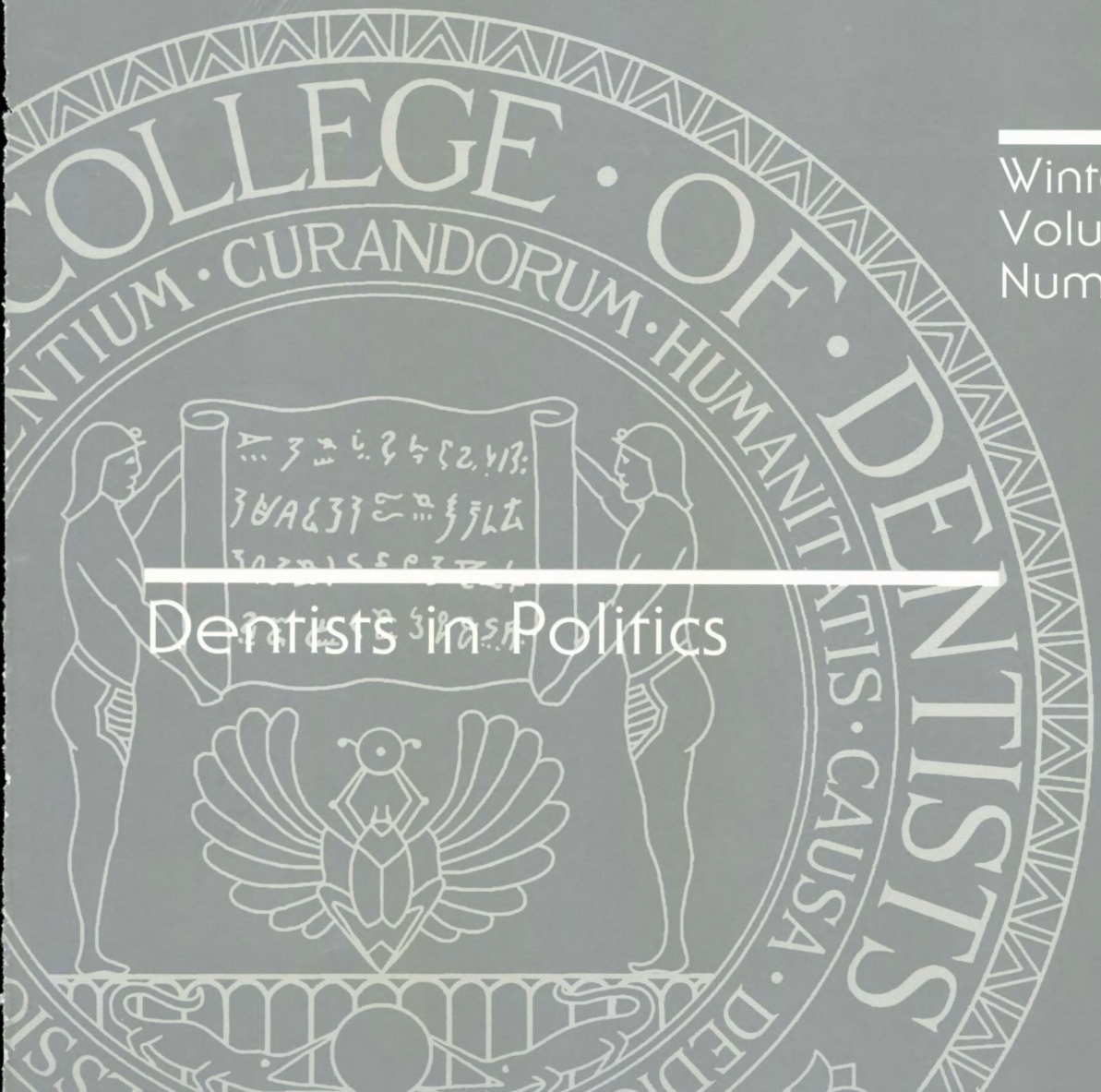
Journal of the American College of Dentists



Winter 2000
Volume 67
Number 4

Dentists in Politics

Journal of the American College of Dentists

A Publication Presenting Ideas, Advancements, and Opinions in Dentistry

The *Journal of the American College of Dentists* (ISSN 0002-7979) is published quarterly by the American College of Dentists, Inc., 839J Quince Orchard Boulevard, Gaithersburg, MD 20878-1614. Periodicals postage paid at Gaithersburg, MD.

Postmaster: Send address changes to:
Managing Editor
Journal of the American College of Dentists
839J Quince Orchard Boulevard
Gaithersburg, MD 20878-1614.

The 2000 subscription rate for members of the American College of Dentists is $30 included in the annual membership dues. The 2000 subscription rate for nonmembers in the U.S., Canada and Mexico is $40. All other countries are $50. Foreign optional air mail service is an additional $10.
Single copy orders: $10.

All claims for undelivered/not received issues must be made within 90 (ninety) days. If claim is made after this time period, it will not be honored.

For bibliographic references, the *Journal* is abbreviated J Am Coll Dent and should be followed by the year, volume, number, and page. The reference for this issue is J Am Coll Dent 2000; 67(4):1-56.

Publication Member of the American Association of Dental Editors

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.

Correspondence relating to the *Journal* should be addressed to the Editor:
American College of Dentists
839J Quince Orchard Boulevard,
Gaithersburg, MD 20878-1614

The business office of the *Journal of the American College of Dentists* can be reached by:

Phone: (301) 977-3223
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2000 ACD Annual Meeting

Issues in Dental Ethics

Departments

FROM THE EDITOR

Above All, Check Your References

Multiple choice:

Which of the following admonitions is NOT found in the Hippocratic Oath?

a. Above all, cause no harm
b. Do not perform abortions
c. Do not perform surgery for bladder stones
d. Give money to your school

About a third of the words in the oath address the obligation to share knowledge with students and other professionals (without fee).

The oath, now about twenty-five hundred years in use, is surprisingly modern. Abortion and physician-assisted suicide are specifically prohibited, as is any dalliance with patients or members of patients' households. Confidentiality of information revealed by patients is insisted on, even none-medical information. The second alternative is not the correct answer.

"I will not use the knife, not even, verily, on sufferers from stone, but I will give place to such as are craftsmen therein." If you chose "c" you missed this one. The exact meaning of this prohibition has been debated. Some have said this is secret language referring to castrations; others have argued that the oath discourages surgery generally. Both views are difficult to defend, the latter because specific instructions are given in other places in the Hippocratic Corpus for a variety of surgical techniques. Generally, physicians in the Hippocratic tradition place heavy emphasis on diagnosis, understanding disease patterns, and working with the body's natural defenses. Hippocratic healers would feel comfortable with emerging approaches to caries management.

We're down to 50:50, and you had better be giving money to your dental school. About a third of the words in the oath address the obligation to share knowledge with students and other professionals (without fee) and to support the community in which one's professional skills were acquired. These exhortations are found immediately following the invocation, so it would be fair to say, "above all, support those who made your profession possible." It should be recalled that there were no medical schools or licensure systems as we know them today when the Hippocratic approach to medicine flourished. The function of the oath was to bind students and practitioners to the Hippocratic community.

So what of the famous dictum *primum non nocere*? Surely that says "above all cause no harm" about as plainly as can be. Yes, but that is Latin and is a gloss not continued in the oath. The sentence on which it is based has been translated by Sherwin Nuland in his book *Doctors* as "I will follow that system of regimen which, according to my ability and judgement, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous."

Three points can be made about this sentence. First, there is no "above all." The conjunction "kai" is simply the English word "and." Second, there are two parts to the sentence and the weight seems to be on doing good. Finally, the sentence addresses judgement and intention, not consequences of action. Let's look at these in detail.

The primary goal of a health care provider cannot be avoidance of harm. The only way to ensure such an objective if it took precedence over all others would be to abstain from treatment altogether.

There are two ethical principles in the sentence we are examining. The first half of the sentence speaks to benefiting

the patient, the obligation to help others. This is the normative principle known as *beneficence*. The second half of the sentence speaks to the obligation not to intentionally harm patients. This norm is *nonmaleficence*. What the Hippocratic community is saying to its initiates is, "You will be given a powerful skill; use your power for good and not evil." Modern ethical theory sometimes waffles on beneficence. Some have argued that it is enough to avoid causing damage but there is no ethical imperative to seek to benefit patients. Healers in the Hippocratic tradition seem to be saying the opposite—avoiding harm is not good enough. If there is a preponderance of emphasis on one norm it is in favor of benefiting the patient.

Now for the hard one. Does the oath really say "cause no harm," even as a collateral goal? W. H. S. Jones, in the classic translation published by Harvard gives us "never with a view to injury and wrong-doing." In his essay on *The Doctor's Oath* published by Cambridge University, he offers two other translations: "I will never use it to injure or wrong them" and "I will keep away all treatment which is intended to cause injury or wrong." In all cases it is the intention (grounded in science and judgement as mentioned in the first part of the sentence) and not the outcome that counts. Jones has uncovered two historical Latin translations of the oath that are similar to the Greek version we have already discussed—no mention of *primum non nocere* there. There is also a Greek version, modified by removing references to Greek gods and thus suitable for Christians. This version omits entirely the second half of the sentence—it only requires that practitioners do good.

You will be given a powerful skill; use your power for good not evil.

Some will see no difference between "practice with the intention of helping patients and not hurting them" and the gloss "above all, cause no harm." The second is too limiting and negative for me. It leaves out the obligation to benefit the patient, it leaves out science and judgment, and it leaves out the intentions of the professional. One hears *primum non nocere* as an epithet some dentists throw against others whose treatment philosophies they disagree with and one hears it in malpractice trails. A close look at the Hippocratic Oath does not support either use. It is also a favorite to be woven into the title of editorials.

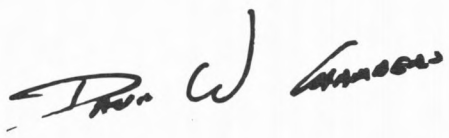
If there is a preponderance of emphasis on one norm it is in favor of benefiting the patient.

One more thought. The oath begins and ends with an appeal to the gods. The last sentence reads, "Now if I carry out this oath, and break it not, may I gain for ever ..."

Multiple choice, once again:
What does a practitioner pray for as a consequence of adhering to the Hippocratic Oath?

a. Big bucks
b. Great skill
c. Power and influence
d. Respect

Hint: it isn't any of the first three.



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

Will You Accept This Responsibility?

ACD President-Elect's Address
October 13, 2000
Chicago, Illinois

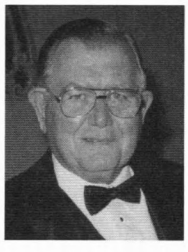
Richard E. Bradley, DDS, MS, FACD

During one's professional life I am sure we all have gained pleasure and satisfaction out of a number of experiences related to dentistry, but I must say that being associated with the ACD is and has been one of the most enjoyable and rewarding times of my professional career. To me the College embodies all the elements of what our profession was intended to be—one that puts the interest and well being of the patient first by insisting on ethical professional behavior, promoting leadership and emphasizing continued learning which in turn enables us to provide better care to those we serve.

As I think back, many of the persons who have enriched my professional and personal life have been active Fellows in the ACD and have carried its principles into their way of caring for their patients which was an inspiration to me. I have heard it said on occasion that the ACD is simply an honorary organization—not true! Not that we shouldn't be proud of our Fellows and promote their accomplishments, but ours is a history of action and all one needs to do is look at the multitude of projects that the ACD had been associated with over the years and you quickly realize that the ACD has been and is a vibrant, proactive organization that stands out as a major leader of our profession. It was the ACD that even in its infancy realized the importance of maintaining the foundation of dentistry by supporting dental education and emphasizing the importance of continued learning and by stressing ethical professional behavior through example and formal discussion. Those early founders of the ACD were people of vision who realized the profession needed an organization that would bring together those that were dedicated to upholding the true meaning of professionalism in the years to come. Unquestionably, the formation of the ACD in 1920 has proved to have had a significant impact in enhancing the way the dental profession regards its responsibilities and mission.

You quickly realize that the American College of Dentists has been and is a vibrant, pro-active organization that stands out as a major leader of our profession.

I congratulate you Fellows–Soon–to Be on what got you here—your leadership, integrity, service to the profession and your communities, and clear evidence of your ethical professional behavior. You represent the dental profession the way it was envisioned by the Founders of the ACD and your entry into the ACD is the first step in what I hope will lead you to becoming active in the projects of your Sections and Regencies. This is where the action has to be if we are to continue to fulfill our organizational mission. I also congratulate the existing Fellows for upholding the ideals of the College to the profession and providing the leadership that so positively effects the way dentistry is practiced through out its sphere of influ-



Dr. Bradley is Dean Emeritus of Baylor College of Dentistry and the University of Nebraska College of Dentistry. He lives at 6424 Crooked Creek Drive, Lincoln, NE 68516.

ence. I am so pleased to see the increasing activities of the Sections in all of the Regencies. During my tenure as a Regent on the Board I witnessed a resurgence of Section programs -- continuing education courses, ethics promotion in the dental schools, professional awards to graduating dental students, scholarship programs, and mentoring programs for students and colleagues to mention just a few. I continue to have a great deal of optimism about the future of dentistry. It plays such an important role in the comfort, health, and esthetics of our population that it will maintain its central role in health care, and I also believe that the ACD will go hand in hand with the profession in helping to assure its viability. The people who have served as your Section Officers, Regents, and national Officers have certainly strengthened my confidence in the leadership of the profession. They are constantly striving to face the important issues of the time and to make plans to address them and the future direction of the College, which in turn influences the profession as a whole. Our Founders and predecessors who directed and worked with the ACD were mindful of such responsibilities and historically took action in a number of ways to address them.

In 1958 a ninety-page document was produced by the ACD that listed suggestions for programs in continuing education that included graduate training, postgraduate instruction, internships and residencies, extension courses, seminars, study clubs, scientific meetings and literature. Also in 1958 the College became concerned about career guidance for college students and sponsored a study of freshman dental students to determine why they chose dentistry as a profession. The study resulted in a book entitled *The Dental Student* which outlined the motivational reasons behind student career decisions. The then ACD Committee on Financial Aid to Dental Education produced a booklet on "Suggestions for Fund Drives to Aid Dental Education" that probably influenced the initiation of "century clubs" in many of our dental schools in the nation.

I continue to have a great deal of optimism about the future of dentistry.

From the beginning the ACD was interested in promoting and supporting dental research and for many years had a standing committee on research which actually funded travel for dental researchers to visit one another as early as 1937, and it even pledged $25,000 from the reserve funds to support a variety of research efforts. That was a considerable amount during the depression era, and this was long before any federal funds were available for dental research. The list of past activities of the ACD goes on: promoting dental health care services to all segments of our society, especially the under served, reinforcing the role of dental auxiliaries and their importance in the overall picture of dental care, and of course continuing emphasis on professional behavior and leadership.

Another area that the ACD has supported through the years has been the history of dentistry and dental journalism. There was two very important activities that enhance our profession. Unfortunately dental history is not being addressed much anymore in the dental schools because of the overcrowded curriculum, which I think is a mistake because it is important to know where we came from in order to better chart a course for the future. I am however very pleased with the how the Journal of the ACD has addressed many of the current issues facing dentistry. It has made every effort to be open and fair in presenting both sides of a question with input from knowledgeable authors and with insightful editorials. And by the way it is now more widely read than ever.

Unquestionably, the formation of the American College of Dentists in 1920 has proved to have had a significant impact in enhancing the way the dental profession regards it's responsibilities and mission.

So as we enter this new century, it is obvious that many problems and issues still need to be addressed by the dental profession, and in turn by the ACD, in order to sustain our important role in the health care of the nation.

We need to continue to support dental education in efforts to incorporate an understanding of what professional ethics means and how important it is to the proper treatment of our patients. With the development of so many advances in technology, treatment procedures, and diagnostic improvements over-treatment is beginning to rear its ugly head in both medicine and dentistry. The College is painfully aware of certain trends in the behavior of some of our colleagues which results in both over-and under-treatment, in the increasing incidence of what is called the "provider effect" (that is, performing treatment that the dentist enjoys but not necessarily what the patients needs), in faulty insurance reporting, in being the spokesperson for certain types of dental products that have not been authenticated by valid research, and by performing procedures beyond dentistss training and ability. These behaviors therefore, among others, make it essential that we focus attention on ethics early in the career of the dentist. Fortunately, these behaviors are perpetrated by a relatively small percentage of our colleagues, but even so they create a problem not only for dentistry's image, but even more important is the negative effect it has on a patients' ability to ap-

prove the best course of treatment. So it is important that these behavior patterns be discussed not only in dental school but as a continuing concern of the practicing profession, and this is where the ACD can continue to take leadership in exerting the value and importance of ethics being taught in the dental school curriculum and reinforced throughout one's professional life through seminars and continuing education. The ACD has just published an "Ethics Handbook" which is an excellent guide for the profession and I hope all of you will read it and recommend it to your colleagues.

Dr. Gerry Timmons once appropriately said, "The dentist does not do full service to himself or his profession when he limits his knowledge to the present and ignores the visions of the future; when he is unaware of the counsel and experience which are available to him in the history and literature; when he is unwilling to accumulate facts and separate them from conjecture and opinion; when his sense of personal responsibility does not extend beyond his personal and provincial interests." These truisms therefore are of continuing concern to the College, and programs need to be in force to address them. The College needs to continue to encourage cooperation and study between medicine and dentistry—to work together in preventing and treating oral diseases. As we learn more about the significant influences of oral disease on the systemic health of our patients it is incumbent that this become an important priority to address by the entire dental profession. This isn't a new interest for the College for in 1934 the College had three committees working on medical-dental relations that resulted in recommendations for facilitating dental appointments to hospitals and for providing medical interns with courses in oral pathology and dental diagnosis.

