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Life Fellows

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excellence, ethics, professionalism,
and leadership in dentistry

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Mission

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

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- 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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LIFE FELLOWS

- 5 **Fifty Years of Change in Dentistry with Dr. Gordon Rovelstad**
Gordon H. Rovelstad, DDS, MSD, PhD, FACD, with Stephen A. Ralls, DDS, EdD, MSD, FACD
- 9 **Dr. Daniel Laskin: Calling Attention to What Matters in the Profession**
David W. Chambers, EdM, MBA, PhD, FACD
- 12 **Walter C. Sandusky, Jr.**
Carl L. Sebelius, Jr., DDS, FACD
- 14 **Dr. Ben Pavone: Getting the Fit Right**
David W. Chambers, EdM, MBA, PhD, FACD
- 17 **Dr. William E. Brown: A 50-Year ACD Member**
Krista M. Jones, DDS, FACD
- 19 **Dr. Howard I. Mark on What It Means to Be a Professional**
David W. Chambers, EdM, MBA, PhD, FACD

ISSUES IN DENTAL ETHICS

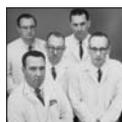
- 21 **The Future of Dental Ethics: Promises Needed**
Donald E. Patthoff, DDS, FACD

SPECIAL FEATURE

- 28 **Blurring the Lines Between General Dentistry and Dental Specialties**
Eric K. Curtis, DDS, FACD

DEPARTMENTS

- 2 **From the Editor**
Ethics as Permissible Behavior
- 4 **Letters to the Editor**
- 33 **Leadership**
Stress



Cover Photograph: Keeping in tune with the times—over a professional lifetime.

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FROM THE EDITOR

ETHICS AS PERMISSIBLE BEHAVIOR

When my students and I discuss evidence-based dentistry, I share the strange case of Dr. B.B. Brown of St. Louis. He had a dispute with his dental organization over the use of amalgam. His colleagues in the American Society of Dental Surgeons wanted him to sign a pledge concerning its use, and he was eventually voted out of membership for refusing to do so. He wrote a letter in his defense saying, "Each member of this learned body must practice in accordance to the dogmas of science, as received by the learned, at the same time, however, exercising his best judgment in reference to the adoption, or non-adoption, of any remedial agent which research, together with careful experiment, may have placed within reach."

The year was 1847; the pledge required promising not to use amalgam because evidence showed it was ineffective; Dr. Brown switched to medical practice; and the American Society of Dental Surgeons went bust, to be replaced by a group that was replaced

by the National Dental Association, which became in time the American Dental Association.

Practitioners would be proud of the debate that follows this case among students who recognize that grounding dentistry in science is not a formulaic process, that groups of professionals need to establish and maintain standards, and that individual dentists must do what is right in their own eyes.

The case of Dr. Brown reveals something of interest about professional codes. There is a difference between the American Dental Association Code of Professional Conduct and the American College of Dentists Core Values and Aspirational Code of Ethics. The first is an "expression of specific types of conduct that are either required or prohibited"; the second is a set of values that "collectively reflect the character, charter, and mission" of the College. Only the former are enforceable. The American Society of Dental Surgeons put out Dr. Brown based on its code of conduct; the American College might have supported Dr. Brown based on our core values of competence, "continual self-assessment about the outcome of patient care," and tolerance, "understanding how differences may affect patient choices and treatment."

Aspirational codes and codes of permissible conduct can be based on ethical principles, but they need not be. Values, character, and other touchstones are sometimes used. The standard principles of beneficence, nonmaleficence, autonomy, and justice (sometimes

veracity as well) are general names for desirable kinds of behavior. They often serve as scaffolding for both codes of permissible conduct and aspirational codes, but by themselves they are incomplete. Interpretation is always an issue and contradictory actions can be defended based on principles.

My students typically come to the position that we need both codes of conduct and aspirational statements. I believe they are right.

A clear sense of ethics as what is permissible can be gathered by reading the "Ethical Moment" department in *JADA*. These columns are framed as questions: "If this happens, what are my obligations?" "Could I do X, Y, or Z?" Often the responses blend ethics and the law. Quite often there is no definitive resolution, and a range of actions (with cautions) is offered for consideration. The point of a code is to define the domain of permissible actions. The ADA parameters of care are another example of this approach.

Among moral philosophers, this process is known as "defining the moral free space." One could think of codes of morally permissible action as drawing boundaries. The actions on one side of the line are unacceptable because they

open one to disapproval and perhaps legal or other sanctions. Everything on the other side of the line is okay. Naturally there is a lot of concern over where the lines should be drawn and wrangling focuses on behavior that is very close to the line. Dentists learn this preoccupation in dental school, where they argue about answers on exams when they are just one point below the cutoff score.

Although codes can be violated many ways and there are multiple permissible behaviors, this is not surrendering to the dangerous position of moral relativism. It is ethical pluralism: many right and many wrong actions, but a clear and publicly agreed way of distinguishing which actions belong in which categories. Some moral philosophers argue that the best ethical systems are those that maximize moral free space.

The view of ethical codes of the permissible is based on the great principle of liberty developed in Europe and America in the eighteenth century. Liberalism (in the philosophical and not the political sense) means that each person should be entitled to the maximum personal freedom consistent with the same freedoms being extended to others. It is a powerful rule and should always be consulted whenever a group considers making rules for the common good. The rule is difficult to apply, however, because of special pleadings regarding just who

those “others” are who should be entitled to the same moral free space we enjoy. That part about “all men are created equal” in the U.S. Declaration of Independence has been troublesome. The extent to which patients participated in the creation of the ADA Code is not clear.

By contrast, aspirational codes do not draw lines. They are points on the horizon, destinations. They help lay the course for the journey to a better common world. Aspirational codes do not raise ethical standards by labeling folks with white hats and gray hats and appointing lawyers to adjust the fence posts. The common good is enlarged by inviting individuals to share a vision requiring convergence on a mutually agreed ideal of oral health.

Ethics committees in schools and component societies should meet regularly every few weeks even if they have no concrete projects for improving the ethical climate of their organizations. Codes of what is permissible invite judgments and appeals from those judgments. Aspirational ethical standards invite discussion and action toward the common good.



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LETTER TO THE EDITOR



I am sure there are hundreds, if not thousands, of retiring and retired dentists who would love to be able to work productively on a limited basis.

TO THE EDITOR:

I am writing in response to the very fine speech by Dr. Machen written up in the Winter 2007 issue of the journal titled "We can be leaders in addressing children's oral healthcare needs."

Two brief responses regarding Medicaid patients and dental treatment should be mentioned.

One: Medicaid patients may have limited access to a general dental office because of fee limitations, but in my personal experience, the greatest obstacle by far is the failure of patients to show up. That is much costlier than low fees—it is no fees. Most of my colleagues have had the same experiences and reluctantly took the same action I did and opted out, despite the fact that we wished to help.

Two: An easily available solution to the shortage of dentists in certain areas, mostly low income, is to allow dentists who have valid licenses in other states to practice in states in which they do not have a license. I realize that with regional boards now in effect licensure is less of a problem.

However, there are still a large number of us who have licenses in just one or two states and are therefore unable to practice except in those states. I am retired and had active Alaska and Wisconsin licenses in good standing. I retired to Arizona and looked into practicing in charitable situations here, even to the extent of inquiring of the Public Health Service Indian Health

Care Division. But the paperwork was prohibitive.

I suggest that arrangements be made, initiated by the College, to allow dentists with licenses in good standing (perhaps with an age limit of over 55) to be allowed to practice in any state of their choice.

As Dr. Machen so ably pointed out, secondary and tertiary levels of dental treatment are actively being pursued across the country, including Alaska in particular. Is not a retired dentist preferable to an ambitious assistant or hygienist?

I am sure there are hundreds, if not thousands, of retiring and retired dentists who would love to be able to work productively on a limited basis in their new communities if state laws would so allow. And I dare say most of us would be happy to work on Medicaid and other limited-fee patients as well. They would just need to show up on time.

Luther L. Paine, DDS, FACD
Chandler, AZ

Fifty YEARS of CHANGE in DENTISTRY with DR. GORDON ROVELSTAD

Gordon H. Rovelstad, DDS, MSD, PhD,
FACD, with Stephen A. Ralls, DDS,
EdD, MSD, FACD



Dr. Gordon H.
Rovelstad

When I began my career, dentistry was a highly regarded profession for the care of the teeth and gums. Dentists conducted individual practices, treating all diseases of the mouth. There were few specialists in the profession: oral surgeons and orthodontists, with some periodontists and prosthodontists. For the most part, dentists only referred patients to other dentists when they found themselves unable to do something such as surgery, endodontics, periodontics, or prosthodontics. The exception was orthodontics, which was quite a different technique for moving teeth, and that was always referred. I chose pediatric dentistry, as the challenging point when most of the dental problems began, after I had one year of an oral surgery internship and two years of duty in the U.S. Navy as a prosthodontist. My practice of pedodontics flourished at the Children's Memorial Hospital of Chicago, and we set up a pediatric dentistry residency as a part of Northwestern University's graduate program.

Duty in the Navy opened my eyes to different techniques and different standards. Some of the finest dental restorations I saw were done in the Navy by Navy dentists. Also, I saw some of the most horrible dental conditions on 17- and 18-year-old men. Private practitioners rarely saw such patients. Dentures were considered a normal result of the process of aging. Some of these young men had to have full dentures.

"Immediate dentures" were just being experimented with. Plastics for denture bases were being introduced to replace Vulcanite. Amalgam was the major restorative material for cavities. Gold inlays were the most reliable material for restoring teeth by private practitioners. Other materials included silicate cement and mixes of zinc oxide.

The air turbine, sandblaster, and ultrasonic instruments were yet to be invented. Slow-speed drills were standard. A cavity preparation for an inlay restoration often took three or four appointments. Most silver amalgam restorations could be inserted in two appointments. Patients justly feared the drill; local anesthesia was rarely used for restorations. Unfortunately, pharmaceuticals for anesthesia more often than not were unstable. The changes that I have seen in dentistry over the course of my career are quite unbelievable:

- New materials have been introduced, along with more natural restorations.
- High-speed air turbine handpieces revolutionized the restoration of teeth. This brought about the need for water spray and vacuum suction of the mouth to reduce heat of teeth due to use of high-speed cutting instruments.

Dr. Ralls is executive director of the American College of Dentists: saralls@acd.org.

The cost of delivering services performed by a greater number of auxiliaries and paraprofessionals, e.g., hygienists and assistants, has placed a greater demand on the dentist to make money. This has influenced the quality of service, diagnoses, and choices of treatment.

- Restorations could be completed in one appointment with the final polishing on a follow-up visit.
- Seating positions of patients were converted from upright to reclining. This change was introduced by Dr. Anderson after World War II, with the chairs being manufactured by a manufacturer in Iowa.
- Fluoride was introduced in community water supplies.
- Preventive dentistry became a respectable component of dental practice.
- The Veterans Administration provided dental care to all veterans, with dental treatment preceding their service during World War II. A fee scale was completed and distributed to all dentists. This immediately had an effect on the profession. Those with lower fees raised them and those with higher fees sought ways to defend them.
- Advertising became much more common.
- Recent developments in the promotion of tooth whiteness and “perfect smiles,” together with practice management methods, have led to the commercialization of dentistry. “Cosmetic dentistry,” “smile,” and similar terms have become common descriptions of types of services to which the public is now exposed.
- The cost of delivering services performed by a greater number of auxiliaries and paraprofessionals, e.g., hygienists and assistants, has placed a greater demand on the dentist to make money. This has influenced the quality of service, diagnoses, and choices of treatment.
- Dental schools converted to more full-time faculty, and this increased the cost of dental education. Private

dental schools developed budgets based on more part-time volunteer personnel.

- It seems more and more dentists are being pushed out of health care and being replaced by technicians.

The College

I was sponsored for Fellowship in the American College of Dentists by Captain Jim English, USN, of Washington, DC. He, along with Bill Ludwick, was the major organizer of research billets in the Navy Dental Corps.

I was inducted in 1956 at the Chalfonte-Haddon Hall Hotel on the Boardwalk in Atlantic City, New Jersey. I remember there was a very heavy rain storm and the hotel leaked. There were puddles on the floor that we had to walk around during the processional. Several new Fellows had to stand under the water that was dripping from the ceiling. The convocation was Saturday afternoon and the dinner dance was later that night. The business meeting of the College was Saturday morning and included the president’s address followed by the invited speaker. Sections did not meet during the College meetings and the few Sections that did exist met during their respective state meetings.

I became a member of the Washington, DC, Section. Meetings were rotated between Walter Reed Medical Center, the Navy Medical Center, and Georgetown University. Attempts at four or five meetings a year were tried. The Washington, DC, Section rivaled the Chicago Section and New York Section—centered in Manhattan—as the most active Sections. The dental school at Howard University was not mentioned when I entered the College, and I cannot remember an African American Fellow at the time. I believe Dr. Clifton O. Dummett was the first.

The College was a small group, and recognized as the highest honor a dentist could achieve. Fellowship was by confidential selection and could not be applied for, which is still the case. Being nominated without solicitation was itself recognition of achievement with high ethical standards. The College has been a goal for dentists who deliver high-quality and ethical dental care. Fellowship in the College represented a small percentage of dentists who followed the standards of practice described in the bylaws.

