



Journal *of the* American College *of* Dentists

YOUNG DENTISTS

Fall 2005
Volume 72
Number 3



Journal of the American College of Dentists

A publication promoting
excellence, ethics, and
professionalism in dentistry

The *Journal of the American College of Dentists* (ISSN 0002-7979) is published quarterly by the American College of Dentists, Inc., 839J Quince Orchard Boulevard, Gaithersburg, MD 20878-1614. Periodicals postage paid at Gaithersburg, MD. Copyright 2005 by the American College of Dentists.

Postmaster—Send address changes to:
Managing Editor
Journal of the American College of Dentists
839J Quince Orchard Boulevard
Gaithersburg, MD 20878-1614

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For bibliographic references, the *Journal* is abbreviated J Am Col Dent and should be followed by the year, volume, number and page. The reference for this issue is: J Am Col Dent 2005; 72(3): 1-36



Publication Member of
the American Association
of Dental Editors

Mission

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

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- A. To urge the extension and improvement of measures for the control and prevention of oral disorders;
- B. To encourage qualified persons to consider a career in dentistry so that dental health services will be available to all, and to urge broad preparation for such a career at all educational levels;
- C. To encourage graduate studies and continuing educational efforts by dentists and auxiliaries;
- D. To encourage, stimulate and promote research;
- E. To improve the public understanding and appreciation of oral health service and its importance to the optimum health of the patient;
- F. To encourage the free exchange of ideas and experiences in the interest of better service to the patient;
- G. To cooperate with other groups for the advancement of interprofessional relationships in the interest of the public;
- H. To make visible to professional persons the extent of their responsibilities to the community as well as to the field of health service and to urge the acceptance of them;
- I. To encourage individuals to further these objectives, and to recognize meritorious achievements and the potential for contributions to dental science, art, education, literature, human relations or other areas which contribute to human welfare—by conferring Fellowship in the College on those persons properly selected for such honor.

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Generations



Cover Photograph: Young dentists are not just incomplete versions of their established counterparts. As they grow into their seniors' clothes, they will make some style changes just as their predecessors have done. Photographer: Jon Draper. ©2005 University of the Pacific Arthur A. Dugoni School of Dentistry.

FROM THE EDITOR

OPEN LEADERSHIP

A few hours of continuing education attendance per year are required for relicensure in most states; leadership is optional. More's the pity. Dentistry needs the leadership.

Someone started a malicious rumor when they winked at their young colleague and whispered, "Leadership opportunities in the profession are limited, you know. The higher you go, the fewer the positions and the fiercer the competition." That isn't true. Leadership is open.

Reading books on leadership is like going to church on Sunday—it is inspiring but it has to be done regularly. The great examples are so wonderful, but they seem to recede from touch as we struggle to get through our day jobs. We need a concept of leadership for the ordinary among us.

We need a concept of leadership for the ordinary among us.

Strangely perhaps, the key comes from continuing education. One of the classics of the training literature (a field much larger than dentistry) is Donald Kirkpatrick's *Evaluating Training Programs: The Four Levels*. Kirkpatrick's notion is simple: there are four places to look to see whether continuing education is effective, and there are often different answers for each course depending on where one looks.

Level 1, process, refers to the conduct of the program itself. Was the speaker interesting, apparently knowledgeable, good PowerPoints, fresh Danish, comfortable room? In a word, did the program meet the participants' expectations for what a CE course should look like? This level is measured by the ubiquitous "happiness sheets." Level 2, knowledge, is a matter of whether participants add to their cognitive repertoires. CE in the journals is accompanied by little knowledge tests. Level 3 is application. Does the dentist practice differently as a result of the CE course? This is almost never measured, because it would have to be done months after the course and in the office. I once conducted research involving pre- and post-course knowledge tests and office visits for a course in four-handed, sit-down dentistry. One dentist reported that the course was valuable because he learned that "blue was a soft color." Although he had not acted on that new knowledge, he had moved the triturator from the lab to chairside, a fact that he had overlooked. The greatest impact of educational

programs in the health professions can only be measured by looking at patients. Level 4 concerns improved health and probably increased income for practitioners. Almost all of the effort to measure the quality of continuing education is bunched up at the low end—Level 1 and a bit of Level 2. Almost all of the true impact is at the higher levels.

