; about $10.*

Men are oriented toward status; women seek affiliation, and their communication styles reflect these different motivations. This explains why miscommunication is likely. "Intimacy is key in a world of connection where individuals negotiate complex networks of friendship, minimize differences, try to reach consensus, and avoid the appearance of superiority, which would highlight differences. In a world of status, independence is key, because a primary means of establishing status is to tell others what to do, and taking orders is a marker of low status. Though all humans need both intimacy and independence, women tend to focus on the first and men on the second."

Editor's Note

Summaries are available for the three recommended readings preceded by an asterisk (*). Each is about four pages long and conveys both the tone and content of the book through extensive quotations. These summaries are designed for busy readers who want the essence of these references in fifteen minutes rather than five hours. Summaries are available from the ACD Executive Office in Gaithersburg. A donation to the ACD Foundation of $15 is suggested for the set of summaries on credibility; a donation of $50 would bring you summaries of all the 1999 leadership topics.

The Manuscript Referee Process

Four unsolicited manuscripts were considered for possible publication during 1999 in the *Journal of the American College of Dentists*. All were acceptable in terms of format. Of the four send for peer review, three (75%) were accepted for publication, some pending revisions.

Sixteen reviews were received, 4.0 per manuscript. Seventy-three percent of the reviews who expressed a clear view were consistent with the final decision regarding publication. Cramer's V statistic, a measure of consistency of ratings was .431. A V-value of 0.0 represents random agreement and 1.0 represents perfect concordance. There is no way of comparing the consistency of the reviews for this journal with agreement among other reviewers because it is not customary for others to report these statistics. 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 reviewers as a means of improving calibration.

Original articles appearing in the Journal this year have been reprinted by permission in *Dental Economics*, the Oregon Dental Association's *Membership Matters*, and the *Bulletin of the Medical Library Association*. Permission was also given for two articles to appear on web pages.

The College thanks the following professionals for their contribution to the dental literature as reviewers for the *Journal of the American College of Dentists* during 1999:

Daniel Boston, DMD, FACD
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Statement of Ownership and Circulation

The *Journal of the American College of Dentists* is published quarterly by the American College of Dentists, 839 Quince Orchard Boulevard, Suite J, Gaithersburg, Maryland 20878-1614. Editor: David W. Chambers, EdM, MBA, PhD.

The American College of Dentists is a non-profit organization with no capital stock and no known bondholders, mortgages, or other security holders. The average number of readers of each issue produced during the past twelve months was 5,375, none sold through dealers or carriers, street vendors, or counter sales; 5,087 copies distributed through mail subscriptions; 5,087 total paid circulation; 133 distributed as complimentary copies. Statement filed with the U.S. Postal Service, October 25, 1999.

1999 Authors

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Beginning in 1995 the journal has published a column in each issue entitled "Leadership." The purpose of this department is to present introductions to various topics in psychology, business, sociology, and other social sciences to dentists whose education most likely emphasized the natural sciences. In each case the topic is applied to problems in dentistry and illustrated by dental examples.

A feature of the Leadership columns is an annotated bibliography of books, journal articles, and other references for readers whose curiosity is aroused by the topic. In each case, written summaries, running about four single-spaced, typewritten pages, are prepared for three of the references. These are available through the American College of Dentists' Executive Office in Gaithersburg. A donation to the ACD Foundation is suggested of $15 for the summaries on a single topic or $50 for the twelve summaries produced each year.

A listing of the issues discussed so far in the Leadership column appears below.

1995	Spring	Information (Not Time) is Money
	Summer	The Vision, the Voice, and the Values of a Leader
	Autumn	The Service Model
	Winter	The Learning Organization
1996	Spring	Brain
	Summer	Strategic Planning
	Autumn	The Clean Desk
	Winter	The First P—Product
1997	Spring	Holes in Our Heads—WNL
	Summer	Competition
	Autumn	Industry Competition
	Winter	How Groups Work
1998	Spring	Meetings
	Summer	Adding Value to Your Work
	Autumn	Tacit Knowledge
	Winter	How the Japanese Work
1999	Spring	Professional Development
	Summer	The Roles of Evidence and the Baseline in Dental Decision Making
	Autumn	Public Health and Its Enemies
	Winter	Credibility

Another service to the readers of the journal is a series of technical notes on statistics and research design that have been attached to data-based papers appearing since 1997. The purpose is to explain a single technical concept that played a key role in the articles which precede these "glossaries." In each case, the statistical or research design issue is explained in a straightforward manner and illustrated by an example from dental practice. These glossaries normally run four or five paragraphs in length. To date, the following glossaries have been published.

1997	Winter	Correlation Coefficients
		Multiple Correlation (R)
		Levels of Significance
1998	Autumn	Making Generalizations
		Scales of Measurement
1999	Autumn	Cross Sectional and Longitudinal Samples
		Chi-square
		Analysis of Variance (ANOVA)

[erratum]

The legend for the figure on page 30 of Volume 66, Number 2 issue of this journal was printed incompletely. The complete legend should read: "Conceptual Model of Clinical Decision Making (from [Gruppen, 1990], copyright by and reprinted with permission of the Medical Library Association)."

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