Our Second Century of Service Begins
Communication Policy

It is the communication policy of the American College of Dentists to identify and place before the fellows, the profession, and other parties of interest those issues that affect dentistry and oral health. The goal is to stimulate this community to remain informed, inquire actively, and participate in the formation of public policy and personal leadership to advance the purpose and objectives of the college. The college is not a political organization and does not intentionally promote specific views at the expense of others. The positions and opinions expressed in college publications 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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Our Second Century of Service Begins
Over the past one hundred years the American College of Dentists has leveraged every available technology in our ongoing efforts to communicate with the dental workforce community in our efforts to advance excellence, ethics, leadership and professionalism. From telegraph to telephone to television to electronic mail and podcasts, we have adopted and adapted to emerging technologies. Essential to our communication efforts has been the quarterly publication of the Journal of the American College of Dentists (JACD). The JACD is one of the oldest peer-reviewed dental journals. The JACD is a scholarly publication presenting proactive and informative perspectives on issues affecting the dental profession and society, together with enlightening features on areas such as leadership, ethics, governmental and private agencies, policy development, the American College of Dentists, and professional history. The journal has been continuously published since 1934 and its first editor was Dr. William John Gies. To fully understand the necessity for publishing this type of journal, one needs to look back at the issues that led to the founding of the American College of Dentists in the last century.
The decade of 1909 to 1919 marked the dawn of dentistry’s renaissance. A surge of interest brought concerted action by selected stakeholders while schools and examining boards helped guide dentistry to broader recognition as a profession. This era brought the advent of the focal infection theory under the prevailing influence of Drs. Mayo, Osler, Hunter, and other noted physicians and educators who held a broader interest in the biological phase of dental procedures. The Dental Educational Council of America also gained traction, ultimately with an initial classification of the dental schools. In short, dentistry was emerging as a learned profession with all of the rights and responsibilities of this new status. The profession needed a publication to reliably capture the evolution of the profession. Existing publications of the time, with rare exception, were largely trade journals that lacked scientific merit. Into this backdrop entered Dr. William John Gies and he is justifiably credited as guiding dentistry’s emergence as a profession. More than most, he understood the basic tenets of professionalism and of advanced study. There have been eight editors since Dr. Gies. For the better part of three decades, Dr. David W. Chambers has served in this role.

Dr. Chambers was appointed Editor of the College in 1994, changing the mission of the Journal of the American College of Dentists to “identify and place before the Fellows, the profession, and other parties of interest those issues that affect dentistry and oral health.” Moreover, he substantially enhanced the format and readability of the journal. This publication is now regarded as one of the most respected journals addressing essential issues in dentistry. Dr. Chambers has the distinction as the longest-serving Editor of the College and for more than twenty-five years he has defined the role of the American College of Dentists as the conscience of dentistry.

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For the past several years, he has challenged us to broaden our communication strategy and provide for more two-way dialogue. He has championed a role for a communications director to enhance our communication efforts. He insists that we cannot rely on the last century’s style of communication for the next century’s issues. We must communicate differently and far more effectively and efficiently. As Dr. Chambers frequently reminds us “listening is often a neglected aspect of communication” and approaches to communication that provide opportunities for interpersonal interaction are far more likely to yield desired behavior change. Furthermore, we recognize that thoughtful strategic communication is essential to critical thinking, complex problem solving and social responsibility. In short, our Fellows, should be part of establishing an environment that is conducive to delivering effective communication activities. Dr. Chambers championed the role for a communications director. Upon the announcement of his planned retirement, the leadership of the College sought to acquire the talents of a Director of Communications.
The American College of Dentists Welcomes its First Director of Communications

Nanette Elster JD, MPH, FACP

A position description was drafted and widely circulated. A list of highly qualified candidates was prepared and after thorough vetting, the field was predictably narrowed. When inquiries were made at leading national and international ethics organizations, the name most often repeated was Nanette Elster, JD, MPH, which comes as no surprise to anyone who knows her. Nanette is a phenomenon and widely lauded in the discipline of health care ethics and health care advocacy.

Ms. Elster is an associate professor at the Neiswanger Institute for Bioethics and Health Policy, Loyola University Chicago Stritch School of Medicine. She has extensive experience in legal, public health and ethical issues related to women’s and children’s health. She has spoken nationally and internationally and is the author of numerous articles on the legal, health policy and ethical implications of a range of public health issues. She has appeared on such media staples as CNN, Good Morning America, the Today Show, NPR and Chicago Tonight.

Nanette served as the chair of the Special Committee on Bioethics and the Law for the American Bar Association. She is the legal consultant to the Committee on Bioethics for the American Academy of Pediatrics. She is the Manager of Ethics Outreach for the Council on Ethics, Bylaws and Judicial Affairs of the American Dental Association. She was elected in 2016 to serve on the executive board of the Association for Practical and Professional Ethics. In 2020, she was elected to a two-year term as board member of the Academy for Professionalism in Health Care (APHC).

Nanette was already well known and revered in the College. In 2017, she received an honorary fellowship to the American College of Dentists. This is bestowed on individuals who do not hold a dental degree but have significantly advanced the profession of oral health and have shown exceptional leadership in areas such as education, research, public health, administration, public service, or related fields of health care.

On October 1, 2020, The American College of Dentists acquired the extraordinary talents of Ms. Nanette Elster as the Director of Communications. Working in concert with the Executive Office, she began to develop her team as well as her communication plan for our second century. In 2021, the JACD will convert to a fully digital format and will be rebranded as the eJACD.

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What are your plans for the eJACD as we turn the page to our next century of service to the profession and the public we serve?

The new digital version of the JACD is symbolic of the shift to the next century. I plan to have the eJACD serve as an information point, a discussion point, and a point of innovation. I want to carry on the wonderful examples set by Dave Chambers. What will change is the expansiveness of viewpoints (age, gender, years of practice, location of practice, other professions) to better reflect the oral health care profession in this next century. Leadership, professionalism and ethics are pillars across health care professions and therefore looking at dentistry in this larger context will be something we strive for.

Do you plan to experiment with the format?

I do plan to experiment with the format. This, however, will require an engaged readership. We will want to know from our readers what is working and what is not. All issues of the eJACD will include academic peer reviewed articles, some issues will be theme-based, some will be in conjunction with other organizations, some may be guest-edited. We will also experiment with new features such as an ethics case discussion, profiles in professionalism—featuring a Fellow of the College, and book/film/television reviews.

How is communication different in this knowledge-based economy of this century?

Communication has changed dramatically. Attention spans are shorter, more information is available, un-vetted information abounds, and the flow of information moves very rapidly. In the new e-format JACD will have more agility and adaptability to meet these changes.

Who do you want to hear from?

I want to hear from a broad readership: fellows of the ACD, students, public health professionals, ethicists, new practitioners and seasoned practitioners. All feedback, positive and negative will be welcome. The eJACD should be a place for thoughtful dialogue and the exploration of a range of viewpoints.

How will you measure success with regard to communication strategy?

Success will be measured in many ways: reader feedback, number of new readers, engagement of existing readers, numbers of submitted articles, requests to guest edit, and when/where articles might be cited elsewhere.

Who do you consider to be great communicators and why?

A great communicator, to me, is clear, open to challenge, engages respectfully even amidst disagreement, and can make the complex seem straightforward without talking down to their audience. I can think of many who exemplify these traits but a few stand outs for me are: Socrates, Barack Obama and Ruth Bader Ginsburg.

The American College of Dentists welcomes Nanette to the family in the role as Director of Communications. We are truly delighted to have her join our team and we are confident that she will bring her unique style and enormous talents to the effort. Communication must be reimagined for the 21st century, and Nanette is committed to delivering on that promise. She contends that by truly listening we learn and, in doing so, we strengthen our ability to build not only an inclusive culture but also enhanced communication. It is famously reported that communication is the real work of leadership and as our second century of service begins, we will explore novel new ways to facilitate the conversations and lead from the front.

The 21st century will continue to be distinguished by new innovations designed to enhance information fluency and an increased dependency on technology. Thanks to this format, information can be delivered in an efficient way which really improves the usability and the end-user experience. In addition, live streaming options will give authors the ability to communicate with their readers directly.

Over the holidays, I had the opportunity to engage with Nanette regarding her plans for the journal as well as her plans for communicating with our Fellows and friends of the American College of Dentists’ Family. Her responses to the posed questions are revealed below.
In 2019, much of the attention of the American College of Dentists was focused on the upcoming celebration of its centennial anniversary. However, two months into 2020, that attention was justifiably diverted to another historic event – one with a much broader impact and dire consequences. Yes, as we prepared to execute the festivities previously planned for the centennial celebration of the ACD, the world was awakening to the emerging threat of a viral pandemic and we entered a period of suspended animation with regard to all planned activities. Shortly thereafter, there was a moratorium placed on all congregate settings to “bend the curve” epidemiologically speaking. Interestingly, in 1920, the year of the founding of the college, the world was living through a similar catastrophe. In 1918, the pandemic flu virus (H1N1) with the unusual characteristic of a high death rate among healthy adults, 15 – 34 years of age, struck with unprecedented vengeance. This so-called “Spanish flu pandemic” proved to be a major disaster in world history; World War I claimed 16 million lives and the 1918 flu claimed 50 million lives affecting over 25% of the US population and over 20% of the world population. A comparable death rate had not been observed prior to this period and has not been observed since, that is until now. The coronavirus (COVID-19) has emerged after 100 years as a new and dangerous infectious disease. What was true in 1918 is apparent today - when a novel and virulent pathogen is unleashed on an unprotected citizenry the result is predictably catastrophic. Today, in the United States alone, 28 million Americans have contracted the disease and more than 500,000 have perished. Worldwide trends are also disconcerting and new variants of virus emerge with alarming regularity.

It is said that the difference between a disaster and a catastrophe is the ability to adequately prepare for it. In 1918, a novel virion appeared for which there was no herd immunity, no vaccine and no reliable treatment, save supportive measures and in 2020 we found ourselves in a similar position with all of the attendant sequelae that...
accompanies global pandemics. It seems that over these last 100 years, the history of epidemics/pandemics was of interest only to the historians and as you will see, a small group of dedicated scientists.

As we look back on the 100 year anniversary of the 1918 pandemic, we reflect not only on the deadly nature of that virus but we have the opportunity also to reflect on the landmark work that lead to the discovery, sequencing, and reconstruction of the 1918 pandemic flu virus – “the deadliest flu in modern history.” This virus’ unique severity led researchers for decades to look at “why was the 1918 virus so deadly?”, “where did it originate?” and “what can we do to better prepare for future pandemics?” Fortunately, a preeminent group of researchers had the insatiable desire to answer these questions. Their persistence over the subsequent decades allowed them to: 1) search for the lost 1918 virus, 2) sequence its genome, 3), recreate the virus in a highly safe and regulated laboratory setting at the Centers for Disease Control (CDC) and 4), ultimately unlock its secrets to better prepare for future pandemics.

The historical recounting of these efforts starts with this interesting example of a small ocean-side village in Alaska called Brevig Mission. During the five-day period from November 15 – 20, the 1918 pandemic claimed the lives of 72 of the villagers out of a population of 80 adult inhabitants. This stands as a testament to the deadly legacy of the virus. At the order of the local government, a mass gravesite marked by small white crosses was created on a hill beside the village. This collective sepulcher stood as a grim reminder of the enormity of the loss for this small community. The grave was frozen in permafrost and left untouched until 1951.

That year, Johan Hultin, a 25 year old Swedish microbiologist and PhD student at the University of Iowa recognized the importance for discovering the 1918 virus and set out on an expedition to Brevig Mission in the hopes of finding the virus frozen in time in the preserved remains of the villagers who had succumbed to the virus. He obtained permission to excavate the burial site and 2 days in, came across the body of a little girl still preserved and wearing a blue dress and red ribbons in her hair. Ultimately, he obtained lung tissue from four bodies at the site but transport of the virus back to Iowa proved problematic and Hultin was unable to procure the 1918 virus from this initial effort.