The same is true for leadership.

Level 1 leadership means looking like a leader. The concern here is title, ritual, and mannerisms. There are more than a few professional organizations where the major activity of the year is to elect and install officers. Going through the chairs and passing the gavel are the leadership equivalents of the "happiness sheets" in CE. The oldest studies of leadership produced trait theories. These were descriptions of the characteristics leaders had in common: intelligence, sociability, hard work, being tall, and being male. Of course we now know this isn't very accurate, nor could any approach be that looked only at the leader.

Level 2 leadership involves the relationship between leader and follower. The old saw applies here—a leader is a person who is going somewhere and has followers. Leaders can be recognized because they change the behavior of those around them. They use power wisely to get compliance. The enormous amount of leadership literature in the

1960s, 1970s, and 1980s demonstrated conclusively that there is no one best method to exercise Level 2 leadership. Adjustments have to be made for various followers, various organizations, and various circumstances.

Inspiration and charisma are the stuff of Level 3 leadership. This type of leadership is transformational. It changes people and organizations. Like Level 3 training, there is almost no way to identify this quality of leadership by looking at the leaders or the presenters; the proof of effect can only be registered months or years later in the differences they make on those who have come in direct contact with them.

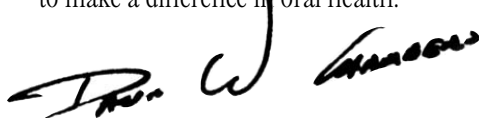
Impactful leadership, Level 4, carries the quest even further away from the person in charge. The operative question is, "Can those whom the leader touches make differences in the lives of others?" A great leader in a company does something worthwhile for the customers (through the employees). A leader in dental education builds students through faculty members. Leaders in dentistry improve oral health.

This should come as wonderful news to anyone interested in leadership. The opportunities are open to all who care to make a difference.

There is an apocryphal story about attendees in a summer executive MBA program. On the first day the instructor asked participants to describe their leadership experiences. The school district superintendent described some

innovations that brought parents into the classrooms but suggested that this wasn't anything very dramatic. A hospital administrator apologized because her safety initiatives were still being resisted by a few physicians even though the morbidity rate had been cut twenty-fold. And so around the group until a colonel observed that he knew for certain that he was a leader because when he ordered a cup of coffee he got a cup of coffee and a "yes, Sir!" The person in charge praised the leadership of all but one of the participants because they were making sustained differences in people's lives (Level 4). He also acknowledges the command prowess (Level 2) of one of the class members and said he had come to the right course.

It is true that access to Level 1 leadership positions is limited in dentistry. But there is no shortage of opportunity at the other levels. The mission of the American College of Dentists is to "promote excellence, ethics, leadership, and professionalism in dentistry." Practice open leadership; elect yourself president of your own program to make a difference in oral health.



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

There are more than a few professional organizations where the major activity of the year is to elect and install officers. Going through the chairs and passing the gavel are the leadership equivalents of the "happiness sheets" in CE.

LETTERS TO THE Editor



DEAR Editor:

Congratulations for the fine articles advising young dental editors in the spring *Journal*. All eight authors wrote gripping pager-turners, and I could see bits of myself in each one.

Like many dental editors, I backed into it. My first organized dentistry adventure was running for sophomore class vice president—and losing. When I demanded a vote recount the administration threw me a bone; student council editor was open. I published five issues of *Disclosing Tabloid* before graduating from Ohio State. When the newsletter received a Special Citation from the International College of Dentists Journalism Awards Competition in 1976, I was hooked.

The next October I presented a paper, “Dental journalism and the practicing dentist,” at the U.S. Air Force dental conference in Garmisch, Germany. In July 1978, I began the prosthodontics training program at Ohio State and took evening journalism class. For the next thirty months I juggled clinical prosthodontics and dual master’s degrees.

Sometimes I thought about dropping the journalism classes, because J-school homework was time consuming and I had two kids in diapers (who both later graduated from OSU), but it kept opening new windows. Seeing public relations from the inside out is like looking

through binoculars for the first time. Besides, good writing skills help in any endeavor.

