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excellence, ethics, professionalism,
and leadership in dentistry

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Mission

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

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 potential for contributions to dental science, art, education, literature, human relations or other areas which contribute to human welfare—by conferring Fellowship in the College on those persons properly selected for such honor.

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2006 ACD ANNUAL MEETING

4 Continuing the Journey to Excellence: ACD President-elect's Address
H. Raymond Klein, DDS, FACD

7 Professional Regulation—Who Decides? Convocation Address
Dame Margaret Seward, DBE, DSc, DDS, FACD

10 2006 ACD Awards

14 2006 Fellowship Class

STATE DENTAL ASSOCIATIONS

18 Making Dentistry Effective at the State Level: South Carolina
Philip E. Smith, DMD, FACD

22 Growing Pains in Paradise: Arizona's Boom
Rick Murray

25 Montana's Regional Initiatives in Dental Education (RIDE)
Mary K. McCue, Esq.

28 A Look Inside the Texas Dental Association
Mary Kay Linn

30 Size and Perspective in Alaska
Jim Towle

ISSUES IN DENTAL ETHICS

33 Using an Ethics Across the Curriculum Strategy in Dental Education
Lawrence P. Garetto, PhD, FACD, and Wendy E. Senour

DEPARTMENTS

2 From the Editor
TV and Dentistry

38 Leadership
A Primer on Dental Ethics: Part I—Knowing about Ethics

48 2006 Manuscript Review Process

49 2006 Article Index



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FROM THE EDITOR

TV AND DENTISTRY

Supplements to good journals that are paid for by single sponsors should not have the look and feel of the regular journal.

I watch television about the same way I read the newspaper—every few days I conduct a scan to make sure it is safe to go on with life and sample part of a story or show. The rest of the paper is useful to mulch the garden or light the fireplace, but the television is nearly useless. My wife and I disagree on this, but I find the commercials of greatest interest. They offer more creativity per second than the fill that fills the space between. And if you listen from the right perspective, you can find out who corporate America thinks you are.

I thought about this as I squinted at bits of the Super Bowl through the drizzle and wondered how many Americans had just paid the big bucks for a huge, high-def, flat-panel model.

What might the tube be broadcasting of interest to dentistry? I understand that the hot new programming is reality shows, awards shows, programs where we get to vote somebody off, and infomercials.

Technically a videocast, there is now a site where we can watch mold growing on cheddar cheese—in real time. Recently there was a contest in England where researchers competed to see who had grown the most interesting molds on their lab coffee cups. There were categories for overall mass, unusual color, or appearance of a design. As far as I have been able to determine, this was not a funded grant. The American

TV version of this phenomenon is mostly insecure adolescents showing off and alternatively obsessing “I wonder if she thinks I’m cute” and “How dare you express an opinion about me; don’t you know in this country I am entitled to my rights and I have just been waiting for somebody to say something I can take offense at.”

Oh, yes, we have the counterpart in dentistry. It is usually mailed free to our offices monthly. It is oversized so that it sticks out in the stack of papers on our desks. Recently it has become so slick that one has to rotate the page regularly and shade our eyes in order to finish a sentence. My wife even agrees with me on this one: the ads really are better than the self-proclaimed expertise and personal exhibitionism of the material that frames them. Some have said that the equivalent of watching mold grow is in the more academic publications.

Awards shows on television have been a staple from the beginning. They are inexpensive to produce and there are always winners—lots and lots of them. Some shows run for three or more hours, and that is just the televised portion. Many of the “academies” start giving recognition at ten o’clock in the morning for categories such as best hair styling in a documentary about animals for an academy member who has no training. And there are academies I have never heard of engaged in this kind of advertising. All you need is a commercial sponsor and someone to write the script and citations.

The only recognition suitable for framing I have kept is for my fellowship in the American College of Dentists. But recently, I did run across one I received a few years back and for some reason filed away. It was in recognition of my outstanding work in the profession and named me to the select group of “Top Ten Dentists.” Of course I was amazed when I opened the envelope and my trembling fingers pulled out the engraved invitation (complete with an order form for announcements and a Plexiglas display stand for my waiting room). My friends were amazed as well, and one even had the effrontery to point out that I am not a dentist. After very careful deliberation, I declined the honor.

The new craze is “Dancing with the Stars,” “Survivor,” and “American Idol” (and “Iraqi Idol”—I kid you not). The attraction here is that you and I get to vote each week to kick somebody off. An innocent enough sadism, considering that we are assured anonymity and the results are certified by CPAs to have high reliability.

That function is handled in dentistry by the state and regional one-shot initial licensure examinations.

I am afraid, by now, that when I bring up the topic of infomercials, some of you will think I am beginning to come a little close to touching on topics with a faint commercial odor. Okay, so you have never actually watched one of those hour-long shows on television where gorgeous people extol the virtues

of a system that will guarantee stunningly white teeth in a few easy sessions. Here’s what you missed: “No need for costly and inconvenient visits to a dentist’s office!” “You have a right to a beautiful smile.” “For a limited time only, rush \$19.95, plus \$250.00 shipping and handling and receive, at no additional cost, a bonus at-home root canal treatment kit.” (Perhaps my memory is not clear on that last point, but I do remember that the offer was unbelievable.)

The counterpart in dentistry is the new blend of pseudoscience and advertising aimed at practitioners. The dangerous one is not the glossy; it is the supplement to an otherwise respectable journal. When the fine print is examined, it clearly states that the entire supplement of the journal was underwritten by Fabulous Company, and to no one’s great surprise, all articles report on products offered for sale by Fabulous and all prove the products are, well, “fabulous.” These articles are infomercials. A year or two ago, we all received a complimentary issue of a supplement to a well-known scientific journal in a plastic bag on our hotel room doors at the ADA meeting. I knew what it was, but thought I would see how close the articles came to being science. In the magazine there was one table that contained data and no quantitative or comparative descriptions of outcomes anywhere else in the entire issue. The whole thing was a “how-to” manual with beautiful pictures of results (how achieved we do not know). That is not biased science; it is a sales program.

“For a limited time only, rush \$19.95, plus \$250 shipping and handling and receive, at no additional cost, a bonus at-home root canal treatment kit.”

I would like to offer a modest suggestion since it is unlikely that my immodest one of getting rid of this kind of pseudoscience journalism is likely to be welcomed. Supplements to good journals that are paid for by single sponsors should not have the look and feel of the regular journal. Dentists know when they are watching the news channel, PBS, or commercial programming. They should be similarly alerted that they have an infomercial and not a scientific journal in their hands by the appearance of the publication.



CONTINUING THE JOURNEY TO EXCELLENCE

H. Raymond Klein, DDS, FACD

ACD PRESIDENT-ELECT'S ADDRESS

OCTOBER 17, 2006

LAS VEGAS, NEVADA

I want to welcome and congratulate the new Fellows of the American College of Dentists for 2006. Each of you has demonstrated through your professional, civic, and community activities the credentials for being nominated and elected into this prestigious dental honor organization. You have excelled through private practice, dental education, dental research, and military service, but you each in your own way have earned this honor and recognition.

You are here because your peers deemed you worthy to be recognized as a professional who has given and achieved above the ordinary and were deserving of this recognition. The lifeblood of any organization is new members. As Fellows of the American College each of you will now have the opportunity to participate in the nomination process by recognizing fellow professionals who are worthy of consideration and nomination.

My 1979 induction into the American College of Dentists in Dallas is something I clearly remember. It was one of the major highlights of my professional career and I'm certain today will be the same for each of you.

I am forever grateful and appreciative to Dr. Charles W. Fain, Jr., past president of the American College, and Dr. F. Lee Eggnatz for my nomination. Today, in the Class of 2006, we have Dr. Eggnatz's son, Michael. He is the third generation of the Eggnatz family to become a Fellow of the American College of Dentists.

TRADITION

Historically, the American College of Dentists was founded in August 1920 in Boston by individuals who felt there was a need to "bring together a group of men of outstanding prominence in the profession and by their united efforts in a field that is not now covered by any dental agency to endeavor to aid in the advancement of the standards and efficiency of American dentistry. Some of the aims of the College are to cultivate and encourage the development of a higher type of professional spirit and a keener sense of social responsibility throughout the profession; by precept and example to inoculate higher ideals among the younger element of the profession, and hold forth its Fellowship as a reward to those who follow such ideals; to stimulate advanced work in the dental art, science and literature; and to honor men who have made noble contributions to the advancement of dentistry."

The founders were men who had a mission and a vision to create an organization that would acknowledge members of the profession who in today's language are givers and not just takers.



Dr. Klein maintains a private practice limited to pediatric dentistry in Jacksonville, Florida.

Members of the College, by their very being, are professionals who are active and involved.

They wanted to recognize individuals who were the very best, not just some of the best—dentists who become involved, put something back, and endeavor to make dentistry a better profession.

Those early formative discussions and planning were the genesis for the development of the most prestigious dental honor organization in the world.

THE COLLEGE TODAY

The Mission and Vision Statements of the American College address the very reason for our existence.

Our Mission is to promote excellence, ethics, professionalism, and leadership in dentistry.

Our Vision is to be the leader in the promotion of excellence, ethics, professionalism and leadership in dentistry.

The leaders and members of the College can only ensure a vital and viable future with visionary leadership, a talented management team, and an energized membership. This requires meaningful projects, adequate funding, and financial support from the members of the American College and the corporate community.

What are we doing to achieve these goals?

STRATEGIC PLANNING

Strategic planning review is done every three years and is scheduled to be addressed in the spring of 2007. The strategic planning process solicits input through surveys from the general membership, new fellows, section officers, and board members. The Board

of Regents has identified five major core values, together with the Mission and Vision Statements, that compose the Strategic Plan. These core areas are:

1. Programs
2. Sections
3. Finance
4. Communications
5. Membership

LEADERSHIP

In order for any organization to be successful it must have strong leadership, including the officers, regents, staff, section officers, and the individual sections. The College has had excellent leadership and this current year promises to be no exception. Our President, Dr. Marcia Boyd, the Board of Regents, and the staff have worked very hard to study areas that need to be addressed. We have tried to identify ways to improve current projects and develop new programs and projects that support our Mission. There are times when section members and section leaders need advice or assistance and your officers, regents, and staff stand ready to assist in any way possible. We welcome this opportunity.

MANAGEMENT

The College is blessed to have an extremely competent management team. They handle any and all administrative issues coming before us—from everyday minutiae to major issues and concerns. They are highly trained, skilled individuals who perform their duties in a professional manner. The College is most fortunate to have them on board.

ACTIVE AND INVOLVED MEMBERSHIP

Members of the College, by their very being, are professionals who are active and involved. They have demonstrated leadership skills, desire and determination to be involved, and they contribute to making their profession better. They are individuals who want to make a difference.

MEANINGFUL PROGRAMS

The American College plans the annual meeting each year to coincide with the ADA annual session. Each year we have an outstanding presentation from the Keynote Speaker. The LeaderSkill Workshops provide members with excellent information and continuing education credit. The Convocation represents an opportunity to induct worthy new Fellows each year, as we are going to do this afternoon. During the Meet and Greet Reception there are chances to socialize, make new acquaintances, and renew old friendships. The annual ACD dinner dance is an event that will have lasting memories for all attendees. This extravaganza features unique food, entertainment, and dancing that will bring back memories for many years.

A Summer Conference and Leadership Workshop is presented biannually at a top-rated resort in an area of interest to our members. The next conference is scheduled for July 4-8, 2007, at the Sun Valley Lodge in Idaho. Attendees will have the opportunity to hear top-ranked

speakers in addition to having ample time for fun, relaxation, and socializing.

The ACD Travel Program has provided travel experiences for many of our members during the past several years. The programs have included a Scandinavian cruise, Alaskan cruise, Mediterranean cruise, a tour of the Imperial Russian Waterways, and most recently, in August 2006, a trip to see the wonders of China and the Yangtze River. The next trip is being planned for the summer of 2008.

MEANINGFUL PROJECTS

There are numerous projects and programs designed to help carry out the Mission and Vision of the American College. The ACD offers Courses Online Dental Ethics (CODE) for participants to review ethical dilemmas. It can be accessed through the ACD Web site at www.dentalethics.org.

The College distributes the *Ethics Handbook for Dentists* and the Ethics Wallet Cards to all dental schools requesting this material. In 2006, over 6,000 were distributed to graduating dentists and other dental groups. An electronic version is also available online at no cost.

Later today, a new project will be announced that will help provide funding for section activities. It will be named the Dr. Cecilia L. Dows Section Activity Fund. Dr. Dows has made a generous contribution to support the initiation of this project.

Projects which support the Mission of the College can only be accomplished if adequate financial resources are available. We are constantly searching and planning for new ways to provide this financial support. Fund raising is necessary and ongoing in our annual activities. Even though operating

The founders of the College wanted to recognize individuals who were the very best, not just some of the best — dentists who become involved, put something back, and endeavor to make dentistry a better profession.

expenses have continued to rise, we have worked diligently to avoid an increase in dues.

Fund raising is necessary to provide adequate financial resources for American College projects and programs. The Gies Fellow Program, Named Funds, and the Silent Auction are means for your supporting these programs. We recommend that members respond to the dues statement line item noted as "Suggested Donation to the ACD Foundation." Your contribution in this area helps defray expenses for ACD projects.

THANK YOU

I would be remiss not to express my sincere gratitude for the opportunity to serve as President of the American College of Dentists. It is an old cliché that "the turtle did not get on top of the fencepost without help." Certainly, in my case, it has not been done without the help of many people.

During my early predoctoral education and specialty training at Indiana University, my professional career was mentored by two faculty members, Drs. Ralph McDonald and Paul Starkey. Both of these men influenced my early dental education, which has served me well throughout my professional career. I am forever grateful for their confidence and the guidance shown to me during those early years.

For the past forty years I have been surrounded, propped up, and guided by fellow professionals who are too numerous to mention. My sincere gratitude and appreciation to each of them.

During the past year it has been a privilege to work alongside a true professional, Dr. Marcia Boyd, our current President. She has given of her time and talent in a most unselfish way. She has served the College well and represented each of us in the most professional manner.

I would also like to acknowledge and thank the ACD staff for their dedication and loyalty to this organization. Daily they live, work, and practice the Mission and Vision of this College. To them—Dr. Stephen Ralls, Ms. Karen Matthiesen, Mr. Paul Dobson, and other staff members, I want to say "Thank You" on behalf of all members of the American College of Dentists.

Not to mention my wife, Renee, would be a grave injustice. For nearly four decades she has been my wife, best friend, and supporter. She is the mother of our three children, and grandmother of four and soon to be five grandchildren. Renee is also a great homemaker and a superb dental hygienist. To her, I want to say "Thank You" and "I Love You."

Finally, to you, the newest Fellows of the American College of Dentists, this is your day. Congratulations on the accomplishments for which you are being honored. Please remember we each have a responsibility to put something back just as those who came before did for each one of us.

I challenge each of you to continue pursuing excellence, ethics, professionalism, and leadership and to contribute to making our dental profession the greatest in the world. ■

PROFESSIONAL REGULATION—WHO DECIDES

Dame Margaret Seward, DBE, DSc,
DDS, FACD

CONVOCATION ADDRESS

OCTOBER 17, 2006
LAS VEGAS, NEVADA

Life is full of surprises! Certainly, it was a surprise for me when I received this invitation to present this prestigious address. Thank you for honoring me in this way, especially in the presidency of Dr. Marcia Boyd. Marcia has been an outstanding leader in our profession who has shattered many glass ceilings, but thankfully contrary to the action of some who succeed, she stretches out her hand to help others up the slippery career path. Thank you, Marcia, for who you are and what you do. Also, I still remember the feeling of surprise when I was awarded Fellowship in this august American College of Dentists. It is always heartening, whoever we are, to be recognized by our peers in terms of individual achievement, within or outside the narrow confines of the profession.

No doubt, many new Fellows here today can readily identify with these sentiments, especially as you join an organization represented by more than seven thousand Fellows worldwide. What an accolade. And I offer my congratulations to you, remembering your sponsors, family, and friends, many of whom are accompanying you today and who will have given you encouragement, indeed sacrifice in time and finance, to help you to this pinnacle of your careers.

My own induction was memorable for a very special reason. There was also a convocation address, of which, sadly, I recall very little as excitement levels ran high. So, likewise, I do not expect you to

remember a great deal about mine this year. However, the memorable event occurred during the culmination of the celebrations in the evening: the glittering dinner dance. I invite you to imagine the event in Orlando when, in true Disneyland style, Mickey Mouse escorted me to the head table for dinner. I did not think there was anything untoward about this as I was president-elect of the British Dental Association at the time. But a surprise was in store for me for which I had not bargained. Here is the menu card from that very dinner—a prize possession, or some would say I am a prize hoarder—and what a feast we enjoyed, all washed down with a delicious chardonnay. Then as we approached the concluding coffee and tea, I idly turned the menu card over and panic set in. There emblazoned on the menu card was my name: I was scheduled to speak!

This afternoon, I cannot claim a lack of time to marshal my thoughts. I have pondered long and hard about the theme I wish to share with you. I finally decided on an issue that I consider, whoever we are and wherever we work or live, holds the key to our future, our survival. That is professional regulation.



Dame Margaret Seward is Chief Dental Officer Emerita of England and the first Dame in Dentistry in the UK.

“Trial by media” is a common occurrence and can be considered the curse of this age of consumerism.

SOME GENERAL THOUGHTS REGARDING PROFESSIONAL REGULATION

George Bernard Shaw, the great Irish playwright, stated in *The Doctor's Dilemma*, “All professions are conspiracies against the laity.” Now, a century later, surely we do not believe that our dental profession conspires against the public, our patients, our clients? What we do know is that the high level of trust, indeed status, placed by previous generations in their doctor or dentist, is not assumed by right. It is a trust that has to be earned and is open to increasing challenge.