The College needs to continue to encourage its mentoring by our Fellows to younger dentists. There was a time when this was widespread in our profession, but I fear it has lost some of its momentum. I recall how the established dentists in my community invited we younger practitioners to their offices to learn special techniques or to help in developing new skills. It seemed as if every locality had study clubs in about every area of dentistry. I appreciated this very much and at a time in my professional life when it was badly needed. So I hope there will be ways to renew such activities throughout the country and I would hope the Fellows of the College lead the way. Over the last few years the College has sponsored two Ethic Summit meetings that brought together all segments of the dental profession and has led to a permanent alliance that will continue to address the whole matter of ethics and professional behavior among the many components of our profession. This all came about because of a committee of the Board of Regents of the ACD and some far-sighted Fellows who saw the need for such a global approach to this issue. I think it has great promise for the future but will need continuing supervision and follow through.

We need to continue to support dental education in it's efforts to incorporate an understanding of what professional ethics means.

We have a proud history of working with our professional counterparts for the betterment of the profession.

All of the things that I have touched on in one way or another have implications for the future activities of the American College of Dentists. I know we can meet the challenge. As active practitioners and educators you are on the cutting edge of dentistry and know the problems and issues first hand that are current and important which the College may be able to address. While the College has obvious limitations and scarce resources it can be selective and prioritize issues for action. Please let us hear from you if you have suggestions for action by the College. I am sure the ACD will continue to be expected to take the lead in addressing the many issues that are inevitably going to arise in the years ahead, and within the limits of our resources we need to be able to respond with timely action and vision. We have a proud history of working with our professional counterparts for the betterment of the profession, and I look forward to those associations continuing long into the future.

Our Executive Director Dr. Ralls stays in close touch with the leadership of many dental organizations and works with them on issues of common interest. It's obvious that we have a talented, dedicated executive office staff, and we are all grateful to Dr. Ralls for his excellent leadership and devotion to the College. I also wish to congratulate Dr. Bob Ragan for his fine term as President of the College this past year and Dr. Jay McCaslin for his term as President of the Foundation, the Regents and David Chambers the Editor of the ACD Journal. They all have done remarkable job's!

In closing, let me reiterate that the College is you, and your active participation is what will make it stay vibrant and important to the future of the profession of dentistry. I am immensely honored and humbled to be taking office as your President and will do everything in my power to uphold the fine ideals and mission of the American College of Dentists. Thank you.

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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 2000 class of Fellows...

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Lubbock, TX

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Dr. Judson M. Knight
Lexington, KY

Dr. James S. Knight
Charleston, SC

Dr. Sreenivas Koka
Lincoln, NE

Dr. Kenneth E. Kolz
Simi Valley, CA

Dr. Gerard F. Koorbusch
Bismark, ND

Dr. Howard E. Kossoff
Solon, OH

Dr. John G. Kostohryz
Dallas, TX

Dr. Robert T. Kramer
Harrisburg, PA

Dr. Jennifer R. Kugar
Indianapolis, IN

Dr. Estel L. Landreth
Wichita, KS

Dr. Timothy M. Lane
Altamonte Springs, FL

Dr. Randy T. Lang
Mississauga, Ontario

Sandra S. Larson
Lincoln, NE

Dr. David A. Lasheen
Versailles, KY

Dr. Norman J. Layton
Truro, Nova Scotia

Dr. Richard J. Lazzara
West Palm Beach, FL

Dr. Richard J. Leupold
Annapolis, MD

Dr. Guy G. Levy
Newport News, VA

Dr. Lewis S. Libby
Towson, MD

Dr. Louie R. Limchayseng
Novato, CA

Dr. Mark W. Lingen
Maywood, IL

Dr. Charles D. Llano
Lakeland, FL

Dr. Barry L. Loffredo
Schenectady, NY

Dr. Mark A. Logeman
Cincinnati, OH

Dr. William R. Long
Indianapolis, IN

Dr. Paul E. Lovdahl
Bellingham, WA

Dr. Larry W. Loveridge
Kennewick, WA

Dr. Gary R. MacDonald
Mount Pearl, New Foundland

Dr. David S. Mallory
Loudonville, OH

Dr. Earl A. Marsan
New York, NY

Dr. Steven D. Marshall
Buffalo Grove, IL

Dr. Joseph A. Mastromatteo
Lake Orion, MI

Dr. Austin W. Maxwell
Bethesda, MD

Dr. Gerald W. McClellan
Costa Mesa, CA

Dr. Timothy I. McConnell
Goose Creek, SC

Dr. James E. McIlwain
Tampa, FL

Dr. John S. McIntyre
Brooklyn, NY

Dr. Byron M. McKnight
Mesquite, TX

Dr. Albert F. McMullen III
Monroe, LA

Dr. Evelyn D. McNee
Vancouver, British Columbia

Dr. Vincent W. Meng
Missoula, MT

Dr. Patricia K. Meredith
Iowa City, IA

Dr. Helen M. Middlebrook
Halifax, Nova Scotia

Dr. Michael E. Miller
Richmond, VA

Dr. Robert C. Miller
Oklahoma City, OK

Dr. Kenneth O. Miller
Indianapolis, IN

Dr. Richard Monahan
Chicago, IL

Dr. Bonnie J. Morehead
Manteca, CA

Dr. Fabienne J. Morgan
Grafton, VA

Dr. Dwight A. Morris
Memphis, TN

Dr. Edwin L. Morris
Baltimore, MD

Dr. Nicholas G. Mosca
Jackson, MS

Dr. Richard A. Moselle
Culver City, CA

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Carrollton, GA

Dr. Aleida G.M. Moss-Salentijn
New York, NY

Dr. Robert J. Mostovoy
San Francisco, CA

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Newark, NJ

Dr. Frederick L. Nance
Chapel Hill, NC

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Brandon, MS

Dr. Matthew J. Neary
New York, NY

Dr. Ken A. Neuman
Vancouver British Columbia

Dr. Kathleen M. Nichols
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Petersburg, VA

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Akron, OH

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Shoreham, NY

Dr. Phillip R. Parker
Norman, OK

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Mesquite, TX

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Manassas, VA

Dr. Arnold H. Peck
Cincinnati, OH

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Winter Park, FL

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Lynn, MA

Dr. Timothy R. Perry
Monroe, LA

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Irving, TX

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Moorestown, NJ

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Waterford, MI

Dr. Craig A. Pettengill
San Jose, CA

Dr. Floid Gary Pfleeger
Lafayette, IN

Dr. Rawle Fabian Philbert
Bronx, NY

Dr. Robert L. Phillips
Oklahoma City, OK

Dr. Gerald S. Phipps
Spokane, WA

Dr. Jeffrey A. Platt
Indianapolis, IN

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North Chili, NY

Dr. William L. Pope
Sevierville, TN

Dr. Thomas C. Porter
St. Petersburg, FL

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Dupont, PA

Dr. Eleanor K. Pruitt
Jackson, MS

Dr. John C. Pryse
Clinton, TN

Dr. Franklin Pulver
Toronto, Ontario

Dr. Judith A. Purcell
Troy, NY

Dr. Charles G. Purifoy
Greenwood, MS

Dr. Thomas H. Raddall
Hunts Point, Nova Scotia

Dr. Aurelio B. Ramos, Jr.
Quezon City, Phillipines

Dr. Kathleen V. Rankin
Dallas, TX

Dr. John W. Rapley
Kansas City, MO

Dr. Michael S. Reddy
Birmingham, AL

Dr. Paul Reggiardo
Huntington Beach, CA

Dr. R. David Remaley
Roswell, GA

Dr. Joseph Renzi, Jr.
Santa Ana, CA

Dr. James H. Reynierson III
Martinez, GA

Dr. J. Darrell Rice
Petersburg, VA

Dr. Marlene K. Richardson
Campbellsville, KY

Dr. Adel Rizkalla
Falls Church, VA

Dr. Miriam R. Robbins
Baltimore, MD

Dr. William E. Rogers
Knoxville, TN

Dr. Mark A. Romer
Lauderhill, FL

Dr. David B. Rosenberg
Vero Beach, FL

Dr. Sylvia Ross
Detroit, MI

Dr. Jack S. Roth
New York, NY

Dr. Lawrence N. Rouff
Binghamton, NY

Dr. Budd E. Rubin
San Diego, CA

Dr. David R. Russell
Millersburg, PA

Dr. Donald M. Russell
Baltimore, MD

Dr. Mehdi Saber
Cranford, NJ

Dr. Karen Debra Sakuma
Kirkland, WA

Dr. Paul Lee Salisbury III
Winston-Salem, NC

Dr. Thomas G. Salmon, Jr.
Greenville, MS

Dr. D. Milton Salzer
Northbrook, IL

Dr. Michael G. Savage
Denver, CO

Dr. Kenneth L. Schenck, Jr.
Hixson, TN

Dr. Ronald P. Schmidt
Aurora, CO

Dr. Michael L. Scholtz
Singapore

Dr. George F. Schudy
Houston, TX

Dr. Carl W. Schulter
Memphis, TN

Dr. Eli Schwarz
Alexandria, VA

Dr. Jane K. Segal
Pittsburgh, PA

Dr. Samuel E. Selcher
Middletown, PA

Dr. R. David Seldin
Newark, NJ

Dr. Doxey R. Sheldon
Frontenac, MO

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Cherry Hill, NJ

Dr. David M. Sibley
Waco, TX

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Baltimore, MD

Dr. Bryan M. Siegelman
York, PA

Dr. Donald O. Simley II
Madison, WI

Dr. Manjit Singh
New Delhi, India

Dr. Annie Chin Siu
Alhambra, CA

Dr. Walter D. Skinner III
Auburn, CA

Dr. Lloyd J. Skuba
Edmonton, Alberta

Dr. Cynthia K. Slack
Rochester, NY

Dr. Gary W. Smagalski
Petaluma, CA

Dr. Douglas B. Smail
Troy, NY

Dr. Neil J. Small
Fairfax, VA

Dr. Michael T. Smith
Tipton, IN

Dr. John B. Snively
Missoula, MT

Dr. Mark B. Snyder
Philadelphia, PA

Dr. George Mane SooHoo
Norwalk, CA

Dr. Campbell M. Sowell, Jr.
Columbia, TN

Dr. Michael D. Spencer
Jacksonville, FL

Dr. James E. Springborn
Appleton, WI

Dr. Frederick L. Sputh
Lafayette, IN

Dr. Douglas L. Starkey
West Palm Beach, FL

Dr. Matthew Steinberg
Austin, TX

Dr. Peter Stevenson-Moore
Vancouver, British Columbia

Dr. Howard R. Strauss
Cumberland, MD

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Lexington, TN

Dr. Curry Dale Sullivan
Nashville, TN

Dr. Thomas E. Sullivan
Westchester, IL

Dr. Lee B. Swearingen
East Liverpool, OH

Dr. Timothy P. Sweet
North Syracuse, NY

Dr. David J. Sweet
Vancouver, British Columbia

Dr. Cyrus Tahmasebi
La Jolla, CA

Dr. Richard L. Taliaferro
Stephens City, VA

Dr. Margaret Ann Tapia-Quiller
Fort Collins, CO

Dr. Thomas E. Tate
La Canada, CA

Dr. Richard M. Tempero
Omaha, NE

Dr. David A. Tesini
Natick, MA

Dr. Paul N. Tolmie
Charlotte, NC

Dr. Bradford M. Towne
Berlin, VT

Dr. Raina Trilokekar
Lexington, MA

Dr. Sharon P. Turner
Portland, OR

Dr. Robert E. Turner
Port Hueneme, CA

Dr. Richard D. Udin
Los Angeles, CA

Dr. John Michael Urcioli
Suffern, NY

Dr. James E. Valentine
Fairmont, WV

Dr. Joseph E. Van Sickels
Lexington, KY

Dr. Thomas J. Veryser
Plymouth, MI

Dr. Timothy E. Wandell
Hoquiam, WA

Dr. Blake E. Wayman
El Paso, TX

Dr. Margaret A. Webb
Vancouver, British Columbia

Dr. Arnold I. Weiss
Brookline, MA

Dr. Richard C. Weiss
Philadelphia, PA

Dr. Wavel L. Wells
Lawton, OK

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Memphis, TN

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Wellesley, MA

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Seattle, WA

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Lilburn, GA

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Tucson, AZ

Dr. Alan M. Winik
Flushing, NY

Dr. Alan A. Winter
New York, NY

Dr. Michael A. Wiseman
Kirkland, Quebec

Dr. Gary Wiser
Perrineville, NJ

Dr. Andrew T. Wood
Albany, NY

Dr. Roger E. Wood
Midlothian, VA

Dr. William H. Wood
Council Bluffs, IA

Dr. Douglas F. Wright
Amherst, NY

Dr. Douglas A. Wyckoff
Cameron, MO

Dr. Roger M. Yamashiro
Torrance, CA

Dr. Craig S. Yarborough
San Francisco, CA

Dr. Mira Yasinovsky
Mexico City, Mexico

Dr. Michael Zakula
Hibbing, MN

Dr. Thomas G. Zarger, Jr.
Knoxville, TN

Profiles in Professionalism: 2000 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.

The highest honor the College can bestow upon a Fellow is the William John Gies Award. This award recognizes Fellows who have made exceptional contributions to advancing the profession and society. This year's recipient is **James Burrows Edwards, DDS**.

Dr. Edwards is a board certified oral and maxillofacial surgeon. He graduated from the College of Charleston in 1950, and in 1955 he graduated with honors from the University of Louisville, School of Dentistry. While at Louisville, Dr. Edwards served as student body president. He attended the Graduate Medical School of the University of Pennsylvania from 1957 to 1958 and in 1960 he completed a two-year residency in Oral and Maxillofacial Surgery at the Henry Ford Hospital, Detroit, Michigan.

Dr. Edwards served in the U.S. Maritime Service from 1944-1947, becoming a ship's officer at the age of ninetesen. After completing his professional training, he served two years in the U.S. Navy as a dental officer, rising to the rank of Lieutenant Commander. He practiced oral and maxillofacial surgery in his home town of Charleston from 1960-1974.

Dr. Edwards served as Chairman of the Charleston County Republican Party from 1964 to 1969 and as Chairman of the First Congressional District Republican Committee from 1970-1971. In 1971, he resigned to run unsuccessfully, as the first Republican candidate for the U.S. House of Representatives from the First Congressional District. He was elected to the South Carolina State Senate in 1972, serving until he was sworn in as Governor in 1975. When he was elected Governor, he was the first Republican to hold that office in South Carolina since the Reconstruction Era. In January 1981, Dr. Edwards was chosen by President Ronald Reagan to serve as Secretary of the U.S. Department of Energy. He resigned that post on November 5, 1982 to become President of the Medical University of South Carolina. He retired from the presidency on January 1, 2000 after seventeen years of service.

Dr. Edwards is a member of numerous professional and civic organizations. He has received eleven honorary degrees and he has served on fourteen corporate and three foundation boards.

Honorary Fellowship

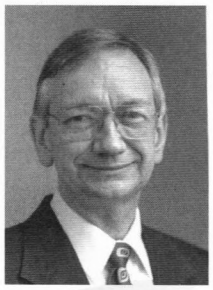
The ACD confers Honorary Fellowship upon persons who are not members of the dental profession, but have made outstanding contributions to the advancement of the profession and its service to the public. These contributions may be in education, research, administration, public service, public health,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

Honorary Fellowship is awarded to individuals who do not hold a dental degree, but have significantly advanced the profession or oral health and have shown exceptional leadership in areas such as education, research, public health, administration,

public service, or related fields of health care. This is the highest honor the College bestows on non-dentists. This year's recipients are **Mae Mun Hom**, **David T. Ozar, PhD,** and **George K. Stookey, PhD**.

Mae Mun Hom is a native of New York, receiving her Bachelor's degree in accounting from Syracuse University. She later received her Master's degree in education from the University of Maryland. Ms. Hom is specially honored for twenty years of faithful and effective service as Controller for the American College of Dentists. In this capacity, Ms. Hom literally saved the College thousands of dollars through her astute and ever-vigilant stewardship of College financial resources. Ms. Hom's uncompromising dedication, unwavering standards, resourceful ideals, attention to detail, and driving personality were primary reasons for the development of the College's sound financial status. Ms. Hom has been directly involved with several landmark financial projects of the College. She has overseen implementation of investment policy, budget development, audit coordination, meeting planning, personnel management, and office financial management. During the early 1990s, she played an integral role in the College's "Campaign for the 90s" that raised $750,000 to purchase the current executive office suites.

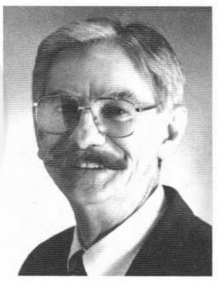
Ms. Hom can be credited with overseeing the meeting planning of annual meetings of the College and numerous other events. For each of these, she planned, negotiated, and coordinated directly with hotels, entertainment bureaus, audiovisual companies, and others to produce meetings that have long had a reputation for excellence. Before the onset a debilitating illness, Ms. Hom was an accomplished tennis player and vocalist, among other talents. She resides in Bethesda, Maryland, and has two sons.



Dr. David T. Ozar is a native of Ohio and received his Bachelor's degree from Loyola University of Chicago in 1965. He received his Master's degree from the same institution in 1968 and completed a PhD in 1974 from Yale University.

In 1975, Dr. Ozar initiated the Loyola Philosophy Department's undergraduate course in health care ethics that he has been teaching regularly ever since. In 1984 he designed the department's graduate program in Health Care Ethics which he directed for seven years and now co-directs. This program offers both a Master's degree in health care ethics, chiefly for clinicians, and a subspecialty in health care ethics for PhD students. Dr. Ozar is Professor and Co-director of graduate studies in Health Care Ethics in the Department of Philosophy at Loyola University of Chicago. More than forty students have received advanced degrees from these programs and another twenty are currently enrolled. Dr. Ozar has been a consultant to the American Dental Association and many other professional organizations, including the American College of Dentists. Fellows of the College will recognize Dr. David Ozar's name from frequent contributions to our LeaderSkills workshops, Ethics Summits, and College publications, among others.

Dr. Ozar has published more than sixty articles and book chapters in professional journals and books. He co-edited *Philosophical Issues in Human Rights: Theories and Applications*, and co-authored *Dental Ethics at Chairside: Professional Principles and Practical Applications*. He has two books and several articles in preparation. Dr. Ozar was founder and first president of the Professional Ethics in Dentistry Network and he serves as Associate Editor of the "Issues in Dental Ethics" section of the *Journal of the American College of Dentists*. Through his expertise in dental and health care ethics and his dedication to promoting ethics, Dr. Ozar continues to contribute to the positive image of the dental profession.



