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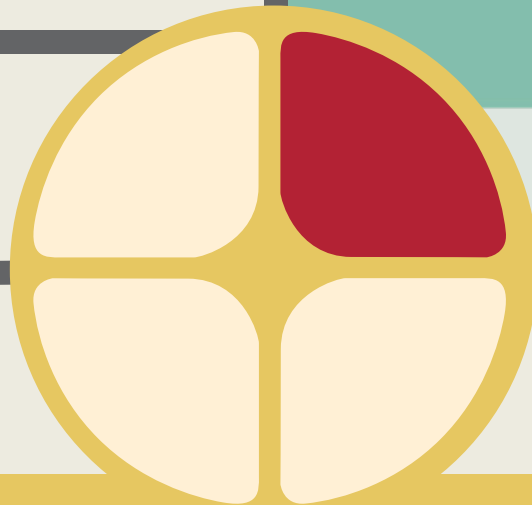
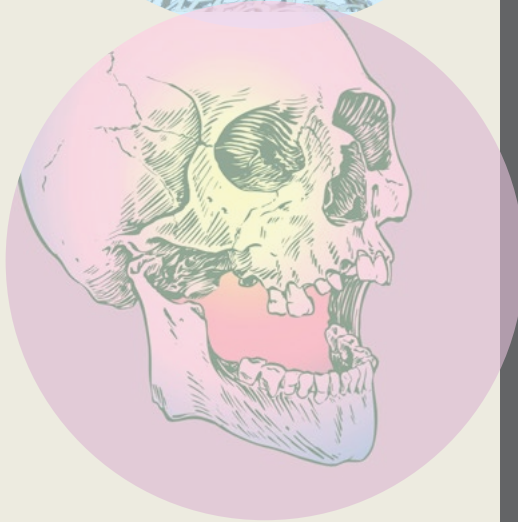
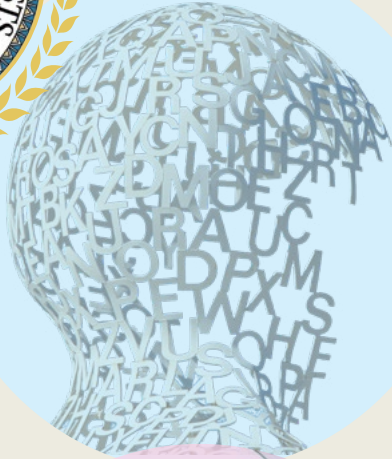
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JACD

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American College of Dentists



Standards for Leadership in Oral Healthcare

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ethics, professionalism,
leadership, and excellence
in dentistry.**

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- F. To encourage the free exchange of ideas and experiences in the interest of better service to the patient;
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The Birth of Standards for Leadership in Oral Healthcare

Sir Nairn H. F. Wilson CBE

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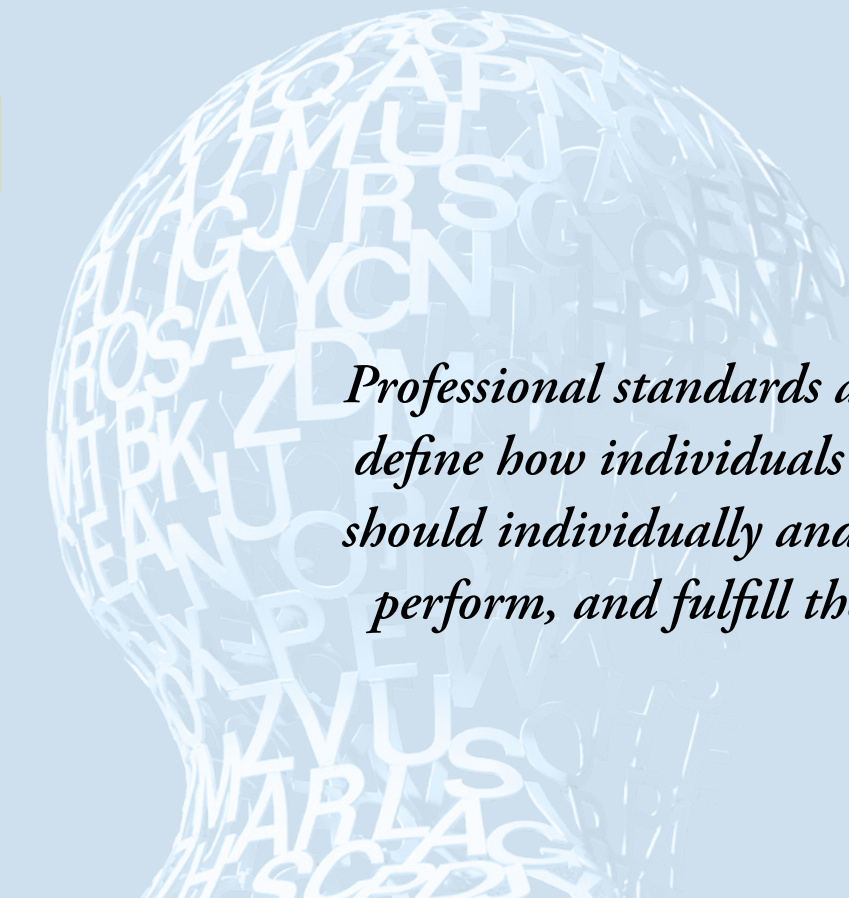
LISTEN TO THIS ARTICLE

Dentistry has well-established, widely accepted standards in clinical practice, education, and research, but not in leadership in oral healthcare. This critical gap was brought to the attention of the American College of Dentists (ACD; the College) at its Annual Meeting and Convocation in New Orleans in 2025. To the great credit of the College, this gap quickly became a focus of new attention, given the evidence from across healthcare that effective leadership in the provision of patient care is associated with improved outcomes, higher staff engagement, and stronger organizational resilience. These findings, supported by emerging research in primary dental care, which has revealed that effective leadership positively influences team cohesion, patient engagement, quality of care, outcomes, and practice performance, were good cause for decisive action.

In beginning to address the need for standards for leadership in oral healthcare, the College shrewdly determined the need for ethically grounded, evidence-based standards for leadership at the chairside and at the practice, regional, national and international levels. This rapid response, which stimulated some intense out-of-the-box thinking, was followed by the

formation of a task group. This put the College at the forefront of standard setting for leadership in oral healthcare. Indeed, in taking the action it did, the College catapulted itself into spearheading an initiative of international importance, with the potential to transform leadership in oral healthcare globally.

The task group formed by the College in early 2025 comprised past Presidents Terri Dolan and Robert "Bob" Faiella (chair), Sreenivas (Sree) Koka and Karl Haden, Michael Graham (executive director), Suzan Pitman (program director), and Sir Nairn Wilson. Working at speed, draft standards, drawing heavily on the *Ethics Handbook for Dentistry* and aligned with internationally recognized principles of service (selflessness, integrity, objectivity, accountability, incorruptibility, openness, and honesty), were prepared, discussed, and revised in time to be the subject of the Fellows Forum at the 2025 Annual Meeting and Convocation of the College in Washington, DC. Valuable feedback from the Fellows Forum was used to refine the draft standards, which were stress-tested at the College's 2026 Spring Meeting.



Professional standards are expectations that define how individuals within a profession should individually and collectively behave, perform, and fulfill their responsibilities.

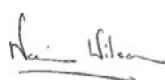
Subsequently, fellows of the College had the opportunity to comment on the draft standards prior to their consideration and approval by the College Board of Regents.

Comment on and support for the standards were then sought from a wide range of dental bodies and organizations nationally and internationally. Feedback has been positive. This issue of the College journal complements the launch of the new standards.

In this issue, members of the task force and others detail and discuss the new standards, indicating how they may be applied to the best possible advantage. The College is to be congratulated on having completed the Standards for Leadership in Oral Healthcare project, from inception to launch, in under twenty months—a remarkable achievement. The challenge now is to have the standards adopted and applied first and foremost for the benefit of patients and to strengthen trust in the profession. Another early challenge will be the inclusion of instruction in leadership in oral healthcare in dental schools to help students prepare to be effective leaders in their future service to society and the profession.

The new ACD mission-centric standards in oral healthcare, which I am proud to have played a part in creating, represent a timely, transformational advancement in leadership expectations for all other healthcare professionals. Adoption and application of these standards, which could be applied in other branches of healthcare, may be anticipated to enhance quality of care, patient safety, and the resilience of the dental team. In addition, these standards will strengthen the standing and status of the profession and reinforce its capacity to meet future challenges, specifically reasserting the role of dentistry in the provision of healthcare in general and sustaining the trust placed in dentistry by patients, communities, and society.

ACD is building on its distinguished past, pathfinding a dynamic future for the provision of oral healthcare.



Sir Nairn Wilson CBE

What a great contribution to the dental editors' community with your piece in *JACD* on generative artificial intelligence. This is going to be directly useful to a lot of folks. The article is rich in examples of dangers associated with over-acceptance of claims. The AADEJ Desk-Side Tool is practical and good, plain advice for editors.

When I was an undergraduate back in the days of hand-cranked computers, we were already deep into neural network logic and machine learning. As far as I can tell, humans and machines learn the same way – modifying expectations based on the trail of experiences. We keep doing what works while probing for better approaches. Just for fun, I reread the *JACD* piece, substituting the term “professional colleague who claims to be an expert” wherever GAI was used. Reads pretty well. It is the user standards that matter, not the delivery system.

Perhaps there is a distinction between AI and GAI where, roughly, one answers questions and the other makes things. I did a PubMed search to see whether patients who use AI have worse oral health or attend the dentist less often. I think that is pretty much an AI operation. Orthodontists now print aligners in their offices based on computer-generated imaging. That sounds like GAI. The distinction between a paper I write based on extensive research and one the computer produces using the same input is a distinction that needs to be worked out. Both might be identically informative to editors, practitioners, and patients.

What really stands out in the article is the stress on responsibility for how information is applied. No claim comes with a certificate guaranteeing universal applicability in all situations. Context matters. Yuval Noah Harari's most recent book, *Nexus: A Brief History of Information Networks from the Stone Age to AI*, is a useful 500-page argument that what makes information valuable hasn't changed, but who participates in sharing it and their motives have.

Standards for sharing information play a part in guiding the process. Our literature is silent on empirical evidence that reviewers for dental journals agree with each other regarding the appropriateness of published claims (ACD did at one time publish average consistency of reviews). I would be delighted to participate in research with colleagues in AADEJ and ACD to gather data regarding the extent to which journal reviewers agree with each other and whether practitioners readily pick up published claims and verify their utility in practice. Much of what matters in oral health does not take place in the dental office. A paper in the *CME Journal of Geriatric Medicine* in April of this year reported that patients who use AI more regularly also attend their dentists more frequently. DOI: 10.61336/cmejgm/2026-04-48

The very rapidly expanding information base in oral health may be changing who is responsible.

Alan Turing, who proved the general computing theorem for machines, proposed a test for AI usefulness. When humans interact behind a screen with either another person or a machine but cannot tell the difference, there is no difference. There are two ways to pass the Turing test: smarter machines and more careless people.

David Chambers, Ed.M., M.B.A., Ph.D., FACD

Dear David,

Thank you for your thoughtful response to my JACD article, *Lessons on Generative Artificial Intelligence from the AADEJ*. I'm gratified that you identified the central message: it is humans, not the technology, who must take responsibility for how information is created and applied. Thank you also for recognizing the AADEJ Desk-Side Tool for the practical advice it offers writers and editors. The tool is a distillation of insights into the technical, operational, legal, and ethical risks of large language model generative artificial intelligence (LLM GAI), drawn from an AADEJ panel's evidence-based review that informed the paper *Guidance for Authors, Editors and Publishers on the Use of Generative AI*. The full paper, available on AADEJ.org, builds practical understanding for readers of how, why, and what to do about the risks posed by GAI. <https://www.aadej.org/guidance-for-use-of-generative-ai>

Your exercise in reading my JACD article, replacing GAI with the phrase "a professional colleague who claims to be an expert," conjured up memories of the character Cliff Clavin from the TV show *Cheers*. The problem with Cliff isn't that he's ignorant; he has an abundance of *information* to draw on. The issue is that he delivers *knowledge* with confidence, even when it's something he's just making up on the spot. He's fluent and quick, sounds authoritative, synthesizes accurate trivia with self-assured babble, and rarely says "I'm not sure"; instead, Cliff hallucinates something wrong-but-plausible rather than admitting he doesn't have the answer. That maps well to the risks posed by GAI.