Much of the discussion among College members when I came in was focused on the question, “What does the College do besides honor its own?” New Fellows were asked to participate in developing projects that would give recognition to the College and its mission, but that did not take hold. Initial attempts to bring Section officers together at the annual meeting were a failure. I remember being one of five members present to hear what Sections were doing. This was at 5:00 p.m. on Friday afternoon of the annual meeting. I believe schedules and procedures were too ingrained to change, i.e., Friday after work; Saturday morning College business meeting with special lectures; Saturday luncheon with a humorist; afternoon convocation; Saturday night dinner dance; and opening session of the ADA meeting on Sunday morning.

The ADA board members were invited and introduced as guests at the College dinner dance. Each year, in turn, the ACD board members were introduced at the opening session of the ADA meeting. The cooperation between the ADA and ACD was outstanding—their annual meetings were always coordinated.

I believe that the ACD set the ethical standards for the ADA. Most ADA officers and board members were Fellows of the College. In summary, the College set the goals for high standards of dentistry—goals to which I would strive.

ISSUES FACING DENTISTRY

Having watched the profession of dentistry being challenged by other groups and many of its own members over the past 50 years, I believe the major issue is that dentistry must maintain its standing as a profession and member of the healthcare field. Efforts to place dentistry in a box with optometry, podiatry, and technicians for rehabilitation centers are risky, as is classifying dentistry with the allied fields.

When I entered practice, there was a rivalry between physicians and dentists. This occurred organizationally. However, my dad worked readily with physicians in our hometown and enjoyed a high level of professional respect. Referrals were common and my dad had privileges in both major hospitals. Criticism was most often directed at those practitioners who limited their practices to prosthetics (dentures) and did not participate in problems involving infections or nutritional disorders.

During my active years I have seen a regional variance. There was professional recognition in the Midwest. In the East, dentists were regarded as an independent profession primarily for the restoration of teeth. In the West, dentists were more commercial than elsewhere. Advertising began to be seen more frequently, with a focus on patient appearance. Several dental schools were more advanced in dental practice as well as pathology.

The entire country was greatly affected by European dentists, anatomists, and physiologists who came to America in the forties. The major texts in dental anatomy and growth and development arose from these scientists. Dental research grew rapidly, sparked by the

There was professional recognition in the Midwest. In the East, dentists were regarded as an independent profession primarily for the restoration of teeth. In the West, dentists were more commercial than elsewhere.

Many young dentists have been underwritten by manufacturers to set up a modern office with a full staff. The overhead is considerably more than the dentists would be able to accomplish alone.

leadership from this group. Not only were dentists stimulated, the dental industry changed. Several Europeans entering the United States after World War II introduced new instruments and new materials, and they developed the companies to provide them.

The recent focus on cosmetic dentistry, with dentists listing themselves as “cosmetic dentists,” is a problem for the profession. This is unfortunately reinforced at dental meetings. The frequent naming of conferences after commercial concerns, with underwriting of costs, is a big contributing factor. All of these activities have turned the heads of many dentists to openly solicit patients and advertise directly to the public.

Many young dentists have been underwritten by manufacturers to set up a modern office with a full staff. The overhead is considerably more than the dentists would be able to accomplish alone. Paying off student loans also adds to this. Higher payrolls have influenced many dentists to do whatever it takes to get patients.

The problem areas can be summarized as:

- High pressure sales techniques
- High initial costs paid for by commercial grants
- People’s response to fancy ads

There is one other problem—the lack of support for dental care under Medicare. This, in a way, removes dentists from the medical team. Only those dental procedures requiring hospitalization are supported by Medicare. Does this add to the subtle downgrading of dentistry as a healthcare profession? Of course it does. The poor, the children, and the aged are the ones who have poor dental health and high treatment needs. New dentists do not enter practice to provide even limited care to the poor, whether it be in

the cities, the country, near the coasts, or in the mountains.

For the College, the effort must be expended on ethics and professionalism, including the delivery of care to the public. There are those who want a nice smile and will pay high fees to have it, and they are determining a lot of what is happening in our profession today.

Dr. Gordon H. Rovelstad was born in Elgin, Illinois, in 1921. He received his DDS degree from Northwestern University in 1944, his MSD in 1948, and his PhD in 1960. He was called to active duty during the Korean War and he remained for a career in the U.S. Navy, emphasizing dental research and serving as commanding officer, Naval Dental Research Institute. He retired with the rank of captain. Dr. Rovelstad is a past president of the American Board of Pediatric Dentistry, the American Academy of Pediatric Dentistry, the William J. Gies Foundation, and the International Association of Dental Research. He has served as professor and chair, Department of Pediatric Dentistry at the University of Mississippi, and later as assistant dean for education programs. Dr. Rovelstad was president of the American College of Dentists from 1979-1980 and was executive director from 1981-1992. He is the recipient of numerous honors and awards and in 1998 received the William J. Gies Award from the College. ■

DR. DANIEL LASKIN: CALLING ATTENTION TO WHAT MATTERS IN THE PROFESSION

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



Dr. Daniel Laskin

“In addition to practicing oral surgery, I teach and write. And I think I am making a contribution to the profession. I don’t tell people how to think or what they should do. Dentists are too smart for that. I just call my colleagues’ attention to matters that are important and share a few thoughts to get them started. If you keep doing that over and over again, pretty soon something good comes of it.”

That is the way Dr. Daniel Laskin describes his more than 50 years of contribution to dentistry. He works to engage the minds of students and practitioners. He believes that ideas have power, and he exemplifies the continuing leadership expected of all Fellows of the College though advancing ideas.

Dr. Laskin is a long-time faculty member at Virginia Commonwealth University School of Dentistry in Richmond and likely holds the record for longest tenure as a dental editor. For 30 years, he was editor of the *Journal of Oral and Maxillofacial Surgery*. That means reading a lot of manuscripts and writing a lot of editorials. He has also contributed an academic’s fair share of research papers and 16 text books. He was editor of the newsletter for the Virginia Section of ACD. He still edits the *AAOMS Newsletter*. In fact, one of his books, *The Changing Face of Oral and Maxillofacial Surgery*, would be a good way to get to know Dr. Laskin; it is a collection of over 200 of his editorials.

“Maybe it started with the writing I did in high school,” says Dr. Laskin, “or

maybe with my work on the newspaper at New York University. I always thought writing was a way to get closer to the people and the issues that were making a difference. When I finished my specialty training, I became involved with what was then known as the American Society for Oral Surgery (later AAOMS) and volunteered to work on the newsletter.” As Fellows of the College know, that is how leadership starts: volunteering to help where your talents can be of service.

Dr. Laskin credits his mother with steering him toward dentistry. “In high school, I was a better athlete than student. I loved basketball. I thought I would major in physical education (what they now call sports physiology) and perhaps become a coach.” When enrolling at NYU, the counselors asked what he wanted to declare as his major. Dr. Laskin said “phys ed would be fine.” But his mother who was there to protect his interests interrupted, “No, put my son down for premed.”

After a year at NYU, Dr. Laskin transferred to Indiana University, where he did complete a premed program. World War II was raging, and although Dr. Laskin had applied to medical and dental schools, he was also called to begin basic training in the U.S. Army. “My acceptance to the dental school at Indiana came about one day after I started basic training.”

The real prize for Dr. Laskin is knowing that he is connecting with dentists and challenging them just a little bit.

Dr. Laskin has two habits that appear to be common among writers. He reads—a lot—and he is curious about things. “I keep a file of potential topics for editorials,” Dr. Laskin reports. “When I am talking to someone or reading something, a turn of phrase, a reference, or an unusual juxtaposition of ideas will strike me as offering insight. If that connects with a topic that is timely and matters for dentistry and I can work it around to being a sound idea, there is an editorial. It used to take me two days to write and rewrite each piece; but now I can get one finished in half a day, especially if it is an idea that really grabs my attention.”

Dr. Laskin’s forte is the editorial, and he is the master in dentistry. He has won the Gies award from the American Association of Dental Editors for editorial writing eight times, and 11 more times he has received honorable mention in this competition. “Heck,” he jokes, “they even gave me an award for winning so many awards.”

The real prize for Dr. Laskin is knowing that he is connecting with dentists and challenging them just a little bit. “Sometimes, I may even challenge them too much. I have received more than a few phone calls expressing disagreement with my positions. I once wrote an editorial titled “Going out with a bang.” Several times a reader tried to call me to convince me I was off base. I finally made the phone call myself that connected us and was treated to a large dose of opinion. Suddenly I realized that I was paying for this useless lecture, so

I excused myself and ‘went out with a bang’—literally putting the phone back where it belonged.”

One disappointment Dr. Laskin ponders is the fact that dentist readers are so reluctant to respond in writing when they have differences of opinion. The phone call, the unwritten letter, and the rumor that someone was heard complaining to friends at a meeting prove that dentists are thinkers with strong opinions. If more of these opinions were worked up into formal responses, that would be a contribution to raising the level of discussion. As a general rule, editors welcome this kind of dialogue.

“There are so many important, complex issues in dentistry—single- or double-degree programs in oral surgery, parameters of care, initial licensure, commercialism, prophylactic removal of asymptomatic third molars. These are big issues, and it is unlikely that any individual will ever have the complete or final word on them. So it is important that we hear from a full range of the practicing community. I wish more people would share their views.”

Dr. Laskin has made a list of some of the changes he has seen during his dental career (see sidebar). He realizes that others could make their own lists, but he emphasizes that each of the changes, cumulatively very substantial, was accompanied by extensive discussion. Each change was large precisely because it affected both new ways of doing dentistry, but also because it required rethinking of prevailing practices. “We have to talk about change if we are going to play leadership roles rather than be jostled and dragged along,” Dr. Laskin believes. “I have been accused of spending my career defending indefensible positions. It isn’t true, of course. I just enjoy talking with my colleagues about ways we might do dentistry better.”

Curiosity, wanting to talk through the issues that matter to dentistry, and a willingness to study up and make a sound argument were the traits in Dr. Laskin that attracted the attention of Dr. Sol Levy and led to Dr. Laskin's induction into the American College of Dentists in 1957.

"To my way of thinking, there are organizations that concentrate on providing membership benefits and there are organizations that inspire. The ACD falls in the latter category. I do not look to them for a discount on anything, an affinity card, or a T-shirt. I like what the College stands for, especially its position on the importance of ethics, and I draw strength from knowing that others in the College feel the same way about dentistry that I do. I orient toward some groups because they make change happen; I appreciate the College because it has provide a stabilizing force for the five decades I have been a Fellow, and has kept our attention on the changeless qualities of ethics, leadership, and excellence that will be the foundation of dentistry no matter what the newest technology, treatment procedures, or materials might happen to be." Ethics matters so much to Dr. Laskin that he recently endowed an annual lectureship on that subject at his alma mater.

"When I was inducted into the College, the initiation fee included my cap and gown. If you consider all the times I have worn them since then, that is one of the best investments anyone could have made in dentistry." But, of course, that is what the American College of Dentists does best—invest in leaders such as Dr. Daniel Laskin. ■

SOME OF THE CHANGES IN DENTISTRY IN THE PAST 50 YEARS

High-speed handpiece and panoramic radiology have altered the profile of treatments offered to patients.

Anesthetic and instrumentation developments have made orthognathic surgery safe and predictable.

Use of small plates and screws have revolutionized the management of maxillofacial trauma.

Branemark's work in implants allows us to offer new options to patients and has made some forms of preprosthetic surgery obsolete.

Surgical removal of multiple teeth in children due to rampant caries is much less common.

Improvements in barrier technique and use of disposables is a consequence of the discovery of AIDS; we have learned to manage such infections.

Oral surgeons are now accepted on hospital staffs and are assuming leadership positions in the Joint Commission on Accreditation of Hospitals.

DDS/MD dual-specialty training has expanded.

The scope for oral surgeons, including direct management of patients, has increased.

The number of recognized specialties has increased, as has the extent of training in almost every specialty.

It has been recognized that TMD conditions are often multifactorial, calling for a team approach to treatment.

Continuous adjustments have been made to the predoctoral dental curriculum in response to new developments in dentistry

WALTER C. SANDUSKY, JR.

Carl L. Sebelius, Jr., DDS, FACD



Dr. Walter Sandusky, Jr.

For 50 years as a Fellow of the American College of Dentists, Walter Sandusky has been described as “upbeat, positive, energetic, and captivating.” Born in Holly Springs, Mississippi, he came to Memphis and graduated with his DDS degree from the University of Tennessee College of Dentistry in 1945. He graduated from the orthodontic program at the same university in 1951 and is still practicing orthodontics with his son, Cooper. He began teaching in the operative department in 1946 and the orthodontic department in 1951, where he is currently professor, Department of Orthodontics, University of Tennessee College of Dentistry.

If the American College of Dentists is composed of dentists who have demonstrated leadership and made exceptional contributions to dentistry, the dental profession, and society, then Dr. Sandusky is that kind of role model. This is a role he has fulfilled all these many years. Not only has he been a mentor to untold numbers of orthodontists graduating from the University of Tennessee, he has lectured extensively throughout the world and has been an active leader of the Tweed Foundation. He has been a responsible citizen: he served his country as a captain in the U.S. Air Force in World War II, was president of the Rotary Club of Memphis East, served his church, and was national president of the Baptist Medical/Dental Fellowship. In addition to all of this, he

has found time for numerous missions to foreign countries.