Dr. George K. Stookey, a native of Indiana, attended Indiana University where he received a Bachelor's degree in chemistry in 1957. He then attended the Indiana University School of Dentistry, where he received his Master's degree in preventive dentistry in 1962 and a doctorate in dental sciences and biochemistry in 1971. A member of the faculty since 1964, he was promoted to full professor in 1978 and served as Director of the Oral Health Research Institute from 1981 to 1999. Dr. Stookey also served as Associate Dean for Research from 1987 to 1996 and as Acting Dean of the School of Dentistry during 1996. He was appointed to his present positions as Associate Dean for Academic Affairs in 1997, as Executive Associate Dean in 1998, and as Associate Director for Exploratory Research of the Oral Health Research Institute in 1999. In 1998, Indiana University conferred Dr. Stookey with the rank of Distinguished Professor of Preventive Dentistry.

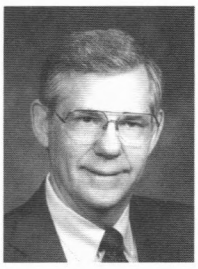
An active researcher, his main interests have been focused on fluoride pharmacology, the use of fluoride to prevent dental caries, and measures of calculus prevention. Dr. Stookey is a world authority on dental caries and fluoride. He is the author of more than 235 publications in scientific journals, 250 presentations at scientific meetings and contributions to more than twenty textbooks. Dr. Stookey is the recipient of numerous honors and awards, including the Maynard K. Hine Award and the Special Service Award from the Indiana Dental Association;

the Meritorious Award from the American Dental Association; and the Distinguished Faculty Award and the Special Service Award from Indiana University School of Dentistry Alumni Association.

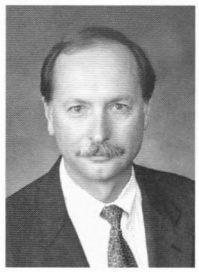
Award of Merit

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.

The Award of Merit recognizes oustanding efforts of non-dentists in roles that support the dental profession and enhance the profession's mission and service to society. This year's recipients are **Bob D. Berry, CAE** and **C. Jay Brown.**



Bob D. Berry, CAE, reared in rural Oklahoma, was an All-State football player in Stephen County and attended Southeastern State University in Durant where he majored in business and earned a Bachelor of Science degree. Following college, Mr. Berry worked with the Atoka County Industrial Association and managed the Wewoka Chamber of Commerce, where he was active in the Lions Club. In 1962 he became manager of the Duncan Chamber of Commerce, prior to becoming the Assistant Executive Director of the Tennessee Medical Association. In 1969 he was hired as Executive Director of the Oklahoma Dental Association and the Oklahoma Dental Foundation for Research and Education. His impact as Executive Director over the years has been significant. He was instrumental in getting Delta Dental of Oklahoma started and he has been a registered lobbyist for the Oklahoma Dental Association. Mr. Berry has been extremely active in professional and community affairs, especially in the American Society of Association Executives where he became the first dental executive in the United States to become a Certified Association Executive. He has served as President of the Oklahoma Society of Association Executives and served as the first Chairman and then President of the American Society of Constituent Executives. Mr. Berry received the 1992 Oklahoma Society of Association Executives Key Members Award and OSAE's highest award as Executive of the Year in 1994. He is an honorary member of the Oklahoma Dental Hygienist Association and the Oklahoma Dental Assistants Association. Mr. Berry has served the dental profession with dedication and distinction for thirty-one years.



C. Jay Brown attended Southern Illinois University where he received his Bachelor of Arts degree in psychology in 1972. He followed this with a Master of Public Health degree in 1976 from the University of Illinois School of Public Health. He began his professional career serving as both Director of the Department of Health Education and Environmental Health Specialist in Pekin, Illinois. Soon thereafter he assumed responsibilities as Coordinator of the Influenza Immunization Program in Wheaton, Illinois, and he was responsible for a county of one million people. In 1976 Mr. Brown became Assistant Director of the Department of House Staff Activities for the American Medical Association. His responsibilities included management of the Resident Physicians Section that nationally represents 22,000 residents in training. After three years with the AMA, Mr. Brown became Assistant Executive Director of the American Association of Oral and Maxillofacial Surgeons. In 1982, he assumed his current position as Executive Director, District of Columbia Dental Society. In this capacity Mr. Brown manages numerous programs, including newsletter and journal publications, legislative activities, continuing education, and the seventh largest dental meeting in the country, among other duties. When he took over, 40% of the society's budget was from member dues; today it is 20% and there have been no dues increases in ten years. He established a "for profit" subsidiary to enhance non-dues revenue. After years without an office, Mr. Brown managed the purchase of a building for the society that has helped greatly to control costs. In a model effort, he negotiated an agreement with the local water authorities to control mercury in wastewater and thus avoid changes in District statutes.

Along with his dedication to dentistry, he has also found time to become active in numerous civic endeavors. He initiated a program to provide dental volunteers and supplies to the Spanish Catholic Center. Mr. Brown also manages the distribution of toothbrushes to the indigent. His tireless efforts have greatly advanced dentistry and the dental profession in our nation's capital.

Politics for Dentists and Dentistry—A Grassroots View

Roger Triftshauser, DDS, MS, FACD

Abstract

A Regent of the College who is involved in county government explains how he became involved in local politics and why participation at this level matters.

We have recently witnessed a bitter, overtime, 2000 struggle for the White House that created a scene like no other in American history. An incredibly close count, determined by a razor thin margin, acclaimed the truest meaning of everyone's vote counting. Challenged to the hilt, our democratic system survived the election night reporting; tedious recounts; dimpled, pregnant, hanging chads; local, state, and federal courts; as well as the frantic mania of endless days and weeks of media coverage. If ever democracy was given the acid test, it was this election! The result final, the announcement proclaimed, the transition operations commissioned, now the healing, uniting, and governing process begins.

Lost in the maze of this election is the fact that many of our grassroots elections often have to reconcile ballots with numbers of people providing the arduous, hands-on task of recounting, viewing chads, and finalizing absentees. Because local politics does not command the national or international attention and coverage, the lay public for the most part never is aware of this.

After the dust has settled, after the winner and loser have congratulated and consoled one another, after the politics goes away, the fundamentals remain.

Grassroots is the key. Remember, all politics is local.

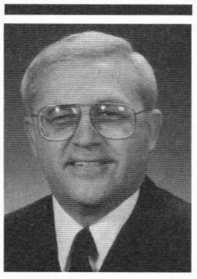
Many wonder why, after a grueling ordeal like this, anyone would choose to enter the political arena. The ensuing will focus on an answer.

The American Dental Association has taken the lead for the dental profession in addressing why we must become involved, what we must do, detailing a step-by-step procedure on how to carry out a clearly defined plan of action, while inspiring a call to duty, through a nationwide effort to organize Grassroots Action Teams. Created in 1994, this action plan was established in response to the threats that were part of health system reform efforts of that time.

"Dentistry: Healthcare that Works" is being perpetuated through our profession's unending desire to become involved at our local level through political involvement. Dentists have that special opportunity to take the time and make the effort to become involved, since we can control our own schedules, to embrace our profession's destiny.

In the local, state, and national arena of dental political action, our component and constituent dental societies participate through our Councils on Governmental Affairs to advance dentistry's voice. These councils address governmental issues and concerns impacting dentistry and identify and explain legislative and regulatory actions which impact our profession.

Dentistry's future is dependent on strengthening working relationships with representatives of Congress, state legislatures, and a host of regulatory and administrative agencies. We must readjust



Dr. Triftshauser is a practicing orthodontist in New York and the Vice President of the American College of Dentists.

our political and legislative strategies to reflect new realities to frame the future for the way we practice.

Understanding Politics

Politics generally has often been denigrated with accusations of unethical behavior, double-talk, compromise, and being aloof or out of touch. Dentists further hear concerns that their practices will suffer if they become involved. While this portrayal runs rampant, as witnessed by the usual low turnout at the polls, we must never give up our aspirations to perpetuate our inalienable right to promulgate our democratic way, the driving force of America.

Our changing political environment has, over the more recent years, seen an increasingly activist role assumed by government at all levels. Everyone seems to be getting into the act, opening the system to greater access to the decision-making process. It is becoming evermore evident that political party influences may be wanting, as demonstrated by the Independence Party election of Minnesota Governor Jesse Ventura and the impact of Ralph Nader's Green Party on the presidential elections. Candidates are more likely to raise their own money, committee chairs do not have the influence over members of committees, and thus individuals are defining their own issues.

Political Action Committees (PACs) are having greater influence, with special interest groups exercising their rights through PACs to assist candidates who share their concerns and interests. There has been a genuine explosion in number, type, and activity of special interest groups in Washington and in our state capitals. Their multiplicity and diversity is changing our political environment.

Since our legislative and political process operates in a highly competitive, special-interest fashion, we can be players in the system as individuals who not only vote, but actively compete within the political and policy-making arena. Alternatively, we can be "victims" of the system. We must take a proactive approach to the legislative process. Grassroots is the key. Remember, all politics is local.

Many dentists are or have been involved in politics in some manner, however, it is imperative to continually reinforce entries to that involvement, including but not limited to the following:

- Use your natural connections as a relative, personal friend, or dentist of representatives, working on their campaigns, gaining their respect and their ear. Ultimately, the future of sdental care will be significantly influenced in the political arena.
- Set up local meetings, civic functions, service club addresses, office visitations, dental study club functions, and social affairs to assist your representatives in getting to know their constituencies.
- Get to know your representatives' staff, directors, administrative assistants, appointment secretaries, legislative assistants (especially those concerned with health care) and work endlessly with them. Staff members are the conduit for all activities, such as researching requests, addressing the representative's issues and concerns, and helping formulate and implement plans and policies.
- Help your representatives understand the issues. They can not "know all" on every issue, since there are volumes of issues to be addressed. They

Genesee County Mission Statement

"The legitimate objective of government is to do for a com - munity of people whatever they need to have done, but cannot do <u>at all</u> in separate and individual capacities." Professed by Abraham Lincoln.

To this end,

- Genesee County government promotes the basic health, safety, and welfare for all citizens within its jurisdiction.
- Genesee County government actively promotes a strong, diverse economic base and efficient services to create a quality of life which values our county as a desirable place to work and live.
- Genesee County government focuses on a vision of a future which clarifies its role, represents the citizens, and respects its heritage.
- Genesee County government is committed to an environment of cooperation, integrity, and open - ness, with a desire to elicit active citizen participation.

As leaders, our Legislators are empowered to:

- Effect change for the best
- Encourage progress
- Rely on people, knowing we cannot do the job alone
- Count on trust among ourselves, a public trust
- And do the right things

must rely heavily on their staffs, and therefore it is important for us to work through staff.

- Take a proactive approach to let your representatives know you want to be involved with their advisory groups, to actively work to raise funds for their campaigns, to contact dental PACs for contributions, and to volunteer to work on campaign organization, planning, and implementation.
- Work with political parties as a committee member of a town, village, city, or county committee. This can be the best way to gain immediate entry into the political arena. Politicians rely heavily on the political committee chair, since the committees have the ability to respond to the call on a moment's notice.
- Participate in voter registration drives, delivering absentee ballots, door to door visits introducing your representatives to your friends, getting fired up by attending political rallies, manning telephone banks to get out the vote, offering rides to the polls, and working as a poll watcher.

Relentless pursuit, perseverance, intestinal fortitude, and "never give up" demeanor were absolutely necessary.

Personal Involvement

My personal involvement has been most satisfying throughout my entire professional career, with a commitment to organized dentistry, the Naval Reserve Dental Corps, and community and public service. All have provided invaluable experiences listening to issues and concerns, thoughtfully deliberating, and making decisions for the common good.

Organized dentistry provided a logical pathway and I served as president of the Eighth District Dental Society, the New York State Dental Association Board of Governors as a delegate to the ADA, and am presently serving as a member of the ADA Council on Governmental Affairs. Further, my activities include being the Northeast Region Representative for the American Association of Orthodontists Political Action Committee and the key contact for Congressman Tom Reynolds (27th district of New York).

My Naval Reserve duties, steeped in leadership training, command duties of increasing responsibility and with a tenure as a Flag Officer, afforded an uncommon opportunity to hone leadership skills in preparation for public service. Turning now to community service, it was here I began to build credibility for a future in public service. Chairing a successful new YMCA building campaign and volunteering efforts with the United Fund, Boy Scouts, and the Rotary Club early on, were pleasurable undertakings and excellent practice builders.

My first elected public office was to the City of Batavia Board of Education in 1979, an experience all who seek public office should serve as a precursor to the governance process. Parents are acutely aware of their children's educational needs and are not afraid to vocalize their desires. Board members are constantly admonished to provide the ever best in education yet not to tax and spend.

Following a four-year tenure on the Board of Education, I was then elected to the Genesee County Legislature. The hours and days of involvement increase in time, areas of responsibility, and effort. As a member of the Legislature since 1982, and as chair for the past five years, it has also been my privilege to serve concurrently as President of the New York Association of Counties Board Chairs. This latter position addresses bipartisan issues and concerns which daily impact the ten million people in fifty-seven counties of the State of New York.

Many of our state and federal representatives have started their political careers at the local level, and understand the needs of the grassroots. They address the same issues and concerns that affect the same citizens of an area or region whom we, as legislators and they as representative, serve. As a dentist and County Legislator, the opportunity to forge a mutual trust and partnership affords a best possible advantage to advance our voice for dentistry as we work one-on-one with a multitude of concerns.

It should also be stated that while the avenue to higher offices, for the most part, is a stepwise progression from local to state to national officers, oftentimes one can seek office without any previous experience at any and all levels. This is a positive aspect of our American way.

Satisfactions That Make Serving Worthwhile

Successful ventures inspire and invigorate the army of volunteers whose efforts make our communities better places to live and work. Let me share a few accomplishments which have motivated a continued desire to make a difference.

YMCA Building Fund Campaign: Chairing the previously mentioned 1974 fund campaign for the construction of a new YMCA building for the City of Batavia, New York, was exciting. Reflecting on the overall campaign game plan, the outpouring of volunteers and infusion of financial support demonstrated a team effort that exceeded all expectations. From its completion in 1977 to present, it is thrilling to witness the frenzy of daily activities as its family and members of all ages overwhelm the facility non-stop.

Visioning the Future: Steven Covey in his book *First Things First* states emphatically, "Visioning is a high leverage mental exercise which clarifies purpose, gives a

Running a Political Campaign is Like Flying Upside Down

- Campaigns operate on a shoestring, take enormous risks, and require that decisions be made by the seat of one's pants.
- They are more concerned with motivation than messiness; more with persuasion than procedures.
- Campaigns are hard work, and that is the difference between winning and losing.
- Murphy's law is the only law that has never been broken in a campaign.
- A campaign's spirit is also its substance.
- Optimism, trust, and enthusiasm are contagious.
- Setting the right example in attitude can give your campaign altitude.
- Discourage cynicism, defeatism, gossip, and back biting.
- Encourage openness, patience, respect, and teamwork.
- The planning is easy; the execution is tough.

sense of meaning, gives peaceful confidence to make decisions, transcends fear, doubt, and discouragement. Great teams and organizations," he says, "thrive on visions." Genesee 2000 and the Genesee County Comprehensive Plan, think tank blueprints defined by a cadre of caring citizens from all walks of community involvement, were formulated from a concern, vision, commitment, and leadership perspective. These scenarios have enabled the County Legislature to strategically plan for a dynamic future for the citizens we serve.

County Courthouse and a Community College for Technology: The 1997 completion of a modern County Courthouse continues the never-ending quest to see that justice will be served and the 2000 dedication of a new Community College Center for Technology expands our capacity to meet the needs of the explosion of telecommunications locally, nationally, and globally. These two successful endeavors met the lengthy planning, approval, and construction process ratified by our County Legislature.

County-Wide Water Project: Elected officials have experienced that "once in a century" venture which was an extraordinary undertaking. That task in Genesee County, the number one priority acclaimed by Genesee 2000 and Genesee County Comprehensive Plans, is at this very time breaking ground for what will be $54 million water supply project. An exhausting, introspective, collaborative four-year study culminated with a source and quantity of supply, an environmental plan, a "smart growth" approach, state approved enabling legislation, intergovernmental water authority agreements, intermunicipality understanding and contracts, requisition and awarding of state and federal grants coupled with bonding resolutions, and of course the thorny litigious efforts of opposing groups. Relentless pursuit, perseverance, intestinal fortitude, and "never give up" demeanor were absolutely necessary. Projects of this magnitude are most rewarding since they can positively impact thousands of citizens locally and in surrounding regions for years and centuries to some.

This document would be incomplete without an assessment of what a political campaign entails. I can honestly say that until you have been a candidate, it would be difficult to understand the rigors of a campaign. The sidebar will provide insight into the campaign modus operandi.

I must emphasize that while I have had this occasion to prepare this essay, there are many dentists throughout the United States who too have served or are serving as elected officials at the local, state, and national levels. Former South Carolina Governor Jim Edwards and present Congressmen Charlie Norwood, Ron Packard, John Linder, and Mike Simpson are brilliant examples of dentists serving at the highest levels of government.

Dentists Serving Their Communities and States

Peter C. Knudson, DDS, MS

Abstract

An orthodontist from Utah describes the motives and rewards for public service at the city and state level. Timing, a desire to give back to the community, and good advice all play a role.

When I graduated from the University of Pacific, School of Dentistry in 1966, I hadn't envisioned that my future life would include my participation in government. My game plan was to serve an internship in the United States Public Health Service and then, if it were my good fortune, to continue my post doctoral education in either oral surgery or pediatric dentistry. While a student I found pediatric dentistry and oral surgery to be the clinical subjects I enjoyed the most. It was during my internship at the United States Public Service hospital, Staten Island, New York, that I actually discovered my keen interest in orthodontics.