Professor John C. Merrill taught journalism at the University of Missouri back then, and he gave the following advice to incoming freshmen: “Don’t go into journalism if you can possibly avoid it.” Although puzzling at first, after consideration it makes sense. Journalism is not something to do for fun, such as crossword puzzles or square dancing. It is more like scuba diving or flying; either do it right or stay away.

Overall, my experience is quite positive, happily serving as editor of the OSU dental alumni magazine since 1982, the same year I became editor of the Columbus Dental Society. I served as Bulletin editor for eight of the next ten years and left to write for the Ohio Dental Association newsletter, publishing eighty-eight monthly “Dental Products News” columns.

My advice to young editors is: If you are going to be a part of the “fourth estate,” the government watchdogs that Thomas Jefferson wrote of, serving as a rumpled reporter to ADA members, then please keep your hat on straight. You can’t ride two horses at the same time. Report the facts faithfully and try to hold a mirror up to society so readers can see what it is.

The dental editor position is often open because some people use it as a political steppingstone. Whatever your goal, be careful not to compromise your integrity. I bumped heads with the Columbus Dental Society director for many years. Imagine the vindication I

felt when this individual was sent to prison for investment embezzling from CBS. Other people, not I, blew the whistle on her.

A Chinese proverb states, “If you sit by the bank of the river long enough, you will watch the bodies of all your enemies float by.”

Respectfully submitted,
Robert B. Stevenson, DDS, MS, FACD
Columbus, OH

DEAR Sir:

I have read, with great interest, your recent editorial entitled “Distributive Justice in Dentistry.” As a lifelong student of business and medicine, I applaud the philosophical examination of the equitable distribution of dental care in the United States. In the spirit of objectives E, G and H of the “Objectives of the American College of Dentists” and as an advocate for those who are arguably the “least advantaged members of society,” I would like to offer some perspective regarding the application of the concepts discussed in the aforementioned article.

People with neurodevelopmental disorders and intellectual disability (ID) reflect “the least advantaged members of society.” A recent survey in my home state found that only 2.7% of people with ID said that it was easy to find a

dentist to treat them. Other surveys have shown that nearly half of these patients will be asked by their dentist to “not return” to their offices. For lack of a politically correct way of saying this, these are patients whom very few dentists want in their practices and, frankly, very few dentists have been trained to care for.

The results of this can be seen in the mouths of people with ID. Studies have shown well over half of adults with ID have obvious periodontal infection, 70% of adults with ID (aged 35-50) are missing teeth, and nearly 35% have untreated decay. A number of lawsuits have been filed against state governments because the dental neglect of this population.

At the outset of the editorial you wrote, an attempt is made to show that dental care in the United States is fair, stable, and efficient. In reference to being “fair” you state that the tax contribution from private practice of dentistry (9%) exceeds the aggregate government spending on dentistry (4%) and, as such, dentists make a fair contribution.

Does this mean that the government could effectively double its purchasing of dental care to 8% of the aggregate and the distribution of dental care would still be fair, so long as the total government purchase of dental service didn’t exceed the tax dollars provided by dental practice? What if the government decided to purchase 15% of the oral health care in the United States? Would it then be fair to tax dentists’ incomes at 50% rather than 30% to cover this increase in government spending? What if the government did not spend any money on dental care at all? Would that be a fair allocation of resources to the underserved? Clearly, defining “fairness” as an

excess in dental service tax revenue compared to public sector dental spending is a dangerous proposition.

Your editorial attempts to equate “stability” with Pareto optimality. Though this nineteenth century economic theory is useful—as a theory—it is difficult if not impossible to show that we, as a society, are anywhere near Pareto optimality with regard to dental care. In order to be in a Pareto optimal state, all states of benefit must be maximized. In other words, any social changes made that benefit one group must make another group worse off, in order to be in the defined state of Pareto optimality.

One of the major assumptions of the editorial is that oral health care is a microeconomy in and of itself. Though one may be able to argue this utilizing nineteenth-century economic theory, oral health care does not exist in a vacuum. When examining the equitable distribution of resources, one must look at the larger ramifications of inadequate distribution of services. Lack of oral health services greatly impacts overall health. As such, it is important to note that when oral health is neglected, that neglect transfers cost into other areas of health care.