Dr. Sandusky was president of the Memphis Dental Society when I first became a member of the ADA. That was the start of a long association with him. He is as much a role model for young dentists today as he was in 1968 when I first met him. We recently had a chance to talk about changes in the dental profession, and I learned his perspective of where we are going. His views give support to the idea that there is such a thing as generational ethics, or how people of different ages look at the same problem and see different answers.

When asked what dentistry was like when he was inducted into the American College of Dentists, Dr. Sandusky replied: “Dentistry was an excellent profession 50 years ago when I became a Fellow in the American College of Dentists. It was certainly more difficult to practice—slow-speed drills and old fashioned chairs requiring the dentist to stand all day. Surgical instruments, in most offices, were sterilized in boiling water. No surgical gloves or facemasks were used, nor were lead aprons used for intraoral x-rays. Requirements in dental schools were very strict and, unless he was capable and applied himself diligently, the student was held back or failed out

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of dental school. The primary restorative materials were amalgam, gold, and silicon material. Excellent gold crowns and inlays could be made, many of which are still in use today in older patients. In orthodontics, full bands were placed on each tooth, requiring several office visits for separation and placement of bands, perhaps a six-hour procedure. Now it is only one hour with today's direct-bond brackets. Excellent results could be achieved then, although with much more time and difficulty involved."

Dr. Sandusky has seen some of what he calls favorable changes as well as some unfavorable changes in dentistry over the last 50 years. Some of the good things include modern operatories with reclining chairs, high-speed drills, and the refined maxillofacial surgical procedures, including implants, that have added a new aspect to dentistry. Cosmetic dentistry with modern materials and procedures has opened a new field to dentistry. We now have dental hygienists and dental assistants who are certified to carry out certain dental procedures, which allows the dentist to accommodate more patients with better overall care. CPR training is now required of all dentists, hygienists, and certified dental assistants. Each must complete required yearly hours of continuing education. OSHA requirements have added to the safety of our patients as we follow the required measures in our offices. The addition of dental insurance has enabled many who otherwise could not afford it to have excellent dental care.

Some of the more unfavorable changes, in Dr. Sandusky's opinion, relate to advertising. He states that "In Tennessee we had one of the best "Healing Arts Laws" in the country. Your name on the sign of your office had to meet certain specifications, as did your name in the telephone directory. There could be no advertising, other than sending out formal announcements of your beginning practice or moving your practice to another location. These laws were struck down several years ago by the Federal Trade Commission. Now we see, sadly, all types of advertising by dentists and physicians in the paper (even the Sunday comics), in the telephone directory, and on the radio and TV, in my opinion to the detriment of our profession."

What has fellowship in the American College of Dentists meant to you? Dr. Sandusky replied: "The high ideals of the American College of Dentists have through the years served as a guideline for my practice. That includes the way I approach the public, certainly not through advertising, although it is now legal, and how I conduct my practice and relate to my patients. The ideals of the American College of Dentists have served to elevate our profession to a higher level, which the public is certain to observe. As such, the great profession of dentistry continues to be admired."

"Be proud of this great profession. Do nothing to degrade it in the eyes of the public."

Dr. Walter Cooper Sandusky, Jr., DDS, MS, should be an inspiration to all of us, not only to achieve 50 years of service but to do it in such an exemplary manner. He leaves us with this advice to those in a leadership role. "Be proud of this great profession. Do nothing to degrade it in the eyes of the public. Continue to train yourself to carry out the responsibilities of treating your patients, always striving for excellence in all procedures. Do not set getting rich as a goal. If we treat all patients as we should, the economics will take care of themselves." ■

DR. BEN PAVONE: GETTING THE FIT RIGHT

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



Dr. Ben Pavone

“It’s a matter of doing the right thing.” Dr. Ben Pavone, former long-term dean at the University of California San Francisco (UCSF) School of Dentistry, is one of the most positive individuals you will meet. He is also by nature a bit cautious. That is not an unusual combination of character traits for a dentist, and it may actually be defining for a generation of leaders in the profession.

“I follow the development of materials and procedures,” he says, “and I watch both the science and the rhetoric that accompany them. But it is too much of a simplification to say that aesthetic materials are better than gold, or the other way around. Implants are wonderful. I was once skeptical that they could be made practical. But they are not for everybody and every situation. We have swung pretty far toward appearance as a criteria and talk less now about performance. But I think there is really a better balance in practice than we hear about. It is about the fit. We have many more alternatives to offer patients. The issue is using those approaches ‘that are indicated’ and not otherwise.”

Dr. Pavone grew up in Oakland, California, the son of Italian immigrants. He jokes that dentistry was picked for him at age five by a family friend who used to say, “Oh Ben, he should be a dentist.” That was a ready-made identity that seemed to have some promise, so he took it. Dr. Pavone received his predoctoral training and a teaching certificate from UC Berkeley and completed his dental

training at UCSF. There Dean Willard Fleming pulled him aside and said, “Ben, you should be a dental educator.” Well, there was another identity with promise, so Dr. Pavone tried it on. It fit. After some time teaching preclinical restorative technique, Dr. Pavone became full-time as assistant dean for continuing education in 1956. Two years later, at age 42, Dean Fleming said he had another role he wanted Dr. Pavone to consider—fellowship in the American College of Dentists.

“That has been a perfect fit as well,” reflects Dr. Pavone. “To this day I recall the excitement of marching into the auditorium and across the stage in my gown. I felt proud; I was honored. You might think it is funny that I can’t exactly recall what the convocation speaker talked about, but I have a perfectly clear memory of the emotions surrounding that ceremony. There is an emotional component to professionalism, and some people have forgotten that in the current interest in things scientific. The College has not forgotten that high ideals, ethics, and instilling the pride to be the best dentist possible are what set us apart from other lines of work.”

When Dr. Pavone was about ten, he sold newspapers on Telegraph Avenue near UC Berkeley. A dentist on the paper route, Dr. Norman Huscher, noticed that the boy had a mouth full of caries. He

placed the necessary amalgams and said, "Pay me whenever you can." Dr. Huscher got a free paper every day. About seven years later Dr. Herb Nordstrom replaced these posterior amalgams with sixteen gold restorations. Other than the two restorations that were replaced, this dentistry has lasted three-quarters of a century. "That's what I mean," says Dr. Pavone, "when I say 'do what is indicated and do it well.'" This seems to be a two-part formula for Dr. Pavone. Today, dentists have a wide range of procedures and materials they can offer to patients. Matching the wishes and needs of dentist, patient, and approach is an enjoyable challenge. But dentists have always had a decision to make about what level of care and quality to provide. "Good materials poorly delivered is not good dentistry," in Dr. Pavone's opinion. "That is the great contribution the American College has made. There are many groups saying that this or that product or method is best. But the College is the leader in promoting the highest standards of conduct. That can make a significant difference."

Although he cautions that things move slowly in dental education, Dr. Pavone can mention a few examples of important changes in the past five decades. Formerly, the basic sciences were a set of individual academic disciplines that sat separate from dentistry. Now the application of basic sciences to clinical dentistry has become more integrated with the employment of dual-degree teachers. Dental science research is finding more important and greater

roles in dental schools. Generally, instead of isolated, subject-by-subject instruction, dental education is moving more toward integrated and interrelated instruction. Total oral diagnosis and complete treatment planning have received deserved attention. Special educational opportunities are provided to students with identified special abilities.

"I was fortunate in my timing," says Dr. Pavone. "I entered the continuing education aspect of the profession just at the beginning of the Golden Age of dental school CE." Prior to the 1950s, there was little continuing education available to dentists. Since the 1950s, development of expansion of continuing dental education was one of dentistry's greatest achievements. Specialty groups, societies, and associations were formed to bring interested professionals together to investigate and complete dental knowledge and to educate its attendees on new techniques, procedures, and information.

In 1956 Francis Conley of USC and Gene Zieler of UCLA Extension helped Dr. Pavone plan UCSF's continuing education program. The school's graduates and friends willingly contributed funds for the construction of UCSF's postgraduate center. University administrators, of course, appreciated that attendees paid the full cost of instruction. The offerings included participation courses, study groups, and one- or two-day lecture and demonstration courses in most of the disciplines of dentistry. The postgraduate

"We have swung pretty far toward appearance as a criteria and talk less now about performance. But I think there is really a better balance in practice than we hear about."

“Do what is indicated
and do it well.”

dental center at UCSF was completed with a dedicated lecture auditorium, clinics, and laboratories.

“That was an important time in the history of dentistry,” Dr. Pavone reflects. “Changes in materials, patient interest, and better fundamental training for dentists meant that general practitioners could begin to successfully perform some procedures formerly reserved for specialists. The range of services offered by general dentists expanded. To support that need, dental schools responded with enhanced, practical continuing education programs.”

That picture may have changed somewhat in recent years. Dental schools now provide a fraction of what they used to offer in CE. States and regional meetings, the Internet, academies and institutes, and a wide range of entrepreneurial enterprises are now responding to (and in a few cases creating) a different kind of need for know-how on new techniques. As Dr. Pavone says with a smile, “There is a little bit of everything now in dentistry.” And he reminds us that no procedure or material is good or bad in itself. It has to meet his criteria of being indicated and performed to the highest standards.

Dr. Pavone practiced dentistry part-time in Berkeley before beginning his administrative duties and continued to do so one day per week while dean, and

even for several years after retiring from academics. “It is crucial to stay in touch with practice,” he says. “I have always enjoyed general practice. It is the foundation for the profession, and its challenge has grown tremendously over the years,”

Until recently Dr. Pavone dedicated himself to fund raising. “There are always so many worthy causes, so many ways to be involved, and such an opportunity to influence—even just a little bit—the future of our profession.” Dr. Pavone was particularly involved with the Native Sons of the Golden West and their program to help children with orofacial anomalies. “This was as rewarding as anything I have done in my professional career,” Dr. Pavone reports. “To see the difference that can be made in the appearance and the lives of these children and their families is inspiring.”

At age 92 and with 50 years experience as a Fellow of the American College of Dentists, Dr. Ben Pavone is still leading the way toward excellence, ethics, and professionalism. He says the basic rules still apply, do what is indicated and do it to the highest standard possible. ■

DR. WILLIAM E. BROWN: A 50-YEAR ACD MEMBER

Krista M. Jones, DDS, FACD



Dr. William E. Brown

Talking with Dean William E. Brown about dentistry 50 years ago when he was inducted into the American College of Dentists was like a walk down memory lane with a dear friend. Dr. Brown was the dean of the University of Oklahoma College of Dentistry while I was in school there. After reacquainting, we got down to business.

Dr. Brown states that in 1958, dentistry was still fairly primitive. Around 1955 the Borden air rotor started being used. Prior to its introduction, there was no high-speed handpiece, and Dr. Brown remembers manipulating the pulley system of the slow-speed to try to jack up the speed, for it only went up to 3000 rpm. A dentist would burn out a bearing in the air rotor in about one week, so there was a lot of upkeep in the new handpiece, but still so much better than the slow-speed. It had a great whistle and they were able to get rid of the belts and pulleys. Dr. Robert Nelson, who contributed to the development of the air rotor, later became Executive Director of the American College of Dentists.

The early 1950s seemed like the early 1900s. Dentists were still doing stand-up dentistry and there was no high-speed handpiece. Then as the Borden air rotor took over, other new equipment came into being with new dental chairs and sit-down dentistry. Comfort for both the

dentist and patient became more of a priority. Local anesthetic was used routinely, but nitrous oxide was not readily available until the 1960s. Without nitrous or premedication, dentists became pretty clever with voice control and were like amateur psychiatrists in those days.

There was a lot of gold work being done, with compounds in copper bands for impressions for Class II restorations. Dr. Brown has nine Class II gold inlays in his own mouth and they are still doing great. It seems there are more full crown restorations being done now. Back then gold was \$40 an ounce and now it is \$800 an ounce.

It seems dentistry may have backtracked in ethical ways. Dentistry may be more oriented to speed, efficiency, and cost, and it may have lost some of the personal attention that patients received 50 years ago.

The American College of Dentists, with its ethics emphasis, has been a

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Dentistry may be more oriented to speed, efficiency, and cost, and it may have lost some of the personal attention that patients received 50 years ago.

strong influence on dentistry over the years. Dr. Brown learned ethics from his father, who was a dentist who started a quality, ethically based practice in 1913. His dad was also the mayor of Benton Harbor, Michigan, so he grew up being exposed to ethics and professionalism early on. Dr. Brown remembers being president of the ACD in 1970 when the ADA meeting was in San Francisco and Bill Banowski, who was president of Pepperdine University, was the speaker at the ACD convocation. Dr. Banowski later became president of the University of Oklahoma where Dr. Brown was dean.

When asked to give a word of advice to those coming into leadership roles today, what would it be? Dr. Brown states that a good leader gets all the information possible from all the possible sources in order to make difficult decisions. Many times the information does not tell all the story, but a true leader takes that information he or she has procured from the different sources and with his or her best judgment makes a decision about what is best for the organization.

Dr. Brown had three or four role models or father figures that were good folks and were helpful in his professional career. He was in leadership roles at a very early age, being dean of the dental school at age 47 and president of the ACD at 48.

Dr. Brown states that, at 86, he is in great health. (I can certainly attest to his mental acuity and memory.) He has lost no teeth and has not had a restoration in over 30 years. Dentists certainly must have been doing things right in those days.