Forty-six years later, in 1997, Hultin had another opportunity to pursue the 1918 virus. He learned from an article in the journal Science that Dr. Jeffrey Taubenberger, a young molecular pathologist working for the Armed Forces Institute of Pathology in Washington, D.C. had successfully extracted RNA of the 1918 virus from lung tissue of a 21-year-old male US service member stationed in South Carolina. The serviceman had been diagnosed with influenza on September 20, 1918 and died 6 days later. A sample of his lung tissue had been collected and preserved for later study. From this tissue, Taubenberger and his colleagues did provide a clearer picture of the pandemic virus but they were not able to discern a complete sequence of the entire 1918 virus genome. There was still much to learn.

After reading Taubenberger’s article, Hultin was inspired once again to recover the 1918 virus. The two men consulted and in 1997, 46 years since Hultin’s first trip to the gravesite, he once again departed for Brevig Mission, obtained permission to excavate the gravesite, hired locals to assist him and began the excavation. After 5 days, he made a remarkable discovery—buried about 7 feet deep was the body of an Inuit woman that Hultin named “Lucy” who likely died in her mid-20’s from the virus. Her lungs were perfectly frozen by the permafrost and this time Hultin was allowed to ship them back to the Armed Forces Institute of Pathology. Ten days later, Hultin received a call – “positive 1918 virus genetic material had indeed been obtained from Lucy’s lung tissue.”

The initial impact of this discovery was first described in a Fall, 1999 paper in the Proceedings of the National Academy of Science entitled “Origin and Evolution of the 1918 ‘Spanish’ influenza virus hemagglutinin gene” by Ann Reid and Hultin. The hemagglutinin (HA) gene of an influenza virus determines the properties of the surface protein which allows an influenza virus to enter and infect an otherwise healthy respiratory tract cell. At the time of Hultin’s second attempt to recover the 1918 virus, Hultin was 72 years old and he paid for his trip at a personal cost of $3200.

In this 1999 study, the authors succeeded in sequencing the full length of the HA gene sequence of the 1918 virus. To do so, it required lung RNA fragments from the 21-year-old Fort Jackson service member, “Lucy” from Brevig Mission, and a third person, a 30-year-old male service member stationed at Camp Lupton, N.Y. This man had been admitted to the hospital on September 23, 1918, and died of acute respiratory failure on September 26, 1918.
The sequencing results of their collective efforts suggest that characteristics of the 1918 virus were more human-like, likely an ancestor or closely related to the earliest influenza virus known to infect mammals. Ultimately, the authors believed the virus likely derived from avian viruses, but were unsure how long the virus may have been adapting in a mammalian host before emerging in pandemic form and that it was likely introduced into mammals shortly before the 1918 pandemic. However, they were unable to find any single feature of this virus that contributed to the pathogen’s virulence. Dr. Reid and her fellow researchers concluded that there were likely multiple genetic factors responsible for the severity of the 1918 virus. From 2001–2005, a series of studies were conducted to establish the genome of the 1918 virus. These studies included the following: 2001, Christopher Basler; 2002, Ann Reid et al; 2004, Ann Reid et al and culminated with the 2005 Taubenberger et al study which completed the decade long process of sequencing the entire genome of the 1918 virus. Research, ingenuity and technology had triumphed.

With the entire genome sequenced and with techniques to reconstruct the 1918 virus as undertaken by doctors at the Mount Sinai School of Medicine in NYC, the process of reconstruction began. The decision to reconstruct the deadliest pandemic flu virus of the 20th century was made with considerable care and attention to safety deciding on the following:

- CDC headquarters in Atlanta would be the location.
- Work would be performed using stringent biosafety and biosecurity precautions and facilities (level 3 – BSL-3) designed to protect the personnel performing the work, the environment, and the community.
- Work on the 1918 virus could not take place alongside work on another virus.
- Only one person would be granted permission, lab access and the daunting responsibility of reconstructing the 1918 virus. That person was Dr. Terrence Tumpey, a highly trained microbiologist.
- Reconstruction was approved by The National Institute of Allergy and Infectious Disease (NIAID) and the National Institutes of Health (NIH).
- Reconstruction work began in the Summer of 2005.
- In July 2005, the complete 1918 virus was reconstructed as labs were ready to study it and unlock its deadly secrets.
- The fully constructed 1918 virus was striking in its ability to quickly replicate, and self-spread in the lungs of infected mice. Four days after infection, the amount of 1918 virus found in the lung tissue of infected mice was 39,000 times higher than that produced by comparison to flu virus.
- The 1918 virus was highly lethal, at least 100 times more lethal. Some mice died in 3 days of infection. The HA gene played a large role in this severity.
- The virus did not cause systemic infection, but rather severe and rapid lung damage – a unique aspect of its severity.
- Ultimately, it was determined that the unique combination of all 8 genes together made this virus exceptionally virulent – “a uniquely deadly product of nature, evolution, and the intermingling of people and animals”.  
- It served as the portent of nature’s ability to produce future pandemics of varying public health concern.
Since 1918, the world has experienced three additional pandemics, 1957, 1968, and 2009 – each less severe than the 1918 pandemic but raising the question of whether a high severity pandemic on the scale of 1918 could occur in modern times. Many experts have thought so and have recommended global preparation for possible pandemics as current preparedness is seen to warrant improvement.\textsuperscript{11,12} Clearly, hindsight suggests that we were insufficiently prepared in 2020 and much attention has been given to this situation.

Fortunately, considerable advancement has been made in health technology, disease surveillance, medicine, drugs and vaccines, medical care, and pandemic planning. Flu vaccines are now produced and updated yearly. And yearly vaccination is recommended for the population at large. Diagnostic tests are available for identifying flu and we now have “rapid molecular assays” to provide flu test results more efficiently and more accurately than in the past. In 1918, these measures were not available – doctors were left with few treatment options other than supportive care. Today, COVID-19 vaccines are available albeit in limited quantities. Vaccine manufacture is being ramped up to meet the demand. Both Pfizer and Moderna report that their vaccines show approximately 95% efficacy at preventing both mild and severe symptoms of COVID-19. This level of efficacy appears to apply across age groups, racial and ethnic groups, and gender, as reported in the Pfizer trial. The Johnson & Johnson one dose vaccine is pending approval.

Additionally, the World Health Organization (WHO) supports a global flu surveillance network that monitors change in seasonal flu viruses as well as the emergence of novel flu viruses. They are supported in this effort by 143 National Influenza Centers, in 114 WHO modern countries. In 2004, CDC expanded its flu surveillance capacity, partnering with 39 countries. In 2008, CDC established the International Reagent Resource (IRR) which considerably enhanced the ability of the global flu surveillance community to track spread of the virus. Since 2010, CDC has used its Influenza Risk Assessment Tool (IRAT) with the development of pre-pandemic vaccines against emergent viruses with the greatest potential to cause a severe pandemic. The Department of Health and Human Services (DHHS) maintains a national pandemic influenza plan, updated in 2017. The CDC has established guidelines for non-pharmaceutical interventions such as school closings and large social gatherings during a pandemic. It has admitted that even with all of the plans and improvements since 1918 a severe pandemic could still be devastating to populations globally. In 1918, the world population was 1.8 billion people; today, 100 years later, the population is 9.6 billion. Likewise, the number of hosts have expanded providing increased opportunities for novel influenza virus to evolve, spread and infect people. And with the mobility of the human population, exotic pathogens find their way around the world.

The best defense against the flu continues to be the flu vaccine, but when it is not well matched to circulating viruses, it can take about 20 – 26 weeks to select and manufacture a new vaccine. Another concern is the inadequate global capacity for mass producing flu vaccines. Also, the majority of countries reporting to the WHO still do not have a national pandemic plan, and in 2016 only one third of countries were in compliance. As recently as 2018, the US and global influenza experts agreed we still faced great challenges to prepare for future flu pandemics and that the major part of the solution is recognizing these challenges and working together with the rest of the world to address them.
Ironically, as we have learned from the study and reconstruction of the 1918 virus, the ability of the virus to change its genome can alter not only the virulence of the virus, but susceptibility of the virus to current therapies. We find ourselves today dealing with a pandemic, the COVID-19 virus, and like our forebears, we are left again with few management and treatment options save supportive care and isolation measures. Our front-line healthcare personnel daily place themselves in grave danger to care for our ailing population. For this sacrifice, they are a population at risk and they are well aware of the risks. Fortunately, we have made great advances in critical care measures such as intensive care, infectious disease support, and the rather routine deployment of mechanical ventilators for those who are experiencing significant respiratory challenges. Regrettably, as dedicated as the healthcare workforce is and as sophisticated as our healthcare delivery system is- we simply do not have enough resources to treat the sheer volume of individuals who may become affected. Many will be hospitalized, some develop long hauler complications and tragically, many will die. As of this writing, there is some encouraging news in battling the pandemic as vaccines are becoming increasingly available. In the United States, an ambitious goal of one million vaccinations a day has been set and we are on glide path to realize that goal.

While we await our turn to access the vaccine, there is much that we can do. We shall be deliberate and disciplined in complying with well-established public health recommendations to limit the spread of the disease. We will shelter in place; we will socially distance and we will maniacally wash our hands and disinfect every surface. In this way, we will reduce the strain on our overburdened healthcare system and responsibly meet our societal obligations to the public we are privileged to serve. We are a profession that is deeply rooted in prevention of disease and the dental workforce community is committed to this public health mandate.

Looking back and looking forward, considering the issue of pandemics—the ultimate lesson suggests that “we can never be too prepared.” It has been said that all pandemics follow the same basic course: they begin, they escalate, they attenuate and they end. What differentiates one pandemic from the other is what we do to bend the curve during the escalation phase and how quickly we can deploy the lessons learned as the enormity of the disease progression becomes painstakingly evident. When this is over, we would like to say with confidence that “we did what needed to be done when it needed to be done.” As health care professionals we should ask no more that this and as a society we should expect no less.

Perspectives on Pandemics: What Does History Teach Us?
Patricia L Blanton, DDS, MS, PhD, FACD
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The Character of a Profession: The Next 100 Years

N. Karl Haden, PhD, FACD

Dr. Haden’s Keynote Address at the Annual Meeting in October, 2020.
The American College of Dentists has been called a “guiding light,” and the “conscience of dentistry.” Dentistry stands or falls on the cornerstones of professionalism and ethics, and the College has ensured these cornerstones are firm and strong. If the cornerstones are professionalism and ethics, the keystone is leadership. Each is embodied in each College Fellow. For 100 years, the American College of Dentists has led and modeled the covenant between the dental profession and the patients and communities it serves.

This article will use the concept of character to describe the dental profession, those who comprise it, and the ACD. I will begin with a memory from my youth. Then, I will talk about the history of character in ethics, leading to a crisis of character facing the dental profession. I will speak of the virtue of humility and its importance to an ongoing dialogue about the profession. I will make the case that some forms of self-interest are legitimate, and we should seek them. I will then turn to the virtue of wisdom and how ACD can pass wisdom forward to future generations. Finally, I will conclude with some observations about the century to come.
REMEMBRANCE

I grew up in the Piedmont region of rural Virginia. We drank water from a well that my grandfather dug with a pick and shovel during the Great Depression. I never knew my grandfather. He died in 1943. I am told he dug wells all over the county to make ends meet during those lean years. Like most homes then and now with wells, we didn’t have fluoridated water. We did, however, have an abundance of Pepsi Cola in south central Virginia. During my youth, Pepsi’s slogan was “You’ve Got a Lot to Live, and Pepsi’s Got a Lot to Give.” Well, Pepsi gave me a number of carious teeth.

Perhaps as a result, I grew up well acquainted with our family dentist. I confess I did not like going to the dentist—the prize I pulled from a jar at the end of the visit notwithstanding. I have only seen my childhood dentist two or three times in the past three decades, but what I remember most about him is not my experiences in the chair.

I remember him as a man who played ping-pong with me. He was an exceptional player, and he tried to teach me to be one. He was also my softball coach during my teenage years. In addition, I remember him as a deacon and usher, a leader in my church, who led our youth group. He gave his Wednesday nights to teach a group of adolescent boys who weekly set new benchmarks for shortest attention span. We schooled him in the virtue of patience.

Our family dentist never charged my father for dental care, not because my father could not afford it, but just because he was a close friend. His commitment to service was remarkable, including going on numerous mission trips to care for those who had no access to a dentist.

