HISTORY: 1943-1993 MANUSCRIPT

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"A vile toothache comes to remind me that I am mortal."

-- Lord John Cam Hobhouse Broughton, 1820

Chapter 1.
The deep roots of endodontics.

No specialty group happens by accident. It comes into being to fill a need. To understand the history of endodontics and of dentistry in general, it is first necessary to look at what came before -- the history of medical ignorance and striving, of misinformation and illumination, of human suffering and concern. From these swirling oceans of the past -- with their high and low tides of progress -- came the gradual evolution of medicine, then dentistry and finally the dental specialties -- including endodontics.

It should be no surprise that the importance of teeth has been recognized since the dawn of time. The laws of the earliest civilizations cite the loss of a tooth as a criminal wrong. Both the *Old Testament* of the Judeo-Christian tradition and the *Koran* of Islam demanded "tooth for a tooth." In ancient Mesopotamia, Hammurabi (1792-1750 BC), ruler of the Babylonian empire, codified the rewards -- and punishments:

Law 200: If someone knocks out the tooth of an equal, his own tooth is knocked out.

Law 201: If someone knocks out the tooth of an inferior, he is fined a third of a minah of silver.

The only difference here is the double standard that made it a less grievous offense to damage the teeth of those below your social station. If you were a noble, you could buy your way out of forcible removal of your own teeth.

If the loss of teeth was an obvious wrong, the preservation of teeth should have been an apparent good. In fact, many of the earliest writers on dentistry urged doing everything possible to preserve one's own teeth.

Francis Bacon (1561-1626) was the last person who could truly say, "I have taken all knowledge to be my province." That meant the great English essayist had something perceptive to say about teeth, too. In his *History* -- published posthumously in 1651 -- Bacon pinpointed the primary consideration for teeth: "The *Preserving* of them."

Despite these voices of reason, the origins of dentistry were driven not so much by reason as by pain. As William Shakespeare so aptly put it, "For there was never yet philosopher That could endure the toothache patiently."

That fear of dental pain extended even to such pioneers as Pierre Fauchard (1690-1761), the founder of modern scientific dentistry. Despite the many advances he made in dental surgery, he found it necessary to offer this advice to other dentists: "One should always take the precaution of hiding the instruments from the patient's sight, especially in the case of extracting a tooth, so as not to terrify him."

In the United States of the 19th and early 20th centuries, only the larger cities could support qualified dentists -- and even there only the well-to-do could afford anything more than basic extractions. For people beyond urban centers, dental care was reduced to what became known as "dentistry of necessity."

Even into the 20th century the people of small towns of the West -- a long way from urban centers -- had virtually no access to qualified dentists. The best they could hope for was primitive dental pulling -- and that at the hands of itinerant dentists or even peddlers. If the patient was lucky, he or she might get an extraction with a pair of forceps. If that wasn't available, the last resort was having the local blacksmith take out the bad tooth with a hammer and metal punch.

Sometimes the lack of professional care forced toothache sufferers to resort to self-treatment. In

one of the more extreme cases, Dr. Messenger Mooney, an English physician of the 18th century, tied one end of a length of catgut around the tooth to be liberated -- and the other end to a bullet. Using a full charge of gunpowder, the inventive Dr. Messenger then loaded the bullet and fired the pistol into the air. The tooth was removed -- literally in a flash.

The pull of extraction.

In this historical context, the urging by dental sages of antiquity to do everything possible to save teeth became irrelevant. Painful necessity and current wisdom erred on the side of pulling teeth at the first sign of trouble, *i.e.,* pain. In his classic 1797 home medical guide, *Domestic Medicine,* Dr. William Buchan naturally addressed dental care: "As a spoilt tooth never becomes sound again, it is prudent to draw it soon, lest it should affect the rest."

Sometimes the decision to remove teeth was based upon nonmedical considerations. For example, the state of weaponry during the U.S. Civil War made teeth a requirement for military service. Infantry soldiers needed anterior teeth to bite off cartridges. This led many draftees to have some of their front teeth knocked out in the belief that this would grant them exemption from military service. Unfortunately for these 19th century draft dodgers, the military announced that toothless transcripts would be accepted by the cavalry, which did not require teeth. The would-be civilians found themselves toothless *and* in uniform.

However, it was the dentists of the day who, forceps in hand, led the charge toward wholesale extraction. A French cartoon of 1873 depicted a dentist crying, "Pull! Don't cure!" This was, unfortunately, the prevalent philosophy of much of dentistry even in the United States, where dentistry emphasized restoration. This bias toward extraction was accelerated by two major advances of 19th century dentistry: anesthesia and Vulcanite, which revolutionized the construction of denture bases. Both made tooth extraction an easier choice.

Defining dentistry.

Obviously, before endodontics could become a reality, the entire practice of dentistry needed to follow in the path of medicine in winning acceptance as a profession. Perhaps the first great move toward legitimizing the field of dentistry came when doctors separated themselves from

the barbers who traditionally served as "tooth-drawers" (*i.e.*, those who extracted teeth). Before the time of Henry VIII, barbers performed surgery. But in 1540 these two disparate vocations were separated and barbers were thereafter restricted to cutting hair, shaving and pulling teeth.

Despite this, barbers and surgeons still constituted one body until 1745, when the split became even more formalized. The surgeons established a special Surgeons' Hall, while the barbers remained at Barber Surgeons' Hall. As a result, it was not always easy to find a doctor who would "lower" himself by extracting a tooth.

As a result, until the 20th century, dentists inhabited a twilight zone -- halfway between medical surgeons and barbers -- and not quite accepted by either. The history of dentistry can be summed up in the struggle for professional acceptance that would allow dentists to better serve their patients with knowledge and compassion. And along the way, a few prominent dentists took the first strides that laid the groundwork for the specialization that would come to be known as endodontics.

When Pierre Fauchard practiced dentistry in the 18th century, cauterization was the only effective means of destroying the dental pulp. This was often the first step in what was as close as 18th century dentistry could come to a root canal. If the dental roots were in good condition, Fauchard left them in place after the cauterization. Then he would attach an artificial crown by binding it to the adjacent teeth with thread or attaching it with screws to the roots. As Fauchard wrote in his most famous work, the 1728 *Le Chirurgien Dentiste:*

> *When one wishes to apply an artificial crown to the root of a natural tooth, one files away the part of the root that emerges above the gum, and even more if possible. One then removes, with proper instruments, all that is decayed in the root itself; after which one stops the root canal with lead and fits the base of the artificial tooth to the root in such a manner that they correspond perfectly to each other. One drills one or two holes in the tooth through which to pass the ends of a thread, which serves to fasten it to the natural teeth on each side of it . . . .*
>
> *If the root canal has been very considerably enlarged by the carious process, so as to have rendered it*

necessary to stop it, the root being, nevertheless, still quite steady, one bores a small hole in the lead as deep and as straight as possible, without, however, penetrating farther down than the root canal. The artificial crown is then united to the root by a pivot . . . .

By the turn of the century, the dental profession saw itself as a well-established and respected profession in both the United States and Europe. Dental education was legitimized by many medical schools, the principles of dental practice had been established and dental organizations were flourishing. Thus, American dentistry was unprepared for the attack that blindsided the dental establishment in 1910.

That's when Sir William Hunter, a prominent London physician, lectured the medical faculty of McGill University in Montreal. His topic: the role of sepsis and antisepsis in medicine. But Hunter's address to this audience of physicians carried a savage denunciation of dentistry in the United States, where restoration was emphasized over extraction.

Hunter claimed to have cured all kinds of obscure ailments by ordering patients to have removed from their mouths prostheses inserted, he claimed, by American-trained dentists. He also said he had found crowns and bridges in septic oral environments -- and full dentures placed over retained roots. He indicated that infection trapped under poorly fabricated restorations led to Americans' "dirty, gray, sallow, pale, wax-like complexions and . . . chronic dyspepsia, internal disorders, ill health, anemias and nervous [neurotic] complaints."

The real focus of Hunter's remarks was infection found around and under poorly fabricated restorations -- not pulpless teeth. But in the process he condemned *all* root-canal therapy. In the process he tarred good dentists with the bad -- Europeans and Americans.

Hunter electrified his audience by characterizing American dental prostheses as "mausoleums of gold over a mass of sepsis," a metaphor immediately picked up by the newspapers of the time. His lecture had an immediate impact. Hunter's remarks were readily accepted by some physicians who used his theory to explain away any disease for which they had no cure. It was all too easy to attribute a patient's illness to a tooth that had to come out.

It was also psychologically satisfying -- both to the physician and the patient -- to believe that disease could be treated so simply. Soon focal infection fever -- the alleged cause of American malaise -- spread the blame beyond poorly fabricated restorations. Now pulpless and endodontically treated teeth began to come under fire as well -- even teeth that showed no sign of infection.

This expansion of the theory created a group of dentists and physicians that called themselves "hundred percenters." They recommended the extraction of any and all pulpless teeth. In fact, they went beyond simple extraction to advocate surgical removal of teeth. The purpose of this more elaborate procedure was to remove the supposed focus of infection from the surrounding periodontal ligament. After extraction, the dentist was instructed to scrape the socket aggressively with a bur or instrument to remove the infected bone immediately lining the alveolus -- a procedure now discouraged.

This attack on American dentists did not go unanswered. Edward Cameron Kirk, the respected editor of *Dental Cosmos,* protested by enumerating the many advances made by American dentistry. He also singled out one possible cause of the problems that triggered Hunter's attack. He noted that it was not unheard of for unprincipled European dentists of that time to add an unearned D.D.S. after their names. Kirk argued that it was likely the work of this unscrupulous minority that Hunter had seen, not that of accredited American professionals.

Nevertheless, a great many Americans suffering from stubborn illnesses clamored to have teeth and prostheses removed. The theory also led to the performance of millions of tonsillectomies because tonsils were also considered a localized area of focal infection.

Dentists, too, jumped on Hunter's bandwagon. A virtual epidemic of unnecessary extractions followed. In the ensuing years, the dental literature was replete with case histories reporting cures of various illnesses following tooth extractions. Although these reports were empirical and without appropriate follow-up, they wrongly justified the continued extraction of millions of teeth.

In time, however, the cures attributed to extraction proved to be short-lived and were considered psychological -- the extraction serving as a surgical placebo. The problem with wholesale extraction is that it left many people with full dentures but still suffering from the ailments that led to the extractions. In fact, sometimes their condition worsened. Only now the patient had to face the additional burden of living with a mutilated dentition.

It took two decades for this epidemic of focal infection theory to run its course. Then in 1930, an editorial in *Dental Cosmos* rejected the application of the focal infection in dentistry. The article stated that:

> *The policy of indiscriminate extraction of all teeth in which the pulps are involved has been practiced sufficiently long to convince the most rabid hundred percenter that it is irrational and does not meet the demands of either medical or dental requirements, and much less those of the patient.*

Instead, the article called for a return to "constructive" rather than "destructive policy" because "the constructive . . . certainly offers more possibilities of making the masticatory apparatus a useful and helpful organ rather than a crippled and constant menace to the patient."

Later population studies conducted in the 1930s found absolutely no correlation between the presence of endodontically treated teeth and the frequency of illness in patients who participated in the studies. The focal infection theory had been laid to rest -- but not permanently.

Whether or not Hunter's attack was justified, in the long run it did do some good. It ignited a reexamination by American dentistry of its body of knowledge and practices. A number of unsound techniques -- the incomplete filling of canals in root canal treatments, for example -- were discarded.

If nothing else, the Hunter episode -- and the ensuing focal infection theory -- led American dentists to launch a crusade for better techniques. The results took the form of significant

improvements in every area of dentistry -- from dental theory to dental equipment. This paved the way for revolutionary advances in dental care, ranging from preventive dentistry to public health dentistry to dental prosthetics.

The focal infection theory also served to encourage much research in the basic sciences -- including microbiology and immunology. The immediate effect was to help transform dentistry from a mechanical art to medical practice underscored by hard science. And long term, this research helped create the scientific and biological basis for root canal treatment.

Endodontic pioneers.

The practice of root canal therapy itself was not new. Louis C. Siegel remembered his father, AAE charter member Rudolph Siegel, a graduate of the Ohio College of Dental Surgery in Cincinnati. This institution, the second oldest dental school in the world, asked the elder Siegel to stay on as an instructor in root canal therapy. And that was in 1908! His son, writing in 1983, then elaborated on the techniques used by his father:

> *He used cotton, wrapped by hand, on smooth steel broaches to clean, medicate, dry and introduce a sealer of chloro-percha into the root canals before filling with guttapercha. The broaches he made by hand, filing a piece of music wire mounted in a broach holder, to a fine thin taper and finishing with an emery disk. These broaches, when wrapped in cotton, would follow the curvature of the canals to the root apex because of their sturdiness and flexibility.*
>
> *The principle is pretty much the same as using a wire-centered pipe cleaner to clean a curved pipe stem instead of trying to push a piece of string through the small lumen. He had learned to hand-wrap these broaches rather rapidly, but the dentists he tried to teach usually found it a too difficult and time-consuming procedure. So there had to be a better way.*
>
> *It was in 1908, a year before I was born, that he obtained a U.S. patent on a small battery-operated motor broach wrapper that would wrap a broach to the size and shape needed for the particular canal in a second or two. This improved and greatly speeded up the cleaning, medicating, drying and filling of root canals. My son and I still use the technique in our practice.*

Before drying and filling the root canals, another essential part of the treatment was the ionization of a two-percent zinc chloride solution with a zinc electrode in the root canal to sterilize the root canal, the surrounding radicular structure and hopefully the involved periapical area. This was probably the most effective treatment of endodontic infections until the introduction of antibiotics -- the sulfas of the early forties, followed by penicillin around the end of World War II and all the other antibiotics.

Unfortunately, practice did not mean acceptance -- and early root canal practitioners fell into general and medical disfavor. The nadir for root canal therapy came in the late 1920s with the publication of E. Charles Rosenow's theory of focal infection. This theory would dominate the practice of dentistry and medicine for years. As Louis C. Siegel, son of AAE charter member Rudolph Siegel, put it, "Extracting teeth became the panacea for all the ills that befell mankind, from falling hair to falling arches." Eventually even the mention of endodontic procedures would be anathema to most dentists and physicians.

If the medical and dental professions suffered from Rosenow, his focal infection theory was one-upped by the writings of Dr. Martin Fisher, a professor in the medical college of the University of Cincinnati. Louis Siegel described him as:

. . . a very personable guru of the medical and much of the dental profession, who believed that the way to eliminate all that horrible infection from decayed, abscessed and periodontically involved teeth was to remove not only the offending teeth but also the alveolus to the root apices. If this makes you shudder, consider the plight of the poor dentists who were faced with trying to construct dentures for these dental cripples with no alveolar ridges. There was even a Murray Clinic established with a staff of physicians to sell and a dentist to perpetrate the destruction. It lasted for several years before, thankfully, it folded and passed into oblivion.

AAE charter member George C. Hare, leader of the early AAE's Canadian component, was a man who spoke little. But when he did, people listened. His first introduction to root canal therapy came in 1916 at the age of 12:

Like so many others, my parents did not realize that the heavily decayed lower molars were not primary teeth and, before I was placed under the care of a dentist, the pulps in both lower first molars and one bicuspid were exposed. Local anesthetics were still in their infancy so nerves were "killed" by placing pledgets of arsenic trioxide over the exposed pulp, under cement, for days at a time until the pulp gave up the ghost.

It was an experience never to be forgotten but, in like manner, I have never forgotten the patience and good humour of Dr. J. O. Wilson as he patiently cleansed the root canals of the pulp. So great was the impression that he made upon me that I announced to all and sundry that I was going to be a dentist and not hurt little boys.

It was in 1924 that George Hare finally entered dental school, an experience that proved eye-opening:

When I reached the operative clinic, I soon realized that extraction of teeth and construction of dentures was the backbone of dentistry. I still see, in my mind's eye, the charts coming out of the examining dentist's room marked "extract all remaining teeth." Then the patients would troop down to the 'gas' clinic for the elimination of their entire masticatory apparatus. There were no electric engines [drills] *on the clinic floor and the cable foot engines rotated at approximately 3500 RPM. When the consequent vibration was added to the routinely dull burs, one can imagine the discomfort level afforded the patient.*

Dr. Hare pulled no punches in reporting on the primitive techniques then at the disposal of dentistry:

Carpule anesthetic was still to be invented in 1926. As a matter of fact, we made our own anesthetics by boiling water in a crucible over an alcohol lamp and dropping two little white tablets of Novocaine into the water, drawing the solution into an all-glass syringe and injecting into the patient. The needles were not the disposable type which we now use but were sharpened in the office. After a number of sharpenings, the bevel was gone and penetration of tissues something to be dreaded.

