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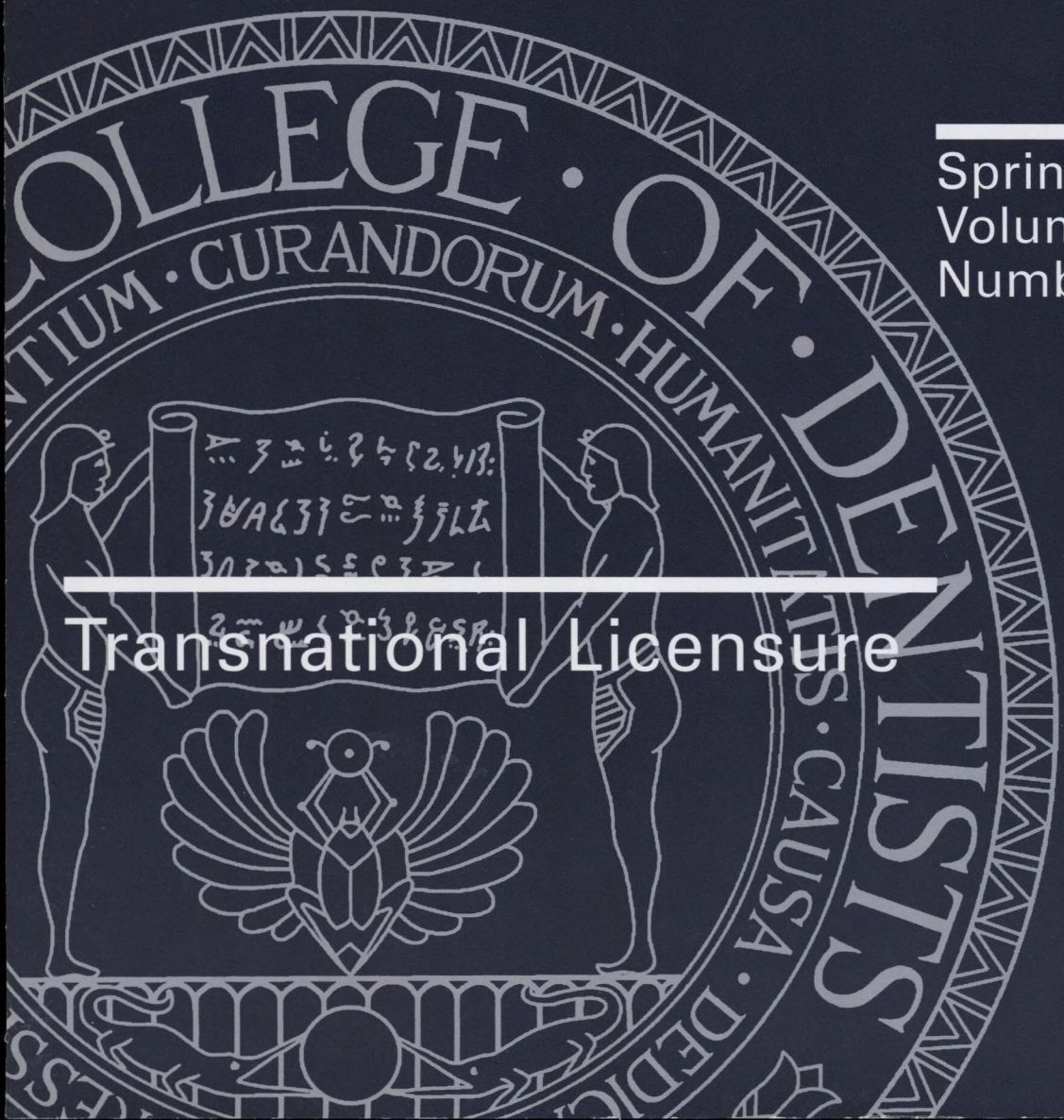

Transnational Licensure

Journal *of the* American College *of* Dentists

A Publication Presenting Ideas, Advancements, and Opinions in Dentistry

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Mission

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

Objectives of the American College of Dentists

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

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

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

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

D. To encourage, stimulate and promote research;

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

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

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

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

I. To encourage individuals to further these objectives, and to recognize meritorious achievements and the potentials for contributions to dental science, art, education, literature, human relations or other areas which contribute to human welfare—by conferring Fellowship in the College on those persons properly selected for such honor.

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FROM THE EDITOR

Righteousness and Reason

At the dental school where I teach, we have a course for students shortly before they graduate called Critical Thinking. We alternate lectures and student lead seminars on topics such as the dental literature and scientific reasoning, EBD, the unusual partnership between dentistry and industry, how to read an advertisement, and what patients are finding about oral health on the Internet.

The Internet is a favorite among students. We ask them to find a Web site designed for patients, describe it to classmates, and evaluates it. Quackwatch.com is a rich source, offering access to bizarre and remarkable results, supported by testimonials and pseudoscience. Students' evaluations of these sites tend to be emotional and shallow. "What does Jane Doe of Anytown, America, know? She's probably the promoter's daughter in law," "It's just too ridiculous to comment on," "Only a fool could believe this stuff," We have a lot of fun in this class and feel quite superior.

One of the faculty tutors in these seminars recently gave the students an ear full over the way they "evaluated" patient oriented Web sites. He observed that using platitudes to put down claims was no different from using platitudes to advance them. If the claims were so spurious, it ought to be possible to explain that.

There is a difference between righteousness and reason.

Patients deserve the respect of receiving a reasonable answer they can understand, even when they ask unreasonable questions.

This is actually rather serious business. There may be negative side-effects in using unsubstantiated dental treatments. Patients can also lose money, suffer prolonged discomfort, and become confused and embarrassed. Occasionally, patients' conditions deteriorate as they postpone seeking proper care.

These reasons why unsubstantiated care won't work have to be explained to patients. It would be an insult to belittle their questions and to imply that they were silly to consider such treatments. Some dentists may be able to get by with a little paternalism. "In my experience, I think this would be unwise for you" may work if the dentist has already established credibility, but it won't earn credibility.

Patients deserve the respect of receiving a reasonable answer they can understand, even when they ask unreasonable questions. The same sort of respect is due to practitioners attending continuing education courses, dentists who inquire about equipment or products from their manufacturers, and professionals who question government policies or professional organizations' decisions.

At UOP we use the Rule of Reason. "Rational people must be able to give reasons for what they say and what they do." This doesn't mean that every sentence contains a justification or that every action is accompanied by mumbled subtitle explanations. It means that a reason exists and will be given if requested.

Being reasonable in our school is not a badge of intellectual snobbery; it is part of our humanistic philosophy. Willingness to discuss why we hold our various

The Rule of Reason is simple in dentistry: if you are not prepared to explain to your colleagues why you are saying what you are saying or doing what your doing, you had better not.

beliefs is a sign of respect. Remember when your parents or older siblings told you "You have to do this, just because ..." That formula is a direct denial of a rational relationship. Remember too how it made you feel badly about the person who said it and about yourself.

When giving reasons, first you have to be truthful. If you offer reasons you don't actually believe, you will be perceived as insincere and manipulating. Second, your reasons must be relevant to the needs of those you are talking to. If you asked a colleague why she purchased a particular digital camera for her office and she told you "the VAT was favorable," you may not accept this as a useful reason. Perhaps you are unfamiliar with the value added tax used in Canada and much of Europe. Perhaps you do to not intend to travel there to purchase office equipment.

Surprisingly to some, the rule of reason does not require the use of scientific explanations. There simply isn't enough science to support all of dentistry, and there are important reasons for things dentist do that are not scientific in nature—such as choosing a practice type, level of quality, or the way patients are treated. A recent issue of the journal *Evidence Based Dentistry*, estimated that there are only about 3000 randomized controlled trials in the entire field of dentistry.

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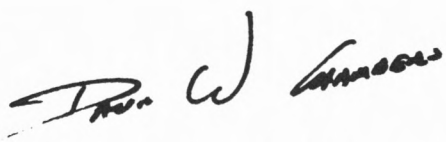
Dentists have generally made a mistake in arguing with anti-fluoridationists, anti-amalgamists, quacks, and their believers by offering science rather than reasons that are understandable to the public.

There is one additional requirement for reasonable dentists. Professionals, because of the collective authority society gives to their knowledge, must be prepared to give reasons that are acceptable to their colleagues. This is why peer review of manuscripts matters in the dental literature and peer review committees matter in professional practice. The Rule of Reason is simple in dentistry: if you are not prepared to explain to your colleagues why you are saying what you are saying or doing what your doing, you had better not.

Righteousness cannot hold a profession together. Let's be reasonable.

On a recent Saturday afternoon, I went through the journals in my office until I had identified one hundred advertisements. I classified them in a variety of ways and made notes on the reasons presented in support of the product claims. Under the heading of "reasons," I counted references to published papers, mention that research was available upon request from the company, testimonials from famous and unknown individuals, and listing of active ingredients or method of operation. In this sample of one hundred, only thirty-eight provided any reason at all in support of the claim. Sixty-two percent of the advertisements were unreasonable.

My point is not that academics can be righteous about industry that does not provide reasons or dentists who do not ask for them when choosing dental products. Here is my reason. A profession that does not respect those it interacts with, says things it does not believe, fails to reach out to be understood by others on their terms, and does not ground its actions and statements in standards acceptable to its peers will fall apart. Righteousness cannot hold a profession together. Let's be reasonable.



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

The College acknowledges the extensive contribution of historical information from Dr. H. Martin Deranian to the story "The First Honor Society for Dentists" which appeared on pages 32 through 34 of the fall 2002 issue of *The Journal of the American College of Dentists*. Dr. Deranian is a past president of the American Academy of the History of Dentistry and a winner of the academy's highest recognition, the Hayden-Harris Award.

Transnational Licensure: The View from Texas

Diane Rhodes

Abstract

Texas has a diverse population with many underserved communities and a dentist-to-population ratio only 80% of the national average. Currently dentists trained in other countries can be licensed after completing four years of dental school and passing either the Western or Central Regional Testing Association's examination or by completing a graduate program in an ADA-accredited specialty. Although there have been careful and lengthy analyses of comparability of training across countries, a fundamental issue is that standards for education are developed by a national voluntary organization (Commission on Dental Accreditation) and standards for licensure are determined by individual states in the United States. Elsewhere in the world, the federal government performs these roles.

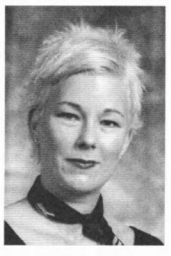
Texas is the nation's second most populous state and the eighth fastest growing state in percentage terms. Almost 45% of Texans are members of racial and ethnic minorities, compared to 30% of the U.S. population. The combination of large segments of the population in the lower socioeconomic strata, lower educational levels, and ethnic groups with genetic predispositions to chronic diseases make Texas especially susceptible to access to care problems.

With a statewide dentist per 100,000 population ratio of 37.8, the overall supply of dentists in Texas is significantly below the national average of 48.4. As a result, many rural and inner city communities are grappling with a shortage of dentists. In fact, the federal government currently designates 76 of the state's 254 counties as (whole county) dental Health Professional Shortage Areas (HPSAs). Similarly, like their counterparts in many other states, the Texas Medicaid and Children's Health Insurance programs have trouble attracting and retaining dentists, resulting in shortages of providers in some communities.

Although the three Texas dental schools (the University of Texas Health Science Center at San Antonio, Dental School; the University of Texas Dental Branch-Houston; and Baylor College of Dentistry, Texas A&M University System) graduate a total of about 250 new dentists each year, most of those graduates choose to practice in urban or suburban communities that are already well served by dentists.

In addition to the federal loan repayment program provided by the U.S. Public Health Service, the Texas Higher Education Coordinating Board operates its own dental student loan repayment program to attract dentists to underserved areas. The program, which is funded through mandatory tuition set aside at each of the state's dental schools, provides an annual maximum loan repayment of $10,000 for dentists who practice for at least one year in a dental HPSA or federally funded community

In 2001 the Texas Legislature authorized the State Board of Dental Examiners to waive the five-year experience requirement for licensure by credentials and issue temporary licenses to dentists licensed in other states who accept positions at community health centers in Texas.



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health center. Unfortunately, with an annual appropriation of approximately $120,000, the program is only able to assist a handful of dentists each year.

To supplement these loan repayment programs, in 2001 the Texas Legislature authorized the State Board of Dental Examiners to waive the five-year experience requirement for licensure by credentials and issue temporary licenses to dentists licensed in other states who accept positions at community health centers in Texas. In a related move, the Texas Sunset Advisory Commission recently recommended that the legislature reduce the experience requirement to three years and direct the state dental board to consider accepting results from other regional testing agencies in addition to the Central Region Dental Testing Service and the Western Regional Examination Board.

No Transportability in Texas

Despite the availability of these programs, however, many communities in Texas continue to suffer from a shortage of dentists. Believing that dire circumstances justify drastic remedies, some observers suggest that one way to improve access to dental care in Texas is to reduce or eliminate barriers to licensing foreign trained dentists, especially dentists from Mexico.

The North American Free Trade Agreement (NAFTA) requires the U.S. and Mexico to develop mutual standards for licensing and certifying professional service providers.

The growth of international trade and commerce has also focused attention on barriers to the professional mobility of dentists and other health care professionals. For example, the North American Free Trade Agreement (NAFTA) requires the U.S. and Mexico to develop mutual standards for licensing and certifying professional service providers.

A significant number of Mexican trained dentists have initiated the process of obtaining licenses in the U.S. As of July 1999, for example, 162 graduates of Mexican dental schools applied to take Parts I and II of the National Board Dental Examination, which is the cornerstone of licensing requirements in all 53 licensing jurisdictions in the U.S.

At present, most foreign trained dentists find it difficult to obtain a license in Texas and in most other states. Under Texas law, graduates of foreign dental schools have two options to obtain a Texas license. Applicants who have not graduated from a dental school accredited by the American Dental Association's Commission on Dental Accreditation (CODA) must either successfully complete a CODA accredited program of at least two years duration in an ADA recognized specialty, or repeat dental school at a CODA accredited institution. These requirements also apply to foreign trained dentists licensed in other states who seek to obtain a Texas license by credentials.