In writing this interview, I have been able to reflect on the strengths of Dr. Brown's generation. I would hope my generation has learned many of those "right things" to carry on to the next generation so we can bring forth the strength in ethics and leadership that Dr. Brown possesses. ■

DR. HOWARD I. MARK ON WHAT IT MEANS TO BE A PROFESSIONAL

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



Dr. Howard I. Mark

“My father believed that who he was spoke louder than what he said. Although he was a humble businessman, he lived his beliefs. Professionals are certainly defined as much by who they are as what they do.” These are the thoughts of Dr. Howard Mark, an oral surgeon and educator and all-around involved person in Hartford, Connecticut. Dr. Mark could have written Daniel Goleman’s bestseller *Emotional Intelligence*: he feels best around people, wearing bright ties, and whistling a tune, and he prefers to be called Howie.

COHI is a good example. Dr. Mark has been involved for 20 years, including as chair, of the Connecticut Oral Health Initiative. Originally a committee of the Connecticut State Dental Association, COHI is a nonprofit catalyst for promoting oral health in the state. It raises money, identifies priorities, builds coalitions, smoothes out barriers, and empowers communities—all to make oral health care available to more citizens. “There are a number of ways to extend the benefits of dentistry,” Dr. Mark says. “COHI does not provide care on a charity basis; neither do we necessarily lobby for more money in the welfare system or advocate for alternative models of delivery. We want to help more people take responsibility for their own oral health, which is so much a part of general health.”

Dr. Mark came into the College under the sponsorship of Dr. Howard McLaughlin. “I knew right away I was in

the right place,” Dr. Mark reflects on that weekend in San Francisco. “The convocation speaker, the programs, and the people I met all talked about what it meant to be a professional. ACD is not an organization you join because it gives you something in the material or prestige sense. What you get is inspiration and support for continuing to work at becoming a complete professional. It is good to be with like-minded colleagues—especially those who believe that ethics is a power for improvement.”

Dr. Mark, now 13 years retired from oral surgery, was one of the original members of the Friends of the University of Connecticut School of Dental Medicine in 1968. He recognized that the state needed a dental school, and with a number of like-minded friends they pledged \$100 a year. “That may not sound like high finance, but multiplying by all the donors and all the years, I know we have helped the school immeasurably.”

Dr. Mark’s idea of help tends more toward involvement. He describes his faculty appointment at UConn as being a “utility player.” He helps where he can in the oral surgery clinic, freeing up regular faculty members for more academic pursuits. “There is no need for me to teach didactic concepts or basic procedures—the full-time faculty does that very well. I am there to help the students learn their ‘doctor skills.’ In my view, professionals are incomplete unless they place relationship with the patient in the

“I spent a lifetime developing a professional manner. It matters a great deal, and I want to pass it on to the coming generations of dentists.”

center of everything they do.” Dr. Mark advocates talking with patients and students on a continual basis: explaining, encouraging, setting expectations, and above all showing interest. “I spent a lifetime developing a professional manner. It matters a great deal, and I want to pass it on to the coming generations of dentists.”

Dr. Mark’s contributions to dental education are not limited to the clinic. For nine years he managed a mentoring program for students in the first three years of dental school. Students spend three half days each year in a network of 95 local dental office and clinics. The double goals of the project are to remind students during the didactic and laboratory years of education that they are ultimately in a people professional and to demonstrate the variety of practice settings available.

Dr. Mark is proud to be his father’s son. “He was a hardware merchant. And I don’t mean he ran a nine-to-five, go-by-

the-company-policy chain outlet in a town we did not live in. It was his life, his service to our community. If somebody needed something specific, he would find it. He was involved in the Chamber of Commerce, our synagogue, Rotary, Kiwanis. During the Second World War, everyone dealt with scarcity and with irregular supply. Some stores marked up the existing inventory every time they received new shipments at higher costs. Not my father. He showed me that honesty means more than following the letter of the law; it means meeting people where they expect to be met and talking about what they need. Every so often I worry a bit about whether dentistry is losing this sense of responsibility to those we serve.”

His father taught Dr. Mark the advantage of being involved. He was in the Boy Scouts as a young person, and then again, when back in Connecticut, for more than 20 years. He was a volunteer firefighter in his youth.

He offers this advice to those starting in organized dentistry: “Two powerful, but underappreciated positions are editor and chair of the membership or social committee. Those positions get you in contact with a lot of people and give you broad perspective.” Dr. Mark began in one or the other of these positions in many organizations. His editorial work led to his service on the American College of Dentists/American Association of Dental Editors committee that crafted the current Code for Dental Editors, as one example. He served as president of the American Association of Dental Editors, and still reviews editorials vying for the prestigious Gies Editorial Award.

For 25 years, Dr. Mark worked with Probus, a coalition of business owners who help children with special needs. He was also director of a general practice residency program for 25 years at Mount Sinai Hospital in Hartford and achieved

the distinction of becoming the first dentist to serve as president of such a medical organization. In addition, he has been president of the Pierre Fauchard International Honor Dental Academy and has been elected to its Foundation Board of Trustees. In this position, he helps determine grant awards for dental service projects across the world.

“Now here is the really hard question to reflect upon,” says Dr. Mark. “There is no doubt that my life based on building the kinds of rich relationships my father modeled for me has been personally fulfilling for Howie Marks. It makes my life rewarding—no, it makes life positively fun. It is the person I have enjoyed becoming.

“But the deeper question is whether this is a generalizable approach to life—something I would recommend to everyone in an unqualified way. I think, yes, at least for anyone who calls himself or herself a professional. Being positive, building relationships, service to others, long-term involvement in community-oriented causes, and working from trust rather than for advantage are the right things to do. I do not know if there is a good name for it—perhaps professionalism. One could also call it ethical behavior in the sense that the American College of Dentists is trying to make ethics the foundation for dentistry.

“I do firmly believe that the more we see of ethics and professionalism in dentistry, the less we will see regulations, lawsuits, stress, commercialism, and self-centeredness.” It is certain this professional orientation will lead to more bright ties, whistling happy tunes, laughing, and well-served patients. ■

ISSUES IN DENTAL ETHICS

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THE FUTURE OF DENTAL ETHICS: PROMISES NEEDED

Donald E. Patthoff, DDS, FADC

ABSTRACT

The future development of professional dental ethics requires a core group of dentists well-trained in ethics: teachers, scholars, and researchers who are also firmly grounded in the clinical aspects of the profession. This will require a significant increase in the number of individuals who can work with a range of moral views, ethical communities, and religious traditions. Proposals for addressing this situation include: the creation of a dental ethics institute, the funding of an endowed dental ethics chair, a one-year professional dental ethics fellowship program, the development of a program of ethics certification, and the initiation of a "positive ethics" self-assessment program designed specifically for dental practices and organizations. Systemic and philanthropic efforts from dental organizations will be needed to support these endeavors. Some can be initiated through existing programs and organizations.

The American Society for Dental Ethics (ASDE, formerly PEDNET) focused its first efforts on educational interventions in dental schools. However, ASDE has increasingly been asked to serve as a liaison among various dental organizations (primarily ADA, ACD, and ADEA) to provide ethics scholarship needed to: (1) offer ethics training for practicing dentists; (2) provide consultation pertaining to ethics-related issues; and (3) identify and discuss questionable ethical concerns within dentistry. ASDE leadership has become painfully aware of dentistry's limits regarding expert

knowledge of professional dental ethics. Although, the existing level of professional ethics expertise, which has evolved within dentistry, may not have been adequately recognized, it is clear that without an expansion of the workforce of people with adequate training in ethics, the future growth of professional ethics in dentistry cannot be ensured.

This paper on the future of dental ethics was preceded in this journal by an essay by David Ozar (Ozar, 2008) on the same general topic. Both were developed for an ASDE/ACD sponsored workshop on the development of future dental ethicists under a program called the Professional Ethics Initiative.

The current paper is an expansion of Dr. Ozar's themes. It aims to provide guidelines for the advancement of formal education and research on professional ethics in dentistry by expanding the discussion of how we can provide more and better-trained dental ethicists.

Prior ethics-related efforts helped this happen—most notably the ACD sponsored Dental Ethics Summits and the American Association of Dental Schools and ACD symposium on access (Catalanotto, Patthoff, & Gray, 2006). (Information about the Ethics Summits can be found at the ACD Web site—

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www.acd.org.) Implicit in these earlier efforts is the view that dentistry struggles daily with complex and systematic challenges to the profession and its mission to serve society and each of its members by preserving and enhancing oral health. Hundreds of ethics efforts involve codes of ethics, education protocols, credentialing standards, major influential strategic plans, and a growing number of self-guiding tools—all now a normal part of health care. The scope of these political, social, and economic activities goes well beyond the professional ethics of individual dentists and major professional organizations.

Professional dental ethics is only one part of a very large and growing ethics endeavor involving a variety of professions all around the world. Dentistry must contribute to the swell of well-trained full-time ethics teachers, scholars, and researchers, while at the same time remaining a collegial part of chair-side dentistry. A few good dentists who see personal growth in ethics as part of being a professional, or who volunteer some of their personal time to the issues of ethics, are not enough. A core group of professionals who make professional ethics their life's work is essential. Furthermore, considering the economic and family costs for individuals who desire such training, and if dentistry is to attract such people from all of its cultural and economic roots, then adequate support for these dentists is essential. A thriving dental ethics environment 20 years from now demands a better manpower infrastructure.

To address this situation, the following five proposals will be discussed:

1. A dental ethics institute
2. An endowed dental ethics chair
3. A one-year fellowship program for licensed dentists pursuing theoretical or applied ethics in dentistry
4. A program of ethics certification
5. A self assessment program designed to help practitioners build ethically sound practices, with possible expansion to dental organizations and educational institutions

A sixth component also exists: it is the leadership, participation, and financial support of key dental organizations. This component is not presented in a distinct and separate manner; it is woven throughout the paper as a crucial element without which success is impossible. The above five proposals, along with the enabling sixth component, are not options to choose from; they are interrelated efforts, each one of which plays an important role in creating a thriving future for dental ethics.

RATIONALE

The very first use of the word professionalism, surprisingly, was in the *Journal of Dental Education* (Parish, 1968). It did not appear in medical literature until ten years later (Masella, 2007). It was used to describe the general influence of commercialism and its growing impact on professions and professional ethics in our culture. "Isms," by their nature, represent a deliberate overemphasis of the subject under discussion, and thus often become the material of cartoons. "Isms" also point out important observations that serve to balance the effects of other "isms." In this respect, professionalism has come to be an integral part of what dentistry is about. In the 1960s, Parish and others were pointing out that while the goods of commerce were easy to see, commercialism could not be applied uniformly to everything because it posed harms to other cultural values. Just like the bonds of families and love, dentistry was making a claim that

the dentist-patient relationship could not, primarily, be based as a business deal.

The interest in applied ethics has been growing in business, health, environment, and public policy for more than 40 years. This interest, though, is not all about professional ethics and professionalism. Over 100 biomedical ethics centers and institutes, for example, have been established across the United States in the past 30 years. They primarily frame and support bioethics conversations and are important instruments in the development of public policy. Hundreds of full-time, trained philosophers, theologians, lawyers, and social workers, some with combined degrees in medicine or nursing, actively work within university settings to help shape, and sometimes protect, curricula and policy within their institutions and within our larger social policies (Degnin, 2007). These larger public policies, however, along with economics and other informal social and cultural tools, can either add to or take from a person's well-being. And since the patient's well-being is the highest ranking core value of professional health care as well as an essential public good, if this end good is lost, then the development of public policy for health care loses its essential orientation (Jonsen, 1998).

Biomedical ethics has prospered in a major way, arguably, because of the scholarship, vigilance, and leadership that derive from its ethics centers and institutes. It makes sense for dentistry, then, to promote the growth and development of its ethics in a tried and true way, just as medicine has done.

Hundreds of business ethics institutes have also been designed to increase fair competition and to raise product quality and customer service. These institutions tend to emphasize the characteristics of individual leaders and the construction of social and industrial systems, some

aiming to control both human and non-human factors. These emphases are good for some forms of commercialism. They often underplay, however, the very nature and end good of professionalism.

Business ethics, for example, depends upon trust in competition, while dental ethics must prioritize and build trust based on collaboration. Business ethics encourages segmentation of the market and the influencing of elective desires. Any consideration about universal basic needs is often, and mistakenly, framed as another consumer decision. Professional ethics, though, must be open to all; it discourages the exploitation of patients and the influencing of elective desires. This derives in part, from the ongoing conversations about basic needs, that society wants the profession to address (Shue, 1996). The adaptations of business ethics to dentistry, then, must be applied with caution so as to ensure that ethics flows freely within a social context and preserves trust, whether between practitioners and their patients or practitioners and their colleagues—either in competition or collaboration.

A profession is not simply a business. Its fiduciary, rather than contractual, responsibility is a foundational characteristic of professions, and any sense of patients' or doctors' rights comes from this characteristic. Professional organizations, such as the ADA and all its affiliates, are a special form of not-for-profit group that does not, and cannot, advocate simply for the interests of their professional members. They are also responsible for articulating the promises that a profession makes with society. A professional dental ethics institute will enhance the profession's ability to function in the marketplace on professional

terms. It will give dentistry its best opportunity to influence its for-profit and not-for-profit interests for the good of its patients and their oral health.

