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How Dentistry Should Approach Its Problems

A Vote for Professionalism

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Abstract

Dentistry, like all professions, has always had ethical problems to contend with, including societal trust, flagrant advertising, commercialism, and access to care. Although the profession's interest and expertise in ethics has grown enormously in the last three decades, the issues facing dentistry have not really decreased, and perhaps have grown more problematic. Thus, despite the invaluable contributions of ethical progress to the structure and function of our profession, this paper argues that reflective ethics by itself appears unable to exact change. For change to occur, dentistry also needs a broad-based display of enlightened, and ethically-driven but action-oriented professionalism. This existed in the 1830s when U.S. dentistry was in its early stages of becoming thought of as a profession. Using the lessons learned from that period of our history, we need to do the same thing now—not excluding ethics, but working hand in glove with ethics. This paper suggests that, as in the 1830s, dentistry now needs the grassroots attention of its membership. Using recent publications about the importance of "connectedness" in dentistry, guidelines are presented that provide a framework for approaching the problems faced by dentistry and contributing to a more satisfying professional career.

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Problems abound for all professions, dentistry included. This was true in the 1830s when U.S. dentistry was merely aspiring to be recognized as a profession, and it is certainly true now. In the 1830s the important issues for dentistry were a failure of societal trust, the absence of clinical standards, widespread flagrant advertising, and a pervasive incompetence (Asbell, 1993). Almost 200 years later, a lack of societal trust is again on the minds of many, as are flagrant advertising and concerns about commercialism, along with the newer problems of access to care and professional misconduct (Rule & Welie, 2009).

Today, as in the 1830s, dentistry's problems, besides being of an ethical nature, are intertwined with our culture and the history of our profession. The good news is that in the last 30 years, dentistry's involvement with ethics has grown enormously. All dental schools must now present courses on professional ethics. A national organization exists that is dedicated to dental ethics, and major organizations incorporate ethics into their mission statements. Dental journals frequently contain editorials with ethical themes, while one major journal offers an ethics case in each issue, and another has a recurring section dedicated to issues in dental ethics. One would think that with all these overt manifestations of concerns about ethics, dentistry ought to be in a fairly good position to figure out how to deal with its problems. However, during the

last three decades, the issues facing dentistry have not really decreased, and perhaps have grown more problematic.

In this paper, I draw a distinction between professional ethics and professionalism in that the former is essentially a theoretical enterprise, whereas professionalism is a matter of practice—in other words, a particular set of behaviors. Since the term "professionalism" tends to be used in very different ways by different authors, most often without a precise definition, let me suggest the following definition for the purposes of this paper: Professionalism is the cluster of commitments and behaviors, shared by the members of a profession, through which they exhibit the values, principles, and norms they hold in common as members of their profession (Welie, 2010).

Considering the above observations, I will argue in this article that professional ethics, though offering an invaluable contribution to the structure and function of our profession, by itself is unable to exact necessary change. Complementary perspective is needed. This paper will develop the idea that in order to make a difference, dentistry needs a broad-based and robust display of professionalism, akin to the spirit that pervaded U.S. dentistry in the 1830s when it was in its early stages of becoming a profession.

Using the lessons about professionalism learned from the 1830s, we need to foster that same spirit of professionalism right now—not excluding ethics, but working hand in glove with ethics. And in my opinion, the concept of an enlightened professionalism has an added benefit. Not only can it help dentistry deal with the issues currently faced by the profession as a whole, it should also increase the satisfaction that each practitioner experiences with dentistry.

This paper will begin with a discussion of the lessons to be learned from the crisis of the 1830s, underscoring the importance of professionalism. Next, I discuss the importance of dentistry's history of "disconnectedness." Following an account of professionalism as exemplified by the concept of "connectedness," the article concludes with a discussion of what each individual dentist can do to contribute to its welfare.