Such a scenario is all too frequent in the population of people with intellectual disabilities. In economic terms, the savings of not paying a few hundred dollars every year for routine dental maintenance can result in expending thousands of dollars in unnecessary emergency medical, psychiatric, or neurological referrals. In terms of economic theory, society in general would be better off by allocating a greater level of resources to the dental needs of people with intellectual disabilities because, in the long run, fewer public healthcare resources would be used.

The intent of my perspective here is not to argue whether we are theoretically in an optimal state of dental service for

our society. My intent is to show that even when we can theoretically show that the system is stable, fair, and equitable, real people are left behind. These people do not have the benefit of economic theory to ease their plight. They are the people who are caught in the netherworld between economic theory, which involves perfect systems that affect all people, and reality, which involves flawed systems that only work for most people.

Respectfully,
Matt Holder, MD, MBA
Executive Director
American Academy of Developmental
Medicine and Dentistry

Editor’s Note

Dr. Holder is right that America would stand taller if more of the unmet oral health needs of the least advantaged members of our society could be addressed. Nonetheless, I still feel pretty comfortable with the points in my editorial. Fee-for-service dentistry does not take resources out of the oral healthcare system; it is a net contributor over and above the care provided. I also see no obvious underutilized resources in the system. The fact that there are individuals who are underserved only means that need exceeds available resources. It does not mean that injustice exists in the distribution of society’s resources. That point has to be argued on other grounds and is, in fact, often argued from limited perspectives.

Today's New Dentists Face Professional Challenges and Opportunities

Teri Barichello, DDS

ABSTRACT

The substantial debt load of new dentists is part of the recent trend toward beginning practice as an associate, in a postdoctoral general dentistry program, or in the military. Other reasons include an opportunity to build clinical speed, learning practice management skills, and earning a guaranteed income. While today's new dentists value the same goals of quality, service, and autonomy that motivate established practitioners, they bring new dimensions to the profession. Diversity and a desire for a balanced lifestyle (among both men and women) affect practice decisions and participation in organized dentistry. The new dentist will look for flexibility and responsiveness to personal and social challenges.

Today's new graduates will tell you dental education is expensive! Dentists who graduated from dental school in the 1970s probably paid about \$10,000 in tuition and fees for their dental education, according to data from the ADA Annual Report on Dental Education (1975/76). On average, today's graduates have paid over \$125,000. And while in the past it was possible for many students to get through dental school without taking on a crushing debt load, it's a rare new graduate today who doesn't face student debt. According to the American Dental Education Association (ADEA) Survey of Dental School Seniors: 2004 Graduating Class, the average educational debt on graduation was \$122,263—and only 10% of new graduates were able to finance their dental education without taking on debt. Despite the daunting level of debt, most dental students are confident that the practice of dentistry will allow them to service their loans. In my experience, most new dentists actually are able to overpay their monthly student loan payment to allow them to get out of debt earlier.

This level of student debt, no doubt, has had an influence on new graduates' choice of occupations. In the 1998 Survey of New Dentists on the Impact of Student Debt, 63% of recent graduates said their level of debt had an impact on their practice options, with new graduates indicating that they could not afford to purchase or start a practice. While private practice is still the top

choice, a much higher percentage of new graduates seek a position as an associate rather than going into practice ownership. More recently, the ADEA survey revealed that only 4.1% of the class of 2004 were planning to go into solo practice on graduation, with an additional 6% expecting to be a partner in a group practice. Over 40% planned to take a position as an associate.

Despite student debt and the likelihood of making additional significant investments when purchasing a practice, new dentists have a good financial situation. In 2002, the ADA conducted a survey of New Dentist Financial Issues that looked at income across occupations, and found that non-owner dentists in full-time private practice (associates and employees) had an average annual income over \$109,000. Federal dentists and dental school faculty made less, but they had higher benefits.