Professional regulation, or more precisely professional self-regulation, is under scrutiny as never before. Are we capable of regulating ourselves? Is it seen as a measure of arrogance that we believe we can formulate our own

rules of competence and conduct and dispense justice to ensure colleagues do not fall below our clearly defined ethical standards? Are we in a government of delusion to believe this cozy relationship exists in 2006? To be blunt: who is really in control of our destiny, who decides? Is it the government? Is it the public? Is it the profession?

Speaking from my experience in the U. K., the government is unquestionably a force to be reckoned with. However, if the professions run themselves in a helpful way, importantly not costing the government money, and ensuring the highest standards of ethical practice, education, continuing professional competence, as well as recognizing the need for lifelong learning, then government and professional interests would seem to run in parallel and peaceful coexistence. If that balance is altered or if relationships become strained, the state may attempt to reduce or modify the self-regulatory powers, although in the worst case scenario, the state may abolish the regulatory body if the relative bargain has, in their eyes, not been honored. This is usually judged against the five principles of good regulation, defined in the U. K. five years ago by the Better Regulation Task Force, but which I consider has universal application. The five principles of professional regulation are transparency, accountability, targeting, consistency, and proportionality.

So how does the government arrive at the notion that all is not well with the self-regulatory process? A potent force today is the increasing clamor of the public, the consumer, the client, your patient or mine, whose voice is not only heard but listened to in the corridors of power. “Trial by media” is a common occurrence and can be considered the curse of this age of consumerism.

However, to combat public concern even when it is unrealistic, self-regulation

has to adapt and has to be fortified by independent scrutiny. Initially, protectionism reigned when members of the Royal College of Surgeons and dental professional organizations were challenged to open their inner sanctums to pay persons and allow them to participate in the decision making processes. To many colleagues it was seen as distasteful to contemplate inviting lay people into the very heart of a traditional dentist's association or society. It was construed that such action could imply that the public did not trust us. In the event, this fear was unfounded. Instead, those of us who have embraced this change have discovered that the introduction of lay representatives into professional organizations ensures a more balanced debate on a myriad of issues, improves the level of understanding, engenders mutual respect, and gives warning signals about potential road blocks that may lie ahead.

To complete the triangular relationship of the self-regulatory bargain, I want to mention the influence of the profession itself, especially in the U. K. through its statutory regulatory body, the General Dental Council (of which you have heard I was privileged to be president for five years and which this year celebrated its Golden Jubilee).

While seeking to modernize our procedures to be “fit for purpose,” we also engaged in blue-sky or creative thinking, looking at new ways to deliver oral health care while always adhering to the council's core activities: well-designed, appropriate and approved curricula for training undergraduates; continuing professional development; and revalidation and relicensure for the qualified. Particularly, we tussled with the burgeoning concept of team dentistry,

so ensuring a dental profession of all available talents. We sought to assist that working within the dental field to climb the skills escalator and undertake procedures within their clinical competence.

More recently, as chief dental officer at the Department of Health in England, I led the discussion of the global challenge of insufficient dentists to deliver oral health care, not only to those who demand it, but also to those who need it. Here, let me reassure you, the sensational report last May in *The New York Times* of a gentleman in the north of England extracting one of his own teeth, due to the shortage of dentists, is not a common occurrence.

However, it is a fact that in the U. K. in 2005, 46% of new dentists entering the Dentists' Register qualified abroad. This is just not sustainable. A workforce strategy cannot be formulated on the expectation that there will be a continuation of the oversupply of dentists in some countries. Recently for us there has been an influx from the countries of the European Union, but we must all guard against stripping developing countries of the skilled professionals needed by their own indigenous people. Imaginative and innovative and necessary ideas to solve the workforce crisis can be seen by some as a threat, if not a devaluation of the status of the profession of dentistry.

BASING REGULATION ON ADDRESSING NEED

I want now to share with you a monumental change in regulation placed before the U. K. Parliament in 2006 which came into operation on 31 July. As a result of the regulations, the General Dental Council has opened its doors wide and now registers, in addition to the long-established dental therapists and dental hygienists, other dental health workers. This encompasses dental nurses (chairside assistants), orthodontic therapists, dental technicians,

and clinical dental technicians (previously called denturists), all collectively known as dental care professionals. This signals that for the first time in Europe, and as far as we are aware worldwide, dentists and dental care professionals are registered and regulated by one entity. [Details of this change can be found at www.gde-uk.org.]

As a direct consequence of this radical change, the former "list of permitted duties" or the practice of "limiting procedures that hygienists and therapists only can perform to purely reversible ones" have been consigned to the history books. Substituted are the responsibilities that come with registration and regulation on equal terms. Every member of the dental team involved in the clinical care of patients will be accountable for his or her own actions. Professional standards will be the same for all. It is the dawn of dental equality, where patients can receive quality dental care from a complete range of registered professionals.

The world would be a very dull place if everyone agreed on everything, so I will assume that there will be some who will view these radical innovations with misgivings, if not frank concerns. I would be the first to admit that with these changes we have moved out of the comfort zone for many of my colleagues worldwide. But I also submit that being prepared to have vision, and thus to extend our boundaries, is the essence of leadership. This is something with which I trust the newly inducted Fellows today will exercise in the future as the acknowledged leaders and visionaries, not only in this great College, but also in the dental profession globally. However, I remain steadfast in the belief that integrating team members into the General Dental Council Registration and Regulatory process will ensure the delivery to communities

It is the dawn of dental equality, where patients can receive quality dental care from a complete range of registered professionals.

of much needed oral health care in a quality, controlled manner.

This newfound status through government legislation will also permit those dental care professionals to undertake the business of dentistry, which again begs difficult questions, and to which I accept only the passage of time and experience will provide answers.

CONCLUSION

If George Bernard Shaw were writing today, would he rephrase his sentiments to capture a new reality: "The laity is a conspiracy against the professions?" I sincerely hope not. No one section of society has the right to decide its own or others' future in isolation. As you will have observed, I passionately believe in the necessity of a strong professional self-regulation framework. Such a framework must encompass a healthy partnership of government, the public and the profession as the mature way forward for protection of those patients whom we all seek to serve. ■

2006 ACD AWARDS

ETHICS AND PROFESSIONALISM AWARD

The Ethics and Professionalism Award recognizes exceptional contributions by individuals or organizations for effectively promoting ethics and professionalism in dentistry through leadership, education, training, journalism, or research.



It is an honor and privilege for the American College of Dentists to recognize the

Academy of General Dentistry (AGD) as the recipient of the 2006 Ethics and Professionalism Award. This is the highest such honor afforded by the College.

The Academy of General Dentistry is a 35,000-member professional association representing general dentists. The core purpose of the AGD is to “advance the value and excellence of general dentistry”; it is committed to advocacy on behalf of general dentists, as well as the patients served by general dentists.

The AGD strives to provide the best possible patient care through its dedication to the continuing dental education of its members. In addition, it provides the public with information to help make informed choices about personal dental care and treatments. The AGD adheres to the American Dental

Association’s Principles of Ethics and Code of Professional Conduct and has its own Fellowship honor code.

Taking the lead in an all-important area, the AGD regularly promotes ethics through editorials in its award-winning publications. The AGD is the only dental organization to offer an editorial column on dental ethics in its publication. Its first column appeared in *General Dentistry* in the July-August 1992 issue. Recent ethics topics covered include: “How strict is confidence?”; “How to refer with confidence”; “Emergency situations”; and “Another doctor’s patient,” among others. The AGD’s emphasis on excellence, lifelong learning, and quality dental care—all within a framework of ethical standards and conduct—set an example of professional care that is in keeping with the highest traditions of the profession.

In 2003 an article written by Polly S. Nichols and Gerald S. Winslow in *General Dentistry* received the ACD-AADE Prize for Dental Journalism, which is presented annually to the paper that best promotes excellence, ethics, professionalism, and leadership in dentistry. The winning paper was “In whose interest?”

The AGD also regularly sponsors courses on ethics during its annual meetings, and this reinforces the ethics-based culture it has worked hard to establish. The AGD is currently working with its Council on Annual Meetings and Conferences to continue to add more ethics-related courses to future meetings, as well as creating a special course code for ethics.

The Academy of General Dentistry has a longstanding, effective, and consistent record of improving the ethical climate of dentistry. Its impact is significant. Mr. President, it is a sincere honor and pleasure to present the 2006 Ethics and Professionalism Award to the Academy of General Dentistry. Dr. Bruce R. DeGinder, President of the AGD, will accept the award.

This award is made possible through the generosity of The Jerome B. Miller Family Foundation, to which we are extremely grateful.

WILLIAM JOHN GIES AWARD

The highest honor the College can bestow upon a Fellow is the William John Gies Award. This award recognizes Fellows who have made broad, exceptional, and distinguished contributions to the profession and society while upholding a level of leadership and professionalism that exemplifies Fellowship. The impact and magnitude of such contributions must be extraordinary.



The recipient of the 2006 William John Gies Award is Dr. Harold C. Slavkin. Dr. Slavkin has had a long and distinguished career in dentistry, one in which he has actively contributed to the advancement of scientific research, dental education, dental professional issues, humanitarian causes, and has provided superior leadership and service to a variety of

activities. His work in academic research has included 28 research grants between 1968 and 1995 in which he was the principal or co-principal investigator. He has nearly 300 scientific papers published in peer-reviewed journals as well as 106 chapters in books. He has edited nine textbooks and authored one published text, with a second currently in preparation.

Administratively, Dr. Slavkin has served many important roles covering both academics and research. For example, he created and launched the first graduate program in craniofacial biology in the United States, for which he served as chair and director for ten years. He went on to found the Center for Craniofacial Molecular Biology at the University of Southern California, a unit dedicated to improving the diagnosis, treatment, therapeutics, and prevention of human craniofacial malformations.

In 1995 Dr. Slavkin assumed two significant national leadership roles. First, he served as Chief, Craniofacial Development Section, National Institutes of Arthritis and Musculoskeletal and Skin Diseases. More importantly, he also assumed the prestigious responsibility as Director of the National Institute of Dental and Craniofacial Research (NIDCR). In this highly visible role, he led efforts that included the first-ever Surgeon General's Report, "Oral Health in America," and such initiatives as "Healthy People 2000" and "Healthy People 2010." He has been an eloquent spokesman for improving the oral health of all Americans while seeking solutions to the disparities in access to oral health care.

In 2000 Dr. Slavkin returned to academics to serve as Dean of the University of Southern California, School of Dentistry, an institution that features an extremely large and diverse academic

program covering degrees in multiple disciplines. Under his leadership, the school converted its predoctoral dental education program to problem-based learning, a learner-directed methodology. As part of a major private research university, he also oversees an impressive research profile.

Dr. Slavkin has continued his humanitarian efforts to improve oral health care and access to it in California's underserved communities. The dental school's outstanding mobile clinic and many community-based programs reflect his interest and guiding influence. He also serves on the Board of the California Dental Association Foundation, which, as part of its mission, contributes improving dental public health in underserved areas.

Dr. Slavkin's broad, exceptional, and distinguished contributions have had a significant, positive impact on dentistry, dental practice, research, education, his community, and his country. He has been an extremely valued resource to dentistry and the country. He is held in highest regard, not only by his colleagues, but also by his friends and business associates.

DISTINGUISHED LEADERSHIP AWARD

Since its founding in 1920, the American College of Dentists has exemplified leadership. The College was founded by the dental leaders of the time, and dentists have always been selected for Fellowship based primarily on leadership in some aspect of dentistry or the community. The Distinguished Leadership Award recognizes individuals having an established record of significant and distinguished leadership in dentistry, public health, or national health policy while in a position of national or international responsibility. This is the most prestigious honor awarded by the College specifically for leadership.



The recipient of the Distinguished Leadership Award is Dr. James B. Bramson. Dr. Bramson is the ninth Executive

Director of the American Dental Association. He assumed the helm of the more-than-140,000 member organization in July 2001 after serving four years as Executive Director of the Massachusetts Dental Society. His current responsibilities include strategic and fiscal policy planning for the ADA, oversight and implementation of legislative advocacy, lobbying activity, membership recruitment and retention, Board of Trustees meetings, continuing education programming, public awareness promotion, and convention planning. He oversees an annual budget of over \$100 million and employment of approximately 430 people at facilities in Chicago, Washington, D.C., and Gaithersburg, Maryland. Dr. Bramson is committed to marshalling the resources of organized dentistry to add value to membership in the ADA.

Dr. Bramson's previous responsibilities with the ADA include eleven years as a member of the senior staff. He originally came to the association as a Hillenbrand Fellow and was subsequently appointed Director of the Council on Dental Practice from 1990 to 1997. At the same time, he served as an officer of the Commission on Relief Fund Activities, the ADA Endowment and Assistance Fund, Inc., and the ADA Emergency Fund, Inc.

A graduate of the College of Dentistry, University of Iowa, Dr. Bramson began as a private practitioner in Iowa. His professional career has included that experience; clinical teaching; implementing and administering key state and national programs and activities; and extensive writing, publishing, and

lecturing on topics such as the evolving dental marketplace, risk management, record keeping, dental office ergonomics, infection control, and liability and clinical issues. He is the principal or co-author of eight different books on various aspects of dental office management, operations, design, and economics. In addition, he has authored over twenty articles on similar topics published in national journals.

Dr. Bramson's record epitomizes significant and outstanding leadership while in a position of great responsibility. He is highly respected throughout the greater dental community, and he is most fitting to be the first recipient of the highest leadership honor the College can bestow.

HONORARY FELLOWSHIP

Honorary Fellowship is a means to bestow Fellowship on deserving non-dentists. This status is awarded to individuals who would otherwise be candidates for Fellowship by virtue of demonstrated leadership and achievements in dentistry or the community except that they are not dentists.

Honorary Fellows have all the rights and privileges of Fellowship except they cannot vote or hold elected office. This year there are three recipients of Honorary Fellowship.



The first recipient for Honorary Fellowship is Mr. Randall B. Grove. Mr. Grove was born, raised, and educated in Indiana.

In 1972 he received a Bachelor of Science degree in Physical Education and in 1974 a Master of Science degree in Health Education. Following graduation he spent three years with the Indiana Department of Public Instruction as an education consultant.

He joined the staff of the American Dental Association in 1977 as Director of the Bureau of Health Education where he supervised and coordinated all health education and audiovisual activities of the Association. From 1986 to 1989 he was Executive Director of the United Cancer Council. He then joined the Chicago Dental Society in late 1989 as its Executive Director.

Among his duties, Mr. Grove is responsible for the administration and coordination of the Midwinter Meeting and the society's official publication, CDS Review. The Midwinter Meeting is one of the premiere dental meetings in the world, in large part due to Mr. Grove's dedicated leadership and guidance. He has developed and expanded the number of dental exhibitors at the meeting, which has made the Midwinter Meeting a world-class trade show. At the same time, he has made the society responsive to the needs of the membership. At his suggestion, the society has allocated significant resources to access programs throughout Illinois. His careful management has further resulted in no dues increases over the last twelve years.

Mr. Grove has been active in many professional organizations throughout his career. He is a member of the American Society of Association Executives and the Professional Convention Management Association. In 1996 he served on the Executive Directors Advisory Committee while also serving as President of the Association of Component Society Executives of the ADA. Mr. Grove has been awarded an Honorary Fellowship in the Odontographic Society of Chicago, an Honorary Membership in the Chicago Dental Society, and an Honorary Fellowship in the International College of Dentists, U.S.A. Section. Mr. Grove has also been consistently active in his community.

Mr. Grove has demonstrated an unwavering passion for dentistry. His

leadership and record of accomplishments are exceptional. The Chicago Dental Society, its members, and the profession of dentistry have clearly benefited from having Mr. Grove as its Executive Director.



The second recipient of Honorary Fellowship is Mr. George R. Rhodes. Mr. Rhodes is Vice President for Professional

Relations and Corporate Communications for Dentsply International, the largest manufacturer of professional dental products in the world. He joined the company in 1973, and in the ensuing years his responsibilities have continued to increase. He is today responsible for the management and direction of the company's varied professional relations activities both in the United States and internationally, as well as all functions of the company's corporate communications.

Mr. Rhodes earned his undergraduate degree in English from York College of Pennsylvania and an MS degree in public relations from The American University. He is an Honorary Member of the American Dental Association and the International Association of Student Clinicians. He has also been awarded the "Roll of Distinction" of the British Dental Association. A former Chairman and current Director of Oral Health America, Mr. Rhodes is a member of the Board of Visitors of the Boston University Goldman School of Dental Medicine and the Dean's Advisory Board at the School of Dental Medicine at Southern Illinois University. Mr. Rhodes has served on the Board of Visitors for the Dr. Samuel D. Harris National Museum of Dentistry and as Chair of the Dental Trade Alliance.

Mr. Rhodes has provided exceptional service and contributions to the dental

profession for over thirty years. In 1959, Dentsply International graciously began sponsoring dental students from each dental school to the ADA Table Clinic Competition. Since the early 1970s, Mr. Rhodes has served as Secretary-Treasurer of the Student Clinicians of the American Dental Association which coordinates that program. His work has served to inspire and motivate dental students in research and educational innovation in the United States and many other countries. The student table clinic competition at each year's ADA Annual Session brings the outstanding efforts of our dental students to the attention of our profession and the public as they pursue their education and scholarly activity.

Throughout his career Mr. Rhodes has served the dental community with the utmost professionalism and ethics. He represents the consummate professional, serving the dental industry with integrity, caring, and compassion. His love for the profession of dentistry is unrivaled.



The third recipient of Honorary Fellowship is Ms. Pamela Zarkowski, Esq. Ms. Zarkowski currently serves as Executive

Associate Dean at the University of Detroit Mercy School of Dentistry and has held senior leadership positions in that institution since 1988. With degrees in dental public health, law, and dental hygiene, she has made outstanding contributions to the fields of professional ethics in dentistry, leadership in dental education, and international dental education development.