I agree that user standards matter more than the delivery system. Evaluating the validity, reliability, and applicability of the information we rely on to draw conclusions depends on the principles of critical appraisal that underpin evidence-based dentistry: assessing the strength of the evidence, the rigor of the study design, the accuracy of citations, the quality of peer review, and the credibility of the source. These principles guide the editorial process in supporting the appropriateness of published claims, with the ultimate responsibility resting with authors, reviewers, editors, clinicians, and readers.

For routine writing with LLM GAI, I offer a strategy called "write first" to help authors mitigate the risks posed by GAI. In this approach, the human author

drafts the text with citations, and the GAI tool is used to refine grammar and suggest revisions that best support the thesis, resulting in a concise manuscript with a logical flow. This process relies on the author's intellectual input rather than AI-generated text, making it easier for the author to review because it is grounded in their original citations and thoughts.

In professional literature, source grounding is another strategy to help users reduce the risk of GAI models searching for answers they don't have. Structured, grounded models are designed to stay within a bounded universe of provided source files rather than rely on training data or wander off to the internet to derive a response of "what sounds right." If the answer isn't in the provided source documents, the structured response is "not found," rather than a plausible-sounding fabrication.

An example is the clinical AI tool "OpenEvidence," which grounds its source literature in PubMed, The New England Journal of Medicine, JADA, and other rigorously peer-reviewed sources. By grounding the data in recognized, valid, and reliable sources and structuring the tool to avoid searching dubious web sources when it doesn't find an answer, the best evidence is rapidly presented with citations, conveniently accessible to the clinician for critical assessment. This enhances workflow that supports the traditional EBD process, which, I believe, creates the greatest value for using GAI. Known barriers to implementing EBD include limited awareness of trusted resources and workflow time constraints. GAI holds promise for promoting evidence-based practice by drawing on grounded, evidence-based sources and making practitioners aware of published guidance with verifiable practice utility.

The challenge posed by the Turing Test is not merely creating convincing AI but maintaining rigorous human evaluation to prevent "careless people" from becoming the limiting factor. Although GAI hallucinations are not as readily identifiable as Cliff Calvin's humorous observations, colleagues can mitigate the risks by being aware of its limitations and adhering to standards and strategies for responsible use.

Sincerely,

Christopher J. Smiley, DDS, CDE, FACD, FICD

What Is a Standard? Perspectives on ACD's Standards for Leadership in Oral Healthcare



N. Karl Haden, PhD, FACD
President, The Academy for Advancing Leadership



LISTEN TO THIS ARTICLE

The American College of Dentists' new Standards for Leadership in Oral Healthcare mark the first attempt in dentistry to articulate standards specifically for leadership, complementing the broader orientation offered by the *Ethics Handbook for Dentistry*. This article explores the basic question, "What is a standard?" Close reading of the document indicates at least three distinct but related senses of the term: an expectation, a norm, and a guiding principle. The article offers an interpretation of how these three senses fit together coherently. Referencing the *Handbook*, the article argues that the leadership standards are most impactful only when habituated, when practiced until they are no longer an expectation but a disposition of character. The article traces how the standards, when properly internalized, answer the question, "What kind of leader ought I to be?" The ACD Standards for Leadership in Oral Healthcare's most important contribution is not compliance but character. Sustained across the dental profession, the standards can ensure dentistry is a profession built on trust.

Keywords: leadership standards, norms, character, habits, leadership competencies, oral healthcare

The ACD Standards for Leadership in Oral Healthcare's most important contribution is not compliance but character. Sustained across the dental profession, the standards can ensure dentistry is a profession built on trust.

The American College of Dentists (ACD) describes the *Ethics Handbook for Dentistry* as a compass, orienting the profession toward compassionate and patient-centered oral healthcare. The *Handbook* codifies the College's four pillars: ethics, professionalism, leadership, and excellence. This article focuses on leadership, described in the *Handbook* as "characterized by personal character, integrity, and commitment."¹ Leadership roles are outlined in four areas: role modeling, team leadership, patient guidance, and engagement with the broader community and health system, each area widening the circle of the leader's impact. As a compass, the *Handbook* points the individual leader in the right direction, but it does not include guidance necessary for exceptional leadership at the level of a section chair, a regent, or a national officer.

Even an experienced sailor needs a nautical chart in addition to a compass to guide the ship successfully through unfamiliar waters. The College's new Standards for Leadership in Oral Healthcare are the chart that complements the compass.² In what follows, I examine what the Task Force means by "standard"—first as an expectation, then as a norm, and lastly as a guiding principle. I argue that a standard read this way does its work only when habituated: practiced until it is no longer a rule but a disposition of character. I conclude by examining how the ACD standards contribute to shaping and sustaining the character of and trust in the dental profession.

The Standards as Expectations

A search for standards and policy documents published by major U.S. associations in medicine, nursing, pharmacy, physical and occupational therapy, public health, psychology, social work, veterinary

medicine, and physician assistant practice found only one comparable document to the Standards for Leadership in Oral Healthcare: the *Scope and Standards of Practice for Nursing Leadership*,³ assessed through targeted web searches rather than a systematic literature review. Outside of the health professions, the Professional Standards for Educational Leaders⁴ and *Army Leadership and the Profession*⁵ are two notable documents delineating standards for leadership. A review of these documents and others shows that the meaning and application of "standard" vary widely.

What passes for a standard bears a resemblance to other concepts such as competencies (knowledge, skills, and attitudes), values (beliefs about what is important, particularly in our relationships to others), and behaviors. In the Background and Conclusion of ACD's Standards for Leadership in Oral Healthcare, standards are identified as competencies and behaviors. Virtues or character strengths also inform the standards. Those specifically named include humility, empathy, respect, integrity, openness, accountability, objectivity, selflessness, honesty, incorruptibility, and trust.

What is in a standard? Standards are composed of statements that articulate competencies, values, behaviors, and virtues. The Task Force defines standards as expectations: "These standards define core leadership expectations...."² The document mentions "expect" or "expectation" 12 times. In essence, the standards are the competencies, behaviors, and virtues expected of a leader in oral healthcare. They are the benchmark, to use another term from the document, against which a leader's performance and development are measured.

What is a Standard? What Is a Standard? Perspectives on ACD's Standards for Leadership in Oral Healthcare

N. Karl Haden, PhD, FACD

The Standards as Norms

The Task Force adds another perspective on the meaning of standards by linking them with norms: "Without standards, there are no behavioral and attitudinal norms."² In a social or cultural context, norms are usually unstated; they are unwritten codes of acceptable behavior of people in a group, community, or society. When stated, they describe behaviors that are considered normal—for example, saying thank you when one receives a gift. Norms, as descriptions of what people—and leaders—actually do, exist independently of anything written down. So, for what reason would the Task Force aver that standards are necessary for behavioral and attitudinal norms?

As used in the Standards for Leadership in Oral Healthcare, standards are not descriptive norms; they do not describe how things are, but rather how they ought to be. Consider Core Standard 1: "Put the interests of others you serve first – Prioritize patient welfare above personal or organizational gain."² We know that not all leaders in oral healthcare put the interests of others they serve first. Standard 1 is shorthand for stating, "The leader in oral healthcare ought to put the interests of those they serve first...." All 40 standards include the same construction. Each standard begins with a verb forming an imperative statement. They are not descriptive norms, but prescriptive norms; they are meant to read as normative for the competencies, behaviors, and virtues that leaders in oral healthcare should embody.

The Standards as Guiding Principles

The prescriptive nature of the standards is their strength and makes the Standards for Leadership in Oral Healthcare distinctive. If they are not presented as normative, then the document becomes another compass. From core standards to team standards, and from local and regional leadership to national and international leadership, the specificity of the

standards describes the behaviors and attitudes required to lead well across progressively more expansive leadership responsibilities.

In the Background section, the Standards for Leadership in Oral Healthcare seem to offer two different, and perhaps incompatible, perspectives on the standards, referring to the standards as "expectations and guiding principles that define the responsibilities and performance expected of individual practitioners and those serving in leadership roles within oral healthcare."² Guiding principles are usually stated in general terms and lack the specificity of expectations. The Standards for Leadership in Oral Healthcare contain 40 specific statements about expectations for leaders. But viewed from the perspective of a guiding principle, this reveals an important nuance in how these standards should be interpreted, practiced, and habituated.

They are not binary rules, functioning like a compliance checkbox, but principles that the leader must interpret and apply in the context of leading. They are not absolutes, but are relative to the leader and the situation. For example, how a leader implements the team leadership standards in a dental office will be different from how that leader expresses them in a professional organization. In addition, leaders have different personalities and life experiences, which also add to the variability of how standards as expectations are exhibited. Lastly, effective leaders grow and mature over time. For example, the way that they build strong stakeholder relationships (Local and Regional Leadership, Standard 2) will likely improve over time with experience and reflective learning. This relativity does not undermine the standards. As benchmarks, they are calibrated across a career to the leader who must meet them.

The Standards as Leadership Habits

The Standards for Leadership in Oral Healthcare complement the *Ethics Handbook for Dentistry* in

What is the right way? Leaders in oral health can read the standards, study them, critique them, and know them verbatim. They can also comply with the standards in the same way that one complies with a protocol, a set of rules, or a procedure. But a standard that is only complied with, not internalized, is fragile when stressed, particularly by self-interest.

the same way that a nautical chart complements a compass. The standards are a comprehensive, if not exhaustive, specification of the competencies, behaviors, and virtues described in the *Handbook*. The *Handbook* captures how the standards are best exemplified: "Leadership is characterized by personal character, integrity, and commitment."¹ I interpret "characterized by" not as an epistemic claim—that leadership is known by integrity and commitment—but as a constitutive claim: Leadership consists in personal character, integrity, and commitment. Integrity and commitment, on this reading, are not additions to character so much as its expressions. Virtue ethics asks the question, "What kind of person ought I to be?" This is a question of personal character, which in turn informs what kind of leader one is. The Standards for Leadership in Oral Healthcare answer the question, "What kind of leader ought I to be?" Following the standards in the right way is a character-forming journey.

What is the right way? Leaders in oral health can read the standards, study them, critique them, and know them verbatim. They can also comply with the standards in the same way that one complies with a protocol, a set of rules, or a procedure. But a standard that is only complied with, not internalized, is fragile when stressed, particularly by self-interest. Not all the standards include ethical considerations, but many of them do. And the standards are like ethics in this regard: The essence of ethics is not that one knows a lot about ethics or complies with the rules but that one becomes an ethical person—intent and motivation matter. Likewise, the point of the

standards is that they become normative to a leader through habituation.

Standards prescribe, but when done often enough, they are internalized and adhering to them stops being a prescription. The norm, which may begin as external imposition, becomes a disposition of character when the leader repeatedly acts on it as a personal expectation. For example, a section leader who treats Core Standard 7—seek assistance early—as a rule before deciding whether to ask for help has not yet arrived at the humility required by this standard. However, the leader who no longer needs to comply with the rule, who asks for help because asking has become who the leader is, has made the standard a habit. The first leader has satisfied the standard, but the second one has been transformed by it. For the experienced captain, reading the navigational chart is not a separate act from sailing the ship.

Conclusion: The Standards as Basis for Trust

What is true for the individual leader is also true for the profession itself: "Individual and collective compliance with these standards is critical to maintaining professional standing, status, and, most importantly, trust in individuals, the profession, and its institutions."² One of the challenges arguably exacerbated in the profession today is making choices in the face of conflicting values. Where are the conflicts? They may exist in the context of different cultural values or the patient's philosophy of care in

What is a Standard? What Is a Standard? Perspectives on ACD's Standards for Leadership in Oral Healthcare

N. Karl Haden, PhD, FACD

conflict with the dentist's. They sometimes exist at the intersections of care and cost. They too often involve incongruities among self-interest, what's in the best interest of the patient, and the many interests represented by the entities that create the context and systems for healthcare. The profession needs individual and organizational leadership to meet these challenges.

The ACD Standards for Leadership in Oral Healthcare guide individual leaders, from the local to

the international level, with expectations that exhibit and develop both competence and character. They also send a message to patients, policymakers, industry, dental support organizations and managed group practices, allied health professions, and others about the character of the profession. The dental profession will not be advanced by this document, but by leaders who have made the standards their own expectations and by so doing ensure dentistry is a profession built on trust.