As a result of all these interactions, what I remember most about my dentist from my childhood and teenage years is that he was first and foremost an honorable person. Dentistry happened to be his profession. The way he practiced dentistry was the way he led and contributed to the community. He was, and I believe still is, a virtuous man. As the Stoic philosopher Zeno said of the virtues, his actions flowed from his character.

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A SHORT HISTORY OF CHARACTER

This article is rooted in character-based or virtue ethics. Virtue ethics has a long history, longer than any other tradition in moral philosophy, dating back to the ancient Greeks and, in the West, owing more to Aristotle than anyone else (MacIntyre, 1985). Virtue ethics also emerged separately in Confucianism, Buddhism, and other philosophies and cultures (Hurthhouse & Pettigrove, 2018; Goodman, 2017). The traits that are admired and respected in others vary across time and cultures, yet bear remarkable similarity.

Virtues are character traits, habits, such as prudence, justice, courage, hope, and charity, that contribute to one’s personal well-being and that of others (Aristotle’s Nicomachean Ethics, 2012). These habits help people to live good lives, treat others well, and contribute to human flourishing in the communities and societies in which we live. One of the unique features of virtue ethics is its concern with a whole life, not simply decision making when something “moral” is at stake (Pelligrino & Thomasma, 1993).

Virtue ethics focuses not on the principles, rules, or processes for solving moral problems, but on the choices that become habits leading to or, in the case of vices, away from a good life (Aristotle’s Nicomachean Ethics, 2012). One might say that virtues are the character traits necessary for living a fulfilling life in a community with fellow human beings.

Over the centuries, medical morality falls primarily into three central themes: character, duties or obligations, and responsibility to the community. The character of the physician has been a consideration since around the fourth century BCE with Hippocrates, often considered the father of medicine. According to Jonsen (2000), the primary texts read by the educated physician during the Renaissance were Aristotle’s Nichomachean Ethics and the Politics and Cicero’s De Officiis (On Duty). These texts were used to inform the moral character of the physician. By the 14th century, medicine had a place in the universities across Europe. Medical texts had proliferated, guilds or societies had been formed, and the seeds of a profession were sprouting.

Also according to Jonsen (2000), the first official honor code appeared in 1803 in Thomas Percival’s Medical Ethics; or, a Code of Institutes and Precepts Adapted to the Professional
“A profession, such as dentistry, is a unique kind of moral agent. It is comprised of a moral community of individuals, who are moral agents, who have specialized knowledge, and who have agreed to use this knowledge for the good of others. The oaths or pledges made by those who comprise the profession of dentistry are in a sense collectively made and reflect the bond of trust between the professional and the patient and society.”

Conduct of Physicians and Surgeons. Percival, a British physician and ethicist, introduced for the first time in the literature the term “medical ethics.” Character remained a key focus. In the dedication to his son, also a physician, Percival writes, “The study of professional ethics . . . will soften your manners, expand your affections, and form you to that propriety and dignity of conduct which are essential to the character of a gentleman” (p. 55). The “gentleman physician” exhibited certain fundamental virtues: tenderness, steadfastness, and respect.

In focusing on virtue ethics, I am not proposing a replacement for principles or rules to guide ethical decision making in dental practice or in life in general. Virtue ethics does not tell us how to solve moral dilemmas. Rather, character-based ethics brings attention to the type of person most apt to show an interest in, a concern for, and a commitment to the application of ethical principles and rules to decision making. To quote the late 20th-century physician, educator, and ethicist Edmund Pelligrino, “Analysis cannot substitute for character and virtue. Moral acts are the acts of human agents. Their quality is determined by the character of the person doing the analysis. Character shapes the way we define a moral problem, selects what we think is a moral issue, and decides what principles, values, and technical details are determinative” (Pelligrino & Thomasma, 1993).

To shape the character of the profession, starting with those who comprise it is helpful. A profession, such as dentistry, is a unique kind of moral agent. It is comprised of a moral community of individuals, who are moral agents, who have specialized knowledge, and who have agreed to use this knowledge for the good of others. The oaths or pledges made by those who comprise the profession of dentistry are in a sense collectively made and reflect the bond of trust between the professional and the patient and society.

A CRISIS OF CHARACTER

Arguably, the profession is experiencing a crisis of character or we might say that some dentists are acting out of character. The Ethics Report: The New Professionalism (Chambers, 2020) describes many reasons leading to a crisis of character. Organized dentistry does not have the same influence it once had. Solo practices and isolation of the profession from the rest of healthcare inhibit community, collegiality, and dialogue. Across the profession, the values of professionalism compete with those of the free market. The character of the profession is fragmented among those who comprise it, like brickwork that is eroded and broken into pieces over time. The character of the profession is morally pluralistic.

When I first moved back to Atlanta from Washington, DC, I needed to find a new dentist. I received a recommendation for a dentist who had graduated first in his class and had been in practice a few years. I made my appointment and went for my cleaning. He was complimentary about how well I had brushed, flossed, and taken care of myself, but at the end of the cleaning he informed me nonchalantly that I needed—either seven or nine crowns. It seemed that Pepsi still had a lot to give so many years later!

I am not a dentist, but I probably know several thousand dentists. Second opinions were easy to get. When I returned to Washington, DC, a week later for business, I made an appointment with my former dentist. What had happened, I wondered, over the eight months since I last visited his office? He quietly examined me and then looked at me in the eye and said: “If I were you, I wouldn’t do anything. Your dentist in Atlanta has suggested an aggressive treatment plan, more aggressive than I would recommend.” By the way, my Washington, DC, dentist is a member of this College.
That was 16 years ago. I did not go back to that Atlanta dentist, even though I did not doubt his clinical competence or that he probably made an A in his ethics course.

This anecdote illustrates a crisis of character: the choice between economic self-interest and the professional commitment to put the patient’s interest first. You might say this is a conflict between self-interest and altruism, the unselfish concern for others. Economics is the “invisible hand”4 that breaks the profession into pieces.

Prior to the Renaissance, payments to physicians were considered honoraria (Jonsen, 2000). Just as for teachers, scribes, and others in the learned professions, compensation for physicians was considered a gift. During the Renaissance, the relationship between physician and patient started to become more transactional or commercial, based on set fees and terms of engagement. In 1918, according to Jonsen, Dr. Richard Cabot, a physician, Harvard professor of clinical medicine, and respected moral philosopher advised, “Among the rewards which the doctor must not expect is wealth. . . . I have known few physicians who fail to get a living in medicine, but from their regard to their own interest.” In his most famous work, known familiarly as The Wealth of Nations, Smith argues that the pursuit of self-interest in the free market benefits society as a whole. Many economists maintain that the human is Homo economicus, that is, a rational maximizer of one’s own interests. A financial balance sheet is an easy scorecard. The balance, however, is far more complex—and infinitely more important.

Adam Smith (1994), the Scottish Enlightenment thinker and the father of modern economics, is famously quoted as saying: “It is not from the benevolence of the butcher, the brewer, or the baker that we expect our dinner, but from their regard to their own interest.” In his most famous work, known familiarly as The Wealth of Nations, Smith argues that the pursuit of self-interest in the free market benefits society as a whole. Many economists maintain that the human is Homo economicus, that is, a rational maximizer of one’s own interests. A financial balance sheet is an easy scorecard. The balance, however, is far more complex—and infinitely more important.

From an economic standpoint, dentistry’s history is as a “cottage industry,” which means literally a business run from one’s own home. Technically, these cottages were corporations—professional corporations or limited liability companies (Brown, 2017). The shape of dental practice is changing dramatically, though, with corporate dentistry taking a variety of forms, from large group practices to dental management organizations (DMOs) and dental service organizations (DSOs). As Brown explains, economic efficiency and profit are two of the reasons for this change.

Private equity and venture capital are flowing into healthcare, including dentistry (Mathis & Metcalf, 2018). Commercialism, with an emphasis on maximizing profit, is a threat to the moral character of the profession, as discussed by Chambers (2020, pp. 228-9). With deference to Professor Smith, a dentist is neither a butcher, a brewer, nor a baker. A dentist’s commitment as a professional is nothing less than a sacred covenant to put economic self-interest behind the well-being of the patient.

That said, my personal story about overtreatment illustrates that self-interest is not a character trait unique to corporate dental practices. Self-interest has always existed in the cottage as well. Economic self-interest, whether in the cottage or the corporation, is a primary driver behind overtreatment, malpractice, fraud, and other business dealings, with the intent to maximize profits even at the expense of patients and the systems that support healthcare. This commercial focus has been exacerbated by the transition Chambers describes from practice models based on "relationships" to ones based on “transactions,” in which “success is measured as the excess of reward to expense” and with “each party seeking to maximize his or her self-interest” (2020,
Even the organized dental profession walks a tightrope between advocacy for the profession and advocacy for the patient. For at least two millennia, philosophers have debated whether self-interest is an innate trait of the human species. Is altruism or beneficence unadulterated with self-interest even possible? I do not have the answer to this question, but we must discuss and debate the related issues. The moral complexities facing the health professions today were unimaginable a century ago. The ubiquitous dilemmas facing the dental profession today, and maybe well into the future, are not those of bioethics, but of what it means to be a professional and a profession; not rules and principles, but the character of the provider and the profession.

**The Virtue of Humility**

Chambers’s Ethics Report “advocates an ethics of engagement...; it establishes an ethical imperative to sit down and talk with all others who are affected by our actions” (Chambers, 2020). Chambers states that “It is more than likely that dentistry will have to redefine what it means to be a professional.” Hence, the subtitle of the report is “The New Professionalism.” This is where the dialogue must begin.

Considering virtues and character, I would argue that the virtue of humility is essential if individuals and organizations—the profession and its stakeholders—as moral agents are to engage in this dialogue. Arguably, humility is an antidote to self-interest. First, humility is the appropriate attitude to knowing that one does not have all the answers to the ethical challenges facing us. Humility is the pathway to what the Zen Buddhist Shunryu Suzuki (2020) called “beginner’s mind.” In the expert mind, there are few possibilities; in the beginner’s mind, there are many.

Humility is necessary for learning. Humility says that no matter how smart one is or how much one has accomplished, they have something to learn from others. Humility sets aside self-interest, so the interests and opinions of others can be heard. The College’s new Ethics Report, by beginning with listening, began in humility. If the dental profession and those who comprise it are to participate in the ethics of engagement, they must participate humbly, knowing that they have much to learn. Secondly, humility recognizes that society has granted the health professional the privilege to obtain special knowledge to be used in the care of others. Humility recognizes that the patient is vulnerable and honors the trust placed in the caregiver. Humility in the dentist and in the profession admits in gratitude its indebtedness to others.

Lastly, humility is essential for empathy. Self-interest is blind to others. But humility sets aside self-interest, so the provider can empathize with the patient and the community. The act of recognizing, understanding, and sharing the thoughts and feelings of others is at the core of humility. Empathy opens the door to compassion. Empathy helps us act for the benefit of others because we can vicariously put ourselves in their place. Humility is the virtue; empathy is the attitude and act flowing from it.

In today’s world, humility is too little appreciated. Along with economic self-interest often comes what the American economist and sociologist Thorstein Veblen (2009) called “conspicuous consumption,” the purposeful and public display of one’s wealth and power. Being humble is difficult when one knows so much and has so much. With the financial rewards possible in dentistry and healthcare that so many dentists and physicians find themselves on the hedonic treadmill is not sur-
If we are to shape the character of the profession, the starting point is with those who comprise it. Even with this focus, it is almost certain that large practices, DSOs, DMOs, and novel forms of corporate dentistry will grow significantly. Medicine serves as an example: in 2018, less than half of practicing physicians in the U.S. owned their medical practice (Henry, 2019). It is not difficult to imagine the disappearance of dentistry as a cottage industry. But large and corporate does not equate to unethical.
prising. The virtue of humility helps in seeing the world aright, that everyone is a debtor (even after paying off student loans).

THE VIRTUES OF SELF-INTEREST

Introducing the virtue of humility broadens the scope beyond how one practices dentistry to how one practices life. The virtues are about human flourishing and provide a broader perspective.