Ms. Zarkowski is currently President of the American Society for Dental Ethics, formerly PEDNET. Ms. Zarkowski was instrumental in taking the lead in strategic planning for ASDE, and it is she who led the organization in implemen-

tation of the strategic plan. She has been one of the major contributors, if not the major contributor, to dental hygiene ethics, and she is a significant contributor to dental ethics in general.

She is also Vice President of the Society for Executive Leadership in Academic Medicine. In recognition of her contributions to dental education, her dental educator peers elected her to serve as President of the American Dental Education Association (ADEA) in 2001-2002. She has recently served as the Chair of the William J. Gies Foundation of ADEA. She has served important roles at international meetings in the fields of international dental ethics and law, women's leadership, and international dental education symposia.

In addition to her administrative responsibilities and commitments to professional organizations, she teaches dental and dental hygiene students in areas of legal and ethical professional development and community dentistry. She is acknowledged as a highly effective teacher by students and colleagues alike. She has been aptly described as prepared, knowledgeable, reliable, open, objective, willing, dedicated, and more. She has earned a reputation for extending herself to assist students, as well as mentoring junior faculty members. She has published numerous articles in refereed journals and has given invited presentations around the world.

Ms. Zarkowski is the recipient of numerous honors and awards. She was selected as a Fellow of both the Pew Dental Leadership Program and the John O. Butler Faculty Legislative Program. In addition, in 1996 she became one of the first two female educators to be selected as a Fellow for Executive Leadership in Academic Medicine Program.

Ms. Zarkowski has an exemplary record of achievement in dental education and research, highlighting a passion for ethics and professionalism. She is a tremendous asset to dentistry.

SECTION ACHIEVEMENT AWARD

The Section Achievement Award recognizes ACD Sections for effective projects and activities in areas such as professional education, public education, or community service.

The **Indiana Section** is the recipient of the 2006 Section Achievement Award. The Indiana Section is honored for its Ethics Award Program. This annual award recognizes an Indiana Dental Association dentist who: a) is a role model for others in his or her component society; b) exemplifies ethical behavior and brings credit to the profession; c) has given wise counsel to his or her society; and d) has the deepest respect and admiration of his or her peers and the public. This program was started in 1999. The awardee is selected by an Award Committee composed of one faculty member, one Trustee of the Indiana Dental Association, a member of the State Board of Dental Examiners, an ACD officer, and the Immediate Past Chair of the Indiana Section.

SECTION NEWSLETTER AWARD

The Section Newsletter Award is presented to an ACD Section in recognition of outstanding achievement in the publication of a Section newsletter. The award is based on overall quality, design, content, and technical excellence of the newsletter. This year's recipient is the **Mississippi Section**.

2006 Fellowship CLASS

The Fellows of the American College of Dentists represent the creative force of today and the promise of tomorrow. They are leaders in both their profession and their communities. Welcome the 2006 Class of Fellows.

Aslim Abdullah
Laurel, MD

John P. Ahlschwede
Central City, NE

Franklin H. Alley
Portage, MI

Mohammad Altamash
Karachi, Pakistan

Victor C. Apel
Melbourne, FL

Eustaquio A. Araujo
Belo Horizonte, Brazil

James L. Armstrong
Vancouver, BC

Harold R. Arthur
Maitland, FL

J. Lee Ayers, Jr.
Columbia, SC

Ann T. Azama
San Francisco, CA

Victor M. Badner
Bronx, NY

Gene Baker
Nashville, TN

Elmer E. Bangloy
Los Angeles, CA

Frank C. Barnashuk
Lackawanna, NY

Richard G. Beatty
Tulsa, OK

Mark G. Beck
St. Louis, MO

Samiran Bera
Georgetown, Guyana

Dennis P. Bohlin
New York, NY

Kim A. Boling
London, KY

Cynthia A. Bolton
Reidsville, NC

Christopher E. Bonacci
Vienna, VA

Leon D. Bragg
Oklahoma City, OK

John F. Brent
Harleysville, PA

Dwyte E. Brooks
Las Vegas, NV

James H. Bryniarski
Chicago, IL

John A. Buehler
Wellesley Hills, MA

Rex B. Card
Raleigh, NC

Norman S. Carter
Chino, CA

Ronald T. Carter
Baltimore, MD

Jerry F. Cash
Springfield, MO

Frank L. Ceja
National City, CA

Eugene K. Chan
Central, Hong Kong

Wa Sham Cheung
Coquitlam, BC

Ann E. Christopher
Baltimore, MD

Todd R. Christy
Berrien Springs, MI

Steven Chussid
New York, NY

Jack W. Clinton
Portland, OR

Madelyn Coar
Birmingham, AL

C. Celeste Coggin
Atlanta, GA

Lee R. Cohen
Jupiter, FL

Lindsey W. Cooper
Nashville, TN

Stephen D. Crocker
Livonia, MI

Harold L. Crossley
Cambridge, MD

Dunn H. Cumby
Oklahoma City, OK

David M. Cummins <i>Bellingham, WA</i>	Sidney B. Eisig <i>New York, NY</i>	Randy G. Fussell <i>Greenville, NC</i>	William A. Hadlock <i>Baton Rouge, LA</i>
Kay D. Curtis <i>Safford, AZ</i>	Larry F. Elliott <i>Fort Lauderdale, FL</i>	Stephen Gandy <i>Jackson, MS</i>	John R. Halikias <i>Brooklyn, NY</i>
Thomas J. David <i>Atlanta, GA</i>	Roy L. Eskow <i>Bethesda, MD</i>	Frank B. Gardner, III <i>Kansas City, MO</i>	Joseph G. Handelman <i>Annapolis, MD</i>
David W. Davidson <i>Urbandale, IA</i>	John L. Farringer III <i>Nashville, TN</i>	Steven E. Gardner <i>Harrisonburg, VA</i>	James B. Hanley <i>Boston, MA</i>
John S. Davis <i>Cumberland, MD</i>	Paul S. Farsai <i>Lynn, MA</i>	James D. Geren <i>Alexandria, VA</i>	John M. Henricksen <i>Chehalis, WA</i>
Allen C. Davis <i>Baltimore, MD</i>	James K. Feldman <i>Washington, DC</i>	Eugene T. Giannini <i>Washington, DC</i>	Gary R. Herberger <i>Bartonville, IL</i>
Reed H. Day <i>Phoenix, AZ</i>	Alvin L. Felts, Jr. <i>Pascagoula, MS</i>	Dat P. Giap <i>Seattle, WA</i>	Kenneth L. Hershenfield <i>Toronto, ON</i>
Pierre C. Desautels <i>Montreal, QU</i>	Larry L. Folden <i>Jacksonville, TX</i>	Kathy T. Gibson <i>Houston, TX</i>	George W. Hodgson, <i>Friday Harbor, WA</i>
Walter D. Diaz <i>Maben, MS</i>	Joe E. Forgey <i>Noblesville, IN</i>	Tony Gill <i>Vancouver, BC</i>	Susan M. Hollinsworth <i>Kent, WA</i>
Giorgio T. DiVincenzo <i>Jersey City, NJ</i>	David B. Fox <i>Louisville, KY</i>	Edward L. Ginsberg <i>Catonsville, MD</i>	Dennis L. Hoofnagle <i>Bellingham, WA</i>
Lawrence A. Dobrin <i>Roselle Park, NJ</i>	Steven W. Friedrichsen <i>Omaha, NE</i>	Michael B. Goldberg <i>Toronto, ON</i>	Scott W. Houfek <i>Big Piney, WY</i>
Jeffrey E. Dodge <i>Woonsocket, RI</i>	David H. Frome <i>Gaithersburg, MD</i>	Sharon M. Gordon <i>Baltimore, MD</i>	Ralph L. Howell, Sr. <i>Suffolk, VA</i>
Kevin Doyle <i>Parksville, BC</i>	Clayton S. Fuller <i>Chula Vista, CA</i>	Anton S. Gotlieb <i>Fort Lauderdale, FL</i>	David W. Howerton <i>Salem, OR</i>
Donald A. Drake II <i>Sioux Falls, SD</i>	Jean G. Furuyama <i>New York, NY</i>	Henry Greenwell <i>Taylorsville, KY</i>	J. Andrew Hunter <i>El Cajon, CA</i>
Pierre Duquette <i>Montreal, QU</i>		Ann L. Greenwell <i>Taylorville, KY</i>	Patricia A. Hunter <i>Richmond, BC</i>
Michael D. Eggnatz <i>Weston, FL</i>		David L. Guichet <i>Orange, CA</i>	

Jeffery M. Hurst <i>Lakewood, CO</i>	Jim Y. Lai <i>Toronto, ON</i>	James W. Mc Daniel <i>Chattanooga, TN</i>	Toni T. Neumeier <i>Birmingham, AL</i>
Janice G. Jackson <i>Birmingham, AL</i>	Sheng-Yang Lee <i>Taipei, Taiwan</i>	Charles T. McCabe <i>Gretna, LA</i>	James S. Nicholson <i>Muskogee, OK</i>
Carey A. Johnston <i>Jackson, MS</i>	Ian J. Leitch <i>Kelowna, BC</i>	Christopher A. McConnell <i>Highlands Ranch, CO</i>	W. Craig Noblett <i>Berkeley, CA</i>
Kenneth D. Jones, Jr. <i>Mansfield, OH</i>	Lionel Lenkinski <i>Toronto, ON</i>	Stephen R. McDonnell <i>St. Paul, MN</i>	Angela P. Noguera <i>Washington, DC</i>
Renee W. Joskow <i>Alexandria, VA</i>	Thomas W. Leslie <i>Berkeley Springs, WV</i>	Eugene F. McGill <i>Prairie Village, KS</i>	Paul O'Reilly <i>Dublin, Ireland</i>
Stanwood H. Kanna <i>Hanapepe, HI</i>	Lawrence M. Levin <i>Hamilton, ON</i>	Geraldine A. McManus <i>Brooklyn, NY</i>	Thomas L. Opsahl <i>Rutland, VT</i>
Raed S. Kasem <i>Clearwater, FL</i>	Nolen L. Levine <i>Chicago, IL</i>	Dwight W. Meierhenry <i>Las Vegas, NV</i>	Daniel L. Orr II <i>Las Vegas, NV</i>
Thomas L. Kassube <i>Sioux Falls, SD</i>	Carla R. Lidner-Baum <i>Colton, CA</i>	Elaine M. Miginsky <i>Baltimore, MD</i>	James F. Otten <i>Lawrence, KS</i>
Terry Kline <i>Vancouver, BC</i>	James M. Lipton <i>Highland, IN</i>	Peter Milgrom <i>Seattle, WA</i>	Maitreya Padukone <i>New York, NY</i>
John A. Kokai <i>Baden, PA</i>	William M Litaker, Jr. <i>Hickory, NC</i>	Jade A. Miller <i>Reno, NV</i>	David E. Paquette <i>Charlotte, NC</i>
Barry H. Korzen <i>Toronto, ON</i>	E. Wayne Looney <i>El Dorado, AR</i>	Donna G. Miller <i>Waco, TX</i>	Susan M. Pearson <i>Silver Spring, MD</i>
James G. Kotapish, Jr. <i>Akron, OH</i>	Jeff A. Lunday <i>Weatherford, OK</i>	David M. Minahan <i>Kenmore, WA</i>	Gerald E. Pearson <i>Toronto, ON</i>
Thomas J. Kraklow <i>Waukesha, WI</i>	Thomas W. Mabry <i>Slidell, LA</i>	Richard D. Mogle <i>Bryan, TX</i>	Anthony R. Petito <i>Warwick, RI</i>
Jeffrey A. Kramer <i>Chicago, IL</i>	Robert B. Macilveen <i>Portland, OR</i>	James Morreale <i>Hamilton, ON</i>	Gregory J. Pisani <i>Reno, NV</i>
Linda S. Krill <i>Loveland, OH</i>	David E. MacLeod <i>Kentville, NS</i>	Joseph D. Moss <i>Florence, SC</i>	Mary Ann Pittman <i>St. Petersburg, FL</i>
James E. Krochmal <i>Norfolk, VA</i>	F. Amanda Maplethorp <i>Maple Ridge, BC</i>	William D. Nally <i>Nashville, TN</i>	Frank R. Portell <i>Springfield, VA</i>
John F. Kruse <i>New York, NY</i>	Thomas A. Martin <i>Kelowna, BC</i>	Richard W. Nash <i>Burlington, WA</i>	Michael N. Poulos <i>Denver, CO</i>
	Christian E. Mathiesen <i>Saratoga Springs, NY</i>		Randall P. Prince <i>Dyersburg, TN</i>
	Daniel T. Mayeda <i>Kahului, HI</i>		Shahid S. Qazi <i>Rawalpindi, Pakistan</i>
	Stephen P. Mayer <i>Vinita, OK</i>		

Michael J. Racich <i>Vancouver, BC</i>	John A. Sherman <i>Lethbridge, AB</i>	Daniel S. Tanita <i>San Pablo, CA</i>	Brian L. West <i>Durango, CO</i>
Irvin M. Rainey, Jr. <i>Jackson, TN</i>	Cynthia E. Sherwood <i>Independence, KS</i>	James H. Tanner <i>Greensboro, NC</i>	Acie Whitlock <i>Jackson, MS</i>
Nelson L. Rhodus <i>Minneapolis, MN</i>	Barry Shipman <i>Miami, FL</i>	James A.H. Tauberg <i>Pittsburgh, PA</i>	Richard A. Wiberg <i>Roseville, MN</i>
Ronald R. Riley <i>Kansas City, MO</i>	Ronald J. Shupe <i>Kelowna, BC</i>	Barry J. Taylor <i>Beaverton, OR</i>	Michele T. Williams <i>Vancouver, BC</i>
Eric T. Rippert <i>Vero Beach, FL</i>	Edward Slapcoff <i>Westmount, QU</i>	David L. Tobias <i>Vancouver, BC</i>	G. Trent Wilson <i>Memphis, TN</i>
Robert W. Rives <i>Jackson, MS</i>	Rebecca L. Slayton <i>Seattle, WA</i>	William J. Tognotti <i>San Francisco, CA</i>	Larry F. Wolff <i>Minneapolis, MN</i>
Robert W. Robinson II <i>Wasilla, AK</i>	Craig E. Slotke <i>Baltimore, MD</i>	Noel K. Toler III <i>Jackson, MS</i>	C. Rieger Wood III <i>Tulsa, OK</i>
Donald P. Rollofson <i>Elk Grove, CA</i>	James F. Smith <i>Omaha, NE</i>	Stephen J. Tsoucaris <i>Fort Lee, NJ</i>	Karl F. Woodmansey <i>Bozeman, MT</i>
Stuart A. Root <i>Peace River, AB</i>	John B. Smith, Jr. <i>Forest, MS</i>	Roger M. Turkel <i>North Kingstown, RI</i>	William G. Woods <i>Mesa, AZ</i>
John J. Ross <i>Virginia Beach, VA</i>	Charles L. Smith <i>Charleston, WV</i>	Ashok Varma <i>Powell River, BC</i>	Marilyn P. Woolfolk <i>Ann Arbor, MI</i>
Avishai Sadan <i>Cleveland, OH</i>	Martha J. Somerman <i>Seattle, WA</i>	Kevin C. Walde <i>Washington, MO</i>	Christopher C. Wyatt <i>Vancouver, BC</i>
Carlos F. Salinas <i>Charleston, SC</i>	David S. Spann <i>Ainsworth, NE</i>	Mary P. Walker <i>Kansas City, MO</i>	William T. Yadon <i>Woodward, OK</i>
Timothy R. Saunders <i>Los Angeles, CA</i>	Steven W. Spivack <i>El Paso, TX</i>	Buron M. Waxman <i>Ellicott City, MD</i>	Jill A. York <i>Newark, NJ</i>
Rhonda R. Savage <i>Gig Harbor, WA</i>	Michael D. Spreng <i>Ashland, OH</i>	Richard A. Weinman <i>Atlanta, GA</i>	Daniel J. Zeiter <i>Hamilton, ON</i>
Mel Sawyer <i>Vancouver, BC</i>	Ann L. Steiner <i>Loma Linda, CA</i>	P. Deborah Weisfuse <i>New York, NY</i>	Gregory G. Zeller <i>Lutherville, MD</i>
Dan J. Schapira <i>Columbia, MO</i>	Michael G. Stevens <i>Billings, MT</i>	Marvin Weiss <i>Plainfield, NJ</i>	Karl J. Zeren <i>Timonium, MD</i>
Jeffrey S. Schmidt <i>St. Joseph, MI</i>	Robert C. Stewart <i>Jackson, MS</i>		Paul N. Zimmet <i>Alexandria, VA</i>
Daniel L. Schmidt <i>Auburn, IN</i>	Kimberly S. Swanson <i>Richmond, VA</i>		Thomas A. Zurfluh <i>Miami, FL</i>
K.D. Schmidt <i>Indianapolis, IN</i>			
Jeffrey J. Sevor <i>Winter Park, FL</i>			

MAKING DENTISTRY EFFECTIVE AT THE STATE LEVEL: SOUTH CAROLINA

Philip E. Smith, DMD, FACD

ABSTRACT

State dental associations must be responsive to the unique needs of the public and dentists in each state. The South Carolina Dental Association has a tradition of proactively partnering with the legislature and others to promote the long-range oral health of the state. Issues of access, licensure, and fair reimbursement are important concerns. SCDA has taken the lead in these areas, as well as in understanding the needs of new dentists, providing services for dentists as part of a non-dues financial structure, and advocating for the interests of individual practitioners.

Some issues in dentistry are best addressed at the level of the local community; others are national in scope. But there is a role for state associations in addressing matters of member services, legislative issues, and access concerns, most of which have a statewide scope.

