Historical Perspective

*Through April, 1993, the **Journal of Endodontics** will continue to feature addresses and/or profiles of all 49 AAE past presidents. Begun in 1991, this feature is intended to give members insight into the history and movement of the AAE and endodontics as a specialty, as we approach the 50th Anniversary of the founding of the AAE.*

James H. Sherard, DDS
Past President, 1963-64

Recollections of the 21st Annual Meeting of the American Association of Endodontists April 17-19, 1964, Washington, D.C.

After considerable thought, pleasant memories and reviewing files and correspondence, my major recollection is of the team I was fortunate to have.

In 1964, the Secretary of the AAE was a one-man operation. His office and his home were the AAE's central office. "Van" Van Valey kept our organization on an even keel with dedication and hard work. Of course he was fortunate to have his wife Ruth assisting him, and we were too.

Much of our success in these early years was due to family efforts and sacrifices, and I am confident this is still true.

This was only the second venture out of Chicago for our annual meeting. It had always run so smoothly in conjunction with the Chicago Mid-Winter meeting, many of us assumed it just happened and thought we would make a mistake to move it too other locations. Dedicated pioneers such as Vince Milas, who served as Secretary for the first 15 to 20 years, and Tom Starshak, who was the General Arrangements Chairman, made everything simple for the rest of us during these years.

The first meeting held outside Chicago was in 1962 in Miami. The Florida group convinced us that it could be done, and done very well. We returned to Chicago in 1963, and the long-term site committee selected Washington, D.C. for 1964.

Washington did not have a large contingent of AAE members, but those few did a superb job. Fortunately, we had a young Navy captain stationed at Bethesda who had established a reputation as a quiet, dedicated, energetic and willing AAE member. Without hesitation he accepted the job of Local Arrangements Chairman. What a job! Jack Bucher could be compared to a Rolls Royce. You could not hear the engine running, but were assured of its dependability, perfection in every aspect and the most comfortable ride imaginable. Perfection personified. We were fortunate that he also had a helpmate, his wife Kitty, who made sure many, many details were checked and double checked. I guess you could say she was the chauffeur of the Rolls Royce.

The heart of our successful meeting was the program. I was successful in convincing a very busy, active young member who everyone recognized would be a leader and world renowned endodontist to be Program Chairman. You are right; it was Dudley Glick.

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Herbert Schilder, DDS
Past President, 1985-86

Changes

Reflections on endodontics and on the AAE come easily as we approach the 50th anniversary of our Association next year.

Growth, strength and respect are images that come to mind. Strong educational support, quality patient care and significant research are pleasant thoughts that flood in as well. And, at last, indispensability and broad public recognition-long sought after goals - seem finally to have been achieved.

Things have surely changed since the founding of the AAE in 1943. The threats of focal infection are seemingly behind us. We have been certified and recertified as a recognized specialty within dentistry. We have 3,925 members, of whom 681 are also Diplomates of the American Board of Endodontics. It is probably fair to say that "endodontics" (or at least, "root canal") has become a household word (associated with extreme pain).

It is also good that no third party dental plan is considered to be a good one that does not provide for endodontic service as a basic, or near basic, benefit. We should both be happy and proud.

But change is constant. We are always in the midst of change - some good, some bad. Changes that benefit endodontics and our Association are always welcomed. Those that affect us adversely should be avoided or redirected, if possible. We have always tried to do so.

In 1974, I was asked to summarize for publication in the brand new Journal of Endodontics an address I had delivered to the AAE at its 31st annual meeting in San Diego. Under the title, "Problems of the Present," it was placed by the editor as the first article in Vol. 1 No. 1 of the JOE in January 1975. Someone besides myself, apparently, thought that some of those problems were of concern to the membership.

The problems I commented on were supply and demand, educational problems and Sargenti/N2. Sound familiar?

The Association's response to these challenges in the ensuing two decades have been prodigious and, considering the enormity and complexity of these issues, effective regarding supply and demand and Sargenti/N2. The educational problems, the ones least visible to the members, have increased in complexity and may threaten seriously, in my judgement, our very continuance as a specialty in dentistry.

The supply and demand issue began with two diametrically opposed trend lines. One, the unprecedented decrease in caries documented in the early '70's and, two, an equally

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Dudley organized a fantastic program whose list of essayists would read like a "Who's Who" in dentistry, especially the specialty of endodontics, which had just been recognized and accredited by the American Dental Association. I invite you to review this program if you have an opportunity. You may know some of our "more mature" members who have saved programs from the past or find them in our headquarters office. I am sure you would be impressed with the quality of many of our early programs.