Humans are aptly called Homo economicus, the economic human, but we also belong to the species Homo sapiens. We are the sapient ones, the wise ones. Except for the universe itself, nothing is more complex than the human brain. It contains somewhere around 100 billion neurons, each of which communicates with thousands of other brain cells. More than a few philosophers have argued that our intelligence is the image of the divine in each of us. With human rationality comes a number of highly unique activities and relationships that are naturally good for our species—physically, mentally, and spiritually.

These goods are legitimate forms of self-interest. Arguably, humans are morally obligated to pursue these goods because we are deficient as human beings if we lack them. They include such things as friendship, citizenship, family, lifelong learning, physical fitness, spiritual exercises, and other activities that contribute to happiness and well-being. They are good for us and generally good for those around us. To enjoy many of these things, a person needs a certain level of financial means. The virtuous person aims to look at all things in moderation, even money. The virtuous person replaces the financial statement, the all-too-easy calculus for success, with life’s balance sheet—far less precise but far more rewarding.

If we are to shape the character of the profession, the starting point is with those who comprise it. Even with this focus, it is almost certain that large practices, DSOs, DMOs, and novel forms of corporate dentistry will grow significantly. Medicine serves as an example: in 2018, less than half of practicing physicians in the U.S. owned their medical practice (Henry, 2019). It is not difficult to imagine the disappearance of dentistry as a cottage industry. But large and corporate does not equate to unethical.

Last year, the Business Roundtable, a group of CEOs from America’s largest companies, rejected the Friedman Doctrine, named for the 20th-century Nobel Prize-winning economist Milton Friedman, that a corporation’s only responsibility is to its shareholders (U.S. Business Roundtable, 2019). These CEOs reframed the purpose of corporations as stakeholder value, not just shareholder value. This means, among other things, that employees well-being, fair relationships with vendors and suppliers, and care for the community and environment are also the purpose and responsibility of business. How this plays out is yet to be seen, but some corporate entities can and do exhibit social responsibility. There are corporations that aim for human flourishing as the end and profits as the means.

Corporations, like other organizations, are moral agents. Culture is the set of norms for how people behave, think, and frame situations. Corporate culture affects the ethical decision-making of the individuals who comprise the company. What constitutes a virtue or a vice is strongly influenced by what the corporation rewards. In 2019, only ten percent of the 59% of graduates entering private practice plan to be sole proprietors; only five percent intend to open a new practice (ADEA, 2020). Choosing one’s employer is a decision that puts one’s character at stake. The contemporary philosopher Edwin Hartman (2013) explains: “If a strong organizational culture can affect one’s character, then the choice of an employer is a most important one. ... It will in effect be choosing which desires to cultivate. ...It is choosing a character.”

In thinking about some challenges to oral health in the United States, particularly access issues, it is arguable that because of resources and outreach, the corporate practice of dentistry offers one of the best means of caring for those who are underserved. The use of new technologies and collaborative care with other health professionals will also advance in these models. Ethical corporations have the potential to contribute to the flourishing of individuals and communities is limitless.

As the College practices the ethics of engagement, it must educate students and influence leaders who take their places in corporate entities. Those are inevitable and even morally obligatory conversations. If economic self-interest in corporate dentistry is a central concern, the College must act to shape the character of the business of dentistry through engagement of those who lead it. Perhaps at some point, the College will have corporate members. These businesses would see their purpose as the flourishing of patients and communities and view profit as the means to this end.
The Character of a Profession: The Next 100 Years

N. Karl Haden, PhD, FACD

THE VIRTUE OF WISDOM

Returning to the premise: in shaping the character of the profession, the starting point is with those who comprise it. The Platonic dialogue Meno abruptly begins with these questions: “Can you tell me, Socrates, is virtue acquired by teaching? Or not by teaching but by training? Or neither by training or learning but comes to men naturally or in some other way?” (Plato, 1982). After exploring the question, no clear answer emerges. The Meno concludes with Socrates speculating that those who possess virtue possess it “as a gift of God.” It takes bravado to proffer an answer where Socrates failed.

The question is often asked, “Can ethics be taught?” The answer to the question is “Yes,” if ethics is defined as following the rules. Like any strategy, ethics can be taught and practiced, even if the intent and the act are incongruous. The Greek root of ethics is ethos, which means character. If the question means “Can we shape the character of the learner and form a person of ethical character?,” we are falling short if for no other reason than the fact that character formation is not the purpose of ethics courses. Their primary purpose is to answer the question “What should I do?” by answering the question “What kind of person should I be?” The first question is more like a science, while the second question is more like art. As Supreme Court Justice Oliver Wendell Holmes Jr. said, “Life is painting a picture, not doing a sum” (Philosiblog, 2016). In virtue ethics, one’s choices are the paint strokes on the canvas of one’s life.

Eleven years ago, I started a Great Books of the Western World club. Getting together every six weeks or so with a group of men and women to discuss and debate timeless ideas is one of the deepest joys of my life. We have read from Homer to Hegel and from Euripides to Einstein. Two things strike me as I reflect on this more-than-a-decade-long journey of the mind. First, the reading is work. It is leisure work, but it requires a willingness to struggle with texts that will easily defeat readers unless they are committed. The commitment says there is a diamond to unearth for those who are willing to dig for it.

Secondly, and more important, a certain level of maturity that comes no other way than through life experience is required to understand these works. This is especially true of great literature. I do not mean to say that we waste these readings on the young, but you often just “can’t get it” without having lived life—in particular, experiencing the inevitable suffering that the years bring. When I was in high school, Herman Melville’s Moby-Dick defeated me. I set it aside. When I read it again several years ago, now in my fifties, it profoundly moved me to consider my own encounters with the Great White Whale.

I am speaking here of wisdom. If gray hair is a sign of wisdom, we have a lot of wisdom in the College! We spend our early years getting things done and our later years considering what was done, why we did these things, and how what we did has led us to the lives we now live. I do not think there is an age threshold for wisdom that fits everyone, but I will say that by the time you are 50, you have seen some things. With age comes a different perspective. The perspective comes from the tutelage of life’s most severe teachers: an aging body, sickness, death, a divorce for roughly 40 percent of the U.S. population, and for some the terrible anxieties of parenthood. Wisdom is possible at any age, but for most of us it accrues with the years.
Many in the College are well acquainted with the things that get dentists into trouble. For example, according to Bloomberg, the amount of income necessary to exit the bottom 99 percent in 2017 was just over $515,000 (Tanzi & Steverman, 2019). Some know from experience that those who aspire to great wealth in life are likely to be disappointed. Many know that greed is always continue—but by broadening the conversation to what constitutes a good life. Many members of the College are academics. While none have taken a vow of poverty, they made a decision at some point in their career that maximizing income is not a core value. Sharing that story with newcomers to the profession is important.

One of the central functions of education and, more specifically, moral education is to teach how to reason in the right direction. Perhaps there is room for a turn to moral psychology in ethics instruction, a turn to the formation of moral reasoning, including the place of desire, emotions, choice, character, contribution to the community, and human flourishing. Perhaps taking time to discuss with students and to learn with colleagues about those legitimate forms of self-interest that make for a complete, fulfilling life can occur.

a rapacious god that devours your soul and leads you not only to make poor clinical decisions, but bad life choices. Some know what it is like to self-medicate and fall into an addiction to cope with a lack of meaning, purpose, and fulfillment in life. Many have been through these things and have picked up wisdom along a hardscrabble road.

Practical wisdom is about making the right choices, and so is ethics, and so is living a fulfilling life. Whether or not these experiences resonate with you, this College is filled with people of practical wisdom. Passing this wisdom forward to a new generation of Fellows is critical to the character of the profession.

How to accomplish that is challenging. This wisdom can be passed on not by abandoning dialogue about what constitutes professionalism—this dialogue is important and must argue that “North American medical education favors an explicit commitment to traditional values [or virtues] of doctoring—empathy, compassion, and altruism among them—and a tacit commitment to behaviors grounded in an ethic of detachment, self-interest, and objectivity.” Unfortunately, the tacit commitment too often speaks louder than the explicit one. This should not be said of academic dental institutions nor of the organized professions. Students will remember teachers long after the coursework has faded from memory. Colleagues will pay attention to what you do more readily than what you say.

Thirdly, and related to role modeling, more heroes in dentistry are needed. For too long, William J. Gies has felt alone on dentistry’s Mount Rushmore. Heroes are made not born. They become heroes by making the right life choices. They create narratives—and dentistry’s heroes can create the narrative of the profession. They are the moral paradigms of the profession. When faced with a moral dilemma, hopefully the dentist will not only think about what principle or rule to apply, but also ask what—who would do. There are countless heroes, people of deep character and commitment, in dentistry. Their stories must be
The Character of a Profession: The Next 100 Years

N. Karl Haden, PhD, FACD

A Swedish proverb states, “The afternoon knows what the morning never suspected.” I wonder if the founders of the American College of Dentists could have envisioned what this College would become. The 1920s was the first decade to have a nickname, the Roaring 20s. It was also called the Jazz Age. It was a time of great prosperity, new music, and silent movies. It was also a time of notorious gangsters and racism as the Ku Klux Klan instigated lynchings across the South. The decade began with a nation exhausted by a world war and a global pandemic that killed more than a half million Americans in 1918 and 1919. It roared to prosperity and ended with a groan on Black Tuesday, October 29, 1929, as the stock market crashed and the shadow of a decade-long economic depression fell.

Back to all those crowns in my proposed treatment plan. After my initial experience, I found a new dentist here in Atlanta. When he first examined me, he said, “If you were my brother, this is what I would do.” And then he proceeded to explain which teeth we would watch. On my first visit, he gave me his card and wrote his cell number on the back. He said, “If you ever need me, call me.” I must have looked at him askance because he said, “I really mean it. Call me if you ever have a problem.” About a year later, I needed one of those crowns. I broke a tooth—on Christmas Eve. He was there for me. When he retired, he sold the practice to another dentist who exhibits the same character and clinical competence as he did. I have had three of those seven or nine crowns since 2004, and when I have the next one, I know who will place it.

I have very little idea what the next 100 years holds for dentistry, which is why I believe in the ethics of engagement for charting and sailing these waters. Moral complexities will inevitably become more complex. But I cannot imagine a society in which we wish for dentists who are greedy, arrogant, dishonest, cowardly, and unfair. If history is any guide, in a century, character will still count.

A Swedish proverb states, “The afternoon knows what the morning never suspected.” I wonder if the founders of the American College of Dentists could have envisioned what this College would become. The 1920s was the first decade to have a nickname, the Roaring 20s. It was also called the Jazz Age. It was a time of great prosperity, new music, and silent movies. It was also a time of notorious gangsters and racism as the Ku Klux Klan instigated lynchings across the South. The decade began with a nation exhausted by a world war and a global pandemic that killed more than a half million Americans in 1918 and 1919. It roared to prosperity and ended with a groan on Black Tuesday, October 29, 1929, as the stock market crashed and the shadow of a decade-long economic depression fell.

One hundred years later, we find ourselves exhausted from another pandemic, our backs bent under the strain of a ravaged economy, and our hands grasping to raise ourselves above racism and social injustice. As in the 1920s, so in 2020, the character of our nation is tested. Turbulent times call for the virtues. We are buoyed by hope: through courage, move forward confidently into the storm, and with wisdom we will persevere and overcome. As the better angels of our character prevail against these challenges, so too these challenges will shape us as individuals, as a College, as a profession, and as a nation for the century to come.
REFERENCES


Welcome to the first eJACD. In the coming months, the new journal format will continue to present scholarly articles and engaging editorials. In light of events the vast changes and varied experiences of the profession resulting from the pandemic, this first issue will be a little bit different, offering reflections and experiences of dentists who have been working tirelessly to safely maintain their practices for their patients, staffs and themselves.

Reflective writing is used in many health care professions as both a tool for teaching and tool for learning. “Reflection . . . can be considered as a process in which thoughts are ‘turned back’ so that they can be interpreted or analysed. The trigger to this sense-making process is usually an event or situation and the outcome of the process is increased understanding or awareness. These insights can then be used in the future when faced with a similar event or situation. It is often through reflective writing that both the reader and the writer can begin to make sense of a confusing, evocative or life altering experience.” 1

The COVID-19 Pandemic has given rise to much that is unclear, ill-defined and forever, life altering not only for individuals but for professions as well. What follows are several reflective essays from dentists from different settings, at different stages in their practice and in different parts of the country with differing rules and regulations. By sharing their written reflections, discussions can begin throughout the profession on how to rebuild, reconcile, and reevaluate personal and professional identities.