South Carolina is a small state. We have a broad topography that goes from the foothills of the Blue Ridge Mountains down to the low country and shore of our beautiful coast. Rich in history, with a rural, agricultural flavor, South Carolina is sprinkled with numerous small communities. Our larger cities have many of the benefits expected in any urban environment, and yet most of our state's population resides in communities with fewer than 25,000 people. Many South Carolinians have limited resources and access to usual healthcare options. Rural communities often lack dentists or specialists to serve their needs. The size and diversity of the population offer recognized challenges for care, and the South Carolina Dental Association is seeking creative avenues to serve this group.

PROACTIVE STRUCTURE AND STRATEGY

The SCDA has acknowledged that to provide care to a population, offer support to its membership, and direct healthcare policy to the state, it must be proactive and insightful. The leadership of our association has chosen to be perceptive in taking a long view and tapping into trends that resonate for decades. This is a quality that serves

South Carolina dentistry well. SCDA has a traditional tripartite system for its general organization, and it uses a mix of committees and task forces to address specific issues. A Board of Governors manages the actions of the association, but we consider ourselves to be a "member driven" entity. The board is comprised of four officers "rotating through the chairs," two leaders from each of the four districts, the Editor, the Speaker of the House of Delegates, the ADA Delegation representative, the Past President, and an ASDA (student) member. Our association office is managed by an executive director, and the staff is composed of five associates.

Access to care is a phrase that encourages and haunts many dental organizations. It is debated whether populations are underserved due to location or availability of dentists. Distribution of healthcare seems to be critical. Approximately eight years ago, the SCDA challenged the state legislature to revise its Medicaid funding. Dentistry believed that many children needed oral care, and that resolution of the disparity in treatment hinged on a more realistic fee structure. In exchange for improved payment schedules, the South Carolina



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dentists promised to enroll providers and offer service to the Medicaid population. This dynamic did occur, and fees were raised to the 75th percentile. More patients than ever were served, because the dental community arranged a system that worked. However, increased Medicaid fees brought increased traffic in out-of-state van-based dentistry, assorted corporate Medicaid clinics, and non-traditional public school centered programs. Whether these prove to be a blessing is still to be seen.

LEGISLATIVE PARTNERSHIPS

The success of this thrust for more access to care depended upon an intimate relationship with the SC State Legislature. Few dentists can practice without the advocacy of a strong dental association, and the SCDA has valued the political leadership that our PAC groups have brought to bear. It was almost thirty years ago when SCDA leaders organized a grass-roots legislative arm for political lobbying. SCDA continues to use this program successfully to convey information from individual dentists to legislators regarding future dental friendly issues. We have a skilled lobbyist firm that appraises statehouse activity and keeps the association well advised on pending dental legislation.

One currently unresolved legislative issue that is the promotion of independent hygiene practice. The SCDA's position on independent hygiene practice is that the association believes the dental team approach is the proper format with the dentist as the head.

This position reflects the wishes of its membership and establishes a continuity that connects all aspects of care. It provides for appropriate referrals and helps ensure comprehensive dental care.

Five years ago, through the facilitation of South Carolina's Public Dental Health Officer, certain schools that had student populations with high Medicaid enrollment were allowed to host hygiene programs that provided screenings, prophylaxis, fluoride treatments, and sealants to eligible children. This could be done under a Memorandum of Agreement with the South Carolina Department of Health and Environmental Control. Both hygiene groups and dental staffs have availed themselves to this opportunity, with the hygienists working under general supervision of the State Dental Health Officer.

The South Carolina Dental Association provided further access to care by gaining an amendment to the Dental Practice Act that allowed general supervision of hygienists in private dental offices under specific guidelines.

STUDYING THE NEW DENTIST

One of the best proactive initiatives in which the South Carolina Dental Association has been involved is the appraisal and evaluation of membership attrition, and demographics. This investigation began as a study in membership dues and projected increases for developing a budget. It soon became apparent that the state dental association would

The leadership of our association has chosen to be perceptive in taking a long view and tapping into trends that resonate for decades.

have a financial shortfall in the near future. We invited a dentist from the Houston Dental Society to share the Society's experience in the same informational inquiry. Houston had recently developed a protocol to better appraise the association's future needs. Our guest explained how the study had opened many avenues for securing the financial and membership stability for the Houston Dental Society.

It was decided that the SCDA would also fund a similar research project, and enrolled a demographic specialist from the University of South Carolina to gather and interpret our data. The census of the dental community took over three months, and the follow-up results were reported to the South Carolina Dental Association Board four months later. During the interview process, dentists from many subgroups were invited to contribute opinions about the strengths and weaknesses of their association. Structured seminars were held with

The SCDA's position on independent hygiene practice is that the association believes the dental team approach is the proper format with the dentist as the head.

The needs of the newer dentists will determine what attracts them to organized dentistry and what dental associations may offer to support their wishes.

dental focus groups like the Women's Dental Study Group, assorted clubs, and dental organizations. Besides insiders, the researchers reached out to nondental parties that interacted with dentistry.

The resultant vision presented was one of enthusiasm—and a rather large dose of pending crisis. The data showed the SCDA leadership the severity of projected membership losses due to retirement, a practice in transition, and death. It was extrapolated to take into account enrollment of new dentists to replace those leaving practice. Association revenue from dues was still in a projected deficit because of the effect of the ADA's step-rated new member fees. In the end, evaluation of our dues structure and fee increases could be presented to the membership in a way that seemed less like an arbitrary dues increase and more like a substantive income adjustment. It is the opinion of the SCDA that this was a great benefit for this effort to be undertaken. The current membership enrollment percentage for South Carolina dentists is 87.5%, one of the highest participation rates in the country.

However, other pluses from the study have allowed the Board of Governors direction in recognition of unique needs for the changing membership. Many associations have recognized that the makeup of the dental population is

becoming more female, more ethnic, and less driven by solo practice development. The needs of the newer dentists will determine what attracts them to organized dentistry and what dental associations may offer to support their wishes. The current generation of dental practitioners may possess a “long view” of the direction of dentistry, but their new counterparts have not been given the advantage of experience that is crafted by years of insight into making global decisions for the profession. This is where a mentoring process can be integrated into welcoming young dentists into the profession.

NON-DUES REVENUE

More emphasis is being placed on generated revenue and non-dues income to run the South Carolina Dental Association. Our research indicates that dentists are being resistant to enroll large contributions for elective programs. Oddly enough, these electives are far more necessary than many dentists perceive. When the SCDA advocates for the dentist in legislative or regulatory matters, much of the underpinning comes from elective donations collected during annual dues renewal. With a reduction in projected finances, the conversation of full utilization of our for-profit corporation becomes important. SCDA Member Benefits Group, the South Carolina Dental Association's business entity, generates resources and provides services that benefit our dental population.

SCDA Member Benefits Group was established in 1997. Initially, its purpose was to assist in the marketing of direct reimbursement dental programs. As the business matured, SCDA Member Benefits Group began handling all member medical insurance service in-house. The group hired and licensed employees to sell insurance products. As the utilization increased, more financial products were offered. This was a true benefit for all parties. Our for-profit corporation was able to shop insurance competitively, and offer reduced rates and options to the member dentists. Profits that were generated were then returned to SCDA as a means to offset revenue, thus keeping member dues to a minimum. In recent years, a full menu of services has been offered to SCDA dentists and their employees. This has become one of the best alliances that the leadership of South Carolina Dental Association has undertaken. SCDA Member Benefits Group also supports efforts in registration for credentials by providing CE courses for HIPPA regulations, radiological accreditation, information for nitrous oxide certificates, and other noteworthy courses.

ADVOCATING FOR PRACTITIONERS

Finally, in any list of actions and services provided to the membership of the SCDA, the role of intervention and advocacy earns high marks. The individual dentist is unable to stand successfully against the

intrusion of unnecessary regulations, rules, taxes, and insurance challenges.

Recently, a letter came across the desk of one of our officers. A major insurance carrier had contacted thousands of patients and indicated that an “overcharge from your dentist had occurred” and that procedures were underway to correct this matter. Patients who received the letter were advised that “no action on their part would be needed.” Dentists were also notified that they would need to refund certain payments, and if no payment was made then deductions would be processed from future insurance checks. The SCDA determined that in fact, the error occurred when the insurance carrier failed to filter premium coverage enrollees from the benefits list. Payments were made that reflected minimal deductions, and maximum coverage. In the end, the patient would need to make restitution with the provider dentist because of the billing error. This correction could reflect payment for services rendered up to a year previous! Although resolution has not occurred, the SCDA stepped in to state a position that more fairly represented the situation, and expressed dissatisfaction that a matter of this scope was not brought to the association’s attention.

The South Carolina Dental Association has a long history of community participation. South Carolina has one of the country’s premier National Children’s Dental Health Month programs. Under the guidance of astute leaders, SCDA has won the Samuel D. Harris

Dental Award eight times. Our Give Kids A Smile effort saw over 1,000 children in 2006, and generated over \$250,000 in donated dental care. The dentists of this state have embraced and encouraged the expansion of our state College of Dental Medicine located at the Medical University of South Carolina in Charleston. The James B. Edwards Clinical Facility has broken ground and has commitments in excess of \$13 million. Dentistry appreciates the need and support of such an expansion to serve the population of South Carolina.

A small state like South Carolina is connected by relationships. There are a few more than 1,800 active dentists in the state, and they know each other well. New members will soon become old friends, and our friendships lead to shared views and outcomes. Like any family we do not always agree but nonetheless, we are a family of unique practitioners. Our strength is our willingness to serve, our touchstone is our association. ■

GROWING PAINS IN PARADISE: ARIZONA'S BOOM

Rick Murray

ABSTRACT

Arizona's explosive population growth has presented challenges for organized dentistry in the state. Among these are the opening of two new dental schools, the desire of many dentists to relocate to the urban areas of the state, and state regulations that require vigorous investigations of suspected irregular practices. The state association's executive director is banking on dentist's traditional active, positive leadership to manage these challenges.

In 2002, my family and I left our hometown of Albuquerque and headed west to Phoenix. We were excited about starting our brand new life, with me in my brand new role as Arizona Dental Association's new exec, and we settled cozily in Scottsdale. Each morning, I would hop into my car just as the sun was peeking over the McDowell Mountains which tower over the landscape. I'd flip on the local cool jazz station, enjoy a leisurely drive into Phoenix and arrive for work calm and smiling. "Ah," I'd think to myself, "another beautiful day in the Valley of the Sun. Gosh, I sure feel sorry for all those poor souls in New York City, LA, DC, and all the other traffic-choked cities. They're stuck in bumper-to-bumper traffic, road raging, shooting each other. Gee, I have it so good. I'm one lucky guy."

That was then. Today, it's hard to tell the difference between Phoenix and any other big city. Here, what were once dirt roads and two-lane streets are now glistening freeways, with freeways literally built upon freeways (one is known as "the stack" and another is nicknamed "the ministack"). My lovely smooth ride to work has been replaced by a mad dash out the door an hour or more before I have to be at work, or that breakfast meeting, or the state capitol... or anywhere I need to be. Yes, I have joined the ranks of the commuter. My once serene daily ritual now encompasses stop-and-go traffic, honking horns and an occasional bird being flipped (never by me, of course). After one particularly

long, brutal ride home after one particularly long, brutal week, I walked in the door and said to my wife, "Toto [not my wife's real name], I don't think we're in Kansas any more."

WHAT HAPPENED TO ARIZONA?

Where did this extraordinary increase in traffic, this astonishing change in our laid-back cowboy town, come from in just five years? The answer is simple—explosive growth. Phoenix led the nation in total job growth over cities such as Los Angeles, New York, and Washington, D.C. More than 83,000 jobs were added in 2005 alone. Flagstaff, Yuma, and Tucson have all experienced higher than normal growth as well. And when we have people moving in, that means we have dentists moving in. Over the past five years, Arizona has seen the dentist ranks swell by more than 1,200. Membership in the Arizona Dental Association (AzDA) has doubled over the past ten years, with 75% of that growth occurring during the past five.

Why have so many dentists flocked here? Well, aside from the beautiful weather, attractive lifestyle, and manageable cost of living, word on the street is:



Mr. Murray is Executive Director of the Arizona Dental Association. He welcomes suggestions for solving the distribution problem at rick@azda.org.

“Go to Arizona where reimbursement is high, managed care is low, and fee-for-service is the norm rather than the exception.” Not one day goes by during which I don’t field a phone call or e-mail from at least one dentist interested in moving to Arizona. As you might imagine, this turn of events has created some interesting, and in some ways troubling, situations for many Phoenix-area dental practices.

OASES IN THE DESERT?

Just like anywhere else in the country, Arizona has patches (a lot when measured by square miles) where there are no dentists, and that makes sense. After all, just as there is no logic in opening a doughnut shop in an area where there are no cops, nobody wants to build a dental practice in a place with no patients. So, when you look at the data, Arizona appears to have a shortage of dentists. But take that same data and apply it to the metropolitan areas of the state and you’ll see a very healthy supply of dentists. Arizona, then, suffers from a “mal-distribution” of dentists rather than a “shortage.”

Unlike northern Arizona’s Lake Powell, a major source for water in Phoenix whose level has dropped by more than sixty feet in the last five years, the proverbial pool of dentists for Arizona isn’t expected to crest for several more years. With the state’s economy ranking in the top five in the nation and the (re)discovery that for-profit dental

education is good business, Phoenix will continue to attract a diverse population of dentists for years to come.

Like the Sonoran Desert on which it rests, Arizona has long been a dry spot for dental education. And like our annual monsoon season where it’s sunny one moment and raining buckets the next, two dental schools have sprung up like oases. A. T. Still University in the Phoenix suburb of Mesa opened the Arizona School of Dentistry & Oral Health in 2004 with fifty-six students graduating May 19, 2007. The class matriculating in 2008 will number eighty. Across the valley in Glendale, Midwestern University will open its College of Dental Medicine when it matriculates one hundred students in the fall of 2008. I’m not a mathematician but I know that adds up to a whole lot of dentists.

With dental schools around the country closing, why is Arizona opening them? It could be a growing economy, the weather or a desire to serve our state’s uninsured, at-risk and underserved patients. Whatever the reasons, members call me frequently to express concern and those conversations typically begin when they say to me, “I’m so glad I’ll be retiring in a few years.”

Look Back to Look Ahead

To put a proper perspective on the dental schools, let’s look back for a moment. Many of you may remember the glut of dentists the country experienced in the mid-1980s. As a matter of fact, many of you were those dentists who came into

Just as there is no logic in opening a doughnut shop in an area where there are no cops, nobody wants to build a dental practice in a place with no patients.

the market at that time. Do you remember what you were thinking after graduation and you heard the ruckus about flooding the market? Sure you do—get into practice ASAP, work-work-work, pay off the debts. So, what do you think the veteran practitioners were thinking at that time? “Our profession is in peril!” some were wailing (and some still are, but that’s another article). Well, did the profession of dentistry implode? No. Did it go through some tough times? Yes. Without the ability to limit who wants to set up a dental school and where (after all, it is still a free market), we must use the knowledge that we have from history to raise awareness and avoid the mistakes of the past.

But are dental schools an issue in Arizona? Realistically, less than 25% of the Arizona students will stay after graduation, and that is likely to be an over-estimation. That means by 2012, some forty-five dental students will be

Arizona has more dentists reported to the National Practitioners Data Bank than the entire state of California, which has nearly ten times as many dentists.

“released” into the Arizona market every year, a number that should not scare anyone. Arizona has other concerns, real issues, on which we must focus. One of those is practice ownership.

Arizona is presently one of only two states that does not regulate who can own a dental practice. More than half of the state’s dental practice laws (twenty-six) consider owning a dental practice a component of practicing dentistry. What I have seen at our state board would discourage even the most seasoned dentist from ever relocating to Arizona because it confirms that the “business” of dentistry and the “practice” of dentistry sometimes don’t see eye to eye. Dozens of employee dentists have been sanctioned because of issues that

were the result of the business practices of non-dentist owners. When this occurs the board ultimately has only one place to turn even when a complaint was the result of an action by the non-dentist business owner.

We also have a state board of dentistry that is—there’s no other way to put it—hyperactive. In the last six years more than 3,000 complaints have been investigated. With roughly 3,600 licensed dentists it’s easy to see how even the most seasoned practitioners aren’t able to escape the dragnet. Arizona has more dentists reported to the National Practitioners Data Bank than the entire state of California, which has nearly ten times as many dentists. While we do have our fair share of “frequent flyers” at our state board, there are not that many bad dentists in Arizona. I promise. The high number of complaints is the result of laws that require all complaints to be investigated, regardless of merit. Ultimately if there is no evidence to support a complaint, it is dismissed. But if investigators determine that records or office protocol were not in order for that particular case, another investigation/complaint will be opened. Still want to practice here?

WAIT, THERE’S MORE

Another emerging issue facing Arizona is licensure by credentials. I know I may be treading on sacred ground here and I am well aware that from a political standpoint, trying to eliminate licensure by credentials is suicide. And no matter how articulate we are in attempting to express our concerns, we could be interpreted as protectionist. In a world of supply and demand, competition is good for the consumer because it keeps prices in check, right? Well, everyone knows it works a little differently in dentistry,

but try explaining that to a legislator, especially one who just had major dental work!

If more competition means lower prices, legislators will be all for it. But the unchecked growth of dentists in the urban areas of Arizona has created some interesting ethical questions with regard to advertising and, on occasion, treatment options. Add to it the perception that dentistry has no compassion for those who are less fortunate and we have earned the hard-to-shake reputation of being RGB (rich, greedy bastards). The prevailing sentiment is that we should be looking at how we can modify the existing laws to encourage dentists to practice in areas where there are none. If anyone can figure that out without attaching a dollar sign to it, please let me know.