Each Saturday morning a specialist from one or another of the various dental specialties would be invited to make a presentation to our group of dental interns. These presentations were always very interesting and rewarding. I found that the presentations by the orthodontists sparked my interest the most. There is no doubt that this was the turning point, early on, that influenced my pursuit of a career in the specialty of orthodontics.

In June 1967 I began a two-year residency program in orthodontics at Loyola University, Chicago, Illinois. Following the successful completion of the residency program my family and I returned to our home state of Utah to begin our career.

Family Values of Service

I remember the conversations my family would have around the dinner table when I was a young boy were centered on current events and political issues. My parents shared a common belief that it is important to give back to society a measure of our time, talents, and resources in appreciation for all the many blessings we receive as citizens of this country. Even though my father didn't have the opportunity to go to college he was an avid reader and became an exceptional businessman. He loved his community and was an activist for good government. He did not seek or held political office, but he supported and encouraged many others in their political endeavors. When my father died in 1978 the *Ogden Standard Examiner*, one of Utah's most prominent newspapers, stated in an editorial written in memory of his life, "Every worthwhile issue in Brigham City was spearheaded, behind the scenes, by Mr. P. C. Knudson." He would have been flattered by these kind words, but he would have quickly added, "It was just my duty."

I remember shortly after my wife, our three-year-old daughter, and I were finally getting settled into our first home and my practice was just beginning to attract a few patients, my father called and invited me over to his place for a heart to heart talk. He expressed his pride in my having successfully completed dental

Dr. Knudson is Senator for the Utah twenty-fourth District and practices orthodontics in Brigham City. He can be reached at 319 State Capitol, Salt Lake City, Utah 84114.

school and my residency in orthodontics, but then he asked if I had given any thought about becoming involved in community affairs. He shared, again, his personal belief that it is important to give something back to the community.

Whenever one makes decisions that effect the lives of one's fellow citizens there are those who support you and there are those who do not.

When I told him that I hadn't really given it a lot of thought he said he hoped I would at some point give it some serious consideration. Before long I became involved in the Kiwanis Club, and eventually even became president, for a year, of the PTA at the elementary school our children attended.

In 1974 while serving as chair of the Brigham City Republican Party I was encouraged by a friend, who happened to be an ardent Democrat, to run for the city council. Being young and naive I didn't give any thought to whether this would be good for my practice or not, I just had a strong desire to serve. My campaign was successful and I was elected. Over the next four years I discovered the joys and heartaches associated with public service. Whenever one makes decisions that effect the lives of one's fellow citizens there are those who support you and there are those who do not; over time and after many issues and decisions one hopes that supporters still outnumber detractors. My tenure on the city council was successful and I believe I earned the respect of the community.

The water and sewer departments were under my supervision. What a great learning experience. One of the highlights of this experience was the opportunity I had to supervise a major public works project, which the city had undertaken, to construct a new, state of the art, waste treatment plant and at the same time upgrade a large portion of the city's sewerage collection system. During my term on the city council I came to realize that my dental education had taught me valuable skills. I learned as a dental student, and in my practice, how to evaluate and solve challenging problems and had gained the self confidence and courage to make difficult decisions that effect the well being of others. As a student, and continuing into my practice, I had learned to be a good listener and had gained a sensitivity for the opinions and concerns of others.

When our mayor decided not to run for re-election in 1978 the door was opened for me. After serving one term on the city council I decided I was ready to run for the office of mayor.

After a very heated campaign, against a very able opponent, I was elected mayor of Brigham City, Utah. The next twelve years were among the most meaningful years of my life. The experience of serving as mayor was a privilege and opportunity that is difficult to compare. Few other elective positions put a person closer to the people, where you are able "to make a difference" in the community. The mayor needs to have a clear vision and then set an agenda that will move in that direction. In order for success to be achieved a close, cooperative working relationship with the city council is essential. The relationship with the city council cannot be under estimated. Good fortune was with me during the years I served as mayor (1978-1990). The city council and I shared a common vision, and we agreed on the majority of the major issues; as a result, together we accomplished many good things for our community.

A Turning Point

The mayor represents and speaks on behalf of the city. As mayor I had numerous opportunities to serve on various regional and state boards and commissions. One of the most rewarding experiences was my involvement the Utah League of Cities and Towns. It was my privilege to serve as president of the Utah League of Cities and Towns and in this capacity worked with community leaders from throughout the State of Utah. While serving in the Utah League of Cities and Towns I became an active participant in the National League of Cities. In 1984 I was elected to a two-year term as a member of the board of directors of the National League of Cities. I was one of two mayors elected from small cities to serve on the board. It was an amazing experience to sit at the same table with mayors from such cities as: Seattle, Washington; Washington, DC; St. Paul, Minnesota; Indianapolis, Indiana; New Orleans, Louisiana; Los Angeles, California; Atlanta, Georgia; and Cleveland, Ohio.

My first meeting as a member of the board of directors of the NLC was very intimidating. As I looked around the room my initial thought was, "What am I doing here?" The meeting was held shortly after President Reagan had been sworn in for his second term. One of the agenda items for discussion was the Reagan budget, and in particular President Reagan's proposal for strengthening the U.S. military. During the debate efforts were being made to draft and pass a resolution in opposition to President Reagan's proposal to rebuild the military. Many of the large city mayors were particularly outspoken in their opposition. They were convinced, so it seemed, that the money could be better spent in rebuilding America's cities. They had little good to say about the President. During the first four hours of debate I had remained silent.

As we were breaking for lunch and I was preparing to leave the boardroom I felt an arm come over my shoulders. I turned and saw a young man, who was a member of the NLC staff by the name of William Harrison. He had been sitting along the side of the room. He looked at me and said, "Mayor Knudson, I can see you are discouraged, and I feel you are intimidated by the mayors from the large cities and you

probably feel you don't have anything to say or to offer." I nodded in agreement. He then said something that I will always remember, "Mayor Knudson, remember this, you have been elected to serve on this board by people who have great confidence in you. They need you to speak in their behalf." When the meeting was reconvened following lunch the president of the National League of Cities announced we would continue the discusion and then called for any further discussion of President Reagan's proposed military budget. I immediately raised my hand and was recognized by the president. There were huge butterflies in my stomach, and I prayed that my voice would not reveal my fear. I don't remember the exact words I spoke, but it went something like this, "Mr. President, I have listened to the debate regarding President Reagan's military proposals and I must speak out in the strongest words possible in support of our President. He has spoken clearly how critical it is for the free world to know our country is strong militarily. He has clearly outlined the risks the world faces if the United States has the second most powerful military force. I believe what he says to be true. I urge this body to take a firm position of support for the President's budget proposals on this critical matter." For a moment the room was quiet. Then hands began to be raised. One after another board members who hadn't spoken before spoke out in favor of the President. Even some who had earlier taken a position in opposition to the President spoke now in favor. It wasn't long before a motion was made to pass a resolution in support of President Reagan's program. The resolution passed. I will always remember Mr. William Harrison and the influence he had upon my life.

After returning home following the meeting of the board of directors I resumed my "normal" life. The Monday afternoon following my return I was busily engaged treating orthodontics patients when my secretary came into the operatory and informed me that there was a woman on the phone who claimed to be a White House telephone operator and she had said, President Reagan wished to speak with mayor Knudson. Upon hearing this I said, "You are kidding." My secretary assured me that she was telling the truth and that the operator was very clear that President Reagan wanted to speak with Mayor Knudson. I immediately went to the phone; the person on the other end said she was the White House telephone operator and President Reagan was anxious to speak with me. I assured her that I was mayor Knudson and would be honored to speak with President Reagan. Shortly, a very recognizable voice said, "Mayor Knudson, this is Ron Reagan, I am calling to express my appreciation for the courage you showed at the recent meeting of the board of directors of the National League of Cities. Your leadership made the difference in having the board pass a resolution in support of my efforts to rebuild our nation's military." I assured the President that I was honored to give him my support and how appreciative I was to have him call me. He then said, "Nancy and I would like to invite you and your wife to visit us here at the White House." I expressed my appreciation and excitement to the President and told him we would be honored to accept his invitation. The President then told me I would be receiving a confirmation within a few days with special instructions regarding the visit to the White House. He then said, "Nancy and I look forward to meeting you and Mrs. Knudson."

As a student, and continuing into my practice, I had learned to be a good listener and had gained a sensitivity for the opinions and concerns of others.

A few days later I received formal confirmation of the President's invitation, including instructions regarding gaining admission to the White House for the purpose of visiting the President of the United States. We were instructed that we were scheduled to visit the President and Mrs. Reagan the following week.

Visiting President Reagan at the White House was an experience my wife, Georgianna, and I will cherish all the rest of our lives. Unfortunately, Mrs. Nancy Reagan was unable to meet with us. We were one of four couples invited on that occasion. The other couples were state legislators and their spouses from different parts of the country. The President greeted us in the East Room of the White House where he spoke to our small group and explained that each of us had recently gone the extra mile to support him, his policies, and his administration. The President next greeted us in the Blue Room where we, individually, had the privilege of being photographed with the President. We then were directed to the Red Room where we were served beverages and a light meal and had the opportunity to spend the next couple of hours visiting one on one with the President. He made us all feel very welcome and was very interested in the issues that were brought forth. He genuinely looked relaxed and seemed to enjoy the evening as much as we all did. When the President excused himself he invited us to take a personal tour of the main and lower floors of the White House and he assured us his staff would answer any questions we might wish to ask regarding any aspect of the White House. Looking back this experience seems like a dream.

When my third four-year term as mayor was drawing to a close in 1989 I decided it was time for me to step down. This wasn't an easy decision to make. I had enjoyed serving as mayor, and I was proud of the accomplish-

ments we had made as an administration.

During the next five years I came to enjoy not having the pressures of public service. This absence from the political arena came to an end in 1994 when I made the decision to run for the Utah House of Representatives. My term of office began in January 1995. Over the next four years I would learn time and time again that it is much more difficult to measure one's success as a state legislator. It takes time to learn the legislative process. Time, patience, and staying focused are key factors in achieving success.

During my four years, two terms, in the House it was my good fortune to successfully sponsor many bills.

Time for the State

Timing plays an important role in much we do in life. At the end of my second two-year term in the Utah House of Representatives the opportunity to run for the Utah Senate presented itself. The state senator for our part of the state announced his retirement. So in 1998 my campaign for the Utah senate proved successful and I began a four-year term in 1999. Over the years several dentists have been elected to the Utah House of Representatives, but, I have the proud distinction of being the first dentist elected to serve in the Utah State Senate. My first two years in the senate have been very challenging and rewarding.

You have been elected to serve on this board by people who have great confidence in you. They need you to speak in their behalf.

Looking back over the past twenty-six years, I can truthfully say that having been involved in government has been a marvelous experience for me and my family. There have been sacrifices, but the rewards have been significant. Would I encourage dentists to become involved in this type of public service? There are many ways in which to serve our communities, but becoming involved in elective government provides opportunities that are unique to this experience. Dentists have shown over the years that they have the intellect, skills, and temperament for this work.

A Commitment to Community

Ron Packard, DMD

Abstract

Retiring Republican Member of Congress for the 48th District of California, Dr. Ron Packard reflects on the qualities of success that are common in dentistry and politics and stresses the importance of community.

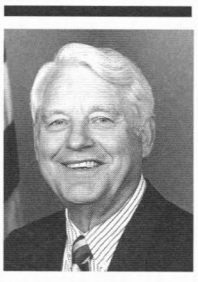
How are politics and dentistry intertwined? In 1959, the year my brothers and I opened the Packard Dental Clinic in Carlsbad, California, the two appeared to have little in common. Now, politics and dentistry, in my case, have complemented one another with uncanny success.

When I graduated from dental school, serving in the United States Congress never entered my mind, but in any business you soon realize the health and well being of the community that surrounds you are crucial to your own business success and more importantly to the strength and success of your family. As I began my practice, I shared a passion for helping my patients, not only with their dental concerns, but also with the happiness and success in their homes. Thus, when the opportunity to serve in public office became available, I took that opportunity and have been rewarded ten-fold.

The people, the experience, and the skills of dentistry were fundamental to my own political and legislative success. Dentistry also provided practical experience with managing a small business, operating within the increasingly complex healthcare environment, and most importantly, working with the people of my community. It was only natural for me to become involved in my community.

Eighteen years ago, voters in California along the coast of San Diego and Orange County, and a corner of the fertile inland Riverside County elected me to the U.S. Congress on only the fourth successful write-in candidacies of our Democracy. Then considered the 43rd Congressional District, Congressman Clair Burgener announced his plans for retirement. A flurry of candidates including myself plunged into this 1982 House race. After narrowly losing the Republican Primary in a heated eighteen-candidate race, friends and supporters throughout the community encouraged me to continue fighting and wage a write-in campaign. In an age of expensive campaigns, splashy media techniques, and political consultants, on November 2, 1982 we won the old-fashioned way with an army of volunteers at the polls handing out three-inch pencils with "RON PACKARD, 43rd Congressional District," etched on the side. This was precisely what the voter had to write-in on the ballot.

As a partner at the Packard Dental Clinic, a former school board trustee, and Mayor of Carlsbad, I had experienced first hand the red-tape and regulatory burdens placed on small businesses, local school boards, and city councils by intrusive and burdensome federal policy. I was also frustrated by the breakdown of limitations on our federal government with tax and spend policies, growing intrusive regulation, and the corruption of the system by special interests. My goals then and now continue to emphasize a building up of our local communities by reducing the federal tax burden, cutting costly government waste, and empowering people at the local level by removing the strings-attached approach to federal legislation. The incomprehensible tax code and overzealous safety and occupational health standards drowning small businesses, like my



Dr. Ron Packard, a Republican Member of Congress for the 48th District of California, will be reiring at the end of the 106th Congress.

own practice, revealed the truth of the federal regulatory mess: its ability to complicate simply paying your employees or meeting needs of patients. Politics, like dentistry, requires you to listen earnestly and observe diligently before prescribing a treatment. A treatment plan must fit the needs of each patient; but federal regulators have tried to create these one-size fits all solutions. Local officials and citizens were being cut out of the process entirely as federal outlays and entitlements climbed. I wanted to restore our limited government principles and instill the values that had made us strong: commitment to family, community, and faith.

This early participation in local government was crucial to my goals and successes in Congress.

Upon winning in 1982, I sold my successful twenty-five year practice in Carlsbad, California, and opened a congressional office some 2500 miles from home. My wife and I boxed up many of our personal belongings, kissed family and friends good-bye, and established a home just outside of the marble-faced buildings that line Pennsylvania and Constitution Avenues in Washington, DC to begin what has truly been an awesome and humbling experience.

For nearly two decades, I have had the rare opportunity to represent the hard-working men and women of California's 48th Congressional District. The 48th District includes some of the most coveted California coastline stretching from Laguna Beach to Carlsbad, California. Camp Pendleton Marine Corps Base, the site of the Corps' largest amphibious assault training facility, encompassing some seventeen miles of coastline and 125,000 acres, is also in my district. More importantly a population of nearly 40,000 Marines and Sailors and their families are part of my constituency. This coastal area is blessed with unique agriculture such as vineyards, citrus, groves of avocados, and field of flowers. The area is also home to high-tech and biomedical companies. The district I represent is truly one of the most desirable places to live and work.

I relocated my family to the small town of Carlsbad to establish private practice in 1959, after studying at Brigham Young University, Portland State University, and receiving my DMD from the University of Oregon Dental School and following a two-year assignment to Camp Pendleton, Marine Corps Base, on duty with the U.S. Navy Dental Corps. Almost immediately, I became active in church and community activities. My first campaign for a public post was as a trustee of the Carlsbad Unified School District. I served in that position from 1962 to 1974, including three years as Chairman. I later served as Director of the Carlsbad Chamber of Commerce for four years, and served for two years on the Carlsbad City Council culminating in my election to Mayor of the city of Carlsbad in 1978. During my four years as Carlsbad's mayor, I became deeply involved in regional affairs. I served for three years on the transportation policy committee of the League of California Cities, and spent four years as Director of the North County Transit District. I also served two years as President of the Council of Mayors for San Diego County.

Never take out of a community more than you can put back into it.

This early participation in local government was crucial to my goals and successes in Congress. I am a better legislator for cutting my teeth on the local level, having wrangled over school board budgets and city building codes. I have had no regrets trying to make every education dollar count for our children or working on bringing businesses to strengthen the local economy. I first ran for public office some thirty-six years ago because I believed the principle, "Never take out of a community more than you can put back into it." This principle still holds as true today as it did when I first was elected to public office.

That is a good policy for each of us. But a policy, by itself cannot accomplish anything. You and I must respond. Your dental practice ought to allow time to serve your neighborhoods, schools, families, churches, and community. That is the genius of America, that we still have a system that encourages men and women to seek elected office and improve our homes simply because we believe there is a greater need than ourselves. That is truly one of the singular differences between our country and many fledgling democracies. Our practices must be a catalyst for political involvement, not an impediment.

I truly believe my experience as a father, a dentist, and a local elected official, gave me keen insight into many of the concerns that face our nation. Sometimes, Congress, and all levels of government, gets caught up in the abstract issues of policy. We forget that legislative and regulatory decisions have a real impact on people's work, on the quality of their children's education, and virtually everything they do in life. It is crucial that men and women of all walks life serve in elected office to keep government responsive to the people needs. That's the only way government, "by the people, for the people, of the people" can flourish.

As dentists we have an obligation to our community not only to ensure health needs are addressed, but also that the greater goals of the community are met. In my own career in Congress, I've had the unique opportunity to work on critical transportation projects throughout much of Southern California and the entire country. As a member of the Transportation Appropriations Subcommittee, I've worked to secure critical funding for mass transit projects, development of bussing systems, and strengthening of our transportation infrastructure, not only in areas of my community, but my state of California and the country at large. These projects translate into a mother making her son's Little League game on time or a father spending more time with a child on homework than on a freeway.

Since my congressional career began, I haven't examined dental x-rays or treated dental disease, but the fundamentals of what dentistry taught me have been an active part of my congressional and entire political career. Dentistry, if anything, instilled values of service, compassion, and to accept no less than excellence from myself. On the eve of my retirement, I have been truly proud to serve my district, my profession, and my country in the House of Representatives.