In reading the five articles that follow many commonalities can be found despite the difference in geographic location, age of the practitioner, years of practice, area of specialty as well as type of setting from private practice to the educational setting. From the early days of confusion, perhaps fear during the pandemic, the professionalism and ethics of dentistry have been steadfast. In each reflection, the commitment to patients, peers and the profession is evident. What is also evident is that dentists are integral primary care providers and must be included in public health planning and preparedness.

In the 2000 Surgeon General’s Report, Oral Health in America, identified a key action item to: “Change perceptions regarding oral health and disease so that oral health becomes an accepted component of general health.” 2 This included, changing public perceptions, policy makers perceptions and public perceptions. 2 While a new report is due out, the imperative of this action item is highlighted in the five reflective pieces presented here.

REFERENCES


After a year of living in the pandemic, I find myself already beginning to forget how strange and frightening those first weeks and months were. A vivid memory I have is of performing an extraction at 8am on a Sunday morning, thinking about how utterly strange life is right now. My ten operatory office is empty except for a single room shared by my assistant, a patient who drove over an hour to get here, and myself. After the procedure is done, I head back to isolate in my home, not to leave until the next emergency.

What strikes me now, though, is that care happened at all. The memory is vivid, but it was the mundane, yet essential, planning and team coordination that made it possible. The pandemic is a once in a lifetime event (we hope). Working during it was rare—and scary. But I took an oath. My duty is to help those in need and, in those early days, to reduce the burden on emergency rooms. Anticipating what might be coming, I managed to acquire 3M N95 masks the first week the virus noticeably arrived in the US. Other preparations meant we had inventory of gowns, gloves, and masks. We didn’t have face shields, so we made them. I sat with my office manager and lead assistant to create a strict COVID screening protocol which allowed us to see emergency patients during the chaos and confusion of March. We elected to have myself and two different assistants do the patient interactions as we all lived essentially alone and had no kids. Everyone got fitted and tested with their N95 masks and we got to work. Our schedule was by appointment only and we worked 7 days a week, trying to keep patients in 1-hour blocks with 15-minute intervals to avoid any contact between patients.

This preparation and planning, the unglamorous time spent adjusting schedules and identifying staffing, meant that we were one of the rare offices not just open, but operating well enough to serve people within a two-hour driving radius of Austin, like that Sunday patient. An emergency room nurse knew we were open and sent us all dental emergency patients they received. In reflecting on those early days, I saw old truths of dentistry in a new light and realized that dentistry needs changes.
COVID-19 has highlighted what should be the pillar of our decision making: prevention. Patients presented throughout the initial wave of the pandemic with pain and swellings that were caused by untreated caries. Many were existing patients who put off treatment for six, twelve, eighteen months before the pandemic. Their stories shared a similar trend, “it started to hurt but I could deal with it and I didn’t want to go in; and then COVID hit and I couldn’t go in when I needed to.” Eventually pain and swelling overpowered fear. Most of these now severe issues would have been simple fixes months or years earlier.

PREVENTION IS DENTISTRY

COVID-19 has highlighted what should be the pillar of our decision making: prevention. Patients presented throughout the initial wave of the pandemic with pain and swellings that were caused by untreated caries. Many were existing patients who put off treatment for six, twelve, eighteen months before the pandemic. Their stories shared a similar trend, “it started to hurt but I could deal with it and I didn’t want to go in; and then COVID hit and I couldn’t go in when I needed to.” Eventually pain and swelling overpowered fear. Most of these now severe issues would have been simple fixes months or years earlier.

In early March, one patient who came in with “10 out of 10” pain had a carious lesion on the distal of her upper left second premolar. The lesion had exponentially grown over the course of a year, from barely through the CEJ all the way into the nerve. It was astonishing to see the caries progression in a year’s time.

Scenarios like this spark the question of early intervention and if we, the experts, should push harder for alternate interventions if the patient is resistant to traditional drill and fill. Discussions about alternative treatment methods blossomed during the early months of the pandemic with a focus on pediatric dentistry and the SMART technique of silver diamine fluoride (SDF) and glass ionomer placement. I utilized this technique on the few children that I did see during the emergency-only months and the ease and benefits are too great to ignore. What about for adults? My use of silver diamine fluoride in all patients has significantly increased over the last year, largely due to COVID. The applications spectrum of SDF is broad and the lack of “fear-inducing” qualities make it a wonderful adjunct for dentistry. I have now seen a few of the SDF applied during COVID adult patients and seen the cessation of their caries and it’s fantastic. It also allows them time to save up for restorative options, as opposed to removing the tooth. This isn’t an advertisement for SDF, but an illustration of how the crisis drove me to adopt a technique and technology I might have ignored or waited on in normal circumstances, potentially to the detriment of my patients.

DEFINING OUR PROBLEMS: EMERGENCY TREATMENT

“What is ‘emergency treatment’?” What about preventing someone from going to the ER? What about preventing an emergency? A handful of patients who needed dental clearances for surgery—some life-saving—and came to me because their dentists had spurned their request because “exams” were not in the list of emergency treatment. The training that we have received as doctors allows us to make clinically applicable decisions that will benefit our patients. We must utilize the fullest extent of our training to balance justice and beneficence to determine an appropriate treatment for the patient.

DEFINING OUR PROBLEMS: SUPPLY CHAIN & MATERIALS

Counting gloves for the week was a harrowing experience. “I can’t treat patients without gloves, pandemic or not” I remember thinking. We began using the appropriately sized glove for our dominant and an incorrect size for our non-dominant hands. We rationed our cleaning supplies while ensuring we could still disinfect rooms. Many more dentists could have provided care early, but PPE was the limiting factor. First, masks were in short supply, then gowns, and later gloves started disappearing. At one point a box of gloves was six to ten times the cost it was a year before. KN-95 masks were being bought by the thousands, only to learn that they were counterfeit.
So, what have we learned? Protocols are crucial for delivery care; our supply chain is sensitive, and new treatments can bring new benefits. The current model is not sufficient to care for people while allowing us to flourish as well. Will we rethink how we deliver care, or will we put this pandemic out of sight and out of mind and return to the status quo?

On top of shortages or proper PPE, there was an influx of dubious products pushed on us that ranged from alien-like contraptions that have extension arms with suction masks on them to put over the patient while we work all the way to full-on hazmat suits, all trying to convince us that we were not doing enough. When in reality, all we need is an adequate amount of gloves, gowns, masks, and face shields. There was even talk of negative pressure rooms. Dentistry has seen the struggle with supply chain issues, but this can be managed through thoughtful preparation and use of materials, while not wasting what we have. We weren’t prepared for this level of PPE, and it will take time before supplies and costs have stabilized.

PERCEPTION, ACCESS, AND OUR CURRENT MODEL

COVID elevated and added to patients’ concerns surrounding dentistry: Is it safe to go out, do procedures spread COVID? It became easy for patients to forgo care because dentistry is expensive, the dentist isn’t fun, and they could catch a virus leaving their home. I can empathize, it was scary for dentists to provide care when we knew very little of the virus. I suspect that the feelings were analogous to the early days of HIV.

Cost remains the major hurdle of dentistry, emphasized further by the pandemic. Dental insurance is not true insurance, but rather a discount plan. The physiology of dental pain does us no favors, “Oh, I’ll wait because it’s not hurting me.” Not just the economically disadvantaged, but solid middle class income patients are electing to forgo care or wait on care due to finances. The wealth gap in the United States continues to widen, while the dental safety nets and insurance coverage for people narrows. Reimbursements can be insultingly low for doctors that drive them away from being a point of access for a certain patient population. Not-for-profit dental insurance companies are transitioning to for profit. We are being torn between financial success and providing access, and we as dentists are often blamed for allowing this to continue despite its systemic nature.

As COVID gave patients an extra reason not to come in, closures and supply constraints hurt offices. Across social media, listservs, and publications, there were daily callings of struggling offices that could not do crowns and implants. Pediatric offices could not survive on prevention and extractions. “My office may have to permanently close” was too common. Thankfully, the majority have recovered thanks to PPE and protocols. However, does this pandemic not show that a prevention focused model would be beneficial for both the profession and society? Calling out the current model will cause many knee-jerk reactions of dissent; however, newer dentists see a different profession than the one they thought they would enter. There is not a clear answer for where dentistry should go, but the profession currently has a chance to not merely “race back to normal” but to instead see that “is this an opportunity to rethink the care model”.

So, what have we learned? Protocols are crucial for delivery care; our supply chain is sensitive, and new treatments can bring new benefits. The current model is not sufficient to care for people while allowing us to flourish as well. Will we rethink how we deliver care, or will we put this pandemic out of sight and out of mind and return to the status quo? This pandemic has laid bare hard problems with our profession and society’s view of dentistry. We need to better define our care, how and when we could deliver care, and we need to strengthen our supply chain. The pandemic should not have shaken our care delivery or protocols. Our current model does not allow for flexibility in care and there is a middle ground between financial success and access to care. It’s time to rethink how dentistry works on the most fundamental level, stop being reactionary, and proactively begin changing the landscape ourselves.
In late February of last year, I was preparing for the 2020 ADEA Annual Session & Exhibition. It would have been my first as ADEA’s President and CEO. However, on March 9, 2020, we canceled our conference as COVID-19 emerged as a significant health threat in the United States. Two days later, the World Health Organization officially recognized the COVID-19 outbreak as a pandemic and on March 13, a national emergency was declared for the United States.¹

In short order, dental schools, dental clinics and dental practices either closed initially or significantly curtailed their services as authorities sought to get a handle on how to stop the spread of the coronavirus. The approaches to closures and subsequent re-openings have varied by jurisdiction, reflecting the numerous (and shifting) state and local orders in play.²

One year later, dental education, like many professions and institutions of higher learning, is still reeling from the impact of COVID-19 and assessing how to move forward. While the pandemic introduced a new series of challenges to our world, it also brought front and center a number of complex issues we have wrestled with for years, ranging from increasing financial pressures on institutions and students alike³ to a long-standing debate about pathways to licensure—and the need for more flexibility.

To a certain, and obvious, extent, the COVID-19 pandemic marks a moment of unparalleled crisis for dental education. On the fiscal front, schools are facing a double whammy: the loss of revenue due to the initial closure and reduced services of dental school clinics juxtaposed against unexpected expenses, such as facility modifications to allow for physical distancing, testing for COVID-19 and the need for more personal protective equipment. Additionally, dental schools and programs have had to invest in new technologies and training to accommodate a breathtakingly rapid shift to virtual formats for didactic education. That shift placed acute demands (and stress) on faculty and students to master these technologies. Perhaps even more acutely concerning are wellness and mental health considerations resulting from the loss of face-to-face interactions, which we have all experienced.⁴
There is little doubt that we can learn and function in virtual formats—and much of that can been seen as a positive development—but we are fundamentally social creatures. I believe we are still calculating the costs to our well-being that come when our professional and personal interactions are largely reduced to remote exchanges on computer screens.

That’s just a taste of the challenges we face, and it would be easy to dwell only on these hurdles and others. But we can take a different perspective—seeing this as a moment to reassess our approach toward dental education and reset our future. As tumultuous and taxing a year it has been for dental education, there are signs we are positioning ourselves for greater success in the very near future. Consider the following:

• Oral health professionals are increasingly seen as indispensable partners in overall health and that’s largely because of their inclusion in the COVID-19 workforce. As of this writing, at least 18 states have granted dentists permissions to administer the COVID-19 vaccine: Alabama, Arkansas, California, Colorado, Connecticut, Georgia, Illinois, Kentucky, Maryland, Nevada, New Jersey, New York, Ohio, Oregon, Rhode Island, South Carolina, South Dakota and Washington, with Connecticut, Nevada and New York also granting permission to dental hygienists. (Dentists in Oregon also are permitted to give COVID-19 vaccinations under a 2019 law that granted them permission to administer vaccines for a variety of conditions.) That recognition of the need to expand the role for dentists underscores the far-reaching responsibility dental educators have in preparing the next generation of oral health care professionals. This sustained interprofessional focus we have had on health care during the pandemic has given us the opportunity to reframe a broader conversation about health care, highlighting how oral health care is part and parcel of overall health and well-being. We have to keep making that point at every opportunity. Walls are (slowly) coming down as we move toward a more integrated notion of health care, and patients will be the ultimate beneficiaries of this new mindset.