Lessons Learned from the Crisis of the 1830s

The dawn of the nineteenth century is a good place to start our historical examination of dentistry and its professionalism. At that time, dentistry was not considered a profession by society at large. Of course, if you were a dentist, you certainly thought of yourself as a professional, especially if you had had some training—for indeed, most practitioners of dentistry did not. By the beginning of the 1800s, there were approximately 1,200 dentists in the whole country. And since there was no standard that required formal training, about 900 of the dentists were a mixture of quacks, wanderers who set up shop wherever they chose, and outright charlatans. Only about 25% of the practitioners had been well-trained, most as a result of apprenticeships with established dentists —the typical pattern in England at the time (Asbell, 1993; Bishop et al, 2002a; 2002b). Parenthetically, this group of 300 included some who had been trained medically but who had decided to concentrate on dentistry. They were considered the cream of the crop.

During the first two decades of the 1800s, little changed. But with the arrival of the 1830s, almost all social sectors in the United States underwent profound disruption (Asbell, 1993). This was mainly due to the major financial upheaval that had begun to simmer. By the early 1830s, the economy was already unstable because of problems with the banking system and wild speculation, both of which were made worse by the experimental financial practices of the Jackson administration. Then, in 1837 a full-fledged financial panic hit the United States. All over the country financial organizations tanked. Almost everyone, from the wealthiest financiers to the most humble laborers, experienced major problems. Businesses went bankrupt, banks collapsed, and unemployment escalated wildly. The country was close to ruin.

Not surprisingly, dentistry was in deep trouble too. Huge unemployment at all levels of society, plus the complete absence of standards for aspiring dentists, became an open invitation for many jobless people to embark on a dental practice as a quick fix for a nonexistent income. Large numbers of laborers left their workshops and ploughs, paid a fee to a cash-strapped dentist, and were inducted into the art of dentistry—often in just a few weeks. As a result, the overall competence level of the fledgling profession plummeted. To make matters worse, the expanded group of untrained dentists flagrantly advertised unproven techniques and products. The small group of trained dentists, who had already been struggling to raise the standards of dentistry, was now faced with even more troubles. Serious public concerns about the quality of dental care rose abruptly and became a preeminent problem (Asbell, 1993).

Ironically, however, it turned out that the Panic of 1837 gave a big boost to dentistry's attempts to be recognized as a profession. But this happened only because the small, well-trained community of dentists coalesced and began to cooperate closely. For the sake of the public's interest, they began to present and demand high standards of dentistry, and to protest the unscrupulous practices of the large number of untrained practitioners. In spite of the fact that they had no national dental association

from which to receive support, it was dentistry's great good fortune that in addition to the energy of the small but well-trained practicing community, several key leaders emerged who gave it direction. It was a demonstration of true grassroots vigorous professionalism. Threatened by destructive crises, they worked together to expose the shoddy practices and misleading advertising of the untrained practitioners and to introduce new standards for dentistry that they hoped would regain public trust.

The grass-roots actions of the band of trained practitioners and their leaders during that terrible time in our nation's history are considered by some historians to be visionary. These dentists were acutely aware of society's essential role in moving dentistry along the path toward recognition as a profession. They understood intuitively that without public trust their goal of recognition was impossible. I fear that they were more aware of the importance of society's role than we are today. Granted, even without this outstanding leadership, dentistry would still have emerged as a profession though not nearly as rapidly as it did. The dentists of those years had a firsthand view—one might even say a battlefront view—of what "connectedness" between dentistry and society meant and how important it was. Did they do this for personal gain? Of course they did. But not only, and maybe not even primarily, to foster their own interests. They understood that the long-term interests of dentists depended on achieving and retaining the trust of society by demonstrating trustworthy competence and trustworthy relationships with their patients.

In the years immediately following the Panic of 1837, these dentists and their leaders turned their attention to three major projects that were designed to draw public attention to the worthiness of dentistry's professionalization (McCluggage, 1959). In 1839 they created the first dental journal to be published in the United States, the *American Journal of Dental Science.* It presented useful clinical and scientific articles, but its most urgent goal was to counteract the widespread stream of false but very influential advertisements about treatments that were ineffective and possibly harmful that were being promoted by the untrained dentists.