The Texas dental board currently recognizes nine ADA specialty programs, including orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, prosthodontics, endodontics, oral and maxillofacial surgery, oral and maxillofacial radiology, oral and maxillofacial pathology, and dental public health. Although Texas dental schools offer graduate programs in each specialty, foreign trained dentists face a variety of obstacles in gaining admission to those programs.

The growth of international trade and commerce has also focused attention on barriers to the professional mobility of dentists and other health care professionals.

In addition to financing the cost of additional schooling and the burden of establishing their academic qualifications, foreign trained applicants encounter intense competition for admission to postgraduate specialty programs in Texas. In some cases, 150 applicants—from both U.S. and foreign schools contend for one or two available slots. Given the competitive nature of the admissions process, some dental school faculty members suggest that it is virtually impossible for foreign trained dentists to gain admission to specialty programs at Texas dental schools.

As a result, many graduates of Mexican dental schools are compelled to repeat dental school in the U.S. In the past, the University of Texas Dental Branch-Houston allowed graduates of foreign dental schools to take a bench test that could enable them to "place out" of the first two years of dental school. However, Houston abolished the bench test several years ago. Neither the University of Texas Health Science Center at San Antonio nor the Baylor College of Dentistry offer special programs to assist foreign trained dentists to obtain admission to dental school.

Mexican trained dentists contend that they should be able to obtain a Texas dental license without having to complete a dental education specialty program or repeating dental school in Texas. They assert that passing a regional dental exam accepted by the Texas board (WREB or CRDTS) should stand as sufficient demonstration of their skills.

This view is based in part on the difference between government regulation of dental education in the U.S. and in Mexico and other countries.

Defining Comparability

The U.S. differs from most of the rest of the world because it relies on accreditation to ensure the quality of dental education programs and to foster a culture of continued improvement. The political dynamics and relative roles of government and private or professional organizations vary greatly from country to country. The U.S. has no federal ministry of education or other centralized governmental authority exercising national control over dental schools. In Mexico and other foreign countries, national governments are often heavily involved in accrediting and setting standards for dental education.

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Differences also exist with respect to the duration of dental education in the U.S. and Mexico. For example, prospective dentists enter dental school in Mexico immediately after completing high school. Completion of a Mexican dental program requires an additional four to five years. Unlike the U.S., where individual states regulate dental professionals, the federal government grants licensure in Mexico and dentists are required to complete one year of social service before they can enter private practice. By contrast, U.S. dentists complete four years of dental school and many have earned college degrees, are licensed by the states in which they choose to practice, and most have no social service obligations.

In an effort to remove barriers preventing more Mexican trained dentists from practicing in the U.S., the Association Dental Mexicana (ADM) has been negotiating with CODA since 1991 to establish conjoint academic programs. ADM reported to CODA in March 2002 that the Mexican National Council on Dental Education (MNCDE) had accredited fifteen of the fifty-eight dental schools in Mexico. At that time, ADM gave CODA a copy of the *Mexican Predoctorial Accreditation Guidelines and Procedures*. CODA then formed a subcommittee to study a translation of the Mexican guidelines and procedures. In order to ensure "license transparency" (that is, the ability of a dentist to transfer his or her license between countries) in the credentialing process, CODA would have to carefully weigh differences between the voluntary peer review process in the U.S. and the government controlled accreditation process in Mexico. At present, CODA and ADM are still discussing developing a mutual accreditation program.

ADM has also attempted to secure a recognition agreement between MNCDE and CODA similar to CODA's current agreement with Canada. In July 2001, CODA stated that reaching such an agreement would be contingent on a demonstration that the two organizations' accreditation standards, policies, and procedures are equivalent. Although ADM hopes to complete a recognition agreement, political concerns and government regulations in Mexico could lengthen the process for several years. Moreover, even if the two sides reach an agreement, it would not help Mexican dentists seeking licensure in Texas, since Texas law and the state dental board would continue to require applicants to graduate from a CODA accredited institution.

Organized dentistry in the U.S. has grappled with accreditation of foreign dental schools for years. For example, in 2001 the ADA House of Delegates considered a resolution calling for development of procedures to accredit foreign dental schools. The rationale was that health care professionals desire freedom of movement not just nationally, but worldwide. The resolution was ultimately defeated. In 2002, the ADA approved a resolution calling for continued study of and support for international dental education programs.

Given the proximity of Texas to Mexico, the Texas Dental Association (TDA) closely follows the issue of credentialing foreign trained dentists. In a July 2002 letter to CODA, TDA's Council on Dental Education, Trade & Ancillaries cited differences in dental education between Mexico and the U.S., as well as shortcomings in infection control procedures taught at Mexican dental schools, as compelling reasons why Mexican trained dentists require additional dental education in the U.S.

Other states, however, are moving toward accrediting foreign dental schools and licensing their graduates. Minnesota, for example, has authorized its dental board to decide if the education and training at individual foreign

The federal government grants licensure in Mexico and dentists are required to complete one year of social service before they can enter private practice.

dental schools is equivalent to that provided at a CODA accredited institution. The law specifically states that a graduate of a dental college in another country may not be disqualified from examination solely because of the applicant's foreign training if the board determines that the training is equivalent to or higher than that provided by a dental college approved by CODA. The Maryland Legislature recently approved a bill to allow foreign dental school graduates to treat pediatric patients. Similarly, the Dental Board of California recently developed its own criteria and granted provisional certification to a Mexican dental school - the University De La Salle in Leon, Guanajato—marking the first time a U.S. dental board has used an accreditation process other than CODA.

Public and Professional Policy

The LBJ School of Public Affairs at the University of Texas at Austin is currently conducting a policy research project (PRP) entitled Border Workforce Issues: Credentialing of Health Professions in the U.S. and Mexico to examine the nature and portability of health professional credentials in the two nations. The project is funded in part by a contract with the Regional Center for Health Workforce Studies of the Center for Health and Economic Policy at the UT Health Science Center—San Antonio. The PRP will host a conference in Austin, Texas, in March 2003 that will bring together representatives of a variety of research institutions and policy makers to discuss topics such as whether licensing Mexican dentists would lead to a mass migration of dentists to Texas, thus creating a dental shortage in Mexico.

Although the Texas Legislature has previously discussed the licensing of foreign trained dentists, it has not addressed that issue in recent years. Some observers wonder whether the legislature would bow to pressure from underserved communities and direct the state dental board to reevaluate its licensing policies for foreign trained dentists. If that does occur, the Texas board could follow California's lead, develop its own accreditation criteria, and accept graduates of state approved Mexican dental schools. Absent compelling evidence, however, that foreign trained dentists would choose to practice in the underserved areas of Texas rather than in communities already well served, it seems unlikely that the legislature would support such a change in the face of strong opposition from organized dentistry.

At present, CODA and ADM are still discussing developing a mutual accreditation program.

Portability of Licensure in Canada Based on Accreditation and Certification

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Abstract

Although registration and licensure of dentists in Canada is the purview of the ten provincial licensing authorities in Canada, establishment of standards and certification of candidates has for fifty years been the responsibility of the National Dental Examining Board. The NDEB administers a validated set of written and objective standardized clinical examinations to educationally qualified candidates. Such candidates include those who have graduated from accredited Canadian and United States schools and graduates of non-accredited schools who have satisfactorily finished a qualifying program. The NDEB cooperates closely with U.S. educational and accreditation programs and the American Dental Association.

The National Dental Examining Board of Canada (NDEB) was established by an Act of Parliament of Canada in 1952. Its purpose was to establish and maintain qualifying conditions for a national standard of competence for dentistry in Canada and to issue a certificate to those general practitioners who meet the standard. The Act was supported by all ten provincial licensing authorities and by the Canadian Dental Association (CDA). Since its inception, the NDEB certificate has been accepted by provincial licensing authorities as evidence of having met the national standard.

Over the years, different methods have been used as the basis of certification for both graduates of accredited and non accredited dental programs. For graduates of accredited programs, certification requirements have ranged from certification without further examination based upon graduation from a program accredited by the Commission on Dental Accreditation of Canada (CDAC) to certification based on graduating and passing a written examination and an objective structured clinical examination (OSCE). Until December 31, 1999, graduates of non-accredited programs had been required to complete a series of written, simulation, and patient based clinical examinations. Since January 1, 2000, graduates of non-accredited dental programs have been required to successfully complete an accredited two-year qualifying program or degree completion program prior to being eligible to take the NDEB written and objective structured clinical examinations.

The American Dental Association's Commission on Dental Accreditation (ADA Commission) and the CDAC maintain a unique reciprocal agreement with respect to graduates of accredited programs. As a result, graduates of accredited dental programs in the United States and Canada are eligible to take whatever licensing examination is in place for that particular jurisdiction. Currently, to receive the NDEB certificate, graduates of these accredited programs are required to successfully complete a written examination and an objective structured clinical examination. Graduates of ac-

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credited U.S. programs are not required to complete any U.S. national, regional, or state board examination in order to be eligible to take the NDEB examinations. Therefore graduates of U.S. dental programs who successfully complete the NDEB written and objective structured clinical examination are eligible for licensure in all Canadian provinces without having to take a typodont or patient based examination. This system has been in effect since 1997 with the support of all Provincial Dental Regulatory Authorities.

Accreditation

Although the NDEB does examine graduates of accredited dental programs as part of its certification process, the examinations are designed to complement the accreditation process in which the NDEB plays an active role.

The NDEB appoints two representatives to the CDAC and one member to the CDA Council on Education. The board also provides for, and financially supports, the participation of an appointee on all DDS and DMD accreditation site survey teams for Canadian Faculties of Dentistry. Additionally, the NDEB and the provincial licensing authorities contribute significant annual grants to the CDAC toward the cost of the accreditation process. In support of the reciprocal agreement with the ADA Commission, the NDEB also periodically supports a Canadian survey team member on U.S. predoctoral dental program accreditation site visits.

In addition, the NDEB actively participates in the review of the CDAC Requirements (Standards) for Accreditation. In the past, the CDAC site visits were focussed more on the process rather than the product of dental education. In the early 1990s, the NDEB, the Association of Canadian Faculties of Dentistry (ACFD), and provincial licensing authorities were involved with the CDAC in the development and implementation of an outcomes assessment component for the accreditation process. Consequently, in addition to the CDAC evaluating the process of dental education, there is also a component of the site visit that involves outcomes, or student product assessment. Both the NDEB and the provincial licensing authority representatives are full partners in the site visit and are specifically designated to participate in the outcomes assessment component. This level of involvement and trust between the partners allows the NDEB and the provincial licensing authorities to critically assess the program evaluation and student assessment process in Canadian dental programs.

The board therefore recognizes that assessment of students is best done in the dental faculties, through a variety of methods, over a period of time, to ensure a reliable and valid assessment of competency. Having been involved for fifty years with the testing of graduates of non accredited dental programs through written, typodont, and clinical examinations, the NDEB understands the vagaries and problems associated with "one shot," high stakes patient based clinical examinations. Therefore, with agreement of the CDAC and the ten provincial licensing boards, the NDEB decided to support and rely on the clinical testing of students within the dental faculty (school) programs.

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Certification of Graduates from Accredited Programs

Graduates of accredited dental programs in the U.S. and Canada are required to take the NDEB written and OSCE examinations in order to obtain certification and licensure in Canada. The written examination consists of two, three-hour papers, administered in one day. Multiple-choice questions test a candidate's understanding of basic biomedical science, clinical, and behavioral science and their application in dentistry. The OSCE is a one day, station type, case-based, patient centered, examination with multiple-choice answers. It is multidisciplinary in nature and focuses on higher levels of cognitive thinking (analysis, synthesis, and problem solving) in the assessment of clinical judgement and decision making. The decision to develop an OSCE followed an extensive literature review and consultation with the

Table 1. Pass Rates (%) for Written and OSCE Examinations for Dental Licensure in Canada.

	2000		2001		2002	
Exam	Canadian	US	Canadian	US	Canadian	US
Written	100	83	98	83	98	94
OSCE	99	78	97	72	99	93

Table 2. Reliability (KR20) of Written and OSCE Examinations for Dental Licensure in Canada.

Exam	2000	2001	2002
Written	.88	.87	.88
OSCE	.73	.73	.69

Medical Council of Canada which had been successfully using an OSCE format for the national medical certification examination. These written and OSCE examinations were implemented for graduates of Canadian accredited programs in 1994 and 1995 and for U.S. accredited programs shortly thereafter. Results and reliability statistics, for these two examinations are shown in Tables 1 and 2.

Both examinations require significant time and funding for test development, review, modification, validation by general practitioners, evaluation, and translation into Canada's two official languages. Content experts from the Canadian dental programs are the test developers and ensure that the questions and cases are fair and represent what is taught across the country. Each examination has a blueprint that supports content validity and is cross referenced against the national competency document. To further enhance content validity, committees of practicing general dentists appointed by the provincial licensing authorities select the questions for each examination. The NDEB has conducted a large concurrent validity assessment of the written and OSCE examinations by correlating performance of 2,300 graduates of Canadian dental programs on the examinations with their performance in their final year of dental school as measured by class standing. The correlation for written examination scores with performance in the final year of dental school was $r = 0.43$ ($p < .001$) and the correlation for OSCE scores with final year dental school performance was $r = 0.46$ ($p < .001$). The correlation of the written and OSCE scores on the examination scores was $r = 0.54$ ($p < .001$).

Certification of Graduates of Non-Accredited International Dental Programs

In accordance with decisions of the Supreme Court of Canada, methods to distinguish between individual graduates of various dental programs must be based on the use of a "bona fide and ongoing system" of accreditation of educational programs. Therefore, as the NDEB has no bona fide information to distinguish one non-accredited dental program from another, graduates from all non-accredited dental programs must be treated in the same manner. As previously stated, until 1999, graduates of non-accredited dental programs were required to pass a series of written, typodont, and patient based clinical examinations.