Arizona dentists are fortunate to be living in one of the most dynamic economies in the country, and we can leverage that to our advantage or sit back and watch what happens, which we know would be dangerous. I’ve come to know and appreciate dentists as leaders, not followers... doers, not slackers... fighters, not wimps—and I feel it’s safe to predict we will continue to manage just fine, thank you. However, I’m not foolish enough to believe we won’t experience our share of growing pains. We know that the way we handle the challenges brought about by our state’s meteoric growth will directly impact, and therefore guide, the level of success of AzDA and its members. Sure, it’s a complicated problem that is exacerbated by a population boom, great weather, and a stellar football team. Okay... two outta three ain’t bad. ■

MONTANA'S REGIONAL INITIATIVES IN DENTAL EDUCATION (RIDE)

Mary K. McCue, Esq.

ABSTRACT

The State of Montana is projecting an increasing shortfall of dentists, but it is not economically feasible to establish a dental school there. The Montana Dental Association is partnering with the University of Washington School of Dentistry to explore a partnership that would train about eight residents of Montana each year in a program where the first and fourth years of dental school would be in state and the two middle years in Seattle. Because part of the training would be in rural and other underserved communities, it is hoped that these young practitioners will help address growing access issues.

The region of Montana called the Hi-Line stretches the length of northern Montana, from the North Dakota border in the east to the base of the Rocky Mountains in the west. Along parts of the Hi-Line and throughout the rural and sparsely populated eastern third of the state, access to a dentist is difficult or nonexistent. In Havre, one mid-size town along the Hi-Line, the dentist-to-population ratio is one dentist to about 3,600 individuals. In the eastern third of the Montana the ratio is one dentist to about 3,300. (The average national ratio is 1:1,550.) In 2000, there were 51.9 dentists in Montana per 100,000 persons compared with the national average of 63.6 (American Dental Association, and the U.S. Census Bureau, 2000).

A Montana task force on health care workforce needs has identified dental workforce shortages as a critical issue. Montana dentists are aging and many dentists who retire are not being replaced, especially in smaller towns and rural areas. Montana does not have its own dental school to assure its youth access to dental education. As the state's population has grown, the number of dentists has not increased proportionately. Montana has depended largely upon dentists from other states to meet its workforce needs. More than half the dentists currently practicing in Montana were not raised in the state.

Other factors that predict problems for oral health in Montana include lack of water fluoridation and the presence

of groups at high risk for dental disease, including low-income persons and minorities, especially Native Americans. Advances in science and technology are also increasing the demand for more complex restorative dental procedures that strains existing dental workforce capacity.

Predictions for continued population growth in the state and the rising numbers of elderly who need dental care also herald a worsening oral health situation. The population of Montana has grown 19% since 1980. The percentage of elderly persons over age 65 living in the state was 13.7% in 2004, higher than the national average of 12.4%. As the Baby Boomer generation ages, the number of elderly individuals will rise dramatically. And more of today's elderly are keeping their teeth and continue to be at risk for dental caries and other tooth conditions.

A PARTNERSHIP

Over the course of the past several years the Montana Dental Association (MDA) partnered with the University of Washington School of Dentistry (UWSOD) to address this workforce



Ms. McCue is Executive Director of the Montana Dental Association; mda@mt.net. (This report is based in large part on the RIDE Feasibility Study prepared by Dr. Wendy Mouradian, RIDE director at the University of Washington School of Dentistry.)

shortage. Montana looked to the University of Washington as a dental school that has trained dentists for sixty years with an emphasis upon excellence in general dentistry. From the partnership that developed between UWSOD and MDA, the Regional Initiatives in Dental Education (RIDE) program was created.

The mission of the RIDE program in Montana is to provide access to high quality, publicly funded dental education to educate dentists who will make a commitment to serve the needs of rural and underserved communities in Montana. The creation of RIDE builds upon the success of the UWSOD regional medical education program that has spanned the states of Washington, Alaska, Montana, Idaho, and Wyoming (WWAMI) for the past thirty years.

RIDE has the potential to address the dentist shortage by ensuring that students receive a significant amount of their education in Montana—something not possible with some of the other dental education models the MDA has explored. In 2005 the Montana Legislature commissioned a feasibility study of the RIDE program; that study was delivered to the 2007 Montana Legislature and the MDA is now seeking funding from the legislature to establish the RIDE program. If the MDA and other advocates for the program are successful in gaining the necessary funding, the first class of students would enter the program in 2008.

A PLAN

With RIDE, first-year students would attend Montana State University (MSU) in Bozeman, Montana, with some course overlap with medical students. They would then spend two years at the dental school in Seattle and at clinical sites in Montana. Students would return to Montana for most of the fourth year of residency training, with a focus on serving the rural areas of the state. Overall, students would spend about 40% of their time in Montana. The RIDE program would enroll and train eight dental students each year, for a total of thirty-two students at any given time once the program is fully implemented. Clinical sites would be spread around the state and include areas of high need, such as rural areas, community health centers, and possibly Indian Health Service sites. Students would serve underserved populations, providing immediate access to dental care for those most in need. Dental students would receive their DDS degree from UWSOD.

UWSOD would take responsibility for accreditation and educational equivalency as required by the Council of Dental Accreditation (CODA) of the American Dental Association. The dental school would also take responsibility for monitoring outcomes of the RIDE program, including educational outcomes and workforce placement.

RIDE would be funded by a combination of Montana state funds, student tuition, and UWSOD resources. The cost to initiate the RIDE program in Montana would be \$2.3 million for the first two years of the program. Expenses would include the start-up operating costs, including resources needed to train community dentists for new faculty roles and for key representatives to participate in the admissions process, create certain new pieces of curriculum at MSU, make arrangements for distance learning

components, and put in place the additional dental administrative infrastructure. Costs also would include expenses for the eight first-year students who matriculate at MSU in 2008.

For many years Montana has spent comparatively small amounts on educating dental students. The state presently spends more than \$3.6 million per year on educating medical students and nearly \$900,000 for veterinary students. It spends only \$234,000 for dental students. MDA believes the time has come for the state legislature to recognize this inequity among funding for professional education programs and take action to fix it.

A PROMISE

The Montana Dental Association believes that RIDE is an important part of the answer to the need for dentists in Montana for a number of reasons. First, RIDE provides Montana with its own dental school without the expensive costs of bricks and mortar. The program would allow eight Montana residents each year the opportunity to attend the University of Washington, an excellent dental school. RIDE would appoint Montana dentists as adjunct faculty to UWSOD who receive training from the University of Washington. MDA believes this would greatly enhance the level of professionalism among Montana's dentists and ultimately benefit all Montana dental patients.

MDA also supports this educational model because it allows Montana students to attend a significant part of their dental education in the state. The program hopes to draw prospective students from rural areas of the state that may choose, upon graduation, to return to their home communities to

practice dentistry. RIDE has the potential to provide great professional positions for many Montanans far into the future.

Dr. Dan O'Neill of Butte, Montana, current MDA president, states, "A critical component of the RIDE program will be a commitment of the RIDE students to return to Montana for a period of time and to specifically identified locations. This component has been endorsed by MDA leadership to be the most important part of the RIDE educational initiative."

Another significant advantage of the program is that it allows Montana students to compete among themselves for designated Montana seats, rather than competing as out-of-state students in a large pool of applicants at the UWSOD. The program lowers tuition costs to Montana students by providing them Washington in-state tuition status. RIDE also provides recruiting opportunities by providing students with extended clinical rotations in the state.

The lack of a dental school in Montana has disadvantaged Montana students seeking to enter dentistry. Admission to publicly funded dental schools in other states is more difficult because of the competition for slots by in-state students. In addition tuition rates are higher for out-of-state residents and at private dental schools. In 2003-2004 there were 23 students from Montana who enrolled in the first year of dental schools in other states, but many more applied.

Supporters of RIDE believe that the shortage of dentists in rural Montana impacts the state's disadvantaged populations the most. Some patients must travel long distances because the only dentist in their community is simply too busy to accept any new patients, or the closest dentist is over one hundred miles away. The RIDE program will address these access issues by directly delivering care to some of our most underserved

population, while introducing students to future practice opportunities in those areas.

Dr. O'Neill comments, "A terrific component to the RIDE proposal is a new relationship with the Native American tribes in Montana. The student and faculty member dentists will be able to experience a cultural and spiritual enlightenment not available with other dental education programs. The MDA is learning firsthand the unique positions of the U.S. Public Health Service, Indian Health Service, and independent tribal health services. It is our hope that the MDA will continue to be the primary advocate of dental care to the underserved in our state."

Essential to the RIDE educational model is a strong interest in collaboration among practicing dentists in private dental offices and Montana community health centers dental clinics, where students would require direct supervision during their clinical rotations. Dentists in Bozeman would also have a central role in supporting the dental portions of the curriculum, much of which will be delivered by distance learning (through the Burns Telecommunications Center) at MSU. Strong faculty and general infrastructure at MSU are also important to meeting the needs of the dental program. All of these key elements have been assessed, and they are present in Montana. Moreover there is high enthusiasm among these key stakeholders and a desire to go forward with a RIDE program. Dentists in Montana who are members of the Montana Dental Association envision the day when they can boast, "We have the smallest but best dental school in the country!" ■

More than half the dentists currently practicing in Montana were not raised in the state.

A critical component of the RIDE program will be a commitment of the RIDE students to return to Montana for a period of time and to specifically identified locations.

A LOOK INSIDE THE TEXAS DENTAL ASSOCIATION

Mary Kay Linn

ABSTRACT

The Texas Dental Association is the third-largest in the United States. In addition to serving a large number of citizens, oral health care in Texas faces challenges of geographic diversity and a long border with Mexico. TDA addresses these problems with a rich array of member services, a full communication network, and programs designed to promote leadership.

It is my pleasure to tell you about the Texas Dental Association. Chartered in 1871, the TDA is the third-largest state dental association in the United States—with 7,500 members, grouped into four divisions across the state and representing the 26 local district dental societies in Texas. The state-level TDA is part of organized dentistry's tripartite structure with the American Dental Association at the national level and district dental societies at the local level.

ORGANIZATION AND STRUCTURE

The TDA Board of Directors, executive body of the association, is composed of member dentists—15 voting members and 6 nonvoting members. The TDA House of Delegates, legislative body of the Association, is composed of 122 delegates representing the 26 Texas component dental societies, members of the Board of Directors, the speaker of the house, and one student delegate from each of the three Texas dental schools.

The Texas Dental Association's 25 councils and committees, comprised of member dentists and supported by TDA staff, recommend policy to the TDA Board of Directors. Each year, the actions of the board are reviewed and acted upon or amended by the TDA House of Delegates. I manage a full-time staff of 30 knowledgeable and energetic professionals.

The TDA owns its four-story office building and grounds in Austin. In addition to accommodating the central office

and two spacious conference rooms, TDA leases additional office space to other tenants.

The TDA communicates with and listens to its members via the Texas Dental Journal (published continuously since 1883), the TDA Today member newsletter; and a robust Web site for members and the public at www.tda.org.

Other types of communication include face-to-face meetings throughout the state; blast e-mails and faxes for urgent information; e-mail list serves for councils, committees, and task forces; TDA member surveys; audio and Web-based conferencing; and interactive electronic meetings of the Board of Directors and the House of Delegates.

ORAL HEALTH NEEDS AND POLITICAL CONCERNS

As a large state with major metropolitan areas, sparsely populated regions, and the longest state border with Mexico, distribution of dental services is a constant challenge. The state Medicaid program provides dental care only for children, and Medicaid reimbursement rates for dentists are among the lowest in the country. Dental benefits under the Children's Health Insurance Program (CHIP) were eliminated in 2003, and restored in 2005, but both dentists and



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patients face frustrations with administration of the program.

Pressing political/dental concerns in Texas include:

- Access to dental care
- Public health dental services plagued by low reimbursement rates, cumbersome administration and claim procedures, and inadequate state funding
- “Dental tourism” as Texans seek dental care in Mexico
- Insurance companies pay claims for services received in Mexico, but often refuse to pay subsequent claims for work done by Texas dentists to correct substandard work performed by dentists across the border

The Texas Dental Association actively promotes its Texas Dental Association Smiles Foundation, a 501 (c)(3) nonprofit affiliate, which offers charitable work performed by TDA members through:

- Texas Missions of Mercy (TMOMs) in various locations across the state, bringing together dentists, auxiliary dental personnel, mobile dental vans, and community volunteers to relieve pain and restore smiles
- Oral health public education programs and activities conducted during TMOMs
- Texas Donated Dental Services (TxDDS) program, which matches elderly and disabled patients with volunteer TDA member dentists for charitable dental care
- Public education program, currently under development as part of the TDA’s strategic plan, to educate the public on the importance of good oral health.

MEMBER SERVICES

TDA Financial Services, Inc, an affiliate of the TDA, negotiates special pricing on

products and services for TDA members, which is a member benefit. Patients also benefit because lower costs passed on to patients make dental care more affordable. For example, a more affordable price for dental office products could make the difference in a purchasing decision for equipment that could improve the quality of care a TDA dentist is able to deliver.

I believe many TDA activities and services are worthy of consideration as “intangible member benefits,” and I have listed just a few:

- TDA Annual Session/TEXAS Meeting, an yearly conference with no registration fees for TDA members and staffs offering continuing education programs to meet Texas State Board of Dental Examiners’ requirements for the entire dental team
- Regularly scheduled ethics and peer review training courses at dental conferences in Texas
- TDA Legislative Day, a formal program for members to review TDA’s legislative agenda and to make personal visits to state senators and representatives
- Secure and time-saving online transactions for TDA members to pay dues, register and reserve housing, purchase photographs taken during the TDA activities, verify continuing education credit, or purchase TDA logo items

One important goal in the TDA’s strategic plan addresses developing leaders for the future. A metric to support this goal is a summer externship program for dental school students to enhance their knowledge about and experience with organized dentistry.

To design a program, the TDA Council on Membership conferred with the American Student Dental Association and the deans of the three dental schools in Texas: Baylor College of Dentistry, Texas A&M University System; the

As a large state with major metropolitan areas, sparsely populated regions, and the longest state border with Mexico, distribution of dental services is a constant challenge.

University of Texas Dental Branch at Houston; and the University of Texas Health Science Center at San Antonio Dental School. The externship program will address five important elements of organized dentistry: legislative and regulatory affairs, membership, governance, continuing education, and charitable dentistry.

Prospective externs must submit a letter of intent, their curriculum vitae, and a letter of good academic standing from their dean. The TDA Council on Membership will select one extern from each of the three Texas dental schools. The majority of the program’s work will be scheduled during the month of June at the TDA central office in Austin, and externs will also be expected to attend additional meetings throughout the year.

We believe this new program can encourage participation in and leadership organized dentistry at the local, state, and national levels. ■

SIZE AND PERSPECTIVE IN ALASKA

Jim Towle

ABSTRACT

By far America's largest state, Alaska has only 350 members, so effective communication matters in overcoming distance. Alaska has led the way in direct reimbursement, diversity in leadership, member involvement, and a distinctive lifestyle for its practitioners. The tripartite structure of organized dentistry is crucial in building understanding the issues involved in providing oral health care to the members of this vast state.

The Alaska Dental Society is three hundred and fifty dentists who choose to live and practice in the nation's largest and most geographically extreme state. Superimpose the state of Alaska upon what Alaskans refer to as "the lower forty-eight" and you will discover that the southeasternmost part of Alaska is near Charleston, South Carolina and Attu, the last island in the Aleutians, will be found in Los Angeles. Barrow, the nation's northernmost community, located on the shores of the Arctic Ocean, would be found in Minnesota, just a few miles south of the Canadian border. The residents of Adak, once a sprawling Cold War U.S. Naval Air Station, now a community of about three hundred people, would be located in Mexico.

EXTREMES ARE A WAY OF LIFE

Distances are not the only extremes that challenge Alaska Dental Society (ADS) members. It is possible on the same day for Alaskans waiting to see a dentist on cloudy Annette Island to be enjoying a balmy 60 degrees, while residents of Fort Yukon on the southern edge of the Arctic National Wildlife Refuge (better known as ANWR) must bundle up under crystal clear skies in minus 40 degrees below zero to get to a dental appointment.

Getting about in Alaska to visit with friends and colleagues presents challenges as severe as the weather. Massachusetts dentists may have only three-tenths of Alaska's landmass in which to stretch out; but they can use 35,000 miles of roads to transverse their commonwealth, compared to the meager 1,200 miles of

highways in Alaska. In spite of global warming, Alaskan dentists flying from Anchorage to the state's capital in Juneau will soar over a solid mass of ancient glacier ice that is larger than the State of Rhode Island.

While dentists in the lower forty-eight can drive from the farthest corners of their state to attend a Day at the Legislature, that's not the case for Alaskans (and Hawaiians). There are three ways to get to Juneau—by airplane or seaworthy sailing vessel. The other alternative is a good pair of hiking boots and the stamina to trek through some exceptionally steep and rugged terrain, with the distinct possibility of encountering some of Alaska's big wildlife, including both black and brown bears (also known as coastal grizzlies).

Many ADS members tell time differently from their southern and southeastern colleagues. (In Alaska, Hawaiians are southerners and everyone else literally lives in the southeast.) When it either doesn't get dark at night (and if you go far enough north, the sun literally doesn't set) during the summer daylight savings time doesn't mean a thing. (Please note that in the winter the sun doesn't rise up over the Chugach Mountains and shine in the window of the ADS office until almost 11 a.m. and sets shortly after 3 p.m. and that for the

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dentists in Barrow there will be no direct sunlight from late November until mid-February.) So time is told more by the seasons, and most Alaskans enjoy the state's six seasons: King, Sliver, Chum, Pink, Sockeye and hunting. The first five are subseasons of the greater fishing season when Chinooks—also known as Kings—come in from the sea to swim upriver and breed, followed by the Coho or Silvers and the remaining runs of salmon. Just to keep life interesting, there's halibut fishing and more than one Alaskan dentist has been known to close the office to set and check crab traps. Lower forty-eighters can brag about their bass boats, but nothing can compare to thirty-five pounds of salmon fighting you on a fly rod.