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Core Standards for Leadership in Oral Healthcare



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This article introduces the American College of Dentists' core standards for leadership in oral healthcare, grounded in well-established ethical principles and in response to ever-increasing expectations for patient-first care. It is suggested that the new standards must be consistently upheld to maintain patient trust and professional credibility. Effective leadership, in contrast to management, improves patient engagement and outcomes, team performance, and resilience. The article calls for more leadership training in dentistry, beginning in dental schools, and highlights the need for effective leadership in oral healthcare to strengthen the profession's standing and status.

Keywords: oral healthcare, leadership, core standards, training

Introduction

Core standards, which create, define, and determine the standing and status of a profession, are the principles that set minimum expectations. In other words, they are principles that apply to every professional in their individual and collective responsibility to uphold and maintain the reputation and public trust in their profession.

The core standards for leadership in oral healthcare developed by the American College of Dentists (ACD; the College) are informed by the College's *Ethics Handbook for Dentistry* and the internationally recognized principles for service in society: selflessness, integrity, objectivity, accountability, incorruptibility, openness, and honesty, all of which underpin

The term “standards” as used in the ACD Standards for Leadership in Oral Healthcare is not intended to carry a legal or regulatory meaning.

Rather, it refers to expectations and guiding principles that define the responsibilities and performance expected of individual practitioners and those serving in leadership roles within oral healthcare.

trust and, in turn, faith in the profession. The term “standards” as used in the ACD Standards for Leadership in Oral Healthcare is not intended to carry a legal or regulatory meaning. Rather, it refers to expectations and guiding principles that define the responsibilities and performance expected of individual

practitioners and those serving in leadership roles within oral healthcare. Complying with the core standards should not pose a challenge. Rather, they should be a well-established element of everyday life and not a list of obligations, i.e., a virtue, providing a moral compass for all oral healthcare professionals.

The core standards aim to:

1. Enhance patient experience and outcomes through improved team effectiveness
2. Establish clear expectations for leadership behavior across all career stages
3. Provide a framework for leadership development and assessment
4. Assist leaders and the teams and organizations they lead to realize their potential
5. Strengthen the profession's ability to adapt to future challenges and ever-increasing expectations

Core standards

The core standards for leadership in oral healthcare are set out in Table 1. In providing chairside leadership in patient-centered care and leadership for the dental team, and even leadership in other situations, all the core standards are important. It is not a case of complying with the majority of the standards, because failure to comply with any one, let alone more than one of the 10 standards, runs the risk of losing hard-won trust. Also, excelling in certain aspects of the standards does not compensate for limitations in other aspects. What is required is strong, well-balanced, if not excellent, compliance across all aspects of the standards. Standing and respect as a healthcare professional are accompanied by expectations. Hopefully, the expectations embodied in the core standards come as no surprise to established practitioners.

Table 1. The American College of Dentists' core standards for leadership in oral healthcare

- 1. Put the interests of others you serve first**
– Prioritize patient welfare above personal or organizational gain.
- 2. Act with purpose, setting aside bias or prejudice,** to ensure decisions and actions are based on fairness, clinical evidence, and professional judgment.
- 3. Demonstrate humility, empathy, respect, integrity, openness, and accountability**
– Model the virtues you expect of other professionals.
- 4. Foster trust and confidence** – Build credibility through consistent, transparent actions, and effective communications.
- 5. Make sound, defensible decisions** based on best clinical practices, best-available evidence, and the values of the patient.
- 6. Acknowledge and address mistakes** – Admit to errors promptly, apologize where appropriate, and take corrective action.
- 7. Seek assistance early** – Request help or refer to avoid adverse outcomes.
- 8. Accept and respond to justifiable criticism**
– Objectively manage and apply lessons learned from valid criticisms.
- 9. Commit to lifelong learning** – Pursue continuing professional development relevant to your role and emergent needs and technologies, e.g., augmented intelligence, adapting to change.
- 10. Maintain personal well-being and resilience**
– Engage in reflection to sustain high-quality performance and ethical decision-making.

In summary, the standards are the behaviors and attitudes you may have expected of leaders in teams you have served in or would expect from a fellow healthcare professional leading a team responsible for your care or the care of a member of your family. A critical self-appraisal “look in the mirror” to compare yourself with the fellow healthcare professional you would wish to lead a team caring for you or a member of your family should not be a negative experience, let alone a much-needed wake-up call.

Impact

The limited evidence available indicates that the majority of dentists tend to acquire and apply management skills and traits rather than leadership skills and traits.¹ In the absence of leadership, management, albeit effective, may enable a team to function but only in a steady state, not evolving or keeping pace with ever-increasing expectations and possibly running the risk of suffering the effects of ever-decreasing circles. By contrast, leadership, specifically successful leadership in dentistry, has been found to be associated with enhanced quality of care, patient engagement, trust and safety, resilience of the dental team, and practice profitability²—a win-win outcome for patients and the dental team, with important spin-off benefits for the standing, status, and future-proofing of the profession. As stated by Carr et al., “Leadership matters because it is the only capability that can systematically bring out the best in people so they can achieve more together than they can alone.”³

Education

Given the importance of effective leadership in the provision of oral healthcare, resulting in enhanced clinical outcomes, patient safety

Core Standards for Leadership in Oral Healthcare

Sir Nairn H. F. Wilson CBE

and satisfaction, and strengthening of the dental team,² it is suggested that the sooner instruction in leadership in oral healthcare is included in primary dental degree programs, the better. In making this suggestion, it is acknowledged that primary dental degree program curricula are already crowded. However, time and space must be found for instruction in a capability that underpins the effective clinical practice of dentistry and strengthens the profession. Early-career dentists and established practitioners who have received no prior instruction in leadership in oral healthcare are strongly advised to seek such instruction, supported by mentorship. Thereafter, practitioners should seek to strengthen their leadership skills and capability through experience, ongoing learning, mentoring, and assessment, together with other activities such as membership of leadership study groups. Leadership in oral healthcare—a professional responsibility—should feature in all practitioners' plans for continuing professional development. There is always something new to learn about leadership and how to be an effective leader.

Future scoping

Predicting the future is inexact. It can, however, be predicted, with a high degree of certainty, that everyone involved in the provision of oral healthcare will face new and emerging challenges and opportunities. These

challenges and opportunities are linked to ever-increasing patient and regulatory expectations; transformational technological advances, including artificial and augmented intelligence; and, among other issues, evolving healthcare delivery models, with a focus on evidence-based, patient-centered, team-delivered care. Effective, fit-for-purpose leadership will be of critical importance to addressing, and wherever possible capitalizing on, upcoming challenges and opportunities, both expected and unexpected. Therefore, future generations of oral healthcare professionals should not only be prepared but inspired to accept the leadership baton when their time comes to lead by example, be the next generation of leadership teachers and mentors, and, in the process, serve as guardians of the standing and status of the profession. Opting out of responding to future leadership challenges would be a dereliction of professional duty and responsibility.

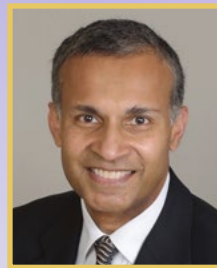
Conclusion

Core standards for leadership in oral healthcare provide a framework for developing effective leadership across the dental workforce. Adopting and applying these standards will benefit patients, strengthen dental teamwork and the profession's capacity to meet future challenges, and enhance patient and public trust, as well as the standing and status of dentistry.

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American College of Dentists Team Leadership Standards



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Leadership standards elevate the profession of dentistry by establishing how leaders can be effective and impactful. The American College of Dentists presents 10 carefully curated team leadership standards that serve as guiding principles for team leaders in dental settings. When these standards are followed, leaders increase the likelihood of creating and sustaining a high-performing, mission-focused team. The importance of each standard is described and, where appropriate, examples are provided.

Keywords: leadership, team leadership, leadership standards, patient-centered care

“No one looks around and says, ‘Where is that mediocre team? That’s what I want to be part of—a mediocre team.’ I don’t care whether you are flipping hamburgers, washing cars, playing sports, or in the military. Everyone wants to be part of something special...”

– Admiral William H. McRaven in *Make Your Bed: Little Things That Can Change Your Life...And Maybe the World*. Grand Central Publishing, 2017

Introduction

Leadership matters because it is the only capability that can systematically bring out the best in people so that they can achieve more together than they can alone.¹ The scientific literature highlights how healthcare relies on the performance of a team for excellent patient outcomes such as preventing adverse drug reactions,²⁻³ reducing mortality and morbidity rates,⁴⁻⁵ optimizing medication dosages,⁶ and overall providing safer and higher-quality care.⁷ Following on, a healthy team environment increases job fulfillment and leads to less work for team members.⁸ The same is true in dentistry. Effective leadership in private practice, a hospital clinic, the dental school setting, and any other environment in oral healthcare improves outcomes by including and communicating with team personnel,⁹ keeping the team focused on patient safety,¹⁰ and creating a culture of continuous improvement.¹¹

In the authors’ experience, one does not see a great team without great leadership. Great leaders understand their mission is to provide their team members with great leadership in the form of resources—both physical and emotional—so that they can do their jobs well and take care of patients. Simply put, a team

cannot provide great patient care unless it runs smoothly and team members are fully engaged in putting patients’ needs first. This can only happen with effective leadership and the selection of the right team members who believe in and live out the team’s mission.

As much as the aforementioned statements may seem intuitive, it is surprising that no set of standards exists to guide the creation and perpetuation of a high-performing oral healthcare team. The American College of Dentists (ACD), recognizing the critical role of leadership in fostering an environment for excellence in patient care, established 10 team leadership standards focused specifically on the team leader’s role. In doing so, the ACD standards provide a blueprint for leaders who are committed to serving patients and who understand that they cannot do so by clinical skill alone. These standards are for leaders who commit to becoming the best leader they can be because the mission demands it. Meeting these standards increases the likelihood of providing the leadership needed to deliver care with the highest levels of quality and safety, and to support team member well-being.

The standards are presented below along with a short summary perspective on each standard.

American College of Dentists Team Leadership Standards

1. **Ensure the patient's well-being** – Every decision is made with the patient's best interests, health, and values as the primary motivation.

Every healthcare environment states that the patient comes first. Yet the reality is that many do not put patients first because their decisions are influenced by incentives that seduce leaders and teams away from the patient's best interests. A team needs a leader who keeps focus on the patient and never promotes alternative approaches. As Colonel Peter Guevara states, "If you permit it, you promote it."¹² Leaders who permit actions that are not in the patient's best interests are undermining dentistry's code of ethics and the vow dental students take at their white coat ceremonies to always put the patient's needs first. Certainly, there are times when a leader must make very hard decisions in this regard. These are the decisions that define a leader.

2. **Lead with fairness and transparency** – Treat every team member with respect, integrity, and openness.

Transparency from a leader may be summed up by three axioms: (1) Tell your team members what you know; (2) tell your team members what you don't know; and (3) tell your team members how you will address #2. This kind of transparency brings team members together, as it signals three critical elements of highly functioning teams: that a leader trusts team members, that a leader is humble enough to share what they don't know, and that they are committed to improving.

Alexander den Heijer said, "When a flower doesn't bloom, you fix the environment in which it grows. You don't fix the flower."¹³

This quote lies at the heart of a leader's responsibility to ensure that mutual respect exists among team members. Modeling integrity and openness in communication leads to shared decision-making, a hallmark of successful teams. Furthermore, a just decision-making process, including those decisions related to personnel when they either fall short of or exceed the team's agreed-upon expectations, is imperative to create an environment perceived as fair and equitable.

A leader is also responsible for the kind of environment to be created and sustained to achieve the team's mission. Although a leader does not "fix the flower," a leader must choose the right "flowers" (team members). Following on, "flowers" that undermine the team in pursuit of the mission cannot remain on the team.

3. **Foster a culture of trust, inclusivity, and collaboration** – Actively create an environment where all voices are heard and valued.