If the problem was an exposed pulp in an upper anterior tooth, we often preferred to avoid the needle by placing a pledget of cotton soaked in cocaine over the pulp covering with a layer of base-plate guttapercha and striking the mass with a sharply pointed orangewood stick under a mallet. If the dentist had the necessary digital dexterity, he could often remove the pulp with surprisingly little pain. Have you ever tried to enter the pulp chamber of a 'hot' pulp-involved tooth with a slowly rotating carbon bur under inadequate local anesthesia? No wonder many patients insisted on the removal of the tooth.

Still, Dr. Hare continued to rebel against unnecessary extraction and began giving clinics on root canal therapy across Ontario. Then one day he received a phone call from someone he described as "one of the rulers of our profession." Dr. Hare was told pointblank to stop giving root canal clinics or face losing his dental license for "unprofessional conduct."

When Dr. Enrique C. Aguilar introduced endodontics to his native Mexico, "The task was arduous and all uphill because of the concept of 'focal infection' predominated as an element against endodontia. My relative professional youth at that time made the task to convince more difficult as I was up against more mature professionals who saw in endodontics a threat to the health of their patients."

This period drove Dr. Walter P. Auslander to "think back to the hard and fast ideas that would brook no deviations. Ideas that stemmed not from lack of knowledge but from lack of daring to try: 'Only remove 1/3 of the contents of a necrotic canal in the first visit and place a dressing' -- 'Never instrument beyond the apex' -- 'Always leave an acute abscess canal open for drainage.'

It took a long time -- but eventually the dental profession came around to the conclusion that it was better for the patient to save pulp-involved teeth. By the early 1940s a group of dentists was practicing and teaching root canal therapy, but they differed in their opinions on how root canal therapy should be practiced. These interested dentists would regularly attend the annual Chicago Dental Society Midwinter Meeting to hear Louis Grossman, Ralph Sommers and others present clinics on root canal therapy. But there was no organization, and for many dentists, even this progress wasn't fast enough.

The foundation of endodontics -- like all of dentistry -- would be built upon the three pillars of science: organization, literature and education. Those three elements would come together, thanks to the work of a handful of dental pioneers who would come to be known as the founders of endodontics. One of these three was the remarkable Dr. Louis I. Grossman, who had vivid recollections of this period:

> *What impelled a small but earnest group of general dentists, in the midst of a war, to come together with the purpose of forming an endodontic association? The time must have been ripe, the milieu must have been conducive to shattering the shackles of the focal infection theory with which the profession had been fettered for more than 30 years. The object of the association was not only to have an interchange of knowledge on endodontics but also to carry to others outside the association that message that endodontic treatment is a safe procedure when properly performed, and that such teeth have not caused systemic diseases of which they have been accused.*

> *For three decades the pulpless tooth had been charged with being the etiologic factor in a number of diseases such as arthritis, myositis, iritis and a long list of other itises. In fact, the first dental meeting I attended after graduation from dental school was in the form of a debate: "Resolved the Pulpless Tooth is a Menace to Health." A physician and a dentist sat on each side of the moderator, debating the pros and cons of the resolution. It was a warm debate, probably neither side influencing the audience; what impressed me was that a physician had taken a stand in defending the pulpless tooth.*

"Every tooth in a man's head is more valuable than a diamond."

-- Cervantes

Chapter 2.

Present at the creation (1943-1953).

War is always traumatic. The greater the war, the greater the impact upon society. And a conflict of the proportions of World War II was guaranteed to touch every element of American society. Naturally, that included dentistry.

The nation's entrance into World War II galvanized the United States. Military preparedness went into high gear. Every male between the ages of 18 and 45 faced the possibility of military service. The Selective Service System geared up the conscription machine that would transform unprecedented numbers of civilians into military personnel by establishing exacting standards of intelligence and physical fitness. That included dental standards. The result was a shock to dentistry and to the American public as a whole.

The Selective Service System had decreed that a potential recruit need only have twelve teeth -- three pairs of matching incisors and three pairs of chewing teeth -- to be accepted in the armed forces. Unfortunately, that standard significantly overestimated the reality of dental health in this country.

After evaluating the first two million selectees summoned for service, the Surgeon General reported that one out of five lacked even this minimum number of teeth. That meant nearly 400,000 potential recruits lacked the minimum dentition required for military service. In fact, dental defects constituted the chief cause for physical rejection for active duty. As a result, the Selective Service was forced to eliminate all dental standards to avoid mass disqualification of selectees.

The long-term effect of this revelation was a concerted post-war effort in the United States and Europe to improve dental health worldwide. But for the short term, the question could not be

ignored: Why were so many people missing so many teeth?

A simple question with a complex answer. Diet. Poor dental hygiene. Inadequate dental care. And one cannot ignore the bias of the medical profession at the time -- for extraction rather than preservation -- of any tooth with a necrotic pulp. It was this bias, after the 1940 centennial of dentistry and against a backdrop of World War II, that drew three men from three different parts of the country to push for the creation of an organization to promote the exchange of knowledge and ideas on root canals. Their drive would lead to the formation of the American Root Therapy Association, a national organization composed of dentists interested in root canal treatment.

The pioneers.

The year was 1943. The three were Drs. W. Clyde Davis of Nebraska, John H. Hospers of Illinois and Louis I. Grossman of Philadelphia, who agreed to serve as secretary of the organizing committee until the association was organized and officers elected. These men were to set in motion a movement that would play a significant role in reshaping modern dentistry.

It began with a letter from Dr. Grossman inviting all recipients to serve on the organizing committee:

Philadelphia, Pennsylvania

February 8, 1943

Dear Doctor _____:

The American Root Therapy Association, a national organization of those interested in root canal treatment, is now being formed. Because of your interest in root therapy, you are being invited to serve on the organizing committee together with the following men, most of whom have already accepted: G.P. Bannister of Cleveland; E. D. Coolidge of Chicago; C. Davis of Lincoln, Nebraska; E. A. Jasper of Memphis, Tennessee; H. B.

Johnston of Atlanta, Georgia; G. C. Sharp of Pasadena, California; R. F. Sommer of Ann Arbor, Michigan, and M. F. Yates of Boston, Massachusetts.

It was proposed that just as soon as all members of the organizational committee had been heard from a notice would be inserted in the Journal of the A.D.A. announcing the formation of the association.

Teachers of the subjects at the dental schools will also be contacted. I am acting as secretary of the organizing committee until the association has been organized and officers are elected.

A prompt reply indicating your willingness to serve on this committee will be greatly appreciated.

Sincerely yours,

Louis I. Grossman

The historic first meeting of the American Root Therapy Association was held on February 25, 1943 at the Palmer House in Chicago and was attended by 21 dentists -- 20 men and 1 woman:

I.B. Bender
Sophia Bolotny
Edgar D. Coolidge
W. Clyde Davis
Paul T. Dawson
Truman G. DeWitt
G.L. Girardot
S.D. Green
Louis I. Grossman
John H. Hospers

Harry B. Johnston

Henry Kahn

Saul Levy

Douglas A. Meinig

George W. Meinig

Vincent B. Milas

J.W. Ritter

Arthur R. Sample

George C. Sharp

T.C. Starshak

Charles M. White

Working in a vacuum.

The year 1943 was not the most auspicious time for founding a society devoted to endodontics. Some dental schools had stopped teaching root canal treatment completely. Others limited students to treating single-rooted teeth. Very few allowed their students to treat multi-rooted teeth.

Working conditions created a further complication. Dental schools consider endodontic treatment part of what was then called the "operative department," where surgical procedures were not always carried out under aseptic conditions. So in a sense, these founders were pioneers working in a vacuum. While interest was building in this new area of root canal treatment, many in the dental community still considered it a controversial procedure. As one of the 31 charter members, Dr. Walter P. Auslander, recalled:

> *As a pioneer, one constantly struggled with the opposition's constant cry of "It can't be done" -- "It is not a specialty" -- "It is only an adjunct of General Dentistry" -- "It's only a fad that will soon disappear" -- "The tooth will be lost soon anyway."*

Even some of the early members of AAE had their doubts. Maynard K. Hine noted that:

No one was totally convinced then that such an organization was essential, or even needed, particularly since this specialty was not well-known or appreciated. About that time a physician asked me what an endodontist did. When I explained, he said "Do you mean to tell me there is a specialty in dentistry that just deals with the tiny nerve in a tooth?"

At this first gathering in Chicago, Harry B. Johnston made an impassioned plea that the new organization dedicate itself to stop the wholesale loss of teeth. The objective, he argued, should be to improve the quality of the root canal treatment then being done. The reason for organizing was to give more weight to the gospel of root canal treatment that the attendees had been preaching:

There is really good news to proclaim to the medical and dental professions. The physician thinks he has solved the patient's problem by ordering the removal of pulpless teeth, but he has not only failed to solve his own problem he has also aggravated that of his patient.

As one of the first full-time endodontists, Dr. Johnston said he concentrated on endodontia "because there is much more pleasure in saving teeth than in destroying them." He also predicted that something of "eternal significance" was starting there. He hoped that the organizing members were willing to commit to the sacrificial spirit necessary to make the organization a reality.

To keep the meeting focused on dental practice, Dr. Hospers -- who chaired that first meeting -- read a paper titled *The Economics of Root Canal Therapy.* Officers were duly elected. Attendees chose as their first president W. Clyde Davis, who would later develop a product called Osogen, marketed for sterilizing and filling root canals. But in the early days of the AAE, he advocated using steam for sterilizing root canals. This involved filling the canal with water and then inserting a hot instrument to create the steam. Dr. Davis was also an early advocate of the partial pulpectomy, which gained acceptance because it precluded overfilling the canal.

There was a certain irony in choosing John H. Hospers as secretary pro tem. His obvious

enthusiasm and organizational skills were often undermined by his more primitive approach to typing and spelling.

Lou Grossman, who would become a giant in the field, had already organized in Philadelphia the first root canal study club and written the first endodontics textbook, *Root Canal Therapy,* in 1939. Years later, at a dinner in his honor, his wife, Emma May MacIntyre Grossman, dryly pointed out that "I have been his legal mistress for 50 years, his wife being dentistry."

After the election of officers, attendees began creating the formal structure necessary to transform an idea into an organization. It was duly moved, seconded and carried that all dentists joining before the organization plans had been approved would be considered charter members and would not have to pay an initiation fee. Committees were formed on Constitution and Bylaws, Program and Organizational Name. Annual dues were set at $2. The next regular meeting was scheduled for February, 1944 to dovetail with the annual meeting of the Chicago Dental Society.

The AAE's Chicago roots.
The organization would continue to meet in Chicago until 1962, prompting these mixed feelings in Dr. Auslander, who preferred the more congenial climate of his native Florida:

> *"I think back to our meetings in Chicago in February, always dreading the flight in and the flight out. Would we have a storm, or would the weather hold out and bless us with sunshine? We were very few in number and were fumbling for direction and identity. We shared our ideas, initially in 'How to Treat,' then 'What to Treat,' and later on 'When to Treat.' We had to creep and crawl before we could walk or run. The evenings were spent in informal seminars."*

When the new association met again in 1944, it had grown considerably. Of 193 paid members, 54 were present. At the business meeting, the main topic of discussion was what to name the new organization. Several names were proposed. The title used on the printed program was the American Society of Endodontists (Organized for the Study of Root Canal

Therapy).

Up to that time the term root canal therapy defined the new field and identified the new organization. But at the meeting some preferred the new term, endodontia -- formed by combining two Greek words: endo, within, and dontia, tooth. he first historian of the organization claims that the term was virtually unknown before the AAE, but Dr. Johnston used the term on his stationery. A mail vote on the issue ended in a tie, but it was finally agreed to accept the Executive Council's recommendation that the name be "The American Association of Endodontists."

The final application for membership was approved, constitution and bylaws adopted, officers elected, and committees appointed. On February 24, all registrants were named Charter Members and the first scientific program was presented.

The breadth and seriousness of the mission of these founders is reflected in the first program. An essay on the history of endodontics in the U.S. was presented by L. Pierce Anthony, editor of the *Journal of the American Dental Association,* with Dr. Grossman who was identified as "research worker" and "Head, Root Therapy Clinic, School of Dentistry, University of Pennsylvania." n other papers, "the root canal problem" was reviewed by a physician and a pathologist as well as by Dr. Sommer as a clinician. The bacteriological aspects of therapy was covered by Robert G. Kesel, who would become a major researcher in that area. A discussion of the program was led by Dr. Coolidge.

The new association selected the Stevens Hotel in Chicago for its next annual meeting, scheduled for February 15-16, 1945 in conjunction with the Midwinter Meeting of the Chicago Dental Society. Reality intervened. Although the program was printed and distributed to the AAE membership, wartime restrictions on travel and cancellation of the MidWinter Meeting led the Association to cancel its 1945 meeting. That proved for the best anyway because the U.S. Air Corps would take over the huge Stevens Hotel for its headquarters. That was not the only impact that World War II would have on the embryonic field of endodontics.

In 1943 the demand for medical personnel in the military had prompted the U.S. Army's Procurement and Assignment Office to take control of the nation's medical schools, including all schools of dentistry. any early advocates of endodontics soon found themselves in uniform -- but still fighting a different battle -- on behalf of the value of this new field. AAE charter member Walter P. Auslander recalled that "By 1943 I was in the Army but still a small part and a cog in our embryo society of 'Root Canal'. . . . They were days of constantly trying to prove to the skeptics in the military and then later in private practice again that endodontic treatment could and would result in success with no loss of teeth."

Dr. Henry Kahn reported a similar experience when, shortly after the formation of AAE, he joined the U.S. Navy:

> *I brought with me endodontic instruments and material that I had, in the hope that I would be able to do endodontics. Once again I had the problem of convincing my peers with the utmost diplomacy of the value of endodontia, while at the same time doing my quota of amalgam fillings and asking no privileges. One day the captain's wife had a toothache that I treated endodontically, and after that he was on my side. I did 1500 cases in Norfolk.*

The postwar dental boom.

The end of World War II did not mean a swift return to pre-war conditions for the U.S. as a whole and for dentistry in particular. Pre-war meant the Great Depression -- ended finally by the economic demands of a wartime economy. Unemployment all but disappeared. Now the long and grueling war effort was followed by a refocusing on recovery and the increasing prosperity of the middle class. The result was the longest sustained period of peacetime prosperity in history.

The field of dentistry would benefit from this economic boom. Some 22,000 dentists had served in the armed forces. Their work convinced those who saw military service that dentistry was a valuable component to healthcare. Thus, a large segment of the U.S. public

would return to civilian life with an appreciation and expectation of quality dental care. This would trigger an unprecedented demand for dental care and a revolution in dental practice. This revolution would extend into the field of dental education as more than one million war veterans enrolled in colleges, including dental schools, under the U.S. "G.I. Bill of Rights."

This revolution was foreseen by Charles West Freeman, then dean of the Northwestern University Dental School. Writing in a 1945 issue of the *Journal of Dental Education,* Dean Freeman made this prophetic statement:

> *It is quite possible that returned veteran dental officers will prove a desirable stimulus to progress to the more conservative dental teachers, for we may find that military experience has encouraged these veterans to challenge many procedures which have traditionally been taught, but which may need vigorous revision and adaptation to new conditions. In fact, the exposure of our veteran teachers to the veterans of war service may prove mutually advantageous.*

The post-war baby boom led the ADA Council on Dental Education to encourage dental schools to develop graduate courses in orthodontics. The Council also underscored the relationship between orthodontics and other dental specialties, setting the stage for a decades-long tug-of-war between general dentistry and its specialties, especially endodontics.

Following the lead of the Philadelphia study club, others were formed in Chicago, Montreal and Buenos Aires. In 1946 the AAE began publishing the *Journal of Endodontia,* issued quarterly until 1949. That's when the AAE found a new editorial medium. The *Journal of Oral Surgery, Oral Medicine and Oral Pathology* added a section on endodontics. At the same time, the American Dental Association's Board of Trustees and House of Delegates approved the affiliation of endodontics with its Section on Operative Dentistry for the ADA annual sessions.

As the AAE began to spread its professional wings, it endorsed the establishment of a

specialty board for endodontics and surveyed the dental schools of the United States to learn the status and potential for formal advanced education in the discipline.

The drive for effective communications prompted the AAE to reenter the publishing business in 1951. Since several other dental specialties also used *Oral Surgery, Oral Medicine and Oral Pathology* as their official organ for scientific and clinical articles, the AAE deemed the journal inappropriate for the dissemination of association news and announcements. So the AAE created a member newsletter that would be published semiannually or quarterly from that year until 1975.