Alaska is the Great Land, but its greatness does not simply come from its vastness and its rugged wilderness. It also flows from the excellence and diversity of its fine arts. Alaska's dental community is able to enjoy access to everything from productions of Puccini's "Tosca" and Gilbert & Sullivan's "The Pirates of Penzance" to such contemporary delights as the percussory hit musical review *STOMP*, which twice sold out to full allotments of seats at the 2005 ADS Annual meeting.

To Alaskans, the infamous "bridges to nowhere" that garnered national political attention are not black holes into which federal funds vanish. They signify bridges between actual places that will mean jobs for patients and economic development and opportunities to make more of the wonders of Alaska

accessible to more people. The same is true for ANWR. To most of the nation it is either the last vestige of pristine wilderness not yet trampled under for oil exploration, or it is a source of petroleum resources that can lessen America's dependence upon foreign cartels controlled by governments that don't have the best interest of America in their business plans.

DENTAL HEALTH AIDE THERAPISTS

Access to dental care in Alaska can be as turbid as the actual ANWR, which is neither a pristine wilderness area, nor a place that all Alaskans see as an economic opportunity held hostage by tree-huggers from Berkley to Bean Town. That is why Alaska finds itself at the vortex of controversy surrounding the introduction of Dental Health Aide Therapists (DHATs) into the paradigm of treatment delivery. The corporations that contract with the federal government through the Indian Health Service (IHS) to provide care to Alaskans of aboriginal ancestry are attempting to exploit vague and ambiguous language in the Indian Health Care Improvement Act (IHCIA). Using the obfuscated language of the act, these corporations are claiming that DHATs they employ are exempt from compliance with the Dental Practice Law of Alaska. The Alaska Dental Practice Law, like the dental practice laws in all other states prohibits anyone other than a licensed dentist from performing such basic surgical procedures as cutting restorations and extracting teeth.

Too many dentists in the lower forty-eight do not see the "Alaska" issue for what it is—an effort by quasi-HMOs that have failed to focus on prevention of oral disease and now are attempting to circumvent Alaska law in order to employ low paid providers of treatment.

The ADS, along with the American Dental Association, has taken a consortium of these corporations to court and challenged their claim that their employees are exempt from state laws.

Too many dentists in the lower forty-eight do not see the "Alaska" issue for what it is—an effort by quasi-HMOs that have failed to focus on prevention of oral disease and now are attempting to circumvent Alaska law in order to employ low paid providers of treatment. Rather they perceive Alaska as corporate image makers have conjured up an image for a lazy news media of poor villagers living in the most remote regions of Alaska suffering from dental decay and

With only two professional staff and a dedicated cadre of officers and volunteers, the ADS finds ways to provide its membership with all of the essential benefits and services that the megaconstituent associations provide at a far lower cost per member.

unable to get access to a dentist. This is a manipulation reminiscent of a postcard picture of Denali rising out of the Alaskan interior and towering above the Alaska Range at 20,320 feet above the sea. Because Alaska has but three members in the U.S. Congress, and Ohio has 20, Denali (“Great One”) officially retains the name of Ohio’s favorite son, William McKinley.

This Alaskan “oral healthcare delivery issue” illustrates the strength and vitality of organized dentistry’s tripartite system. Alaska’s dentists must now rely upon the tripartite structure of organized dentistry and work with their colleagues in other states to rally Congressional support for another version of the IHCA. Congressional delegations across the nation are alerted to what is happening in Alaska and the bill can be amended to ensure that it clearly states that the governance of all healthcare professions remains under the clear and direct control of state legislatures and boards of dental examiners, and not within a federal bureaucracy where a single dentist, who oversees the DHATs is the only dentist empowered to decide which DHATs are allowed to perform invasive procedures.

In the 1990s the ADS was in the forefront of promoting direct reimbursement. It is again on the leading edge, or perhaps this time the bleeding edge of change driven by the question: Who should pay? Dentistry is finding itself on the spear point of a growing struggle by government policymakers and political leaders as they wrestle with finding ways to provide more care to the nations’ ever-increasing numbers of uninsured. The Alaskan corporations are setting a precedent in how to provide more treatment to more people at less cost to the corporate bottom line. Politicians, policy wonks, and taxpayers will be watching. The numbers of uninsured continue to grow. Advocates for the poor and indigent are demanding “more access” and greater ease of access to what they proclaim should be “affordable” care and treatments. The HMOs have responded on the medical side by employing and empowering so called mid-level providers—physicians’

assistants and nurse practitioners in order to contain cost and provide treatment.

OVERCOMING THE SIZE PROBLEM

That is a tall order for a state society with a membership smaller than many local component societies. With only two professional staff and a dedicated cadre of officers and volunteers, the ADS finds ways to provide its membership with all of the essential benefits and services that the megaconstituent associations provide at a far lower cost per member.

Where great physical distances separate one of organized dentistry’s smallest cohorts, it is a testament to the local dentists’ commitment to their profession that the ADS is able to maintain a membership level in excess of 80%. It is telling that Alaska is producing a generation of Alaskan-grown dentists; sons and daughters of dentists who came to Alaska in the waning days of territorial governance and in the first blush of statehood, who are following in their fathers’ footsteps and practicing dentistry and assuming roles of leadership in their Alaska Dental Society. It is also telling that the first woman serve as president of the ADS, Dr. Geraldine Morrow in 1971, went on to become the first to serve as president of the ADA. Since then the ADS has had four more women presidents. All are wet fingered dentists today.

For an opportunity to see the Great Land where the sea breaks its back, log on to www.akdental.org and register to attend the Alaska Dental Society’s 54th Annual Meeting in Anchorage May 3rd through the 5th. ■

ISSUES IN DENTAL ETHICS

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USING AN ETHICS ACROSS THE CURRICULUM STRATEGY IN DENTAL EDUCATION

Lawrence P. Garetto, PhD, FACD and
Wendy E. Senour

ABSTRACT

The curriculum in ethics and professionalism at the Indiana University School of Dentistry is described. The principles upon which the program is based include integration throughout the entire curriculum, extensive use of cases and group discussion, and incorporation with the problem-based learning methodology used in the school. Symbolic events, such as a White Coat Ceremony and discussion of cases with Fellows of the American College of Dentists are used to reinforce the material. Evaluation of the students on ethical knowledge and behavior are conducted in simulations and in clinical ratings.

Teaching ethics in professional schools is an essential component of educating, as is graduating responsive and responsible healthcare practitioners who will be able to appropriately address ethical problems that they will encounter in their practices. The controversial position that ethics curricula don't work has been expressed in the recent literature (Bertolami, 2004). Yet other authors recognize that for practitioners to appropriately respond to ethical issues, they must first recognize them (Jenson, 2005; Koerber et al., 2005). We too believe that ethical development is an educational imperative because a student entering a healthcare profession must learn the principles, values, attitudes, and behaviors that are integral and

essential components of that professional life. A crucial point in making this argument is that the expectations of students, once they embark on their professional lives (on day one of dental school), are substantially different from expectations for members of the laity. The ethical "contract" of service to society that is a hallmark of a profession (Welie, 2004a; 2004b) is perhaps an important ideal for citizens in general, but it is a defining responsibility of a healthcare practitioner.

IUSD CURRICULUM AND INSTITUTIONAL PRACTICES

The Indiana University School of Dentistry (IUSD) aims to educate its students in ethics and professionalism through a formal dental ethics curriculum that spans all four years of the program and through institutional processes and practices that are formative outside the classroom as well. IUSD does this in concordance with its own mission of developing "...ethical and socially responsible practitioners of general dentistry, dental hygiene, and dental assisting" and in doing so, complies with the relevant American Dental



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Students begin to learn the rudiments of ethics and professionalism concepts literally on the first day of matriculation as part of their new student orientation.

Association Commission on Dental Accreditation standards.

Two such standards pertain directly to educating dental students in ethics and professionalism:

- Standard 2-20: Graduates must be competent in applying ethical, legal, and regulatory concepts to the provision and support of oral healthcare services.
- Standard 2-21: Graduates must be competent in the application of the principles of ethical reasoning and professional responsibility as they pertain to patient care and practice management.

At IUSD, ethics, professionalism, and professional responsibilities as well as legal and regulatory concepts are addressed in various ways throughout the four year DDS curriculum. The concepts of professionalism and ethics underpinning the provision of health care in addition to the responsibilities of the dentist in the doctor-patient relationship are among the earliest topic areas introduced in our curriculum. Students begin to learn the rudiments of ethics and professionalism concepts literally on the first day of matriculation as part of their new student orientation. As well, the concepts of profession and professionalism are a major focus of the Introduction to Critical Thinking and Professional Behavior (ICTPB) course that runs during the month of July in the D1 year in advance of other courses. Some of the earliest discussions in this first course of the dental curriculum focus on comparing and contrasting the ethical responsibility of a lay member in society to that of a member of the dental profession. These early discussions are supported by readings from professional literature that address the historical

basis of professions, the societal contracts incumbent in the status of dentistry as a profession and the challenges faced by the profession resulting from potential mismatches in what the profession espouses versus how it actually performs (Welie, 2004a; 2004b; 2004c).

However, in our curriculum, the principal delivery mechanism for ethics and professionalism content and concepts are approximately thirty-seven problem-based learning (PBL) cases that students work through in small student-centered groups during the first four semesters of the DDS curriculum. Cases present scenarios which are supported by specifically written learning objectives that cause students to focus on issues in ethics, professionalism and professional responsibility. These objectives focus generally on the relationship between the dental profession and society. More specifically, concepts of doctor-patient relationship, patient confidentiality, autonomy, responsibilities for patient access to care, informed consent, peer review, etc., are intentional elements built into PBL cases. Students in the PBL groups must be able to identify ethical and professional issues present and use an ethical reasoning strategy (Ozar & Sokol, 2002) to make a judgment and come to a decision as to how the problems should be managed. To initiate students to this approach, the PBL cases are intensively supported early in the curriculum during the ICTPB course with large-class interactive lecture experiences discussing major topic areas in ethics and professionalism (Table 1).

The conceptual framework and basic elements of professional ethics are intentionally introduced at the very beginning of the DDS curriculum in order to facilitate continual revisiting and exploration of how they apply in the context of healthcare problems as they address the “patients” in the PBL cases (D1 and D2 years). Because these

concepts are presented early in the curriculum, a basis is established for subsequent discussion of issues in cases presented during the Applied Clinical Patient Management module in year D3 and in the Clinic Rounds meetings in years D3 and D4.

In addition to these major curriculum components, our students participate in numerous large and small group and individual didactic activities that cause them to critically reflect on ethics and professionalism. At the beginning of their D1 year (two weeks after the beginning of the D1 curriculum), incoming students participate in a “White Coat” ceremony jointly sponsored by IUSD, the Indiana Dental Association, and the Indiana Section of the American College of Dentists. This event occurs early in their tenure at IUSD so as to both welcome them into the profession as colleagues-in-training and to impress upon them the unique responsibilities that they undertake in “accepting the mantle of the profession.” As well, near the end of their tenure at IUSD, at the beginning of year D4, these same organizations also collaborate in a small group discussion of three to five “ethical dilemma” cases used with permission from the published series in the *Texas Dental Journal* and mentored by Fellows of the Indiana Section of the American College of Dentists. This program focuses on both reviewing principles and providing perspective on ethical dilemmas faced by practicing dentists (Table 2). With facilitation from the ACD mentors, the small groups of students discuss each case and come to a decision as to the course of action to take based on ethical code principles and central values arguments.

In addition to the specific didactic discussions, students actively demon-

TABLE 1. INTRODUCTION TO CRITICAL THINKING AND PROFESSIONAL BEHAVIOR ETHICS AND PROFESSIONALISM THEMES

Defining a Profession
Elements of Professionalism
Professional Behavior
The Dentist-Patient Relationship
Ethical Concepts and Ethical Decision Making
Central Values of the Dental Profession
IUSD Code of Professional Conduct
Principles of Ethics and Codes of Professional Conduct
American Dental Association
American College of Dentists Guide to Professional Conduct
American Dental Hygiene Association

TABLE 2. SAMPLE THEMES OF SMALL GROUP DISCUSSIONS WITH INCOMING SENIOR DENTAL STUDENTS MENTORED BY ACD FELLOWS

Ethical Principles: Review the ethical principles relevant to dentistry and health care.

Ethical Decision Making: Recognize ethical issues, problems and dilemmas presented in the cases and relate them to the ethical principles involved.

Code of Ethics: Review the purpose and demonstrate the role of the dental code of ethics and the central values of dental practice in the provision of dental care.

Patient Primacy: Recognize models of Doctor/Patient relationship that are sensitive to the patient’s goals and values and congruent with patient-centered, comprehensive oral healthcare philosophy.

Impaired Colleague: Identify what actions to take with regard to the incompetent, impaired or unethical colleague.

Our goal is to develop practitioners with a habituated attitude of ethical awareness to future problems that they will certainly face.

strate professional responsibility via the IUSD Professional Conduct System. This integral element of our institution consists of a peer review component, conducted by the Student Professional Conduct Council (SPCC), with oversight from a faculty-level Professional Conduct Committee on which the president of the SPCC is a voting member. SPCC membership is elected from each DDS class (Dental Hygiene and Dental Assisting program representatives also participate in conjunction with the DDS students in this schoolwide process) with representatives serving one-to-two-year terms, with reelection possible. This peer review component is student driven and represents another manner in which our students participate in ethics activities that correspond to the responsibilities of professional practice.

Acceptable understanding of legal and regulatory requirements is also a component of professional responsibility to both practice and patients that students will encounter in practice. Many PBL cases have specific objectives associated with legal code and regulatory concepts (e.g., HIPAA, informed consent). As well, a number of courses in years D1 and D2 contain specific segments on both HIPAA and universal precaution infection control. Small group activities in year D3 and D3/D4 Clinical Rounds also discuss specific or general patient care scenarios containing elements of these concepts.

In year D4, legal and regulatory concepts are thoroughly addressed in modules on: 1) Jurisprudence, and 2) Practice Administration and Current Concepts. The Jurisprudence module (T820A) is an online self-study course that is available throughout year D4. This module is comprehensive in scope,

covering topics including Indiana practice law, employee relations, contracts, malpractice, etc. The practice management component of our curriculum is principally taught by faculty from the Pride Institute and presents numerous topics related to practice administration. These experiences are focused on developing appropriate business practices that are ethically compatible with professional ethics. A principle goal is to develop practice management strategies that minimize a practitioner's legal vulnerability and maximize their professional responsiveness.

COMPETENCY ASSESSMENT IN ETHICS AND PROFESSIONALISM

Competency is assessed at multiple levels evaluating the development of ethical reasoning and professionalism. In the D1 and D2 years, written essays discussing clinical scenarios containing ethical or professional issues and conflicts are routinely assessed. These questions evaluate students' ability to provide a reasoned response citing ethical code principles and central values arguments. Students must attain at least a "meets expectations" score on these essays. Students who score below this level (i.e., below expectations or unsatisfactory) are required to rewrite their response addressing specifically directed critique.

D1 students are also evaluated orally in Triple Jump Examinations (TJE) (Smith, 1993) that include an assessment of students' ability to identify ethical issues in a patient scenario. These examinations, given at least three times in year D1, are effective in identifying weakness in a students' self-directed learning process. Most TJE cases contain an ethical or professionalism related issue, and students are encouraged to identify and develop strategies in resolution as part of the process. A remediation experience is individually developed for

students who fail TJE to address specifically the area of their weakness to the satisfaction of the remedial tutor, which will include discussion if the student failed to identify properly and rationalize a solution for the ethical dilemma. Students are then reexamined by an independent examiner to assess satisfactory performance.

Finally, authentic assessment of students' ethical and professional judgment occurs in a clinic setting during the provision of oral health care. Students are assessed on "professionalism" including professional judgment by attending clinic faculty for each clinical encounter with a patient. Clinic Directors also independently assess each student's professional responsibility in the care of patients at the end of each academic year. Continued competency in professional responsibility is assessed on each discreet clinical competency exam involving a patient and a passing mark on this component is required irrespective of technical performance.

SUMMARY

Our curriculum in ethics and professionalism is by no means a finished product; it is constantly under review and revision. A principal rationale for our curriculum and our institutional processes and practices is overt recognition that our graduates will deal with issues in their professional practice that are ethical in nature and that will continue to change with the times (Kress, Hasegawa, & Guo, 1995). As such, our goal is to develop practitioners with a habituated attitude of ethical awareness to future problems that they will certainly face. ■

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A PRIMER ON DENTAL ETHICS: PART I

KNOWING ABOUT ETHICS

David W. Chambers, EdM, MBA,
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ABSTRACT

The field of dental ethics has matured to the point where it is worthwhile to summarize it. An overview is presented of the methods commonly used to present ethics in dental schools. The three most popular approaches to ethical theory are normative principles (good rules), virtue ethics (good people), and utilitarian views (good outcomes). Each of these approaches has advantages, and each is incomplete. The general problem of converting ethical knowledge to moral conduct will be presented in a subsequent essay.

Dental ethics is a large field. It would be a shame to get excited by part of it without at least surveying the whole field. Any map of the territory will be necessarily a bit arbitrary and reflect an individual frame of reference. So here is my individual and arbitrary structure.

In both dental schools and in practice there are six doors to open to get a good look at the subject. The first three doors concern ethics proper, or the study of right and wrong. Those who are comfortable in these realms sound knowledgeable, can advise others how to behave, and have every reason to know the most appropriate courses of action, even if they fail to act ethically. The other three doors concern moral conduct. This is the domain of practicing good work and the creation and leadership of moral communities.