Trust is the bedrock of all successful teams. It is hard to attain and easy to lose. One mistrustful episode can undo years of trust-building, because humans evolved to be hypersensitive to betrayal. Therefore, prudent leaders must view all their behaviors and decisions in terms of whether trust will be enhanced or diminished. Gaining trust is much easier when all team members feel valued and included. Hence, communication must be a two-way experience. Information must flow to team members, feedback must be sought from team members, and that feedback must be truly heard by the leader. The importance of information flow was discussed earlier as a key to transparency.

The highest-performing teams are careful about how collaboration and competition among team members are encouraged or discouraged. In general, competition between

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teams can be productive, as can competition to determine who is brought onto a team, e.g., an interview process can be considered a form of competition. However, competition between team members is fraught with the risk of creating winners and losers, leading to a dire situation in which, for one team member to win, another must lose. This leads to some team members feeling excluded, and the team could unravel. By contrast, high-performing teams institute systems and processes that incentivize collaboration among team members rather than competition. The highest ceiling for a team is always a result of collaboration when all team members are invested in the performance of their fellow team members in the pursuit of their shared noble mission.

4. **Lead by example** – Model professionalism, ethical behavior, and clinical excellence in daily practice.

Team members assess their leader's credibility by determining whether the leader behaves consistently with the leader's stated values and the organization's mission. A leader who says one thing and then behaves in a contradictory manner will lose the trust and respect of team members. By contrast, a professional leader who leads by example and conducts herself/himself in a professional manner that promotes excellence will be followed. The acronym "DYDWYSYWD" represents the phrase, "Do you do what you say you will do?" and is an excellent reminder to lead by example.¹⁴

In his book *From Values to Action*, Kraemer describes four key principles of leadership, all of which promote leading by example.¹⁵

- **Self-reflection** – Here, leaders reflect on what they stand for, their values, and what matters most to them.
- **Balance** – Balanced leaders see situations from many different perspectives to gain a holistic and multifaceted understanding.
- **True self-confidence** – Here, leaders accept themselves for who they are, recognize their weaknesses and strengths, and are always trying to improve.
- **Humility** – Humble leaders don't forget who they are; they appreciate the positive values in all and treat everyone with respect regardless of celebrity, wealth, power, title, education level, or role.

5. **Ensure team effectiveness** – Align people, attitudes, behavior, processes, and resources to deliver safe, high-quality care and achieve the team's mission; be alert to and effectively manage conflicts.

The judicious implementation of systems and processes will foster the team's effectiveness in achieving its mission. One model that was learned by one of the co-authors during leadership development programming at Northwestern's Kellogg School of Management is to leverage four specific actions:¹⁶

1. Empower
2. Enhance
3. Enable
4. Engage

Intentionally committing to all four of these actions and building conversations around what is best for the patient helps center the decisions that follow on the prime directive of

patient care. These decisions will require an attitude of "we can only achieve our mission by working together" and behaviors that reinforce collaboration.

An example from Mayo Clinic is that all consultants in the Department of Dental Specialties, regardless of specialty, years of practice, patients seen, clinical income, publications, or grants, receive the same salary. By removing salary as a variable in the equation, the consultants are free to focus on the other, arguably more important, elements of creating the team environment needed to serve the patient's best interests. Indeed, this salary structure extends across all clinical divisions/departments at Mayo Clinic.

A dark side to leadership is the necessity to confront individuals who are not aligned with the mission and whose actions undermine the work of other mission-aligned team members.¹⁷ Ideally, a nurturing leadership environment offers a path for realignment based on constructive criticism by leaders and a team member's willingness to improve. But when the misalignment is around values and attitude, difficult decisions related to whether someone needs to be let go, albeit painful in the short term, must be made. In doing so, the message from the leader is that for a team to be effective, attitude and values are as important as technical skills or work ethic. Why a team member comes to work matters.

6. **Assume responsibility for decision-making and delegation** – Own the outcomes of the team's choices and actions.

Shared decision-making, where all team members contribute and consensus is reached, is ideal.

Because many times consensus is not attained and the leader must make difficult

decisions, these actions described earlier significantly increase the probability that unpopular decisions will be supported and/or accepted by team members. Ultimately, the final responsibility for these decisions lies with team leaders, and they must accept responsibility for their decisions.

Effective leaders understand that their role is to protect their teams by accepting responsibility for failures or suboptimal outcomes while giving credit to team members for the team's successes. In doing so, effective leaders exhibit one of the most important qualities of effective leaders: humility. A team will work harder for a humble leader because humility signals that a leader places the mission, the team as a collective, and team members as individuals before their own motives.

7. **Support team well-being and resilience** – Recognize and address burnout, stress, and professional challenges.

All healthcare professions are struggling with high stress and high burnout among their ranks. In turn, the number of colleagues who are cutting back or leaving the profession altogether is on the rise. Inasmuch as prevention is better than cure, an environment that both prevents burnout and promotes resilience is necessary. A sense of belonging to a caring community is one of the best ways to prevent burnout. Although tempting, resisting the wrong priorities such as profit or maximum efficiency at the expense of togetherness is mandatory. Programming to build well-being and community is necessary, as it takes communication and activities to show team members that their well-being is a priority.

It is also important that leaders prioritize their own well-being. Leaders who are in distress may harm the team. Therefore, every leader

should learn the signals that indicate they are struggling or close to struggling, knowing that each leader has different signals, reactions, and solutions. As discussed earlier, two capabilities of effective leaders are the ability to self-reflect and attain balance. Both capabilities help leaders prevent their own burnout and promote their well-being.

8. **Promote continuous professional development** – Embed a reflective ethos of learning and continuous improvement.

Teams that continuously strive to improve understand that resources don't just come in the form of equipment, supplies, people, money, and space. These "physical" resources need to be utilized optimally and, to do so, require continuous improvement of "emotional" resources such as culture, trust, selflessness, mission focus, etc. Many teams mistakenly believe that accumulating more physical resources will solve their problems. The reality is that truly great teams optimize both physical and emotional resources because the synergy is exponentially powerful. In professional settings, leaders who view themselves as a "coach" of their team members often attain greater engagement and better morale. Therefore, investing in leadership, management, and team-building skills is vital.

9. **Encourage feedback on leadership** – Invite constructive input to strengthen the team and help develop leadership insights, capabilities, and performance.

It can be difficult to signal humility. Asking for feedback, sharing the results of the feedback process, and committing to improve as a leader by seeking guidance from team members on how to improve demonstrate that a leader cares deeply about learning how to better serve the

A compassionate and strategic leader understands that showing appreciation for work done well is necessary because team members who truly care about the mission like to know that their work is making a difference in the pursuit of that mission.

team. Engaging in leadership development programs to build the capabilities and skills needed to lead effectively can have a profound impact on a leader. Team members want to follow a confident and capable leader. An effective leader understands that confident performance is a highly desirable consequence of humility.

Along with feedback about leaders on a personal level, feedback on the team itself is valuable to gather and review. Important questions are, "Are team members functioning well together?" "Are the 'what' and 'how' of the team's approach aligned with the team's 'why'?" etc. Feedback from these questions will reveal impediments to progress, and leaders must go out of their way to create a trusting environment where team members are safe sharing their thoughts and feelings.

10. **Acknowledge good performance** – Express appreciation for professional contributions.

A compassionate and strategic leader understands that showing appreciation for work done well is necessary because team members who truly care about the mission like to know that their work is making a difference in the pursuit of that mission. Each person has a different way of wanting to be appreciated; however, a good leader will take the time to learn what works and what

doesn't for each team member. There can be confusion about whether it is "fair" to treat people differently. Much as parents treat their children differently based on each child's needs and personality, the same is true for team members. It is better to determine how team members respond to appreciation, then appreciate them accordingly. While doing so, leaders must be transparent about their intent and why the different forms are present. Often, sharing this kind of information builds trust within a team and shows that everyone's contributions are important enough to warrant individualized appreciation. At the same time, leaders must maintain a professional distance between themselves and their team members. Many leaders have learned the hard way that this distance is vital to their ability to be fair and to make difficult decisions without inviting accusations of favoritism based on friendships. In this regard, leadership can feel lonely.

Conclusion

The ACD's 10 Team Leadership Standards are designed to guide dental professionals in forming and sustaining mission-driven, patient-centered teams. By meeting these standards, leaders will serve the best interests of patients and team members and exemplify the ACD's mission of ethical, humane, and professional leadership.

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Standards for Leadership in Oral Healthcare: Applying Local and Regional Standards in Practice



Teresa A. Dolan, DDS, MPH, FACD
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The dental profession has well-established standards governing clinical practice, education, and research, yet has lacked comparable standards to guide leadership behavior. The American College of Dentists (ACD) Standards for Leadership in Oral Healthcare Task Force developed a comprehensive framework spanning four levels: 1) core; 2) team; 3) local and regional; and 4) national and international. This article describes the local and regional standards, which include 10 standards organized into three themes—Building Foundation, Leading with Purpose, and Developing Others—and their application through interactive workshops at the ACD Spring Leadership Conference 2026. Using structured role-playing exercises, Section leaders and Regents stress-tested the standards against three realistic scenarios: balancing corporate sponsorship with professional independence, addressing an underperforming colleague, and evaluating a nominee with undocumented ethical concerns. Discussions validated the standards' practical utility while identifying critical needs for operational policies, implementation tools, and training to support consistent application. Local and regional leadership is where the ACD mission becomes tangible; these standards provide a framework for leading with intention, integrity, and impact across the profession.

Keywords: leadership standards, oral healthcare, organized dentistry, local and regional leadership, professional development, dental ethics, leadership competencies

Standards for Leadership in Oral Healthcare: Applying Local and Regional Standards in Practice

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Introduction: The Significance of Standards for Leadership in Oral Healthcare

The oral health profession faces a complex and rapidly evolving landscape: rising patient expectations, transformational technological advances, persistent workforce shortages, and fundamental shifts in healthcare delivery models. Meeting these challenges demands exceptional leadership at every level of the profession—from individual practitioners at chairside to those leading national and international organizations. Yet, despite decades of progress in establishing standards for clinical practice, dental education, and oral health research, the profession has conspicuously lacked standards to guide leadership itself.

This absence is consequential. As Carr and colleagues observed, “Leadership matters because it is the only capability that can systematically bring out the best in people so they can achieve more together than they can alone.”¹ Without agreed-upon standards, leadership development in dentistry has been inconsistent, behavioral norms for leaders have been undefined, and those stepping into leadership roles have lacked clear guidance on what is expected of them. This void has caused a disservice to the profession and, ultimately, to the patients it serves.

In response, the American College of Dentists (ACD) established a Standards for Leadership in Oral Healthcare Task Force in 2024 to develop the first comprehensive leadership standards framework for the dental profession. Chaired by Dr. Robert Faiella and comprising Drs. Teresa Dolan, Sreenivas Koka, Karl Haden, and Nairn Wilson, the Task Force guided a deliberate, consultative development process grounded in the ACD *Ethics Handbook for Dentistry*² and internationally recognized principles of public service:

selflessness, integrity, objectivity, accountability, incorruptibility, openness, and honesty.

Research across healthcare settings supports the importance of this work. Studies have demonstrated clear links between effective leadership and improved patient outcomes, staff satisfaction, and organizational performance. Healthcare organizations with strong leadership report meaningfully better patient satisfaction scores and higher staff engagement.^{3,4} Research specific to dental practice similarly indicates that leadership effectiveness correlates with treatment plan acceptance rates, quality of care metrics, team retention, and practice profitability.^{5,6}

The resulting framework, *Standards for Leadership in Oral Healthcare*, establishes expectations for professional leadership behavior across four levels: core standards applicable to all dentists; team leadership standards; local and regional leadership standards; and national and international leadership standards. This article describes the local and regional standards, the rationale for their importance, and findings from interactive workshops in which ACD Section leaders and Regents applied the standards to realistic leadership dilemmas.

The Void in Leadership Standards for Oral Health

Dentistry has developed robust standards in three domains of professional practice. Clinical practice standards define quality of care expectations and protect patient safety. Educational standards establish requirements for learning environments and minimum levels of attainment. Research standards ensure ethical conduct, reliability of findings, and transparent reporting. These standards have elevated professional performance and public trust across each domain.