Membership issues are critical to any association. How you define membership defines the organization itself. So at the association's 1946 business meeting, it was suggested that the membership committee be informed that membership in the Association is by invitation and not by application. The purpose of this move was to limit AAE membership to those interested in endodontia. At the same meeting Dr. Coolidge, a member of the executive committee, presented the paper he had been scheduled to present in 1945: "The Objectives of the American Association of Endodontists." In this paper he asked the seminal question that, to this day, still drives the AAE:

> *"What objectives should be kept before an association of dentists whose main desire is to conserve natural teeth with comfort and impunity to health as long as possible? What objectives should be necessary other than honest and conscientious devotion to our professional ideals?"*

To meet the challenge thus defined by Dr. Coolidge, the AAE established four formal objectives:

1. To promote interchange of ideas on methods of pulp conservation and root canal treatment.
2. To stimulate research studies, both clinical and laboratory, among its members.
3. To assist in establishing local root canal study clubs.
4. To help maintain a high standard of root canal practice within the dental profession by disseminating information through lectures, clinics, publications, etc."

These goals would later be reworded to meet new challenges in the field of endodontics. But the basic message has not changed -- and, in modified form, these are still the first four objectives in the AAE Constitution.

One new tool for attaining these goals was the association's quarterly *Journal of Endodontia.* The first issue, dated March, 1946, carried articles by Drs. Grossman and Coolidge introducing the new association -- plus an article by the AAE's incoming President Robert Kesel on the bacteriologic aspect of the pulpless tooth. At this meeting the growing interest in the medical aspects of dentistry -- and in pulpal biology -- also took shape as a recommendation that the AAE give an award to the best endodontic student in each of the accredited dental schools.

Definition, development and dissemination of the technical terms of endodontics continued. The terms "endodontic" and "endodontia" were substituted for "root canal therapy" in the Constitution and Bylaws. In addition, the proper use of the terms was submitted to the ADA's Committee on Nomenclature. The ADA was also requested to create a section on endodontia. The AAE's own *Journal* was expanded to 24 pages while the association placed greater emphasis on the teaching of endodontics.

By 1947 the AAE's research thrust was emphasizing the role of bacteria in endodontics as the ability to treat infected pulpless teeth with antibiotics and other drugs opened new endodontic possibilities. The association's own *Journal of Endodontia* -- as well as several other dental publications -- carried articles on endodontics, emphasizing the use of antibiotics within the root canal.

Yet these small victories were part of a larger battle that would rage for decades: the relationship between specialty groups and general dentistry. At the 1948 meeting, Dr. Houghton presented an address on dental specialties with emphasis on endodontia and the creation of a specialty board. A survey of the AAE's 324 members also demonstrated that a majority were in favor of a specialty board for endodontics.

At the heart of this battle were two key issues: The first was social and political. And, yes, medical associations can be as political as a New Hampshire primary. To say that is not to slur of any of these organizations that are so critical to medical progress. It's more a reflection of human nature. As children grow older, they are constantly redefining the boundaries of their relationships with their parent. In the same way, as a medical specialty evolves, it must work out its relationship with the parent organization. Like adolescence, the process can sometimes be a little rough on both parties. But like adolescence, both parties recognize its necessity.

The other issue was a medical one. The AAE still met in conjunction with the Chicago Dental Society Midwinter meeting and the April, 1948 issue of *Journal of Endodontia* carried an editorial by Dr. Grossman on a speaker at the Chicago Midwinter Meeting who "made a number of devastating statements against pulpless teeth that were both inaccurate and misleading."

Dr. Grossman described this speaker as energetic and persuasive but "apparently lived in the scientific past and still carried on a crusade against pulpless teeth." Dr. Grossman called on members to correct such misinformation by word of mouth in their daily contacts as well as in print. "Little has appeared in dental literature to correct the mistaken notions of the past. Let us not default with silence." To emphasize its agreement, the AAE elected Louis I. Grossman as its next president.

Meanwhile, the AAE continued to explore the establishment of a specialty board in endodontics. The immediate thrust was a study of existing boards and academies in allied dental specialties. The association also did some self analysis. The status of endodontic practice was indicated by a 1950 survey of the AAE membership:

- 341 accepted referrals and 23 did not.
- 34 limited their practice to endodontics.
- 24 were limited to endodontics with periodontics.
- 30 were instructors in endodontics.

There was also a pressing need for a working terminology that would keep pace with advances in endodontics. The first report of the Nomenclature Committee, appointed in 1950, included

many revisions made to the AAE's *Glossary of Endodontic Terms.* And to underscore the growing importance of endodontics, the University of Pennsylvania School of Dentistry hosted a World Conference on Endodontics, chaired by Louis Grossman.

The AAE was now ten years old. Its first decade was marked by sustained growth. But more important was the organization's profound desire to share knowledge and exchange ideas about endodontics. By the end of this first decade, the AAE's original 21 members -- whose purpose was to prevent the wholesale extraction of teeth -- had increased to 418. The organization was now focused upon the teaching of endodontics, the formation of study clubs and communication with its members. This work was more than necessary. It also provided the foundation for the next critical stage of the AAE's young existence: the struggle for professional recognition.

"A great wind is blowing, and that gives you either imagination or a headache."

Catherine the Great

Chapter 3.
The struggle for recognition (1954-1963).

The emergence of modern dentistry in the nineteenth century is the story of dentists' fight for professional recognition by the medical profession. It was a battle fought on two fronts. On one hand, dentists had to establish the scientific foundation of their work. But they also had to fight against every blacksmith, barber and medicine show pitchman who could claim to be dentists simply by announcing that they were.

The ADA's strategy on both fronts was to build a monolithic professional organization that had the resources to put dentistry on a scientific footing and the clout to shut down the amateurs and charlatans. It was a smart strategy -- and it worked. But one of the rules of organizational behavior is that today's solutions often hold the seeds of tomorrow's problems.

A century later, the still-monolithic ADA saw the emergence of endodontics and the other seven specialties -- plus the newly emerging specialties still struggling for recognition -- as splinter groups that would weaken the strong dental organization that it had labored to build since 1860. But from the AAE's point of view, the ADA was the strong but unresponsive parent who failed to support the child's inevitable push for independence. Both were right -- and both were wrong.

The inevitable conflict would transform the AAE from a close-knit but informal federation of regional study groups focusing on endodontics into a national advocacy group that would push the boundaries of what the ADA thought acceptable. The dental profession of the 1950s preached prevention -- particularly in pediatric dentistry. (This was the time of the ADA's great push on behalf of fluoridating water.) But for most of dentistry, the focus was on repair, extraction and replacement. So before the eager group of would-be specialists could save teeth, they would first have to join forces to save their careers.

At first, their goal was simply to learn more about this new field of endodontics in which they so passionately believed. In the 1950s that meant traveling to the best sources of information on the subject: meetings of the various dental societies. Even there, AAE charter member Walter P. Auslander points out that "Root canal never received top billing. We were lucky to get the crumb of a table clinic hidden in a remote corner."

At these events they would meet the same handful of people interested in endodontics. As Dr. Auslander remembered:

> *"I recall one visit to Chicago where Bert Wolfson sought me out. He wanted to talk to the character* [Dr. Auslander] *who advocated mechanical stimulation of the periapical tissue with an area present in order to create an inflammatory response and thus obtain healing; where he was suggesting the use of cortisone ointment to reduce the inflammatory response. We talked long into the night with Dudley Glick, Al Frank and my Associate, Leon Schertzer -- all participating in the exchange of ideas and technic which brought a better understanding among all of us."*

These sessions led to a better conception of root canal anatomy and a better grasp of canal deviations. Better instruments were developed and shared and their function and handling better understood. In Dr. Auslander's words:

> *"We were not crawling now; we had direction and were walking . . . . walking steadily toward a common goal -- not running -- but driving ahead steadily on a firm foundation of facts piled on top of facts -- documented by years of clinical observation and study."*

At such sessions, perhaps they would hear that Coolidge, Grossman or Sommer would be giving a seminar or course on endodontics in a few months. So the same group would show up again to learn more. And in the process, they got to know pioneers such as Coolidge, Grossman and Sommer, who became mentors to the next generation of endodontists.

This commitment to establishing endodontics as a specialty created a degree of purpose and harmony among the collection of strong personalities that formed the Association's early

membership. The diversity of that membership led some early observers to conclude that the Association would not survive this alliance of necessity. Some of the members -- people like Lou Grossman -- were pure scientists who sought to advance endodontics as an academic discipline. Others like Ralph Sommer were missionaries who could pack a lecture hall with 500 dentists to fervently preach the gospel of endodontics to the unconverted.

Finally, there were the dental politicians -- people like Vincent B. Milas and Thomas C. Starshak. Their families' deep roots in the ward politics of Chicago bred in them the understanding that strategy and compromise are necessary arts in advancing any human organization.

Dr. Milas (AAE President, 1962-63) had been active in the AAE since its inception. His strategic location in Chicago -- and his influence in dental circles -- made him a pivotal player in the AAE's formative years. Dr. Milas served the Association for many years as its official historian and was the author of the AAE's 25th anniversary publication, *A History of the American Association of Endodontists -- 1943-1968* (to which this book is deeply in debt).

Tom Starshak had a thorough grounding in Association affairs and "could shoot down an opponent with a quotation from *Roberts Rules of Order."* Milas and Starshak were "the movers and shakers behind the scenes in getting things done for the AAE where the ADA was concerned."

Without the common bond of endodontics, one wonders how long these diverse personalities would have stayed in touch. But the truth was that the viability of the organization demanded this holy dental alliance of the academics who brought legitimacy to endodontics, the preachers who created professional awareness and the politicians who made things happen. Whatever they brought to the table, each also brought credibility to the new organization because each was deeply committed to the value of saving teeth and maintaining dentition.

With their eye on the horizon of a new dental specialty dedicated to saving teeth, these pioneers learned to use each other's strengths to further the new field of endodontics. Nowhere was this

willingness to work together more apparent than in the long struggle for ADA recognition.

The early members knew that the academic and technical aspects of endodontics needed further development. They had to learn from each other before they could educate others -- and they missed no opportunities to do so. The 1954 annual meeting saw the Association's first educational use of television. The meeting was preceded by a televised course in endodontics presented at the University of Illinois School of Dentistry and the University of Michigan. This popular course was given for several years.

Next year's meeting was highlighted by a presentation titled *A stereobinocular microscopic study of root canal apices and the surround area of anterior teeth.* The lecture was presented with three-dimensional equipment that required the audience to wear special glasses.

The members also took an active and leading role in the formation of local and regional endodontic study clubs. These clubs served a twin purpose: educating existing members and recruiting new members to the field of endodontics. The approach obviously worked because the Association saw an increase in the number of members who began limiting their practices to endodontics, a development noted by the ADA -- and not with pleasure.

This struggle was formalized in 1954 with an amendment to the AAE constitution, which added an additional objective for the Association: "To act in the public interest, through its Executive Committee, in an advisory capacity to other dental agencies for setting up standards of study and practice for those who desire to specialize in endodontics." This amendment, published in the March, 1954 newsletter, would permit the AAE to take the necessary steps for the establishment of an American Board of Endodontics.

When the American Association of Endodontists was incorporated under the general Not-for-Profit Act of the State of Illinois on April 21, 1955, it had 568 members. Dr. George C. Stewart, who would later serve as president of the AAE (1958-59), conducted member surveys, which added hard data to his extensive one-on-one member consultations. The outcome was a consensus that the time was ripe for the AAE to create a certifying board for endodontists. And

so it came to pass. The American Board of Endodontics (ABE) was organized in 1955 and incorporated in Illinois on July 30, 1956.

At the time there were 41 dental schools in the United States of which 10 reported having endodontic departments. Still, that was a long way from specialty recognition. Thus, the ABE was created as a springboard toward realizing this recognition. Its purpose: to evaluate standards of endodontic practice within the dental profession by certifying candidates in the field of endodontics. The composition and election of the Board was formalized, and the duties were delineated: to examine candidates for designation as diplomates of the ABE and to issue certificates to those who successfully fulfill the requirements.

Dr. Stewart contacted the ADA's Council on Dental Education for information on the requirements for recognition as a special area of dental practice. He then prepared a preliminary draft of the aims and objectives of the American Board of Endodontics plus the requirements for certification by the ABE.

The AAE executive committee then created a special committee to pursue formal incorporation of the ABE. The committee members, appointed by Dr. John Pear, then AAE president (1956-57), included himself plus Edgar D. Coolidge, Louis I. Grossman, Elmer A. Jasper, John I. Ingle, George C. Stewart, Ralph F. Sommer, F. Darl Ostrander and Harry J. Healey. These nine prominent endodontists would later become the first members of the ABE.

In 1957, the year in which the First International Conference on Endodontics was held in Philadelphia, the Council on Dental Education of the American Dental Association, following action by that association's House of Delegates, ended a moratorium on accepting applications for the recognition of specialty groups in dentistry. The American Board of Endodontics immediately filed an application for recognition as a special area of dental practice. Recognition was denied and, the next year, the ADA House of Delegates reimposed a moratorium of one year on the recognition of new specialty boards.

Rejection was not enough to keep the American Association of Endodontists from pushing for

progress in what it knew was a legitimate field of dentistry. To promote the extension of endodontic therapy into dental practice, the AAE executive committee approved recommendations that general practitioners be:

1. Encouraged to join study clubs.
2. Trained in the basis sciences.
3. Encouraged to seek postgraduate training in endodontics.
4. Present a minimum of five case histories for membership.
5. Trained to present clinics and papers on endodontics.
6. Encouraged to obtain good standard equipment.

Study clubs were also asked to send accounts of their activities for the AAE newsletter and a list of individuals available to present clinics and papers to the study clubs. A committee was appointed to investigate developing an official AAE seal. The Ladies Auxiliary of the AAE was organized.

There was also encouragement from others in the dental field. In 1958 the AAE received an invitation from the Society for a Graduate Center in Dentistry, organized for the purpose of setting up facilities to train better teachers in all phases of dentistry. That same year the AAE initiated the process of standardization of root canal instruments and materials. This step would lead to cooperative efforts with the International Association for Dental Research, the American Dental Association and national, as well as international standards organizations over the next three decades.

For the AAE, the highlight of 1959 was the election of Edgar D. Coolidge as Honorary President in recognition of his outstanding efforts, research and promotion of endodontics through the years. Often called the "dean of endodontics," Dr. Coolidge was the first recognized authority on endodontics. He was also remembered fondly by his fellow AAE members. To Lou Grossman:

"Edgar D. Coolidge was an inspiration to both the young and older members of the dental profession. He was tall and straight of stature with snow-white hair covering his intelligent-looking head; a truly

distinguished-looking person. He was a father image to many. His domain of learning and teaching was not only endodontics but also periodontics; he was paramount in both fields. Edgar was very helpful during the organization period of the AAE when two groups with the same purpose in mind nearly clashed with each other. He helped to steer the two into unison and thereby avoided a dichotomy. Edgar was always kind, gentle and helpful -- a true example of a gentleman and a scholar."

AAE Past President (1988-89) Joseph D. Maggio also recalls visiting Dr. Coolidge after his retirement and subsequent illness: "I would visit him approximately once a week. I remember fondly that, when we walked together, he would adjust the cadence of his step to coincide with mine. A perfectionist even in that."

Perhaps the greatest tribute to Dr. Coolidge, who died in 1967, are the words of charter member Henry Kahn, who wrote of his mentor:

"I had lost both parents during the time that I was at school, and somehow he seemed to understand my needs without either of us quite knowing it. He was my father image; he was kind, warm, gentle, patient and understanding. He went through life with true dignity and respect for his fellow man. His life was not an easy one but he met his difficulties with silent strength. My emotional involvement with him was strong and will ever be so. As a teacher, Dr. Coolidge believed that the mind was not simply a vessel to be filled, but rather a flame to be kindled."

Not surprisingly, Dr. Coolidge was universally admired throughout the dental profession. But it is also fair to say that this respect -- and the other AAE highlights of this period -- distracted neither side from the ongoing battle for professional recognition. Still, it would not be fair to accuse the American Dental Association of that era of being totally anti-endodontics. In response to an invitation from the ADA, group endodontics clinics were planned for presentation at the 1957 ADA annual session. And the ADA sponsored a two-day Conference on Areas for Dental Practice in 1960 at which the American Association of Endodontists was a participant.

This conference led the ADA House of Delegates to create a new Reference Committee to hear

discussion on whether to create new areas of specialization. As a result of the hearing and on recommendation of the Reference Committee, the House lifted the moratorium on applications for recognition of specialties. Of course, the American Board of Endodontics soon submitted a new application for specialty recognition to the Council on Dental Education. Even though the AAE had voted its commitment to give "moral, ethical and financial support as needed to the ABE," the application was turned down by the Council's Committee on Dental Specialties on September 6, 1961.

The AAE's executive committee retaliated by recommending that the ABE announce and give examinations for certification. The committee's purpose was clear: The next time the ABE applied for recognition, it would present the ADA Council on Dental Education with a *fait accompli.* But this was not the only issue before the AAE's 1961 business meeting.