Every annual meeting should have a social and entertaining aspect. This meeting reached a new plateau, and I am confident has been a tough act to follow. My associate in practice for over 30 years and a very good friend, Julian Kelly, was Chairman of the Banquet Committee. He arranged to have an outstanding entertainer fly in from Dothan, Alabama. Sharon Elabash was a successful Harvard graduate lawyer and, while standing, he played several classical selections on the piano and sang with a highly trained operatic voice. He then quoted Shakespeare with annunciation and an accent that would convince you he was truly an Englishman. He then brought the house down when he performed the same acts with his Southern Alabama accent, as he would have done it in the Dothan High School his senior year.

Preceding this banquet, the Southern Endodontic Study Group, of which I am very proud, surprised me by hosting a cocktail party. They were dressed in formal attire, with Dixie flags in their lapels, and a dixieland band furnished the music. The evening truly had a Southern accent. Eleven of us formed this Southern Endodontic Study Group in 1956. Its membership now is about what the AAE membership was in 1964. You might say it was conceived by Jake Freedland and born in my playroom in Atlanta. Dr. B. Nygaard Ostby from Norway was visiting Jake and was our guest at this first meeting.

The AAE was a relatively small group in 1964, but very strong in enthusiasm because we were constantly spreading the gospel that quality endodontic treatment could save our natural dentition. Because of this enthusiasm, our business meeting enjoyed an almost 100% attendance. We were the youngest specialty in dentistry, looking forward to a bright future, but realizing there were still many aspects to be converted. It was my duty to preside, so I announced that our policy stated that anyone who wished to speak should give their name and the city and state they were from. I then smugly said, "I am Jimmy Sherard from Atlanta and am sure it is not necessary to say which state." A big tall Texan stood up in the back of the room and said, "The H____ (I think he said 'heck') it isn't, because I'm from Atlanta, Texas." This was Frank Trice speaking, who became our president a few years later.

I was very fortunate and received many compliments for 1964, but as you can see, I had a fantastic team who would make anyone look good. Thanks for the memories and best wishes for the future.

Dr. Sherard retired from dentistry in 1989 and divides his time between two homes in Atlanta, Georgia and Highlands, North Carolina. He counts he and his wife, Veda, fortunate for havingsustained health and enjoys playing golf and preparing breakfast every Sunday for 300+ street people at the First Presbyterian Church in Atlanta.

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in caries documented in the early '70's and, two, an equally unprecedented increase in dental manpower orchestrated by the federal government.

"Busyness" became a buzzword for both the ADA and AAE. The inevitable occurred, with all parties trying to protect their "turf." General dentists started doing procedures which they had traditionally referred to specialists. Endodontists became accustomed to the reality that, for the most part, their practices would no longer include uncomplicated anterior teeth. They also became aware of a growing subspecialty of "retreatodontics" in their practices, i.e. the retreatment of cases previously attempted by referring generalists.

One of the happy outcomes of this has been the Association's outstandingly successful public awareness program. What a political hot potato that was for your officers, with its special assessments attached to your dues for several years in the mid-'80's!

We've learned to cope with Supply and Demand.

Regarding Sargenti/N2, no one can really believe that the AAE is seriously threatened by this problem today. I wrote in part in 1975: "Angelo Sargenti is a paradoxical unifying force for endodontics. Neither Sargenti, nor his material, nor his technique are basically scientific issues, although I have no doubt to his own belief in his claims. He cannot [however] be ignored..."

Surely this Association has not ignored N2 in the ensuing years. But no one sitting in the House of Delegates of the ADA in 1989 and seeing the unanimous 417-0 vote in recertifying endodontics as a specialty can feel that N2 and its adherents pose a serious present threat to endodontics. If continuous vigilance is necessary, the AAE has demonstrated its capacity to be vigilant.

My own impression on this subject, however, has not changed. The Sargenti phenomenon taught us more about ourselves than it did about him. We got better; we reached out to general dentists more. And for the most part, those endodontists who had done so stopped the "trivialization" of endodontics with commercially directed quick-fix cures of their own design and one-day miracle courses. Our relations with general dentists have probably never been better than they are today.