Leadership, however, has remained the exception. Unlike clinical or educational

Local and regional leaders also serve as the critical bridge connecting grassroots practitioners to the broader national and international professional agenda. Their decisions about Fellowship nominations, continuing education programming, community outreach, and collegial accountability directly reflect and shape the values and standards of the profession at large.

competencies, leadership behavior in oral healthcare has not been subject to defined professional expectations. Without shared standards, leadership development programs across dental schools, professional associations, and practice organizations have varied widely in content and emphasis. Aspiring leaders have had no consistent framework against which to assess their own development, and the profession has missed opportunities to systematically cultivate the leadership capabilities needed to advance oral health.

The Standards for Leadership in Oral Healthcare are designed to fill this void. Importantly, they are not intended to replace the many valuable leadership development programs that already exist within organized dentistry and dental education. Rather, they establish a shared professional foundation or a baseline of expectations from which all programs can build and against which all leaders can reflect and grow.

Why Local and Regional Leadership Matters

Among the four levels of leadership addressed in the standards, local and regional leadership holds particular significance. It is at this level—within ACD Sections and Regencies, state dental associations, local dental societies, and community-based professional networks—that

most Fellows first experience and develop leadership skills. It is here that the mission of organized dentistry becomes tangible in the daily lives of practitioners and communities.

Local and regional leadership is distinctive in several important ways. First, context matters: Legal, regulatory, and cultural factors can vary across regions, requiring leaders to understand and navigate local expectations while upholding universal professional principles. Second, the focus is inherently external. Effective local leaders must build relationships and partnerships beyond their immediate teams, engaging with stakeholders, community organizations, media, and interprofessional partners. Third, the scope is strategic. Local leaders often plan and act across multiple practices, institutions, and organizations rather than within a single clinical or administrative setting. Fourth, the potential for collective impact is substantial. Change at the local and regional level reverberates throughout communities, shaping the professional culture in which dentists practice every day.

Local and regional leaders also serve as the critical bridge connecting grassroots practitioners to the broader national and international professional agenda. Their decisions about Fellowship nominations, continuing education programming, community outreach, and collegial accountability directly reflect and shape the values and standards of the profession at large.

Standards for Leadership in Oral Healthcare: Applying Local and Regional Standards in Practice

Teresa A. Dolan, DDS, MPH, FACD; and Robin Henderson, DDS, FACD

The Local and Regional Leadership Standards: 10 Standards, Three Themes

The 10 local and regional leadership standards are organized into three thematic clusters that reflect the distinctive responsibilities of leaders at this level.

Theme 1: Building Foundation (Standards 1–3)

Standard 1: Understand local and regional leadership requirements.

Effective local leaders must understand the specific legal, regulatory, and cultural context of their region. This knowledge enables them to act appropriately, avoid inadvertent violations, and build the credibility that generates trust among Fellows, colleagues, and community stakeholders.

Standard 2: Build strong stakeholder relationships.

Leadership at this level requires active cultivation of relationships across a broad range of entities—professional associations, community organizations, educational institutions, and media—not simply within one's immediate network. Effective communication builds standing and extends the profession's reach and influence.

Standard 3: Foster collaborative partnerships.

The complex challenges facing oral healthcare cannot be addressed by dentistry alone. Local leaders who forge and sustain strategic partnerships with medicine, public health, education, and community organizations amplify their impact and model interprofessional collaboration.

Theme 2: Leading with Purpose (Standards 4–6)

Standard 4: Promote ethical and professional behavior.

Local leaders shape organizational culture through their own conduct and through the expectations they establish and model. Promoting ethical, inclusive professional culture is not incidental to leadership—it is a primary responsibility.

Standard 5: Lead strategically.

Effective local leaders look forward, anticipate challenges, plan strategically, and inspire their communities toward continuous improvement—actively advancing the quality of leadership across their region rather than simply maintaining the status quo.

Standard 6: Be accountable and consultative.

Accountability at the local level means seeking input from those one serves, acting transparently, and treating feedback as an essential tool for growth. This standard reflects the principle that leadership development is an ongoing, reflective process.

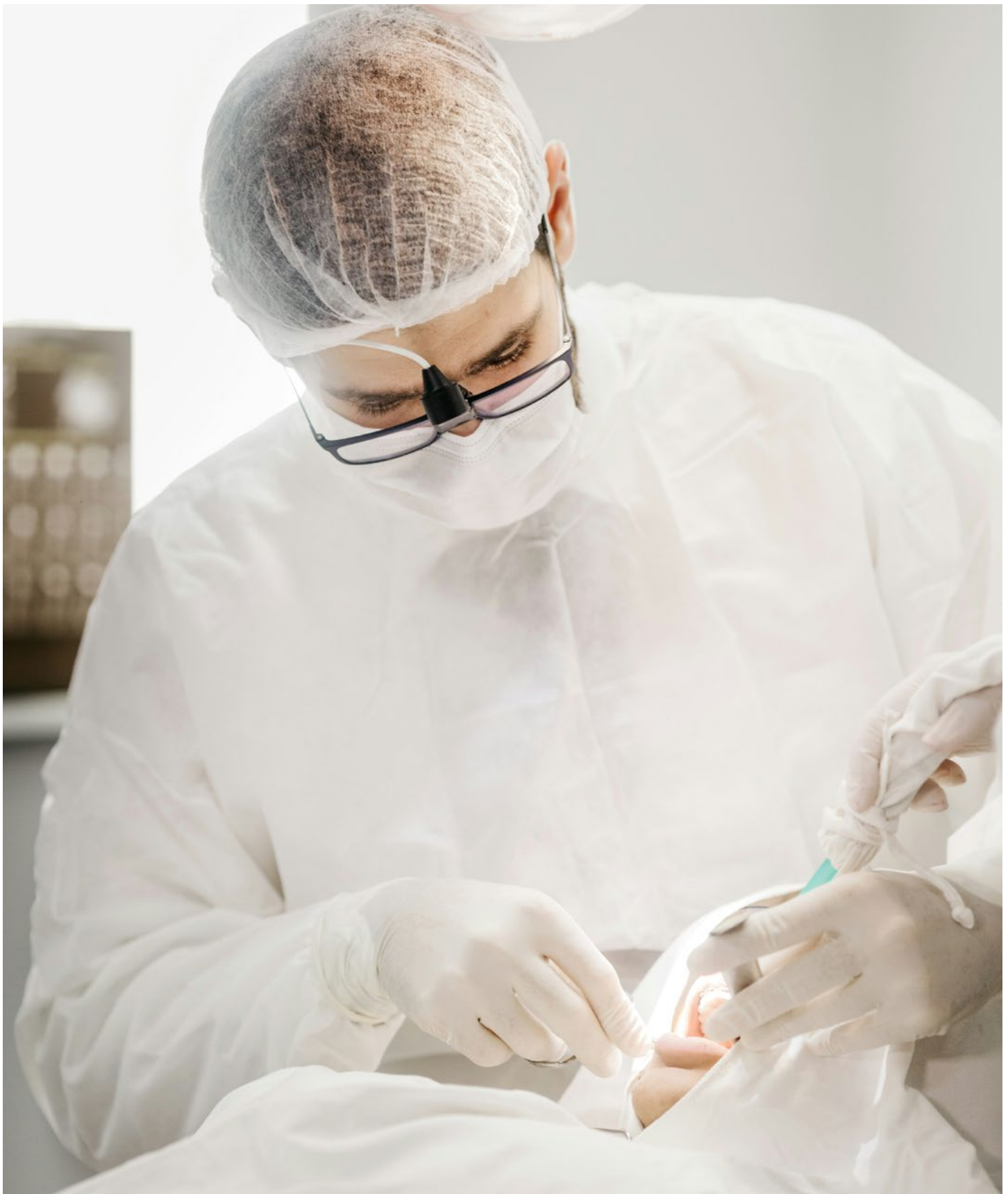
Theme 3: Developing Others (Standards 7–10)

Standard 7: Learn from peer leaders.

Effective leaders recognize that peer learning is among the most valuable forms of professional development. Actively exchanging insights, challenges, and best practices with counterparts across the region strengthens the collective capacity of organized dentistry's leadership.

Standard 8: Take responsibility for leadership decisions.

Accountability is non-negotiable at every leadership level. Local and regional leaders must



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own the consequences of their decisions—including difficult or unpopular ones—and demonstrate the integrity that sustains trust.

Standard 9: Manage conflicts.

Conflict is an inevitable feature of professional life, and its presence in organizations is not a sign of failure but of the human complexity that leaders must navigate. What distinguishes effective leaders is not the absence of conflict in their organizations but their willingness and ability to address it promptly, honestly, and with genuine respect for all parties involved. Humanistic conflict management—grounded in empathy, fairness, and a commitment to preserving relationships and organizational trust—reflects the highest expression of the character standards that underpin all leadership in oral healthcare.

Standard 10: Mentor emerging leaders.

The sustainability of strong leadership depends on cultivating the next generation. Local leaders who actively identify, encourage, and develop emerging leaders, including advocacy in public health, fulfill one of the profession's most enduring obligations: ensuring that the pipeline of capable, ethical leaders remains strong.

Stress-Testing the Standards: Workshops at the ACD Spring Leadership Conference 2026

Workshop Design and Methodology

To evaluate the practical utility of the local and regional standards, three interactive workshops were conducted at the ACD Spring Leadership Conference 2026 with Section leaders and Regents from across the United States and Canada. The workshops were designed to stress-test the standards and evaluate whether they provide meaningful guidance when applied to complex situations that local leaders actually face.

Each workshop used a structured role-play methodology. Participants worked in teams of three, assuming rotating roles of Regent (advisory influence), Section Leader (decision-maker), and Observer/Coach (standards application monitor). Teams engaged with three realistic scenarios drawn from the actual experiences of ACD Section leaders, each designed to surface a core leadership tension.

Scenario 1: The Influential Sponsor.

A Section leader planning the annual meeting receives a significant corporate funding offer conditioned on sponsor influence over speaker selection and content. This scenario explored the tension between financial sustainability and professional independence, implicating Standards 1, 4, 5, and 6.

Scenario 2: The Underperforming Colleague.

A respected, long-tenured member of the Section leadership team and personal friend is failing to meet leadership responsibilities, missing deadlines, and impacting Section performance. This scenario explored the tension between personal loyalty and organizational accountability, engaging Core Standards on empathy, integrity, and accountability alongside Standards 5, 6, and 10.

Scenario 3: The Questionable Nomination.

A Section committee evaluates a highly qualified Fellowship nominee about whom quiet concerns exist regarding undocumented past ethical lapses. This scenario explored tensions among due process, organizational reputation protection, and fairness, engaging Standards 1, 4, 5, 6, 8, and 9.

Each scenario concluded with a structured small-group debrief followed by a large-group discussion addressing cross-cutting patterns and implications for standard application and organizational culture.

The local and regional standards address leadership at the level where the profession's values are most directly enacted in communities and where most professionals first experience and develop their leadership capabilities.

Workshop Findings

The standards provided useful guidance.

Across all three workshops, participants referenced specific standards when reasoning through difficult decisions. The standards helped depersonalize challenging conversations and validated leaders' instincts about appropriate behavior. Standard 5, emphasizing sound, evidence-based, defensible decision-making, was consistently cited as especially valuable.

Standards require operational support to be effective. The workshops revealed that good intentions and clear principles are insufficient without supporting policies and procedures. Operational gaps emerged with particular urgency. Section leaders often navigate commercial independence questions inconsistently and without clear direction. Participants identified the need for practical tools, such as templates for difficult conversations, decision frameworks, and onboarding guidance for incoming Section leaders.

Competing values create the most difficult leadership moments. Participants reported that leadership felt most difficult when multiple standards appeared to be in tension. The workshops reinforced a fundamental insight: Standards do not eliminate difficulty; they provide a framework for navigating it. Effective leaders must exercise judgment, character, and courage in applying standards to the realities of organizational life.

Character and competence are inseparable.

A recurring theme across all three scenarios was the recognition that technical leadership competencies become ineffective when not grounded in character. Integrity, empathy, accountability, and transparency are not supplementary to leadership effectiveness; they are foundational to it.

Local knowledge is an underutilized organizational asset. Section leaders possess contextual knowledge about sponsorship opportunities, colleague circumstances, and nominee histories that do not consistently reach organizational decision-makers. This can result in gaps in organizational risk management and hamper decision quality.

Conclusions

The Standards for Leadership in Oral Healthcare represent a landmark advance for the dental profession—the first comprehensive framework establishing shared expectations for professional leadership behavior across career stages, practice settings, and organizational levels. The local and regional standards address leadership at the level where the profession's values are most directly enacted in communities and where most professionals first experience and develop their leadership capabilities.