Their second effort was to establish a school of dentistry. This was a project of high priority because they were convinced—correctly as it turned out—that such a school would play a major role in helping to reassure the public that dentistry was concerned about the standards and competence of its practitioners. In 1840 the Baltimore College of Dental Surgery was created as the nation's, and indeed the world's, first dental school proper.

Their third project, also initiated in 1840, was to create a professional organization that would provide necessary resources for the aspiring professionals and ultimately help negotiate with state legislatures for favorable competitive positions in the marketplace. And so the American Society of Dental Surgeons was formed as the first national dental society.

Thus, in three amazing years, three cornerstones had been laid to help dentistry make its case that it should be considered a profession. These accomplishments had a huge impact on the development of dentistry as a profession. In all that was done, the driving force was a robust professionalism.

However, dentistry still had a long way to go. One swallow does not make a summer, and so it would be necessary to expand from a single dental school to a national system of dental education that would, over time, ensure a standardized

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education for all dentists. It would be decades before that goal was accomplished. In addition, there was the immediate need to lobby for legislation that regulated licensure. However, the prevailing political climate in the Jacksonian era was so highly oriented toward individualism and personal rights that any ideas about restricting anything—even obviously beneficial proposals like those requiring training and licensure—were dead in the water. As with a national system of dental education, nothing happened on the licensure front for decades.

Dentistry faced many struggles in its movement towards recognition as a profession. All professions have experienced comparable milestones, and for all of them the process has been painstakingly slow. Society's bestowing of professional status operates at a snail's pace. Even after an occupation is undisputedly recognized as a profession, the maturation process continues. In the United States, it was not until the late 1800s and early 1900s that the current economic conditions of dentistry and other professions were solidly established and their advantageous positions in the marketplace were secure (McCluggage, 1959).

Dentistry's History of "Disconnectedness"

In the previous section, the intuitive understanding by the dentists of the 1830 of dentistry's need for "connectedness" with society was mentioned. It was also suggested that their understanding of it probably was more robust than it is now. To understand the importance of "connectedness," one first needs to understand the impact of its opposite, "isolation" or "disconnectedness," on the challenges faced by the profession of dentistry (Haden et al, 2003).

The issue of access to oral health care offers a good example. The United States Surgeon General's report *Oral Health Care in America* illustrated how pervasive and significant oral disease is among the most vulnerable segment of our population (U.S. Department of Health and Human Services, 2000). As with most of the broad issues faced by dentistry, the cause of oral health disparities is complex and often extends beyond the aegis of dentistry to include cultural and economic factors. Nevertheless, the dental profession and its members, as part of the problem, share the responsibility of correcting it.

Welie and Rule (2006) have proposed that "...the root cause for dentistry's relative ineffectiveness in reducing oral health disparities (relative, that is, to other health professions) lies deeply in its longstanding pattern of disconnectedness, or isolationism." In addition, the American Dental Education Association (ADEA) has stated that, "Reduced access to oral health care is one of the prices of professional isolation that has too often characterized dentistry" (Haden et al, 2003). Similar statements can be made with regard to other major issues facing dentistry, including commercialism, flagrant advertising, and professional misconduct. One can conclude that the importance dentists allot to personal autonomy and privacy tends to restrict how they approach broader issues.

These observations should not come as a surprise. Disconnectedness and dentistry have a long history together. For example, the greater part of U.S. dentistry has always been practiced apart from other kinds of medicine. In addition, until podiatry and optometry came along, the teeth were the only part of the body that had its own group of healers; all the other parts, organs, and organ systems were treated by medically trained healers.