Occasionally, I'll stumble across the golf-pencils with my name etched on the side and I have to reflect on the tremendous contribution those fine men and women, many of whom were my former patients, who helped me get elected in 1982 that resulted in an eighteen-year career. But I am quickly reminded that it has never been about my career, but the community and the nation that I am so blessed to serve as a legislator and a dentist.

From Private Practice to Public Policy

Angelique D. Skoulas, DDS

Abstract

A dentist describes her journey from private practice to legislative assistant. Beginning with work in the ADA's Government Relations Office and then through the American Dental Association's Congressional Fellowship, Dr. Skoulas has now taken a full-time position monitoring and developing legislation for Congressman Edward J. Markey.

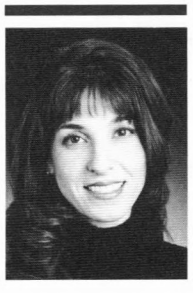
It was January of 1996. A typical weekday morning as I enjoyed my daily ritual of reading the morning paper with my steaming mug of coffee. The California sunshine streamed through my kitchen window, spilling over onto the table where I sat comfortably flipping through my favorite section of the *San Jose Mercury News*—the section on national politics. To my surprise, Washington, DC was shut down. Our federal government was closed due to a vicious storm that coated the nation's capital in solid ice, leaving its streets and roads slick, treacherous, and non-negotiable.

I was bemused by the thought that the most powerful and sometimes arrogant city in the world was vulnerable to the whims of Old Man Winter. I thought it ironic that the country's most important matters, discussions, and negotiations had been literally frozen. It seemed fitting that even those in power were captive in their own homes, rendered powerless against nature's forces. It's good to be reminded of your limitations and your vulnerability I thought, especially when you're establishing policies for millions of Americans. Maybe, I thought, this weather will serve to help lawmakers understand the consequences of gridlock—the needs of the people go unmet when powerful interests take over. Would the wintry weather help to thaw relations between partisans so that consensus could be reached on the issues that are important to me as a citizen and a health care provider? Maybe this cold, bitter weather would move lawmakers to legislate the way that I would if I had any influence; maybe I was completely kidding myself. Maybe somebody slipped something into my coffee when I wasn't looking—what was I thinking? Ice storms don't make policy...people do. But how? On that day, I wanted to know.

The ADA has done an excellent job in hiring the best and the brightest to make their case in Washington

At the time, I was practicing dentistry with my mother, also a dentist, in Santa Clara, California. I loved dentistry, enjoyed making a difference in the lives of my patients and enjoyed the satisfaction of teaching one day a week at the University of the Pacific, School of Dentistry. But there were also frustrations.

I was frustrated with the hefty student loan payments so many of my fellow classmates were paying, frustrated with treatment plans by preferred pro-



Dr. Skoulas is a legislative assistant for Representative Edward J. Markey, 2108 Rayburn Building, Washington, DC 20515.

vider organizations being dictated to me, and frustrated with terrible reimbursement rates for treatment of our most vulnerable patients. And I wasn't sure how to go about relieving these frustrations.

I realized that each staffer seated behind the member was the eyes and ears for his or her respective boss.

National politics and health care policy in particular have always intrigued me. Growing up, discussions in our home often focused on politics, but our family's interest was more of a hobby —political involvement was limited to writing occasional letters to representatives and donating to campaigns. Politics provided debate at the dinner table, while health care provided a career. My mother was a liberal Democrat. My father, a cardiologist and a Greek immigrant, was a progressive Independent. Our family had a profound respect for the values of democracy. And my parents taught my brother and me that we were privileged to live in the United States where all citizens have the right to vote, to freely express opinions, and to communicate with their government to affect change.

So on that January morning I decided it was time for me to learn how I could affect change. Thus began my efforts to learn the "ropes" in Washington, DC.

I decided my best contacts in Washington would be through my profession, through the American Dental Association's Government Relations office. I phoned them that icy morning in Washington and of course, had no choice but to leave a voicemail message because the city had closed down. Ultimately, I worked out a deal with my associate—my mother—to take a leave of absence from our practice for three months to volunteer for the ADA's Government Relations Office in DC with the intent of learning the legislative process. I had no idea that I would be educated by some of the most talented lobbyists in Washington—the ADA has done an excellent job in hiring the best and the brightest to make their case in Washington.

My experience with the ADA was informative and exciting. The first hearing that I attended was on "gag rules" built into contracts with managed care plans. These contracts limit physicians and dentists from offering treatment options not covered by a patient's health plan. Then-President Bill Ten Pas eloquently testified before the Commerce Subcommittee on Health and Environment on behalf of the ADA. Sitting in the rich, wood-paneled Commerce Committee hearing room before the twenty-eight House Members of the subcommittee was a real thrill. The atmosphere in the room was electric. I sat transfixed as witnesses testified and the members posed serious, well-thought-out questions. Tense moments ensued as debate between health industry representatives and health care providers wore on.

I took note of the staffers seated behind the members who whispered suggestions to legislators and frantically scribbled down notes. As I watched the Members of Congress come and go during the course of the hearing, I realized that each staffer seated behind the member was the eyes and ears for his or her respective boss. And "the boss" had little time to spend in any one place as he or she ran between floor votes, mark-ups, press conferences, and hearings. The schedules of a Member of Congress is jam-packed, and they trust their staff to inform and advise.

It was on that very day, as I listened to statements and testimony and watched legislative aides wield their opinions with furtive notes passed to overtaxed members, that I discovered exactly how I wanted to make a difference. I wanted my whispers to influence hearings. This was where I wanted my voice to be heard.

Over the course of the next two years I returned to Washington for several extended periods of time. During that time, I worked as a fundraiser for the Democratic National Committee and enjoyed a three-month fellowship working for Senator Tom Harkin as a health policy aide.

But it was in 1998 that my greatest opportunity arrived. I was awarded the American Dental Association's Congressional Fellowship. Sponsored by the ADA, I would spend one year in the Congressional office of my choosing—working on policy, and hopefully making a difference. The fellowship was administered through the American Association for the Advancement of Science. This annual fellowship program takes thirty professionals from health and scientific backgrounds, provides a two-week orientation of "how Washington works" and then cuts these wide-eyed fellows loose on Capitol Hill to interview with committees and personal offices. The hope is that each fellow will find work in an office or committee that suits him or her from both a policy and political perspective.

Given my political leanings, I wanted to work for a Democrat. I interviewed on both the House and Senate side and after much thought and consideration, I decided to join the office of a liberal Democrat from Massachusetts, -- a bright, energetic, and active politician with a gift for communication and a reputation for getting things done. His name is Edward J. Markey. He was a senior member of the powerful House Commerce Committee and the author of legislation that curbs "gag" practices—the subject of the first hearing I attended. Representative Markey spelled out an agenda for my fellowship, telling me I would be tasked with drafting legislation on medical privacy and creating a task force on Alzheimer's Disease. He was asking me to become a congressional expert in these areas. On the issues

of medical privacy and Alzheimer's, I would be the one to whisper in his ear at hearings. If successful, my voice would be heard.

And so, in October of 1998, my congressional fellowship began. During my first few months, I was truly overwhelmed by Capitol Hill—the process and the politics took a lot of getting used to. Coming from my clinical practice in Santa Clara, California, was, to put it mildly, an adjustment.

First, I had to get used to the fact that I was expected quite early on to be an "expert" on the issues with which I had been tasked. As a dentist, I had "practiced" dentistry for seven years and still didn't feel like an "expert."

However, I came to realize quickly that most legislative aides on the Hill know a little bit about a whole host of issues—a talent that requires a quick, sharp, and decisive mind. I had just spent the last ten years of my life focused on the practice of dentistry. I simply wasn't ready to make such a rapid transition to the world of a typical Hill staffer and was grateful that I was expected to work on only a couple of issues. Because there were few House Democratic Members who had made medical privacy or Alzheimer's Disease their policy priority, and because my boss sat on the committee with jurisdiction over these issues, the terrain was ripe for Representative Markey to take the lead. As a congressional fellow, I couldn't have accepted a better position and I knew I was in for a great year.

My days on the Hill were spent in a cubicle in Congressman Markey's office in the Rayburn House Office Building. Space is limited for House staffers and privacy is...well...let's just say there isn't any. I quickly learned to concentrate with phone conversations and political discussions swirling around me, all the while C-SPAN blared proceedings from the House floor. This scenario may sound like a less than perfect work environment but to a political junkie...it's nirvana.

So, I quickly learned to focus while seated in "political nirvana," spending the first months of my fellowship asking lots of questions, reading, researching, reviewing past and current legislation by other Members of the House and Senate, and learning the nuts and bolts of how a bill becomes a law.

And in those moments I knew I was finding my voice, learning how to get my point across to a lawmaker.

I also used my position on the Hill, and my background as a dental professional, to contact real experts in the fields of my issues of interest. I spent hours combing through articles on medical privacy, jotting down the names of the top academics and researchers quoted, and then phoning them with questions.

In addition, I spent a lot of time in meetings with groups and lobbyists who care about medical privacy with the hope of crafting a good bill they could support. And finally, I worked with the legislative aides of other Members of Congress with whom my boss would introduce his comprehensive medical privacy bill. Of course, throughout this time, I was always checking in with my boss and my chief of staff for political and policy advice and as the months passed, I found that my political instincts and judgement were improving.

Often, I would spend time briefing my boss. These sessions were challenging and rewarding. My boss would pepper me with questions, half of which I could answer and the rest of which I would have to refer to the "real" experts with a phone call. But there were moments when my advice was on target and my boss was satisfied with my response. And in those moments I knew I was finding my voice. Learning how to get my point across to a lawmaker.

By the springtime of my fellowship, the medical privacy bill was completed and endorsed by at least ten relevant groups. And in March, H.R. 1057, The Medical Information Privacy and Security Act of 1999, was rolled out at a press conference with my boss and several other Members of Congress, including Senators Ted Kennedy (D-MA) and Patrick Leahy (D-VT) who sponsored the Senate version of the Markey bill.

The political climate didn't allow for this bill to pass into law, let alone see a hearing—remember the Democrats are in the minority. However, there were several hearings on the isssue of medical privacy and I enjoyed being the staffer in the background working with my boss to ask the most pointed questions of adversarial witnesses, frantically scratching out notes, and sometimes even whispering in my boss's ear.

And ultimately, my voice did make a difference—on a small scale and through a most unexpected route. The Financial Services Modernization bill which passed into law in November of 1999 included provisions which pertained to privacy. I was drawn into the negotiations of the bill because some of these provisions were specific to health information. By that time I had become the House Democratic "expert" on medical privacy. What that really meant is that I knew the right people to call and the appropriate questions to ask on the issue. Nonetheless, because of this label, I played a small role in crafting what is arguably one of the most significant legis-

I knew the right people to call and the appropriate questions to ask on the issue.

lative achievements of the 106th Congress.

And since that time the one hundred thirty Congressional Members of the Task Force on Alzheimer's Disease, which Mr. Markey chairs and we started during the course of my fellowship, has provided support for several bills that I helped draft. Two of those bills will have become law by the time this article is published. My voice is slowly getting stronger.

Today, I am still working for Representative Markey. He hired me as a full-time legislative aide at the end of my fellowship, and in doing so my job description has changed and expanded.

I still handle the issues that grew out of my fellowship, but included in my portfolio are a whole range of new issues. In addition, I monitor the proceedings on the House floor for my boss and advise him on every vote he takes in the course of a legislative day.

We work in a stimulus-response institution which means that lawmakers respond when the people prod.

I am making a small, and I hope positive, difference with my work as legislative aide but one doesn't have to work for Congress to make a difference. One simply has to be motivated to find his or her own voice and then get to work in affecting change. As my boss always says, "We work in a stimulus-response institution" which means that lawmakers respond when the people prod. And having seen it first hand, I know this to be true.

To date, my plans are to keep working on Capitol Hill, to continue to learn more and do more to positively impact a broader range of issues. I don't know where my experience in Washington will ultimately lead. But I do know I've learned one way to make a difference. I've learned how to influence American policy and politics. I've found my voice and to my surprise it's no longer just a whisper.

Issues in Dental Ethics

Professional Ethics in Dentistry Network

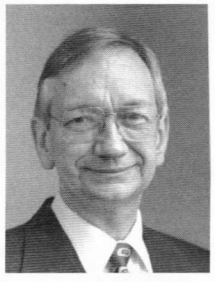
Correspondence relating to the Dental Ethics section of the *Journal of the American College of Dentists* should be addressed to:

PEDNET
c/o Center for Ethics
Loyola University of Chicago
6525 North Sheridan Road
Chicago, IL 60626
e-mail dozar@luc.edu

Codes and Communication

The history of any profession's published codes of ethics illuminates not only the ethical issues its members have faced, but also its changing relations with the larger community.

The focus of Laurance Jerrold and Hengameh Karkhanehchi's essay is the history of the American Dental Association's formal statements about the ethics of dental advertising, including the ADA's dramatic encounter with the Federal Trade Commission in the late 1970s. Bruce Peltier's essay, "Reflection, Introspection, and Communication; A Psychologist's View of Dental Ethics," reproduces his Presidential Address at the recent fall meeting of the Professional Ethics in Dentistry Network. Peltier examines the core components of ethics education for dentists, especially in our dental schools, and identified communications as a crucial skill that every dentist needs to respond effectively to the ethical challenges of daily dental practice.



Dr. Ozar is a Professor and Co-director of Graduate Studies in Health Care Ethics in the Department of Philosophy at Loyola University of Chicago and a founding member of PEDNET. He can be reached at dozar@luc.edu.

Reflection, Introspection, and Communication: A Psychologist's View of Dental Ethics

Bruce Peltier, PhD, MBA

Abstract

A psychologist with experience teaching ethics in dentistry observes that ethical practice involves three skills: reflection (to understand the ethical issue), introspection (to discover the forces for action), and communication (to carry ethics into action). Several short cases are presented showing how ethical communication can be difficult. Direct communication (what psychologist call confrontation) is recommended and some tips are offered.

Another year has passed, an other year at a dental school. As the years go by, trends have begun to emerge in my psychologist's mind, trends in dental ethics. I don't see things the same way that dentists do, and that is both good and bad, useful and distracting at the same time. This essay formally presents some of my psychologist's observations about dentists, dentistry, and ethics in a way that might be thought-provoking and helpful. Since psychologists focus on intrapersonal and interpersonal events, it is likely that our views have something important to contribute to the ethical practice of dentistry.

Ethical practice consists of three essential activities, one from the realm of philosophy and the other two from psychology. They are: reflection, introspection, and communication. While dental schools and ethicists do a very good job with reflection, I think we give the other two short shrift. This essay reviews several difficult issues that face dentists routinely and advocates increased direct communication, even when it is difficult to do.

Ethics Skill #1: Reflection

When bio-ethicists work on a case, they reflect. When we teach students about ethics in dental schools, we teach them how to reflect. We teach cognitive tools that are essentially philosophical. For example, students learn decision models such as Kant's deontological approach or a utilitarian approach or Ozar's central values or any of three or four others. The *Ethics Handbook for Dentists*, just published by the College (American College of Dentists, 2000) provides methods for ethical decision-making. These models require students to sift through complex dental cases to discern facts such as:

- What is the standard of care?
- Whose interests are at stake?
- Which "decision principles" or laws seem to apply?
- Which of the central values of dental practice apply, and in what order?
- What obligations exist?
- What options are available and how should we rank them?

Ethics, as defined by the College's *Handbook*, is a branch of "philosophy and theology" and "the systematic study of what is right and good with respect to character and conduct." It involves questioning, reflection, and judgment about what ought or ought not be one. When we reflect, we sift through options and "unpack" the logic behind those options. Key questions include: What do things mean? How do we value them? Who gets what?

We define our terms and check each party's perception to make certain that we agree on the basic definition of things. We use a certain linear logic to get to a solution that makes sense and is likely to be accepted by several parties, including those in positions of authority. This is a process, essentially, of practical philosophical inquiry.

Dr. Peltier is Associate Professor in the School of Dentistry, University of the Pacific in San Francisco—bpeltier@uop.edu. This essay is based on his PEDNET presidential address, Salt Lake City, UT, October 2000.

The process of reflection is the essential first step, for it informs us about how to proceed.

It is the tool we use to figure out the right thing to do. But it is only the first step. Often, however, in dental school and in ethics gatherings, it is also the last. We are left with the mistaken impression that, when we have sorted through the philosophical issues and come to a reasoned conclusion, we have solved the problem. Dentists in practice are well aware that this is just the beginning of the process.

Good ethics requires good communications.

Ethics Skill #2: Introspection

Once we have decided on the right course of action, we have to get ourselves (or someone) to actually carry out the action. Occasionally this may be simple or easy.

But if an extended course of reflection has been necessary, it is much more likely that our solution is "easier said than done." Introspection is essential to determine the internal forces, the forces within us that influence the action we take, and even whether we take action at all.

This second skill is substantially in the domain of the psychologist. The question is: How do we get ourselves to do what we think we should? This is a problem each of us faces in everyday existence. How do you get yourself to stop smoking? How do you get yourself to stop eating junk after your physician reads you the cholesterol riot act? Your lead dental assistant has been coming in late after lunch for the past several months. You know what to do. Now you have to figure out how to get yourself to do it. You can make all the right judgments in the world, but without action, they are, well, you know what.

At some point it becomes time to look inside of one's self and figure out why you haven't taken action and what it will take to get yourself to do it. At the dental school, students come to faculty members to ask them to stop another student from cheating. Faculty members approach administration to ask them to discipline a student or another faculty member. In many such cases, one person really needs to step forward and say something directly to another person about behavior they perceive to be objectionable. But they prefer to try to get others to take care of it for them. They hope that "Mom" or "Dad" will take care of it for them. Ethical inaction takes place for reasons that are understandable, if not commendable. First, remember that most ethical problems have some or all of the following characteristics:

- They involve embarrassing matters, including mistakes or bad outcomes;
- They imply future loss (money, reputation, license, and privileges);
- They require sanctions;
- They represent a negative judgment of another person.

Second, most dentists have little or no experience with direct confrontation. They do not do this regularly. They often have an office manager who takes care of the tough discussions.