Standards for Leadership in Oral Healthcare: Applying Local and Regional Standards in Practice

Teresa A. Dolan, DDS, MPH, FACD; and Robin Henderson, DDS, FACD

The spring 2026 workshops demonstrated that the standards resonate with Section leaders and Regents as practical, relevant, and valuable tools for navigating complex ethical and organizational challenges. Participants engaged authentically with difficult scenarios, applied specific standards to reasoning through decisions, and articulated clear needs for operational infrastructure to enable the standards to fulfill their promise.

The development of this infrastructure—sponsorship policies, nominations process guidance, training programs, practical toolkits,

and self-assessment instruments—represents the next essential phase of work. Standards will only be as effective as the support structures built to enable their application.

The dental profession now has an opportunity to lead other healthcare disciplines in demonstrating what explicit, shared leadership standards can accomplish: elevating professional culture, strengthening public trust, improving organizational performance, and ensuring that oral healthcare is guided at every level by leaders of exceptional integrity and capability.

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From State House to World Health Assembly: The Distinct Missions of National and International Leadership in Oral Healthcare

A narrative companion to the Standards for Leadership in Oral Healthcare



Robert A. Faiella, DMD, MMSc, MBA, FACD

William R. Calnon, DDS, FACD



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Leadership in oral healthcare has long been treated as a skill assimilated over time through experience rather than intentionally defined, taught, and assessed. Unlike clinical practice, education, research, and infection control, leadership in oral healthcare lacks consistent standards despite its critical role in integrating these systems and guiding the profession's future. As healthcare becomes increasingly collaborative and global, dentistry must deliberately develop leadership capabilities at multiple levels. This article examines leadership at the national and international levels, using the American Dental Association's role within U.S. and global health and dental organizations as examples. It explores why these leadership contexts require distinct competencies and why establishing appropriate standards is essential to dentistry's continued influence and effectiveness.

Keywords: oral healthcare, standards, national leadership, international leadership, leadership competencies, national federation, global diplomacy

From State House to World Health Assembly: The Distinct Missions of National and International Leadership in Oral Healthcare

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Leadership in oral healthcare has long been treated as a skill assimilated over time through years of committee work, election to office, and watching those who came before them, rather than something clearly defined, taught, and measured. This is unusual, because almost every other part of the profession has clear standards. Clinical practice follows evidence-based protocols and infection-control rules. Dental education is shaped by accreditation requirements. Research is governed by ethics review and reporting guidelines. Leadership, arguably the one skill that determines whether all these other systems actually work together, has none of this structure.¹ As healthcare moves toward more integrated, team-based models, dentistry's failure to define requirements for leadership risks leaving the profession out of decisions that will shape its future.¹ Writing about leadership in academic dentistry, Verma and colleagues reached a similar conclusion that change in dental education and practice is happening fast, but the profession is not deliberately building the leadership capabilities needed to guide that change.² The result is a profession that trains excellent clinicians and scientists but leaves it to chance whether those same people, once placed in positions of institutional authority, are actually ready for what that authority requires.

This article looks at two of the highest and most important levels where that authority is used: leadership at the *national level*, where an organization like the American Dental Association coordinates fifty state associations and their local districts, and leadership at the *international level*, where representatives of that same organization work with global groups, such as the FDI World Dental Federation and the World Health Organization, to advance oral health as a shared global priority. These two roles are often discussed as if they were the same thing, with international leadership just being national leadership on a larger stage. That view misses real differences between

them and misses what capabilities leaders at each level actually need. This article does not list the specific standards that will be added elsewhere in this publication. Instead, it explains, in plain terms, why those standards need to be developed differently for national and international leadership, and why getting both right matters for the profession's future.

The National Leader as Steward of a Federation

To understand what makes national leadership in American oral healthcare different, it helps to start with the structure it operates in. The dental profession in the United States is not run through one chain of command. It is organized as a federation; a national organization sets policy direction and represents the profession to the federal government, while fifty constituent state associations, each made up of component local districts, keep significant control over their own decisions, priorities, and culture. A leader elected to national office does not command this structure so much as manage and guide it. Success depends less on driving policy and more on building lasting agreement among groups whose situations differ greatly. A busy urban district in one state and a rural district with limited access to care in another may view the same national policy in very different ways.

This guiding role has become harder in recent years, not easier. Data from the American Dental Association's Health Policy Institute show the size of the practical challenges the profession faces at home, such as shortages of dental hygienists and dental assistants that have continued well past the worst of the COVID-19 pandemic, with most practicing dentists still reporting trouble hiring staff, and staffing shortages ranking among the top concerns dentists name when asked about what lies ahead.³ These are not abstract policy debates. They directly affect whether dental

The national leader has to know enough about health policy, workforce economics, and regulation to work credibly with federal agencies and lawmakers, while still being accountable to a membership whose day-to-day experience differs by state and by district.

teams across the country can deliver care, and they put clear pressure on national leaders to respond in a coordinated way through licensure agreements between states, education and accreditation policy, or workforce data efforts in ways that individual state associations could not manage as well alone. As such, a national leader's job is to take a problem that is felt unevenly across fifty different states and turn it into one clear, evidence-based national response, without ignoring the real differences in how that problem shows up locally.

A broader question in healthcare leadership research is what can help a group develop consensus to drive outcomes for the mission at hand. Research in nursing and health services supports this idea. Murray and Cope, writing about leadership and patient safety, argue that engaged, visible leadership directly affects whether safety systems truly protect patients, a finding highly relevant to a federation whose central purpose is to protect the patients its members serve.⁴ For national dental leaders, the stakes of this guiding role extend beyond organizational effectiveness. They influence whether standards of care, ethics, and safety remain sufficiently consistent across fifty state regulatory systems to preserve public trust in the profession as a whole.

What sets the national leader's role apart most clearly from other kinds of institutional leadership is a mix of broad representation and deep policy knowledge. The national leader has to

know enough about health policy, workforce economics, and regulation to work credibly with federal agencies and lawmakers, while still being accountable to a membership whose day-to-day experience differs by state and by district. Leadership at this level does not fail because of one unpopular decision. It fails when the leader loses the trust of the federation as a whole, which is when state and district leaders no longer feel that national leadership understands or reflects their situation. Keeping that trust over many years and multiple administrations, while still moving the profession's national goals forward, is the central challenge of national leadership. It is a very different challenge from the one faced by leaders working on the international stage.

The International Leader as a Bridge Between Systems

If national leadership works within a federation held together by shared regulatory and professional structures, international leadership works in a space with no shared structure at all. When an ADA delegation works with the FDI World Dental Federation, the World Health Organization, or partner global health groups, it enters a space defined not by shared governance but by negotiation among independent countries, each with its own way of financing healthcare, regulating its workforce, tracking disease, and understanding its own culture. Authority in this space cannot be handed down through policy

From State House to World Health Assembly: The Distinct Missions of National and International Leadership in Oral Healthcare

Robert A. Faiella, DMD, MMSc, MBA., FACD; and William R. Calnon, DDS, FACD

The World Health Assembly, the governing body of the World Health Organization's 194 member countries, adopted Resolution WHA74.5 on oral health, formally recognizing the global burden of oral disease and its links to other chronic conditions, and calling on member countries to build oral health workforce capacity and fold oral health into universal health coverage.

directives. It has to be built, maintained, and sometimes lost, through ongoing relationships, technical credibility, and a clear willingness to work as a partner rather than to simply push one country's model onto everyone else.

What is at stake has become much clearer over the past several years. The Lancet's 2019 series on global oral health showed that oral diseases affect a very large share of people worldwide and create a heavy economic burden, due to both treatment costs and lost productivity, while still receiving less attention than the problem deserves.⁵ In a companion paper in the same series, Watt and colleagues argued this neglect is not an accident but instead a structural problem, based upon how oral health has historically been kept separate from mainstream public and universal health coverage efforts. They called for coordinated, strong action across research, policy, and professional leadership.⁶ More recent analyses using the Global Burden of Disease framework show that the overall impact of oral conditions has changed only slightly over three decades, suggesting that past approaches pursued alone by individual countries and professional groups have not been enough.

With this background, oral health reached a milestone in 2021 rarely seen in the profession's history. The World Health Assembly, the governing body of the World Health Organization's 194 member countries, adopted Resolution WHA74.5 on oral health, formally recognizing the global burden of oral disease and its links to other

chronic conditions, and calling on member countries to build oral health workforce capacity and fold oral health into universal health coverage.⁷ The resolution led to the development of a full Global Strategy and Action Plan on Oral Health, adopted by the WHO for 2023 through 2030, with goals covering governance, prevention, workforce, care delivery, information systems, and research.⁸ The FDI World Dental Federation, representing over a million dentists worldwide, publicly welcomed the resolution as a landmark achievement and pushed for it to be fully carried out, including attention to issues such as access to affordable fluoride toothpaste and community water fluoridation in the places that need them most.⁹ The American Dental Association, for its part, committed to be an active partner in following through on these global commitments.

This chain of events shows exactly what sets international leadership apart from its national counterpart. The resolution did not happen because of the authority of any one country's dental association. It came out of years of coordinated advocacy among national associations, research groups such as the International Association for Dental, Oral, and Craniofacial Research, and community partners, each adding credibility and pressure within a system that runs on consensus among many countries.¹⁰ Looking at dentistry's role in global health more broadly, Hugo and colleagues argued that the profession's research and policy priorities need to stay actively connected to these larger global health efforts, or oral



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health risks slipping back into the isolation the Lancet series described.¹¹ Keeping that connection requires exactly the skills that set international leadership apart, such as the diplomatic skill to build coalitions across dozens of health systems that share no common regulatory framework, the humility to recognize that a standard that works in a well-funded, insurance-based system may not be realistic in a low-resource setting, and the patience to invest in relationships that may not pay off for years.

Research on how dental leaders experience this work supports this. Harnagea and colleagues, interviewing dental leaders about how they approach global leadership for the profession, found that these leaders consistently described building coalitions to expand access to oral healthcare as one of the hardest parts of their role, and that leadership development for this kind of work does not get enough attention within the profession.¹² Their findings suggest leadership that can work in a truly international, cross-system environment is not just national leadership performed on a bigger stage. It calls for a different set of skills altogether, with skills built around influence without authority, agreement without command, and credibility earned through long-term partnership rather than given by a title.

Two Missions, One Profession

None of this means national and international leadership are separate career tracks. In practice, they are often carried out by the same people over the course of a career, as leadership experience gained in a state or district association grows into national office and, for some, into international representation. But seeing that connection should not hide the real differences in what each level requires. National leadership succeeds by holding together a federation of fifty different states around one clear, evidence-based

domestic agenda, while staying accountable to the members that agenda is meant to serve. International leadership succeeds by building lasting influence within a system of many countries that answers to no single national authority, advancing shared global goals through diplomacy, credibility, and patient relationship-building across very different health systems.

The cost of neglecting either mission is not the same, but both are serious. National leadership that fails at its role risks fragmentation: inconsistent standards across states, lost trust among the federation's own members, and a weaker ability to speak with one voice to government. International leadership that fails at its diplomatic role risks something different, but just as costly: being left out of the rooms, such as the World Health Assembly, where decisions that shape the global direction of oral health are actually made, and missing the chance to help turn a global commitment, like the 2021 resolution and the strategy that followed it, into real action. The profession's credibility, both at home and abroad, depends on leaders at both levels understanding not just their own responsibilities, but the different nature of the responsibilities carried by their counterparts.

This is exactly the gap this Standards for Leadership initiative aims to address. By setting out standards that are built for the specific demands of national stewardship and international diplomacy, rather than treating leadership as one single, undefined skill, the profession can start to close the gap between the size of the challenges it faces and how deliberately it prepares the people who will be asked to lead through them. The evidence reviewed here, from the ongoing workforce pressures documented by the ADA's own Health Policy Institute, to the successful but still fragile global recognition of oral health secured through the WHO resolution and its follow-up strategy, makes clear that both levels of leadership matter, that they matter for different reasons, and that neither can replace the other.

A profession that only leads well at home will struggle to shape its future on the global stage. A profession that only leads well abroad will find that stage hard to hold without a well-run, unified base behind it. The task now is to prepare

leaders who understand which mission they are serving at any given moment, and who bring to each the specific skills it requires.