This isolation of the oral cavity from the rest of the body has had far-reaching consequences. Dental education is largely conducted apart from medical education. The licensing boards for dentists and physicians are distinct. Dental and medical insurance programs are organized completely separately, and in many countries dental care is not part of publicly supported health care financing systems. That is true, for example, of Medicare in this country (Welie & Rule, 2006). And as a matter of fact, much of this separation is just how dentistry wants it. It certainly provides some advantages to dentistry, particularly with respect to avoiding some of the regulatory and financial constraints that medicine has been forced to accept.

On the other hand, the American Dental Education Association points out that the consistent separation between medicine and dentistry opens the door to assumptions by the public, by policymakers, and by other groups of healthcare providers that oral health lacks the importance of general health. It may also be true that dentists themselves often make the same assumptions and perhaps think of themselves as less important than physicians (Haden et al, 2003).

In addition, these patterns of isolation are fostered by the very structure of dentistry. Most physicians work closely with their colleagues in clinics and hospitals. In contrast most dentists either work solo or in relatively small practices. "Dentists like to be their own boss, run their own office, and practice dentistry their way" (Welie & Rule, 2006). And a lot of people enter dentistry in part because of these intrinsic features.

There are other examples of "disconnectedness" in dentistry. Our concerns about our own professional privacy generate suspicion of such intrusions as treatment protocols, utilization reviews,

practice standards, professional regulations, and governmental control. Dentistry's isolationism is also reflected problematically in its reluctance to engage in constructive peer review. Self-regulation is supposed to be a hallmark of any profession. However, dentistry has been less forthcoming than most professions in developing effective peer review programs (Welie & Rule, 2006).

Just how damaging to the public's trust the profession's wariness of standardization can be is illustrated by an article that appeared in a 1997 *Reader's Digest* entitled, "How Honest Are Dentists?" (Ecenbarger, 1997). In the article a journalist pretending to be a patient made appointments with 50 different dentists and received examinations and treatment plans from each of them. The treatment plans varied hugely, as did the costs of treatment, which ranged from $500 to $30,000. The article itself was damaging enough, but the cover title of the magazine was even worse: "How Dentists Rip Us Off." Dentists were clearly outraged, but for many patients it was a source of genuine concern.

Similarly, the trustworthiness of dentists in the public eye was called into question by Gordon Christensen in a 2001 monthly column published in the *Journal of the American Dental Association.* Christensen had noted the public's concerns about the trustworthiness of dentists and judged that it was based on their perceptions that dentists were overly concerned with making money and with other aspects of their own interests—but not so concerned with the interests of their patients. [Editor's Note: See the editorial in the spring 2009 issue (Volume 76, Number 2) of this journal for corrections to the facts underlying Dr. Christensen's remarks.]

Dentistry's isolationism and disconnectedness from the public is furthermore manifested by the increasing wave of commercial competition among dentists, as evidenced by salesmanship tactics surrounding elective treatments, flagrantly misleading advertising, and for-profit sales of commercial products within the dental office. These concerns about commercialism and its failure to fulfill societal expectations are well articulated by Ozar (1985) and by Ozar and Sokol (2003). Along with many members of the profession, Rule and Welie believe that this demonstration of isolationism, in the form of rising self-interest over the interests of the public, "is nothing less than the transformation of dentistry from a profession to a business" (Rule & Welie, 2009).

The concern here is that dentistry may be heading towards its own ultimate disconnection: claiming the status of a profession while operating mainly as a business. The first indication of this development was the U.S. Supreme Court ruling in 1975 that certain professions, including dentistry, were no longer exempt from antitrust laws. This ruling paved the way for the Federal Trade Commission's (FTC) decision soon afterwards that the ADA (along with the American Medical Association and the American Bar Association) functioned as trade organizations because their primary concerns were the business interests of their memberships. As a result, these professions could no longer prohibit advertising.