Up until this time, all AAE annual meetings were held in Chicago to coincide with the Midwinter Meeting of the Chicago Dental Society (CDS). Besides its primary function as a national scientific gathering, the huge event was also an annual gathering of dentists with common interests. Thus, it also served as a Petri dish for the social and intellectual dialogue that would incubate specialty groups. In fact, five of the eight dental specialty organizations were founded at Midwinter Meetings.

Building their endodontic association around the Midwinter Meeting made it easier for the AAE to book quality speakers for its programs -- speakers who were also appearing at the CDS. Since AAE members would also attend the ADA meeting, the members' travel expenses and time away from their practices were minimized.

AAE President (1972-73) I. B. Bender was a member of the Root Canal Study Club in Philadelphia and was one of the first to join the fledgling AAE. Lou Grossman described him as someone who "has always been known to stand up for that which is right." Before his election as AAE President (1972-73), he kept a low profile but had an active behind-the-scenes role in guiding the young association. Dr. Bender recalled those early meetings vividly:

"Traveling to Chicago in midwinter was no easy task. I recall that members in the East always arranged for two reservations: a plane and a train. Taking the train was no sure thing either. One year I came to Chicago 18 hours late; the pipes on the train froze. I was on the program and I missed my presentation. The program chairman wouldn't talk to me. It was understandable. He was from Chicago, as were all local arrangements chairmen."

As the organization grew and Chicago winters continued to take their toll, dissent became a regular attendee of AAE meetings. Dr. Bender recalled the battle:

"The need to hold our meeting in Chicago in the winter time created rumbling of dissent and the quality of our programs was being questioned among the membership, which grew to a comparatively large size in a short time. Within about 15 years we had over 600 members, a representative composition or make-up of American society, labelled politically as conservative, reactionary, liberal, etc.

The business meetings were well attended. Partly because of inclement weather and because there was no place else to go. Also, the discussions became quite heated. For the first time, the officers of our organization were beginning to be challenged. As one member stated to them from the floor, 'you were only appointed, not anointed.'

Finally, in 1961, the die was cast. At the business meeting, a resolution came from the floor:

"Mr. President! I wish to make a motion that our annual meeting be moved from Chicago to other cities selected on a rotation basis."

The man launching that motion -- and the following heated debate -- was Dr. Dudley H. Glick, who would serve the AAE as president a decade later. He recalls that he was pushed into being the "culprit" by another member, Dr. Len Parris, who quickly seconded the motion. The long and stormy debate quickly polarized the membership around two principal arguments.

Those who wanted to move the meeting hated Chicago winters and the inevitable

transportation problems they caused. Keep in mind that this was before the introduction of commercial jet travel. Air travel by prop planes was more subject to the whims of weather. So was intercity train travel. The national interstate highway system was still only a gleam in some transportation engineer's eye. Getting there was not half the fun.

The members who wanted to keep the meeting in Chicago were either Chicagoans -- or some non-Chicagoans who would miss the warm hospitality of their Chicago brethren. But cold is a convincing argument. One member, attempting to break the tension of the spirited debate, offered the following tongue-in-cheek argument: "I made a study of the pulp and found that the cold in Chicago is deleterious to the pulp."

The final voice vote was close but those who wanted to move the meeting carried the day. Still, there was a price to pay. As Dudley H. Glick later reported, "I incurred the disfavor of several Chicago friends and one in particular. Vince Milas. For many years he shunned me at meetings until he learned that my father had been born in Lithuania, as was Vince. From then on until his death we were friendly."

By 1961 the American Association of Endodontists had grown to represent a national and international constituency with sufficient interest in an extended scientific program distinct from that of a recognized general dental meeting. Future annual sessions would be scheduled independently from other national meetings and at various sites in the United States and Canada. It would also be necessary to change the date of the event. The AAE's relatively small membership did not give it the clout to obtain warm-climate hotel space in midwinter. The date of the annual meeting was pushed back to April or May.

To meet the growing cost of the annual meeting, a symposium on *Biology of the Dental Pulp,* with Dr. Samuel Seltzer as chairman, was presented one day before the 1961 meeting in Chicago. The cost was $25. To everyone's surprise the event raised more than $3,000. The surplus was allocated to finance the 1962 program in Miami Beach. This financial infusion would make a significant difference in the scope and quality of next year's program. In previous years, chairmen were budgeted only $150 to $300 to run the scientific conference *and* print the

program.

The annual meeting did return to its birthplace, Chicago, in 1963. But that was to herald the twentieth anniversary of the AAE -- "twenty years of progress and advancement through education and research in the art and science of endodontics." Unfortunately, what should have been a time of celebration was marred by the sudden death of Elmer A. Jasper. The AAE past president (1949-50) had taught root canal therapy at St. Louis University. He was a disciple of Edgar Coolidge and an innovator in his own right. It was Dr. Jasper who introduced silver points in sequential sizes. He literally gave his last breath on behalf of endodontics. He collapsed and died at the podium while presenting a paper on *Tissue changes following endodontic therapy*.

The shock of Dr. Jasper's death stunned the membership. But life -- and associations -- must go on. The AAE was now committed to holding future annual sessions -- independent from other national meetings -- in the spring at other (i.e., non-Chicago) locations in the United States and Canada. Thus one chapter in the development of the Association closed and another opened.

The location of the annual meeting was an organization flea compared to the real issue gnawing at the AAE membership: the desire for ADA recognition of endodontics as an approved dental specialty. In 1961 the American Board of Endodontics submitted to the ADA's Council on Dental Education a new application for specialty recognition. The Council conducted a lengthy review of the application. AAE representatives also met face-to-face with the Council's Committee on Dental Specialties. Nevertheless, the ABEs application was once again rejected.

The American Association of Endodontists had lost another battle but continued waging the good fight for recognition of endodontics. In 1962 the AAE membership roster listed 766 members. A section on endodontics was added to the examinations given by the National Board of Dental Examiners. The U.S. Army Institute for Dental Research initiated a Registry of Periapical Pathology. And the American Dental Association published and distributed a lay brochure titled *Your Teeth Can Be Saved*, prepared by the American Association of Endodontists. And the AAE adopted its present organizational seal and logo.

The following year, 1963, was a significant year for endodontics and the American Association of Endodontists. Early in the year, the AAE submitted a new application for specialty recognition to the ADA Council on Dental Education. Much to every endodontist's delight -- and surprise -- the Council on Dental Education recommended recognition of the American Board of Endodontics as the certifying board for this specialty. This initial recommendation was soon followed by formal approval of the Board of Trustees of the American Dental Association.

Following a hearing before a special Reference Committee that recommended approval, Resolution 35 -- "Resolved that endodontics be recognized as a special area of dental practice" -- was sent to the House of Delegates. in October in Atlantic City, New Jersey. Ironically, the Speaker of the House of Delegates at the time was Dr. F. Darl Ostrander, a past president (1952-53) of the AAE and a member of the ABE. His task of maintaining proper decorum during daylong debate was far from easy, because of the volatility of the issue. No special area had been recognized by the ADA in more than a quarter century.

Finally, the House of Delegates voted in favor of recognizing the ABEs certifying authority in endodontics as a special area of dental practice.

The ADA action came just in time. Some endodontists were already taking other, more perilous roads to recognition -- like the one traveled by Dr. Harold Epstein. Earlier this Chicago dentist convinced the State of Illinois to license dental specialists. He then applied for licensure as an endodontist, took the exam and was subsequently approved by the state. The effect was to make Dr. Epstein the world's first licensed endodontist.

Drs. James Best, Michael Heuer (AAE president 1986-87) and Hal Gerstein were the second, third and fourth dentists to so follow this pioneering route. After mustering out of the Navy -- where he had the opportunity to practice endodontics almost exclusively for 18 months -- Dr. Heuer entered the dental graduate program at the University of Michigan. There he insisted on specializing in endodontics -- even though just about everyone else thought he was crazy.

"One person came flat out and said, 'Why are you spending a year of your life in graduate

training in a discipline that is so far out in left field that nobody recognizes it anyway?'" Dr. Heuer remembers. But far out or not, he did it anyway. And after completing the program, he applied for and received his license from the State of Illinois, thus becoming the world's first licensed endodontist to come out of a graduate program.

The ADA position was that any dentist announcing the limitation of practice not recognized by the ADA would be dropped from its membership as an "unethical practitioner." The reality was that you could practice endodontics. You could even quietly limit your practice to this new field. But if you announced it, you could lose your ADA membership, which is the same as getting drummed out of dentistry.

This dental equivalent of "don't ask, don't tell" left dentists like Epstein, Best, Gerstein and Heuer in a rather awkward position -- licensed practitioners of a specialty not recognized by the ADA, which could consider the state license as an declaration of practice limitation. This would give the ADA legal footing to take action against this challenge to its authority. The four dentists were offering to put themselves up as a test case before the ADA. The vote in New Jersey made that challenge unnecessary.

At the time of the resolution recognizing endodontics as a special area of dentistry, AAE membership was 842. Application for approval of the American Board of Endodontics was filed with the American Dental Association's Council on Dental Education which approved it and submitted it to the House of Delegates which met in San Francisco, California. On November 11, 1964 the House of Delegates unanimously approved the American Board of Endodontics as the national examining board in the discipline.

No other currently recognized special area of dental practice went through this process in order to achieve recognition by the profession. Thus, endodontics took its place among the other recognized special areas of dental practice. Now the American Association of Endodontists could focus on getting its own house in order.

"In no country in the world has the principle of association been more successfully used, or applied to a greater multitude of objects, than in America."

Alexis de Tocqueville, 1835

Chapter 4.
The AAE in transition (1964-1979).

Name a human endeavor, and it's an ironclad guarantee that you'll find an association of the people involved in that endeavor. That's why you can find the Popcorn Institute, the Asphalt Institute, the Soap & Detergent Association, the American Ladder Institute, the Piano Technicians Guild, the United Soybean Board and, inevitably, the American Society of Association Executives -- not to mention a wide range of medical and dental organizations.

Equally guaranteed is that every association goes through evolutionary stages so inevitable that they seem programmed into association DNA. It its primordial state a group of individuals sharing a common interest gather together periodically for discussion, camaraderie and the exchange of ideas. At some point the need that the group fulfills triggers the transition form informal interaction into a more formal association. Officers are elected and the most masochistic of them becomes secretary, usually doing the administrative work in the evenings at home.

Because even the best-laid plans often degenerate into work, the officers -- and especially the secretary -- soon learn that running even a small association entails an enormous amount of work. Realism eventually overcomes optimism and the officers admit they need administrative assistance. So the first association secretary is hired.

That secretary usually works part-time and, in the association's lore, she would, in time, be viewed as a larger-than-life figure. This part-time job eventually becomes full-time. Then the secretarial position evolves into an executive director, but the association's administration is still pretty much a one-man (or one-woman) band. But as the association grows, so does its need to interact with an expanding membership -- and to provide that membership with widening

levels of service -- publications, education, annual meetings and conferences.

Now the association must also interact with a larger number of audiences upon a much broader stage -- legislators, the public, the news media, industry vendors and related professional groups. Accommodating all this requires adding staff members with specific expertise plus broader administrative and technical support. By now the executive director's office has grown into a full-fledged association management staff.

It should come as no surprise that the AAE has followed the same evolutionary path trampled smooth by so many other business and professional associations. From its birth in 1943 until 1968, the AAE operated out of the home or office of whomever happened to be secretary that year. The paperwork was often done on the kitchen tables of whomever was AAE secretary. Often by their wives.

One thread in the history of the AAE -- and of many another association -- is the greatly underappreciated role played by the wives of the early members. Part of this role involved providing the emotional support that allowed their spouses to add one more complicating factor to their already busy lives. But often this support extended to sharing the workload that running an association entailed.

The tradition was alive and well through the mid-1960s when secretary of the AAE was still a one-man operation. That man was Edwin G. 'Van' Van Valey. A past president (1946-47) of AAE, Van volunteered his office and home to serve as the AAE's central office. But "one-man operation" was something of a misnomer, and AAE Past President James H. Sherard (1963-64) was quick to set the record straight: "Van was fortunate to have his wife Ruth assisting him, and we were too. Together they helped keep the Association organization on an even keel with dedication and hard work."

Inevitably that had to change. By 1968, Van's son, Dr. Edwin C. Van Valey was now president of AAE. He pointed out that "the activities of the Association had grown to the point where it was considered necessary to hire an executive secretary and to establish a central office."

Dudley Glick (AAE president, 1971-72) credits Robert A. Uchin, who would assume the AAE presidency in 1975-76, as the man "who helped shape the future of AAE when he recognized the Association's growth potential and a need for a full-time executive secretary."

Bob Uchin was in a position to observe the Association's impromptu approach to self-administration:

> *When I joined the Association, Ned Van Valey and his Wife, Ruth, served as secretary and assistant from their New York office. Several years later Jack Bucher assumed the secretarial responsibilities and, with the help of his wife Kitty, ran the AAE from their home in Gainesville, Florida.*

Another AAE past president, Paul E. Zeigler (1979-80) also looked back on those days with mixed emotions:

> *My first contact with the AAE central office was when it was located in Jack Bucher's kitchen. Jack was then the current secretary to whom I had forwarded my American Board of Endodontic case histories. When I didn't receive an acknowledgement from him, I made a frantic phone call to his home. He finally found them. I've always suspected that they were lost in his wife's recipe files somewhere between the directions for cheese cake and rhubarb pie. It was a banner year for the AAE and Jack's wife when we finally got out of her kitchen.*

What led to that decision? Jack Bucher became ill and could no longer handle the AAE workload. That prompted AAE President Samuel S. Patterson (1968-69) to appoint an ad hoc committee to investigate the feasibility of employing an executive secretary and establishing a central office. The investigation would lead to the hiring of Elinore McClintock Baker as the Association's first full-time secretary. Her home in Fort Lauderdale, Florida became the AAE's office. It was Bob Uchin who started this particular administrative ball rolling:

> *Having joined in 1960, I watched our Association grow from 200-300 members to an organization of almost 1,500 by 1976. The original small "fraternity,' a study club atmosphere where you knew almost*

everyone, had emerged into a large Association of practitioners who were now responsible for sponsoring the American Board of Endodontics, the Endowment and Memorial Foundation [now the AAE Foundation] and, yes, an independent Journal of Endodontics.

Fortunately, Uchin had prepared himself for the responsibility of the office and, in fact, had a hand in the evolution of the Association's administration:

In 1968, the nominating committee asked me to serve as secretary of the Association. I asked for and was granted one request: the authority to hire a part-time assistant to assist with the increased paperwork. Mrs. Elinore Baker was hired as a part-timer, while also working as a part-time assistant for the Florida Swimming Pool Association. Our work load increased, as did our membership, our budget, our recognition and our responsibilities.

By 1970 the Association had grown to 950 members and the time had come to hire an accounting firm to audit the financial records and to propose a more modern accounting system. A year later, the growth in the sheer workload of running a growing association prompted the decision that it was necessary for the executive committee to meet twice a year, with an additional meeting held prior to and at the site of the ADA meeting.

As the executive committee's workload escalated, so did Ellie Baker's. Her job soon evolved into a full-time position and, in 1971, moved with her to Atlanta, when Julian Baker became AAE secretary. In 1976 the Association moved its bank accounts from Fort Lauderdale to Atlanta as well. She would continue to serve the AAE from 1968-78, a decade of service that Paul Zeigler would call a "giant step forward" for the AAE:

True, the office was still in a home -- Ellie set aside only one of her spare rooms for us. Calls to the new Atlanta central office would sometimes be placed on hold while Ellie tended to the pot roast in the oven. As our organization continued to grow, Ellie progressed from being just a secretary to being executive secretary with a staff. We still had to wait for the pot roast checks, but no one minded. The homey atmosphere gave one a sense that we were still a small tightly knit group of friends, but a look at our membership roster decried otherwise.

A year later Elinore McClintock Baker became the AAE's first executive secretary. But how that came about depends upon who you talk to. The AAE's records declare that Elinore McClintock Baker was appointed the first executive director of the Association. But Michael A. Heuer (AAE President, 1986-87) tells a different story: "She anointed herself as executive director 'cause the guys didn't want to give her that kind of authority."

Meanwhile, other forces were at work that would take the AAE's administration up the next rung of the evolutionary ladder. It began with an interesting 1968 report from the AAE's Long Range Planning Committee. This group had the foresight to conclude that it was important for the AAE to avoid becoming an association exclusively for those limiting their practice to endodontics.

In 1976 this same logic would lead the Association to officially object to the phrase "general practice limited to endodontics" at an ADA conference on the ADA Principles of Ethics. But in 1968 the committee was already recommending that the Association encourage interest in the AAE by general practitioners and other dental specialists.

The logic of this recommendation brought into sharper focus the problems that had grown out of the AAE's growth in membership and its relationship with organized dentistry. In the words of AAE Past President (1980-81) Edward Osetek: "As we grew, the demands also grew. As relationships with other organizations in dentistry became more complicated, so did the job of guiding the Association through these relationships."