Since dentistry was early on the bandwagon of professional ethics, it is worth wondering why it has no ethics institutes similar to medicine, bioethics, and business. Although the American College of Dentists does elect its members on the basis of excellence, ethics, professionalism, and leadership, dentistry itself has no scholarly institution whose members are recognized as skilled experts in professional ethics. Dentistry also has a few highly skilled and dedicated individuals in various non-dental, yet relevant, fields. For example, a sociologist whose primary job is to teach community dentistry, manage a clinic, and conduct social research is also asked to teach ethics part time. Such individuals expand their expertise in a loose networked fashion to fill in the gaps of dental ethics while struggling to meet the responsibilities for which they were originally recruited.

An institute would be a home base for developing, strengthening, and linking skilled professional dental ethicists. The few dentists with degrees in ethics or bioethics, and several others currently in such programs, could help seed its foundation. It should be pointed out that no ethics degrees are specifically designed for dentistry. However, since ethics conversations pertaining to dentistry and public policy for the society at large are essential and ongoing, dentistry must develop well-educated dental ethicists skilled in professionalism. In addition, these ethicists must remain in viable partnership with the dental profession and stay current with the ethics experts in the larger society with whom they discourse.

The scholarly agenda that might be considered by a dental ethics institute is extensive and exciting. It could begin by

An endowed chair in ethics would be similar in purpose to an ethics institute—to provide recognition of ethics expertise and to stimulate scholarship in the field of dental ethics.

exploring the professional ethics that has been evolving within dentistry for at least the past 150 years, defining how it is both related to and distinct from other forms of ethics. The institute could also deal with the deeper concerns of ethical relativism and commercialism that are a constant and growing challenge to the profession. In doing so, it could research the fundamental philosophical and theological origins of these two movements and then proceed to studies of their potential negative impact on oral health. An institute could also explore the boundaries of two other basic philosophical and theological concerns: fundamentalisms and moralisms, both of which could undermine such approaches as are being proposed in this paper. In its entirety, the scholarly work of a professional dental institute depends upon sound education about the fundamentals of ethics that fosters research about new and emerging developments within society, health care, and ethics (Chambers, 2007; 2008). Dentistry was early in its articulation of the notion of professionalism and its preservation. Since its sense of professionalism is based on both what “we” as professionals “do” and what “we aim to be,” dentistry is well positioned to pursue this endeavor to revitalize professionalism in our culture.

PROPOSALS

A DENTAL ETHICS INSTITUTE

A dental ethics institute would be devoted to the core values, unique interests, and needs of professional ethics in dentistry. Therefore, its goal would be to provide a source of expertise and leadership for all aspects of professional ethics in dentistry, including undergraduate curricula, continuing dental education,

research, standards, scholarship, and the debate of ethics issues.

The ADA, ACD, ADEA, and ASDE emerge as natural initiators of a dental ethics institute. Their leadership in the arena of dental ethics has been long and continuous. In addition, an academic leader, such as a dental dean, also should be involved. Furthermore, foundations with specific dental missions like the American Fund for Dental Health, the Gies Foundation, or the ADA Foundation would be essential to generate enough support to get one practical and very specific professional dental ethics program outlined, agreed upon, and operational. Eventually the institute would need to be systematically linked to the ADA, ACD, ADEA, and ASDE.

Location of an institute is important because program substance is of vital importance to dental academia, to other scholars in ethics, and to the leadership in organized dentistry. Such an ethics institute might, arguably, be housed at the ADA, ACD, the National Institutes of Health (NIH), or at a dental school. Certainly the demands of collegial scholarship would require any professional dental ethics institute to partner with an existing biomedical ethics center or institute. Each potential site would define the nature of an institute and its particular mission differently; each has its pluses and minuses in terms of opportunities for scholarship, liaison with professional groups, academic interrelationships, and funding.

The funding of a dental ethics institute is an issue of great importance and will require organizational leadership over a period of time to generate the amount of money necessary to launch such a project. Its annual budget allocations would need to draw from existing dental organizations and allow for adequate development and growth. This first institute would become the center for future institutes that could develop around the country.

AN ENDOWED ETHICS CHAIR

An endowed chair in ethics would be similar in purpose to an ethics institute—to provide recognition of ethics expertise and to stimulate scholarship in the field of dental ethics. Since its first focus is on a single person rather than a new organization, an endowed chair would require less funding than a dental ethics institute. The chair could be located in a dental school, a dental organization such as the ADA or ACD, an existing biomedical ethics center or institute or ethics center, or even in the yet-to-be-established dental ethics institute.

Candidates for the chair would be selected based on guidelines compatible with academic criteria. The chair and its holder could be at the specific service of a university, a dental school, or a department. Alternatively, it could be designed as a free-moving chair. In this scenario, the chair would be under the specific discretion of a broader dental organization or a consortium of dental organizations and academic interests. Holders of the chair would be allowed to function within any of the sponsoring interests, or even within other selected academic locations or organizations for specific periods of time, for example, for as little as one year (as for a sabbatical leave) to as much as three to five years. In this alternative design, appointments to the chair would be competitive with selections made by a task force composed of representatives of the various supporting dental organizations.

A ONE-YEAR ETHICS FELLOWSHIP

An ethics fellowship would provide formal training for dentists wanting to assume roles of leadership in ethics teaching and in other aspects of

professional ethics at local, state, or national levels. Candidates would be from two sources. One source would be career academicians interested in ethics and desiring additional training either at the outset of their careers or later in a sabbatical leave. The other source, hopefully a significant one, would be that of practicing dentists wishing to play ethics leadership roles in professional or community organizations or wanting to participate more fully in continuing and undergraduate dental ethics education.

Carving a year out of a practice is always hard. However, if fellowship programs were available in six to eight regions of the country and designed as a combination of on-line courses and active campus and community experiences, the financial and logistical challenges to potential candidates could be significantly less. Fellowships could start as an extension of existing ethics programs connected with, or close to, dental schools or to major dental organizations such as the ADA, ADEA, ACD, or AGD.

Each fellowship could accept one or two students every year. Each program would need to concentrate some of its content on the special issues of professional ethics in dentistry. This would require the development of a core curriculum, recommended areas of scholarly interest, and criteria for assessing fidelity as well as outcomes. Fellowships could be supported by combinations of self-paid tuitions, existing scholarships, grants already existing for closely related interests, and development of philanthropic efforts designed specifically to encourage such pursuits.

A PROGRAM OF ETHICS CERTIFICATION

There are relatively few individuals who provide ethics-related courses to dental audiences. And more ominously, few replacements have been identified for

those who currently serve this function. Even if the planning for an institute, endowed chair, and a fellowship program were all to begin today, and were ultimately successful, it would be years before the workforce problems in professional dental ethics are solved. An ethics certification program is a realistic and promising initial means to address this issue.

Programs for certification would be established that would meet certain criteria, including the verification of published ethics papers, core ethics courses attended, relevance of books read, courses taught, etc. The ACD, in conjunction with other collaborating organizations, is well positioned to consider this task. Instead of creating a degree-granting program (the modern definition of a college), the ACD would set standards, provide support, and formally recognize specific levels of ethics expertise among individuals (the original definition of a college). Three functions need to be addressed to structure such certification programs.

Establishing Standards

Activities that could be standardized include: a specified number of hours of formal training distributed across various areas; the creation of several pieces of scholarly work; a specified number of hours of ethics presentations and professional instruction in various formats to different audiences, and sponsorship by recognized individuals. This process is used by the Malcolm Baldrige National Quality Award (see below), the International Standards Organization, the Joint Commission on the Accreditation of Healthcare Organizations, and others.

An institute would be a home base for developing, strengthening, and linking skilled professional dental ethicists.

Support

A recruitment process would be necessary to inform interested individuals of the availability of certification. The ACD could then use existing ASDE, ADA, ADEA, AGD, university, and other networks to assign a formal mentor. Support groups of participating individuals would be developed, and, it is hoped, financial assistance offered.

Certification

Certification of candidates would be based on the evaluation of a portfolio, the recommendation of the mentor, and completion of a curriculum as mentioned above. Face-to-face meetings and standardized testing are not envisioned. Instead, the portfolio would be reviewed by a certification board established by the ACD working with ASDE. Potentially the certification process could be expanded through the existing support and recognition programs of other groups such as the AGD, ADA, and ADEA.

It is recognized that the ACD's involvement in the credentialing of individuals as mentioned above would put the ACD in the "accreditation" business, but only a little more than what it already does with its Fellowship. In many ways, it is a return to the historical foundations of the College—the establishment of standards, support to those who are trying to elevate the standards of dentistry, and recognition of those who have done so. In effect, this

innovation of certification would get the ACD into the accreditation of excellence in ethics.

Besides focusing on the needs of individual candidates, the certification processes could be extended to organizations such as dental schools, or residency programs. Dental schools, for example, would be informed of the availability of an ethics audit. A small team, probably two individuals, could oversee the process—one with deep ethical training and one with deep organizational training. The final product would be a confidential report to the dean containing a diagnosis of the organizational ethical culture, and recommendations as indicated. Another option, the actual recognition of organizations that meet standards for ethical organizations, is less clear. It could take on a larger process, such as that used in the Baldrige awards.

A SELF-ASSESSMENT PROGRAM THAT HELPS PRACTITIONERS BUILD ETHICALLY SOUND PRACTICES

The previous four recommendations dealt mostly with the provision of human and institutional resources for undergraduate and graduate dental education. This program, however, describes a systematic method that helps practitioners build the ethical foundations of their practices. Specifically, it involves the initiation of a "Baldrige-like" self-assessment tool designed for interested practitioners who choose to participate in the program. (Information about the Baldrige National Quality Program can be found at www.quality.nist.gov/criteria.htm.) The essential features of this program are described below.

The Baldrige Awards Process

The Baldrige awards process was established by Congress in 1987 to encourage and recognize performance excellence as a competitive edge for manufacturing and service businesses, including those involving education, healthcare, and nonprofit organizations. Based on a process of voluntary self-assessment, the Baldrige system evaluates seven areas: (a) leadership; (b) strategic planning; (c) focus on patients, other customers, and markets; (d) measurement, analysis, and knowledge management; (e) human resource focus; (f) management process; and (g) results. The awards serve to promote the underlying goals of the program; they are not given for specific products or services. The actual awards are presented by the President of the United States.

If the Baldrige process were adapted to the needs of dentistry, significant changes would be required. For dentistry, its purpose would be to advance professional ethics rather than gaining a "competitive edge." Therefore the awards would be based upon the evaluation of different categories and different requirements for self-assessment. Thus, for dentistry there would be considerations of such issues as dentists' fiduciary relationship with patients in need, their collaborative interaction with their colleagues, and their presentation of evidence of adequate care.

Construction of the Self-Assessment

The construction of the self-assessment would be guided through a broad-based ethics discourse that would include a prioritization of professional ethics within dentistry in conjunction with such documents as the ADA's *Principles of Ethics and Code of Professional Conduct* and the ACD's *Handbook for Dentists* (Patthoff, 1992; 2007). Coupled

with the self-assessment instrument would be a set of standards, guidelines for self-evaluation, and suggested activities for improvement. Practitioners who complete the program and meet the standards would be jointly certified by the ACD and the ADA

This program would initially be designed for dental practices, but could eventually be used by dental organizations and dental education institutions. As with other proposals in this paper, its development, implementation, integration, and evolution would require collaboration with the ASDE, ADEA, and the ADA's Council on Ethics, Bylaws, and Jurisprudence, and in addition, the ADA Foundation's "Dental Education—Our Legacy, Our Future."

CONCLUSION

Recent discussions, involving both individuals and organizations concerned with dental ethics, generated several proposals that address various systematic challenges to the future of dental ethics and, thus, to the dental profession and society at large. Proposals include: a dental ethics institute, an endowed dental ethics chair, a one-year professional dental ethics fellowship program, a dental ethics certification program, and a voluntary professional ethics self-assessment tool. All of the proposals will require strong systemic and philanthropic efforts from multiple dental organizations. Some, however, can be initiated with little effort within existing programs and organizations. The profession's desire to operate within a specific vision of professionalism must hold priority over many of the competitive commercial influences both within society and individual professionals. ■

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Coupled with the self-assessment instrument would be a set of standards, guidelines for self-evaluation, and suggested activities for improvement.

BLURRING THE LINES BETWEEN GENERAL DENTISTRY AND DENTAL SPECIALTIES

Eric K. Curtis, DDS, FADC

NOTE

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It used to be easy to articulate a dentist's duties, and the lines between specialties seemed to be etched in stone. Periodontists gardened gums. Orthodontists bent wires. Prosthodontists made the tough dentures. Pediatric dentists saw cranky kids. Endodontists hunched over abscesses. Oral surgeons pulled impacted third molars. And general practitioners plugged fillings. "The dentist," said novelist Graham Greene, "is a specialist in holes."

Not any more. These days, many observers believe, it is becoming increasingly difficult to say with precision just which kind of dentist is a specialist in what area. "Dentistry is different now," says Robert S. Roda, DDS, MS, a Scottsdale, Arizona, endodontist and associate editor of the *Journal of Endodontics*. "It used to be discrete. You could say with certainty, 'This is an endo procedure, and that is a perio.' But these days, the procedures are being blurred. At dental meetings, you see endo-restorative courses and ortho-perio courses. The concepts are being blended."