Any such restriction placed upon a profession is of concern because it represents a battle that was fought and lost by the profession. At first glance, it may also appear that victory belonged to the public. However, because of what actually happened, such is not the case. The FTC ruling opened the door for dentists to fully embrace a competitive business model and focus on building multi-million dollar practices using all available business tactics. The real loser was actually the public. Patients, already rendered vulnerable by their oral

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disease, dysfunction, and pain, now had to adopt a "buyer beware" attitude instead of simply trusting that their dentist would act in their best oral health interests. Then again, if dentistry exchanges its professional paradigm for a commercial paradigm, as the FTC contended it already had by the late 1970s, the public has little choice but to impose on dentistry the rules of the business game.

More recently, again usually with strong opposition by state dental organizations, more such battles with the public were lost—the general issue this time being access to care. For example, the California state legislatures passed new laws that conditionally credentialed certain Mexican dentists to provide services in California in a move to increase access to oral care services to certain groups of people. And in the mid 2000s, a plan to provide dental care by nondentists was initiated by the Alaska Native Tribal Health Consortium despite the ADA's attempts to block it legally (Nash & Nagel, 2005). Most recently, Minnesota has embarked on developing a system of midlevel oral providers with the goal of reducing oral health disparities, and other states are moving in that direction as well (Minnesota SF, 2009; Connecticut HB, 2009; New Hampshire GC, 2009).

In most of the above examples, the actions of state legislatures were intended to address a problem that the public thought was not being dealt with adequately by the profession. Furthermore, the actions by state legislatures were in most instances met with vigorous opposition by the profession. When a profession and the public are at odds with each other, the situation must be taken seriously. In the 1830s the trained dentists of that era intuitively understood the importance of dealing effectively with the concerns of the public. At that time the chief public concern was whether dentists could be trusted to provide competent care. Public concerns change over time, but after almost 200 years, public trust is once more an issue, as is commercialism. In addition, there is the entry of access to care as a new and powerful concern to the public. It makes little difference whether one agrees with the details of the remedies for access to care issues that have been proposed and initiated. The point is that the profession and the public are at odds about very important issues, and the profession's view has not prevailed. Given the importance that public approval has on the well-being of professions, dentists must do a better job recognizing the concerns and needs of the public. Failing that, we must pay the price of decreased trust and public esteem, and ultimately the potential loss of our status as a profession.

Professionalism's Four Realms of Connectedness

From this author's standpoint, if one is concerned about dealing effectively with the issues of the day—and for that matter, adding to the satisfactions of one's professional life as well—the path to take is a combination of two approaches. First, remember the lessons learned from the 1830s. In that time of crisis, a small group of 300 trained dentists, among them some outstanding, visionary leaders, showed that hard work, a cooperative spirit, and a robust professionalism could have an enormous impact on their profession.

The second approach starts with the previously discussed premise that dentistry's disconnectedness (or isolation) contributes substantially to its own problems. Thus, the obvious thing to do is to promote its opposite. This section shows the range of contributions that "connectedness" can make to professionalism.

In 1994 Hershey stated that what is needed is, "A willingness to be connected —a willingness to go beyond the isolation of narrowly interpreting one's professional role in order to be connected to the concerns of other individuals and to the overall well-being of society" (Hershey, 1994). In 1994 DePaola, also discussed connectedness, but from an educational standpoint: "It is imperative that students in all education settings, including dental education, be taught in a manner where they are connected to the world and the quality of connectedness is ingrained in the very culture of the institution" (DePaola 1994). The belief here is that if dental professionals would demonstrate a comprehensive connectedness in their approach to professionalism, it would be an important first step in reducing the structural problems facing the profession.

The concept of "connectedness" with respect to professionalism covers four different realms (Welie & Rule, 2006):

1. *With Patients.* This is the most familiar component of connectedness and includes, for example, the idea of a fiduciary relationship and the understanding of the partnership of patients in the dentist-patient relationship.
2. *With the Profession.* This includes the understanding that the concept of a profession is social in nature and embodies collective action rather than the action of its individually committed members.
3. *With the Community.* This includes the understanding that dentists are expected to contribute to the well-being of their communities, often in leadership roles. Their contributions can focus on oral health issues, general health issues, or general concerns of community betterment.
4. *With Society at Large.* Dentists should be fully aware of the role of society in the sanctioning of profes-

sions and therefore have concerns and responsibilities for the well-being of society at large.