They may have a front desk person who negotiates problems with patients. And they may live in a hierarchical office structure where they sit at the top, and their judgment is rarely questioned in a direct way.

Here are some intrapersonal questions that dentists might ask themselves when facing a difficult ethical problem:

1. How do I *feel* about this problem or question? Angry, nervous or afraid, bored, saddened, confused?
2. How would I feel if I did nothing?
3. What would my favorite person do in this situation?
4. What would my favorite person think if I did nothing?
5. What have I got to lose if I act or fail to act?
6. What will I think of all this five years from now?
7. What are my strengths and weaknesses relative to this situation?
8. Do I have any mixed motives or conflicts?
9. Is this a good time for me? (Am I stressed or feeling hostile?)
10. What do I need to do to get myself to act?

Ethics Skill #3: Communication

It is clear, but rarely mentioned or taught: Good ethics requires good communications. At the same time, good communications skills are extremely valuable, but rare.

Dentists sometimes lack sophisticated interpersonal skills. (This is, of course, a generalization. Many dentists, the most successful ones in particular, are exquisitely good at professional communication.) But dentists rarely choose their profession because of its social aspects. They choose dentistry for other positive reasons, such as a desire to help or heal people, a desire to join the family practice, an interest in an autonomous career life-style, or a wish to have a lucrative career. If they wanted to spend their professional time talking and listening, they would have chosen to be a psychologist or teacher or attorney.

Dentists receive precious little training in communications skills, and communication in dental practice might just be the most difficult of all the professions. Patients often don't want to sit in the dental chair and are afraid; they sit with their mouth full of gear for long periods, unable to speak; and many dentists move from patient to patient briskly and efficiently. Most dental schools now include explicit communication training in their curricula. But given the complexity of the task and the difficulty of the skills involved, there isn't room in crowded curricula for adequate training; ample communication and behavior science training

might add months to an already crowded dental school schedule.

Once students graduate from dental school, they must figure out how to master these skills on their own. Some do a marvelous job of this, and some possess good skills even before they matriculate. These lucky souls typically thrive. If they possess the baseline practical skills and decent judgment, they end up with lovely private practices, full of happy people, staff and patients, alike. Other dentists look around for models or night classes, but don't find them.

The Communications Problem

To reiterate, ethics training in most dental schools (such as the one where I teach) and in local professional organizations typically focuses on how to *think* about moral problems. We teach students and dentists how to spot ethical problems; and we teach them how to dissect and analyze these problems. We teach decision models, so that they will be able to work their way through difficult ethical situations in the future and think their way to an effective solution. But the solutions often require that they speak directly to someone about a matter that is very, very difficult. We don't do a good enough job of teaching dentists what to say and how to say it. There are too many possibilities and variations in real dental practice and real life and we can't rehearse for them all. Worse yet, more often than not, the ethics discussion actually stops when we reach a conclusion about the best decision. What most dentists need are the communications skills that will get them from the right decision to an effective resolution.

From time to time I am called upon to remediate dentists who have gotten in trouble with the law or with their state dental board. It has been my impression that many of these dentists' problems have resulted from an inability to communicate effectively. Sometimes they were unable to assert themselves when patients made unreasonable demands; sometimes they were unable to respond appropriately when staff members behaved poorly. Sometimes they were unable to handle demands placed upon them by their own family members. When I have been able to psychologically test them, they have frequently shown to be introverted, sometimes highly so. They are often interpersonally isolated. Some dentists write multiple prescription narcotic painkillers for patients who give implausible reasons for their requests. Sometimes male dentists treat female patients alone without other staff in their office on the weekend or in the evening. Sometimes dentists don't know how to verbally reprimand staff members or provide clear behavioral guidelines. Some dentists aren't able to assert themselves with their bookkeeper or accountant. Eventually, it is the dentist who takes the fall, even if the setting involves missteps by others.

Of course, not all dentists who lose their licenses are passive or poor communicators; but in my experience, many are. Had these dentists known how to handle admittedly difficult communications problems, they might have avoided a terrible personal setback.

Common Cases

There are several kinds of difficult "cases" in dentistry that require sophisticated application of complex interpersonal skills in order to solve ethical problems. Here are a few examples.

Case 1: Bad Outcome. In this situation, the result of dental treatment doesn't work out as well as one would like. Perhaps the caries was extensive and close to the pulp chamber. Exposure of the root was unanticipated, but it happened. Now the patient must be told that a root canal is necessary and that she will be paying five times what she was originally told. Perhaps the margins of a crown are not as close or precise as the dentist would prefer, and now he or she has to decide whether to do it over, even though it is probably "good enough." You don't have to be a "bad" dentist to make mistakes, either. As Hasegawa and Mathews noted in a recent article in this journal, if your work is 99.95% error-free, and you see ten patients per day and work four days per week for fifty weeks each year, you will make fewer than one mistake each month, but ten mistakes per year. Over a ten year period, that's one hundred errors.

Case 2: The Work of Other Dentists. All dentists get to see the work of many other dentists. (This is much different from the psychologist's situation. We have virtually no idea about what other psychologists really do when they work with patients. It is all done behind closed doors, and the discourse is confidential.) Dentists don't always know what happened that resulted in the outcome that they are staring at, but most have a theory or point of view. What do you do when a crown looks terrible? Or when a bridge seems to have been ill-advised? Or when a crown doesn't seem to have lasted as long as you'd have liked (or as long as the patient wished it had)?

Case 3: Whistleblowing—You Know of Terrible Behavior of a Colleague. Occasionally, every professional comes across a situation where it appears that a colleague has done, or is doing, something reprehensible. Although it is not always clear, sometimes it really seems as if action should be taken. A child has been neglected. An immigrant shows up with restorations on every single occlusal surface.

A confused patient seeks counsel because a new dentist has presented them with a $30,000 treatment plan, and you can't find much pathology in the mouth. Maybe you have begun to see a disturb-

It would be a rare relationship, indeed, that never needed an occasionally difficult conversation or confrontation.

ing pattern of poor work by a dentist from whom you have been receiving referrals for years.

Ethical practice consists of three essential activities, one from the realm of philosophy, and the other two from psychology.

Case 4: Adolescent Confidentiality. In this case, your patient is a pregnant adolescent. Perhaps she doesn't want to be x-rayed. At any rate, she insists that you do not inform her parents of her condition, as she plans an abortion soon.

Case 5: The Unreasonable and Demanding Patient. Your patient wants treatment that you think is a bad idea. For example, your patient has many untreated carious lesions and a few loose teeth due to periodontal disease. When you present your treatment plan, which is expensive, she tells you to simply remove all of her teeth and give her dentures. She nearly begs you to see things her way. She tells you that she is not likely to reverse long-standing oral habits.

Case 6: Your Employer is Systematically Taking Advantage of Patients. You are an employee dentist. Perhaps you are a young or new dentist, recently minted. You are not ready to start or buy your own practice and you have some tuition bills to pay. Or maybe you have recently moved to a new state to accommodate your spouse, so you take a position in a large dental practice or clinic. Initial screening and treatment planning is done by senior dentists who then pass cases along to treating dentists, like yourself. Soon, you begin to see a disturbing pattern. Although the principals seem legitimate and sincere, their treatment decisions seem too profit-driven to be ethically defensible.

Case 7: Dual Relationship. For one reason on another, you have developed multiple relationships with several of your patients. For example, you treat your accountant, or your contractor, or the principal of your child's school. Perhaps you even date one of your patients. That person makes a decision that you don't like very well. In fact, they do something downright objectionable. Or, you decide that you don't desire to continue the social relationship with them anymore. How do you handle this ?

Case 8: An Employee of Yours (or a Patient) is Harassing Another Employee. There are several possible scenarios in this area. Let's say that one of your best employees tells you that one of your other high performers is sexually harassing her. In another scenario, a patient is telling sexually loaded jokes, and one of your dental assistants seems embarrassed by them. Or one of your employees seems to regularly try to convince others to join her religious faith. Or one of your employees is trying to recruit others in a real estate scheme.

Each of these cases includes a challenge for ethical reflection. The thoughtful and ethical dentist must first wade through the dental and moral issues to come to a conclusion about the right action. Although these cases are difficult ones, decision making models are available to help with the process. See Ozar and Sokol's text, *Dental Ethics at Chairside* (1994) or Rule and Veatch's *Ethical Questions in Dentistry* (1999) or some of the other references provided at the end of this essay. In some cases, a prioritized set of responses is ideal. Create a Plan A and a Plan B, just in case. But, after one has decided about the right action, the plan must be put into place—that is, you must somehow get yourself to do it—and for each of these cases, clear and direct communication is called for under difficult circumstances. Not everyone is going to get what he or she wants. Someone is going to hear some bad news. That's life in the real world of practical ethical behavior.

Sadly, there are many nonproductive ways that humans tend to handle difficult interpersonal situations. Here are some examples.

1. Do nothing and act like every thing is okay. Since most of us are chickens when it comes to conflict, our first choice is to avoid the issue. Maybe it will go away, if we just ignore it or walk around it. Maybe we can just put it off for a while and nothing bad will happen. At least, then, we won't have to think about it or worry.
2. Use the "silent treatment." When someone is behaving poorly or they have offended us, we communicate displeasure by not communicating. This way, we don't have to take any risk, but we can still let them know we are unhappy with them.
3. Attack or accuse the person whom we think has done a wrong thing. We line up our evidence and let them have it. While this seems like the only thing to do sometimes, given how poorly other people can behave, for some people it is a standard response to challeng - ing situations.
4. Talk about the situation with countless peripheral people who are likely to sympathize with us and support our point of view. Tell them how upset we are.
5. Use indirect messages, sarcasm, or oblique references.
6. Try to enlist someone in a position of authority to step in and take care of the problem for us. This is the "Mom" or "Dad" solution.

All of these approaches are sub-optimal precisely because they lack directness and honesty. They do not involve a clear communication with the essential parties. On the positive side, so to speak, they do not require much courage; but they are conflict-avoidant to a fault.

Direct Communication

Recently, I was working with a dental practice to help the members strengthen

their team. In talking to them about direct communication, I used the word "confront" and was met with a negative reaction. "We really don't like that word," they said. "Maybe you could call it something else." The term "confrontation" has gotten a bad rap lately, and many in the dental profession are simply afraid of it. Perhaps some of the nasty elements of daytime TV or rap music are the culprit, implying that when people confront each other it is unseemly or even dangerous because someone will throw a chair or start shouting or shooting. In avoiding confrontation, many people seem to have concluded that politeness is more important than authenticity. But there are positive as well as negative aspects of conflict, and it is a mistake to thoughtlessly avoid it.

Confrontation can be done in ways that are respectful. It can reveal important information and differences in viewpoints. It can increase your understanding of yourself and others. It can deepen your relationship with important people because each time you work through a conflict—assuming you do it in a relatively healthy way—it strengthens your connection. On the other hand, if done poorly or recklessly, it can permanently scar a relationship and can disrupt the workplace, creating long-lasting uncomfortable emotions. It can steal time from other kinds of work functions, and it can keep people on edge. Sometimes it is indeed best to just avoid a conflict, especially when the matter is small. Also some people are extremely uncomfortable with conflict because they grew up in a yelling or violent family. Others are avoidant because their family of origin was so sweet and gentle. But consistent, even compulsive avoidance of conflict typically leads to entrenched and unresolved issues that ruin the atmosphere in an otherwise good office.

Appropriate confrontation is not only a good thing in dentistry and life; it is an essential thing. We must confront each other from time to time in order to establish and maintain an authentic and functional relationship. It would be a rare relationship, indeed, that never needed an occasionally difficult conversation or confrontation, even if the conversation is simply to clear things up. ("What did you mean when you said that last week? I thought maybe you were talking about me. Did I do something wrong?"). When conflict is mindlessly or even compulsively avoided, misunderstandings and resentments are almost sure to follow.

Introspection is essential to determine the internal forces, the forces within us that influence the action we take, and even whether we take action at all.

What most dentists need are the communications skills that will get them from the right decision to an effective resolution.

Some Tips for Direct Confrontation

1. Check with your liability carrier. Get some friendly advice from an attorney if there is any possibility that legal issues are involved. For example, they may have a lot to say about how you speak to patients about the suboptimal outcomes described in Case 1, and they may urge you to avoid certain phrases when you speak to patients. Your insurance company will be happy to give you advice if it means that they can avoid a costly action. In some cases they may render an opinion that is too conservative, but in others they may insist that you confront a situation directly.
2. Decide whose interests are at stake and how they affect your proposed action. This is critical in Case 2 (The Work of Other Dentists), for example, when you spot work that you think is unacceptable or below the standard of care. Several parties have an interest in the situation: the patient, the previous treating dentist, that dentist's malpractice carrier, and yourself. Are you likely to avoid direct communication because of the embarrassment it might cause you (in the case of an error you might have made)? Would open discussion of a difficult situation cause you to lose money—and does that have an impact on your decision-making ability? These are interests that you have at stake in such a case.
3. Ask the question: Will direct confrontation hurt someone unnecessarily? This aspect of the situation must be factored into the equation. Sometimes uncomfortable words must be said that will cause hurt feelings; and sometimes the matter can be resolved other ways. There is no sense in hurting someone unnecessarily. The whistleblower case (Case 3) is a perfect example. What should you do when you fear that an older dentist has lost his "touch?" What should you do about the possibility that what you might say could really hurt?
4. When you confront someone, be sure that you are talking to

the right person. There is no sense in a confrontation if you are not dealing with the decisionmaker or the actor. The point of confrontation is to clear things up so that things change. Don't waste time and energy grousing about the matter to those in the periphery unless they can help you to get the job done, somehow.

Appropriate confrontation is not only a good thing in dentistry and life; it is an essential thing.

5. Pick a good time and place. As the saying goes, "Timing is everything." Choose a setting that is non-threatening and reasonably comfortable, and don't spring difficult messages on people in elevators or at the end of the day, just as they are leaving the office. Don't do it in front of others either. Find a quiet, private place and take your time. A brief, on the spot discussion with the pregnant adolescent (while she sits in your dental operatory) may not be the best time or place to get anything accomplished. You could actually do more harm than good.
6. Listen. Most people are not willing to listen until they feel that they have been heard or that they will be heard when their turn comes. Communication is always a two-way street. A good conversation is like a good game of "catch." It only works if you toss things back and forth. If one person brings a stack of Frisbees and just starts hurling them, one after another, the person on the receiving end will soon become tired or frustrated or worse. The talking must go back and forth, no matter what the original purpose of the interaction, hear the other person's side of the story. It might even change your own view.
7. Learn and use "active listening." Teach yourself to repeat back to the speaker, in some form or another, what you think is an accurate representation of what you understand them to be saying and meaning. Do it until they agree that you have got it right. Conversations with angry or "difficult" patients are terrific opportunities to practice listening. As a rule, patients who feel that they have been heard are much easier to deal with. There are many stories in the healing lore about patients who forgive serious errors in doctors' judgments simply because they believe their doctor cares about them and is eager to understand their point of view.
8. There are many other useful skills and techniques available to make direct communication work, including how to use "I" statements, contingency statements, and requests. References are listed at the end of this article, and practice consultants all have their favorites.

It is difficult to consistently do the right thing in any professional practice, and the first steps, decision-making and introspection, include philosophical and psychological skills. But the hardest part of the equation is often the last one: communicating your solution to the right person at the right moment in an effective way.

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Advertising, Commercialism, and Professionalism: A History of the Ethics of Advertising in Dentistry

Laurance Jerrold, DDS, JD and Hengameh Karkhanehchi, DDS

Abstract

The authors "read" the historical dental codes prohibiting advertising and the U. S. Supreme Court decision striking down prohibitions against advertising by lawyers in Arizona, and by extension, professional advertising generally. The arguments presented in defense of prohibiting professional advertising and the court's responses to each are presented in detail. The current ADA code is analyzed in this context.

The learned professions have always had a problem with the concept of professionals advertising. From the days of dentistry's first code of ethics, the profession's governing organizations have attempted to address this issue with the intent of restricting commercialism that was deemed to be at odds with professionalism. These attempts have been acutely unsuccessful when viewed from a historical perspective, culminating in legally mandated changes in the American Dental Association's code in the late 1970s. One cannot appreciate the trials of the present without understanding the tribulations of the past. Why our code of ethics is as it is, and how it got that way is a fascinating retrospective into our profession.

1866 to the Early 1970s

The first code of dental ethics, adopted in 1866, was all of three pages in length. Article II Section 3 dealt with advertising in one paragraph:

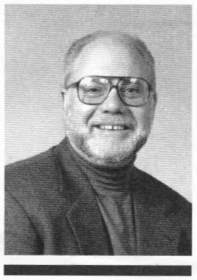
> "It is unprofessional to resort to public advertisements, cards, handbills, posters or signs calling attention to peculiar styles of work, lowness of prices, special modes of operating, or to claim superiority over neighboring practitioners, to publish reports of cases, or certificates in the public prints, to go from house to house to solicit or perform operations, to circulate or recommend nostrums, or to perform any other similar acts."

Reading between the lines one can see that almost all of the prohibitions have an anti-competitive slant. In 1866 only a few dental schools existed, so many practitioners did not have any kind of formal training, yet our forefathers would not permit the public access through advertising to information that would enable patients to differentiate in their selection of a dental practitioner.

The year 1899 brought the next major code change. Regarding advertising, the 1866 paragraph was kept virtually intact. But the following sentence was added:

> "But nothing in this section shall be so construed as to imply that it is unprofessional for dentists to announce in the public prints, or by cards, simply their names, occupation, and place of business, or, in the same manner, to announce their removal, absence from, or return to business, or to issue to their patients appointment cards having a fee bill for professional services thereon."

It was now thirty-three years later, the turn of the century, with the industrial revolution in full swing, and by all accounts our society was fairly prosperous. The dental profession wanted to make sure the public knew where dentists were located, when their appointments were,



Dr. Jerrold is Associate Professor and Program Director of Post Graduate Orthodontics at New York University College of Dentistry. Dr. Karkhanehehi is a second-year resident in the Post Graduate Orthodontics Program at New York University.

and how much patients owed on their accounts. Advertising of any other sort was sharply limited.