This guidance took many forms: Astute legal advice, for instance. For this, the Association turned to Harvey Sarner, a former attorney for the American Dental Association. His expert legal counsel helped the AAE work through the growing pains and necessities involved in sponsoring the American Board of Endodontics and the Endowment and Memorial Foundation, both of which shared a portion of the Association's office expenses.

Then there was the need for member insurance. George A. Zurkow, the AAE president at the

time (1977-78) remembered the Association's response with pride: the AAE insurance program which started with a disability and term life program and presently includes office overhead, universal life and long-term care. The other innovation of Zurkow's term related to the fact that, once they left office, past presidents felt isolated from the mainstream of organized AAE activities. Zurkow recognized what these men -- accustomed to playing an intimate role in the life of the Association -- were experiencing:

> *Being out of the loop left them with a sense of emptiness. To address this situation, at the suggestion of my predecessor, Frank Trice, I started an informal Past Presidents Breakfast. This was designed to renew camaraderie developed through the years among past presidents and to receive a briefing from the incumbent president regarding the state of the Association. It was never intended to be an action or advisory group to the Association.*

These issues never distracted the Association from its need to integrate endodontics into the mainstream of organized dentistry. The AAE's eyes turned toward Chicago, home of the ADA and other dental specialty groups. When it came to organized dentistry, this was where the action was -- and continues to be. But not without a last, reluctant look back at the system that the AAE was forever changing. Again, it was Osetek who saw the need for change yet was fully aware of what the Association was leaving behind:

> *We certainly owe a debt of gratitude to Jack Bucher's wife Kitty, the spouses of all our former secretaries and to Elly Baker, our first hired professional. She and her staff provided strength and stability during our early years.*

The relocation of the AAE's central office to the ADA Building in Chicago on July 1, 1980, was approved to coincide with the retirement date of the executive director, Elinore Baker. Paul Zeigler reported that Elly did not seem to mind.

> *Working with Ellie as a lame duck executive secretary posed few problems. Her heart was really in a place called Big Canoe, where she and her husband Bill were building their dream home. In spite of the divided loyalty, Ellie and her staff were a great help in getting me through the year.*

Meanwhile, a search committee was appointed for a new executive director -- a search that led to Irma S. Kudo. At the 1980 annual meeting in Los Angeles, it was left to Past President Paul Zeigler to close out this era in the Association's history:

> *The board of directors felt it was important that the central office be moved to the American Dental Association building in Chicago. The era of the home office ended at the close of my term as president in 1980 . . . . At the annual meeting in Los Angeles we fondly said goodbye to Ellie and hello to Irma.*

Other major accomplishments of this annual meeting, the Association's first designated international meeting, were leasing of office space in the ADA building in Chicago and the preparation for the move of the central office.

And as a side note, one cannot help but wonder if this formal return to the city that witnessed the birth of the AAE brought a wry smile to the faces of those early members who had argued against moving the annual meeting away from the nastiness of Chicago winters. But as Dr. Edward M. Osetek, who would serve the AAE as its first president of the new era put it:

The decision to move to Chicago, to establish an office in the ADA building and to employ the services of a professional administrator signaled the Association's resolve to enter, seriously, into a partnership with the rest of organized dentistry. It was difficult to say goodbye to the old way of doing business but it was essential to move on and up. The nature of our professional relationships required that we not only be organized but also be visible, viable and clearly in control. If you can't run with the big dogs, stay on the porch. We got off the porch!

"There is at bottom only one problem in the world and this is its name. How does one break through? How does one get into the open? How does one burst the cocoon and become a butterfly?"

-- Theodore Mann (1875-1955)

German novelist

Chapter 5.
Educating the profession (1964-1980 revisited).

The trouble with being "down from the porch," as Dr. Edward M. Osetek put it, was that it put the AAE in the middle of the hurley burley, interacting with a dental profession still not entirely persuaded to the cause of endodontics. Its practitioners found that ADA recognition of endodontics as a special practice area did not in itself confer automatic respect. AAE members constantly came up against the twin needs to argue the value of what they did and to educate other dental professionals in endodontic technique (or "Technic" as it was known to early practitioners). It was as if the endodontists of 1964 found themselves trapped in a continuous loop, re-experiencing the frustration of the pre-endodontic era -- frustrations bitterly recalled by Dr. Walter P. Auslander in 1983:

"The presentation of a Technik always led to many statements. 'I don't have time to put on a rubber dam -- I use cotton rolls, and anyway I don't know how to place a dam.' Or 'Dr., I used your technik exactly as you demonstrated -- but the tooth blew up. Why?' Sterility was something to talk about but not practice. Non-sterile instruments, no rubber dam, etc., but they always followed your technik exactly."

In 1980 -- 37 years after the founding of the AAE -- that same frustration still echoed in words of Edward M. Osetek, who felt the need to galvanize the membership into action:

"It was the year that the association committed to gaining the recognition it truly deserved and to crafting the image that the AAE is the parent of the specialty of endodontics. We members knew that from the very beginning nearly 40 years earlier but we took for granted that organized dentistry also knew and believed that. Unfortunately, probably because of our low profile, that perception did not

emerge as a universal truth."

Part of this problem stemmed from the fact that endodontics was still evolving as a field of study. While this evolution brought great advances in endodontic knowledge, it also meant that its practitioners were still wrestling with their identity. The need for recognition -- and self-recognition -- sparked a concentrated AAE effort to disseminate current endodontic knowledge on a scientific basis through conferences, workshops, continuing education and publications. Emphasis was placed on research in order to justify clinical procedures.

In 1964, for example, the Third International Conference on Endodontics, under the direction of Louis I. Grossman, was held at the University of Pennsylvania dental school. A year later The ADA House of Delegates approved a resolution submitted by the AAE to amend the ADA's bylaws to include endodontics as a special section of the ADA annual session scientific program.

The year 1966 saw another milestone in the history of the AAE: the founding of the AAE Endowment and Memorial Foundation on the recommendation of Jacob B. Freedland who served as its the first chairman. The Foundation was incorporated in the State of Illinois in 1966, with the primary purpose of supporting research and education in endodontics. The following year the Endodontic Research Group was incorporated into the AAE as part of the Research Committee.

A 1969 conference on the Biology of the Human Dental Pulp was held in Memphis, Tennessee, co-sponsored by the three endodontics entities: AAE, ABE and the E&M Foundation. Its goal was the accumulation, correlation, evaluation and dissemination of current basic scientific data related to the living dental pulp. The highly successful conference featured 22 presentations and was attended by some 350 teachers, researchers and clinicians. That same year a Pulp Registry was started, under the leadership of Harold Stanley and supported by the E&M Foundation.

AAE President (1968-69) Dr. Samuel S. Patterson appointed a Council on International Relations to work with the ADA to promulgate concepts in endodontics throughout the world and to facilitate an exchange of information. A year later, a workshop on the Biologic Basis of Modern

Endodontic Practice was held in Chicago. Attended by more than 60 endodontic educators, the workshop concentrated on pedodontic-endodontic practices, periodontic-endodontic relations, inflammation and infection of the pulp and periradicular tissue and the treatment of the traumatized tooth.

The Louis I. Grossman and the Ralph F. Sommers Awards were created. Dr. Grossman was the first recipient of the Louis I. Grossman Award established "for cumulative publication of significant research studies which have made an extraordinary contribution to endodontology." The presentation was made to him "for superlative and meritorious contributions to the art and science of endodontics and for exemplary dedication, service and leadership to dentistry, and this association."

Interest in the growing field of endodontics was not limited to the United States. The Fifth International Conference on Endodontics was held in Philadelphia, September 21-24, 1972, and was attended by more than 300 participants. If fact, this worldwide interest had a direct impact on endodontics -- in the form of increased international membership and requests for professional information. These were the seeds for the eventual formation several years later of the International Federation of Endodontic Associations (IFEA).

In 1974 the AAE's Education Committee announced plans for a workshop on Teaching Teachers to Teach -- as well as a continuing education program the following summer in London in conjunction with the British Endodontic Society and the American Dental Society of Europe. The National Library of Medicine agreed to provide a current endodontic bibliography in cooperation with its Medlars Program to be made available to all advanced programs and the AAE headquarters.

The membership riddle: who is an endodontist?

As research and education progressed, the association remained torn by deciding who was an endodontist. This conflict went much deeper than mere labels. Membership requirements are a highly volatile issue. How an association defines the qualifications for membership determines the nature of the organization. Change the membership requirements and you inevitably

change the organization. Thus, most associations tend to approach membership changes with extreme caution. This proved especially true of a young specialty organization still working to define itself.

This pursuit of a definition was complicated by the conflicting views of two special classes of endodontists: AAE fellows and diplomates. A Fellowship Committee was appointed in 1960 to establish a "Fellow of the AAE" category to recognize members who had distinguished themselves in the field of endodontics through limited practice, teaching, research, publication and professional service. In addition, candidates were required to pass a written examination on the art and science of endodontics.

It was the intent of the Fellowship committee that all members who passed the examination in 1966 would be granted Fellowships; however, a one-year moratorium on Fellowships was declared. The Executive Committee asked for a reevaluation of the purposes and objectives of the Fellowship Committee. Following the ADA approval of endodontics as a specialty of dentistry, the rationale for a fellowship was no longer valid as qualified members could seek Diplomate status with the ABE. Ultimately the Fellowship Committee would be dissolved in 1968 and replaced by the Honors and Awards Committee, which also encompassed the Student Awards Committee.

Diplomate status involved a more rigid educational standard -- determined by examination -- at least in theory. But the ADA's acceptance of the AAE as a recognized specialty group came with a price. By agreement with the ADA Council of Dental Education, a limited number of qualified individuals was granted Diplomate status without examination. Dr. Coolidge was designated the first Diplomate of the American Board of Endodontics.

Applicants who did not meet the formal education requirements but did, in fact, devote their practices exclusively or primarily to endodontics for a period of not less than ten years, could be accepted for examination for a ten year period, until December 31, 1974.

The ABE would hold its first examination of 127 qualified candidates on April 29, 1965 in

Detroit. A second examination of 140 qualified candidates for Board Certification would be held that May in Memphis. Both Diplomates of the ABE and Fellows of the AAE were designated by a symbol in the official AAE roster. Fellows who are Diplomates would be designated as Diplomates only.

Thus, the AAE's executive committee spent 1964 debating a formal course of instruction for a prescribed period of time for specialist status, guidelines for endodontic study clubs and the establishment of an Ethics Committee to develop guidelines for specialty practice and the aspect of specialization in two areas of dentistry.

This was also the year that the AAE began its sponsorship of the annual Dental Student Endodontic Award for senior dental students, a program that continues to this day. It was also during this annual session that the submission of ten case histories became a requirement for membership. Now that endodontics was a recognized specialty, the ADA Board of Trustees was requested to establish a separate section on endodontics at the annual ADA session.

Finally, in 1965 the AAE made a significant change in its membership requirements, emphasizing the applicants' interest and practice of endodontics. Requirements included membership in ADA or recognized dental association of country of residence, sponsorship by two active AAE members in good standing, a letter of endorsement from an officer and another from a member of his local dental society. The applicant had to devote 20 percent of his professional time to endodontics, and submit 10 case histories with acceptable radiographs and 6-month recalls.

In addition, a graduate student section was approved so that a dentist enrolled in a two-year graduate or postgraduate program could apply for student membership with a letter of recommendation by the head of the endodontic department and endorsement by two active members of the AAE. A graduate student would have all the rights and benefits of AAE membership -- including the *Triple O Journal,* the newsletter and the privilege of attending meetings -- with exception of voting or holding office. Upon graduation, the graduate student had to submit a new application for full membership in the usual manner. Newly sponsored

Student Endodontics Awards were presented to 39 dental schools.

By 1967 the AAE's Executive Committee had established five membership categories: active, associate, honorary, life and student. Guidelines for the clinical practice of a Diplomate were revised to read "A Diplomate of the American Board of Endodontics is not required to limit his practice, provided that limitation has not been announced."

During the following year, active AAE members who chose to pursue graduate study in approved courses were granted student membership during their training period. Upon completion of their program, they automatically became active members, without having to submit additional case histories.

The ADA also had its input into defining endodontics. In 1968 the ADA Conference on Dental Education requested that the AAE prepare guidelines for advanced programs in endodontics, including evaluation methodology. A year later the ADA sent its definition of endodontics to the AAE. This took the form of *Guidelines for the Limited Practice of Endodontics.* Meanwhile, the ABE was charged by the ADA Council on Dental Education charged the ABE with preparing "guidelines for graduate courses and establish minimum standards of clinical experience necessary for certification."

In September 1973, the AAE held a long-range planning workshop in Chicago. Titled "Our Association Tomorrow," this was the first of several such planning workshops with ADA staff and representatives of other specialty organizations. One result of this first workshop with was an amendment to the AAE bylaws that provided for regional components. Representatives of specialty organizations also met during the year to exchange ideas and to gain better representation in the ADA House of Delegates and on various councils.

By January 1, 1974, there were 403 Active Diplomates of the American Board of Endodontics. The House of Delegates of the American Dental Association had approved the Commission on Dental Accreditation in 1973 and the American Association of Endodontists formally requested the formation of an Advisory Committee on Endodontics to assist the Commission in 1974. Endodontics was the first dental specialty to request an advisory committee. The others soon followed suit. The association assisted the Commission in the development and adoption of new Guidelines for Advanced Endodontics. The timing was fortuitous in that on December 31, 1974 the "grandfather clause," which allowed endodontists to establish eligibility for examination by the American Board of Endodontics without meeting education requirements, would expire.

With the 1974 expiration of the "grandfather clause" for educational waiver candidates, the ABE announced the publication of new policies and procedures for certification. A total of 285 general dentists attended an endodontic course presented by AAE members at the Academy of General Dentistry meeting, an example of the mutually beneficial relationship between the two organizations.

This evolutionary process culminated in the AAE membership approving this revised 1976 definition of endodontics:

> *"Endodontics is that branch of dentistry that deals with the diagnosis and treatment of oral conditions which arise as a result of pathology of the dental pulp. Its study encompasses related basic and clinical sciences including the biology of the normal pulp and supporting structures, etiology, diagnosis, prevention and treatment of diseases and injuries of the pulp and periradicular tissues."*

There were also efforts to improve relationships with general dentists, other specialties and the ADA. In 1967, the AAE contributed $3,000 to the ADA Fine Arts Fund for a metal wall sculpture for the lobby of the new ADA Headquarters building in Chicago.

On a more substantive level, a 1969 recommendation of the AAE's Long Range Planning Committee was to encourage interest in the AAE by general practitioners and allied specialists to avoid becoming an association exclusively for those in limited practice of endodontics. One outcome of this move was a three-day Conference on the Teaching of Endodontics was held at the University of Michigan, cosponsored by the AAE and the ADA Fund for Dental Education. It was attended by representatives of 50 dental schools in the U.S. and Canada.

A Public Awareness Committee was formed in 1974. A year later it began the tradition of holding a reception for officials of the American Dental Association and those delegates and alternates who held membership in the American Association of Endodontists at the annual sessions of the ADA. The purpose of these meetings: to keep these guests informed about the AAE's concerns on issues before the ADA House of Delegates.

While these events were crucial to the development of the AAE, it would be wrong to assume that the organization's focus on membership and professional issues made it oblivious to everything else. As important as these issues were -- and are -- in 1968 they were all put on the back burner -- however briefly -- when the AAE paused to celebrate its 25th anniversary. To mark the event the association published *A History of the American Association of Endodontists, 1943-1968*, written by Vincent B. Milas, AAE historian. Dr. Milas was commended for his tremendous effort in compiling the material for the history. A complimentary copy was sent to all members and scientific libraries.

In summarizing the final year in his history, 1967-68, Dr. Milas pointed to a membership that had reached 1,000. He also noted that several endodontists were deans or presidents of state dental societies. In 1968 the association could also take pride in the existence of 27 endodontic department chairs, 172 endodontic teachers in dental schools and the first endowed

professorship for endodontics, Morris B. Auerbach at New York University. Sixteen dental schools and 6 government programs and hospitals provided accredited advanced education programs in the specialty. Dr. Milas also cited an ADA agency's report of 193 endodontic research projects being conducted by 183 investigators in dental schools, military facilities and at the National Institute for Dental Research.

The year 1968 took its toll upon the association with the passing of Edgar D. Coolidge. Seven years after his honorary presidency, AAE founder Dr. Coolidge died at age 86. Harry Blechman suggested establishing the Edgar D. Coolidge Memorial Lecture to be delivered at a special luncheon. The person invited to deliver the lecture would be honored by the Association. The Coolidge Award was established for presentation to a "member who has actively participated in the AAE during his or her professional life, displaying outstanding leadership and exemplary dedication to dentistry and endodontics." The first award was presented posthumously to Dr. Coolidge.