Besides providing a stable income to start paying down debt, an associate-ship position helps new dentists get more clinical experience and increase productivity. Another option for gaining experience and speed is a postdoctoral program: more than one-third of today's



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graduates complete a general practice residency or other postgraduate program following dental school. A typical operative dentistry appointment in dental school today will last three hours, regardless of the procedure scheduled. This level of productivity just doesn't translate well in the real world and dictates a period of adaptation for a new graduate to get accustomed to a faster pace. I remember looking at my schedule on my first day in private practice and wondering how I could possibly see that many patients or complete that many procedures. A postgraduate program or an associateship allows a new graduate the opportunity to focus on honing clinical skills as well as increasing his or her speed without the added pressure of managing a staff and running a business.

For dentists who desire practice ownership, spending time as an associate helps new graduates better understand the small business aspects of private practice. There is a lot of variability from school to school in terms of the amount of training, but most new graduates agree that they are not completely prepared for setting up an office, managing staff, or other practice management responsibilities. I started practice as an associate. I focused solely on my clinical skills for the first year and started to learn more about the business side of running a practice in my second year. That second year prepared me for the purchase of half the practice and I have been a fully participating partner since then.

But it's hard to generalize about what new dentists want when it comes

to an associateship. While many do look forward to practice ownership, others may be looking for a flexible lifestyle without the hassles of running the practice. That is why it is so important for established dentists and potential associates to talk about what they are looking for. If you are interviewing a new graduate who is hoping to buy your practice in three years, but you just want somebody to share the patient load for a percentage of collections, your goals are not in sync. It is crucial to sit down long before any employment contract is drawn up and have an honest conversation about the goals and practice philosophy of each person.

Even with much discussion beforehand and a written associateship agreement which spells out patient allocation, the reimbursement method, practice valuation and purchase arrangements, a successful associate relationship is not guaranteed. Patient care philosophy and communication style are just two of the intangibles that make a good relationship and ultimately make a successful business partnership.

In addition, an established practitioner seeking an associate should be prepared that a new graduate is likely to be very interested in emerging technology. Digital technology has already been incorporated into the curriculum in many dental schools. Students are also keenly aware what innovative equipment

Most new graduates agree that they are not completely prepared for setting up an office, managing staff, and other practice management responsibilities.

is available outside of dental school and many are anxious to include it into their daily practice. A potential associate may use the level to which a dental practice is digitized as a determining factor in their decision to join a practice.

New graduates also seem to be more open to non-private practice dental occupations today than in the past. While the numbers of new graduates going into academia or research remain low, at less than 1%, there continues to be 7 to 8% who go into the federal dental services, such as the military or the U.S. Public Health Service. Group practice models, such as community health centers and large group practices, are also attractive to some new graduates because they allow the dentist to concentrate on patient care.

Of course, one big change in the dental profession is the diversity of today's dentists! Back in the 1970s, dentistry was mostly a white male profession. Women were often encouraged to

As the profession becomes more diverse, it will be important for dental organizations to be inclusive in order to remain relevant. The interests of the new generation of diverse dentists may be different that what attracted members twenty years ago.

become hygienists or dental assistants. But enrollment is now approaching 50% men, 50% women. And while over 60% of today's students are white, almost 25% are Asian, with a considerable number of black and Hispanic students as well. As the profession becomes more diverse, it will be important for dental organizations to be inclusive in order to remain relevant. The interests of the new generation of diverse dentists may be different from what attracted members twenty years ago. Organizations may have to alter their recruitment strategies and what they offer as member benefits.

It is not surprising that dentistry is attractive to young women—balancing work and family is very important to many women, and dentistry offers a rewarding, professional lifestyle with flexibility. But it is a mistake to assume it is only women who are interested in flexibility. In my experience, many male new graduates are just as focused on family as their wives are. In older generations, the male dentist was the breadwinner and often had a stay-at-home wife. Today, dual career couples (or even dental couples) are very common. This generational change has had an impact across occupations: even the October 3 issue of *American Medical News* featured a front page story about specialty choices in medicine headlined, “Men, Too, Seek Work-Life Balance.”