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Standards for Leadership in Oral Healthcare

A Project of the Board of Regents of the American College of Dentists

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**The following photos are from the 2025 Fellows Forum
and the 2026 Spring Leadership Conference where the
standards were developed and stress-tested.*



Introduction

The oral health care profession faces new and emerging challenges and opportunities: ever-increasing patient expectations, transformational technological advances including artificial and augmented intelligence, workforce shortages, and evolving healthcare delivery models.

Oral health care demands exceptional leadership at every level -from individual practitioners to leaders of international organizations. Yet, unlike most other aspects of dental practice, leadership in oral health care lacks standards, creating a critical gap that impacts the quality of patient care, outcomes, professional satisfaction, and public trust.

By establishing clear benchmarks for leadership behavior and emphasizing continuous reflection, evaluation, and improvement, these standards offer practical guidance for practitioners at every career stage while strengthening public trust in the profession.

Leadership in oral health care is both a responsibility and an acquired capability. It is strengthened through experience, structured education, mentoring, and ongoing assessment. Establishing clear, ethically grounded leadership standards is therefore essential to guiding professional behavior, shaping expectations, and advancing leadership excellence across the career continuum.

Standards for Leadership in Oral Health Care

ACD Task Force for the Standards for Leadership



Background

To address the need for standards, the American College of Dentists has developed Standards for Leadership in Oral Health Care, aligned with internationally recognized principles of service. These standards define core leadership expectations, outline progressive competencies at team, local/regional, and national/international levels, and provide a foundation for leadership development, assessment, and continuous quality improvement.

As used in this document, the term “standards” is not intended to carry a strict legal or regulatory meaning. Rather, it refers to expectations and guiding principles that define the responsibilities and performance expected of individual practitioners and those serving in leadership roles within oral health care.

Individual and collective compliance with these standards is critical to maintaining professional standing, status, and, most importantly, trust in individuals, the profession, and its institutions. Without standards, there are no behavioral and attitudinal norms. Standards serve as a benchmark for personal behavior, development and advancement, defining minimum levels of competency and achievement. Knowledge and understanding of standards inform judgements about how oral health care leaders should act and provide insights into the actions necessary to sustain and advance the profession for the benefit of patients, communities, and populations.

In dentistry, standards have been developed and embraced many aspects of clinical practice, education, and research. In clinical practice, standards ensure quality of care and patient safety. In education, standards focus on features of the learning and teaching environment and minimum educational attainment. In oral and dental research, standards are vital to ethical conduct, the reliability and validity of findings and reporting.

To date, there has been an absence of standards to guide leadership in oral health care, a void which is considered to have caused a disservice to the profession and the patients it serves. As stated by Carr et al. (2025): “Leadership matters because it is the only capability that can systematically bring out the best in people so they can achieve more together than they can alone.”

Adopting these standards will strengthen the profession's capacity to meet future challenges, enhance patient experience, improve team and organizational performance, and support the sustained trust placed in dentistry by patients, communities, and society. The standards represent a timely and essential advancement in leadership expectations for oral health care professionals.

Research

Research in health care leadership demonstrates clear links between effective leadership and improved patient outcomes, staff satisfaction, and organizational performance. Studies show that health care organizations with strong leadership report 12% better patient satisfaction scores and 18% higher staff engagement (West et al., 2015; Shantou et al., 2017). What little research has been reported on leadership in oral health care indicates that leadership effectiveness in dental practice correlates with treatment plan acceptance rates, enhanced quality of care metrics, team retention, and practice profitability (Nash, 2010; Hanks et al., 2020).

Looking Forward

In oral health care, leadership is, and will remain essential at all levels, from chairside and practice leadership to local, regional, national and international leadership. Core standards, which may be considered a professional responsibility, apply at all levels. Acquiring and applying knowledge, understanding, capabilities and experience in ascending levels of leadership should be regarded as part of career development. Leadership is not innate; it is an acquired capability. This capability is developed through experience, together with structured learning and teaching, mentoring and proactive appraisal and feedback. Quality leadership has many benefits, including a rich source of professional fulfillment.

The future of oral health care, and the critical part it plays in general health care and well-being, will, in large part, be determined by the quality of leadership in the profession going forward. The present initiative to set standards in leadership in oral health care is the key to that future.

This document, and all related materials, should be considered living and working documents to be reviewed and updated periodically.

Standards

The following standards for leadership in oral health care are informed by the Ethics Handbook for Dentistry of the American College of Dentists, and the internationally recognized principles for service in society: selflessness, integrity, objectivity, accountability, incorruptibility, openness, and honesty, all of which underpin trust and, in turn, faith in the professions.

All dentists, as health care professionals, should exercise leadership to be effective in their service to patients and society, and to uphold and enhance the standing and status of the profession.

Leadership by dentists in the provision of oral health care and in service to society is both a responsibility and a privilege.

These standards aim to:

1. Enhance patient experience and outcomes through improved team effectiveness
2. Establish clear expectations for leadership behavior across all career stages
3. Provide a framework for leadership development and assessment
4. Assist leaders and the teams and organizations they lead to realize their potential
5. Strengthen the profession's ability to adapt to future challenges and ever-increasing expectations

Standards for Leadership in Oral Health Care

ACD Task Force for the Standards for Leadership



Core Standards

The following core standards in leadership are integral to the professional behavior expected of a dentist:

1. **Put the interests of others you serve first**—prioritize patient welfare above personal or organizational gain.
2. **Act with purpose, setting aside bias or prejudice**, to ensure decisions and actions are based on fairness, clinical evidence, and professional judgment.
3. **Demonstrate humility, empathy, respect, integrity, openness and accountability**—model the virtues you expect of other professionals.
4. **Foster trust and confidence**—build credibility through consistent, transparent actions and effective communications.
5. **Make sound, defensible decisions** based on best clinical practices, best-available evidence, and the values of the patient.
6. **Acknowledge and address mistakes**—admit to errors promptly, apologize where appropriate, and take corrective action.
7. **Seek assistance early**—request help or refer to avoid adverse outcomes.
8. **Accept and respond to justifiable criticism**—objectively manage and apply lessons learned from valid criticisms
9. **Commit to lifelong learning**—pursue continuing professional development relevant to your role and emergent needs and technologies, e.g., augmented intelligence, adapting to change.
10. **Maintain personal well-being and resilience**—engage in reflection to sustain high-quality performance and ethical decision-making.

Team Leadership

1. **Ensure the patient's well-being**—every decision is made with the patient's best interests and values as the primary motivation.
2. **Lead with fairness and transparency**—treat every team member with respect, integrity, and openness.
3. **Foster a culture of trust, inclusivity, and collaboration**—actively create an environment where all voices are heard and valued.
4. **Lead by example**—model professionalism, ethical behavior, and clinical excellence in daily practice.
5. **Ensure team effectiveness**—align people, attitudes, behavior, processes, and resources to deliver safe, high-quality care; be alert to and effectively manage conflicts.
6. **Assume responsibility for decision making and delegation**—own the outcomes of the team's choices and actions.
7. **Support team well-being and resilience**—recognize and address burnout, stress, and professional challenges.
8. **Promote continuous professional development**—embed a reflective ethos of learning and continuous quality improvement.
9. **Encourage feedback on leadership**—invite constructive input to strengthen the team and help develop leadership insights, capabilities, and performance.
10. **Acknowledge good performance**—express appreciation for professional contributions.

Local and Regional Leadership

1. **Understand local and regional leadership requirements**—be familiar with legal, regulatory, and cultural expectations.
2. **Build strong stakeholder relationships**—establish trust and effective lines of communication with community partners, professional networks, and media.
3. **Foster collaborative partnerships**—develop and maintain strategic professional, interprofessional, and other partnerships to enhance the impact and outcomes of local/regional leadership.
4. **Promote ethical and professional behavior**—encourage fairness, respect, integrity, inclusivity, and openness.
5. **Lead strategically**—develop and implement well-reasoned plans that drive sustained improvement.
6. **Be accountable and consultative**—share decisions transparently and actively seek diverse opinions.
7. **Learn from peer leaders**—exchange insights and best practices with local and regional leaders to strengthen collective leadership capacity.
8. **Take responsibility for leadership decisions**—accept responsibility for your actions, communications, and outcomes.
9. **Manage conflicts**—promptly and effectively arbitrate disputes.
10. **Mentor emerging leaders**—identify, encourage, and prepare others for leadership roles, including advocacy in public health.



National and International Leadership

1. **Understand national and global leadership responsibilities**—be informed about policy, laws, governance, and cultural differences across jurisdictions.
2. **Establish effective lines of communication with diverse stakeholders**—develop credibility with professional organizations, policymakers, and national/international media.
3. **Develop and maintain strategic alliances**—forge partnerships that advance oral health, professional standards, and health care innovation nationally and across the world.
4. **Champion ethical leadership**—advance high standards of professional behavior, fairness, respect, integrity, openness, and inclusivity nationally and internationally.
5. **Demonstrate visionary leadership**—through well-reasoned, forward-thinking strategies to address emerging challenges and opportunities.
6. **Maintain accountability and openness**—be consultative, accountable and encourage feedback on the leadership provided to further develop leadership skills and performance.
7. **Continuously learn from national and global peers**—share and adopt best practices from diverse health care systems.
8. **Accept responsibility at the highest level**—take responsibility for leadership decisions, actions, delegation, communications, and their outcomes.
9. **Exercise statesmanship**—use negotiating skills to achieve consensus and, in the process, resolve differences and conflicts.
10. **Develop the next generation of leaders**—encourage, train, and mentor future national and international leaders to ensure a strong leadership pipeline.

The following matrix summarizes these leadership competencies by level.

Competency Area	Team Level	Local/ Regional Level	National and/or International Level
Communication and Conflict Resolution	Patient interactions and team meetings	Community engagement, local media	Policy makers, global forums
Strategic planning	Practice improvement	Regional development	Profession-wide transformation
Partnership development	Intra-and interprofessional teams	Community collaborations	National/ International coordination
Mentorship	Team members	Local and regional colleagues	Future leaders in the organized profession

Assessment and Continuous Improvement

Effective leadership requires regular evaluation and commitment to growth. Leaders should assess their effectiveness through multiple sources including patient feedback from surveys, ratings, and direct input; team perspectives gathered through staff surveys, 360-degree appraisals, and team meeting consensus; organizational outcomes measured against performance goals and benchmarks; and honest self-reflection examining their behaviors, decisions, and leadership style. No single assessment method fits all situations or leadership levels. The most valuable approach combines quantitative metrics with qualitative insights, conducted as objectively and fairly as possible, with external facilitation enhancing objectivity when appropriate.

Critical to success, leaders must not only seek feedback but act on it. Meaningful improvement requires regular evaluation cycles rather than one-time assessments, honest self-reflection on both strengths and growth areas, concrete action plans based on findings, follow-through and accountability for change, and reassessment to measure progress.

Assessment is not an endpoint but rather part of a continuous cycle of reflection, learning, adjustment, and improvement. Leaders who embrace this cycle create cultures where excellence becomes the norm and both individuals and organizations reach their full potential. Without this commitment to ongoing evaluation and growth, even the most talented leaders plateau, and their teams and organizations fail to achieve their full capacity for impact and innovation.

Conclusion

The development of standards for leadership in oral health care represents a critical advancement for the profession at a pivotal moment in health care delivery. These standards—spanning core professional behaviors through team, regional, and national leadership competencies—provide a framework that addresses the current void in leadership expectations while positioning the profession to navigate emerging challenges in technology, workforce dynamics, and evolving patient needs.

By establishing clear benchmarks for leadership behavior and emphasizing continuous reflection, evaluation, and improvement, these standards

offer practical guidance for practitioners at every career stage while strengthening public trust in the profession. Implementation of these standards, supported by ongoing assessment and refinement, will enable dental professionals to systematically develop leadership capabilities that enhance patient outcomes, elevate team performance, and ensure the profession's continued relevance and impact in advancing oral and systemic health.

The oral healthcare profession now has the opportunity to lead other health care disciplines by demonstrating how explicit leadership standards can transform professional practice, education, and service to society.

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Fellows' Comments from the Standards for Leadership Review Survey

CORE STANDARDS

How can resilience and well-being be integrated into leadership expectations?