Even as it mourned Dr. Coolidge, the AAE was still able to react to events in the outside world. A special meeting of the Executive Committee was called to consider a proposed resolution to oppose holding the 1969 annual meeting in Chicago in reaction to the events surrounding the 1968 Democratic convention there.

The response to this resolution was very emphatic in stating that the AAE is a scientific, professional organization dedicated to the purpose of advancing the art, science and profession of endodontics. It is not fitting or within our expertise to enter into civic problems that have to do with race, color, creed or politics. In order to preserve this honored position as a renowned scientific, professional organization, it is absolutely necessary that we guard against using the AAE for any other purpose than that for which it was intended.

This did not mean that the association was oblivious to the impact that politics would have on dentistry. In 1973 the AAE would establish a Political Awareness Committee. This new committee would play an active role in the other major battle that the AAE would fight during this period -- the battle against N2.

N2 the fray.

The AAE's 1967 conference was held in St. Louis, where President John I. Ingle (1966-67) commented on the special significance of that city to endodontics:

> *"One hundred years ago in this city, Dr. Bowman announced the use of gutta percha as a root canal filling material. ...There are not many products in use today that were developed a century ago. And as yet, we have not in all this age of technology developed an endodontic filling material superior to gutta percha."*

Dr. Angelo Sargenti had a different opinion. The Swiss dentist advocated a compromised root canal technique that abandoned conventional enlargement, cleansing and filling of the canal with gutta percha or similar dense material. Instead, the Sargenti method begins with a simple pulpotomy. He then filled the canal with his specially formulated paste (N2).

The procedure poses two problems for the serious endodontist: First, the basis of Sargenti paste is paraformaldehyde, which is highly toxic to tissue and can cause extensive destruction of bone and loss of tooth. To the AAE this was barely one step beyond the caustic mummification technique of 19th century dentistry. Second, the short-cut technique lends itself to abuse, which can lead to damage -- for example, Sargenti paste pushed past the apex into surrounding bone. In extreme cases, N2 has been forced through the tooth into the main canal of the lower jaw, resulting in permanent damage and paresthesia. Even without such abuse -- and without N2 seeping beyond the tip of the root-- the Sargenti technique still results in a significant number of failures.

Nevertheless, the Sargenti technique was adopted by a number of general dentists, who saw the technique as an easy alternative to referring cases to endodontists. Dentists who accepted and used the technique even formed their own association, the American Endodontic Society (AES). This was the beginning of a battle in which there were no neutrals. This is how AAE Past President (1971-72) Dudley Glick recalled the impact of N2:

"I was appointed chairman of an ad hoc committee to evaluate the use of paraformaldehyde pastes. This was the beginning of an emotional venting that kept the membership involved in an ongoing controversy with the AES (as well as the ADA and FDA). It seemed like every member had an opinion and a solution, and demanded that they be heard. Annual business meetings were filled to overflowing and lasted for hours."

The result of all this debate was a letter sent by AAE President (1970-71) John F. Bucher to the ADA, to the American Academy of General Dentistry and to the director of continuing education of each dental school. In the letter he clearly stated that "the AAE was not associated with the American Endodontic Society. This society is composed of general dentists who perform root canal therapy with a paraformaldehyde paste filling material known as N2 (Sargenti paste)."

To Dr. Glick that should have been the end of N2: "It finally died an 'unnatural' death. Or so I thought." It wasn't. Four years later three AAE members appeared before the House Government Operatories Subcommittee to testify at an investigation into the FDA's handling matters relative to N2. Members also appeared at a hearing before the Dental Advisory Committee of the FDA the following month.

Dr. Glick would later describe -- with more humor than is usually associated with the subject -- another resurgence of N2 in 1993:

"I see the controversy has been exhumed and Joe Maggio is now fighting the good cause. This is getting to be like the Terminator *films (ad nauseam), where the bad guy is seemingly eliminated at the conclusion of one episode but, Phoenix-like, comes back in the next."*

Today, the American Endodontic Society, N2 and the dental practitioners who use it are all still around. This may be inevitable in a healthcare environment in which low-cost quick fixes may appear initially attractive. The best response for the American Association of Endodontists is to continue its tradition of educating the public, when it comes to root canals, of doing it right.

Education: the AAE in print.

Publishing played a key role in the association's efforts to educate the dental community about the value and role of endodontics. During this period, the association would sponsor a wide range of special publications. These ranged from newsletters to educational pamphlets, from glossaries of endodontic terms to a history of the AAE.

The first *Glossary of Terms Used in Endodontics* was compiled by Charles G. Maurice and the Nomenclature Committee in 1967. Copies were sent to members and each scientific library and insurance carrier approved by the ADA. For the first time the AAE was able to communicate with other interested parties using a commonly accepted language. In 1970 the Association responded to the spread of dental insurance coverage by instructing the Insurance Committee to develop a standardized insurance form to be used in conjunction with the *Glossary.* The *Glossary* was be an ongoing project. The second edition -- written by the Peer Review and Professional Standards Committee and titled *Basic Clinical Procedures for Endodontic Therapy and Guidelines for Evaluation of Completed Endodontic Therapy* -- would be published in 1974 published in booklet form, this time with insurance codes included.

The AAE celebrated its twenty-fifth anniversary as an organization in 1968 with the publication of *A History of the American Association of Endodontists, 1943-1968.* Its author, AAE historian Vincent B. Milas, was commended for his tremendous effort in compiling the material for the history. A complimentary copy was sent to all members and scientific libraries. Dr. Milas' history ended with the then-current year 1967-68, which he used to outline the state of endodontics. He announced a membership of 1,000, several endodontists who were deans or presidents of state dental societies, 27 endodontic department chairs, 172 endodontic teachers in dental schools and the first endowed professorship for endodontics, Morris B. Auerbach at New York University. He also pointed to 16 dental schools and 6 government programs and hospitals that provided accredited advanced education programs in the specialty. He cited an ADA agency's report of 193 endodontic research projects being conducted by 183 investigators in dental schools, military facilities and at the National Institute for Dental Research.

Regular communication with its members is the lifeblood of any association, a fact long

recognized by the AAE. In fact, the association's struggle for "respectability" was paralleled by its efforts to find ways to communicate more effectively with members and the broader dental community. The AAE's newsletter was supplemented by the Endodontic Section in the *Triple O Journal.* But space limitations in this publication led to the rejection of many worthy articles. As a result, the association once again floated the idea of a journal dedicated to endodontics. Such a publication would permit more scientific articles on endodontics and related areas to be published. An ad hoc committee was appointed to evaluate the possibility of an independent journal or one combined with periodontology.

Although approval was given in 1972 for the continuance of the Endodontic Section in the "Triple O" Journal, the Long Range Planning Committee would later recommend a separate journal. Two years later the AAE approved publication of the *Journal of Endodontics,* to begin January 1, 1975. To Albert L. Frank, AAE president at the time, "January 1975 will always be remembered as a most important moment in the history of the AAE. Dr. Worth Gregory brought to fruition the birth of the first issue of the *Journal of Endodontics,* to which he had devoted so much arduous effort for an endless period of time."

Total subscriptions far surpassed the most optimistic expectations -- with 4,848 paid subscribers after just one year. As a result, *JOE* became financially secure in its very first year of publication, not requiring subsidization by the American Dental Association as anticipated. And by the end of the following year, subscriptions to the *JOE* numbered 6,100 and monthly issues were expanded from 35 to 40 pages. This success led to discontinuation of the AAE's newsletter. News of interest to members was incorporated into *JOE.*

This overwhelming acceptance of *JOE* was a clear demonstration of the need for a broader print forum for endodontics. The power of *JOE* was demonstrated from the first article of the first issue. Herbert Schilder, who would become AAE president in 1985-86, used this first issue as a platform to tackle the key issues then facing the association. One involved the need for combating misinformation that led to ill-advised procedures masquerading as endodontics. The other went right to the heart of the AAE's relationships with other dental practitioners. The article, titled *Problems of the Present,* was taken from an address Dr. Schilder had delivered at the

association's annual meeting in San Diego. Almost a quarter century later Dr. Schilder's article is still relevant -- and he knew why:

"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 judgment, our very continuance as a specialty in dentistry.

"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 beliefs 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 of 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.

"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 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."

The year that ended this period of the AAE's history -- 1980 -- would provide a significant watermark in the association's history -- for a number of reasons:

- The AAE had grown to 2,634 members, 90 percent of which limited their practice to endodontics. This included 2,167 Active, 51 Affiliate, 68 Life, 21 Retired, 7 Honorary, 1 Associate and 319 Student members in the United States and throughout the world.
  - There were 479 Active Diplomates of the American Board of Endodontics.
  - The AAE headquarters had relocated to the American Dental Association building in Chicago, where it occupied 1200 square feet on the eighth floor.
  - The Constitution and Bylaws were rewritten to include the office of the executive director as well as to define the role of the Executive Committee (which began meeting in February and August in the interim between meetings of the Board of Directors in April and October) in the management of Association affairs.
  - Advertising in the *Journal of Endodontics* was approved, the third edition of the Glossary of Terms Used in Endodontics was published and the Endowment and Memorial Foundation began its grants-in-aid program to provide start-up funding for endodontic research.
  - The association sponsored a symposium titled Accreditation Review and Critique of the Process in cooperation with the Commission on Dental Accreditation The year 1981 would see publication of *Guidelines for Pre-doctoral Education in Endodontics* in the *Journal of Dental Education.* This project was initiated by the Association Education Committee and the Endodontic Section of the American Association of Dental Schools in 1978.
  - Specifications for Endodontic Filling Materials (American National Standards Institute MD 156.57) were adopted in 1981 following the adoption of Specifications for Endodontic Instruments (MD 156.28) in 1976.

These actions were no happenstance. Instead, they were the direct result of more than 20 years of activity by the American Association of Endodontists. If this era of AAE history ended with broader -- if grudging -- acceptance of endodontics by the dental profession, it was because the AAE membership was able to effectively wield the same three tools that helped the association overcome the previous hurdles of creating a new specialty and winning formal recognition for it: political skills, salesmanship and the academic rigor of research. While the first two were critical elements in getting the AAE over the organizational speed bumps, endodontic research would have the most significant impact. As J. Henry Kaiser, who served the AAE as president in 1959-60, liked to recall:

> *"Anton Carlson of the University of Chicago, one of the greatest physiologists that I studied with, said to me, 'Your interest in clinical science, and many men like yourself in your profession, will bring out the greatest research in Dental Science as forerunner of the health profession.' Endodontia did this more than any other field in the Health Sciences. Many of our investigators were the most committed researchers in the clinical sciences. The Barometer of Disease is manifested in the Oral Cavity."*

Now it was time for the AAE to take that message beyond the circles of organized dentistry . . . and bring it to the general public.

"He that will not apply new remedies must expect new evils; for time is the greatest innovator."

-- Francis Bacon (1561-1626)

English essayist, philosopher and statesman

Chap 6:

New beginnings (1980-1987).

Identity is the number one priority for a professional individual offering a service to the general public. That public's perception of endodontics becomes the reality that each endodontist must deal with. In that sense, it doesn't matter how good an endodontist you are. If the public doesn't know, understand or value what you do, the world will not beat a path to your practice. That's why the AAE came to realize the importance of the public's perception of this specialty -- and the corresponding need of a public awareness program to create an image to identify endodontists as the preferred providers of a specific dental service.

As far back as 1965, the AAE began considering the need for a committee to establish guidelines for radio and TV broadcasts and press releases by AAE members. But it was not until 1976 that the AAE hired a public relations firm to represent the association in its public and professional relations. The firm of Caldwell-Van Riper of Indianapolis, Indiana was hired.

One of the firm's first initiatives was to develop a portable public relations exhibit for display at dental association meeting. A brochure titled *Your Teeth Can Be Saved* was distributed in conjunction with the exhibit. In 1979 the Public and Professional Affairs Committee reported the AAE exhibit had been shown with great success at the major dental meetings, including the ADA, Chicago Dental Society Midwinter meeting, the Hinman meeting in Atlanta, the California state meeting and the AAE annual session. The exhibit received the award for best exhibit in its class at the ADA Annual Session in Dallas, in October 1979.

That same year a 30-second television public service announcement, produced in collaboration with the ADA, was distributed to 550 television stations. All this still wasn't enough to move the stalled image of endodontists, leading AAE President (1987-88) Charles J. Cunningham

reminded endodontists to recall the status of endodontics in 1979:

> *Remember the 'busyness' issue was with us. The newest specialty of dentistry was not a 'household' word to folks with toothaches and abscessed teeth.. Conversations required us to follow up 'endodontists' with 'root canal specialists.'*

When Dr. Donald E. Arens assumed the AAE presidency in 1983, he made strengthening the image of the endodontist a major focus. That task fell to a future AAE president (1989-90), Dr. Gerald C. Dietz Sr. He was instrumental in organizing an awareness campaign targeting both the general public and the dental profession. The result was a three-year AAE public awareness program financed by assessing active members $100 per year.

The public relations firm of Professional Communications Inc. (PCI) of Chicago was selected to develop and operate this program. The goal was to create a program that walked a tightrope: aggressive enough to capture the attention of the general public but sensitive enough not to offend the legitimate prerogatives of the general dentist. One of PCI's first steps was the development of endodontic press kits for regional and national media relations programs. A practice promotion kit was also developed to aid members in building their practices and to better meet the needs of their patients.

The AAE also expanded its embryonic AAE speakers program introduced in 1978. All the officers and selected members from 24 of the top 30 major markets will be invited to attend a spokesperson's training seminar. This gave the AAE a resource pool of speakers -- 24 in its first year, 35 the following year -- for media interviews.

These endodontists addressed a range of topics: pain control, trauma, the avulsed tooth and bleaching as well as the benefits of endodontic therapy and the special expertise of the endodontist. In its first full year of operation, the program produces 80 "hits" for regional spokespersons -- 8 print and 72 electronic placements -- with a total audience of more than 6 million people. The most notable of these attempts to reach the public was a 1985 appearance of an AAE representative on an Oprah Winfrey Show dealing with dental phobias.

These media placements imposed an additional workload on the AAE's central office staff. A *Better Homes and Gardens* article on bleaching resulted in more than 1,000 requests for pamphlets. By 1987 the staff had responded to requests for 38,000 brochures -- and another 500,000 were sold. Media placements of regional spokespersons totaled 355.

In just three short years the success of that program could be measured in hard numbers: A 1986 survey -- a follow-up to an earlier national poll conducted to gain an understanding of the public's knowledge and attitudes about endodontics -- demonstrated that national public awareness of endodontics had risen from 9 percent to 12 percent. By 1987 the program, like the AAE itself, had shifted its emphasis from endodontics to the endodontists.

Not every endodontist appreciated these efforts on their behalf. There were some occasional outraged complaints about the $100 assessment. In fact, some members refused to respond to the non-voluntary assessment. They were reminded that failure to pay the assessment could lead to termination of membership. But the cost issue died when a 1988 dues increase to $115 a year -- and additional belt-tightening -- made it possible for the board to discontinue the public awareness assessment. But the work of the Public and Professional Affairs Committee continued. By now 48 members had been trained as regional spokespersons for radio and TV placements. A speakers kit was available for members to take local initiative in promoting endodontics to lay audiences.

As Dr. Charles Cunningham reminded members during his presidency (1987-88), "Each AAE member, whether in private practice, academics or federal service, is called upon to assist in projecting our image as the providers of endodontic services. As long as we have to explain what we do or who we are, our public and professional campaign must continue."

Most members agreed. A 1993 membership survey showed that 92 percent of the AAE respondents supported informing the public of the value of endodontics care and the role of the endodontist in delivering that care. Thus, the awareness campaign was simply the AAE's response to its commitment to serve as the collective voice of endodontists.

The *JOE* in transition.

While the public relations program continued to make a dent in public perception of endodontists, the *JOE* remained a significant vehicle for taking that same message to membership and the rest of professional dentistry. But while the editorial quality of the AAE's flagship publication remained consistent, the mechanics of getting it published had its ups and downs.

While the AAE was the owner of *JOE*, the ADA had been serving as managing editors and publishers. Differing perceptions of how the magazine should be operated led to periodic conflict between the two bodies. When those differences could not be resolved, the ADA advised the AAE early in 1981 that they wished to withdraw as publisher and managing editors of the *JOE*, effective Dec. 31, 1982.

Under the leadership of Editor Irving Naidorf, *JOE* had become a scientifically exemplary and fiscally sound publication. But now with the ADA publishing relationship severed, the AAE needed to find a new publisher. Eventually, the board settled on the Baltimore firm of Williams and Wilkins Co., which assumed publication of the *JOE* in 1983. The new publisher's first move was to reformat the *JOE* and add additional pages.