In order to improve the certification process for graduates of non-accredited dental programs, the NDEB, with the support of the provincial licensing authorities and the ACFD, established an alternative certification method. This system replaced the use of "one time," high stakes, patient based clinical examinations with university-based educational programs. Accredited qualifying programs or degree completion programs are now established at a majority of faculties in Canada. In order to be accredited by the CDAC, these programs must have valid and transparent admission procedures and the graduates must meet the same requirements for competence as DDS and DMD graduates.

Portability and Trust

Similar to the United States, regulation of health disciplines in Canada is entirely a provincial responsibility. Nevertheless, having a national approach to certification in Canada has worked extremely well for over fifty years. This national approach has strengthened both the accreditation system and the clinical evaluation of students within dental programs. In addition, this approach has developed and maintained a level of trust which has enabled the provincial licensing authorities to support a truly national system of portability for dental licensure in Canada. Therefore, in general, dentists licensed in a province can obtain licensure in another province without further examination.

The reliance on accreditation has also placed an important responsibility on the faculties of dentistry (dental schools). The faculties of dentistry are the primary "gatekeepers" that protect the public. The faculties of dentistry recognize their responsibility and also understand that if they shirk their responsibility, the current certification system will not be maintained.

As is required for all regulatory boards, the NDEB certification process is dynamic. The board continues to develop and evaluate methods to help the CDAC improve the outcomes evaluation in their accreditation process. The NDEB also continues to investigate innovative methods that could improve the reliability and validity of its examinations. These potential changes would be consistent with the NDEB's mandate to establish and maintain qualifying and testing conditions for a national standard of competence and would help sustain portability of dental licensure throughout Canada.

Towards Higher Standards in Dental and Stomatological Education in Europe

Paul A. Dowling, BDentSc, DOrth, MOrth;
Ellis Delap, BDentSc;
M. Veronica Bucur, MD; and
Diarmuid B. Shanley, MA, MScD

Abstract

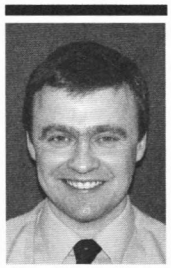
In the creation of the European Union, attention was given to portability of licensure for professionals. Considerable differences exist among countries in culture, economic conditions, and educational resources and practices. In dentistry, these differences in professional training have been addressed through a peer consultative process rather than through political and legal means. The process of visits to dental schools throughout Europe and the organizational structure (DentEd) used to conduct the visits and summarize findings are described.

Europe represents a collection of diverse nations with distinct cultural identities, languages, and religious practices. Historical differences and past conflicts have resulted in barriers to movement of individuals between countries within Europe. One of the aims of the European Union (originally established as the European Economic Community in 1957) is to promote freedom of movement of goods, individuals, and ideas among member states. The European Union currently has fifteen member states, and there are a further twelve states mainly from Central and Eastern Europe, that have accession status. It is anticipated that these accession countries will become full members within a relatively short time frame.

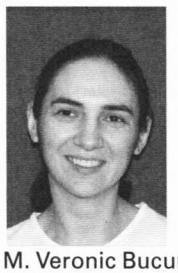
Freedom of professional movement within the EU is facilitated by a series of "directives" that were devised to ensure comparability of education and training in specific professions. In the dental context, the Dental Directive (1978) and the recommended profile of the European Dentist (1993) provide guidance on basic educational and training standards. However research into this area cast serious doubt over the merits of these directives (Banoczy, 1993; Hjorting Hansen, 1996; Shanley et al, 1997). It is the view of many dental educators in Europe that the current differences in training standards throughout Europe are significant and in some regions sufficient to compromise levels of oral health care for patients (Shanley, Dowling, Claffey, & Nattestad, 2002). In some cases, inadequate training may result in a dentist providing treatment for patients which may result in serious consequences for that patient's well being. Examples of this include inadequate cross-infection control, inappropriate use of ionizing radiation, and failure to recognize early signs of serious systemic disease or oral cancer.

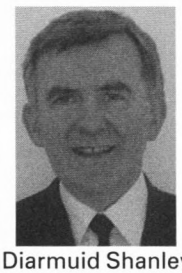
Stomatology and Odontology

From a historical perspective, the organization of dental education within Europe has resulted in two main methods of training. At one end of the spectrum is odontology, which is dental education independent of medicine. This model is typical of Northern and Western Europe and is similar to the model in the


Paul Dowling


Ellis Delap


M. Veronic Bucur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United States and Canada. In Europe, dentistry is an undergraduate program. At the other end of the spectrum is stomatology, in which students pass through a significant amount of medical education initially and later study dentistry as a specialty or sub-specialty (Hobdell & Petersson, 2001). The stomatology model is prevalent in parts of Central and Eastern Europe.

One criticism of the stomatological approach is that the concentration on medical subjects is achieved at the expense of the study of the essential dental subjects and the acquisition of clinical competence in primary dental care.

One criticism of the stomatological approach is that the concentration on medical subjects is achieved at the expense of the study of the essential dental subjects and the acquisition of clinical competence in primary dental care. In addition, there may be excessive levels of detail in medical and biological subjects with a dominance of passive learning and memorization (Shanley, 2001). However, the stomatology model also has noteworthy strengths based on the importance it places on biological and medical subjects. There is an aging population in Europe and dentists in the 21st century must be prepared to collaborate fully with physicians and surgeons in treating increasing numbers of elderly and medically compromised patients. It is clear that the argument over the appropriateness of either model is futile and it is of greater value to assess the achievement of specified outcomes from either type of program.

Challenge of Convergence of Standards—The DentEd Project

Deeply rooted cultural and historical differences between countries inhibit the effectiveness of legislative change as a realistic option in the short term for ensuring comparability of standards of dental education and training throughout Europe. In order to seek convergence towards higher standards, it was considered more appropriate to avoid actions that would stifle innovation or impose a single curricular or educational approach.

The DentEd Thematic Network project (TNP) was funded by the European Union's Directorate for Education and Culture in 1997 and was established to achieve convergence towards higher standards in dental education in Europe. The principal aims of the project are to establish a network of dental schools and related institutions in Europe and to assist schools in converging towards higher standards in their own programs. Special emphasis has been placed on dental students achieving similar levels of competence in defined primary dental care procedures. The long term goal is to facilitate freedom of movement of dental professionals within Europe and ultimately to have positive influence on the oral health care of European citizens.

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Participation in the project, the first round of which has now been completed, is on a voluntary basis and significant amounts of time and effort have been devoted to encouraging participation through personal contacts. Communication has been established and maintained through a series of plenary meetings and via an interactive Web site (www.dented.org/dentedevolves.php3) where all details of the project may be found. The project has coordinated a series of dental school visits to forty-six schools from teams of international peers. Prior to each visit, the host school engaged in a process of self assessment which sought to elucidate not only factual information but also areas the school perceived as its own strengths and weaknesses. A team of five or six international peers from a range of countries and disciplines, visited the schools for five-day, structured visits. Visitors were reminded prior to the visit that this process has no formal status and they were asked to carry out their task within the context of the regional needs, resources, and priorities of the school visited rather than their own institution.

From the outset, it has been the intention that as many people as possible should participate as visitors. Visiting teams were selected to include both experienced and inexperienced visitors from different regions and disciplines and often a representative from the American Dental Education Association (ADEA) was included as an observer. This significant alliance has been forged between the American Dental Education Association and DentEd because of the recognition that both organizations face many similar issues. As a result of the participation of members of ADEA, the credibility of the project was enhanced and others have been encouraged to develop greater interest.

The visitors comment on each section of the self assessment document and summarize their perceptions of the school's strengths, weaknesses, best practices, and innovations. The findings and recommendations of the visitors, along with the self assessment document, were

developed on an interactive Web site into a final report. Once the host school agreed with this report, permission was sought (and in virtually all cases granted) to make it available on the Web site.

Each school report was organized into nineteen sections covering different facets of the school's infrastructure, curriculum, and research activities. Working groups were established to analyze each of the nineteen sections from all of the schools visited. This analysis was carried out initially using the Web site. A set of guidelines was given to each of the working groups in order to ensure consistency. At a plenary meeting in Stockholm in September 2000, the reports were finalized and an innovative dynamic rotation of group members was established to facilitate further exchange of ideas and experiences. The collective finalized reports were published in a book entitled *Dental Education in Europe: Towards Convergence.*

Evaluation of Project Outcomes

The DentEd project undoubtedly achieved its primary aim of establishing a network of dental schools and related institutions in Europe. Approximately one-third of all schools in Europe participated in the visit process. The analysis of the school reports confirms that there are serious disparities in the levels of education and training experienced by students throughout Europe and casts further doubt on the usefulness of the Dental Directives.

Informal feedback from all those who have participated in DentEd reflects a unanimous enthusiasm for the project. Many would view the activities of DentEd as the most significant advance towards freedom of movement of dentists within Europe and all would agree that participation has broadened perspectives as well as facilitating numerous collaborative efforts in education and research between participants. For-

Many would view the activities of DentEd as the most significant advance towards freedom of movement of dentists within Europe and all would agree that participation has broadened perspectives as well as facilitating numerous collaborative efforts in education and research between participants.

mal evaluation of the project's outcomes is currently underway by means of a questionnaire to all schools visited complemented by a series of formalized group discussions in a number of schools. Data from these efforts will clarify the perceived value of the DentEd visitation process and the extent to which the recommendations of the visitors have been implemented. It is hoped that this analysis will be completed in the near future and it is anticipated that the results from this study will help to shape further progress in the area of bringing about convergence towards higher standards.

The position of the twelve accession countries (those seeking admission to the European Union) merits special consideration. Ten of these countries will become full members in 2004 and the remaining two in 2007. It is very encouraging that all the accession countries have had DentEd visits to at least one school. A review on the structure of dental education in the accession countries reveals that these schools have subsequently engaged in a process to implement the recommendations suggested by the DentEd visitors. It is hoped that these schools will serve as role models for other schools in these countries and encourage significant progress towards higher standards.

There is a realization that issues confronting dental educators and licensing authorities are similar throughout the world.

A Rising Tide Lifts All Boats

Formal accreditation processes work well in situations where there is a well established and accepted method of achieving stated aims. In the absence of methods and goals that have been agreed upon, the imposition of compulsory accreditation is likely to be counterproductive. Such is the case with dental education within Europe. Any such accreditation would be likely to be harmful to many schools that are striving to achieve higher standards within the context of their history, culture, regional needs, and resources. DentEd operated on the basis of encouragement and at all times attempted to be developmental and not judgmental. In situations where considerable diversity exists, this type of model is likely to be more successful than a purely legislative one.

The work of the DentEd project is on-going through continuation of the Thematic Network Project, DentEdEvolves. This project has continued the process of school visits and in addition has focused more widely on global issues in dental education involving alliances with groups from North America and Asia. The further this project reaches, the more there is a realization that issues confronting dental educators and licensing authorities are similar throughout the world. It is through pooling of resources and openness that satisfactory solutions to problems are likely to be achieved.

Through the Association for Dental Education in Europe, the DentEdEvolves network will seek to foster further convergence in standards of education and training. In the wide context of third-level education, the European Community is placing more emphasis on comparability of educational standards to ensure competitiveness in international knowledge based societies. Collaboration with the United States is being encouraged to share experiences and the mutually complementary knowledge bases following the events of September 11th, 2001. For some, convergence may seem a burden that can reduce progress in respect of narrowly focused objectives. Convergence has far broader horizons for the international community in which dentistry and dental education can play an exemplary role.

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Transnational Licensure: Foreign Dentists in America Reclaim their Profession through the Program for Advanced Standing Students (PASS)

Naty Lopez, PhD and Peter Berthold, LDS, PhD, DMD

Abstract

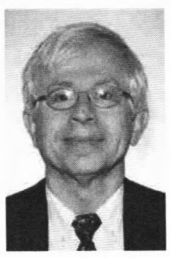
The Program for Advanced Standing Students at the University of Pennsylvania School of Dental Medicine accepts highly qualified individuals who have earned a dental degree in a foreign country. They earn an American dental degree in two years, following a program that is nearly identical to the final years of the traditional DMD program. PASS students have been highly successful in their educational program and they contribute in diverse ways to the dental profession upon graduation.

Winah is an Indonesian dentist who married an American marine engineer working in Indonesia for several years. She opted to sell her practice in Indonesia and moved to the U.S. twelve years ago when her husband's term in Indonesia ended. After completing the Program for Advanced Standing Students (PASS) at the University of Pennsylvania School of Dental Medicine in 1996, she bought a practice in North Philadelphia, right in the heart of a socioeconomically deprived and very diverse community. This is a part of the city that desperately needs an infusion of health care, oral health care, and other services. She continues to practice in this part of the city.

Reinaldo is from Cuba. He managed to get out of the country and settled in Miami, working odd jobs until he got his U.S. citizenship. He worked for the Army before applying to PASS. Today, he is back in the Army serving as a professional dentist. Like Reinaldo, Ramon from the Philippines is also in the service. He worked as a dental assistant prior to PASS. He resumed his service in the U.S. Navy after graduation, where he currently works as a dental officer.

Yi is a Chinese dentist from PRC whose one passion is research. She completed her doctor of science degree in the U.S. and then worked as a researcher in molecular biology for six and a half years. But while she loved her research job, she also ached to practice dentistry. She applied and was accepted to the PASS program. While in school, she continued doing research with a faculty member with the same research interest on Herpes virus. She joined the AEGD program at PENN in order to continue her research. She still works in the school satellite clinics. Asked why she chose a lower paying job compared to working in private practice where she could earn more, Yi replies with the enthusiasm of one who has struck two birds with one stone, "I am able to practice dentistry and do research. I love both. I would not want to be anywhere else."

These are just a few examples of graduates of the PENN PASS program that graduated its first class of twelve students in 1988. Every year, hundreds of foreign dentists apply to the Program for Advanced Standing Students, a two-year DMD program at the University of Pennsylvania School of Dental Medicine. Applicants come from all over the globe, from Albania to Zimbabwe. They hail from Africa, the Middle East, Asia, South and Central America, and Europe.