Change can be difficult, but change can be good. In my final Presidential Message in the April 1986 *Journal of Endodontics*, I summarized with these remarks:

"The natural consequence of all this for endodontists is that we will be busy in the decades ahead, but we will be treating, for the most part, the difficult cases, the youngest and oldest patients, the calcified and tortuous canals, and cases in which an initial attempt at endodontic treatment has been unsuccessful. Then will the endodontic specialists be called in to salvage the case, to find the canal, to bypass the ledge, the calcification, the paste, the broken instrument, to seal the perforation, to hemisect the root, to reverse seal the apex, to do the magic to save the case. If it sounds like your practice this week, you are not alone. But after the culture shock, cheer up; you are training for the future, and there is going to be an immense need for us in the years ahead." Optimistic then and optimistic now, on those scores at least.

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But things still change and the vigilance of this Association must be directed at more than N2 alone. Two current trends leave me with profound concern for our specialty. One is relatively new. The other is quite old.

The new concern is the effect that Implant Dentistry may have on endodontics in the years ahead. I do not mean the placement of implants into edentulous areas where teeth have been extracted because of hopeless periodontal conditions or because of impossibility of performing successful endodontic treatment. I refer to the growing likelihood of teeth being extracted instead of being treated periodontally or endodontically. This may be a touchy subject, but this may also be a deadly serious one for our Association.

As periodontists, prosthodontists, maxillo-facial surgeons and general dentists discover that implant dentistry constitutes an increasingly significant portion of their practice incomes, economic decisions regarding extraction of salvageable teeth may blur treatment decisions. This threat is real.

The Association must face this reality head on and propose ethical responses to it promptly!

The other major current problem is one of the old ones, more insidious now more than ever: the Educational Problem.

Your Association is seriously engaged at present with a critical shortage of endodontic teachers to train new endodontists and to train general dentists who still provide the majority of root canal treatments in this country.

To quote briefly from my 1975 paper: "Our second major problem is that our schools are in fiscal difficulty...With only few exceptions, most endodontic faculties are too small to teach the number of students being thrust upon them...Are teachers underpaid? Would higher salaries attract and retain more highly qualified teachers?..."

Well, our schools are in greater fiscal difficulty today than they were then. More and more schools, to better balance budgets, are folding previously independent endodontic departments into larger groupings within dental schools. This saves money in many demonstrable ways, including reduced faculty and support staff expense, reduced space and material requirements. etc. This is fraught with a huge set of problems for already harassed endodontic faculties. When combined with programs of "comprehensive dentistry," the outcomes may be catastrophic.

In comprehensive care predoctoral dental programs, patients are assigned to dental students who become responsible for all the dentistry those patients require. On the surface it sounds great. In its best form it does have some educational merit. In its worst form it smacks of the old "supergeneralist" idea which flourishes still after a decade and a half of anti-specialist dental educational dogma.

Under ideal circumstances, the comprehensive care patient has his/her complex specialty treatment needs met by referral from the predoctoral student to the graduate specialty service clinics of the school. The simple specialty service needs are provided by the predoctoral student who does the treatment either in a predoctoral, comprehensive clinic area ubder supervision of an appropriate faculty from the school's specialty departments, or by that same student in a predoctoral clinic for that specialty, again under supervision of the appropriate specialty department faculty.

The problem is that some schools are closing their predoctoral specialty clinics (saves $) and are allowing GENERAL DENTISTS to supervise specialty services in the general comprehensive care clinic area (saves $).

It is happening now! The trend is increasing. If it is not checked, a generation of dental students will be graduated who have seen endodontists as lecturers, maybe as preclinical instructors, but not as clinical instructors.

To say that the endodontic education of these students is shortchanged puts it mildly. Such inadequate specialty education threatens equally the endodontic treatment needs of these students' future patients. What need or knowledge of the value of working with endodontists will graduates of such programs possess?

"Joining them," either in the case of implants or "going along" in the case of the educational crisis, may meet the personal needs of certain endodontic colleagues. I can empathize with that. But no needs of endodontics nor of the AAE will be met by such aquiescence.

The Association's early attention to these emergent problems is essential. There are no present solutions to either of these problems unless we take the reins with the determination to forge solutions.

Stripped of scientific posturing and philosophic jargon, these are pocketbook issues, often the hardest ones with which to deal. Yet deal with them we must, if we are to celebrate our second fifty years in 2043, as self-fulfilled as we hope to celebrate our first fifty years in Chicago next year.

Don't leave it to our Officers and Board of Directors alone. Get involved with these issues yourselves. Each and every one of you. I bet that will make a change in your enjoyment of endodontic practice in the years ahead.

Dr. Schilder resides in Brookline, Massachusetts and is currently Professor and Chairman of the Department of Endodontics at Boston University's Goldman School of Graduate Dentistry. A former Director of the American Board of Endodontics, Dr. Schilder remains active on all levels of organized dentistry.