If we want dentistry to overcome its historical tendency towards isolationism through the development of the four realms of professional connectedness, then we must rely on the practitioners themselves to take the first steps. The following paragraphs present suggestions about how ethics, professionalism, and connectedness are joined together as important influences on how one thinks and functions as a dentist.

What Should Be Done?

We know from the 1830s that concerned professionals with good will and a willingness to work together can make an important difference in the issues they face. Concerned professionals today who want dentistry to ensure its future as a helping profession and who want the satisfaction of participating in that process should get together to talk about their profession. Ozar and Patthoff (2009) have suggested a similar approach: "Each new generation of dentists should contribute to the general dialogue about how to address the current ethical challenges that differ from those faced by their predecessors."

The idea is to form your own small groups, or use the format of an existing study club, or encourage dental societies to hold discussions as part of their agendas. Using the framework of the discussion questions given below, which are based upon the four realms of connectedness—or discussion questions and topics of your own making—find out what the members of the group believe about their profession and their roles in it.

Discuss Connectedness between Dentists and Their Patients

How would you like to be thought of by your patients and by your colleagues? Are you satisfied with your own perception of yourself as a professional? What is the nature of the relationship between you and your patients? Is part of your relationship fiduciary in nature, and if so, what does that mean to you? What are your rights and responsibilities in contrast with those of your patients? What does it mean to consider the patient as a full partner in the dentist-patient relationship? Discuss and analyze examples of successes and failures to be a full partner.

Are the days of paternalism in the dental office really gone? Is there a difference between being paternalistic and making recommendations based only on the patient's clinical needs? Are a patient's clinical needs synonymous with a patient's best interests? Some people think that it is impossible for a professional to really know the best interests of the patient. Do you agree?

If a dentist sells electric toothbrushes for profit in his or her office, is it an acceptable professional paradigm? Does its acceptability depend upon how marketing occurs? Does its acceptability depend upon the dentist's disclosure of profit? Is this practice consistent with a fiduciary relationship?

Are you satisfied with your informed consent process? Do you view it as a legal or as an ethical process? Which should it primarily be: an important risk management procedure or an important demonstration of your relationship with your patients? How do your patients view your informed consent process?

Discuss Connectedness between Dentists and Their Profession

What does it mean to you to be a member of the dental profession? How has being a dental professional changed you? What do you like and dislike about what you do? What kinds of professional activities give you the most satisfaction?

Besides your obligations to your patients, what do you see as your obligations, if any, to your profession? Do your obligations include maintaining and improving your clinical skills? Should you feel obligated to join the ADA and your component societies? Why or why not? If so, does joining mean that you are also obligated to play an active role?

Do you think your local dental society and state and national associations function primarily to further the professional obligations of dentistry or to advance its business interests? What do you think should be the balance between the two? Should there be changes made in the agendas of these organizations?

What role should professional organizations play in their communities and states? And with respect to national organizations, what role should they play in societal interests?

One of the characteristics of a profession is that it is self-regulating, partly through collegial discipline. What does collegial discipline mean and what does it entail? Does collegial discipline work well as a self-regulatory method? When you see a member of the profession operating outside the bounds of acceptable behavior (anything from incompetence to the use of drugs), what do you see as your responsibility to that dentist, to affected patients, and to the profession? Do your responsibilities extend to making contact with the offending dentist? What is the biggest obstacle to discussing problems with an offending dentist?