Dentistry, accounting, teaching school, and selling insurance can be engaged in without opening all of the doors and having a satisfying look around. You have probably been offended or know of cases where lives have been damaged by individuals who lack a working knowledge of ethics and moral conduct. The purpose of this essay is to place a label on each of the first three doors so it is clear what is inside. Signage for the remaining three doors will be provided in a subsequent essay.

TEACHING DENTAL ETHICS

It is customary in American dental schools to cover ethical theory pretty well. Certainly, more curricular hours are devoted to this topic than was customary in previous decades or will be done during the years of practice. The principle focus includes learning about ethical theory and professional codes of conduct. This is covered by lectures from faculty members trained in the field, by guest lecturers, and through reading. This is the most passive of ethical activities; it is often tested by multiple-choice tests, as on so-called "ethics tests" that state boards administer to candidates seeking a license.

A more active engagement, also prevalent in American and Canadian schools, engages students in discussions, usually around ethical dilemma. These are cases that have built-in internal inconsistencies in values. The personal give-and-take of explaining and listening to alternative points of view helps build awareness of the complexity of some ethical situations and lets students "try on" different ethical perspectives and moral roles. In dental school, these are short written descriptions of dental situations, and the environment is a safe simulation of real experience. Any dentist who has served on a peer review committee or as an insurance consultant understands that real dilemma are just as complex.

The immersion version of ethics in school and practice is essentially ceremonial. This is not a deprecating remark; the clear voice of leaders, the dignity of

due process, and the oft-repeated stories of the hero who did it “because it was the right thing to do” celebrate high standards and create professional expectations. Where they are neglected, it is noticed. White coat ceremonies, reciting professional oaths, sermons from the dean or a significant dignitary, or a hall conversation that begins “What do you think about that guy who had his license suspended for...” may be more formative than anything that can be read in an ethics text.

STUDYING RIGHT AND WRONG

The three doors to be introduced in this essay are in the wing of the building devoted to the “individual understanding of right and wrong.” This section gets its name from the Greek term $\epsilon\theta\omicron\sigma$, which we translate “ethos” or habit; eventually the term, when applied to specific applications, became $\epsilon\theta\zeta\kappa\omicron\sigma$ (ethics), and took on the meaning of guiding action by general habits or principles.

The big program for ethics is to find the first principles or generalizations and teach them to others. There are five important assumptions in this description of ethics: 1) sufficient ethical principles exist and need to be discovered (or rediscovered rather than created); 2) the work of revealing ethical principles is rational and normally performed by specially trained academics; 3) knowledge of these first principles or generalizations is a necessary precondition, perhaps a sufficient one, for doing good; 4) ethical behavior is learned from contact with individuals who know the principles or generalizations; and 5) the ethical unit is an individual, not a group.

Too often this conception has led to agreements to disagree while secretly harboring a conviction that the other guy is unethical and his or her failure to see it your way is proof sufficient. The

prospect of leaving others to figure out ethics without the benefit of ordained experts is just too scary to serve as a useful approach. Ethics may not be for everyone (only folks like us). Aristotle was clear on this point: ethics was beyond the *hoi polloi* (the common man), certainly not suitable for women, and entirely too sophisticated for young men. But we cling firmly to the belief that knowing what is right will lead to right conduct. At least if this connection doesn't hold, we are not to blame since we told them what to do. And if they don't act accordingly, it is on their head. This is the “bad apple” approach to ethics.

We have twenty-five hundred years of work in this tradition—in the oriental, occidental, and aboriginal cultures. The evidence of success has not been piling up at anything like a notable rate. In the second essay, I will insinuate that our slow progress is at least partially due to having taken the wrong road. In the mean time, the path to understanding moral conduct seems to pass through the ethics wing

DOOR #1: PERSONAL AND UNIVERSAL ORIENTATIONS TOWARD ETHICS

A general assumption behind the first three doors to dental ethics is that there is a perspective or orientation that constitutes the moral high ground. There are better and worse ways to look at ethical situations, and those who have already achieved the superior position have a duty to help the others up. Those with substantial experience in teaching ethics realize that there are alternative orientations that seem to work as well as others, and they generally offer one or a combination of such orientations as approaches that might be considered. The situation resembles, to a certain extent, the practice of optometrists prescribing various lenses to patients based on what makes the view clear for the prescriber.

The clear voice of leaders, the dignity of due process, and the oft-repeated stories of the hero who did it “because it was the right thing to do” celebrate high standards and create professional expectations.

NORMATIVE PRINCIPLES OF ETHICS (THE “GEORGETOWN MANTRA”)

Autonomy is the right of a competent individual to choose free from coercion. Informed consent is the quintessential example of autonomy in dentistry. Many feel autonomy applies to dentists as well as to patients and to relations to insurance companies or the freedom to decline care to a patient if the dentist believes it is not in the patient's best interests (hence would damage the dentist's and the profession's reputation).

Justice is the fair distribution of resources. Who gets into dental schools, access to care, and fair quality for price paid are issues of justice. Several dental schools, most notably those which religious affiliations specifically recognize, have the principle of justice in their mission statements.

Veracity is telling the truth, or more properly, acting so as to justify continued trust. (Remaining silent when one should speak out—as when gross or continuous negligence in a colleague's work is recognized—is not lying, but it is an example of a breach of veracity. By far the majority of items in the ADA Code speak to veracity.

Benevolence is an obligation to do good. Associations with beneficent individuals leave others better for the interaction. [ADA example] It is sometimes stated that society grants a monopoly to professions in exchange for members of the profession benefiting others. That would certainly not be an ethical argument; it is a straightforward business deal. One might just as well argue that patients have an ethical obligation to benefit dentists by paying their fees.

Nonmalevolence is an obligation to avoid harm. Although similar in appearance to benevolence, the constructs are logically separate. An ethical person must be both—we cannot choose which we would like to emphasize in a particular situation. [ADA] It is often incorrectly stated that the Hippocratic Oath contains the admonition *primum non nocere* (Latin for “first, do no harm”). The Oath appears in a side bar, and readers can satisfy themselves that the phrase does not appear. Rather, there are two instances (one general and one specific) where both benevolence (first) and then nonmalevolence are enjoined on the professional.

NORMATIVE PRINCIPLES

This is the most common approach to grounding dentistry in ethics. The leading notion is that appropriate behavior can be deduced from a small set of general principles. Other things being equal, the world would be better to the extent that individuals act in ways that conform to such principles. For example, patients' health history information should not be revealed publicly or patients' oral health should not be worse when they leave the dentist than it was when they come. Both of these points have been codified in law, but each is also an example of a normative ethical principle (autonomy and non-malevolence).

The so-called “Georgetown Mantra” contains the four normative principles of autonomy, justice, benevolence, and nonmalevolence; and a fifth (veracity) is commonly groups with the set as well. The ADA Principles of Ethics and Code of Professional Conduct is organized around these principles. For example, 1.A: “Patient Involvement: The dentist should inform the patient of the proposed treatment, and any reasonable alternatives, in a manner that allows the patient to become involved in treatment decisions” (autonomy). In addition to specific examples under each principle, there are advisory opinions in the Code that explain the application of principles in specific situations. Twenty of the twenty-eight advisory opinion concern veracity and address such concerns as dental amalgam, fee determination, marketing, unearned degrees, dentists leaving the practice, and announcement of unrecognized specializations.

It would be surprising to find a dental student or practitioner who does not recognize or would not accept the five normative principles in the Georgetown Mantra as ethical touchstones in dentistry. Most could match the correct principle

or principles to a concrete example in practice after five minutes of explanation, and three minutes is enough to get a conversation started (spelling “non-maleficence” takes longer). In learning to name ethical principles, dentists and future dentists acquire a common language for discussing ethical issues, expand their perspective on the ethical implications of practice, become familiar with some of the tender concerns in the profession, and begin forming a rationale for various actions they may take.

The problem is that being able to name principles is not the same as using them to guide behavior. Questions involving normative principles appear on the National Dental Board Examinations and on “ethics tests” administered by various state licensing jurisdictions, but the word on the street is that dentists exhibit more moral weakness since such testing began. Naming a problem and solving it are distinct matters. This can become an issue of some importance if it is assumed that recognition of normative principles is the sum and substance of ethical training or that the profession has done its duty because it tests for such knowledge.

A second concern with basing ethics on normative principles is their indeterminate relationship to moral action. That is a fancy way of saying that alternative, and even contradictory, actions can be justified by selecting accepted normative principles. Dentist autonomy counsels for selecting only high-income compliant patients; justice argues for greater access. Beneficence can be evoked to justify an implant as the treatment of choice; veracity requires disclosure of the fact that the dentist who makes this recommendation has never done one like this before, while patient autonomy seems to leave an out for the patient to go with a flipper.

The problem of indeterminate relations between principles and actions is deeply rooted in philosophy (not

EXAMPLE OF AN ETHICS TEACHING DILEMMA: HEINZ

In Europe a woman was near death from a special kind of cancer. There was one drug that doctors thought might save her. It was a form of radium that a druggist in the same town had recently discovered. The drug was expensive to make, but the druggist was charging ten times what the drug cost to make. He paid \$200 for the radium and charged \$2,000 for a small dose of the drug. The sick woman's husband, Heinz, went to everyone he knew to borrow the money, but he could only get together about \$1,000, which is half of what it cost. He told the druggist that his wife was dying, and asked him to sell it cheaper or let him pay later. But the druggist said, “No, I discovered the drug and I'm going to make money from it.” So Heinz got desperate and began to think about breaking into the man's store to steal the drug for his wife.

dentistry); there is no way around it. But the tradition in teaching ethics has been to exaggerate the problem by placing the use of dilemma in the central role in ethics education. Dilemma (literally, two assumptions) are specific cases designed to evoke a conflict within an individual because contradictory courses of action are justifiable based on principles the individual holds. They are instances of built-in ethical conflict in principles. (Note that ethical conflict—situations where different individuals hold differing principles—is generally avoided in ethics education.) Further messiness is supplied because teaching dilemma are hypothetical (rather than real) simulations (rather than concrete) descriptions that allow great flexibility in interpretation independent of ethical matters. Having used cases for teaching, I regularly encounter the protective hypothetical stance that begins “He should” rather than the personally responsible one of “I would...”

The dilemma of Heinz is perhaps the most famous in ethics education. It appears in an accompanying side bar. Readers are invited to spend a few minutes analyzing Heinz. Notice that all five normative principles can be

The problem is that being able to name principles is not necessarily the same as using them to guide behavior.


But we cling firmly to the belief that knowing what is right will lead to right conduct. At least if it doesn't, we are not to blame since we told them what to do.

identified and that they justify contradictory courses of action. Note as well that the dilemma changes as the reader assumes the role of different individuals in the case. The case can be dramatically altered by adding one or two assumptions (facts the analyst may not have been aware of). There are no solutions to the Heinz dilemma. Those who teach with dilemma assume that students learn depth of analysis and the capacity to understand multiple ethical perspectives by working with such cases. Some people who teach ethics like to use dilemma because there are so many right answers.

DUTY ETHICS

The technical name for this orientation, also an example of normative universals or "should" language, is deontological ethics. The quest is to ground behavior in some principle that applies equally to all. There have been attempts to survey diverse cultures in hopes of finding standards that apply in all situations for all people. So far, we can come close with taboos against incest and reciprocity, but there always seem to be exceptions.

The most famous approach along these lines is Immanuel Kant's categorical imperative: "Act only on that maxim which you can at the same time will that it should become a universal law." This is sometimes characterized as the Golden Rule. I have heard some dentists say, "Treat all patients as though they were members of your family." (Kant intended his principle to be categorical, meaning that it always applies for everyone, regardless of the situation. The feeble opposite of categorical is *prima facie* ethical standards. These are rules or rights that always and everywhere apply unless one can think of something else that might be better.)

There is much to like about this approach. One rule and you get to be the ultimate standard of ethical behavior. Kant was a harmless academic raised in a Pietistic German family in the last half of the eighteenth century. For the most part, one could do worse than living by his rules. But what about the dentist whose personal values place aesthetics above function, or vice versa? Is that really the universal standard for dental care? Could we let a well-meaning sociopath use the categorical imperative to disrupt society? Whenever a single individual sets himself or herself up as the standard for ethics, we run up against paternalism or often worse. Saying that others are welcome to play by those rules does not help much. Being forced into a position of having to decide what is right for others should be resisted. What is easy is not the same thing as what is right. (Look again at ADA Code statement 1.A. and ask whether allowing patients to "participate" in treatment decisions captures the full meaning of autonomy.) When two paternalistic people get into an argument, ethics is usually **shot** as an innocent bystander within the first few minutes. 

Kant recognized the untenability of his categorical imperative and retracted it (although the announcement hasn't gotten around much to philosophers and practitioners yet). His reformulation states: "Act so that you always use humanity, in your own person as well as in the person of every other, never merely as a means, but at the same time as an end." This is a powerful version of the normative principle of autonomy.

RIGHTS LANGUAGE

On rare occasions, dentists encounter orientations to ethics that are couched in "rights" language. "All Americans have a right to oral health" is a public policy version of this position. "Everyone deserves a bright smile" is an advertising

slogan that has pretty much the same status. A right is something one is due by virtue of who they are, not how they behave. Civil rights are due citizens, but not aliens. Parental rights concern relationships with children. Human rights are due all. Rights imply corresponding obligations on someone else's part to supply these rights.

Most rights are negative—freedom from religious oppression, freedom of speech, etc. There are very few positive rights—none pop into my mind at present. Rights cannot be surrendered or sold. Discussions on these themes are often frustrating because rights are self-evident to those who want them and just as obviously inapplicable to those who oppose them, and rhetoric builds very rapidly while reasoning dives for cover.

There is no professional ethicist in medicine or dentistry who holds that health care or oral health is a right. (Some policy makers do hold these views, but the conversation tends to skirt the corollary obligation that someone has to pay for these rights.) Often the introduction of rights in debates about ethics signals that an impasse has been reached in an ethical conflict and there is nothing left to say except “I want it; it's my right.”

DOOR #2: CHARACTER ETHICS

Perhaps it is wrong (it is certainly unclear) to seek to base ethics on universal principles. Perhaps ethics is something more personal. Perhaps ethics is essentially grounded in the way ethical people behave. The approach that ties ethics to personal habits of behavior is called character ethics. Three common forms will be considered: 1) virtue ethics, 2) aspirational ethics, and 3) care ethics.

VIRTUE

Among the oldest conceptions of ethics are those based on the nature of people, or gods, thought to embody the good. The Taoists and Confucians of China emphasized perfecting the soul of the “good man” or prince, a legacy further developed in Buddhism. The Judeo-Christian tradition places great emphasis on right action and development of talents. In the Sermon on the Mount, Christ admonishes his hearers to “be perfect, even as your father which is in heaven.” The word “perfect” is the Greek term *telos*, which means one's inborn nature. Christians are called to fulfill the purpose for which they were created—not have straight teeth. But virtue ethics is most strongly associated with the Greek philosopher Aristotle and his *Nicomachean Ethics*. (Nicomachus was Aristotle's bastard son who, authorities believe, compiled his father's notes on the subject.)

The work of character development is to perfect right patterns of conduct to the point where they become human nature. As we build character, it is increasingly likely that our actions will be ethical. In former times the actions of a “gentleman,” a “knight of chivalry,” a “saint,” or perhaps a “professional,” sprang from deep traits that defined who one was and what one's place was in life. A gentleman's veracity was never in question (unless one was prepared to duel) and it was assumed that one lived to advance noble causes rather than make big bucks. The concept is a bit strange to modern ears since we are more accustomed to the superficial notion of “personality,” and its veneer-thin portrayal in the pop media. The modern word “integrity” comes close to the meaning or virtue in its double sense of honesty and harmonious wholeness. Virtue ethics emphasizes moral education and patterning one's life after

worthy examples. It also places weight on public appearance in general; one's reputation matters. Virtuous people will do the right thing.

As charming as this notion seems, the flaws are easy to discover. We only know which of the dueling gentleman was killed; we don't know which the virtuous one was. When are religious wars just and denominational squabbles proper? Who is to decide among them—lawyers? It is becoming nearly impossible these days to distinguish between a virtuous individual and a self-promoting humbug. Of course, history will always reveal the truth, but most of us can't wait that long. Aristotle's syllogism, “Virtuous men act ethically; Nicomachus is virtuous; therefore Nicomachus acts ethically,” seems to be unclear with regard to which is the major premise. I would rather have it that “Individuals who act ethically are virtuous; Nicomachus acts ethically, therefore Nicomachus is virtuous.” But, I confess, there is no independent way to verify the major premise in either syllogism. And it has already been noted that virtue was reserved as a possibility for only a tiny minority of well-born men. We also have this troubling problem that ethical people act ethically out of habit and that one becomes virtuous by first acting ethically to build habit.

Virtue ethics fares poorly in a pluralistic world. There are perspectives from which the Ayatollah Khomeini was virtuous, or Mao, or Malcolm X. What is even more troublesome is the research evidence that we are not of a piece in our moral behavior. Classical studies by



ASPIRATIONAL STATEMENTS OF THE CORE VALUES OF THE AMERICAN COLLEGE OF DENTISTS

The central aspiration of the American College of Dentists is that all members practice their profession in an ethical manner. The American College of Dentists identifies the following as aspirational statements of the core values: (stated in alphabetical order)

Autonomy: A Fellow of the ACD recognizes the dignity and intrinsic worth of individuals and their right to make personal choices.

Beneficence: A Fellow of the ACD acts in the best interests of patients and society, even when there is conflict with the dentist's personal self-interest.

Compassion: A Fellow of the ACD is sensitive to, and empathizes with, individual and societal needs for comfort and help.

Competence: A Fellow of the ACD strives to achieve the highest level of knowledge, skill, and ability within his or her capacity.

Integrity: A Fellow of the ACD incorporates the core values as the basis for ethical practice and the foundation for honorable character.