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They come to the U.S. for various reasons, but 70% of those who are accepted are U.S. permanent residents who have married U.S. citizens or whose parents are U.S. immigrants. Some obtained their permanent residencies through a lottery conducted by the INS. Chinese dentists often come to the U.S. to work as researchers in universities but would want to return to dentistry after about five years. Like Yi, many continue in research while practicing dentistry. Indian dentists constitute 30% of the applicant pool. The majority are women who are married to software engineers who have worked in the U.S. for some time. In recent years, an increasing number of dentists from Eastern and Central Europe have applied. With the collapse of communism in their countries, the doors have opened to Western influence, including a less bureaucratic process to emigrate and an opportunity to win a lottery visa to reside in the U.S. One dentist from Nigeria, for example, obtained her permanent residency through the lottery. A friend dropped her name in the lottery pool without her knowledge. But the visa to the U.S. provided her the change and new opportunity for her and her daughter, something that she needed after the death of her husband. Dentists from war-torn countries like Sudan, or countries like Iraq, where religious or political oppression still exists, come to the U.S. as refugees.

Many of these immigrant dentists choose to work in dentistry related jobs, as dental assistants or dental technicians while waiting for the opportunity to go back to school. In several instances, they are offered a position in the same practice by their employers after they obtain their U.S. license. Some work as teacher's aides or social workers, operating room assistants, restaurant managers, or nursing home administrators. Others take whatever job is available such as gas station attendees, newspaper carriers, etc., to support themselves and their families. A few undertake postgraduate specialty programs in endodontics, periodontics, or orthodontics. But realizing the difficulties and limitations to practice their specialty in the U.S. without a basic U.S. dental degree, they apply to PASS or other similar programs.

PASS students attend the same classes, take the same exams as any other student, and are fully integrated into the clinical group program.

All dream of practicing dentistry again, but opportunities to get an American degree in order to apply for licensure is limited since not all dental schools offer advanced standing programs. The PASS program at the University of Pennsylvania School of Dental Medicine, like other similar programs, is highly competitive. Only 4% of the applicant pool is accepted. Applicants have to pass the National Dental Boards Part I and the TOEFL (Test of English as a Foreign Language). They have to submit their transcripts and diploma from dental school in their home country. Only qualified applicants are interviewed. They are invited to attend a whole day orientation and interview sessions with three faculty members. They receive information about the program, the university, and the city; tour the dental school, discuss the educational budget and other financial issues, and meet with PASS students.

Each year a class of twenty-five to thirty starts in April with an intensive summer program. Each class represents from fifteen to seventeen countries, but the diversity lies not only in the richness of the cultures that the students bring with them but also in their experiences.

Only 4% of the applicant pool is accepted. PASS students are integrated with the four-year DMD class after an intensive summer program where students review the major parts of the first two years of the dental curriculum, excluding the basic sciences.

In one class for example, there were three orthodontists who had practices in their countries: a Colombian, a Mexican, and a Yemenite who was educated and practiced in Paris. There were also three oral surgeons in the same class: an Albanian who received training in England, a Sudanese who has both a medical and dental degree, and a Japanese with a PhD. The class average on the National Dental Boards is above 90. The lowest average over the years is 87.

PASS students are integrated with the four-year DMD class after an intensive summer program where students review the major parts of the first two years of the dental curriculum, excluding the basic sciences. The summer course includes 110 lecture and 20 seminar hours, and 134 hours of laboratory sessions to successfully complete 18 preclinical projects and 8 pre-clinical practical examinations. All completed projects and examinations are identical or similar to those given to four-year students in pre-clinical courses. During the school year, PASS students attend the same classes, take the same exams as any other student, and are fully integrated into the clinical group program.

The PASS program is consistently evaluated and changed to meet both the students' needs and faculty expectations. A new development this coming academic year is training using the virtually reality based DentSim (Denex, Israel) mannequins during the intensive preclinical program in the summer months. It is believed that this will further increase all

the students' competitiveness and clinical skills.

PASS students tend to be high achievers. In a current class, there are four students who obtained a GPA of 4.0 and three with a 3.98. They also tend to accomplish more in the clinics and complete their requirements early. PASS students integrate well with the four-year students and are helpful in the clinics. Many four-year DMD students have expressed appreciation for the assistance they have received from PASS students.

But it was different during the early years of the program. PASS students were viewed with suspicion and with some degree of resentment by other students and sometimes by faculty and staff. But through the years, both students and faculty have come to see them as fellow citizens and no longer as aliens but as colleagues and not competitors. Some clinical faculty members have requested PASS students be assigned in their clinical groups. Perhaps, it is because of the focus and seriousness in their work or because they complete their requirements early and then become available to assist junior students. Some are recruited as teaching assistants in the pre-clinical laboratory classes.

The PENN PASS program has become an important pool for recruiting faculty in this time of faculty shortage. Several PASS graduates now serve on the faculty, either full-time or part-time. Three PASS graduates currently on faculty were given faculty awards by graduating classes in the past years. Although a majority of PASS graduates go to private practice after dental school, 35% of each class proceeds to postgraduate programs.

Although a majority of PASS graduates go to private practice after dental school, 35% of each class proceeds to postgraduate programs.

In view of the continued lack of dentists from underrepresented minority groups, the reeducation of foreign dentists who have migrated to this country can provide the much needed personnel to deliver care to various ethnic groups where access to care is identified as a problem. PASS graduates share the same culture, values, and language with these groups. They understand their health beliefs and communication patterns and are thus able to promote more positive health outcomes. Over the years, several PASS alumni have served in these communities. Currently seven PASS graduates are working with community organizations that care for the underserved in several cities.

Through PASS, foreign dentists are able to reclaim their profession and take part in the American dream. Children of PASS alumni are now applying to dental schools. At Penn alone, a PASS alumnus from India has a son in the third year and an alumna from Iran has a daughter in the second year of a seven-year curriculum.

On the whole, however, the issue of transnational licensing in the U.S. should be seen in a wider context, both domestically and globally. Population statistics tell us that the U.S. will become increasingly diverse, even if we stopped all immigration today, and that is not about to happen. It is far wiser to use all resources available to increase integration of our society. Health care professionals who can be licensed through a program such as the PASS program represent a force devoted to providing ethnically appropriate care to numerous groups that otherwise may go without care. In the near future, the U.S. will have a serious shortage of oral health care providers and academicians and these colleagues will become even more important.

The importance of integration of these dentists should also be seen globally. In today's world, there are two major but opposing forces—globalization and isolationism. Today, at least, it seems that globalization has the upper hand in spite of the current precarious situation in many parts of the world. It then becomes even more important and necessary that we accept and try to understand those who are different from the mainstream in their culture, religion, and lifestyle. The world is at our doorstep, right in our neighborhoods. The United States has always been a society of mixed ethnicities and cultures, and will continue to be the same in the future. The dental profession cannot but reflect the diversity of the society that it seeks to serve and will need to integrate fellow dentists who have moved to this country.

Manuscript

A Retrospective of America's Second National Dental Association

Clifton O. Dummett, DDS, FACD and
Lois D. Dummett, BA

Abstract

This article describes one hundred and fifty years of history concerning organized dentistry among African Americans. African Americans were welcomed in the National Negro Medical Association of Physicians, Dentists and Pharmacists (NMA) as early as 1895 and later created a dental professional group, the Interstate Dental Association, in the mid-Atlantic states. The "second" National Dental Association, a national-wide African American association was created in 1932. African Americans earned full membership in the American Dental Association in 1964. This article traces these developments against the background of changing American society and concludes by mentioning some of the recent accomplishments and collaborative relationships of the current NDA.

"What's in a name?" is an apt question about American dentistry's understandable confusion with the name "National Dental Association." Bound volumes of the *Journal of the National Dental Association* dating from the 19th century confront curious readers of dental history. Yet, there is valid historical data proving the creation of a National Dental Association in the 20th century. It is logical to look beyond nomenclature and uncover the *raison d'etre*.

More than one hundred years ago the title National Dental Association belonged to an organization purporting to represent all American dentists. Up to that time, there had been two principal groups—the American Dental Association, established in 1859, and the smaller Southern Dental Association, begun in 1869. There was a schism between American dentists as revealed in the appearance of a designated regional dental organization. The breach was caused by the secession of the South from the Union. Intense regional antagonisms between North and South were the social and political cauldrons into which all facets of life in the United States plummeted. American dentistry was no exception.

At the Civil War's end there was a slow process of reconciliation, and despite prolonged incompatibilities, eventually the two groups merged in 1897 under the name National Dental Association. Internal peace was tenuous, but it held after reorganization of the association in 1913, and nine years later during the 26th annual meeting, July 17-21, 1922, at the Ambassador Hotel, Los Angeles, California, the name National Dental Association was discarded in favor of the earlier title American Dental Association, claiming itself representative of "American" dentistry. Despite the name change, rancorous racial and religious biases and remnants of regional antipathies did not die.

The Second NDA

In truth, neither the so called "American" nor "National" dental associations of that time fully represented all American dentists. Until fairly recent times, the dental profession was held hostage to prevailing customs of racial separation throughout the nation, thereby restricting membership acceptance. With only rare exceptions, African American dentists were not welcome in the country's local, state, and national dental organizations.

The needs of black dentists in securing scientific, professional, and social out-

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The needs of black dentists in securing scientific, professional, and social outlets were partially met in 1895 when a national society of African American physicians was formed in Atlanta, Georgia.

lets were partially met in 1895 when a national society of African American physicians was formed in Atlanta, Georgia. In a remarkable development of interprofessionalism, that organization extended membership to black dentists and pharmacists. It was called the National Negro Medical Association of Physicians, Dentists and Pharmacists (NMA). Leadership of founding president, Dr. Robert F. Boyd, a qualified physician and dentist, was responsible for creating an inclusive multi-professional membership policy, an innovation endorsed and solidified by his successor, Dr. Henry T. Noel, also a physician/dentist and dental classmate of Dr. Boyd.

The amalgamation of the three professional groups gave cohesion in pursuing social and professional goals. There was "strength in numbers" in facing the obstacles encountered by these pioneer black health providers. Moreover, there existed emotional security in the easy camaraderie enjoyed among peers. The majority of the dental members were quite satisfied to find acceptance, together with opportunities to pursue additional scientific knowledge and to develop organizational skills. They also were aware that public esteem favored medicine and physicians above dentistry and dentists and thereby felt enhanced by close association in a multi-professional organization.

Although black dentists within NMA were treated with consideration, inclusion, and respect, early on there were a small number of dentists less comfortable with their status. They felt their particular needs and aspirations could only be fully satisfied in an organization comprised solely of dentists, and they became the nucleus of strategies to fulfill latent yearnings.

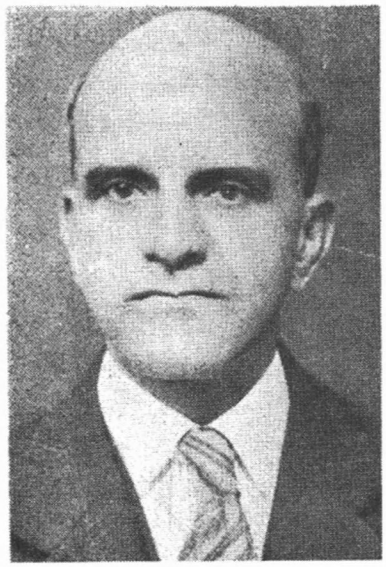
Incorporation of dentists into local and state medical societies became a common practice among American health professionals in early 20th century. Additionally, in the black community, small dental "study clubs" engaging dentists in specific locales were developed ostensibly to satisfy dental aspirations. The first of these, the Washington Society of Colored Dentists, was organized in 1900 by a local group of dentists in the nation's capital. Favored with a cadre of intrepid members, the society soon garnered a highly respected reputation not only in dental matters, but also in battling for civil rights. It was not long before black dentists in other cities followed the example of the Washingtonians and began to organize local societies within their communities to replicate similar goals. Several local black dental groups bore names of admired role models who had contributed to the dental profession, namely, William A. Jackson Dental Society of Philadelphia; Charles A. George Dental Society of Houston, Texas; and Alva C. Garrott Dental Society of Los Angeles, California.

By contrast, the pace of development at the state level was a slower process. Not until 1937 did black dentists in Georgia withdraw from their multi-professional organization to form the Georgia Dental Society. Similarly, in North Carolina there was the Old North State Dental Society, and in Tennessee the Pan Tennessee Dental Association. Other state units included Old Dominion Dental Society of Virginia; Commonwealth Dental Society of New Jersey; Gulf State Dental Society of Texas; Wolverine Dental Society of Michigan; and Pelican State Dental Association of Louisiana.

The vision of an all embracing national organization of black dentist had its genesis in 1900 when that small nucleus of restless NMA malcontents made a futile effort to achieve the yet elusive goal. They soon recognized and accepted their unpreparedness for such a large, intricate venture and were willing to bide their time.

As local groups mushroomed across the country, black dentists gained confidence and grew in self esteem. They began to feel more interconnected as they established a network of beneficial relationships. On July 19, 1913, in response to an initiative engineered by the moving force for nationalization, Dr. David A Ferguson of Virginia, thirty dentists convened at the Bay Shore Hotel in Buckroe Beach, Virginia. Although the number was small, hope was large as they formed a regional coalition binding together dentists in Virginia, Maryland, and the District of Columbia. The fledgling entity adopted the name Tri State Dental Society. Within five years Tri State became a beacon to black dentists in other states—primarily in the southeastern area—to the extent that in 1918 the name was changed to the Interstate Dental Association.

Buoyed by this achievement, the Interstate sought to energize its members



David Arthur Ferguson, DDS, the first dentist elected president of the National Medical Association and founding president of second National Dental Association in 1932.

by providing thoughtful discussions on dental issues that would improve the quality and delivery of health care to the largely neglected black population served by black dentists. Annual meetings were established and they included scientific sessions, phases of practice management, as well as entertainment for families and friends. The Interstate also conducted an ardent campaign to woo dentists reluctant to leave the protection and familiar landscape of the National Medical Association.