As the traditional lines between general dentistry and dental specialties become less well-defined, general dentists perform more procedures that once might have been reserved for specialists—including endodontic, periodontic, prosthodontic, and orthodontic therapies. Some specialists may even offer procedures outside their specialty. Periodontists, for example, might extract hopelessly compromised teeth in the

course of a periodontal treatment or prepare bone for implants. Endodontists might place restorations at the behest of general dentists who do not want to attempt a post and core. Orthodontists might bleach teeth, make sleep apnea devices, perform laser-assisted frenectomies and minor gingivectomies, and even place mini implants in the course of tooth movement.

Why the Boundaries Blur

Experts posit a variety of explanations for why the boundaries are blurring. One is the increasing sophistication of education and number of undergraduate, graduate, and continuing educational opportunities. "Students today are better prepared and smarter than ever. They expect more," says Arthur A. Dugoni, DDS, MSD, emeritus dean of University of the Pacific's Arthur A. Dugoni School of Dentistry. "Schools must provide opportunities for individuals to grow professionally and personally. Dental schools are expanding their programs. At Pacific, for example, we now offer, in the predoctoral program, extensive opportunities for students to have clinical experiences in endodontics, implants,

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laser therapy, esthetic dentistry, and orthodontic clear aligner therapy.”

The development of technologies that promise fewer complications and greater predictability also challenge boundaries. Evolving treatment modalities can be hard to pigeonhole. A case in point is implants. “Oral surgeons, periodontists, prosthodontists, general dentists—everyone seems to be placing implants,” says Joel F. Glover, DDS, 14th District Trustee of the American Dental Association and a general dentist who practices in Reno, Nevada. Dr. Roda notes that many graduate endodontic programs now teach, or are planning to teach, residents to place implants, noting that perhaps another influence on the blurred boundaries is commercial. “One of the most prominent sponsors of last year’s American Association of Endodontists meeting was an implant company,” he says.

Convenience also plays a part in the blending of traditional roles. “Patients ask the dentist, ‘Can’t you do this? I don’t want to go anywhere else,’” Dr. Roda says. “Sometimes you have to resist a patient’s wishes in order to provide the best treatment.”

Demographics contribute to the clouding as well. While most medical doctors are specialists, most dentists are generalists, and most dental treatments are accomplished by general dentists. “Out of an estimated 22 million root canal procedures performed last year in the United States, 75% were done by general dentists,” says Marc Balson, DDS, of Morris Plains, New Jersey, the immediate past

president of the American Association of Endodontists. “There is no way that the 6,000 or so endodontists can do all of those root canals.” What is more, dentists outside urban areas may not have convenient recourse to specialist help.

“There is probably not a shortage of specialists in America, although there may be a maldistribution,” says Dr. Roda. “For example, in Arizona, there is one endodontist for about every 60,000 people, which is considered a normal ratio. In Boston, on the other hand, there is one endodontist for every 18,000 people. If you train more dentists, they will not filter evenly throughout the whole country. They will concentrate in urban environments. You can train all of the oral surgeons you want and they will still move to big cities.”

Donald E. Patthoff, DDS, of Martinsburg, West Virginia, past president of the American Society of Dental Ethics, believes a fundamental change in the definition of a profession has allowed competition, deeply embedded in American culture, to break down barriers. “Professions traditionally did not respond to markets,” he says. “Professionals promise to limit their activities to certain defined areas, and in return society grants them a monopoly. But now the monopoly is gone, and professions behave more like businesses.” Dr. Dugoni says, “Our world has become much more competitive. People are not only

I hear patients talking about cosmetic dentists who advertise themselves as board certified, even though there is no ADA-recognized specialty or board in cosmetic dentistry.

Disagreement over what constitutes proper treatment also may blur the lines. While dentists may agree on the results of excellence, the scientific basis of excellence can remain elusive.

competing fiercely to get into professional programs or universities or even top high schools—they are competing to get into first grade.”

As a result, says Dr. Roda, “There are financial incentives for dentists to hold themselves out as different or better than their colleagues. I hear patients talking about cosmetic dentists who advertise themselves as board certified, even though there is no ADA-recognized specialty or board in cosmetic dentistry.” And general dentists are not the only ones advertising. Some specialists, and some specialty organizations, engage in non-traditional direct marketing to patients.”

Competition may represent a quest not only for income but for excellence. Dentistry is an art and a science. “Every dentist has a different set of abilities—that is the art part,” Dr. Balson says. “Some specialists may not be as good in some procedures as some general dentists. If a specialist does not do any better than you can as a general dentist, then do it yourself.”

Orthodontist David Harnick, DDS, MSD, of Albuquerque, New Mexico, was a general dentist for 11 years. “I got into orthodontics because I was not satisfied with the treatment, with the facial profiles, that some orthodontists were producing,” he says. “There are many different treatment philosophies, differences of opinion, and strongly held perspectives.”

Disagreement over what constitutes proper treatment also may blur the lines. While dentists may agree on the results of excellence, the scientific basis of excellence can remain elusive. “My brother is a prosthodontist,” says Dr. Roda. “He told me recently that no matter what he says about the right way to handle a given case, there are bright people who disagree. We talk a lot these days about evidence-based dentistry.

The truth is that there is not really much evidence to base our decisions on. Mostly there just are not good studies. Many outcomes assessments—success-failure studies—are only slightly better than anecdotes. The lack of true evidence allows education programs to not be uniform as to what they present as good practice.”

Licensing freedoms allow competition among dentists to be essentially unchecked. “Dentistry is like golf. You keep your own score and call your own penalties,” says Dr. Balson.

“Dentists are not comfortable in peer oversight situations,” says Kenneth L. Kalkwarf, DDS, MS, dean of the University of Texas Health Science Center at San Antonio Dental School and president of the American Dental Education Association. “Once dentists get a state license, they essentially credential themselves. We do not have a system, such as hospitals do, in which doctors are credentialed procedure by procedure to perform the treatment modalities they apply for. When a dentist decides to do a new procedure, he or she can learn it at a variety of venues and levels of thoroughness. A dentist may take a weekend class in a hotel, a week-long course at an institute, or a year-long program at a university and decide when he or she is ready to perform the procedure. Everyone else then has the ability to distrust his or her judgment.”

Specialty boundaries are not only blurring. In some cases, they are being redrawn. “A few years ago, oral and maxillofacial radiology received ADA-specialty recognition,” Dr. Glover says. “In 2004, the American Society of Dental Anesthesiologists and the American Academy of Oral Medicine asked the Council on Dental Accreditation to

accredit advanced dental education programs in oral medicine and dental anesthesiology. The commission agreed and has drafted accreditation standards for these two areas. The specialty group looking for recognition at present is the American Academy of Craniofacial Pain. However, the Council on Dental Education and Licensure has considered the application and is recommending to the 2006 ADA House of Delegates that the request be denied.”

Opportunity Knocks

Leaders in dentistry agree that the blurring of boundaries brings opportunities for both increased professional service and personal satisfaction. “There are certain advantages, including more freedom for creativity in dentistry and more cross-fertilization of ideas,” says Dr. Patthoff.

“I would like to think that dentists should learn to periodically reinvent themselves. Why should we continue to live a life of sameness?” asks Arden G. Christen DDS, MSD, MA, professor emeritus of oral biology at Indiana University School of Dentistry.

“My colleagues who are the most frustrated with their professional lives are those who do the same things over and over for years, never expanding their horizons, never learning new skills,” says Dr. Kalkwarf. “We could, and should, continually move our practices up to a more sophisticated level as knowledge develops.”

Some leaders in dentistry worry that blurred boundaries will lead to turf wars. But Dr. Roda says, “The model of referral-based specialty practice, done correctly, still works well—including the assumption that general dentists will do a broad range of treatments, then refer the most complex cases.” Other indicators suggest that loosening strictures allows dentists of various backgrounds to more fully collaborate. For example, the

American Academy of Pediatric Dentistry offers membership to general dentists, as well as specialists. “Specialists do not have any objection to sharing responsibility for cases,” says Dr. Balson.

Bruce G. Valauri, DDS, of New York, New York, president of the American College of Prosthodontists agrees. “We as prosthodontists want to embrace our general dentist colleagues,” he says. “We encourage their participation in our meetings and courses. We offer continuing education courses all over America.”

Dr. Dugoni, a past president of the American Board of Orthodontics, describes a win-win situation when dentists share treatment. “The specialist has to be open to the fact that generalists can and should do more, but must be trained to the standard of care,” he says. “In orthodontics, for example, the generalist can learn to bond brackets, apply nitinol wire, and use the clear aligner appliance. When specialists are generous with generalists, general dentists will perform more specialty treatment, but they also will refer more specialty treatment because their awareness and experience is expanded. They see bigger possibilities. In orthodontics, for example, the general dentist becomes more aware that many more cases could be enhanced by orthodontics. Is there a second molar tipped into a missing first molar space? Instead of simply placing a bridge, the educated generalist will now think about uprighting the tipped second molar.”

Dr. Valauri also believes that shifting boundaries can change the relationship among dentists for the betterment of patients. “Specialists used to take referrals for treatment only,” he says. “But nowadays we are here to help plan treatment. Prosthodontists are moving toward a diagnosis-based model for relationships with general dentists and

other dental specialists, rather than a procedure-based model. Our training emphasizes diagnosis and comprehensive treatment planning.”

“A lot of endodontists complain that they are left out of the diagnostic loop,” Dr. Balson says. “Maybe a failing endo is salvageable. All specialists want is for people to realize that those two or three years of postgraduate training give us some credibility. Are there superb general practitioners? Of course. But day in and day out, specialists did that additional schooling and have a unique perspective as a result. We ask general dentists to share in our knowledge. I love sharing my experience with my colleagues.”

“We are doctors,” Dr. Harnick says. “Our first duty is to do what is best for our patients. Anytime general dentists and specialists meet and everyone gives their perspectives, no one leaves without understanding the case better. We are approaching a point when general dentists and a variety of specialists could meet on-line and share treatment plans, pictures, and radiographs for a given case.”

“The scope of practice is definitely expanding,” Dr. Dugoni says. “However, complex cases will take a multidisciplinary approach. All of this brings about an awareness of multiple areas of responsibility. There are three groups of people who have responsibility. The first is the specialists, who have to maintain and demonstrate the standard of care and work cooperatively with the generalists to look completely and comprehensively at the best interests of the patient. The second is the generalists, who must realize that treatment cannot

The real issue is continued competency assessment throughout a practitioner's life. That is what society expects.

be experimental. They cannot subject the patient, for instance, to a five-hour extraction of a palatally impacted canine. The third group is the dental educators. Dental schools must offer programs and courses structured to provide training opportunities that allow generalists and specialists alike to perform procedures to the standard of care. No one wants to provide substandard treatment. It is incumbent on all three of these groups to respect and communicate with each other. The best interests of the patient have to come first."

Education is Key

Technology alone cannot improve a dentist's ability. "Nickel titanium instruments do not level the playing field. No one can prove they improve success rates in root canal treatment. They are just faster," Dr. Balson says. "And microscopes

are not guaranteed to improve the success rate in endodontics either, but seeing better makes you more meticulous.

Education and sensitivity to your abilities are crucial. The best customer an endodontist has is an educated general dentist. The more generalists know, the better—for patients and the profession. Everyone leaves dental school with the same degree. Within your envelope of comfort you can practice as you see fit. You should know what you know and know what you do not know. But what is scary is when you do not know what you do not know. One of the most important skills any dentist can learn is knowing—with all due respect to Kenny Rogers—when to hold and when to fold."

Dr. Harnick says, "Good orthodontics can be done by general dentists and bad orthodontics can be done by orthodontists. It is an odds game. It is not a guarantee by any means, but the odds are greater that a case can be done better by an orthodontist. If your eye is not trained, you do not see some things. Orthodontists tend to have more information with which to evaluate things."

But while specialists acknowledge that specialty education offers an excellent grounding in both science and technique, a graduate program by itself is not enough to ensure continued success. "I get leery of specialists saying it is the specialty degree or certificate that sets them apart if they are not keeping up with new procedures," says Dr. Kalkwarf, who is a periodontist.

Depth of training is crucial for generalists and specialists alike. "I am concerned about weekend courses in all areas," says Dr. Valauri. "One weekend in occlusion does not confer expertise, just as a single glowing review of a certain composite or impression material does not make it the right one to use. You get

limited information with a short course, which you cannot apply wisely without general knowledge to back it up.

Continuing education must represent a comprehensive, systematic effort to learn, not just a collection of hours."

"I do not care if prosthodontists, endodontists, or general dentists place implants if they are appropriately trained and credentialed," says Dr. Kalkwarf. "The key is that dentists have got to be trained and competent at specific procedures with outcomes that are acceptable to society. What is more, dentistry has an obligation to undergo oversight processes that result in external credentialing. Dental societies could provide that oversight. Study clubs also offer oversight and outcomes assessment, as do public health and military programs. The real issue is continued competency assessment throughout a practitioner's life. That is what society expects. Society has given us the designation of a profession, so we are self-regulating. We have an obligation to assess ourselves."

"A doctor must rise to a level of responsibility above the ordinary and put the patient's interest above the pocketbook," says Dr. Dugoni.