In 1985 the office of editor of the *JOE* became an appointive rather than elective position. This move reflected the growing importance of the *Journal* as an AAE publication. Steve Montgomery was appointed interim editor because of Editor Naidorf's failing health. After Dr. Naidorf's death, a memorial issue of *JOE* celebrated his life and contributions to the AAE.

Steve Montgomery would spend three years at the helm of *JOE*. When he resigned in 1987, his performance as editor earned him a standing ovation from the AAE board. By that time a sizable backlog of manuscripts made it necessary to increase the *JOE* to 70 pages per issue. Montgomery's successor was Henry J. Van Hassel, dean of Oregon Health Sciences University dental school. The editor's office was moved to Portland, Oregon, in December, 1987.

The *Journal* was not the sole AAE avenue of print communication. In 1983 the AAE also began publishing *The Communiqué,* an internal newsletter for members, to the enthusiastic reception of the membership. Then in 1987 the ABE announced publication of the first issue of the *Diplomate* newsletter.

In a related publishing activity, the library subcommittee recommended in 1985 that the AAE establish a central repository at the central office to collect, safeguard, protect and preserve historical and current textbooks, journals and monographs. The committee also suggested the development of bibliographies that would be available to members. These moves reflected the AAE's believe that a legitimate scientific specialty such as endodontics demanded a coherent and organized body of scientific literature.

A crisis in leadership.

The year 1982 began on a somber note. Warren Wakai was to have been installed as AAE president-elect at the April annual session in Phoenix, Arizona. As 1982-83 President Noah Chivian recalled, "When I arrived in Phoenix for our annual session, I learned of the death of Warren Wakai. Although Warren's illness has precluded his active participation in the association's affairs for some time, he had lived with the dream of recovering in time to assume his position of leadership. Unfortunately, this was not to be."

Although Dr. Wakai did not live to serve his term as president, he occupies a permanent place in the history of the AAE. Later that year Dr. Chivian would represent the AAE at the third annual session of the Japan Endodontic Association, an event that moved him:

> *The congress, held in Tokyo, was a spectacular event highlighted by numerous scientific sessions and elegant social functions. At the meeting, they bestowed upon me the honor of leading a memorial service for Warren Wakai, who is revered in Japan for his endodontic teachings throughout the country. The warmth and friendship engendered during my trip to the Land of the Rising Sun. Very little was lost in the translation."*

However, before the honors -- and back in the United States -- the personal tragedy of Dr.

Wakai's death also had a larger implication for the AAE: There was no provision in the association's constitution and bylaws to cover such a situation. Thus, this unexpected development had the potential for creating a leadership vacuum. But as the shock of Dr. Wakai's death began to wear off, the realization sunk in that the board of directors had to take action to assure an orderly transition of officers. Here's how Dr. Chivian remembered the ensuing events:

> *"The board, under the firm but Solomon-like direction of [1981-82 President] Henry Van Hassel, acted as the nominating committee and selected Donald Arens for president-elect and Stephen Schwartz for vice president. My initial concerns at the loss of a devoted colleague were replaced with a renewed sense of anticipation at the prospect of working side by side with accomplished leaders who were also personal friends."*

The board of directors, acting in executive session as a special nominating committee, nominated Donald E. Arens as successor. He was elected by the general assembly. With leadership continuity back in place, the AAE could now refocus on the major task that lay before it: responding to the American Dental Association's call for information on the future of dentistry. The AAE created a committee of its leadership, past and present, to address these issues. Here's Dr. Noah Chivian report:

> *"The committee, chaired by past president and this year's Coolidge Award Recipient Edward Osetek, functioned with military-like precision and efficiency. They identified four areas of special interest, prepared position papers and responses, and held a two-day conference in Chicago in July, 1982."*

Dr. Chivian also noted that "At the time, the ADA hierarchy had not granted us favored organization status, and it took considerable persuasion at a face-to-face meeting with ADA President Robert Griffith to have him attend the opening session of that conference." The proceedings of this conference provided the raw material for the AAE's response to ADA's request for input. But, according to Dr. Chivian, much more work was required before that report would be ready for submission to the ADA:

"A writing conference was held two months later with participation by Drs. Arens, Chivian, Heuer, Osetek and Schilder. After two more days of brainstorming and headknocking, we arrived at a clear sense of purpose. The AAE had accepted the challenge. We spent a significant portion of our annual budget and countless man-hours in preparation of a remarkably explicit and in-depth document. The final instrument, edited by Mike Heuer, was presented to the ADA leadership and received glowing reviews. For the first time, the leadership of the ADA stood up and took notice of the 'new kids on the block.' And for the first time, the AAE had ventured into a thoroughly introspective look at our identity and direction. This successful effort proved to be the impetus in our ongoing proactive stand with regard to long-range planning."

The membership takes charge.

How many dentists are too many? That was the question that made 1983 a year of doom and gloom for dentistry in general -- and the AAE in particular. Ironically, modern dentistry had created its own economic crisis. Water fluoridization, dental advances and greater public awareness of the value of preventive dentistry meant healthier teeth -- at a time when dental schools were graduating more and more dentists.

As general dentists sought to maintain the income base of their practices, they began performing procedures that, in flusher times, would have been referred to specialists -- including endodontists. This dental domino theory began cutting into the incomes of endodontists, who turned to the AAE leadership for help. President Donald E. Arens (1983-84) asked the membership for input -- and he got it. Here's how he described the members' reaction:

"The response was instantaneous, critical and exhibited an air of apprehension, fear, bitterness and frustration. Five truly constructive letters stood out, and prompted me to change the Dental Care Committee to the Dental Care and Clinical Practice Committee. This was a perfect example of your association responding to the membership. These additional five individuals were appointed to the committee.

All five of these people would later serve on the AAE's board and three have gone on to become

president of the AAE. More important, this experience convinced Dr. Arens of the need to personally hear more from the membership:

> *"I visited different areas of the country and I listened. One late snowy night in Rochester, New York, I realized that effort must be made to enhance the unity of the organization and to establish a truly geographic representation of members' needs. Past presidents and present officers were called upon to organize state and district affiliates into a governing body."*

As part of this process the AAE studied the nominating process for directors. This would ultimately lead to a restructuring that gave the membership greater representation in the decision-making processes of their association. But this drama would play out against the backdrop of a larger struggle between the AAE and the ADA.

The relationship between endodontists and organized dentistry -- personified by the ADA -- remained rocky. In 1983, the ADA stated that "It is not in the public interest for the profession to be fragmented by the recognition of a multiplicity of specialties." On the heels of this statement, the ADA distributed at its annual session a 50-page publication on current concepts in dentistry. The role of endodontics was reduced to one short paragraph -- quoting only general dentists and ADA staff. No input from the AAE or endodontists.

Dr. Arens took the issue directly to ADA President Burt Press, asking to plead the AAE's case directly to the ADA board of trustees. The AAE representatives -- Dr. Arens, AAE Secretary Mike Heuer and Executive Secretary Irma Kudo -- were, in Dr. Arens' words, "cordially but deafly heard." The response to the AAE's plea was summed up by ADA Trustee Ashur Chavoor: "You don't represent endodontists. Your group is made up of general dentists and foreigners."

That rebuttal would serve as the catalyst for a period of soul-searching that would transform the very nature of the AAE -- from an organization whose members were dentists with at least an interest in endodontics to one in which the primary criterion for membership was specialization in endodontics. Everyone involved realized the potential consequences of this far-

reaching decision to limit active membership to endodontists. It risked alienating two segments of the AAE: members who were general dentists and those who were from other countries. But as bold as this plan was, it was not a new idea. As Dr. Heuer explains:

"Then was the transition we went through. We had to start educating the public all over again. But before we could make that happen, we had to decide what exactly the AAE was. First of all, we were an organization that had a study club format. Plus we had members all over the world. How were we going to be an effective advocate for North American endodontists if, in fact, our membership consisted of general practitioners and foreign nationals? How do we legitimately claim to be the American Association of Endodontists?

"Don Arens was the first one to point that out, because he had been head of the public relations committee, which involved selling our message to the public and increasing our credibility as a specialty among the dental profession. He had also headed the AAE government relations committee, which involved playing a more politically active role. When Don Arens became president in 1983 -- he was the first of the AAE's activist presidents of this period – he said that the basic premise of our organization was wrong. Anybody could point to us and say, 'Hey, you have X number of general dentists and you have all these foreign nationals that are full voting members. So you don't really represent the American endodontists.

"There was also internal agitation on the same issue, primarily because the board diplomates wanted to form an activist organization as the legitimate endodontists. I can honestly say -- as a former secretary of the board and secretary of the association -- that at the time I was opposed to an organization of diplomates within the AAE because now you're setting up a new tier operation, the same kind of two-tier organization that Hillenbrand feared at the ADA. It would come to the AAE eventually, but at that time it would have been terribly disruptive."

The risks involved in change.

On the night before that momentous 1983 board meeting, Dr. Arens called together members of the AAE executive committee meeting and a few selected past presidents to discuss this volatile issue. He remembers telling them, "If anyone does not wish to take the heat and the risk of

severe criticism and revenue loss, leave now." No one left the room. The die was cast.

In changing the focus of the AAE -- from endodontics to endodontists -- the purpose was not to disenfranchise members who were general dentists or non-U.S. endodontic practitioners. Instead, its purpose was to answer the ADA objection by having the American Association of Endodontists live up to its name -- by having U.S. endodontists assume the role of specialty leadership within the profession. Said Dr. Heuer:

> *"The first step of the reorganization was to change the basis of voting membership. In 1985, the Association adopted a bylaws change that required all future active members of the association to be in limited practice of endodontics -- or be eligible to announce limited practice -- in the United States and Canada."*

Thus, 42 years after its founding, the association ceased to permit general dentists to attain active membership. A non-voting associate membership class was created for general dentists interested in endodontics. However, regular voting membership was grandfathered for generalists who were already members. But in the future, full voting rights would be reserved for those who were educationally qualified. As crucial as this change in membership requirements proved to be, to Dr. Heuer it was only the beginning:

> *"The second step was to change how the directors were elected. In some cases this meant transforming study clubs in each state into statewide endodontic organizations. This move would allow the AAE to parallel the ADA's state organizational structure. And then, because it would be impractical for the AAE to have 50 directors, regional structure based upon commonality in education and custom -- was necessary."*

To make this happen, the AAE approved three objectives:

- "To promote interchange of ideas on the scope of the specialty."
- "To assist in establishing endodontic study clubs and affiliate organizations."
- "To maintain a higher standard of quality care in the practice of endodontics."

In these motions, "affiliate association" was defined as an organization of endodontists formed within a state or other recognized jurisdiction in accordance with the requirements and guidelines set forth by the Member Services Committee and approved by the AAE Board of Directors.

The objectives of the affiliate associate structure were to disseminate to the grass roots level information on actions taken by the AAE as well as what is happening politically in other states that may be important to endodontists. The affiliate structure was also intended to afford a viable means by which the membership can express its opinions to the leadership of the AAE. Finally, affiliates would provide an AAE-recognized organization that could respond to local problems with the support and backing of the national organization and to serve as a basis for future regional representation.

The member services committee was charged to develop a sample constitution and bylaws to assist in the formation of affiliate associations. The requirements for an affiliate association's constitution and bylaws: membership composed of active and life members of the AAE within the jurisdiction; eligibility for membership of all Active and Life members within the jurisdiction with no member being excluded, and agreement to abide by the AAE constitution and bylaws.

By 1985, 33 associations had submitted constitutions and bylaws for approval to be recognized affiliates. Two were rejected for not meeting AAE affiliate requirements -- and five states were not forming affiliates, either by deliberate choice or because the number of resident endodontists was too small.

The board approved the guidelines for the use of the AAE logo, the Quality Assurance Guidelines and the Peer Review Manual. Violators of the use of the logo would have their membership terminated or a civil suit. The local affiliates would have the responsibility of monitoring the use of the logo in the yellow pages to indicate the distinction between nonspecialist and specialist. Qualifications of nonspecialist and specialist were to be determined by individual state regulations.

A more democratic AAE.

The concept of grassroots representation became a reality in 1986 when the AAE General Assembly adopted a reorganization plan for restructuring the process for nominating directors from the membership as represented in state affiliate societies. An ad hoc committee of past and present officers formulated the plan for reorganization of the AAE into state affiliates to be divided into six districts representing the states of the United States and Canadian provinces and federal dental services. These districts that ultimately would provide regional representation on the board of directors.

As part of restructuring the election process, the nominating committee would now include two sitting Directors in addition to the three immediate past presidents. The senior director of each district would serve as chair for the district caucus to guide the members in the nominating process for AAE Directors. In 1988, for the first time the nominees would stand for election by the AAE membership at the General Assembly.

Another result of this process was a major restructuring of the standing and special committees of the association with organization of the board of directors into five reference areas: association affairs; membership; membership services; communications/publications, and education/development. The year 1987 saw the first reference committee meetings and district caucuses, providing an open forum for discussion. This was a giant step toward greater membership involvement in association affairs -- one that didn't come about by accident. Dr. Heuer provides the context:

> *"It was a series of constitutional changes, step by step. But the reality is that the AAE leadership of officers and directors who later became officers had a very clear vision of kind of organization we ought to have. But they did it step by step, making a compelling argument for each step of the way, piece by piece, exactly as we did on the membership issue. And we offered associate membership to the foreign members -- all but voting rights at a lesser cost. Getting it done was a complex amalgam of offers, your deals and negotiations."*

The AAE around the world.

The other major segment of AAE membership affected by this decision was the association's non-U.S. members. Because of the significant and loyal support that they had given the AAE throughout its history, the board approached the issue of their continuing membership with great concern. An international federation organizing committee was formed under the leadership of AAE Past President (1975-76) Dr. Robert Uchin.

The concept was to parallel the AAE's affiliate structure within the United States and Canada by creating affiliate organizations of endodontists in other countries. The basis of these international organizations would be a new category of AAE membership: the associate member. Letters were sent to all non-American active members to inform them of their eligibility to transfer to Associate membership. The various national associations -- plus the American Association of Endodontists -- would create a worldwide specialty group to be called the International Federation of Endodontic Associations (IFEA).

In 1985 the AAE's International Relations Committee recommended that the AAE underwrite the start-up costs of IFEA on a reimbursement basis. The charter founding groups were those who paid their appropriate share of their financial obligations at the first meeting, set for Boston in 1986. The AAE proposed that each organization joining IFEA would have one vote for the first 250 within the respective organization and will be provided with one additional vote for each additional 250 members.

The IFEA's constitution was ratified at the 1985 annual session in San Diego. The AAE acted as an organizational clearinghouse, lending to the IFEA the manpower and expertise of the international relations committee and the central office staff.

The first meeting of the International Federation of Endodontic Associations (IFEA) was held on the day before the AAE 1986 annual session in Boston. This organizational meeting, with the AAE acting as sponsor and Secretariat, drew 2,025 endodontists from around the world. It would also have produced a number of world-class conferences.

A sense of completion.

When Dr. Mike Heuer stepped down from the AAE presidency in 1987, there was broad recognition that his term of office saw the completion of a great many AAE initiatives:

- The organization of district caucuses to nominate associate directors.
- The introduction of reference committees that allowed members to take association policy or administrative issues directly to officers, directors and committee chairs.
- The restructuring of standing committees.
- A public awareness program that was an ongoing AAE activity financed by members dues.
- The initial planning for a world congress in endodontics sponsored by the IFEA.

- The incorporation of all the organizational changes approved by the board of directors and general assembly since 1982 into the association's revised *Manual of Operations.*

However, Dr. Heuer refuses to take all the credit for these accomplishments. Instead, he argues that his presidency represented the culmination of the AAE's collective efforts at organizational reform. There were many other people involved in shaping the AAE into what it is today:

"We had a rather ? period, a remarkable group of people that were all contemporaries -- Don Arens, Chivian, Schilder and myself -- that had a common agenda of how to remake this organization, transform it from a study club governance in a study club organization into an advocacy group which really represented American endodontists. And how to create a district structure for electing directors. Instead of every office being nominated by past presidents, we wanted a true nominating committee that would put the nominating process in the hands of the membership. It was a tough battle, but we did it.

"We were strategists with a game plan. Burt Kunick from Texas was head of the constitution committee and I was secretary. They used to call it 'Mike and Burt's Choo-Choo,' because the only power that the General Assembly has is the power to amend the constitution and by-laws. We used to choo-choo that. We ran that steam train through all the obstacles. In Schilder's administration, the last piece of it went in place. And in my administration the whole package was put together.

"That was the first year that we were functioning as a national organization, with national representation, and reference committees. It all came together at the 1987 annual session in San Antonio. All the initiatives agreed upon five years previously and pursued so diligently were finally in place."