It is easy to understand the varied reasoning behind the desire of many black dentists to remain active in the National Medical Association. Several of them had gained prominence within NMA, holding elected office and securing desirable committee appointments. The NMA was an established organization highly regarded in the black community and therefore able to wield a measure of power wherever counsel was sought. NMA also had a voice heard in the larger community when matters pertaining to sensitive social issues had to be dealt with. Some black dentists were loath to give up NMA and embark on the turbulent waters of a new, yet untried, dental organization.

Reluctant dentists had NMA support in resisting the siren call of Interstate. NMA benefited from payment of dues, from being able to point with pride to a large membership roster, and the assured support of endeavors initiated by the organization. Nevertheless, when it became apparent that a new era had begun, NMA gracefully relinquished its efforts to retain dental members and offered the hand of friendship, support, and goodwill. NMA recognized that in 1897 amalgamation was essential, but policies, practices, and philosophies of health professions were undergoing nonretractable changes. Dissolution was inevitable.

In 1932 the Interstate Dental Association applied for and received the title National Dental Association representative of African American dentists. In choosing a new title for the Interstate Dental Association, probably little thought was given to the possible confusion such a step might stimulate. The most likely principal motivation was name synchronization with that of the National Medical Association, which had effectively represented African American physicians and dentists since 1895. There may have been a few dissenters with expressed reservations about using a discarded title to represent African American dentists who, in reaction to racially biased membership restrictions, had been able to carve out a professional organization of their own.

In the black community, small dental "study clubs" engaging dentists in specific locales were developed ostensibly to satisfy dental aspirations.

Initially, Caucasian dentists were inclined to differentiate the "new NDA" as the "Negro Dental Association," or the "National Dental Association of Negro Dentists." The undisputed fact is that after a convoluted cycle of circumstances, the title abandoned in 1922 was resurrected to become essentially the second National Dental Association.

Assistance in Reaching Goals

Two related examples of rare moral and intellectual principles occurred during and just after the War Between the States. A southern African American youth, Robert Tanner Freeman, worked as a dental assistant in the Washington, D.C., office of Dr. Henry Bliss Noble, a prominent Caucasian practitioner of his time. Impressed with Freeman's ability, Noble tutored and encouraged him to study dentistry. Several proprietary schools refused acceptance of Freeman on account of race, but Dr. Nathan Cooley Keep, founding dean of Harvard School of Dental Medicine, declared that the school "would know no distinction of nativity or color in applying standards of acceptance of students." Thus Freeman was admitted to the initial 1867 class of dentistry at Harvard and in 1869 became the first African American to receive the dental doctorate in the United States.

Harvard also opened its doors to George Franklin Grant, a native New Yorker whose slave parents had migrated from the South. At graduation in 1870, Grant became the second African American university educated dentist. Dr. Grant later distinguished himself as the first African American member of his alma mater's dental faculty, as well as becoming private dental practitioner to Harvard's President Charles W. Eliot. With interest not limited to dentistry, Grant also achieved some prominence in the "golf legends" as developer of the wooden tee, for which he procured a patent from the U.S. Patent Office.

More than half a century after the Freeman/Grant breakthroughs, uplifting advancement in dental education occurred with the 1926 publication of the Carnegie Report on Dental Education by the redoubtable William J. Gies, PhD. This far-reaching, status-altering document was responsible for elevating educational standards in U.S. and Canadian dental schools. It resulted in closures of sub-standard proprietary dental schools and reassessment of the future of dentistry as a scientific health profession. Moreover, it shed light on the dental needs of African American communities and the education of African American dentists. Additionally, Gies specifically recommended retention and financial support of two dental schools for African Americans—Howard University, Washington, DC, and Meharry Medical College, Nashville, Tennessee.

In 1931, the Interstate Dental Association held its annual meeting at Howard's College of Dentistry. Widely heralded Dr. Gies was the featured speaker who contributed greatly to the success of the sessions. He discussed the Report's findings and congratulated

Howard University dental Dean Arnold Donawa for endeavoring to follow specific recommendations to improve the College of Dentistry. Significantly, this was the last meeting at which the organization used the title Interstate Dental Association before it changed the following year to National Dental Association (NDA) at the 1932 meeting convened at Bordentown, New Jersey.

As in earlier times during the struggle by African Americans to overcome obstacles based on racial bias, subsequent NDA successes could not have been accomplished without significant help from many quarters and especially from empathetic Caucasian educators, practitioners, and administrators. Disregarding possible ridicule and ostracism from colleagues, friends, and family, several northern and southern Caucasian dentists were sufficiently courageous and influential to challenge many ignominious racial policies and practices in the profession of their times. Others quietly rendered spiritual and financial support to programs for the advancement of African American dentists, dental students, auxiliaries, and later to NDA programs. Some prominent dental humanitarians included Louise C. Ball, Arthur D. Black, Phillip Blackerby, Robert E. Blackwell, Dayton Dunbar Campbell, M. Don Clawson, D. Walter Cohen, James Dunning, William Elsasser, Bion R. East, Willard Fleming, Walter Guralnick, Leonard Gorelick, Harold Hillenbrand, Maynard K. Hine, Robert J. Kesel, Lon W. Morrey, Norman H. Olsen, Errol Reese, A. E. Rowlett, Paul Scheman, Harry Seldin, Joseph F. Volker and Jay Wolff. Their performances affected outcomes of many interracial dental professional issues.

Building Relationships

Geography and minority population demographics were dominant factors in the genesis and development of the second National Dental Association. In addition, the southern landscape was dotted with federal Land Grant and church-sponsored colleges established to educate progeny of the freed slaves. Despite steady immigration of southern blacks to towns and major cities of the North, the majority of black citizens—and NMA and NDA members—lived in the Old South. Included also were black dentists in the nation's capital as well as some eastern states. Moreover two predominately black institutions, Howard University (a federally supported institution) located in Washington, DC, and Nashville, Tennessee's Meharry Medical College (private and missionary supported), produced almost all of the nation's African American health professionals. It was logical that the second NDA would emerge in the southeast and then begin to find its way westward in pursuit of the primary objective of unhindered inclusion into mainstream American dentistry.

During the Fifties and Sixties black professionals were active participants in the Civil Rights Movement.

The early years of NDA were characterized by a laudable focus as elected officers pushed firmly toward systemization of the organization's aims. General Secretary Treasurer J.A. Jackson of Charlottesville, Virginia, allowed his home and dental office to be official NDA Headquarters in order to provide a central location for preservation and maintenance of NDA records, as well as a designated address for the financially limited association.

By 1939 carefully nurtured efforts to reach out to fellow black dentists as well as the National Medical Association bore fruit. The rising stature of NDA was manifested by its 1939 convention in New York City held concurrently with that of the National Medical Association. This 1939 conclave also benefited from occurring during the New York World's Fair which attracted people from all over the nation and abroad despite the outbreak of hostilities in Europe. A felicitous relationship between the two foremost black health professional groups facilitated clinician and keynote speaker interchanges on the general and scientific programs of both organizations. The New York North Harlem Dental Society, an early NDA affiliate, hosted the memorable annual meeting.

North Harlem Dental Society enjoyed a reputation for sophistication in organized dentistry and contributed to an eastern regional pride in the gains made by many members who were graduates of northern Caucasian dental schools. The region's relatively progressive interracial tolerance—particularly in New York—gave impetus in some measure to prideful feelings. Excellent presentations by clinicians and headliners elicited widespread expressions of interprofessional respect and goodwill from attendees at the 1939 NDA annual meeting presided over by Dr. Simmons C. Hamilton of Chicago, the first dentist from Illinois to be elected to the NDA presidency.

Pearl Harbor in 1941 and U.S. involvement in World War II interrupted the tranquil business as usual atmosphere in which all Americans, regardless of racial identity, went about their daily lives. NDA along with other health organizations fully supported the nation's military and civilian conduct in European and Asian theaters of war. Racial discriminatory practices continued in effect even in the armed forces, but minority citizens accepted their responsibility to fit themselves and their abilities to war demands.

There was also an expectation that creditable military services would provide impetus for post-war changes of unfair pre-war practices. It was an expectation vigorously enunciated and pursued by NDA officials who also sought support from their Caucasian counterparts in organized dentistry. By the end of the war, the onerous racial barriers within the military had been rescinded and some recognition gained for worthy contributions by African Americans.

Post WWII Years

After World War II there followed a period of national recovery and return to civilian concerns and ambitions. In the 1950s core activities of U.S. organized dentistry shifted generally from East to Midwest under the American Dental Association with headquarters in Chicago. The Windy City became the center of official American dentistry, offering abundant resources, excellent convention facilities, famous restaurants and entertainment outlets, beautiful parks and lakefront, renowned museums, and shopping districts. Furthermore, the city was centrally located, within easy access by any means of travel from anywhere in the United States. Chicago also was home to the renowned Chicago Dental Society, component of the American Dental Association. It was within this milieu that the development of NDA's westward thrust would yield a good harvest.

NDA officialdom recognized the implications of the confluence inherent in the African American population surge to major urban areas of the United States and the importance of organized dentistry's concentration in Chicago. The Lincoln Dental Society had worked well with the National Medical Association and was prominent among NDA components. In 1950, Dr. William D. Giles, a Lincoln Dental Society past president became NDA president, and fellow Chicagoan Dr. Charles E. Williams, Sr., was elected chairman of the NDA Executive Board. At this opportune time, these two adept Lincoln Society members were positioned at the helm of the national organization of African American dentists and were committed to reinforcing and expanding NDA's potential.

The 1954 U.S. Supreme Court decision outlawing separate education emboldened open remonstrations and demonstrations against injustice whether pertaining to civil rights in general or particular exclusions in organized dentistry. Representatives of minority health professions broadened the horizon of their mandates to include full involvement in these dissensions. Unanimous consensus insisted that exclusions and discriminations effectively limiting full performance of duties and services to the American people must be eliminated. During the Fifties and Sixties black professionals were active participants in the Civil Rights Movement.

ADA Executive Director Harold Hillenbrand in 1968 congratulates newly elected NDA President James C. Wallace, Jr.

In 1959 the American Dental Association celebrated its centennial with great pride and pomp at the Waldorf Astoria Hotel in New York City. There was every reason to celebrate the evident successes in dental technology, professional care, economic progress, medico-dental relations, and self direction in American dentistry. However, socio-professional successes were neither as numerous nor as illustrious. A more equitable distribution of dental services to impoverished communities and peoples loomed as a vital professional responsibility that was compromised by the existence of racial and religious distinctions. In some parts of the nation there existed strong desires and fervent solicitations for removal of inequities during dentistry's second century.

A major contribution to the anniversary was an ADA sponsored history of the association. The well-documented, detailed treatise carefully recorded the story of the first National Dental Association, but no mention was made of America's second NDA. Notwithstanding pointed omissions of their existence and contributions, African American dentists joined in the collective goodwill about the nation's undeniable dental professional excellence.

During its first fifty years, the second National Dental Association demonstrated that it could emulate the model of more experienced organizations in good performance and set proper standards. Among other proficiencies, NDA presented outstanding clinicians, af-

Historic 1962 ADA/NDA Liaison Committee during the 103rd annual ADA sessions at the Fontainebleau Hotel, Miami Beach, FL. (Seated from left) Richard Layne, NDA president; Gerald Timmons, ADA president elect; Russell A. Dixon, dental dean, Howard University; Harold Hillenbrand, ADA executive director. (Standing from left) Matthew Mitchell, NDA president elect; James C. Wallace, Jr., NDA executive board member; John R. Abel, ADA president; C.O. Dummett, NDA editor; G. W. Hawkins, NDA executive board member.

forded a forum for discussions of dental professional and scientific topics, endorsed tested dental public health measures, supported dental health insurance programs and policies, and disseminated timely information to its members, including publication of an official journal.

Although disparities existed between ADA and NDA on account of racial separatists seeking to circumvent U.S. constitutional rights and privileges, a nucleus of goodwill facilitated improved relationships between the two organizations. Of the many persons playing important roles in this vital phase of health professionalism none outweighed the impact of ADA's Harold Hillenbrand and NDA's James C. Wallace, whose combined leadership skills and superior performances successfully implemented racial integration in American dentistry.

Dr. Harold Hillenbrand, ADA executive director, had often declared that racial discrimination was wrong and had warned that so long as a single black dentist was denied ADA membership on account of race, adversarial relations and confrontations would continue. He lent credence to his belief through attempts to educate ADA officers and influential members about the need and responsibilities of ADA to represent all dentists. It was his basic premise that if they so desired, all qualified American dentists should be bona fide members of the association with all the rights and privileges to which membership entitled them. In tandem, he strongly insisted that the ADA constitution should be adhered to faithfully, and that ADA membership should be achieved by way of the component and constituent societies. Thus he thoroughly resisted devious efforts to circumvent the ADA constitution and bypass local and state dental organizations by means of offering direct ADA membership to those African American dentists who were confronted by all manner contrivances to obstruct their efforts to gain ADA membership.

Dr. James C. Wallace, Jr., of Chicago, a member of the Lincoln Dental Society, was one of the most effective African American dentists who toiled unceasingly for civil rights within the profession. Over the years he served the local and national organizations in a succession of positions, earning the respect and trust of his peers. Ultimately he was elected to NDA's highest offices, chairman of the Executive Board and president NDA. Wallace worked closely with Hillenbrand, and together they produced a series of meetings and conferences between both organizations resulting in the formation of an ADA/NDA Liaison Committee. Negotiations ultimately led to the adoption of an ADA resolution that in effect called for the suspension of representation of a constituent society if it should be determined that the ADA constitution or bylaws were being violated. This unprecedented action by the ADA House of Delegates in 1962 was a major step toward removing race based barriers to inclusion of minorities in the nation's foremost dental association.