• There’s a new spirit of collaboration and innovation in dental education. Born of necessity during the pandemic, this new-found enthusiasm for rethinking how we develop and deliver dental education will serve us well as we navigate an ever-changing landscape. One indication of that creative spirit can be found in ADEA’s Journal of Dental Education, which last summer introduced a new section called “Advancing Through Innovation.” It focused on showcasing solutions to pandemic-related challenges in health professional education. Submissions soared as faculty members and administrators shared their successes, such as one school’s experience with asynchronous faculty evaluations via video for remote learning exercises as well as their failures. Within an eight-month period in 2020, the journal received more than 230 submissions for the “Advancing Through Innovation” section. Additionally, deans from the 68 dental schools within the United States are conferring and collaborating, sharing their experiences and insights through online Town Hall meetings and forums hosted by ADEA, such as ADEA Connect, our collection of online communities. These conversations, and others, will help drive consensus as we tackle challenges and explore ideas, such as the possible devel-
opment of more universal curricula that cut across institutions.

• We’re seeing incredible strides in the use of technology in both dental education and dental practice. Teledentistry has mushroomed this past year, including its use in consultations between dentists and patients or dentists and peers. In addition, the rise of virtual classrooms during the pandemic is a change that’s here to stay. That’s not to say face-to-face learning is a thing of the past, but it is becoming part of a broader portfolio of options for education. I foresee further advances in technology that will reduce the need for live patient-based competency procedures in school. We face an interesting balancing act as we embrace more technology that could improve access to both education and care for patients—and eventually cut costs—while being mindful of the tremendous value of human-to-human interaction that, I believe, must remain a hallmark of dental education and health care in general.

Each one of these developments is reason enough to be excited about the future of dental education. But what gives me the greatest hope about our future is, quite simply, the moment we are in. I believe the biggest hurdle in our profession, and likely for many others, has long been inertia. Most of us are comfortable with the familiar. But the pandemic threw the familiar out the window.

There’s an appetite, a need, for change and fresh thinking that we would be foolish not to leverage. The pandemic has forced some states to introduce more flexibility in pathways to licensure, and we are finding more receptivity in some quarters to looking beyond live-patient procedures as the sole means of assessing student competency. We’re living in a moment when the status quo simply won’t cut it, and there is a broad recognition of the fact.

I’m cheering on the fresh thinking and the creative spirit that I see on display at dental schools. My hope is that we build on this momentum, making sure that accreditation commissions, licensing agencies and individual state legislatures are also looking anew at how we prepare and educate the next generation of oral health professionals, assess their competencies and license them.

Oral health is inextricably linked to overall health, whether it relates to individuals or the general population. The COVID-19 pandemic, as devastating as it has been, has provided us a unique opportunity to take dental education to new heights as we explore the endless possibilities that exist to meet the needs of tomorrow’s dental patients.

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Having started my dental school education in New York City during the height of the HIV/AIDS epidemic, I was accustomed to universal precautions to prevent disease transmission in the dental setting. In fact, as compared to our physician colleagues, many of whom did not even have masks in their offices, we, as dentists were way ahead in the infection control game.

As I watched and read what was happening in Wuhan, I began to feel a bit less confident in our overall preparedness as private practice dental clinicians. Surgical masks began to be rationed by the dental supply companies and the new kid on the block, the coveted N95, was difficult to find. Our expertise in preventing the transmission of bloodborne pathogens was not the same knowledge base that was needed for a disease that was transmitted by respiratory droplets and aerosols.

Our office was closed by state mandate for almost eight weeks. During this time, we formulated plans to help protect the patients, the dental team members, and ourselves from an invisible vector that would be invading the place we spend our days. We were kept busy by sifting through the rapidly evolving guidance from the CDC and state dental association.
When we re-opened our practice there were many changes. Appointment confirmation phone calls were updated to include health and travel related questions with the goal of ferreting out COVID-19 symptoms before a patient arrived for treatment. In order to create social distancing, the reception room was closed; patients would now wait in their cars until we were ready to see them.

Body temperatures were taken, COVID-19 questionnaires and releases provided by our dental malpractice carrier were signed, and the patient’s hands were sanitized before the patient was brought into a treatment room.

Antimicrobial rinses were implemented to decrease the viral load in the patient’s oral cavity before and during treatment. Air filtration systems that used UV lights and HEPA filters were installed in the ceilings. High volume extra oral suction systems were also placed into use with the hopes of decreasing the spread of the virus.

Our team members were outfitted with N95 masks, face shields, and disposable gowns to protect everyone from the dreaded aerosols created with the use of high-speed handpieces and ultrasonic scalers. Our fears were fanned by a New York Times article that framed dentistry and dental hygiene as some of the most high-risk professions for contracting COVID-19 in the entire workforce model.

As practitioners, we changed as well. Gone were the white coats that we wore to meet our patients replaced by scrubs that could be cleaned more effectively. Lunch in our break room with our team members was replaced by lunch in the car by ourselves. More importantly, we felt that the doctor-patient relationships that we spent so many years building were being eroded by the physical and psychological distance placed between us and our patients.

Much like the initial phase of the HIV/AIDS crisis, we were afraid of our patients. Who harbored the virus that we could potentially take home to our families? Should we really do an elective procedure that creates an aerosol cloud? Is three-month recall really necessary or should we keep our elderly high-risk patients away from the dental office environment?

COVID-19 testing evolved in much the same fashion as HIV testing. Initially the test was difficult to get. The days after the test were filled with anxiety waiting for the results. Were the fever and cough just a run-of-the-mill cold or was it COVID? Now, tests are plentiful and accurate results are available much more rapidly.

Fortunately, there is hope and a pathway back to a new version of pre-pandemic dentistry. Our team members have all received both doses of the COVID-19 vaccine and our patient population is slowly becoming vaccinated as well. While we have not relaxed our updated infection control protocols, we are beginning to feel less anxious about doing what we do best – caring for our patients. And, our patients, in turn, are ready to return to the practice for the dental care they need and desire.

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Where we go from here is still to be determined. The gloves, masks and protective eyewear that were introduced to dentistry in the mid 1980s during the HIV/AIDS crisis have remained a constant in the practice of dentistry. Some of the protocols recently adopted to curb the spread of COVID-19 will also become a routine part of the dental care delivery system as well.

Even as optimism makes me feel that there is light at the end of the proverbial tunnel, my hopes were tempered as I learned of the death of a colleague that succumbed to COVID-19 who practiced just a few miles from my office.

While some paint dentists with the broad brush stroke of stolid and staid practitioners, we have proven that to the contrary, we are nimble leaders who can quickly adapt our procedures and protocols to serve our patients and continue our role as leaders in patient safety.
Pandemic Panic

As we begin COVID-19 vaccinations throughout the world in record time, we pause to reflect on what has transpired in the dental profession over the past 10 months. Dentistry has consistently been presented with ethical dilemmas throughout these challenging times of COVID-19, necessitating a close look at the historical timeline of the demands and the responses with which the profession has weathered during this ethical storm.

Dentists strive to serve the best interest of their patients’ dental needs, as the ADA’s over 150-year-old Principles of Ethics & Code of Professional Conduct states should be done. Yet in mid-March, when the realization that a worldwide pandemic of unknown duration was impacting the relationship between patient and caregiver, dentists were told to close their offices except to treat only those patients in acute, emergent situations, leaving the vast majority of patients of record without preventive and/or restorative dental care for an indefinite period.

Dentists followed the orders implemented in their states but were troubled about whether this was right for patients. Unease mounted as offices were shut down except for seeing what individual dentists considered to be the emergent case, second guessing the nuances of the imposed moratorium. Staff became either redundant or, at best, needed minimally. Questions arose about whether it would be right or prudent to relieve them of their positions, and in some instances, staff left their jobs—and the profession for good out of fear of the transmissibility of COVID-19.

The ADA’s Guiding Light

Throughout the pandemic, the ADA Health Policy Institute kept members abreast of many ethics and other professionally-related information, such as staffing, PPE availability and other data. Rather than leaving dentists to interpret the CDC’s initial guidelines as to what constitutes “emergent care,” the ADA was in communication with the CDC to ensure that dentistry had a voice. The ADA became the source for the dental profession providing information on what constituted a dental emergen-
Throughout the pandemic, the ADA Health Policy Institute kept members abreast of many ethics and other professionally-related information, such as staffing, PPE availability and other data. Rather than leaving dentists to interpret the CDC's initial guidelines as to what constitutes “emergent care,” the ADA was in communication with the CDC to ensure that dentistry had a voice. The ADA became the source for the dental profession providing information on what constituted a dental emergency, and created algorithms on triaging patients, screening protocols, and minimization of risks of disease transmission, among a multitude of other advisories.

In the face of concerns about neglect of individual patients in the first months of the pandemic, some state dental leaders appealed to their respective departments of health to explain how certain maintenance procedures were in fact time sensitive and of medical importance, which opened the way for dentists in some states to practice more expanded procedures once deemed nonessential. According to Brian and Weintraub, oral health care should be a public health priority. Pertinent to this philosophy, a recent study out of Sinai Hospital in Toronto, that was published in the Journal of Dental Research stated that patients with untreated periodontal disease are susceptible to more rapid and virulent responses to the COVID-19 virus. It is the continued investigation of the balancing of consequences caused by overtreatment versus undertreatment that will help us better define individual/community risk and benefits.

Despite the many restrictions, the ADA Health Policy Institute reported that as of November that 98% of dental offices were open, with 1/3 reporting “business as usual.” As of nine months from the start of the pandemic, the ADA reported that...
fewer than 1% of US dentists had a COVID positive transmission.\textsuperscript{11} This is a testimonial to the exemplary efforts made by the dedicated leadership at the ADA, its member practitioners, the profession, as well as those who teach proper infection control and overall professionalism in our dental institutions. Although this pandemic has placed ethical burdens never before seen on the profession, it has nonetheless left dentists with more knowledge, resiliency, and determination as they continue to strive to meet their obligations to both individual patients and the wider community.

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From the outset I want to state that this epidemic, no, this pandemic, has turned the world and healthcare upside down. I have never seen anything like it in my 43 years of professional life; I hope I never see it again. It caused me to lose two bets in March of 2020, details of which I will share later.

To say that I am a seasoned veteran would be the kind way to refer to me. In my practice I refer to myself as “The Old Guy.” In May, I will be starting my 44th year in dentistry; in fact, I have practiced in six different decades. I say all of this to let you know I have been around the block and have seen a lot. I will be addressing this pandemic from a practitioner’s lens as I am not an academic in the traditional sense.

Before addressing COVID-19 I would like to review the nuances of dentistry beginning in the 1970’s and up through the present time. Gloves, what were gloves used for except oral surgery rotations? Masks, what were masks? At best, dental handpieces were wiped down. We even had little disposable prophy cups, not angles, that were snapped on metal prophy angles. Some practitioners even used ovens to sterilize instruments. And, yes, we did wash our hands, which is probably the only thing that is common with today’s practice.

Two significant events happened in the 1980’s that had a profound effect on the practice of dentistry. The mid 80’s saw the HIV/AIDS epidemic emerge. My referring periodontist was in residency at that time, and he tells of practicing dentistry in what appeared to be space suits with plastic draping on the walls and floor. That epidemic really shook-up dentistry. It was common to have telephone calls inquiring if HIV patients were treated in our practices. This epidemic required the utmost sensitivity to ensure access to care and confidence in the environment of care. Starting then, education courses in HIV transmission were required for license renewal. The emergence of HIV as a deadly pathogen had profound effects on our knowledge of the immune system and revolutionized the field of immunology. Another transformational event in the 80’s was the availability of the Hepatitis B vaccine. It did not protect against HIV, however it provided protection from dentistry’s number one nemesis, HBV.