Dr. Valauri describes the professionalism required for such responsibility as a blend of integrity, rigor, and education, with a dash of flexibility: "The restorative dentist Harold Shavel used to say, 'I use a semi-adjustable articulator, but I have a fully adjustable mind.'" ■

STRESS

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ABSTRACT

We all experience stress as a regular, and sometimes damaging and sometimes useful, part of our daily lives. In our normal ups and downs, we have our share of exhaustion, despondency, and outrage—matched with their corresponding positive moods. But burnout and workaholism are different. They are chronic, dysfunctional, self-reinforcing, life-shortening habits. Dentists, nurses, teachers, ministers, social workers, and entertainers are especially susceptible to burnout; not because they are hard-working professionals (they tend to be), but because they are caring perfectionists who share control for the success of what they do with others and perform under the scrutiny of their colleagues (they tend to). Workaholics are also trapped in self-sealing cycles, but the elements are ever-receding visions of control and using constant activity as a barrier against facing reality. This essay explores the symptoms, mechanisms, causes, and successful coping strategies for burnout and workaholism. It also takes a look at the general stress response on the physiological level and at some of the damage American society inflicts on itself.

At a regional dental extravaganza, two dental school classmates who have not seen each other in ten years grab a quick breakfast together to catch up on old times. Each of them claims he has only a minute to spare because of important commitments.

Dr. Pusher is a non-stop talker and has mastered the art of framing his numerous accomplishments in respectable professional terms. “Somebody had to run for treasurer of the state dental association. Besides, this profession has given us so much, we are supposed to give something back.” “Man, the Cerex machine and the cone-beam I bought, with some colleagues, are wonderful. Now I can provide the kind of care my patients deserve. But that creates so much pressure because I have to book so many patients to make them pay for themselves. It runs me ragged.” “I wish I could spend more time with my family, especially Misty, who’s now six. But there’s no rest for the wicked—or however that thing goes. My family comes first and I am going to provide for them in the manner they deserve, even if it kills me.” “Here’s a picture of my office. Pretty attractive, don’t you think? I mean the interior decorating, not the staff. I figure I should be out from under that in about 15 years.” “By the way, I am going to be presenting some of my cases here on Thursday. About 10 o’clock. You should drop by. There’s a perio-pros case I worked on for years. It’s gorgeous; you wouldn’t believe the woman is seventy.” “But enough about me, let’s hear from you: what do you think of my office?”

Dr. Goodboy’s story comes out in smaller pieces. “I don’t know. That all sounds so great. I used to have those sorts of ideals, but I discovered that the world is not as appreciative of hard work as one would imagine. At least that’s been my experience.” “I practice five and a half days a week and I haven’t heard a ‘thank you’ in two years. I keep grinding away like I did in dental school. I think I work for my staff instead of the other way ’round.” “I might stop by your presentation. I have been going to a lot of CE recently. I think I have an obligation to keep current. I tried the patient management system proposed by Dr. Wonderful. I think it might work for some doctors. But I’m working as hard as ever. Maybe there’s something more I’m supposed to be doing. That’s why I’m here at this meeting.” “Do you take Medicare patients? I really think it is my obligation to do that. That’s one whole day of my practice. But the no-show rate is so high that I get less than half a day’s productivity out of it.” “Have you tried ginkgo biloba? I’ve got to do something to get that energy level back we had in dental school.”

Dr. Pusher is a workaholic; Dr. Goodboy is a burnout. These are more than differences in personality or the types of practice each maintains. Each is trapped in a different pattern that is robbing him of a fulfilling life. Dr. Pusher is a candidate for divorce, substance abuse, and legal problems. His classmate

Burnout, workaholism, drug abuse, or any stress disease are self-reinforcing, maladaptive response patterns that trap their victims precisely by causing a fixation on symptoms.

is apt to smolder into cynical, chronic poor performance. Neither is being damaged by dentistry; each is fighting problems created by the way he has chosen to react to dentistry. Neither one is fun to be around. And that is surprising; both pleaded previous commitments and the quick breakfast lasted two hours.

BURNOUT

Burnouts are dragged through life by their unattainable ideals. This is captured in the phrase sometimes heard in the corporate world: "Pity the poor over-worked executive for the liability he or she represents." Burnouts have chosen to suffer in noble silence, seldom suspecting that they are being taken for granted by those they serve.

MECHANISM

Burnout can be identified by chronic fatigue, discouragement, and rigid under-performance caused by failure to achieve a self-appointed mission involving service to others. The burnout says, "It isn't working like it is supposed to. Maybe if I tried harder, maybe if someone would just 'get off his inertia' and help a little, I could get this job done." It is a guilt-blame-try harder cycle that spins down into exhaustion, frustration, and inadequate outcomes. But the burnout never gives up and never changes his or her expectations.

Burnouts are idealistic. They were probably a "good boy" or "good girl" when young, or wanted to be. They have internalized the helper role; people count on them. They are strong and silent and they do not want to let others down. They gravitate toward the helping professions such nursing, social work, and teaching or become housewives, and they volunteer for the support roles of secretary, local arrangements chair, or outreach coordinator in organizations.

Some individuals chose dentistry precisely because it offers the prospect of fulfilling their idealism.

There is nothing wrong with having high goals, especially ones that involve service. There is, however, danger in persisting in those goals when they are not attainable. Smart idealists scale their dreams to the circumstances; burnouts redouble their effort. At first escalating effort may work (although it changes the rules of the game by committing the burnout to ever higher effort). The opportunity becomes a challenge, then an obligation, and finally a burden that must be borne with dignity.

The middle stages of burnout are characterized by frustration, fatigue, and fantasy. The burnout is exhausted and disappointed, both with the outcomes and with the seeming endless needs of those being helped and the lack of responsiveness of others who could assist. But these expectations of others are seldom voiced: "They should know what to do without my having to ask them." Burnouts also imagine that more and better resources could fix the problem. They are self-improvement junkies. At this stage, they are suffering, silent, self-martyrs.

End-stage burnout involves dysfunctional exhaustion. The burnout still clings to his or her idealism but now occasionally lashes out at the injustice and ingratitude of "the system" or at those who do not recognize the "rights" they are working to achieve. Extreme burnouts even criticize those they have been trying to help as ungrateful, unwilling to assist themselves, taking help for granted, or having unrealistic expectations. Burnouts in advanced stages of their condition realize that they are not coping effectively, but their attempts to correct the situation are typically self-defeating. They stubbornly resist cutting back on their self-appointed savior role and their image of being able ultimately to solve the problem (if others

would just be reasonable), and they resist negotiating for help. Instead, they refocus their efforts. They abandon or neglect other interests—first their own, then their family's and those of their friends. Their actions becomes rigid and stereotyped. This is called “perseveration”: the intensification of repetitive effort in the face of frustration. Creativity and adaptability are gone. In fact, the vision of successful outcomes and the joy they may bring are also gone, replaced by never-ending effort. The big-time burnout seems to be saying, “No one can fault me for not trying. That, at least, is my duty.” The problem is that dysfunctional effort has become the burnout's definition of life.

Burnout entails damage to the combination of emotional, intellectual, and value systems that Europeans would call “existential.” What is “burned out” is the meaning of activities. The formal role and behavior remain, but the individual experiencing burnout becomes alienated or distanced from the work. It becomes routine, efficiency is a higher goal than effectiveness, former allies and those served turn into obstacles and drags on the process. Judgment may become impaired, or at least it tends toward habit and loss of spontaneity and creativity. The idealistic goals that animated the early burnout remain, but now they have the tinge of slogans and others are accused of “not wanting it badly enough.” Caring hurts, so means must be found to protect oneself from feeling too deeply.

DIAGNOSIS

There are many stress inventories available. None of the handy paper-and-pencil ones should be understood as clinically diagnostic; they are merely suggestive. The American College of

Dentists has an extensive survey available on-line that is keyed to the concepts in this essay. You are invited to go to the Web site (www.acd.org) and take the test. You will receive confidential feedback.

MANAGEMENT

There is a danger in tests such as the one for stress suggested above. Such tests focus on symptoms. That is part of the vicious cycle of burnout: it cannot be managed by attending to symptoms. Burnout, workaholism, drug abuse, and all stress diseases are self-reinforcing, maladaptive response patterns that trap their victims precisely by causing a fixation on symptoms. Self-improvement, enlisting codependents, and working harder are like trying to get out of a hole by jumping in and digging faster.

The key to breaking the cycle of burnout is found in the old Vaudeville gag: “Doc, I broke my arm in two places; what should I do?” “Stay out of those places.” The eminent systems theorist, Peter Senge, in his book *The Fifth Dimension*, identified downward spiral, closed systems as patterns that waste resources, and the more resources invested, the more will be wasted. The only way to break the cycle is to reframe the game. Unfortunately, that is almost impossible from within the game.

The self-help books on burnout counsel getting in touch with our inner selves, reflection, talking it out with a friend. If that works, so much the better. But that smacks of backing into a solution with a slight variation on what has not been working so well up to this point. The examples of successful recovering burnouts run more toward someone or something taking the issue out of the burnouts' hands. Nonfatal heart attacks, an ultimatum from a spouse, discovery of an embezzling employee, a disability, bankruptcy of the community project, or breakup of a

partnership should not be sought, but they are often valuable, if undeniable, signals that the burnout has to give up the old game.

The two standard ways of breaking the burnout cycle—surrendering one's dreams or waiting until they are snatched away—are understandably unattractive. I suggest a third alternative. Grab a different dream. If practice has become a burden, develop an interest in organized dentistry. If disillusionment has taken over dental politics, redesign the practice. Become a docent, teach, read ethics, become an assistant to your spouse's passion (but do not compete), teach, become a Civil War reenactor, teach. This advice is based on the concept that a self-sealing habit can only be broken by substituting a new habit. An obvious problem is that the true burnout has almost no apparent energy and will assume there is nothing to invest in a new project. Absolutely false: the exhaustion is largely specific to protective patterns in burnout activities, and new energy will certainly emerge. The real danger is that, in time, the new dream will be burned out as well. That is the nature of the burnout orientation. But the early stages of burnout on a new project are preferable to the terminal stages of burnout on one that has been used up. And there is always the possibility that some lessons and coping skills will carry over to retard future burnout.

Workaholism

The chance meeting between Drs. Pusher and Goodboy was no favor to either. Dr. Goodboy probably admired the cases his colleague presented and drank in the success atmosphere of the meeting. He returned to his office with new resolve to overcome all obstacles. We can expect to see him next year, a little more tired, a bit more cynical, and still determined.

Dr. Pusher will also return from the convention with renewed determination—and with a lot of new gadgets, plans, and contacts he intends to impress. He expects to come back next year as a headliner.

MECHANISMS

Workaholics derive their identity from their accomplishments; they are what they do—addictively so. They do not do good dentistry; they are the best dentist. They do not work long hours; they are never off (they take their work wherever they go, recruiting patients on the golf course and taking vacations with colleagues or the office staff).

Workaholics fear loss of control. That is why they make lists, talk about their accomplishments, and have a well-developed scanning system to look for continuous validation. Dentistry is a good profession for workaholics because solo practice is designed for the illusion of doctor control. Who could fault a dentist working long hours and sacrificing his or her personal life to serve patients? The American business model supports this approach with fee-for-service rewards. The equation of individual effort with success is clear, and the major threat to anyone willing to work hard is any compromise to personal control.

Workaholics fear being separated from their work. They need their fix. They bring it home with them and take it on vacations. They proudly buy devices to keep them in touch. They even have backup addictions such as food or alcohol. They turn their hobbies into competitions or moneymaking opportunities. The story line that accompanies this behavior is “I have heavy responsibilities, people depend on me, you can’t really count on others to do it right.” Although workaholics frame their habits in terms of their being indispensable to work, the opposite is, in fact, the case. Workaholics fear loss of identity if they become distanced from their work. They often use their work as a screen to protect themselves from reality, including the potential relationships they wall off. Recall in the example of Drs. Pusher and Goodboy how the workaholic talked incessantly—not because he was self-absorbed but more so as a defense against having to listen or to see the world as it really is.

As much as burnouts avoid crises, workaholics relish them for validating their sense of being indispensable. Workaholics are known to precipitate confusion, emergencies, and “everyone on deck” issues so they can swoop in to save the day. They are not good team players. They would not work for someone like themselves. They can also be great procrastinators, waiting for the perfect time to make things perfect. They sometimes go on “work binges.”

It is claimed by some that workaholism is inherited from our parents. Certainly growing up in a household where parents made praise contingent on good behavior and repeated that upholding the family honor involved significant accomplishments would establish these habits early. It has also been suggested that women overwork to fill voids and men overwork to prove their superiority. Workaholism is a disease of the Boomer generation.

That may be too broad a generalization, but it certainly appears to be truer of Boomers than Gen X-ers or especially of Millennials. And if their younger colleagues appear disinterested in working themselves to death, that sends a threatening message to Boomers who assume it is the royal road to success.

DIAGNOSIS

The inventory on the ACD Web site can be used to identify tendencies toward workaholism as well as burnout. Also on-line through ACD is an inventory known as the Quality of Work Life Scale. There are four primary scores on the QWL instrument: (a) meaningfulness of work (the outcomes make a difference); (b) autonomy or control over when, where, and how work is accomplished; (c) feedback, both from task completion (intrinsic) and from others (extrinsic); and (d) identification with work. The first three factors (meaningfulness, autonomy, and feedback) are characteristics of the job; identification is a characteristic of the job holder. It is the latter factor that identifies the workaholic. A low score on work identification is pathological: those with very low identification with work should not even hire themselves. A high score is also a danger signal: one would normally be unfulfilled in a marriage or working for someone with an intense identification with work. Most dentists score high on meaningfulness and autonomy—that is the nature of the profession. Feedback is sometimes on the low side, and identification with work is often too high.