With time pressures and competing priorities that so many new dentists face, it is no wonder that many established dentists are concerned about the potential impact on organized dentistry in terms of volunteer involvement. However, as chair of the Committee on the New Dentist, I have the opportunity to meet new dentist volunteers from around the

country, and interest and enthusiasm remains as high as ever. The strength of the American Student Dental Association—at over 85% membership and with their emphasis on involving extraordinary young leaders in organized dentistry—reinforces my belief that tomorrow's organizations are in good hands.

That does not mean that the status quo will do. One thing that is changing is the pace! New dentists are willing to pitch in, but the task has to be well-defined and really make a difference. Standing committees that hold endless meetings with no real results won't attract and keep new dentist volunteers. Organizations will need to adapt to and adopt emerging information technology to ease the time requirements of their volunteers. People who do a great job need to be rewarded with more opportunities right away. The traditional protocol of “moving up the leadership ladder” may not be relevant in the future.

As a new dentist, I have to say that the future of dentistry is very bright. I am very impressed with the caliber of dental students we are training today and with their involvement in organized dentistry. Our profession is based on sound science, and we are making new advances on a daily basis that will benefit the patients we serve. New dentists are getting a sound return for their investment in dental education and enjoy financial well-being and a wonderful professional quality of life.



REFRAMING DIVERSITY: YOUNG DENTISTS AND THE NUMBERS GAME

Ivan Lugo, DMD

ABSTRACT

Diversity is not the same thing as equality, although it creates pressure in that direction. As America becomes more diverse, we would like to see greater progress in access to education and equitable entry into the profession. The new dentist is increasingly both young and a member of a minority group. Foundations, such as Kellogg, Robert Wood Johnson, and the California Endowment, and the Hispanic, the National, and other ethnically affiliated dental associations and the American Association of Women Dentists are becoming a voice to convert diversity into equality.

The bus Rosa Parks rode was diverse. Only when she took action did the long and unfinished ride toward equality for African Americans begin. Diversity is a word that is used to signal the mere presence of minorities, but diversity alone does not signal the power of those present.

The noted chronicler of the state of public education for children, Jonathan Kozol, lamented in a recent *New York Times Magazine* article that schools in New York City call themselves diverse even though 99% or more of the students are minorities. As long as there was one white student attending, the Board of Education labeled the school “diverse.” And of course, the inverse is true: how many dental schools, workplaces, and dental practices call themselves diverse if one or two minority students, faculty, or staff are present?

Is there a “right” number or ratio that signals real diversity? Is there a critical mass, a number that automatically changes the power dynamic? Or are numbers simply the PC measurement of diversity?

The American Dental Education Association states in its policy regarding equality and diversity that “increased access to education by all qualified and motivated students is the nation’s best hope for longterm economic growth and social progress.” To them the goal of diversity is critical to the nation and its changing demographics and critical to social justice. It is interesting that the ADEA separates equality and diversity.

Diversity may lead to equality, but in and of itself, diversity does not guarantee equity or opportunity.

The United Kingdom’s National Health Service understands that and states in its May 2005 publication: *Equal Values: Equal Outcomes: A partnership action plan for the medical and dental workforce* that: “equality and diversity are not interchangeable. There is no equality of opportunity if diversity is not valued.” They have the diversity numbers to substantiate that assertion. The report states that 54% of current UK dental school students are of BME background (black, minority ethnic). Even with those numbers, the NHS still feels these students lack equality of opportunity when they graduate, and they have instituted a five-year action plan to address inequalities.

The high school student in that diverse NYC school knows simply being present, no matter in what number, does not guarantee opportunity. So does the Hispanic faculty person passed over for the deanship. So does the National Health Service. Does the new dentist



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know this as well? Today's new dentists, those practicing for ten years or fewer, have for the most part been in dental schools that have had a concentrated effort to increase the levels of minority and underrepresented students and graduates.

NEW TO THE POWER OF TWO

According to the 2004 Sullivan Commission Report: *Missing Persons: Minorities in Health Professions*, ten years ago in 1995-96, dental school graduation rates for underserved minorities—Black, Hispanic and Native American—were 951, 966, and 73 respectively. For the year 2003-2004, they were 972 African American, 1,058 Hispanic, and 77 Native American, representing an increase of 117 graduates.