The 1990’s ushered in OSHA Universal Precautions and the required training in Bloodborne Pathogens which were born out of the HIV epidemic. This was one of the first of the clinical disrupters in practicing dentistry. Initially, gloves were a nuisance. Not only did we start gloving up for procedures, but we also found out we needed to keep Material Safety Data Sheets (MSDS) on all products and supplies, including the least threatening of supplies such as gauze and cotton tips. The routine use of masks was yet to come. OSHA had surprise inspections of dental offices and fines were levied for lack of compliance. No one likes change, however the advent of the Bloodborne Pathogen Standards propelled dentistry into the 21st century, well ahead of other professions. Change is hard. Change involves instituting a new paradigm; it costs money and requires extra time. Was it an inconvenience? Yes. Did it protect my patients, my staff and me? Yes. Did it make dentistry safer? Absolutely.

Much has been said up to this point, but COVID-19 has not been mentioned. Not much happened in dentistry regarding communicable diseases in the first two decades of the new millennium; our hands were full with insurance company PPO’s and corporate dentistry DSO’s. Then came 2020.
A General Practitioner’s Response to Covid-19: A Conversation
Terry L. Norris, DMD, FACP

Getting back to the lost bets in March of 2020, I lost one to my assistant and the other to a dentist. Several dentists called to ask if dentistry would be shut down, and I emphatically said no. My reasoning was that our precautions and sterilization efforts to prevent the spread of HBV would be sufficient to remain open. If we are doing due diligence in regard to HBV, then COVID-19 would be a piece of cake. It seemed clear to me that dentistry understood contagion and the needed precautions in the dental office. Given that, I thought dentistry would not be shut down. How could it happen? Dentistry was safe and still is. There seemed to be a misunderstanding, too broad a measure was being taken. During the lock down, in order to protect our staff, the dentist-owner of my practice and I worked four mornings a week seeing emergencies and assisting each other without any issues.

There was so much information and misinformation to weed through and absorb. Even some of the information and guidelines from the experts were changed multiple times. Yet, this is the very nature of an emerging infectious disease. Is the transmission airborne or bloodborne? If airborne, what was the limit that air could carry it? What is the life of the virus? What will kill it and under what protocols? Do masks really work? Before COVID-19 I had never encountered KN95 masks.

Organized dentistry was critical during this time of unknowns. Organized dentistry has boots on the ground, and our advocacy is well heard. When news came out that dentistry could soon re-open under guidelines approved by the governor there were a series of meetings on a Sunday. The Kentucky Dental Association, the Kentucky Dental Hygiene Association, the State Dental Director, and the Kentucky Board of Dentistry met to develop guidelines. This cooperative effort led to a practical set of guidelines which were submitted to the State Public Health Commissioner who approved them and sent them on to the governor for his approval and signature. All of this happened in one day and offices were allowed to open on Monday. We chose to open a few days later after having an office staff meeting and removing items in the treatment rooms that could harbor the virus, doing safe distancing in the reception room, and implementing new safe practices.

So, what was new? COVID-19 screening is completed daily on each staff member, and each patient is screened for the virus. We now have KN95 masks, or level 3 masks with face shields and have disposable gowns. Additional time is allowed to disinfect the treatment room once patient procedures are completed before the next patient is seated. The common areas of the office are sanitized each evening and safe distancing is practiced. When scheduling, utmost care is taken to leave the doctor alone to finish restorative procedures to not interrupt him or her to do hygiene checks; this conserves PPE. As for sterilizing handpieces and wiping down the rooms, that is part of the mandate of the Bloodborne Pathogens Universal Precautions which has been followed since the 90’s. I chuckle at the advertisements from handpiece manufacturers concerning stocking up on handpieces to meet sterilization guidelines. My generation would say that is “old school” since we have been doing it for the last 25-30 years.

From a practitioner’s standpoint, where has this pandemic brought us? Financially it has been a major disruptor. This has also been a teaching moment between the dentist and the patients. Once the virus is fully explained to the patient and the relative ease of killing it compared to HBV, some patients feel even safer than before COVID-19. Office tours are now routine, and very few patients have delayed coming back to the dental office. As I related earlier, much of this is due to the advocacy of dentists within Kentucky stressing the safety in the dental office.

I know that I am blessed and will continue to be blessed no matter what happens. To say this will be the last crisis in my lifetime or yours would be naïve. The question is when will the next one be? Will we be ready for it? Have we been advocating to place dentistry in a positive light? Now is the time to ensure that policy makers understand how safe dentistry has been and that it has been so since the institution of the 1990 protocols with continued advancements through the COVID-19 era. I heard a quote recently by David Jeremiah that he expanded from John C. Maxwell, “If you are proactive, you are preparing. If you are reactive, you are repairing.” We still have work to do and we are committed to doing the hard work necessary to ensure the patient-safe, patient-centered oral health care that our communities so richly deserve.
As integral members of the health care team delivering oral health care while battling a pandemic, we have been called upon to operate under extraordinary circumstances. Our capacity has been forged in the crucible of uncertainty and powerful alliances have been reimagined. VUCA is the military acronym that best sums up the current state of affairs – we are living in a volatile, uncertain, complex, and ambiguous environ. It is said that leadership in VUCA environs is about progress not necessarily perfection. We must be willing and able to plan, execute, and adjust to changing conditions in real time. Not surprisingly, the dental workforce has risen to the task and made adjustments to the delivery of care as the situation evolved.

As a regular feature, we intend to highlight “ethics in action” and have chosen the contributions of Dean Cecile Feldman and her colleagues at the Rutgers School of Dental Medicine for this inaugural issue of the eJACD. Dr. Feldman and her team of professionals were at the geographic epicenter of the first wave of the pandemic. Their decision to repurpose clinical space at the dental school for hospital bed space helped offset critical shortages and served as an exemplar for dental workforce utilization in a public health crisis. Recently, we reached out to Dr. Feldman to get her responses to the following questions.

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What was the ethical issue that you were trying to reconcile?

As healthcare providers during a public health crisis, we had to re-examine the roles and responsibilities of dentists. What obligations do we have to our patients if SARS-CoV-2 can harm my staff and my family? What if the scope of practice in my state limits my ability to screen for or diagnose COVID-19? As a healthcare provider, do I have an obligation to make resources available to assist in the pandemic response effort? The COVID-19 pandemic was a stark reminder that the social contract which provides dentists an honored place in society carries an obligation to put others' welfare ahead of our own. As providers with specialized knowledge, skills and facilities, we have a duty to ease the suffering of others and provide assistance however we can.

How did you and/or your organization champion the effort?

There was an immediate willingness among the Rutgers School of Dental Medicine (RSDM) community to step up during the crisis, despite a national climate of panic and fear. The school quickly setup a COVID-19 dental emergency clinic to minimize patients arriving at hospital emergencies rooms. A teledentistry service was also created. Our oral and maxillofacial surgery residents crossed services helping in the ICU, emergency room, and other critical areas. Faculty, staff, students, and residents provided volunteer support where most needed. Students substituted their in-person community service efforts with Zoom meetings so they could provide families with oral health education and even help with kids' homework.

But our most prominent contribution occurred during the height of the first wave in April, when we converted our pediatric and special needs clinics to fill a critical need for bed space at our principal teaching hospital, University Hospital in Newark.

The hospital is directly connected to the RSDM through hallways, enabling easy access between the two entities. As the pandemic worsened in New Jersey, the hospital’s census quickly rose, outpacing the number of beds. While it was able to provide sufficient intensive care and ventilator services, the need for bed space became critical for patients in need of lower-acuity hospital services. Since the dental school has over 300 operatories with water and vacuum, it became the logical place to provide support if space could be overhauled in time.

Pediatric dental chairs placed into storage in the Rutgers School of Dental Medicine atrium.

While different options were examined, the pediatric dentistry clinic was determined to be the ideal location because it is plumbed for nitrous oxide with oxygen lines connected to a central tank holding closet. Chairs were removed, beds brought in, and oxygen line connectors were switched to accommodate standard hospital fittings. Glass was removed from windows so exhaust fans could be connected to HEPA filters, creating negative air pressure and ensuring the virus would not enter the school’s ventilation system and spread virus remnants through the rest of the building.

Rutgers School of Dental Medicine’s pediatric dental clinical set up as a hospital wing with beds in place of operatories.
What was your timeline?

On March 27, when the Governor of New Jersey issued an executive order closing all non-emergency medical and dental services, the school began immediately converting our urgent care service to a COVID-19 emergency service. The dental clinic conversion took two weeks once the final decision was made and it remained operational for two months. Staffing was augmented by the Army, which sent a unit to assist University Hospital. A team of physicians, nurses and other unit members were assigned to the dental clinic, providing consistency of staff. Conversion back to the pediatric dental and special care clinic took another two weeks with cosmetic repairs completed after our clinic was back in operation.

In the meantime, pediatric and special care patients needed to be funneled to other clinics. It was a particular challenge since these are some of our most vulnerable and high-need populations. But the RSDM community went above and beyond to accommodate them and make them feel welcome during the relocation.

What was the result of the effort?

While dental offices were closed, the Rutgers School of Dental Medicine provided over 2,000 in-person emergency visits and another 1600 teledentistry visits. Patients came from all over New Jersey. The temporary dental school space turned out to be perfect as a COVID-19 step-down hospital ward for patients who were a few days away from discharge. Each operatory made for an ideal hospital bed bay with water, vacuum, and oxygen in each bay. The 32-operatory facility was converted into a 20-bed in-patient annex including areas set aside for dispensing food service, laundry, nursing station, spare equipment storage, and physician stations.

What were the lessons learned?

There are many ways we can contribute to the public health response during an infectious disease pandemic. Collaboration and partnerships enable leveraging of resources with the sum greater than its parts. Thinking outside the box enabled creative ideas to emerge. When there is a will, there is a way.

Is this expanded institutional capacity scalable at other academic healthcare institutions?

As we have seen, schools across the country contributed in many ways. Because many are part of academic health centers with several located either within their partner hospitals or within close proximity, collaborations between the two are extremely logical. Other dental schools who aren’t in proximity to partner hospitals but are part of anchor institutions in their communities can help lead public health initiatives. Throughout the nation, dental schools came forward to provide emergency care along with a myriad of other actions taken to help lessen the impact of the pandemic; and as the public health needs of the pandemic evolve, academic health care institutions will continue to respond as evidenced by schools’ participation in public health messaging, testing efforts, and vaccination programs.

Fire and law enforcement personnel thanking all healthcare workers (including dental school personnel) on the University Hospital and Rutgers Biomedical Health Campus in Newark, New Jersey.

Thank you and directional signage for Army and University Hospital personnel at the Rutgers School of Dental Medicine.

Hospital Surge Unit trailer outside of the Rutgers School of Dental Medicine.
The American College of Dentists came into existence a hundred years ago and its primary aims were to cultivate and encourage a higher type of professional spirit and broader sense of social responsibility, to encourage and promote professional conduct, and to acknowledge such through fellowship in the college. Each decade brought unique issues to the dental profession, and the college had the leadership, talent, and resources to effectively confront them. Among other successes, the College’s push for educational and curricula reform set new standards for dental education. Today, the American College of Dentists continues to embody its founding principles through a thousand acts of professionalism and commitment, thereby maintaining its unique distinction as the conscience of dentistry. The College remains dedicated to creating new opportunities in education, leadership, and professionalism.

As an integral part of our centennial celebration (1920-2020), we published a commemorative book that details our long and laudable history. Supported by the digital archive project, we were able to preserve our past as we prepare for our second century of service. However, historians must do more than merely document the past for posterity, they must also ensure veracity in documentation. Dr. Stephen A. Ralls champions this effort in the following article: A Centennial Puzzle.

Learn more about the history of the American College of Dentists

History of the ACD

The American College of Dentists was born in the post-pandemic haze of the Roaring Twenties where postwar prosperity was responsible for much of the roar. World War I veterans returned to the labor force and fueled an explosion of industrial growth in the United States, Canada, and beyond. Indeed, this was a period of social, artistic, cultural, and economic dynamism. America stood at a crossroads between innovation and tradition. From this backdrop, a thoroughly modern America emerged, and the soundtrack was jazz.
A Centennial Puzzle

Stephen A. Ralls, DDS, EdD, MSD, FACD

Much like the famous rhetorical question posed by Tertullian, we can also ask, “What does Cedar Rapids have to do with Boston?” Cedar Rapids? Yes, that is correct. Given the timing of this spring issue, it seems appropriate to roll the clock back 100 years to the spring of 1920—to Cedar Rapids, Iowa.