I think that those in leadership positions, especially dentists, tend to disregard their own well-being for others, which can lead to health and mental health issues later in life. Learning personal well-being would help avoid this and allow dentists to perform long term and maintain their high-quality standards.

(Core Standards are) Desperately needed in all dental schools.

Other comments about the Core Standards?

I appreciate the call for leadership standards. I do hope that we can focus a lot on the details. While I can appreciate broad concepts like trust, professionalism, and leadership, there is so much unpacking to make those concepts actionable.

TEAM STANDARDS

Which elements of team leadership are most challenging in practice--delegation, conflict resolution, and feedback?

There are so many leadership styles that focus on humanism and well-being. Leadership styles like this could be promoted in addition to supporting emotional intelligence and other tools and skills that help us to be human while being a leader. It is not clear to me that dentistry does much by way of connecting us to each other and to do the introspective work of keeping ourselves well and whole.

LOCAL AND REGIONAL STANDARDS

What barriers prevent greater local/regional leadership participation?

Feeling like one is not ready.

Time is the greatest barrier especially with female dentists. Trying to balance a practice, family, local roles, and organized dentistry and have time for self-wellness is very difficult.

NATIONAL AND INTERNATIONAL STANDARDS

How can standards ensure leaders balance advocacy for patients, the profession, and global equity?

Leaders must wear many hats, seeing and respecting the view of patients, dentistry and the world. This must be done through an ethical view.

Standards should be committed to justice, and advocacy should be with patients not just for patients.

Next Step...

Creation of Standards for Leadership Handbook – The work on this resource will begin with the Fellows during the Regency Breakout Sessions at the 2026 Annual Meeting and Convocation in Santa Barbara, with online collaborative activities to follow.

Richard J. Rosato, D.M.D.
President

July 16, 2026

Robert A. Faiella, D.M.D., M.M.Sc., M.B.A., F.A.C.D.
Chair, Standards for Leadership Task Force
American College of Dentists
103 North Adams Street
Rockville, Maryland 20850

Re: *Standards for Leadership in Oral Health Care*

Dear Doctor Faiella:

On behalf of the more than 150,000 members of the American Dental Association (ADA), we are pleased to support the *Standards for Leadership in Oral Health Care*, a project of the Board of Regents of the American College of Dentists (ACD).

As our profession continues to evolve, so must its leaders' abilities to rise to the challenges and opportunities that impact today's dentists and the communities they serve.

The *Standards for Leadership in Oral Health Care* fill a void in the array of shared standards that guide our profession and succeed in establishing clear benchmarks for leadership professionalism, with an emphasis on continuous reflection, evaluation and improvement.

As an Association built by generations of principled volunteer leaders, we are proud that these leadership standards effectively elevate professional excellence, guide dentists throughout their careers and reinforce the public trust that is the foundation of our profession. The ADA has long championed ethics and professionalism in dentistry. As the ADA *Principles of Ethics and Code of Professional Conduct* states: "The dental profession holds a special position of trust within society. As a consequence, society affords the profession certain privileges that are not available to members of the public at large. In return, the profession makes a commitment to society that its members will adhere to high ethical standards of conduct." Leadership standards grounded in these same tenets are essential to sustaining that trust.

We understand that input to the *Standards for Leadership in Oral Health Care* has already been provided via discussions between ACD's executive director and the senior director of the ADA Council on Ethics, Bylaws and Judicial Affairs (CEBJA). The ADA would be most pleased to provide any additional assistance that may be needed or desired by ACD as the task of assembling vehicles for implementing and disseminating the Standards for Leadership begins. Toward that end, as CEBJA is the ADA agency with expertise that is the most aligned to the leadership work underway at ACD, please do not hesitate to include Tom Elliott on any requests that ACD may have.

We commend the American College of Dentists for developing the *Standards for Leadership in Oral Health Care*, and we share in the belief that these standards would ensure a consistent foundation for leadership development across the profession. We look forward to working with the American College of Dentists on the implementation of these standards.

Sincerely,



Richard J. Rosato, D.M.D.
President



Nader A. Nadershahi, D.D.S., M.B.A., Ed.D.
Executive Director



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July 23, 2026

Robert Faiella, DMD, MMSc, MBA, FACD
Chair, Standards for Leadership Task Force
President, American College of Dentists Foundation
Immediate Past President, American College of Dentists
Submitted via email to office@acd.org; suzan@acd.org

Re: Standards for Leadership in Oral Health Care

Dear Dr. Faiella,

On behalf of the American Academy of Pediatric Dentistry (AAPD), thank you for the opportunity to review the Standards for Leadership in Oral Health Care and to provide feedback on this important initiative.

AAPD applauds the American College of Dentists for its thoughtful efforts to articulate a shared framework for leadership across the oral health profession. We agree with the underlying premise that leadership is essential at every level of dentistry and that a common set of guiding principles can help strengthen professional development, organizational effectiveness, and ultimately patient care. The document reflects many values that resonate strongly with AAPD's mission, including patient-centered care, ethical conduct, professionalism, collaboration, mentorship, and service. We are pleased to offer our support for the Standards in concept.

As this work continues to evolve, we respectfully offer several observations for consideration:

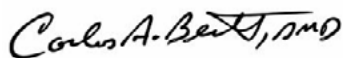
- Clarification regarding implementation. While the Standards provide an important aspirational framework, additional information regarding how they will be operationalized would be valuable. In particular, understanding expectations for adoption, accountability, reporting, assessment, or benchmarking would help organizations.
- Relationship to existing leadership programs. Many organizations, including AAPD, have invested significantly in leadership development programs. We would welcome additional guidance regarding how the Standards are intended to complement, not duplicate or supersede, existing programs and curricula.
- Examples of application. Several of the Standards are intentionally broad and values-based. The inclusion of practical examples, behavioral indicators, or suggested actions could help leaders at different stages translate these principles into meaningful day-to-day practice and measurable outcomes.
- Engagement across the profession. As this is intended to serve the entire oral health community, we encourage continued engagement with specialty organizations and other stakeholders to ensure the framework reflects the diversity of leadership roles and practice environments throughout dentistry.

- Future implementation resources. We appreciate the Task Force's intention to develop supporting tools and resources. Such materials will likely be essential in moving the Standards from aspirational principles to practical instruments that can enhance leadership development across organized dentistry.

We offer these comments in the spirit of collaboration and continuous improvement. We believe the Standards represent a positive contribution to the profession and provide a thoughtful foundation upon which future leadership development efforts can be built.

Thank you again for inviting AAPD's participation in this process. We appreciate the significant work undertaken by the Task Force and look forward to following the continued evolution of this living document. We also look forward to opportunities for future collaboration as implementation strategies and supporting resources are developed.

Sincerely,



Carlos A. Bertot, DMD
President
American Academy of Pediatric Dentistry

cc: Dr. Jessica Y. Lee, AAPD Chief Executive Officer

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American College of Dentists
President Robert Faiella
Chair, Standards for Leadership Task Force

The International College of Dentists (ICD) recognizes the inherent need for leadership in the oral health care profession and supports the Standards for Leadership in Oral Health Care. We look forward to working with the American College of Dentists on the implementation of the Standards.

The ICD recognizes the constantly evolving global landscape of delivery models, access challenges and inequities impacting oral health. As these challenges become increasingly complex, we agree the need for exceptional leadership within oral health at every level is increasingly critical. A clearly defined and stated set of principles for oral health leadership is essential to effectively addressing complex issues with changing variables and differing contexts.

Two of the ICD Core Values are Leadership—"Uphold the highest standard of professional competence and personal ethics", and Recognition—"Recognize distinguished service to the profession and the public worldwide." The ICD recognizes and honors the world's leading dentists, who are carefully identified and vetted through a rigorous peer-review process and held to the highest standards both personally and professionally. ICD leaders range from practitioners to teachers to policymakers to industry representatives to humanitarians. There are many environments and contexts for which ICD leaders engage, influence, serve and lead. These Standards may provide valuable framework for leadership development, reflection, mentoring and the consideration of relevant ICD programs and governance practices. Any future application within the ICD would need to take account of our governing documents, international structure, and differing legal, professional and cultural contexts.

The ICD commends the American College of Dentists for their thoughtful and evidence-informed development of these Standards, working with a cross-sector oral health professionals and experts from around the world. There are many programmatic and governance areas where ICD can incorporate these Standards, which will continually improve our leadership, advocacy, outreach and contribution to oral health advancement.

We look forward to working with the American College of Dentists on the implementation of the Standards.

Sincerely,

Julio Rodriguez, DDS, MICD
Global President

Chelsea Segren, CAE, FICD (Hon.)
Executive Director



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June 8, 2026

Mr. Mike Graham
Executive Director
American College of Dentists
Via e-mail

Dear Mr. Graham,

The Academy of General Dentistry recognizes the inherent need for leadership in the oral health care profession and supports the Standards for Leadership in Oral Health Care. We look forward to working with the American College of Dentists on the implementation of the Standards.

Our organization submits the following comments for consideration:

under the Core Standards, #9, continuing education, be moved up on the list to 1 or 2, and under Team Leadership, #8, also be moved up, both to reflect AGD's emphasis on CE

We look forward to working with the American College of Dentists on the implementation of the Standards.

Sincerely,

Daniel Buksa
Executive Director
Academy of General Dentistry

CC:
Dr. Marc Worob, AGD President
Dr. George Schmidt, AGD President-Elect
Dr. Kim Wright, AGD Vice-President



Submission Guidelines

The Journal of the American College of Dentists

The Journal of the American College of Dentists (JACD) is a scholarly publication presenting proactive and informative perspectives on issues affecting the dental profession and society. The *Journal* has been published since 1934, and its first editor was Dr. William John Gies. The College's communication policy is to identify and present to the Fellows, the profession, and other interested parties those issues that affect the dental profession and oral health. The goal is to stimulate this community to remain informed, engage actively, and help shape public policy and personal leadership to advance the College's purpose and objectives.

Submissions must include:

1. Between 1500 and 3000 words, including an abstract of no more than 250 words.
2. 5-7 keywords after the abstract. These terms represent the key topics presented in the article.
3. Inclusive language, including gender-neutral pronouns, unless referring to specific persons.
4. Sufficiently de-identified descriptions of patients and/or clinical encounters as appropriate.
5. Formatting of text and references in *The American Medical Association Manual of Style, 11th Edition*.
6. A cover page that includes:
 - A designated corresponding author.
 - The full name, e-mail address, mailing address, and phone number for each author. If the article is selected for publication, a headshot photo will be required for each author.
 - Degrees and institutional affiliation (if appropriate) of each author. If an author is an ACD Fellow, include the FACD designation as part of their official credentials.
 - A disclosure statement of any conflicts of interest.
 - A statement that affirms the work is original and that it has been authored

entirely by the submitting authors and their research team. If Artificial Intelligence (AI) is used to generate content, follow the guidelines below.

Guidelines for AI Use:

AI tools cannot be credited as authors. Authors must disclose any use of AI in *generating content* for their submissions on the cover page of the article. A disclosure statement should specify the tool used and its purpose. However, authors *do not* need to disclose the use of AI for grammar and language refinement. Authors remain fully responsible for the accuracy, integrity, and originality of their work.

Peer Review Process:

The editor (or, in some instances, a "guest editor") will review the manuscript within 21 days of receipt to determine whether it meets the general content and quality criteria for publication in the *JACD*. All manuscripts that are suitable for publication will undergo blinded peer review. Typically, there are two anonymous peer reviewers, both subject-matter experts. Because all peer reviewers are volunteers, the review may take between 4 and 6 weeks. Once reviewer comments are received by the editor, a decision will be made to accept the manuscript as is, accept it with minor revisions, accept it with significant revisions, or reject it. *JACD* reserves the right to edit manuscripts to ensure conciseness, clarity, and stylistic consistency.

Important Dates for Submission:

ISSUE	SUBMISSION DEADLINE	PUBLICATION TIMEFRAME
Spring	January 15	April Publication
Summer	May 15	July Publication
Fall	July 15	September Publication
Winter	November 15	January Publication

Please direct all questions and submissions to editor@acd.org

AMA 11th Edition Style Guide resources with examples (Accessed March 4, 2026)

- https://mym.cdn.usa.edu/WritingCenter/AMA_References_11th.pdf
- https://researchguides.uic.edu/ld.php?content_id=54861424





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