The wheels of change turned slowly and in 1965, three years later, the New York and Michigan dental societies submitted a resolution to ADA requesting bold action to enforce the intent of the 1962 ADA resolution. An unanticipated boost to remove bans against membership of African Americans came from a resolution submitted by the ADA Board of Trustees with a recommendation for passage. Prodded by notice from the U.S. Department of Health, Education and Welfare that a complaint had been filed alleging that ADA did not comply with Title VI of the 1964 Civil Rights Act, the board sought to forestall ADA complicity in unwarranted actions by some of its constituent and component societies. The penalty for violation of the 1964 act could be withdrawal of federal assistance to the ADA program at the National Bureau of Standards and the withholding of grants that were made to the association for dental research projects. The urgent implications of government intervention was not lost on members of the House of Delegates who conceded defeat in efforts to pacify those persons yet clinging to the past. Both resolutions were approved, thereby resolving the racial issue within the American Dental Association.

In view of the furore these resolutions created at all levels of ADA, Executive Director Hillenbrand's leadership and hard work throughout all events leading up to and including this milestone cannot be overestimated or undervalued. His dedication to fairness and to the elimination of discriminatory practices while maintaining the integrity of the ADA constitution testified to his innate humanity and administrative skills.

Progress toward collegiality was manifested in 1965 when ADA and AADS (American Association of Dental Schools) joined NDA in presenting the

The first National Conference on Dental Research and Education in Washington, DC, October 1965, sponsored by the National Dental Association, American Dental Association, and American Association of Dental Schools, and supported by the Procter & Gamble Company (From left) Verling Votaw, manager P & G Professional Relations; Maurice Hickey, president AADS; Fritz Pierson, president ADA; H. R. Primas, president NDA.

First National Conference on Dental Research and Education. Convened at the International Inn, Washington, DC, dental school deans, university vice presidents for research and education, and research coordinators were among the more than two hundred delegates from Canada, England, and the United States in attendance at the three-day sessions. The conference was fully supported by the Procter & Gamble Company, which had always been among several industrial companies that consistently encouraged NDA professional education programs through the years. For the National Dental Association, the conference was especially significant inasmuch as it represented the first time NDA became involved in hosting an erudite symposium to discuss research and education with internationally accredited authorities in the topics under consideration. It was a historic first, and the NDA Executive Board Chairman Wallace was hailed for instigating the conference.

At the Crossroads

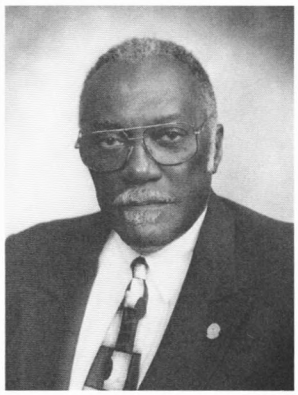
Long and protracted resolution of open access to ADA membership without racial distinction resulted in another challenge of a different kind. The NDA leaders took note of efforts by the American Dental Association to improve and augment membership benefits. Emphasis was placed upon such items as the ADA health evaluation program, ADA insurance programs, marketing program, member retirement program, ADA Journal, and ADA news publications—all formulated as advantages of organized dentistry to be communicated to present and future ADA members. ADA efforts to improve access to dental care and creation of public health dental services were additional incentives to ADA membership. Lacking resources to establish a similar bureaucratic operation to create and manage such programs for its members, the National Dental Association recognized its inability to compete with prerogatives and conveniences of ADA membership.

Exclusion of black dentists from organized dentistry was the impetus for formation of NDA, but now that this particular objective had been achieved, black dentists were compelled to review NDA's original goals through the prism of other influences. Among these were increased cost of living adjustments; lessened practice incomes; ramifications of dual NDA/ADA membership; professional, scientific, honor, and specialty organization dues; financial contributions to civil rights groups; student scholarship support; funding base for NDA programs. It became necessary for NDA leaders to reassess the options.

Mid-decade of the Seventies seemed to move NDA and its minority concerns more toward support from individuals and groups in the private sector. This awareness coincided with extensions in influence of the NDA Foundation that had been first proposed on October 22, 1971. It was ratified by the NDA House of Delegates at its initial session on July 30, 1972 and promptly approved by the NDA Board of Trustees. A watershed period in NDA self perception began in 1974 following authorization of a Task Force Reorganization Study that produced changes in NDA structure and function. Included in recommendations by the Task Force was a serious reactivation of the NDA Foundation.

The path from tentative beginnings to full-fledged independence has not been without obstacles that tested the mettle of black dentists, individually and collectively.

By the final decade of the 20th century, reorganization within the association, accompanied by changes in leadership, stabilized attitudinal and program directions. There was consensus that NDA and its members still had a role to play in the black community while at the same time participating in mainstream dentistry. In particular, the NDA Foundation, now under the leadership of NDA Past President Roosevelt Brown, was successful in establishing a number of partnership activities with the Colgate Palmolive Company in the areas of dental education, research, and public health. To support programs for minority student recruitment, enrollment, and retention, with Colgate patronage and counsel, the Foundation designed a scholarship program that provided thousands of dollars to enable poor but promising students not only to pay tuition costs, but also to purchase basic supplies needed for the study of dentistry.



Roosevelt Brown, DDS, President, NDA Foundation.

An NDAF/Colgate Palmolive partnership research program was aimed at encouraging, developing, and expanding potential research capabilities at three historically African American institutions, namely, Howard University College of Dentistry, Meharry Medical College School of Dentistry, and Morehouse College, School of Medicine in Atlanta, Georgia. This program make possible much-needed support to dental education at these predominantly black schools. In addition, Colgate/NDAF "Bright Smiles, Bright Futures" mobile program brought public dental educa-

tion directly into black communities in selected cities to reach and teach children and their families the need to acquire habits of good dental hygiene and nutrition.

Before the end of the 20th century, NDAF led the way to fulfill a long held yearning by the association—a permanent NDA headquarters building. This had been an unrealized ambition of NDA leaders, but in 1978 the association and its Foundation initiated a Housing Committee to organize and manage a building fund. After two decades of sporadic efforts, the NDAF Housing Project gathered momentum, fueled by deliberate progress in fund raising among NDA members. On May 1, 1998 a renovated building at 3517 Sixteenth Street, Washington, DC became the official headquarters of NDA and NDAF. The occasion was appropriately commemorated on November 7, 1998 with a continuing education symposium. The day-long activities concluded with "1998 Scholarship Gala," a fundraiser jointly supported by the Foundation and the Robert T. Freeman Dental Society of Washington, DC.

Coda

The original National Negro Medical Association of Physicians, Dentists and Pharmacists formed in 1895 set the stage for propitious beginnings of organized dentistry in the African American health professional community. Black dentists are forever indebted to black physicians for spontaneous inclusion in a multi-professional organization that provided them with confidence in status, a sense of health professional values, and a thirst for establishing an organization of their very own.

The path from tentative beginnings to full-fledged independence has not been without obstacles that tested the mettle of black dentists, individually and collectively. Today's National Dental Association can take justifiable pride in its pioneers and in many supporters who fought and never surrendered during struggles for humane justice in the world's leading democracy.

The present century challenges new generations to dislodge vestiges of past inequalities, and whole-heartedly embrace bountiful opportunities for oral health services and productivity that lie ahead.

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Issues in Dental Ethics

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My Way or the Highway: Do Dental Patients Really Have Autonomy?

Larry Jenson, DDS, MA

Abstract

Ethical dilemmas arise when it is not possible to simultaneously optimize conflicting values, each of which independently is worthy. This paper analyzes three cases where patients' autonomy is in conflict with dentists' professional judgments about their own practice patterns and what is in the best interests of patients' oral health. The hierarchy of values proposed by Ozar and Sokol is a valuable aid in addressing such dilemmas, but the dentist must still engage in a detailed analysis of the situation.

Consider the following case scenarios:

1. Anita is a regular patient of Dr. Chen and has read about porcelain veneers in her favorite women's magazine. She asks Dr. Chen to place veneers on her anterior teeth in order to improve their shade. In Dr. Chen's opinion, Anita's anterior teeth are in excellent health and the shade is nearly a Vita porcelain shade B 2. He tells Anita that it would not be in her best interest to have veneers done merely to gain a slight difference in shade. He tells her that if she wants the veneers she will have to seek dental care elsewhere.
2. George is a new patient to the office of Dr. Brewer. After a detailed examination and explanation of his findings, Dr. Brewer recommends to George that five carious teeth be restored with gold castings. On learning the cost for the five castings, George asks for a more affordable alternative. Dr. Brewer informs George that the teeth could be restored with amalgam but that he considers it an inferior restoration to gold and will not provide this treatment. If George wants the amalgams he will have to seek dental care elsewhere.
3. Jack is a regular patient of Dr. Lewis and is being seen for a routine check up. Dr. Lewis discovers an abscess on a mandibular premolar tooth that is

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asymptomatic and she recommends endodontic therapy followed by a crown because it is her personal practice philosophy to do everything she can to save teeth. Jack has no interest in saving this tooth and prefers to have it pulled and then have a bridge made. He is convinced that an endodontically treated tooth is likely to cause him more trouble later and would rather eliminate the tooth now. Dr. Lewis cannot agree to this approach and asks Jack to seek dental care elsewhere.

These cases represent a very common occurrence in every day dental practice: patients and dentists at odds in negotiating treatment. Ethically, they are interesting because they put the dentist's obligations to promote the patient's oral health and to follow his or her personal practice philosophy in conflict with the patient's right to make an autonomous choice. Are any of the dentists in these examples ethically justified in declining to treat their patient? And if so, in what sense do these dental patients have autonomous choice?

Unrestrained beneficence is usually called paternalism and is generally rejected as an ethical objective in the doctor-patient relationship.

Two things are fairly clear in contemporary dental ethics: First, dentists have an undeniable obligation to protect and promote the oral health of their patients. This obligation arises from the ethical principle of beneficence and is not without constraints. Unrestrained beneficence is usually called paternalism and is generally rejected as an ethical objective in the doctor-patient relationship (Beuachamp & Childress, 1983; Ozar & Sokol 2002). Second, dentists also have an undeniable obligation to respect a patient's autonomous choice (Beuachamp & Childress, 1983; Jonsen, Siegler, & Winslade, 1992; Ozar & Sokol, 2002; Timko, 2001) This too is not without its limitations. For example, patients should not expect dentists to do treatment that would result in harm to their oral or general health. Somewhat less clear but no less important in this situation is the general consensus that dentists have the right to chose whom they will serve, as long as they do not discriminate on the basis of race, religion, gender, or disability. Moreover, dentists have the right to practice in a manner that enhances the care they provide for patients (Ozar & Sokol, 2002).

Ethical dilemmas result precisely when two or more obligations or rights cannot be honored at the same time, as is the case in these three scenarios. Which obligation should prevail? Is patient autonomy a stronger obligation than promoting the patient's oral health? Are there times when a dentist's personal philosophy of practice trumps the patient's desires? Is there ever a time that a dentist is compelled by duty to deliver care that he or she would not choose for himself or herself?

A tool to help us in these types of ethical deliberations has been devised by dental ethicists David Ozar and David Sokol (Ozar & Sokol, 2002). Ozar and Sokol argue convincingly for a ranking of the professional values (and thus obligations) that are at the center of the dental profession. Their "hierarchy of values" places six values of the dental profession in the following order:

1. The patient's life and general health
2. The patient's oral health
3. The patient's autonomy
4. The dentist's preferred patterns of practice
5. Esthetic values
6. Efficiency in the use of resources

The way this hierarchy is used in ethical deliberations is to follow the general rule that it is unethical to take an action that would choose a lower value on the list over a higher value on the list. Thus, a dentist would be unethical if he or she chose to provide treatment to a patient that enhanced the patient's oral health and yet put the patient's general health in jeopardy, for example, removing an infected tooth without prescribing antibiotics for a patient who is susceptible to bacterial endocarditis.

This is not to say that the hierarchy can be used uncritically without regard to unusual circumstances, nor does it provide definitions of what counts, for example, as oral health. Still, it provides us with an excellent place to start. It is not the intention of this paper to reproduce Ozar and Sokol's arguments but rather to use the hierarchy in considering the three scenarios presented at the beginning of this paper to see if the hierarchy produces results that cohere with our general notions of ethical behavior.

At first glance it may appear that the hierarchy has placed beneficence (oral health) as a morally superior value to patient autonomy. Thus, it may seem to support some sort of paternalism. However, it would be a mistake to make this assumption. Dentists should do all they can to promote the oral health of the patient, but they must not insist on it at all costs, as would be the case in traditional paternalistic practices. For example, it would be unethical to lie to a patient or to coerce a patient to obtain a positive oral health outcome. Autonomy here is a lower value primarily because it is clearly unethical for a dentist to honor a patient's request for treatment that would result in harm to the patient.

Analysis and Application

For the three scenarios presented, obligations and rights pertaining to the second, third, and fourth values (oral health, patient autonomy, and preferred patterns of practice) are clearly at issue. Yet they are each, it will be argued, different in substance and thus have very different resolutions. In all three scenarios we will assume that each dentist has provided a thorough and balanced explanation of the risks, costs, and benefits of the proposed treatment and that each patient is fully competent to make autonomous choices.

Health Rewards and Risks. In the first scenario, Dr. Chen has evidently de-

termined that the risks and costs of doing veneers for Anita outweigh the benefits and thus would result in diminishment (or potential diminishment) of her oral health. If this is indeed the case, he would be ethically justified in declining to treat her, in spite of the fact that her autonomy is not respected in choosing treatment. The hierarchy of values precludes choosing actions that favor a lower value over a higher one. Conversely, with the same set of circumstances, if Dr. Chen agreed to do the veneers, he would be acting unethically.