Though the wording changed slightly in 1922, the gist of the section of the code dealing with advertising remained unchanged except that now nothing "...prevent[ed] a practitioner who confines himself to a specialty from merely announcing his specialty on his professional card." In the 1924 and 1927 codes, instead of run-on sentences, there was introduced a list of prohibited activities. Section 2 now read:

> "It is unprofessional for a dentist to employ letters, handbills, posters, circulars, cards, signs, stereopticon slides, motion pictures, telephone, radio, newspapers, or any kind of printed, or written publications, or any other device or means for the purpose of:
>
> 1. Advertising personal superiority, or ability to perform services in a superior manner;
> 2. Advertising definite fixed prices, which in the nature of the pro - fessional service rendered must be variable;
> 3. Advertising statements that might be calculated to deceive or mislead the public;
> 4. Advertising under the name of a corporation, company, asso - ciation, parlor, or trade name;
> 5. Advertising special methods of practice or peculiar styles of work;
> 6. Publishing reports of cases or certificates in the public print;
> 7. Employing or associating with or making use of advertising solicitors or free publicity press agents;
> 8. Giving a guarantee or warrant - ing operations."

Why change to a list ? One plausible explanation is that these were the *rigores de jour* and therefore were precisely the activities that the drafters wanted to proscribe.

Three other sections dealing with advertising were added in 1927. The first dealt with directory announcements. Section 3 stated:

> It is unethical for a dentist to announce his name in any city, commercial, telephone or other public directory, or directories in public or office buildings, using what is known as display type or type that is in any way is similar in size, shape, or color to that used for other names of dentists in the same directory.
> It is likewise unethical for a dentist to announce his name in any kind of public directory under a heading such as "Specialists," "Surgeon Dentists," or any other heading that might create in the minds of the reader the impression that the individual so listed is superior to those whose names appear under the simple heading—"Dentists."

The reality for every profession is that the one providing the service should make sure that the recipient has a clear understanding of the fees to be charged prior to actually providing the service.

Section 4 of the 1927 Code was unique for its time because it recognized a schism within the profession regarding specialists. The section read:

> "In communities in which it is customary for professional men to insert a card in the local press, or in programs for social events, theaters, etc. the same custom may be observed by the dentist, but such cards must be [of] modest size and type and shall not include more than the dentist's name, title, address, telephone number, and office hours. If he confines himself to the practice of a specialty, he may announce in modest type —"Practice limited to," announcing the specialty, but nothing more. *This Association, however, believes such custom to be unbecoming to professional men and urges its members to abstain from such practice* (emphasis added in original text)."

Finally, Section 5 of the Code dealt with announcements and stated:

> "A dentist is permitted to use personal professional cards of modest type announcing his name, title, address, telephone number, and office hours, and if he confines his practice to a specialty he may so announce it; he may also use modest appointment cards and diagrams for designating needed radiograms or operations. No cuts or other printed matter shall appear on professional cards. The same rule shall apply to letter-heads, bill-heads, envelopes, etc. He may mail to his patients similar modest announcements, informing them of his absence from or return to practice; of the opening of an office; a new location etc. He may use modest sized lettering announcing his name, title, and profession on his office doors or windows, or at the entrance of his office, and if he practices a specialty he may state "Practice limited to ..." (announcing the specialty). Large display signs or peculiar lighting, objects, characters, or anything that imitates the unethical methods of the charlatan shall be deemed unethical."

One can only surmise that the more entrepreneurial dentists of the past, using the modern technology of their time, were eating into the patient base (pocketbooks) of other practitioners. Human nature being what it is, the governing professional organization moved to address this problem by codifying lists of violations to say, in effect, "this type of behavior is not professional, it is commercial; and we as a profession are above it."

The late 1920s ushered in the first specialty in dentistry and that created a perceived need to control the aura of superiority that the public might place on

any specialist, with a resulting economic detriment to the generalist. By limiting a practitioner's ability to advertise as a specialist in a public directory or an office building, the profession risked misleading the public and arguably harmed the public's best interest. This proscription was, however, just one more sign of the times.

A quarter of a century later, in 1950, the code changed its form and advertising was relegated to one paragraph. Section 12 now read:

> "The dentist has the obligation of advancing his reputation for fidelity, judgment and skill solely through his professional services to his patients and to society. The use of advertising in any form to solicit patients is inconsistent with this obligation because it reflects adversely on the dentist who employs it and lowers public esteem of the dental profession."

These were the Eisenhower years, the good times, the happy days. It was simple enough to believe the above stated sentiments because we wanted to believe them. People had jobs, the economy was good, a professional could graduate from school, hang out a shingle, and prosper; and dentists did not need to worry about competition and advertising.

Sections 13, 14, and 18 of the 1950 code dealt with cards and letterheads, office door lettering and signs, and limitations of practice respectively. These sections merely stated that these acts were permissible but had to be "consistent with the dignity of the profession and with the custom of other dentists in the community."

Section 15 dealt with announcements. It too gave deference to community standards. But some anti-competitive sentiments did creep in: "...announcements may be sent only to dentists, members of other health professions or to patients of record." Once again, attempts to announce to the public at large who you were and where you were located, what you did, etc. were unacceptable. Section 16 permitted generous use of one's professional title and degree; but these could not be used "...in connection with the promotion of any drug, agent, instrument, or appliance." This might give someone a competitive advantage. Section 17 dealt with the terms clinic and group practice. While it was permissible to practice in such a venue, one could not advertise this fact "...when the use of such term may mislead the public directly or indirectly." Finally, Section 19, addressed directories and again paid deference to community customs by providing that "...all dentists in similar circumstances have access to a similar listing."

The 1958 code saw very little change. Board certified specialists could use the term "Diplomate," but a dentist who was dual trained was not allowed to announce that he was a specialist in more than one area of dentistry. What other reason could there have been for this prohibition than to limit a perceived competitive advantage of the dual trained specialist ? The revision of the code that appeared in 1969 was virtually identical to the 1958 code as far as regulating advertising.

The court stated that historically, early bans on advertising originated as rules of etiquette, not ethics.

The Law Intervenes

For the last quarter of a century, professional advertising has been legally permissible, mainly because two lawyers from Arizona challenged their professional association's advertising restrictions, claiming that their First Amendment rights regarding freedom of speech were being infringed. The fight went all the way to the U. S. Supreme Court, which held that: "Commercial speech serves to inform the public of the availability, nature, and prices of products and services, and thus performs an indispensable role in the allocation of resources in a free enterprise system."

The *Bates* case provides an excellent review of the legal reasons allowing professionals to advertise. Two prior cases are also important to this history. In the 1975 antitrust case, *Goldfarb v. Virginia State Bar*, the United States Supreme Court ruled that all learned professions were subject to antitrust laws. This case focused on what the court determined to be illegal price fixing by the Fairfax County Bar Association. The Federal Trade Commission initiated the action under its authority to deal with issues concerning restraints of trade. Using the "Commerce Clause" of the U. S. Constitution, the court ruled that anti-trust laws do apply to the "learned professions" and their associations because they are engaged in "commerce" as defined by the law.

In another mid-1970s case, *Virginia State Board of Pharmacy v. Virginia Citizens Consumer Council*, the Supreme Court ruled for the first time that commercial speech, in this case the advertising of drug prices by pharmacists, could qualify as a "protected" form of expression under the "Free Speech" protections guaranteed by the First and Fourteenth Amendments to the United States Constitution.

These two cases laid the groundwork for *Bates*, in which the United States Supreme Court took the next step of declaring that the disciplinary rule against advertising by attorneys not only violated the freedom of speech of the lawyers involved, but had a secondary effect of depriving the public of beneficial information.

In 1976, the Federal Trade Commission alleged that the ADA and state dental societies that had banned advertising had violated federal antitrust laws. The formal complaint charged that these restrictions on advertising reduced competition among dentists and that this pre-

vented consumers from obtaining necessary information regarding fees and availability of dental services. Given the legal history, the ADA agreed to enter into a consent agreement with the FTC in September, 1979. It required that the ADA remove from its code the provisions prohibiting advertising or the solicitation of patients. Under the terms of the settlement the ADA had to agree not to restrict or declare as unethical, truthful advertising by its members. The final FTC ruling on this case ordered the ADA to:

1. Desist from restricting, regulating, impeding, declaring unethical, interfering with or advising against the advertising, or publishing of prices, terms of condition, or other information on the availability of dentists' services or facilities;
2. Desist from inducing, urging, encouraging, or assisting any dentist or any organization to take any actions that prohibit advertising;
3. Inform each constituent or component society by first class mail of the relevant details contained in the final order;
4. Remove within ninety days, any official statements that prohibit truthful advertising;
5. Require as a condition of affiliation that affiliated societies adhere to the provisions contained in the order; and terminate for a period of one year its affiliation with any society within one hundred and twenty days after learning of any violation of the provision in the order.

In order to appreciate the challenge faced by organized dentistry as a result of *Bates,* that case will now be examined in detail, with the application to dentistry highlighted by italicized inserts.

The facts of the *Bates* case are straightforward:

1. Bates and colleagues, the plaintiffs in the federal case, had opened a legal *(dental)* clinic to provide low cost service;
2. They relied heavily on use of paralegals *(expanded duty utilization);*
3. They only did routine work *(basic restorative procedures, nothing so phisticated)* using standardized forms *(economies of scale);*
4. They relied on computerization *(electronic billing and computerized tracking of all business statistics);*
5. They advertised to increase vol ume stressing low fees (same in dentistry);
6. The State Bar of Arizona had required that they stop advertising in order to conform to the state's code of professional ethics for lawyers.

The State Bar of Arizona, who were the defendants in the federal case, offered six arguments outlining why advertising should be restricted:

1. The adverse effect that advertising fees has on professionalism;
2. The inherently misleading nature of professional advertising;
3. The adverse effect that advertising has regarding the administration of professional services;
4. The undesirable effects of advertising;
5. The negative effect that advertising has on the quality of service provided;
6. The difficulties encountered relating to enforcement.

Addressing the first claim that price advertising has an adverse effect on professionalism, two separate concerns were offered. First, advertising results in commercialization that leads to a decreased sense of dignity and self worth both to the individual and the profession. Secondly, the hustle of the marketplace will irreparably damage the balance between a professional's need to earn money and his obligation to selflessly serve the public.

In its decision, the United States Supreme Court answered that this argument presumes that professionals conceal, both from themselves and the public they serve, that they make their living by providing the services that they do. The court chided that this type of self-deception is ludicrous and noted that patients expect to pay something for professional services rendered. The reality for every profession is that the one providing the service should make sure that the recipient has a clear understanding of the fees to be charged prior to actually providing the service. Also, the court reasoned, if financial information can be ethically disclosed in the office, then it is inconsistent to condemn the same revelation through advertising before the client *(patient)* comes to the office. Obviously this argument can be easily transposed to dentistry.

The court rejected the claim that a professional's reputation in the community will be sullied as a result of advertising. The court stated, by not advertising, the profession might not be doing its best to reach out and serve the community. In addition, there is also the dichotomy that exists because the members of the profession reject advertising on one hand while, on the other, often structuring their social and civic lives and associations so as to provide themselves with plenty of exposure to potential patients. The court stated that historically, early bans on advertising originated as rules of etiquette, not ethics. Such habits and traditions, when used as a basis for restricting advertising, are anachronistic at best and, in today's society, are not a proper basis for restraining this activity.

The court rejected as dubious, and as an underestimation of the public, the fear that the public lacks sophistication to comprehend the limits of professional advertising.

The State Bar of Arizona had claimed that advertising professional services is inherently misleading because such services are so individualized that advertising prevents informed comparisons about the availability and quality of the service, especially since the consumer is unable to determine in advance what services may be required.

The court responded that, while it agreed that many of the services rendered are unique, it is precisely for this reason that fixed prices for those procedures are not advertised, only fees for basic services. While these services may indeed vary slightly from client to client *(patient to patient),* there is nothing misleading as long as the service advertised is actually rendered for the advertised price.

The court also rejected the argument that advertising ignores the diagnostic role. Clients *(patients)* don't go to lawyers *(doctors)* seeking clean bills of legal (*dental*) health. While they may not know the extent of any necessary tasks to be performed, they certainly know that an examination is undertaken to ascertain the extent of intervention, if any, that may be recommended; and if the professional does recognize the need for a specific procedure to be performed, the client *(patient)* is informed via appropriate diagnostics as to the degree of complexity regarding the proposed service.

Finally it was claimed that advertising is an incomplete foundation on which to base one's selection of a professional. While this may be so, the court noted it seems peculiar to say that no information is better than some information when a person needs to make an informed decision. The court rejected as dubious, and as an underestimation of the public, the Arizona Bar's fear that the public lacks sophistication to comprehend the limits of professional advertising. If indeed the public is that naïve, the court stated, then it is up to the profession itself to assure that the populace is sufficiently informed.

The court next addressed the third claim, that advertising has an adverse effect on the administration of delivering professional services; and that it also opens the floodgates as far as fraud and misuse of services is concerned. The court responded that, while advertising may increase the use of a profession's services, this may not be a bad thing. The court noted that a significant portion of the population that does not seek necessary professional services on a routine basis and sometimes not even on an as needed basis, fails to utilize professional services out of fear of the procedure, fear of the cost, or access problems. By its very nature, advertising can address all of these concerns.

Since advertising is "...the traditional mechanism in a free market economy for a supplier to inform a potential purchaser of the availability and the terms of exchange," a rule restraining advertising would be at odds with the profession's ethical imperatives to help facilitate the making of legal *(dental)* professional services fully available to the public.

The court next considered two other proposed arguments against professional advertising as worthless. Namely, that it would increase office overhead with these costs being passed on to the public in the form of higher fees; and that advertising costs would create an entry level barrier to those entering into practice. The court stated that a ban on advertising actually insulates professionals from competition and serves to increase clients' *(patients')* difficulty in discovering the lowest cost seller of acceptable quality service. History has shown that where advertising exists, prices tend to be reduced; so advertising could well serve to lower costs to the consumer, not raise them.

Secondly, without advertising, professionals within a community have no other avenue to generate a flow of business than to rely on their personal contacts. In view of how long it takes to establish these relationships, this in and of itself may perpetuate the market position of established practitioners over entry-level practitioners.

The next argument for restricting advertising is that advertising professional services *en masse* may not serve the needs of any one individual, thus affecting the quality of service (*overtreatment*). The court answered that restraints on advertising are not effective in preventing the provision of substandard care since a professional who cuts quality will do so whether advertising is allowed or not.

The final argument is that a wholesale restriction on advertising is justified because of the problems relating to enforcement. After the fact enforcement for deceptive or misleading advertising does not protect the interests of the public if substandard services have already been rendered. Because of this, an increase in the regulatory mechanism and its associated costs is necessary.

Responding to this claim, the court held that most professionals will act as they always have...they will abide by their solemn oaths to uphold the integrity and honor of their profession. For every one who overreaches through advertising, there will be thousands of others who will be honest, candid, and straightforward. It is the responsibility of those thousands to help weed out the few who abuse the public trust. In summary, the prohibition of advertising is not the best or even an effective way of preventing substandard service to clients (*patients*).

The legal profession, like dentistry, actually allowed advertising at the time of the case. But there were only certain kinds of information that the legal profession permitted the public to have. In response the Supreme Court noted that, by allowing the advertising only of generic information such as the name of the lawyer, his title, address, office hours,

The prohibition of advertising is not the best or even an effective way of preventing substandard service to clients (patients).

specialty status, etc. "...the State's protectiveness of its citizens rests in large measure on the advantages of their being kept in ignorance." The court countered that a better approach would be to assume that allowing more information via advertising is not necessarily harmful and "...that people will perceive their own best interests if only they are well enough informed, and that the best means to that end is to open the channels of communication rather than to close them."

The Code Since 1979

Given this legal history, it is no surprise that significant changes were made in the 1979 revision of the ADA's code. One important change was the title of the document itself. Instead of being known as a Code of Ethics or the Principles of Ethics, dentistry's best known statement of professional guidelines would now be known as the *Principles of Ethics and Code of Professional Responsibility.*

As required by the consent agreement with the FTC, Section 5 addressed the regulation of professional announcements and succinctly stated "the dentist should not misrepresent his training and competence in any way that would be false or misleading in any material respect"; however this phrase was not defined here. Section 5-A addressed advertising in only one sentence: "Although any dentist may advertise, no dentist shall advertise or solicit patients in any form of communication in a manner that is false or misleading in any material respect." Section 5-B made the same admonition about false and misleading statements regarding practicing under a trade or assumed name.

Section 5-C was of special importance in that it was the first time that organized dentistry formally acknowledged that the public makes the selection of whom they choose to be treated by, and does so on the basis of various criteria. Advertising the completion of advanced training in an accredited program is one way of providing this information. Dual trained specialists could now announce both areas of specialty practice, the burden of responsibility to not mislead patients about which dentists have specialty training and which do not now rested with the specialist. A general dentist who desired to provide specialty services to his patients was "...permitted to announce the availability of [specialty] services so long as he avoids any communications that express or imply specialization. The dentist shall also state that the services are being provided by a general dentist." The 1979 code, in a footnote, also required that no State or Organizational Code may be in conflict with the newly adopted version which was to be the principal standard for determining ethical propriety of professional activities.

The 1988 revision was virtually unchanged, but it was the first to include advisory opinions in the text to enable the reader to see how the principles and code items should be applied. The phrase "false or misleading in any material respect" was now defined so it referred to statements that:

> "(a) contain a material misrepresentation of fact, (b) omit a fact necessary to make the statement considered as a whole not materially misleading, (c) contain a representation or implication regarding the quality of dental services which would suggest unique or general superiority to other practitioners which are not susceptible to reasonable verification by the public, and (d) be intended or be likely to create an unjustified expectation about results the dentist can achieve."

Included as examples of false and misleading statements are the use of an unearned or non-health degree in any announcement, using the attainment of a fellowship in an advertisement, and announcing board certification or diplomate status in a non-ADA recognized specialty. The last three items have since been challenged in the courts, which have ruled that such language is not false or materially misleading as long as the claims are truthful.