Justice: A Fellow of the ACD treats all individuals and groups in a fair and equitable manner and promotes justice in society.

Professionalism: A Fellow of the ACD is committed to involvement in professional endeavors that enhance knowledge, skill, judgment, and intellectual development for the benefit of society.

Tolerance: A Fellow of the ACD respects the rights of individuals to hold disparate views in ethics discourse and dialogue and recognizes these views may arise from diverse personal, ethnic, or cultural norms.

Veracity: A Fellow of the ACD values truthfulness as the basis for trust in personal and professional relationships.

Hartshorne and May in the 1930s demonstrate that individuals behave morally in one area and questionably in others at the same time. For example, we may be circumspect in our reputation for honesty but not stumble over scruples when it comes to income taxes or up-coding insurance claims. Certainly Aristotle had a different understanding regarding wedlock than is held high today.

I work hard to develop my integrity, character, and reputation and I certainly hope you do as well. But I can't break

free of the doubts that some people are on the wrong track in their virtue development and that parts of my development are lagging way behind others and I am thus a fraud when taken only at my best.

ASPIRATIONAL CODES

The ADA Code is based on normative principles; the Ethics Code of the American College of Dentists is based on character ethics. It is aspirational in the sense of identifying characteristics of dentists that Fellows are expected to continuously strive to develop. These aspirational values are presented in the side bar.

The function of aspirational codes is slightly different from the role of normative principles. Core virtues may be touchstones for choosing actions in specific situations, as normative principles are. They are also intended as useful daily exercises for becoming a better dentist. In this sense they resemble the queries used by Quakers in their religious life. On a regular basis, the aspirational values of the College should be reviewed and one should ask, "Is there anything I need to be doing today to bring me closer to this ideal?" If the answer is yes, there is an obligation to take appropriate action.

CARE ETHICS

A modern form of character ethics is the notion that just behavior requires an authentic bond between those involved in ethical actions. Those who hold this view would be concerned in a special way over sound advice from a physician to the caregivers of an invalid who is, for example, a Christian Scientist. An advocate of care ethics would be troubled by efforts to improve the oral health of indigenous Alaskans that did not place their values on an equal footing with the values of the care givers, the corporations that are paying for the care, and socially

conscious advocacy groups that have no direct role in the care. One cannot care for someone we do not understand and who has not given us permission to do so.

Care ethics is most clearly associated with Carol Gilligan, a Harvard School of Education professor who gained fame for attacking, not prevailing ethical theories, but those people who were putting them forward. Her argument goes something like this: Ethical theories have been of limited value because they were mostly developed by dead white men. What do they know of the world I live in? We need to build new theories of ethics that are inclusive of those who are expected to participate in them.

While there is much that is fresh and right about Gilligan's approach, we should recognize that a valid approach to the good cannot be built on attacking others—no matter how valid the attack may be. Gilligan has been subsequently challenged by African-American women who wonder how she (Gilligan, a white woman) can presume to speak for all women. And that has been followed by the voice from the rural, the poor, and others in a dandy reduction ad absurdum.

There is something very grating to me about care ethics, its sister "feminist ethics," and the whole family of writing that is called "critical theory." In critical theory, one assumes that all pronouncements, including ethical ones, come from a specific position. Those who are allowed to speak, especially those who speak officially, enjoy the power of privileged position. Honest discussion can only be achieved by equalizing or neutralizing the power that hides behind institutions and public media. On this view, I start all ethical discussion in a one-down defensive position just because I am an old, white guy. I can't do anything about that, but I don't want who I

am to predetermine what I can say about ethics any more than I intend to prejudice others because of who they are. Saying that my intentions are beside the point because my prejudices are subconscious, as some critical theorists do, is pretty much of a conversation stopper. Nor do I want to pretend I am not who I am (the technical term is "bracket") as a precondition for having a conversation about what is good in dentistry. And those who know me say it would be useless to attempt that one.

DOOR #3: CONSEQUENTIAL ETHICS

We have tried to find a firm place to take our ethical stance based on good intentions and based on who is taking the stand. But the ground is still shaky. Perhaps the right approach is to look to the outcomes of actions to determine whether they are ethical.

UTILITARIANISM

Plato was first with the idea that the public good is a useful guide to ethics. In the Republic, a fifth century BC utopia, he declared "Our aim in founding the state is not the disproportionate happiness of any one class, but the greatest happiness of the whole." The early eighteenth century Scottish philosopher Francis Hutcheson revived the notion and passed it on to the Englishmen, Jeremy Bentham and John Steward Mill who worked out the details in the modern scheme known as utilitarianism. The idea is something like our monetary system, but instead of cash, we maximize "utils," imaginary units of utility or happiness. The right thing to do is behave in such a fashion that the sum of utility, taken across an entire group, is maximized—the greatest good for the greatest number. If we didn't count the dentist, utilitarian thinking would point toward fillings and simple prostheses on many poor people rather than large

cosmetic cases for a few. Prevention makes much more sense ethically than it does economically.

In practice, the utilitarian approach is a helpful heuristic in approaching ethical problems. (Heuristics are general techniques that often advance the issue without guaranteeing an optimal solution.) Ethicists of this persuasion ask questions like, "Let me make certain I understand all who are involved in or affected by this decision; let me know what their interests are and what they stand to gain or lose; let us generate alternatives that satisfy many of these concerns." It often happens that there is a course of action that is mutually satisfactory, even though it does not maximize the benefits to one party or another. When that is not the case, at least all the cards are face up.

The problems with this approach have been known for centuries. First off, we are very inexact at the calculation of "utils." There are too many involved, they are poorly defined, they don't stay put (one minute a man is satisfied, the next he is hungry). Often we let the free market or the political system stand in for us in doing this messy work or sorting out whose interests count. We also are notoriously biased in comparing others' values with our own. Voltaire is supposed to have noted that one of the easiest pains in the world to put up with is someone else's toothache. Further, there is the issue of whether everyone's utilities should count, or should count

It is wrong-headed to assume we should give up on ethics because we have no prospect of getting it perfect. Some principles are better than others and most are better than none.

equally. Is it fair, for example, to care for patients who neglect their oral condition at the same level as those who are dedicated to it? Do we really want to count psychopaths and prostitutes into the equation for determining the greatest good, let alone politicians? At the same time, as a nation we have clearly stated that some folk's utilities count more than others because there are protected groups who can sue for discrimination while others are denied access to the courts for the same purposes because they are not protected. Affirmative action is an example of double-counting in totaling up the greatest good.

THE SOCIAL GOOD

Sometimes the rhetoric over rights is really meant to be a debate concerning social benefits. Many philosophers and writers on public health policy, and the recent *Surgeon General's Report* in particular, hold that oral health is a social good. Societies that invest in oral health reap benefits such as fewer days of school or work lost to poor oral health. As a social good, oral health competes with education, security, publicly funded pro football stadiums, and other distributions of the common good. The consequences of pro-health behavior are favorable generally, and they can often be used as an ethical loadstone.

WHAT HAVE WE FOUND?

We have opened three of the six doors to ethics, the three in the section of the building labeled ethical theory. What we have found as we look into each room is either somebody else telling us what we should do or a reflection of ourselves as the standard for all ethics. Sometimes these individual preferences are intended to be passed off as universal truths, but they don't seem up to doing that work on anything like a regular basis. There is a lot of wobble in the system, with some principles or standards serving as rationale for inconsistent or even contradictory behaviors. There are enough theories to keep us engaged in debate for another two and a half millennia with no hope of reaching agreement on either theory or action. Look on the bright side: guaranteed employment for philosophers and inexhaustible topics for editorials!

This is an appeal for more work and not a council of despair. It is wrong-headed to assume we should give up on ethics because we have no prospect of getting it perfect. Some principles are better than others and most are better than none. I would rather lose an argument over what is the best way to precede than to ignore the question. But I much prefer to proceed than to argue.

That points us in the right direction. We must pass to the next section of the building and open the next three doors, since that is where moral action is found. We will do so soon. ■

RECOMMENDED READING



Summaries are available for the three recommended readings marked by asterisks. Each is about eight pages long and conveys both the tone and content of the original source through extensive quotations. These summaries are designed for busy readers who want the essence of these references in 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 generations; a donation of \$50 would bring you summaries for all the 2006 leadership topics.

American College of Dentists

<http://acd.org/acdetethics.htm>

American College of Dentists resources such as *Core Values and Code of Ethics*, *Ethics Handbook*, reports from four Ethics Summits, position paper on Fraud and Quackery, and an online course in ethics. Start here; bookmark it!

American Dental Association *Principles of Ethics and Code of Professional Conduct*

<http://www.ada.org/prof/prac/law/code/index.asp>

American College of Dentists (1996). *Journal of the American College of Dentists*

Volume 63, number 4 of the 1996 *Journal* is devoted to the analysis of issues in managed care from multiple ethical perspectives. The positions represented include: principles, virtue theory, casuistry, rational self-interest, discursive ethics, moral problem solving, and ethical development

Aristotle.

Nicomachean Ethics.*

From *Wheelwright's Aristotle*.
New York: The Odyssey Press.

Ethics is identified with the character of virtuous men, very narrowly defined as a small elite who have been endowed with gifts from the gods and trained themselves through right living to the point where good conduct is a habit. The aim in life is happiness, characterized as virtuous living (not pleasure), and its highest form is intellectual contemplation and its highest expression is politics.

Foucault, Michel (1973).

The Birth of the Clinic: An Archaeology of Medical Perception.*

A. M. S. Smith (Trans.). New York: Vintage Books. ISBN-679-75334-6; 215 pages; about \$10.

Traces the origins of modern medicine to the end of eighteenth century when physicians first connected what was given to perception to its underlying foundations. Foucault is a leading expo-

nent of critical theory, the belief that all statements of what is or ought to be are confounded by the position and privilege of the speaker. For authentic dialogue to begin, the privilege of perspective must be bracketed off—a mysterious process that is certainly political in its own right.

Kane, Robert (1994).

Through the Moral Maze: Searching for Absolute Values in a Pluralistic World.*

New York: Paragon House. ISBN: 1-55778-601-1; 249 pages; cost unknown.

This philosophy professor from Texas attempts to escape relativism through noting that individuals aspire to objective worth—value as ends, not means, from any perspective. The concept of the moral sphere, the realm where people are treated as ends, is a useful suggestion. A guide to ethical behavior is to attempt to preserve the moral sphere, and action (the least necessary) can be taken against any who damage it.

Ozar, David T. & Sokol, David J. (1994).

Dental Ethics at Chairside: Professional Principles and Practical Applications.

Washington, DC: Georgetown University Press.

This is widely regarded as the standard reference text for dental ethics. It is practical and eclectic and covers such topics as approaches to ethics, professionalism, codes, relations between patients and professionals, central values in practice, ethical decision making, bad outcomes, social justice, and patients with special relationships arising from their needs and status. There are numerous cases.

2006 MANUSCRIPT REVIEW PROCESS

Four unsolicited manuscripts were considered for possible publication in the *Journal of the American College of Dentistry* during 2006. One manuscript was returned to its author as being inappropriate in topic or format for the journal. All three of those sent for review were accepted for publication. Nine of the eleven reviews reviewed were favorable and two were noncommittal.

The Editor is aware of seven requests to reprint articles appearing in the journal and six requests to copy articles for educational use received and granted during the year. There were four requests for summaries of recommended reading associated with Leadership Essays.

In collaboration with the American Association of Dental Editors, the College sponsors a prize for a publication in any format presented in an AADE journal that promotes excellence, ethics, and professionalism in dentistry. Twelve manuscripts were nominated for consideration. The winner was a set of personal reports on sliding into and then recovery from substance dependency, written by Dr. Peter Cannon and appearing in *Northwest Dentistry Magazine*, entitled "When the walls came tumbling down." Sixteen judges participated in the review

process. Their names are listed among the *Journal* reviewers below. The Cronbach alpha for consistency among the judges was an extremely high .939.

The College thanks the following professionals for their contributions, sometimes multiple efforts, to the dental literature as reviewers for the *Journal of the American College of Dentists* during 2006.

Norman Becker, DMD
Shirley, MA

Howard Bookman, DDS
Londonderry, NH

Marcia A. Boyd, DDS, FACD
Vancouver, BC

D. Gregory Chadwick, DDS, FACD
Charlotte, NC

James R. Cole, II, DDS, FACD
Albuquerque, NM

Bruce Corsino, PhD
Reston, VA

Eric Curtis, DDS, FACD
Safford, AZ

Caswell A. Evans, DDS
Chicago, IL

Geraldine M. Ferris, DDS, FACD
Winter Park, FL

Kent W. Fletcher
Alsip, IL

Lawrence Garetto, PhD, MS, FACD
Indianapolis, IN

Steven A. Gold, DDS
Santa Monica, CA

Frank C. Grammer, DDS, PhD, FACD
Springdale, AR

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

Larry Jensen, DDS
San Francisco, CA

Michael Maihofer, DDS
Roseville, MI

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

Mary McNally, DDS, FACD
Halifax, NS

Detlef B. Moore
Milwaukee, WI

Laura Neumann, DDS
Chicago, IL

Dr. John O. Keefe, DDS, FACD
Ottawa, ON

Steve Ralls, DDS, FACD
Gaithersburg, MD

Harriet F. Seldin, DDS, FACD
Encinitas, CA

Thomas J. Wickliffe, DDS, FACD
Billings, MT

Pamala Zarkowski, JD, FACD
Detroit, MI

2006 ARTICLE INDEX

JOURNAL OF THE AMERICAN COLLEGE OF DENTISTS, 2006, VOLUME 73

EDITORIALS

- Commercialism in Dentistry and Its VictimsNumber 1, page 2
David W. Chambers
- Cornpone.....Number 2, page 2
David W. Chambers
- How Thornless Blackberries Got Big FruitNumber 3, page 2
David W. Chambers
- TV and DentistryNumber 4, page 2
David W. Chambers
- Letters [*R. D. Berringer, R. J. Gherardi, R. Ivan Lugo*].....Number 1, page 4
- Letters [*L. J. Singer, F. Catalanotto, Kenneth D. Jones*].....Number 2, page 4

COLLEGE MATTERS

- Continuing the Journey to Excellence [President-elect's address]Number 4, page 4
H. Raymond Klein
- Professional Regulation—Who Decides? [Convocation address]Number 4, page 7
Dame Margaret Seward
- ACD Awards, 2006Number 4, page 10
- Manuscript Review Process, 2006.....Number 4, page 48
- Fellowship Class, 2006.....Number 4, page 14

THEME PAPERS

- Articaine and Paresthesia: Epidemiological StudiesNumber 3, page 5
Daniel A. Haas
- Challenges to the Introduction of New Technology to Dental PracticeNumber 2, page 21
Michael L. Barnett
- The Chicken-Little SyndromeNumber 3, page 25
Ronald S. Brown
- Clinical Trials and Oral Care R&DNumber 2, page 26
Robert W. Gerlach
- The Dental Enterprise: Its Transition from Xenodontic to Biodontic Dentistry.....Number 2, page 32
Edward F. Rossomando

THEME PAPERS, CONTINUED

- Development of the Curvex Toothbrush.....Number 2, page 18
Stephen D. Harada
- The Ethics of Adopting a New Drug: Articaine as an ExampleNumber 3, page 11
Bruce Peltier & James S. Dower, Jr.
- From the Laboratory to the Operatory.....Number 2, page 10
Linda C. Niessen
- Growing Pains in Paradise: Arizona's Boom.....Number 4, page 22
Rick Murray
- Is This Idea Worth Anything? Mechanics of Technology TransferNumber 2, page 14
J. Max Goodson
- A Look Inside the Texas Dental AssociationNumber 4, page 28
Mary Kay Linn
- Making Dentistry Effective at the State Level: South Carolina.....Number 4, page 18
Philip E. Smith
- Montana's Regional Initiatives in Dental Education (RIDE)Number 4, page 25
Mary K. McCue

PAPERS OF THE COLLEGE

- Organizational Meeting.....Number 1, page 6
- Early Statement of Purposepage 12
- Commission on Journalism.....page 14
- Reporting Policy through JACDpage 18
- The Mace and Torch.....page 22
- A Tribute to William J. Giespage 25
- Research Institutepage 27
- Survey of Dental Students.....page 29
- Selection of Local Anesthetics in Dentistry: Clinical Impression versus Scientific Assessment.....Number 3, page 21
Arthur J. Jeske & Patricia L. Blanton
- Size and Perspective in AlaskaNumber 4, page 30
Jim Towle

MANUSCRIPTS

- Adult Patient Visits to Physicians for Dental ProblemsNumber 2, page 47
Leonard A. Cohen & P. Ann Cotten
- Commercialization of Dental Education: Have We Gone Too Far?.....Number 3, page 30
Peter M. Spalding & Richard E. Bradley
- The Good Name [Forum].....Number 2, page 7
Steven Chan
- I Had to Be an American Woman Activist.....Number 3, page 4
Cecelia L. Dows

ISSUES IN DENTAL ETHICS

- Ethics and Professionalism: The Past, Present, and Future.....Number 1, page 42
Henry Chalfin
- Ethical Reflection in Dentistry: First Steps at the Faculty of Dental Surgery of Toulouse.....Number 3, page 36
Olivier Hamel, Christine Marchal, Michel Sixou, & Christian Hervé
- Using an Ethics Across the Curriculum Strategy in Dental Curriculum.....Number 4, page 33
Lawrence P. Garetto & Wendy E. Senour
- Why Our Ethics Curricula Don't Work [Journalism Prize Winner].....Number 2, page 35
Charles N. Bertolami

LEADERSHIP ESSAY

- Friendly Competition.....Number 3, page 40
David W. Chambers
- Mentoring.....Number 2, page 53
David W. Chambers
- Performance.....Number 1, page 48
David W. Chambers
- A Primer on Dental Ethics: Part I—Knowing about Ethics.....Number 4, page 38
David W. Chambers



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