The extenuating circumstances in this case revolve around definitions of what counts as oral health and what counts as a benefit to the patient. In his risk-cost benefit analysis, it is not sufficient for the dentist to consider only what he personally regards as either benefits or dangers to the patient's oral health. As Ozar and Sokol note in their discussion of esthetic values, and as others have noted regarding subjective values, the dentist's analysis must include information from the patient since the benefit here has a large subjective component. It must also include considerations of what is generally regarded as oral health and relevant esthetic values in the community of dentists in which one practices (Abrams, 1982; Ozar & Sokol, 2002; Wear, 1998). Ultimately, however, the dentist must do the ethical analysis and make a professional judgement. The "weighing of the risks and benefits" is, unavoidably, a judgement. The ethical demand here is that the dentist considers all the relevant information and gives appropriate consideration to the patient's desires. He cannot, for example, simply substitute a general rule from his preferred pattern of practice that he never does veneers unless the patient has tetracycline stains. In this scenario, we could probably find consensus among dentists and (as importantly) among non-dentists, that cutting perfectly healthy teeth to place restorations that will no doubt need to be replaced periodically carries too much risk and cost to the patient's oral health to justify the attainment of a small shade change. Dr. Chen is arguably justified in declining the patient's request.

The "weighing of the risks and benefits" is, unavoidably, a judgement.

The hierarchy of values precludes choosing actions that favor a lower value over a higher one.

Dentists' Preferred Practice Patterns. In the second scenario, we encounter a similar situation. However, it should be somewhat obvious that Dr. Brewer's determination that placing amalgam restorations would not be in the patient's best interest is based less upon a reasoned consideration of the risks, costs, benefits, and the desires of the patient and more on his preferred patterns of practice and his personal values. If this is the case, according to the hierarchy of values, Dr. Brewer cannot ethically decline to honor the patient's wishes. Doing so would promote a lower ranked value above a higher ranked value; in this case, placing his preferred pattern of practice over the patient's autonomy. There is no doubt consensus in the dental community that gold is a superior restorative material to amalgam. To honor the ranking of patient's oral health, it is only necessary to avoid decisions that would diminish the patient's oral health, as long as they provide some benefit and not to maximize that health at all costs. In this case, the patient has not asked Dr. Brewer to harm him. An amalgam restoration would adequately treat the carious situation in the patient's teeth and thus deliver a net health benefit to the patient. One would have to show that amalgam restorations have inherently more risk and cost associated with them than do gold restorations to claim that the patient is choosing a harmful course of treatment in preferring amalgams.

Now, it may make many dentists uncomfortable that they would be required to perform a treatment for a patient that they would not choose for themselves or their family. However, if this were not sometimes the case, the entire notion of patient autonomy would have no relevance to dentistry. If dentists could justifiably do things only their way, dental patients would not in any real or significant sense have autonomous choice. Simply sending the patient down the highway to the next dentist is hardly a good and ethical choice either for several very important reasons. First, patients usually have established a relationship with the dentist that includes a high level of trust and, in many ways, a dependency. It is no small matter for a patient to re-establish this relationship with another dentist. Secondly, the dentist must be sure that the patient will receive competent care or be guilty of putting the patient at increased risk of harm. A patient should not have to make the decision of either agreeing to treatment or finding another dentist. This is a form of threat or coercion that can not possibly find support within the doctor-patient relationship. Ozar and Sokol note that the dentist's obligation to treat in a case of this sort is greatest when the patient does not have reasonable access to another dentist. (Ozar, 2002)

Patients' Personal Preferences. The third scenario is more problematic than the first two. In this case it is more than a clash of subjective values and preferences. Both parties have good rational reasons for wanting a particular course of treatment. Both the dentist and the patient have well formed and strong beliefs about how to treat the existing disease. For Dr. Lewis to prevail ethically in this instance, she would have to show that following the patient's desires would somehow result in a dimin-

ishment of the patient's oral health. According to the hierarchy of values, she would not be ethically justified in merely placing her personal practice preferences ahead of the patient's autonomy.

What case does Dr. Lewis have? There is little question that extracting an infected tooth is an effective way of removing infection. In fact, it could be argued that this procedure not only has a long tradition in dentistry but is also a very common treatment in dental offices everywhere and thus, well within the standard of care. It is unlikely that Dr. Lewis could show that the attendant risks involved in extraction are greater than those for root canal therapy. Both treatments could result in an acute infection immediately following treatment. However, the risk of future infection from a failing root canal therapy are, in fact, much greater than future infections resulting from extractions since the source of the infection has been removed entirely in that latter case. Her best argument would be to show that the removal of a tooth and the placement of a bridge in some significant way diminishes the patient's oral health. For instance, she could try to make the case that subjecting adjacent teeth to crown preparations involves risks that would not occur with the root canal and crown option

Putting risks aside for the moment what are the actual, direct disadvantages of extraction bridge option, does the patient lose function? A properly fabricated bridge certainly functions as well as a natural tooth in masticating food. Does the patient have pain and discomfort from the bridge? There may be some limited post-operative sensitivity, and there will no doubt be a period of time for the patient to get used to the unique contours of the bridge, and there may be a greater tendency for food impaction. Is the periodontal tissue health compromised? Again, a well fabricated bridge should not in any way damage the periodontium and we know that patients are very capable of maintaining these prostheses over many years. Does a bridge put undue stress on other teeth or predispose them to added stress? Certainly no more than the crown would in the root canal crown option.

In the absence of a clear, objective difference in risks between treatment options, patients ought to decide how much risk they are comfortable in taking.

In considering risks, we know that root canal therapy has a considerable history of failure: recurrent infection requiring re treatment and apicoectomies, fractured crowns, and fractured roots are common. On the other hand we also know that there are risks involved in preparing the abutment teeth for the bridge. The abutment teeth could become necrotic following preparation, necessitating root canal therapy. And there is an increased risk of recurrent caries given the increase in susceptible crown margins. Do these risks cancel each other out? This is hard to determine due to the fact that risks and the tolerance of risk have a strong subjective component (Abrams, 1982). Some people accept more risks in their lives than others and consequently, patients have the right to choose treatment that contains risks that are different from what the dentist would choose for him or herself. Evaluating risk is not a value-free exercise and in the absence of a clear, objective difference in risks between treatment options, patients ought to decide how much risk they are comfortable in taking.

In this scenario, it suffices to say that there is no overwhelming disparity in risk between the two potential treatments from an objective point of view. Either choice could be ethically justified from the standpoint of risk as well as actual costs. What remains is the patient's level of comfort with the stated risks. It is unethical for the dentist to impose his or her risk comfort level on the patient. Jack has stated his preferences very clearly, and Dr. Lewis must respect his right to choose the risks attendant to his preferred treatment.

So what should be done in this situation? We have not been able to demonstrate a clear objective preference for one treatment over another. There is no indication that either treatment option would result in a diminishment of Jack's oral health. Nor is there a clear choice based on risks. Thus, Dr. Lewis cannot claim that her action is supported by an appeal to what is best for the patient's oral health. What is left is Dr. Lewis' personal practice philosophy to save teeth at all costs. According to the hierarchy of values, it would be unethical for Dr. Lewis to decline to treat Jack based on this personal preference. This would be placing preferred patterns of practice ahead of patient autonomy. Jack has every right to expect that his ability to make an informed choice (his autonomy) will be taken seriously by his dentist and that she will treat him accordingly.

For a patient to have true choice he or she must be able to act on that choice. It makes no sense to offer alternatives to a patient if the dentist is unwilling to provide the treatment that is within his or her competence.

This being said, it is not at all being suggested that a dentist should be forced to deliver a treatment that he or she does not feel competent to deliver. We will assume that in this case, Dr. Lewis is perfectly capable of fabricating a bridge. If she did not have this competence then

she would be ethically justified, indeed, ethically compelled to refer to another dentist.

Autonomy in Context

While all three of these scenarios deal with the same competing values and obligations it can be seen that different circumstances may lead to different conclusions if there is a judicious employment of Ozar and Sokol's hierarchy. And while the results argued for above may not match any particular dentist's opinion, they certainly cohere with generally accepted bioethical principles. The hierarchy seems to possess the sensitivity and specificity we would require of a good tool.

Current biomedical ethics in the United States places a large emphasis on patient autonomy, and rightly so. Patients must be able to control their lives whenever they have the capacity to do so. Dentists must realize that respecting patient autonomy goes beyond informed consent. For a patient to have true choice he or she must be able to act on that choice. It makes no sense to offer alternatives to a patient if the dentist is unwilling to provide the treatment that is within his or her competence.

There are true limits to the autonomy of dentists. It is never the case that the dentist's mere preference among equivalent treatment options prevails over the desires of the patient. Resolving such ethical dilemmas by sending the patient down the highway cannot be ethically supported.

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The Mumpsimus

David W. Chambers

Abstract

It is an unfortunate side of human nature, on occasion, to stubbornly refuse to change our minds or listen to evidence that challenges our beliefs. In the extreme form, such individuals are called mumpsimuses. This column describes what research has been able to tell us about why individuals continue to escalate their commitments to failing causes and why beliefs are so resistant to change, even in the light of reason. In fact, it is usually best to leave a sleeping mumpsimus lie.

Sometimes outrageous human foibles become associated with their early perpetrators, typically in a comedic way. Spoonerisms, for example, are unfortunate transpositions of the initial sounds in adjacent words. Examples would include "nothing so inevitable as teath and daxes," a "hit of rabious corpus," or even "getting one's tang tungled." The habit is named for one William Spooner, a preacher in the Church of England. The reverend was especially vulnerable when praying for his "dear queen." The English playwright Sheridan, in the 1775 play *The Rivals*, introduced the world to Mrs. Malaprop. Her peculiarity was to substitute incorrect words that sounded a lot like the intended ones. Malaprops would be involved in "going to medical school to become a plastic sturgeon," "seeing the glass as half full because you are an optometrist," or the complaint "I resemble that remark." Mrs. Malaprop herself was nothing but "a big bladder mouth."

Nicolas Chauvin was one of Napoleon's officers. He was a good solider but an expressive proponent of the emperor's political policies. He was lampooned in a 1831 play, *La Cocarde Tricolore*, by the brothers Charles and Jean Hippolyte Cogniar. Chauvinism now means any excess of zeal. In an ironic case of blaming the victim, Chauvin himself was one of the first to be ridiculed for being politically incorrect. (I have no idea how the pig got into this.)

The mumpsimus is another example of an exaggerated type. Mumpsimuses cling determinably to views that have been demonstrated to be wrong. In celebrating mass, a priest in the middle ages habitually substituted the term "mumpsimus" where the correct word is "sumpsimus." His mistake was regularly and forcefully pointed out to him, but his attitude was "I will do as I please, I am not open to consider evidence to the contrary." Mumpsimism did not die in the middle ages. We are currently very well stocked.

At this point, it would be customary for the author to write a paragraph listening contemporary examples in dentistry. That would be risky. Mumpsimuses are notoriously prone to take offense and not tell anyone but their friends about it. Instead, I will invite the reader to reflect for a minute and compose his or her personal list. Good places to look would be unsubstantiated dental procedures, policies from organizations and agencies, and rules that have been in place so long no one can remember why they were started. Anyone who says "we've always done it this way" or "it is just obvious, only a fool would propose changing it" is a viable suspect. Remember, a mumpsimus is not just someone you disagree with; it is someone you cannot talk with.

Remember, a mumpsimus is not just someone you disagree with; it is someone you cannot talk with.

Generally there are three paths to becoming a mumpsimus: being entrapped into escalating commitment of resources to lost causes, managing access to information to protect one's beliefs, and perverse obstinacy. In this column, we will look at the first two.

Entrapment

How do we make a mumpsimus? There's actually about forty years of solid research evidence regarding why people defend untenable positions. The most compelling result of these studies show that the condition is situational rather than personal. Each of us is subject to being trapped by a lost cause from time to time. Standing on prin-

Table. What Research Reveals About How People Become Entrapped into Escalating Commitment to Lost Causes.

Entrapment is more likely where ...
Individuals have taken a personal role in initial investments
Where inadequate attention was paid to initial conditions
Benefits are overestimated and costs are underestimated
Conditions and outcomes are ambiguous
Individuals are active in the "game"
Individuals are passive in committing resources
Payouts are seen as investments to win rewards rather than expenses to control loss
Competing against aggressive or unlikable people
The context is characterized as competitive
Others model entrapped behavior
Men are in competitive conditions, (but not where they are in cooperative ones)

ciple, sending good money after bad, and feeding a dead horse are likely to happen to anyone. It is just sloppy language and wishful thinking that allows us to describe the mumpsimus as having a character flaw or a defective personality profile.

The accompanying table summarizes current research on how people become entrapped. Entrapment is defined as escalating commitment to a failing course of action, executed to justify prior resource allocations. Examples include going to the same quack or incompetent healthcare provider year after year because of one's initial choice, continuing to hold stock whose value is plummeting because one was so cleaver to purchase it on a hot tip, or waiting for a long overdue bus or friend. Some dentists defend techniques that were marvelous in their day but are no longer current. Some parts of the profession defend policies and programs that were appropriate in the 1920s and are no longer relevant. The logic of entrapment underlies the lost cause writings of Jubal Early regarding the Civil War (it's not over yet) or more tragically, Charles Dickens's novel *Bleak House,* showing how the legal system destroys lives.

The dynamic of entrapment begins with an initial chance situation where an investment appears to have a favorable payoff prospect. Additional investments are required on a regular basis. These may be active investments such as purchasing additional shares of stock or going to meetings; or they may be passive such as social security deductions from one's paycheck or waiting for one's colleagues to see the wisdom of your insights. The most dangerous kinds of entrapment are those where investments gradually escalate and the probability of payback gradually declines.

There is a psychological dynamic of entrapment. Initially, an individual is rational in analyzing the situation, and choices are made about participation, degree of investment, and search for and use of relevant information. This is what we would expect when a senior dentist interviews prospective associates, a political crisis such as Iraq emerges, or a new product comes on the dental market. Gradually, however, as investments begin to mount, the relationship between the individual and the situation changes to one that emphasizes psychological dynamics. The commitment of resources is now based on principle and one seeks to justify earlier commitments and to appear reasonable, when in fact one is not.