You’ve no doubt heard about the founding of the College in Boston on August 20, 1920, especially during this, our centennial year. Obviously, the College did not just spontaneously spring to life one day ex nihilo. The watershed meeting at the Copley-Plaza Hotel was the premeditated outcome of discussions that took place in Cedar Rapids nearly four months earlier.
THE STORY

The history of the College compiled by Otto W. Brandhorst circa 1970 indicates our origins can be traced to the interchange of four dental leaders who had been invited to the home of Dr. and Mrs. John Finn for dinner, the location being specifically mentioned as 1403 Second Avenue SE. That dinner event took place in Cedar Rapids during the 58th annual meeting of the Iowa State Dental Society (ISDS), May 4–6, 1920. The four organizers were John V. Conzett of Dubuque, Iowa, H. Edmund Friesell of Pittsburgh, Otto U. King of Chicago, and Arthur D. Black, also of Chicago. The four were, respectively, the president, president-elect, and secretary of the National Dental Association (now the American Dental Association), and president of the National Association of Dental Faculties.

A meeting was ultimately planned in conjunction with the National Dental Association session later that year in Boston and invitations were sent to key dental leaders around the country. The meeting took place and the rest is history.

WHICH FINN?

So far, so good. As the story goes, our organization was conceived sometime between May 4–6 at the home of Dr. John Finn in Cedar Rapids. Well, not so fast. Unfortunately, there are some showstopping discrepancies. There is no Dr. John Finn found in Cedar Rapids anytime near 1920. Enter Dr. William Finn, Jr. William Finn was not only a dentist, he was “superintendent of clinics” and “general chairman of local arrangements” for the 1920 annual meeting of the ISDS. He was also a candidate for president of the society in 1920 and was included in a contemporary article in The Cedar Rapids Evening Gazette of May 5th that also mentioned Drs. Conzett, Friesell, King, and Black, among others. There was also an early connection between John V. Conzett and William Finn through a small dental organization that limited its membership to 30. Drs. Conzett and Finn both served as founding officers of the E.K. Wedelstaedt Study Club, established December 17, 1902, in Cedar Rapids. Another connection became evident in 1923 when William Finn moved to Pittsburgh to join the faculty of the dental school, which was then under the deanship of H. Edmund Friesell. It seems clear that any Finn connection with early College history had to have been through Dr. William Finn, Jr.

WHICH HOUSE?

But now the plot thickens. William Finn did not live at 1403 Second Avenue SE, the address given by Brandhorst as the location of the all-important dinner meeting. William Finn lived at 392 Twenty-first Street SE and city directories indicate he lived at that address from at least 1917 through 1922. His 1955 obituary even mentions “392 Twenty-first street SE” as his address while living in Cedar Rapids. Who, then, lived at 1403 Second Avenue SE? That address belonged to Rev. Hiram H. Brownell, pastor of the Grande Avenue Presbyterian Church, who lived there with his family from at least 1907 through his death in 1924.

Brandhorst also added an unusual twist. He noted in his history that
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“The Finn House” at 1403 Second Avenue SE was moved to 1405 Second Avenue SE “to make room for a filling station,” the notation being captioned under what is implied as a post-move photograph of the house. This just leads to more confusion. Using Google Street View, the photograph is unquestionably the house at 1407 Second Avenue SE. Moreover, the visual evidence for a filling station is lacking and the numbers of the adjoining houses jump from 1403 to 1407—there is no 1405 address.

A relatively recent article by Diane Langton clarifies the history of the corner house at 1403 Second Avenue SE and indicates Brandhorst’s focus on it was definitely misplaced. Her piece, “Time Machine: House of Teachers,” appeared in the May 18, 2015, issue of The Gazette, and it addresses the specific house where the historic dinner meeting supposedly took place. Langton includes a 2015 photograph and confirms what my research was showing that it is the same house occupied by the Olmsted family in 1900, and which then passed to the Brownell family before 1910. The house pictured by Brandhorst in his history is the one next to the house at 1403 Second Avenue SE, and it is not the house on the corner formerly occupied by the Olmsted and Brownell families. The Langton article clearly indicates the house found today at the 1403 address is the same house, in the same place, and largely as built in 1896. It was never moved. The article also provides its ownership pedigree and from that we can dispense with the notion that the 1403 house ever belonged to any Finn family.

THE BREAKTHROUGH

It was a mess that needed cleaning. Quite fortuitously one newspaper entry provided the key that helped unlock this enigma. A notice in The Cedar Rapids Evening Gazette dated February 14, 1916, stated, “Mrs. J.G. Crozer and her daughters, Mrs. William Finn and her daughters, Mrs. William Finn and Mrs. Robert Hall, entertained informally this afternoon at the Crozer residence, 1409 Second avenue, . . . ” Come again? Yes, and importantly, the house at 1409 Second Avenue SE was immediately adjacent to the house at 1403 Second Avenue SE that was mentioned by Brandhorst.

A few facts provide important background and perspective. William Finn had married Lucy Mae Crozer in 1895. Lucy Mae’s parents, Mrs. and Mrs. James G. Crozer, purchased the house at 1409 Second Avenue SE in 1911. Her parents then died two weeks apart, her mother dying last on May 14, 1919. Mae C. Finn was named administratrix in early July. Her mother’s will left “all the property real, personal and mixed” to her three daughters, including “Mrs. Mae Finn,” to “share and share alike.” As the lone exceptions, she left her husband $100 and imposed the condition that her daughters provide for his support. Since he had already died, those provisions were moot. Now in their possession, the property at 1409 Second Avenue SE was sold on July 16, 1921 by Merette L. Abel, Mae C. Finn, and Katherine Hall, who were the three married daughters of Mr. and Mrs. Crozer. “Wm. Finn,” stated as Mae’s husband, was one of the witnesses to the sale. The legal description given on the deed, “Lot Seven (7), Block Six (6), Bever Park Addition,” has been consistently associated with that property and survived today.

The property maintained its 1409 street number until about April-June of 1965 when it strangely shifted to 1407. Based on a legal notice of April 30, 1965, the owner of the house may have introduced the 1407 number when he was appealing a ruling to the Board of Adjustment regarding a “14 feet wide minimum combined side yards requirement.” The notice interestingly describes the house as the “premises at 1407-1409 Second Avenue SE.” Since then, the house that had been numbered 1409 has been recognized as 1407 and is so indexed in the City Assessor’s Office. That office also indicates the house was built in 1900 and is currently classified as multi-residential. Of particular interest, when the Land
Records Map of the Linn County GIS Portal is searched for “1407 2nd Ave SE, Cedar Rapids” and the “Address Label” layer is selected, the property displays both the 1407 and 1409 house numbers on the structure.

What about the assertion by Brandhorst that the house identified in his history as the place of our conception was originally moved from 1403 Second Avenue SE to make room for a filling station? There is no known evidence for any moves involving that house or the one next-door at 1409 Second Avenue SE (now 1407). The street number change from 1409 to 1407 for the latter house may well have been a factor in Brandhorst’s confused addresses. There is also no known connection with a filling station for those houses or the one at 1415 Second Avenue SE, which was on the opposite side of the 1409 (now 1407) house and became a parking lot sometime after 1972. The filling station story is perplexing, and its basis remains a mystery.

What does all this mean? It seems clear that the key dinner meeting of our organizers took place at 1409 Second Avenue SE (now 1407). At the time of the dinner, the Crozer couple had died and the house was in the hands of their three daughters. So, in a sense, the dinner was at a Finn house because at that point, William Finn’s wife did own a share of the house. The reason for the use of that home rather than the Finn’s residence at 392 Twenty-first Street SE is unclear, but is probably related to size, condition, or location.

There is positive news. Brandhorst had the right lot location, with the right house on it, and the photograph in his history depicts the correct house. Besides the Finn misnomer, what’s not correct, however, is the house numbering and the assertion that the house in the photograph was originally moved from 1403 Sec-
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Stephen A. Ralls, DDS, EdD, MSD, FACD

second Avenue SE to its current location. The address attributed to the house in the photograph is also incorrect. It was erroneously labeled as 1405 Second Avenue SE where it should have been identified as 1407 Second Avenue SE (or as 1409 Second Avenue SE if referring to the property before April-June of 1965).

WHICH DAY?

On another positive note, the actual day the College was conceived can be narrowed down considerably. The date of the ISDS meeting was May 4–6, 1920. On Tuesday, May 4th, John V. Conzett provided a major evening presentation entitled, "The Problems of Local Infection." On the same evening H. Edmund Friesell conducted a special initiation at the Psi Omega banquet, where he also acted as toastmaster for the evening. With two of the organizers occupied with evening speaking events on May 4th, that date can be scratched as a possibility for the dinner hosted by the Finns. There is a similar situation on the evening of May 5th where Arthur D. Black provided the principal address, "Chronic Mouth Infections and their Treatment." Using the same reasoning, May 5th can also be eliminated as a possible date for the Finn dinner. The ISDS meeting finished up May 6th with the last scheduled events beginning at 1:30 p.m. By a process of elimination, that leaves the date for the dinner as Thursday, May 6th. It is remotely possible that the Finn dinner took place on Monday, May 3rd, but given that three of our four organizers would have been traveling in from Chicago or Pittsburgh, probably by train, it seems quite unlikely that Monday would have been used for that purpose. The Thursday, May 6th, date also leaves open the realistic possibility that the Finn dinner may have been an impromptu event conceived during the ISDS meeting.

FINAL THOUGHTS

If the College was first envisioned by the four organizers at the house of a Dr. Finn in Cedar Rapids during the ISDS meeting of 1920—and the evidence supports that statement—then it can be reasonably concluded that the College was conceived at the house that had belonged to the in-laws of Dr. William Finn, Jr., which at the time was 1409 Second Avenue SE and partially owned by Dr. Finn’s wife. The street address for the property was changed 55 years ago to 1407 Second Street SE. As to the date of the famed dinner hosted by the Finns, it appears that happened on the evening of Thursday, May 6th.

One pesky question remains. Why wasn’t William Finn included as one of the founders? His name is curiously absent. It seems strange that Dr. Finn and his wife would host a dinner for our four organizers that would prompt discussion of a new organization, and with Dr. Finn presumably sitting in, but then not including him in the formal founding in Boston. Perhaps he was invited that night to participate but declined. To add to the intrigue, the 1955 obituary for Dr. Finn indicates he "held a fellowship in the American College of Dentists," but there is no record of his induction in Brandhorst’s history.

 Corrections can be awkward, and this is one of those times. This account is not meant to diminish in any way the remarkable record, profound impact, and stellar reputation of Otto W. Brandhorst. No criticism is intended, he was working with what he had available. With that, this chapter closes on the centennial puzzle. The events in Cedar Rapids represent our true genesis and deserve more recognition. The centennial focus now turns south to the Sunshine State.

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Dr. Ralls can be reached at smugcod@gmail.com.
The American College of Dentists was founded August 20, 1920 at the Copley-Plaza Hotel, Boston, by a group of visionary leaders who believed dentistry must look beyond today and plan for the future. These visionaries understood the issues facing the profession and the impact that the Flexner Report had on medical education and the corresponding Gies Report would have on dental education. The founding members of the American College of Dentists actively participated in the landmark Gies Survey of dental education for the Carnegie Foundation. They advocated for educational and curriculum reform that set a new standard for dental education. From its inception, the American College of Dentists was established as a nonprofit organization dedicated to the highest ideals of the dental profession and service to humanity. Their charge was to create an organization to promote and encourage the growth and expansion of the dental profession. Over the years, the American College of Dentists has faced important challenges and created new opportunities in the delivery of oral health services, professionalism, journalism, education, and research. We hope this look back at the distinguished past of the College will inspire enthusiasm, energy, and involvement of ACD Fellows in our dynamic future.