As for the dental workplace, while the statistics are not presented by age, the Sullivan Commission found that in 1996 there were 5,201 Blacks, 5,178 Hispanics, and 194 Native Americans resulting in the following percentages: African American 3.4%, Hispanic 3.3%, Native American 0.1%, Asian 6.9%, and White 86.3%.

The American Dental Association in its published statistics available from the ADA master file for the end of year 2003 states the percentage of minorities in the profession as: Black 3.5%, Hispanic 3.3%, American Indian 0.2%, Asian 8.1%, Unknown 28.3% (since the study relies on self-reporting, this number is assumed to be White), and White 56.6%, representing a 1.4% increase in minority representation.

The new minority dentist is new²—new to the power of two—not only a youngster new to the profession, but as a representative of a minority, literally a new force in the workforce, and one, if

we heed the above statistics, that is certainly not increasing exponentially. But, as *The Big Cavity: Decreasing Enrollment of Minorities in Dental Schools* (March 2001, prepared for the W.K. Kellogg Foundation) asserts, “to keep pace with minority population growth, the number of minority dentists will need to triple by year 2050.” If the previous numbers hold—a 1.4% increase over six years—we can expect an increase of less than 10% in the minority workforce by 2050, not the 300% needed to serve a rapidly changing society and, as the ADEA reminds us, contribute to its economic growth and social progress.

The theme of this issue is to reframe the politically correct (PC) notion of “new” to better reflect the role of the recent graduate in the workplace. For the minority in the workplace, PC has become redefined as “Professionally Challenged.”

EQUITY OF PROFESSIONAL ENTRY?

Unlike our United Kingdom counterparts, whose health system dictates a workforce under the aegis of the National Health System—a sort of universal employer—our system is not that easy to quantify. However, one barometer of success is financial reward. Dentists' net income has risen 89% since 1990 from \$94,000 to \$178,000, according the *Survey of Dental Practice* (American Dental Association, 2001). The ADA indicates that sole proprietorships are the most financially lucrative in terms of dental practice and the most sought after: “75.7% of Asian dentists, 77.1% of Black dentists, 76.5% of Hispanic dentists, and 85.4% of white dentists in private practice were practice owners, either as sole proprietors or in partnership. The demonstrated disparity between White and minority dentists may be because the minority dentists were comparatively younger: while 23% of White respondents were new dentists, in practice fewer than 10 years, 42% of Asian, 31.7% of

Black and 40.5% of Hispanic respondents were new dentists.” (*ADA Community Brief*, January 2004: V2, Issue 1)

Underrepresented minorities are entering private practice; are they benefiting? “For sole proprietors, partners and employees, White dentists earned more than Asian, Black or Hispanic dentists in the same category. Asian dentists netted 86% of White dentists' income; Black dentists netted 63%, and Hispanic dentists 81%.” (*ADA Community Brief*, January 2004).

As more young, underrepresented minority (URM) dentists enter private practice, other workforce opportunities for dentists, such as academia, hospitals, and health policy organizations suffer the loss. Minorities are underrepresented within the healthcare leadership, where 98% of senior leaders in healthcare management are White. Few minorities hold senior ranks or senior management positions in academic medicine and dentistry. In fact, according to the *Sullivan Report*, only 30% of dental schools have an URM in their associate dean or dean ranks, and most of those are in schools that traditionally serve the URM.

These professional challenges for the young dentist are why even in the United Kingdom, where 38% of hospital and community health services medical and dental staff have Black and minority ethnic backgrounds (*Equal Values*, May 2005), there is still a recognition that committing to strengthening career progress is the true commitment to equity.

Addressing the professional challenges of the young dentist in private practice, and increasing the diversity of educational and policy leadership are universally understood as the mechanisms to

achieve parity and access to dental care for the larger underserved minority population. The ADA, ADEA, and *Sullivan Report*, all recognize that the young minority dentist is the major provider of dental care to the minority population.

As the Kellogg Foundation states in *The Big Cavity*: “Declining minority dental school enrollments mean that the two fastest growing segments of the nation’s population, the African American and Hispanic communities, will have even more oral health problems in the future.... Minority providers, whether dentists or physicians, are often more culturally sensitive to the needs of patients from their own subculture.”