A typical laboratory situation used to study entrapment illustrates the dynamic over time in a very simple fashion. Called the Dollar Option Game, a group of individuals is offered a chance to bid for a dollar. The rules are similar to traditional auctions in that the dollar will be given to the individual who makes the highest bid in exchange for the amount of money that person bids. The unusual twist is that the person who makes the second highest bid must surrender the amount he or she bid but receives nothing in compensation. The situation is not entirely artificial if you think of political campaigns, competitive bidding for contracts, or courtship involving two rivals. It is captured in the rule that the person who loses the most in a poker game is not the person with the worse hand; it is the person with the second best hand. What happens repeatedly in the Dollar Option Game is that a large number of individuals bid initially at very low values—a nickel or a dime in hopes of getting the dollar—and then they drop out. Eventually, the auction is between two individuals who escalate their bids well beyond one dollar. It is not uncommon to see bids of twenty, thirty, or more dollars offered in exchange for the one dollar prize. So we have bids that are very low and bids that are very high, and very few commitments that are equal in value to the expected return. This is easily explained in the shift from rational to psychologically

defensive postures as the entrapment process unfolds.

Entrapment is especially likely to occur once an individual has past a point where it is logical to expect future returns to equal future investments. This is especially true when resources are committed in an effort to justify one's previous decisions. Escalating commitment to a lost cause is significantly reduced if individuals can distance themselves from previous commitments. This is one reason why democracy work, the ADA has frequent turnover among elected and appointed officers, and bankruptcy rules are necessary. Entrapment is likely to occur when individuals fail to pay attention to initial rational information about costs and benefits. In con games and aggressive sales tactics, rational analysis of initial conditions is intentionally distorted. This weakness is compounded by human nature, which tends to overestimate promised rewards and underestimate costs.

Human nature does not process investments and expenses using the same arithmetic. We exaggerate likely benefits and discount likely negative events, even when the numbers are identical.

Entrapment is more likely when the logic of investments and returns is ambiguous. A game where returns follow investments in a known, predictable, and unvarying way will be played if it is rewarding and stopped if it is not. When chance and ambiguity are added to the same cost/benefit structure, individuals will play the game even when it is not rational to do so. The reason for this is that, in ambiguous situations, we tend to exaggerate our own effectiveness when things go well and to emphasize the role of "bad luck" when things go poorly. Entrapment is more likely if an individual is actively engaged in the process. Casinos know they can get players to accept worse odds if they are allowed to pull levers, punch buttons, or turn cards then they would by simply consulting a payout table. Charlatans generally give their dupes some minor and meaningless role to play in their own care.

Entrapment involves repeated investments or commitments over time. When these investments are passive (waiting for something to happen or authorized unless specifically countermanded—"one CD will be shipped approximately every month, but can be canceled upon prior notice") entrapment is more likely to occur then when the repeated commitment must be made actively. Making repeated, active choices is somewhat more likely to provoke the entrapped individual to engage in rational calculations. It also matters whether the repeated commitment is considered to be an investment or an expense. An investment is resources going out in hopes of a positive result. Expenses are resources going out in an effort to manage possible negative consequences. Human nature does not process investments and expenses using the same arithmetic. We exaggerate likely benefits and discount likely negative events, even when the numbers are identical. This is why there are more stockbrokers than there are people selling long term care.

There are also group dynamics involved in entrapment. For example, competing against another individual who is disliked or seems to be belligerent or aggressive will increase the chances of entrapment. (Have you ever wondered why some sales people regard rudeness and aggression as an effective tactic?— it is!) When the context is understood to be competitive, when others around you act in a competitive or entrapment fashion, and when you are part of a group that values social conformity over independent critical thought, you are more vulnerable to being entrapped. When it is necessary to save face, entrapment is likely. (The staggering number of bad loans carried by Japanese banks has been a substantial drag on their economy for a number of years.)

Competition seems to cause entrapment, and men frequently find themselves in entrapment situations. This sounds so suspiciously contradictory to the general claim that there are no personality types especially susceptible to entrapment that it deserves detailed comment. Another research finding that must be borne in mind is that men are more successful in negotiating or bargaining situations that require cooperation than are woman, just as they are more competitive in situations that are structured competitively. Men tend to fill more extreme positions than do woman in areas such as educational accomplishment or leadership and antisocial behavior. This means they are more often trapped in competitive situation and more often the leaders in cooperative ones. (I would love to be at the dinner table tonight when husbands try to explain this to their wives.)

Entrapment is best managed by not starting to play losing games.

The research on commitment to lost causes offers some insight into how entrapment can be avoided. A vigilant perspective is helpful. This involves active, rational monitoring of both costs and benefits on a continuous bases. Entrapment is best managed by not starting to play losing games. If it is determined that a potentially entrapping situation should be explored, it is wise, prior to beginning, to set limits on the extent of resource commitment. Such limits should be non-negotiable and should automatically trigger change in behavior when

they are reached. Recalling that entrapment is a process that moves from the rational to the psychological, an important rule to remember is that entrapment situations look different from the inside than they do from the outside. If you suspect that you are being trapped, get some objective advice and follow it.

There is a curious flip side to entrapment logic. Many habits we regard as healthy could be construed as entrapment. Stopping smoking, eating correctly, losing weight, exercising, and reading the *Journal of the American College of Dentists* and other professional literature carefully could be increased through "intentional self entrapment." To be successful, self entrapment needs to reverse the rules of escalating commitment to lost causes. For example, no limits should be set on one's accomplishments. Friends of weak resolve should be avoided; contrary information should be ignored; the commitment one makes should be as public as possible; and information about successes should be sought, recorded, and analyzed.

The Stability of Unsupported Beliefs

There is ample scientific evidence that individuals cling tenaciously to notions in the face of disconfirming evidence. The mumpsimus is not a wimp. Sometimes rational people forget that the defensibility of an idea and the certainty with which people hold it are two different things.

Ideas are alive and personal, and they affect those who hold them. Once an individual has made a decision or taken a position, it is predictable that he or she will be in a state of discomfort. This follows from the fact that the decision, if it means anything at all, was arrived at by a process of considering several alternatives. Having made his or her choice, the mumpsimus now has to contend with the advantages of the alternatives not chosen and the disadvantages of the position accepted. In the famous example used so often in the literature, an individual chooses one car over several alternatives—say an Edsel. The Edsel owner will look for information in advertisements, reports, and conversations with friends that supports the advantages of the Edsel or uncovers shortcomings in other cars. In a word, a decision made is still alive and has a naturally self-preserving instinct. We know, for an example, that liberals read the *New Republic* while conservatives listen to Rush Limbaugh, and those who see themselves as somehow urbanely above politics read the *New Yorker*.

Entrapment situations look different from the inside than they do from the outside. If you suspect that you are being trapped, get some objective advice and follow it.

It can actually be counterproductive to push a mumpsimus. Studies on the effects of anti-propaganda show that individuals are quite adapt to protecting themselves against messages they do not want to hear. To maintain their beliefs, individuals accept the counter argument offered and spin it out by circuitous routes to contradictory conclusions or they reject the message entirely. The most typical way mumpsimuses protect themselves from things they do not want to hear is to discredit the source. Dentists who don't like one material or product are fond of saying, "Oh, the spokesperson for that technology and its manufacturer have commercial interests in making their claims. (The same can be said for the technology they prefer, but mumpsimuses don't think like that.) There is even evidence showing that individuals selectively forget those things that are most challenging to their cherished beliefs after they have learned them.

A dramatic example of the stubbornness of beliefs occurred during the Second World War. Japanese Americans in internment camps were offered a choice of retaining their American citizenship or revoking it in favor of Japanese citizenship with the promise of being returned to Japan once war conditions permitted. A small number chose to renounce their citizenship. These individuals firmly believed that Japan would win the war. They also discounted every effort on the part of Americans to improve their situation, feeling, for example, that American hospitals were experiments, that increases in food supplies were attempts to gain favor, and that all news of the war was lies. Even on the boats returning them to Japan in 1946, these individuals persisted in the belief that Japan had won the war and had forced America to return them while America was falsely attempting to take credit for honoring its promise.

It can be a bad business to force the mumpsimus to confront his or her unfounded beliefs. When individuals are coerced into making public statements that are contrary to their private beliefs through enormous rewards or severe punishment, they persist in their private views. Their natural defense is that any reasonable person would say such things to avoid the outrageous consequences. Galileo's recanting of his heliocentric view of the universe was an example. After all, they were threatening to burn him alive.

When pressure is brought to bear on an unfounded belief but the pressure is insufficient to cause a change in behavior, the worst results of all have occurred. It is like a vaccination. The mumpsimus builds his or her resistance in the face of a threat to a cherished idea. It is well to remember the old adage, "better to have tried and failed then not to have tried at all." When it comes to changing people's minds, that rule is dead wrong.

It is human nature to chose our friends so we have people around us who share our beliefs. In fact, that may

be one of the reasons for social groups. There primary function might not be social at all, but rather the maintenance of beliefs about the world around us. The mumpsimus tends to be an isolate.

Rumors are one way we protect our beliefs. We tell ourselves stories that justify our fears. They are descriptions of reality based on very thin evidence that are circulated in groups, usually in an effort to establish status within that group or to protect the identity of the group. Research on crisis rumors shows that those individuals directly involved spread rumors, but they do tend to be fairly realistic and minimally exaggerated. Those who are on the periphery of the crisis or for whom the crisis might occur tend to spread wild and exaggerated rumors. Although such research has been conducted using situations such as war or catastrophes like earthquakes and floods, the same might be true of political and economic crises. For example, among my dentist friends who take insurance patients, there is grumbling about specific problems and shortcomings with the system. The strident rhetoric comes from those who have few insurance patients or never had any at all.

A research study conducted by Leon Festinger over forty years ago illustrates the dynamics of strong views and social support. Individuals were initially surveyed regarding, among other things, their views on wire tapping. All individuals then listened to a very strong persuasive presentation about the advantages of wire tapping. Next, individuals were told that they would be discussing this issue with two other individuals who were also participating in the research study. Written profiles of the others' beliefs about wire tapping were provided for preview. Of interest were the individuals who had high dissonance—those whose beliefs about wire tapping were most devirginate from the strong persuasive message. Those individuals overwhelmingly chose to form discussion groups with colleagues who held initial beliefs similar to their own. Those who had low dissonance—those whose original position had not been challenged by the message—chose a mixture of discussion partners who had similar and dissimilar views. Participants were asked at the end how confident they were in their original positions. Those who had experienced strong dissonance and chosen to discuss the issue with those who held similar views claimed to be very confident that they were right in the first place. In fact they often claimed greater confidence after being challenged and then supported by peers with similar beliefs.

Don't share this article with a mumpsimus. If you have read this far, I am confident you are not one yourself.

Recommended Reading

* Brockner, Joel (1992). The escalation of commitment to a failing course of action: toward theoretical progress. *Academy of Management Review, 17* (1), 39-61.

"Escalation situations include repeated decision making in the face of negative feedback about prior resource allocations, uncertainty surrounding the likelihood of goal attainment, and choice about whether to continue." New research seems to indicate that the major factor is attempts to justify previous decisions rather than taking a rational future view.

* Brockner, Joel and Rubin, Jeffrey Z. (1985). *Entrapment in Escalating Conflicts: A Social Psychological Analysis*. New York, NY: Springer Verlag. ISBN: 0-387-96089-9; 275 pages; price unknown.

"Entrapment is the escalation of commitment to a failing course of action, executed in the service of justifying prior resource allocation goals" (126). When we are entrapped, we are living in the past. This scientific monograph summarizes a large number of laboratory studies under controlled conditions to isolate the variables associated with becoming entrapped and what happens during that process. The authors were psychology professors at Tufts University at the time the book was written. It is largely reports of experiments and quite technical.

* Capers, R. S. & Lipton, E. (1993). Hubble error: time, money and millionths of an inch. *Academy of Management Executive, 7* (4), 41-57; Stein, B. A. & Kanter, R. M. (1993). Why good people do bad things: a retrospective on the Hubble fiasco. *Academy of Management Executive, 7* (4), 58-62; Capers, R. S. (1994). NASA post Hubble: too little too late? *Academy of Management Executive, 8* (2), 68-72.

A summary of the Pulitzer Prize journalistic investigation into the train of errors leading up to the multimillion dollar bungle of the Hubble telescope and why no one fixed those errors. Of particular interest is the Harvard B-School analysis that identifies the root cause as the complexity of our scientific-industrial complex. The final article by Capers describes what NASA did to prevent such problems recurring.

Festinger, Leon. (1957). A Theory of Cognitive Dissonance. Stanford, CA: Stanford University Press. No ISBN; 292 pages; out of print.

While an individual is making choices, he or she is in conflict while each alternative and its attendant uncertainty is weighed. Festinger's concern is what happens after choice takes place. The tension between alternatives that remains after decisions are made or opinions are formed is called dissonance. Dissonance has the power to motivate individuals seeking the kind of information that will reduce this tension. The book describes theories and presents experimental evidence about how individuals behave after making a decision, when they are forced to act contrary to their beliefs, when they are exposed to contrary information, and when they are part of a group whose believes are not confirmed by events.

Harvey, J. B. (1996). *The Abilene Paradox and Other Meditations on Management*. San Francisco, CA: Jossey-Bass.

Imagine a family discussing where to eat. One member of the group makes a ridiculous suggestion (drive fifty miles to Abilene to eat in a cafeteria). No one questions the suggestion, assuming that it was serious, and so off everyone goes. Groups can get into a lot of trouble when people fail to express their true feelings.

Editor's Note

Summaries are available for the three recommended readings preceded by asterisks. Each is about four pages in length and conveys both the tone and content of the original source through extensive quotations. These summaries are designed for busy readers who want the essence of these references in fifteen minutes rather than five hours. Summaries are available from the ACD Executive Offices in Gaithersburg. A donation to the ACD Foundation of $15 is suggested for the set of summaries on mumpsimuses; a donation of $50 would bring you summaries for all of the 2003 leadership topics.

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