One final diagnostic test for workaholism: if the preceding paragraphs sound like exaggerations or seem impractical, there is a fair chance that the reader is at least a closet workaholic.

MANAGEMENT

Workaholics take a good thing too far. A healthy work ethic is necessary and satisfying to any professional and to those they serve. But it is a matter of control. The problem comes when work controls the professional. It is an addiction, in the sense that developed coping habits actually perpetuate the problem. It is self-reinforcing.

There is a Twelve-Step recovery program available for workaholics, and many workaholics have co-addictions such as alcoholism. Despite certain similarities between recovery from workaholism and other addictions—such as overcoming denial, accepting group support, and relinquishing the illusion of self-control—there are differences. Recovery from workaholism cannot feasibly involve abstinence.

Work redesign can play an important role in recovery from workaholism. Group practice arrangements have much to offer anyone working under the illusion that he or she is indispensable. This does not mean hiring an adoring, supporting staff; it means sharing the load with one's equals. Delegation can be effective, but it is difficult. The autonomy subscale on the Quality of Work Life Inventory can be useful in this respect. The person to whom work is delegated has to experience a real increase in autonomy. It is the authority that is delegated, not the responsibility. That, generally, comes very hard for workaholics. Allowing others to share control (not over the work, but over the workaholic) is also useful. A spouse or colleague (usually an equal) can be given some control over segments of the workaholic's time. This is a commitment for several hours each week with no work.

Finally, consider the issue of dentists' traditionally low scores on the feedback component of the Quality of Work Life Inventory. There is no obvious character-

istic in dental practice that blocks a satisfactory level of information coming back to tell the dentist how things are going. The problem is more likely in some dentists themselves, since one of the characteristics of workaholism is to use work and perfectionist routines to wall out contact with reality. Constant activity is used as a barrier to having to see the effects of the workaholic's life style.

Diane Fassel calls workaholism a disease caused by dishonesty. The typical workaholic will bristle at this and immediately go out to ask somebody at the front desk if there are any problems in the office. Then they will believe the answer they get. It is not easy for addicts to break through the self-deceptive defenses they have created. If they have any talent at all, the years of work they have put into making systems to protect themselves from seeing the effects of their lifestyles have become pretty effective. Defenses take years of work to dismantle, beginning with a few peeks over the wall.

A DEEPER UNDERSTANDING

The amount of attention paid to stress and its negative effects has increased in recent years. More people are dying of stress-related conditions. The reason is that we are less likely to die of trauma, infections, poisoning, and other direct attacks. Modern medicine has come to the aid of the body's natural defenses so successfully that the defenses and their abuses are now becoming a problem. Autoimmune diseases were not an issue 100 years ago. Nor were cosmetic concerns in dentistry.

Dysfunctional stress habits are designer diseases, custom crafted by burnouts, workaholics, and others, some of whom are rather proud of what they have created.

Those who live long and meaningful lives have mastered the art of distributing stress in a balanced fashion. After all, it is the weakest of our adaptive responses that determines how long and well we play.

The stressors of life—those things that push our buttons—may have changed from wild animals and the plague to air pollution and the IRS, but it would be difficult to make the case from mortality data that we face more stressors today than our ancestors did. The reaction to stressors, called the stress response, is the wear and tear placed on our adaptive capacity. Part of what determines our life satisfaction and longevity is the stressors to which we are exposed, part is the protective system we inherit from our parents, and part is our choice about how we react to stressors. The vast majority of burnout and workaholism are not caused by the profession or by birth defects in dentists; they are the consequences of choices dentists make for managing the way they practice. Like obesity, substance abuse, and smoking, they are diseases of choice. Dysfunctional stress habits are designer diseases, custom-crafted by burnouts, workaholics, and others, some of whom are rather proud of what they have created.

The Czech-Canadian endocrinologist Hans Selye explains it this way. Stressors—anything from a needle stick to an angry patient—trigger neural alarms. These prompt nonspecific hormonal responses carried through the blood. When they arrive at an unaffected site, say the big toe, they are ignored; when they show up where they can be used, they activate local protective responses such as elevated blood pressure, sweating, or inflammation. The overall system is called the General Adaptation System; the peripheral, targeted response is called the Local Adaptation System. Selye defines health as appropriate adaptation to environmental insults.

The trick is making the responses appropriate. There are four ways the

system can go wrong. Usually, the first breakdown that comes to mind is failure of the system to detect or respond to threats. Virtually every living adult has been exposed to tuberculosis and the body's defenses have successfully walled off the invaders—we are tuberculosis survivors. But some individuals have deficiencies at the local level in the lungs or are in such poor overall health due to malnutrition that they cannot successfully fight the infection and they develop the disease clinically. Some individuals have switched off the guilt and shame detectors that naturally protect us from dishonest or socially offensive behavior. Some ignore the signs of burnout or workaholism. Sometimes the system just needs a kick to get started. Bloodletting was actually an effective treatment in some cases because it activated a General Adaptation System that was dormant. Shock therapy can be effective as a treatment for some mental disorders. Coffee is a self-administered toxin that does not directly increase alertness; its effect is indirect by stimulating an activation response against the coffee.

Thus, the first problem with the stress system is its failure to protect us from environmental insult. But there are also “diseases of stress.” Specifically there are three of them. The most pernicious of these diseases of stress is over-response or unnecessary response. Allergies are one example. Those who suffer from hay fever are almost never troubled by the pollen; their torment is the protective inflammatory reaction prompted by the allergen. Allergy medications are taken to reduce the body's natural stress response. Self-medication with alcohol or other drugs are examples of the same process. Anxiety is one of the worst “allergens” of this type. Free-floating anxiety triggers a constant stress response that places wear and tear on the system. Machismo is another example. Alpha males and females are so preoccu-

pied with their status that it can kill them. This is physically the case in gang cultures, but it is also part of the operating mechanism in workaholism. Selye reports on an experiment where male tree sloths fight for dominance and are then physically separated, but in close proximity. The loser exhibits classical signs of stress and may die within a month, even though physically safe. If it happens to sloths, imagine the toll in human society caused by setting up little competitions so individuals can prove themselves. Selye claims that modern culture's addiction to hormone highs is a worse addiction than alcoholism, and certainly may be a contributing factor to it.

The final two diseases of stress involve wearing out of the General Adaptation System. It happens to all of us, and it is literally what it means to die. We inherit a reservoir of adaptive capacity at birth, and when it is exhausted or overwhelmed we are done. Local Adaptation Systems can be recharged through rest and diversion. Although rest, but not diversion, helps for the General Adaptation System, stress is cumulative. Rest and diversion allow our bodies to forget the contorted habits we adopted as expedients under pressure and allow us to reassert more natural responses. Test this view by paying careful attention to what happens during the first hours back from a vacation. If the way work is perceived has not been altered, the vacation was a failure.

The final concern is imbalance in the adaptation systems. We rotate the tires on our cars to prolong their life, and we should do something like that in our lives. When one or a few local adaptation mechanisms are overworked, they grow weaker and the entire system is thrown out of balance. Those who live long and meaningful lives have mastered the art of distributing stress in an equi-

table fashion. After all, it is the weakest of our adaptive responses that determines how long and well we play.

A CULTURE OF STRESS

Burnout, workaholism, and stress are not private concerns. Anyone who works with a stressed individual or has such a friend knows that. Individuals who are so wound up that they disrupt the lives of those around them should know as well how pervasive stress is. Even organizations suffer stress; and right now I am thinking of several regulatory groups whose whole purpose for being seems to be to cause stress. Silicone Valley and Wall Street are addresses for workaholics. Some fraternal and service organizations, some churches, even golf courses are burned out. A good case can be made that the American healthcare system as a whole is burned out.

Recalling the advice of the physician to the man who broke his arm in two places can be a useful part of managing the stress culture of life. Exposure to challenging situations should be done in moderation; but systems that promote unhealthy coping should be avoided as vigorously as possible. That is difficult with self-help stations beginning to outnumber news and entertainment on the television. A key component of commercialism is the implication that a potential buyer can get short-term access to any missing capability for a price. Our inability to keep up with the demands of electronic communication, for example, could be solved with a smaller, faster device that is kept nearby all the time. That is questionable advice because it engages us in a symptoms arms race. It should appeal only to those who brag about the large number of e-mail messages they cannot answer.

If we were to choose to design an optimal environment to promote burnout or workaholism, we would want to include some of the following

elements. The first requirement is a vague impression of inadequacy. Our victim is not living up to his or her potential; there is more that could be done. But it is essential that this "something more" not be defined. It might have certain recognizable features, such as a BMW, but the target must be constantly moving and, better yet, essentially open-ended. Next, we work to make sure our victim forgets about the original goal and fixates on the processes and symptoms of his or her mismanagement of the enterprise. After all, is not yellow spandex what makes cyclists so fast? Now it is time to bring in the codependents—those folks for whom the workaholic can show off and who pity the burnout. By now we should have things pretty much in shape so that the burnout and workaholism cycles are self-reinforcing.

If you meet Dr. Pusher or Dr. Goodboy at a dental function, buy them a cup of coffee and listen to their tales. If you want to be a friend, do not agree with them or dispute them. The best thing you can do to help is repeatedly ask why. "How did that come about?" "What were you trying to accomplish when you did that?" "What did you expect might come of that?" "Why do you think you are the way you are?" Dr. Pusher's and Dr. Goodboy's recovery depends on their answering these questions themselves (and they certainly will reject any solutions you might suggest). ■

RECOMMENDED READING



Summaries are available for the four recommended readings with asterisks. Each is about eight pages long and conveys both the tone and content of the original source through extensive quotations. These summaries are designed for busy readers who want the essence of these references in fifteen minutes rather than five hours. Summaries are available from the ACD Executive Offices in Gaithersburg. A donation to the ACD Foundation of \$15 is suggested for the set of summaries on stress; a donation of \$50 would bring you summaries for all the 2008 leadership topics.

Donald E. Cole (1981).

Professional Suicide: A Survival Kit for You and Your Job *

New York, NY: McGraw-Hill.

ISBN 0-07-011697-0; 232 pages; price unknown.

Professional suicide shows up as suddenly quitting, often to take jobs below one's true level of ability; disruptive behavior; extreme passivity and "retiring in place"; engaging in a succession of crises that make one obsolete; psychosomatic symptoms; and actual suicide. Underlying all is deeply wounded self-esteem. It is caused by usually well-meaning organi-

zational structures that use ambiguous charters of individual responsibility and suppress meaningful feedback. This is labeled the management style of subordinate commitment.

Stephen R. Covey (1980).

The Seven Habits of Highly Effective People: Restoring the Character Ethic

New York, NY: Fireside.

The message is simple: avoid stress by building positive habits of character.

Diane Fassel (1990).

Working Ourselves to Death: The High Cost of Workaholism & the Rewards of Recovery *

San Francisco, CA: Harper San Francisco. ISBN 0-06-254869-7; 164 pages; about \$15.

Light reading on a heavy topic; full of generalizations pulling work through the standard twelve-step structure.

"Workaholism is a progressive, fatal disease in which a person is addicted to the process of working. As a result of the addiction, the person's life becomes increasingly unmanageable in relation to work, and all other areas of life are affected." Workaholics "are dishonest, controlling, judgmental, perfectionist, self-centered, dualistic in their thinking, confused, crisis oriented, and ultimately spiritually bankrupt."

Herbert J. Freudenberger (1980).

Burn-Out: The High Cost of High Achievement *

New York, NY: Bantam Books.

ISBN 0-5520048-8; 215 pages; about \$3.

"A burn-out is someone in a state of fatigue or frustration brought about by devotion to a cause, way of life, or relationship that failed to produce the expected reward. Whenever the expectation level is dramatically opposed to reality and the person persists in trying to reach that expectation, trouble is on

the way." Because the perfectionist personality of potential burnouts and their engagement in caring for causes and others, their efforts at recovery are often self-defeating "just trying harder." The key to recovery is self-awareness and engaging others on an authentic basis.

Hans Selye (1976).

The Stress of Life *

New York, NY: McGraw-Hill.

ISBN 0-07-056212-1; 515 pages; about \$6.

Selye is a famous endocrinologist who recounts his discovery of theories about responses to stressors in the environment, mediated by our interpretation of them. A General Adaptation Syndrome, with alarm, resistance, and exhaustion phases triggers local responses that are specific and may cause problems either by failing to effectively resist insult or by overreacting. The General Adaptation System capacity is gradually used up over a lifetime. "Disease is due neither to germs as such, nor to our adaptive reactions as such, but to the inadequacy of our reactions against the germ." Sprinkled throughout the book are reflections on the philosophy of science.

Peter M. Senge (1990).

The Fifth Discipline: The Art & Practice of the Learning Organization

New York, NY: Doubleday Currency.

A healthy individual or organization is one that is continually expanding its capacity to create its future. Such organizations are devoted to the four core disciplines ("a body of theory and technique that must be studied and mastered to be put into practice") of personal mastery, mental models, building shared vision, and team learning. The fifth discipline, systems thinking, is what holds it all together.



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