Today Mike Heuer believes these changes were a legacy of 1960s activism:

"Every system, every organization, has both insiders and outsiders. We were outsiders but we learned to work within the system and to work the system. That has made a refreshing change in American politics -- and the politics of professional organizations. Today's AAE is much more participatory

than it was during the 1930s, '40s and '50s. In those decades, the AAE was very paternalistic with everything flowing from the top down. Today that doesn't work so well -- not in dental organizations and not in patient-dentist relationship. Me doctor, you patient, I say, you do. That's history. But it's taken us a while to get there. In that sense the evolution of the AAE mirrors the social evolution of this nation."

"The will to win is important, but the will to prepare is vital."

Joe Paterno

U.S. college football coach

Chapter 7. Rerecognition and maturation (1989 -1993).

It is often the case that the factors having the greatest impact upon an organization are not internal affairs but external events that force themselves upon that organization. By now it should be obvious that an ongoing theme of the AAE's history was its fluctuating relationship with the ADA. The Council on Dental Education's first denial of recognition of the AAE -- and the ADA's continued recognition of the American Endodontic Society (AES) -- were potholes in the road to smoother relations.

In the early 1990s, Charles A. Scott, AAE's 1973-74 president, expressed his amazement at the progress made by endodontics since his presidency: "The quality of education, research and scientific advances in techniques and instrumentation just boggle the mind. There are, however, severe sociological pressures from outside the health professions that have created urgent need for change. Government programs, third-party payments, increased patient loads, economic and educational growth all add to the complexity of the practice of dentistry, creating even greater demand for endodontic services.

In fact, Gerald C. Dietz, AAE president 1989-90, asked endodontists to remember that the AAE has undergone a significant change of direction. As a result, the Association had matured and progressed:

> *So much has been accomplished in such a short time that my greatest concern was that there would be no major project or issue to tackle for my term as president. I had just about resigned myself to a year of business as usual, or 'keeping the faith' as they say, when all of a sudden* 'it' *happened!*

The "it" that Dr. Dietz referred to was denial of the AAE's application for re-recognition as an approved specialty. he Association had anticipated -- even expected -- that re-recognition

would be forthcoming. Why? Because the AAE had been planning the application for re-recognition for some time. As far back as 1987 the AAE had a Task Force on Recertification working at preparation of the document to support recertification of endodontics. This blue ribbon committee consisted of Chairman Ed Osetek, Chuck Cunningham, Mike Heuer, Joe Maggio, Herb Schilder, Eric Hovland and Steve Schwartz.

Report forms were distributed to more than 200 members who had agreed to provide statistical endodontic practice data to be used in the recertification application. And in 1988 AAE President Joseph D. Maggio attended an ADA-sponsored forum which brought together the eight recognized specialties to exchange ideas and improve communications.

The first draft of the AAE's recertification report was completed in August -- and it generated unusual optimism among all who read it. This optimism was based upon more than the long hours and hard work that had gone into drafting the application. The consensus of the AAE's leadership was that the document was equal to or better than the applications of other specialty groups that had already applied -- and been recognized.

The application was submitted to the ADA Council on Dental Education. Then, in Dr. Dietz's words, "something went terribly wrong." That "something" was the ADA's continuing reluctance to recognize new dental specialty groups, a reluctance which would penalize newer but previously recognized groups such as the AAE. Here's the story in the words of one ring-side observer, Dr. Michael Heuer:

> *The AAE was the only specialty that had been accepted under the ADA's old ground rules. Unfortunately for us, the ADA wanted to discourage new specialty groups pressing for recognition. So the ADA House of Delegates changed the ground rules. But if the ADA wanted to do that, it was imperative to have all specialty groups adhere to the same standards. Most of the other specialty organizations sloughed this off. But the endodontists were vulnerable because we were the youngest specialty -- and the only one that came in under original standards.*
>
> *Then something else happened -- something I'll never forget. We were at a meeting of the American*

Association of Dental Schools, where they had already gone through re-recognition of several specialties. Our proposal was already in and organizations seeking recognition were giving testimony. On the public platform, agitating to become specialists, were the implantologists, the oral radiologists, the anesthesiologists -- none of which had successfully passed the gauntlet of committee approval process they used.

Then oral surgery came up. The oral surgeons said we sent the ADA a letter that said we're recognized specialists, have been since 1917, don't screw around with us. The new executive director of the ADA said that was true. To any lawyer sitting in the audience, this was a public admission of a dual standard.

The ADA executive director had admitted openly that the ADA was not applying the same acid test -- or at least enforcing the previously recognized specialties -- under the same rules that the new specialties were expected to meet. I turned to Irma Kudo and said, with our application in their hands, I can't tell you where they're going to get us. But because of that political statement, because of the notes being taken by these lawyers for groups seeking recognition, we're going to get it. We're going to get the ax -- regardless of the merits of our case. And so will pediatrics, which has yet to apply.

It had nothing to do with our application. Nothing to do with the facts. What it had to do with was the ADA's credibility -- not the very real situation before them. The ADA lost credibility because of that man's statement on this public record. They were going to have to demonstrate that they picked apart the re-applications of recognized speciaties just like they do they applications of unrecognized specialties. We're next on the docket. Watch out.

Dr. Heuer's analysis proved correct. The applications of the next two recognized specialties up for re-recognition -- pediatrics and endodontics -- were put under the microscope. As Dr. Dietz again picks up the story, "and so on May 15, 1989 -- eight days into the new administration -- our application for re-recognition was denied on two counts."

Then the Council on Dental Education delivered the real kicker. Under the appeals process -- cast in stone by the Council's rules -- a re-submission of the AAE's application would not and

could not be considered for 18 months -- at the 1990 ADA meeting in Boston. Dr. Dietz recalled the impact of the Council's rejection:

> *The news hit the executive committee -- McGraw, Tenca, Hovland, Fountain and myself -- like a near death experience. We were reminded when, in 1957, endodontics' first application for recognition failed. A series of moratoriums and bureaucracy delayed its final approval until 1963 -- six full years later. Could this happen again? Obviously this was serious business and something had to be done immediately. It was.*

The Association's leadership knew that the AAE could not afford even a minimum of 18 months of "twisting in the wind" -- let alone 6 years. For endodontists, the stakes --economic, litigious, educational -- were enormous. Dr. Dietz's presidency suddenly had a cause -- in spades.

The AAE response was galvanic. The executive committee -- reinforced by the Executive Director Irma Kudo, legal counsel and most of the blue ribbon task force -- met in emergency session for two solid days and nights. As the brand-new president of the AAE, Dr. Dietz faced the crisis with some understandable feelings of inadequacy:

> *Although the team was enormously talented and totally experienced on the subject, a new quarterback had to be substituted. The new quarterback (president of the AAE) would know little about the process, the problem or the solution, but he would need to get in the game because only the president of the AAE would have possible access to all the parties who create the solution. This called for a giant leap of faith and cooperation on the part of the team.*
>
> *I was reminded of and took courage from the experience of my old friend Earl Morral, All-American quarterback at Michigan State in '53-'55. In 1972 he stepped in at midseason for the injured Bob Griese and kept the Miami Dolphins unbeaten for the only time in NFL history, en route to a Super Bowl victory.*

Dr. Dietz, the AAE "quarterback, made his first call of the game: The two sections of the application under question were examined, reviewed and rewritten by the blue ribbon task

force of the AAE. Even more critical was the need to develop a strategy to change the flawed Council time schedule, which would have delayed the AAE's re-recognition effort for 18 months. The crisis committee set the ADA 1989 meeting in Hawaii as the target date.

Even though getting approval for this accelerated time line seemed impossible at the time, the committee had to be prepared . . . just in case. That meant working on the final piece of the puzzle: developing a strategy to win over Council on Dental Education delegates to assure a positive vote on AAE re-recognition.

As if all this wasn't challenging enough, all three pieces of the AAE re-recognition strategy had to be accomplished simultaneously since time was of the essence. That's where the story -- much of which may never be fully known -- gets interesting, according to Dr. Dietz:

> *Mike Heuer spent the Memorial Day weekend revising the section in question for immediate distribution to the team for comments. The team would operate independently from all parts of the United States with Irma coordinating information in Chicago. Most of the contacts would be confidential and some bordered on covert. Each member of the team had goals to accomplish without ever knowing if the rest were doing their job or meeting with any success. They never gave up!*

The first concrete product delivered by the team was a letter, which Dr. Dietz described as "the finest letter I've ever signed." It was drafted and redrafted in committee. Those committee members who could not be physically present gave their input by phone and fax:

> *Faxes were new and not available in many places, and I'll never forget faxing an early draft to a 7-Eleven store in Boston where Herb Schilder had walked to receive it and later refaxed his input. What a team! The letter was written in final form by a truly gifted and inspired writer who shall remain nameless for now. I hope that letter is in our archives.*

The letter was a battle plan -- and a battle cry. It laid out both the AAE's problems with denial of re-recognition and its concerns with delay in the review process. The document also reminded the Council on Dental Education of the AAE's good record with organized dentistry. It

concluded with what Dr. Dietz called "strong demands for action. It became the road map for our strategy and focused our mode of action."

The AAE strategy began eroding the barriers to re-recognition. One after another the obstacles fell -- until a glimmer of hope appeared: The Council allowed the possibility of including the AAE's request for a change in the review procedure on the agenda of its last monthly meeting before the ADA meeting in November, 1989. But since every silver lining has a cloud, that hope was dashed when the Council reversed itself and dropped the AAE petition from its agenda.

Drastic situations demand drastic action. Dr. Dietz flew to Chicago and, with Irma Kudo, showed up -- unannounced and uninvited -- at the Council's doorstep. That's when the serious lobbying to be placed on the agenda of the ADA Council on Dental Education's Subcommittee on Dental Education began:

> *We then disappeared for hours until we finally heard that our new revised application would be rescheduled for immediate review, speeding up the process by 12 months.*

The next obstacle the AAE faced in winning reconsideration of its application was a face-to-face meeting with the Council's Subcommittee on Specialty Re-recognition. The subcommittee wanted to question the AAE's case for re-recognition. Here's how Dr. Dietz prepared for the ordeal:

> *Knowing that I would be at the meeting with* the *walking encyclopedia of dental procedure and bureaucracy, Mike Heuer, on my left and the most charming and most respected executive director in dentistry, Irma Kudo, on my right, I felt freed up to prepare for what I considered a crucial sales job.*
>
> *To get in the mood, I pasted the picture of the chairman of the committee on the mirror on the wall in my hotel room and practiced the INTRODUCTION, QUALIFICATION, PRESENTATION and CLOSE for my 'sales pitch' while gazing at his picture to be sure I would be comfortable and convincing the next day. We passed our orals and the rest of the story is history.*

Drs. Dietz and Heuer and Mrs. Kudo appeared before the subcommittee and gained approval of the revised application. And thanks to the AAE groundwork of networking and lobbying that had prepared the way, the ADA House of Delegates unanimously supported the re-recognition application on November 8, 1989. Thus, the AAE's re-recognition task force ended its work with a significant victory.

The next phase.

With re-recognition now a reality, the AAE could refocus its energy and resources on the future of endodontics -- and endodontists. This was no idle question. As AAE President Charles J. Cunningham (1987-88) has pointed out:

> *Significant societal changes were occurring and this demanded that we not only change with society but also anticipate the future and position ourselves -- as a specialty, as an organization, as individual professionals -- to meet the competition in whatever manner it presents.*

This process had actually begun early in the decade with a study by the AAE long range planning committee to consider whether it was necessary to reformulate the objectives of the AAE. The report, presented by the committee in 1984, called for:

> *A detailed audit of our members - who they are, where are we as an Association, what are the future trends, how does the Association meet their needs, and how should the Association address future trends and the member needs.*

To make that happen, Dr. Cunningham called for a strategic planning workshop to take the lead in developing a strategic plan for the Association. He wanted the workshop to be representative of the AAE. So participants were selected:

> *to ensure diverse challenging opinions and input to develop the ultimate agenda that would umbrella every issue of the AAE. The strategic plan hinged on developing an anticipatory mode of thinking to forecast future trends that would affect our special status in the unknown future.*

The goal of this workshop -- held in March 1988 -- was to consider options for the next five years and beyond. These options would then form the basis of a strategic plan that would guide the AAE's leadership in determining Association policy on clinical practice, education, research and participation in local and national organized dental activities.

The report issued by the workshop amounted to a long-range plan for the Association itself. In April the plan was debated and adopted in concert with the AAE's response to the ADA's proposals for changes in the Recognition of Special Areas of Dental Practice and the Requirements for Advanced Education as well as the Future of Dentistry Report. The initiatives and decisions reached during this critical period and adopted by the AAE set the Association's agenda for the next several years. Five task forces were appointed to carry out the plan.

Dr. Cunningham did not see the long range plan as something carved in stone: "It was realized that subsequent modifications would need to occur to reflect the ever-changing societal and professional currents." Thus, he expected that the plan would be subject to change by "subsequent AAE leadership and 'Monday morning quarterbacks.'"

Still, he -- and the AAE board -- had the foresight to realize that "outstanding long-term results demand outstanding present-day planning." Thus, the American Association of Endodontists could look forward to 1993 -- its fiftieth anniversary as an Association -- with a strategic plan in place -- a plan that would serve future AAE board as a guide to getting a firm grip on that large, gray, amorphous marshmallow called the future.

"We should all be concerned about the future because we will have to spend the rest of our lives there."

Charles Franklin Kettering

U.S. engineer and inventor

Chapter 8.

Epilogue: the next 50 years.

In its half century the AAE has grown from the dreams of its founders to an internationally recognized organization that has and will continue to make significant contributions to the science and practice of dentistry.

Root canal therapy was once a controversial procedure, practiced by very few dentists. In general, pulpless teeth were extracted because they were considered to be foci of infection and the cause of many medical complaints and diseases. Untold numbers of teeth were unnecessarily sacrificed because of this theory which has been refuted.

Not any more. Five decades of dedicated research, education and advocacy by the AAE has changed all that. But does that mean the Association's work is done? That the AAE can rest on its laurels? That the passion of the AAE's founders can be damped down to the cooling embers of a trade group that gets together for business and social reasons?

To any thinking endodontist, the answer to all these questions is a resounding *"No!"* For two reasons:

First, there is still much more work to be done. The National Institute of Dental Research has estimated that there are an estimated 500 million unfilled cavities in the United States alone. How many of these teeth will require root canal therapy? And how many will be lost because of lack of dental care?

Second, the great pendulum of ideas that dominates all fields of human endeavor also swings in endodontics. Writing in 1983, AAE charter member Walter Auslander noted:

I have seen the philosophy of fillings in canals come full circle from Lou Grossman pointing up the superiority of silver cones over guttapercha to now where only guttapercha is acceptable. The pendulum swing is not realistic, for all fillings are only as good as the operator who employs and places them. It is inconceivable to me that the philosophy of only guttapercha as an acceptable filling can be so high in the ascendancy of endodontic thinking. For me it can only be likened to the presentation of a great symphony orchestra with its string section, brass, woodwinds and timpani, and then the sudden announcement that only the strings hereafter would comprise a complete orchestra. The other instruments are to be discarded. How inadequate, confusing and ridiculous. Every type of filling has been employed in my practice successfully. Silver cones, guttapercha condensed to place and, yes, even instruments sealed to place. They all have their moment to be heard in our orchestra. There should be no rigidity in our thinking."

Dr. Auslander's words are as true today as they were in 1983. As the AAE enters its second half-century, this venerable body can afford neither rigidity or complacency. Too much can happen.

The late movie producer Samuel Goldwyn once advised, "Never make forecasts, especially about the future."

Nevertheless, one is on fairly safe ground in stating that the next 50 years -- even the next 10 years -- will drop new challenges on the AAE doorstep. Some will take the form of resurrected issues that endodontists thought settled. (Will it ever be possible to put a permanent stake through the heart of the focal infection theory?) Others will be brand-new problems. Ones that no one in the dental profession has even an inkling of now -- but are guaranteed to trigger their share of organizational and professional headaches tomorrow.

The AAE and its members already are dealing with the impact of AIDS, crises in dental education and traumatic change in the healthcare environment. As Past President Herbert Schilder noted in 1992:

"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 of 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, maxillofacial 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 options. 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 difficulties 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 who does the treatment either in a predoctoral, comprehensive clinic area under supervision of an appropriate faculty from the school's specialty departments, or by that same student in a predoctoral clinic for that 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 is to put 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 graduate if these 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 acquiescence.*

"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 50 years in 2043, as self-fulfilled as we hope to celebrate our first fifty years in Chicago next year."

Whatever that AAE's tomorrows may bring, there is only one effective way to meet them. That is by continuing to build an AAE that is alive with the passion and commitment of the people who brought life to this history -- the endodontists who made a difference. And all it takes is for each member of the American Association of Endodontists to remember these words of Dr. Walter Auslander:

"I would like to leave you with one thought. Take the ball and run with it, don't kick it away, and forget rigidity. We the pioneers tried to establish a firm foundation that can be built upon. Our fire is not out, the hot coals are still there. Don't let us down. Run!"