The close of the twentieth century marked another important change in the ADA *Principles of Ethics and Code of Professional Responsibility.* In the 1998 revision, for the first time, widely accepted bioethical principles were incorporated into the text. The sections dealing with announcements and advertising were virtually unchanged; but several relevant subjects were addressed in new advisory opinions 5.F.1. and 5.F.2, which state:

> "Subjective statements about the quality of dental services can also raise ethical concerns. In particular, statements of opinion may be misleading if they are not honestly held, if they misrepresent the qualifications of the holder, or the basis of the opinion, or if the patient reasonably interprets them as implied statements of fact. Such statements will be evaluated on a case by case basis, considering how patients are likely to respond to the impression made by the advertisement as a whole. The fundamental issue is whether the advertisement, taken as a whole, is false or misleading in a material respect."

Section 5.F.4 discusses referral services and proscribes the use of commercial services for which a fee is paid; for by engaging in this activity, one may be found to have engaged in fee splitting relative to the referral of patients. Section 5.H.2. deals with specialist announcement in non-recognized specialty areas such as "Cosmetic Dentistry," "TMJ," or "Implant Dentistry." Section 5.I. and related subsections echo proscriptions of the past regarding how generalists are allowerd to announce their services. Finally, Section 5.I.2. addresses the issue of fellowship announcements and states that "The use of abbreviations to designate credentials shall be avoided when such would lead the reasonable person to believe that the designation represents an academic degree, when such is not the case."

This foray into the history of ADA code was undertaken to put efforts at regulating advertising into historical context. Dentistry's code of professional ethics is an ever changing document that offers a unique perspective into dentistry's "professional personality" at various points in time as it adapts to and tries to reconcile the needs of the public, the needs of individual practitioners, and the needs of the profession.

Having Your Say

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

Abstract

Effectiveness in speaking at meetings is more a matter of fit with the emerging image the group has of itself than the persuasiveness of the speaker. In addition to rhetorical messages, people speak at meetings to confirm their right to membership, obtain or exercise status, achieve social goals, and provide or reinforce the structural and procedural needs of the group. Persuasive speeches should fit the flow of the meeting, state the desired result of the speech, and give a reason. Style points are also mentioned.

This column is about speaking in meetings. It is something dentist do often, especially if they are involved in organized dentistry. The message is, "fit matters more than being articulate."

In Tolstoy's epic *War and Peace*, a counsel of war is described that illustrates the ineffectiveness of crafting the ideally persuasive message. Napoleon's armies have crossed the frontier into Russia, and the Tsar's advisors, drawn for many nations, are meeting to discuss strategy. The coucill accomplishes little more than a vague agreement on who should be blamed should the campaign fall apart. Tolstoy caricatures the participants. "Pfeuel was one of those hopelessly and immutably self-confident men, self-confident to the point of martyrdom as only Germans are, because only German's are self-confident on the basis of an abstract notion—science, that is, the supposed knowledge of absolute truth. A Frenchman is self-assured because he regards himself personally, both in mind and body, as irresistibly attractive to men and women. An Englishman is self-assured, as being a citizen of the best-organized state in the world, and therefore as an Englishman always knows what he should do and knows that all he does as an Englishman is undoubtedly correct. An Italian is self-assured because he is excitable and easily forgets himself and other people. A Russian is self-assured just because he knows nothing and does not want to know anything, since he does not believe that anything can be known."

Tolstoy's point is that we too often are confident when we have our say because we have convinced ourselves of the inevitability and persuasiveness of our own position. Our convictions can be blinders when we speak out in public settings.

What the Group Wants

Eloquence that fails to match the needs of the moment is generally wasted. Speaking may be a right in some situations, but being listened to is always a privilege. Effective speakers realize they must earn both the opportunity to speak and the opportunity to be listened to.

Speaking may be a right in some situations, but being listened to is always a privilege.

Every speech is not intended to make a rhetorical point. There are multiple objectives in speaking one's mind, and success is largely the matter of fit between the speaker and the needs of those who are listening. I will mention just five purposes for speaking.

Membership

The clothes we wear, our demeanor, and certainly much of what we have to say in meetings goes towards proving that we really do deserve to be sitting at the table. The currently fashionable "pass word" is insurance bashing as a way proving one is a real "fee-for-service" dentist or a CE guru who has the best interests of private practitioners in mind. These speeches are not made to insurance executives, politicians, or even the public. Another example of speaking to demonstrate membership is Abraham Lincoln's speech on the Mexican-American War made during his single term in the House of Representative in order to demonstrate political solidarity with his party. Some of his remarks came back to bite him during his presidency.

Occasionally, a speaker is demonstrating membership with an audience that is not present. Lincoln's remarks in congress, like those of many politicians, were intended as much for consumption at home as in the capital. Sometimes speakers will state extreme positions to prove their loyalties. This can be very damaging as Harvey points out in his best seller *The Abilene Paradox*. When speakers propose what they feel others want to hear, all may end up where no one really wants to be.

Status

Sometimes people speak *ex cathedra* and sometimes they speak in order to gain status. In both cases, the message is a vehicle. We are usually aware of *ex cathedra* speeches because they are announced as such. "Before dinner we will have a few remarks from the president;" "the chairmen brings greetings from our sister organization." President Lincoln's Gettysburg address was exactly such an occasion. The main speaker at the dedication of the cemetery at Gettysburg was Edward Everett. Lincoln was invited as an afterthought. Although he was unpopular, he was still the President, and he was strictly admonished to make his remarks brief.

Some speakers are notorious for talking as long as needed for them to think of something important to say.

The other kind of speaking for status is in an attempt to impress ones hearers with how reasonable you are as a person rather than how reasonable your remarks are for use by your listeners. The Lincoln-Douglas debates were such a circumstance. Although Lincoln spoke extensively about slavery and state's rights, he did not expect his listener to manumit their slaves or take individual action on national unity. What he expected was to acquire enough respect for himself based on what he said to win election to the United States Senate. He failed.

Social

Sometimes speech is not intended to make any reasonable point at all. The joke that defuses a tense moment; the roasts that both honor accomplishment and reminds us we are somehow still human; and the invitation to let a so-far-silent member of the group join the conversation are all examples where the purpose of speech is to maintain the identity and functioning of the group. Effective groups actually spend a large portion of their time engaged in social speech as a foundation for later task-oriented speech.

A commencement address is stereotypical social speech. We all know the difference between a good one and a bad one, but we are not expected to remember either or to act on what either says. Just so with Edward Everett's three-hour oration at the dedication of Gettysburg Cemetery, which by all accounts was a much more moving and memorable performance in the minds of those present them was Lincoln's. Lincoln, himself, was the master of social speech. His home spun humor, normally taking the form of extended antidotes, put visitors at ease, disarmed political crisis, and guided the mood of many meetings — as well as irritating the heck out of the stuffed shirts in Washington. During his life time, there were many popular books sold containing Lincoln stories and other material attributed to him.

Structural

Sometimes speech is meant to give structure to the actions of the group. The chair of the committee calls for a vote; somebody, hopefully the chair, reminds members of the agenda and where the group stands on it; a mechanism is determined for recognizing speakers. These are housekeeping matters and issues of agenda management. It isn't always the one with nominal authority in a group who controls the flow of conversation or the selection of topics. Watch carefully in a contentious meeting as a new person begins to speak and you will see frowns and shifts in body positions as well as comments intended to stir the group towards or away from certain topics of conversation.

Lincoln, the great diplomat, controlled the structure of many conversations by refusing to engage in them. Congress was not sympathetic to Lincoln's position as the war drew to a conclusion and he avoided consultations with the war senators in particular. He also outlined very clearly which items were on the table for discussion concerning a peace treaty to end the war and which were not.

Content

Although we think of speeches in meetings and other gatherings as dominated by rhetorical presentation of arguments intended to shape the action of the group, the previous discussion shows

that much more is going on. Speaking one's mind with the hope of enlisting support from the audience is the essence of rhetoric and will be the focus of the rest of this column. Examples from Lincoln include his "house divided" speech made before he sought the presidency which stated the position of union over state's rights and is second inaugural address calling for a kind and rapid healing of the nation. The first of these great speeches actually divided the nation and the second angered Congress. Many believe had not Lincoln been assassinated he surely would have been impeached as his successor was.

Sometimes speech is not intended to make any reasonable point at all.

Speaking to Persuade

As the quotation from Tolstoy at the head of this column illustrates, individuals have their own views of what makes speeches persuasive. Forget that. Persuasiveness grows out of the needs of the audience.

Groups have their own way of judging what is a good speech and what is not. There are rules both for how something can be said and for what can be said. Although it is pretty obvious that a group has a collective sense of what is in its best interests, groups can be rigid about how they arrive at those best interests. There are numerous studies in the psychological literature where identical messages have different impact depending who speaks, when they say it, and how it is presented. Status within the group matters. So does gender and seniority. Consultants are often given exaggerated credibility in terms of describing the real world outside the group and little credibility for knowing what the group really values. Groups protect their members, individually and collectively, and they often reject a sound idea if it appears to be offensive to some. Many groups abhor voting or any other means of decision making that creates a dissatisfied minority. An argument that carries the day often unravels as it's implications for all members of the group become apparent.

A useful metaphor for evaluating rhetorical arguments in a group is to imagine that the group has a fuzzy image of itself, how it works, and what it is trying to achieve. Each rhetorical argument is a suggestion that a different image be adopted by the group. If the alternative image is vague because it is not communicated clearly; if it creates division in the current image of the group between identity, procedures, and mission; or if the group prefers its current image to the alternative being proposed, the speaker's argument will be rejected or left on the table. The fact that the speaker is proposing an image for the group that he or she feels is preferable can be taken for granted. Even if the alternative is better in some objective sense, it will not be accepted if it is ambiguous or if it challenges some of the assumption the group has about itself and how it operates.

It is discouraging to learn that an argument has been primarily a misunderstanding about the way words are used.

Abraham Lincoln's policy regarding the seceeding states following the conclusion of the war—"let 'em up easy"—was inconsistent with the image of both the Abolitionist and the War Republicans. He failed to offer an alternative image of the country that these groups thought was preferable to punishing the losers.

Guidelines for Having Your Say

In its simplest form, speaking with the intent of influencing a group has three elements: (a) context, (b) hoped-for impact, and (c) reason. It is easier for listeners if they know something about who is talking and why. In very formal meetings, this is ritualized when individuals step to the microphone and state their names, relevant affiliations, and who, if anyone besides themselves, they speak for. In informal groups, the same question shifts to a matter of context or timing. People in a committee know who is speaking but they like to know why that person is speaking at this particular point. Brief explanations such as "I agree with the last two comments in general but would like add a cautionary note about a particular situation" or "I think we are setting up a potential conflict" help the listener orient to what is to follow.

Sometime speakers are so involved in explaining the reasons behind their views or in making a point based on principle that the listeners can only wonder what was said. Some speakers are notorious for talking as long as needed for them to think of something important to say, or in some cases talking at length without ever coming to a point. A simple rule is to follow the introductory explanation of why you are talking now with a succinct description of what you would like a group to do based on your remarks. "I think we need to get more information about cost before we approve this project" or "I think we should add an escape clause to this contract" are examples.

The third rule is always give a reason. There should be a "because" in every persuasive speech in order to show respect to one's colleagues as rational indi-

viduals. Giving a reason does not ensure your argument will carry the day because there are so many reasons for any issue of significant. Failing to give a reason that has meaning to the group is insulting and pretty certain to kill your suggestion.

Style Points

The basic model is to establish the context or perspective from which you are speaking, state what you would like the group to do, and give reasons. Beyond this there are some tactical skills that generally work to make it more effective when you are speaking your mind.

Know What You are Going to Say Before You Begin to Speak

Every message should have a "this is what I would like you to do" and a "this is the reason why" section. Unless you are very clear about what these two parts are before you start talking, it shouldn't be surprising if others are unclear about them when you finish. If you go back and forth between action and reason, this is symptomatic of your own fuzzy thinking.

Do Not Repeat Yourself

It is bad form to make the same persuasive speech twice to the same group. What you are saying is either "perhaps I did not make myself clear" or "perhaps you were not listening." Neither of those is very flattering. Don't count on repetition to correct the problems of poorly designed communication.

Timing Matters

It is hard work for groups to listen to multiple perspectives and frame a common understanding. Your contribution will be appreciated if it makes the group's work easier by fitting the natural flow of conversation. You had better have a clear and compelling reason to shift the group's attention, either in a surprising new direction or back over materials that has been covered previously. One way to increase the chances of timing your remarks so they will get a good hearing is to imagine where the conversation will go next. It is time for you to speak up when you anticipate that the collective consciousness of the group is approaching the point of view you wish to express.

Don't Split the Group

Sometimes it may be tempting to frame an argument so that it is attractive to some to the members of the group while you know it is offensive to others. The audience you are playing to may be the majority. But groups are protective of their collective identity. They may value solidarity more than progress and they almost always prefer consensus to compromise.

Provide a Golden Bridge

Sun Tzu wrote a manual on the art of warfare in about the fourth century BC in China that is still studied today. Among his most famous principles is the notion that only a foolish general will leave his opponents with no means of escape. When trapped, it is human nature to fight to the death. The wise general leaves a golden bridge for his enemy to retreat on. Experts in the field of negotiation advise that it is sound to find a way for your opponent to save face.

Use Concrete Language

It is discouraging to learn that an argument has been primarily a misunderstanding about the way words are used. It is more disastrous to discover that an agreement has been reached that later unravels when it is discovered that the same words mean different things to those present. The likelihood of these awkward situations can be reduced by preferring concrete language, examples, and a detailed descriptions of anticipated consequences rather than general or abstract terms. Let your listeners make up their own minds based on understanding what you say rather than making them duck your emotional blasts.

There should be a "because" in every persuasive speech in order to show respect to one's colleagues as rational individuals.

Recommended Reading

Harvey, J. B. (1996). *The Abilene paradox and other meditations on management.* San Francisco, CA: Jossey-Bass.

It may be dangerous to try to fit in with the group. Sometimes people speak with a goal of being polite to others. When this is taken at face value representing the speaker's true motives and reinforced by others trying to be nice, the group can end up agreeing to a course of action no one really wants (on the assumption that everyone else what it).

* 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.

* Schrage, Michael (1995). *No More Teams! Mastering the Dynamics of Creative Collaboration.* New York, NY: Doubleday Currency. ISBN 0-385-47603-5; 241 pages; about $20.

This book sets out to delineate the conditions for collaborative creativity. This is said to have been generally confused with teamwork. "I discovered that meetings are the awkward social ritual that organizations put their people through in the hope that they might productively collaborate" (ix). "The concept of teams obscures, rather than reveals, the real relationship challenges our organizations face. Teams are a fiction, a verbal convenience, rather than a useful description of how people in a firm cooperate and collaborate to create value" (xi). "Far too many organizations are so intellectually lazy that they don't define their problems and opportunities in ways that can seduce their people into enthusiastic, unrestrained collaborative efforts. They'd rather manage things the old-fashioned way: divvy up the problem and delegate it. It's motivation by delegation. If an organization wants to reap the synergies of collaboration, motivation by delegation represents a failure of leadership" (xiv). "If there is a core theme to this book, it's that people must understand that real value in the sciences, the arts, commerce, and, indeed, one's personal and professional lives, comes largely from the process of collaboration. What's more, the quality and quantity of meaningful collaboration often depends upon the tools used to create it" (27).

Sun Tzu (1963). *The art of war.* (S.B. Griffith, trans.) Oxford: Oxford University Press.

This manual was written in about 500 BC in China for both generals and politicians. The essence of good war is to avoid it; there has never been a protracted war from which either contestant emerges victorious. Once war has begun, however, deception is a powerful weapon. This manual contains the admonition to leave one's enemy a "golden bridge" — a means of escape — since trapped people fight to the death.

Tannen, B. (1986). *That's not what I meant!.* New York: Ballantine.

Light reading about the differences in conversation style among men and women. Both purpose and manner of speaking matter along side what is said.

* Ury, William (1991). *Getting past no: Negotiating your way from confrontation to cooperation.* New York, NY: Bantam Books. ISBN 0-553-37131-2; 190 pages; about $14.

"How can you turn confrontation into cooperation? How can you transform conflicts to be fought into problems to be solved" (ix)? "I have shifted the emphasis of the book from negotiating with difficult people to negotiating in difficult situations" (xi). The five steps are: (a) get your own perspective, (b) help the other side get perspective, (c) reframe the negotiation as joint problem solving, (d) build a graceful way for the other side to agree with you, (e) use power to educate.

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 having your say; a donation of $50 would bring you summaries of all the 2000 leadership topics.

The Manuscript Referee Process

Nine unsolicited manuscripts were considered during 2000 for possible publication in the *Journal of the American College of Dentists*. Two were returned without review because they did not meet the mission statement of the journal. Of the seven sent for peer review, two (29%) were accepted for publication, some pending revisions.

Twenty-eight reviews were received, and average of 4.0 per manuscript. Seventy-five percent of the reviews were consistent with the final decision regarding publication. Cramer's V statistic, a measure of consistency of ratings was .471. 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 journals because it is not customary for others to report consistency 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.

During the year, the journal received and granted ten requests to reprint in other journals articles appearing originally in the *Journal of the American College of Dentists* and requests to copy for educational use nine articles from the journal.

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 2000:

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Douglas Young, DDS
University of the Pacific School of Dentistry

[erratum]

The following acknowledgment was inadvertently omitted from the article "The ethical complexities of dual relationships in dentistry" which appeared in the Summer 2000 issue of this journal: "Parts of this paper were presented in a poster exhibit at the 73rd Annual Session of the American Association of Dental Schools, San Francisco, California, 1996."

Journal of the American College of Dentists

2000

Statement of Ownership and Circulation

The *Journal of the American College of Dentists* is published quarterly by the American College of Dentists, 839J Quince Orchard Boulevard, 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 5,408, none sold through dealers or carriers, street vendors, or counter sales; 5,107 copies distributed through mail subscriptions; 5,107 total paid circulation; 144 distributed as complimentary copies. Statement filed with the U.S. Postal Service, September 28, 2000.

2000 Articles

2000 Authors

American College of Dentists
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Gaithersburg, MD 20878-1614

Periodicals Postage
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