With respect to colleagues who are incompetent, should dentists with significant knowledge of a problem interact with them? Are the considerations the same with impaired colleagues? What about dishonest colleagues or those who engage in legally dubious behaviors? Under what circumstances, if any,

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should dentists act as whistleblowers against incompetent, impaired, or dishonest colleagues? What should be the role, if any, of state boards in the kinds of issues listed above?

Since much of the concept of self-regulation is manifest in the educational system of the profession, do you think that dentists have a responsibility to participate in the process of dental education and even in dental research? Should dental organizations encourage their members to participate in the education of future dentists and the advancement of the science of dentistry?

How do you assess the *ADA Principles of Ethics and Code of Professional Conduct?* Do you ever refer to it? Do you think it is a useful and meaningful document in terms of enhancing collegial discipline? Do you see flaws within it? Should some changes be initiated?

One of the concepts that is inherent in the structure of professions is that they have "a service rather that a profit orientation." Another concept that is widely endorsed is that "professionals should consider their services to be ends unto themselves rather than a means to an end." What do you think these statements mean? Do you agree with them?

Do you agree with how professional peer review committees in dentistry usually function, which is primarily to resolve disputes between patients and their dentists? Is the current peer review process suited to fulfill an expanded role that includes, for example, patient safety and error prevention programs? Should peer review committees perform monitoring functions related to patient care?

It is clear that professionals may legally advertise. However, many dentists believe that advertising is unprofessional. What are the boundaries between acceptable and unacceptable advertising? Given the legal restrictions on the control of advertising, how can the profession assure that advertisements by its members foster the public's trust in the profession?

Regarding the issue of the encroachment of commercialism on the profession, what are examples that concern you, if any? Are any or all of the examples a threat to the public or to the profession?

Discuss Connectedness Between Dentists And Their Communities

Is there an obligation for dentists and dental organizations to be involved in oral health programs that benefit the community? If so, in what way: financial support, through actions in their offices, community clinics, through participation in Medicaid?

Should individual dentists and professional dental organizations help promote and be involved in general health issues such as heart disease, breast cancer, smoking cessation? If so, in what way: financial support, volunteer activities, involvement in community clinics, collaboration with medical organizations?

Should dentists consider their arena of interest or responsibility to include involvement in non-health community activities, such as town or city government, charity drives, bank directorships, homeless shelters? If so, with what motivation?

Discuss Connectedness between Dentists and Society at Large

At the general societal level, how should dentists view their responsibilities to become involved in socially based oral health problems such as oral cancer screening or access to care? Is there any duty for dentists to participate in the improvement of access to care at some level? If so, what is the extent of a dentist's duty to do so?

How do you view the above questions with respect to societal concerns of a general health nature?

Should dentists be engaged in public causes, such as fighting gender or racial discrimination, environmental issues, or global projects in developing countries?

Finally, if the concept of connectedness becomes important to you or your organization, and you do good things as a result, then take credit for it. For example, organizations could catalog and publicize their community oriented oral health activities, their collaborative efforts with dental schools and with other professions, and their non-health related activities that benefit the community. Outreach efforts such as public health initiatives, public nutrition, reducing racial discrimination, Big Brother or Big Sister organizations, and community church programs are all good examples of connectedness with one's profession, with the community, and with society at large.

Conclusion

Addressing the problems that currently confront dentistry, such as commercialism, flagrant advertising, and a reduction of public trust requires the consideration of several components. An emphasis on ethics is essential, but unless it is combined with a robust professionalism such as existed in the 1830s when U.S. dentistry was in its early stages of becoming a profession, beneficial change is not likely. This paper holds the view that the concept of "connectedness"—with patients, with one's profession, with community, and with society at large—is an important component of professionalism. In addition it provides guidelines for discussing questions of importance to dentistry that are based on the four realms of professionalism. Finally, while readily admitting that I have not provided evidence in this paper to support this conclusion, I am convinced that the broadening concept of "connectedness," besides being a worthwhile approach to dealing with dentistry's problems, can play an important role in enhancing the satisfaction in a dentist's own professional life. ■

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