NEW VOICES

Who is pushing the effort to augment, increase, support, and strengthen the ranks of minority dentists at all points along the continuum to practice? A major voice for the minority dentist and an effective one for placing their needs before the public and policymakers, are the professional organizations: The Hispanic Dental Association, The National Dental Association, the American Dental Association, with its affinity groups, and the American Association of Women Dentists. They, along with foundations such as Kellogg and Robert Wood Johnson, are pushing for policies that will guarantee the economic growth and social progress sought by the ADEA.

What are the policies that may make a difference? The Hispanic Dental Association recommends the following improvements:

- Dentist participation in Medicaid
- Loan forgiveness programs
- Scholarships
- New dental schools
- Tax incentives
- Expanded allied programs
- Changing licensure requirements
- Primary school-based clinical care
- Hospital-based programs

Others expand the above list to include changing not only individual state licensure requirements (such as lifting restrictions on state-to-state movement, mandating diversity, or improving cultural awareness training) but revising accrediting bodies, such as the Joint Hospital Accrediting Committee or the educational accrediting agencies, to deny accreditation to institutions that do not make a systemic commitment to equity through diversity. They also mention state initiatives to fund and provide workforce development training.

The California Endowment, in its *Policy Issue on the Dental Workforce: Diversity and Community Based Dental Education*, issued in November 2004, discusses the effects of two additional measures: the lack of up-to-date data on the dental workforce, which they feel, hinders policy changes; and the idea that a postgraduate year of community service should be required for all DDS or DMD graduates. The endowment did not get positive response to the postgraduate service requirement from current providers and policymakers, but it recognizes that if only underrepresented minorities serve the minority community, other dentists will not gain the cultural competency to serve what is fast becoming the majority community.

The issue of diversity is compelling and complex. This article has only touched on the underrepresented minorities. Clearly, the role of women and other minorities impact the workforce and the ranks of the young dentist. The ADA reports that in 2002 38.8% of DDS and DMD graduates were women, and it sees 40% as becoming the norm. It is interesting to compare this with the United Kingdom, where 58% of the workforce is female. Equity issues must

also recognize the “invisible” minorities, such as lesbian and gay dentists, as well as the needs of the disabled dentist.

The “young dentist,” regardless of racial or ethnic affiliation, is experiencing a changing demographic in the United States and must become more diverse and culturally competent in order to reach the destination of providing good oral health care for all Americans. ■

The new minority dentist is new²—new to the power of two—not only as a youngster new to the profession, but as a representative of a minority, literally a new force in the workforce.

NEW DENTIST SHOWS COMMITMENT TO COMMUNITY AND PROFESSION

Karen Burgess

ABSTRACT

In 2005, Dr. Jose Peralez won the ADA's Golden Apple Award for New Dentist Leadership. He is a second-career native of the Rio Grande Valley who returned after his 1995 graduation from dental school to serve the community he grew up in. Dr. Peralez helped to purchase, manage, and staff a mobile clinic, create a voucher program administered through school nurses, and engage legislators in issues of oral health care for the underserved. He believes that "habits of involvement" are cross generational and contagious.

In the late 1980s, Jose Peralez had a satisfying career as a middle-school science and math teacher—coaching football, basketball, and track—in Texas' Rio Grande Valley. But when one of his father's best friends, Dr. J. I. Ochia, said "We need dentists in this community—you should go to dental school," the young man rose to the challenge.

"I started dental school at the University of Texas-San Antonio in 1991," Dr. Peralez said. "I was one of the older students there, at thirty-one—even older than some of the part-time faculty! With dentistry as my second career, I knew just what I wanted: to go back to my home town as a general dentist."

After his 1995 dental school graduation, Dr. Peralez did just that, moving to Edinburg, Texas, just fifteen miles from the Mexican border. He worked as an associate for two different dentists, as well as giving one day a week to the county dental clinic.

"I did a lot of work with the indigent and saw a lot of Head Start kids and Medicaid patients, and many of my patients had no insurance at all—a sliding fee scale was essential."

According to Dr. Peralez, although the Edinburg area is one of the top three metropolitan areas in terms of growth, it is also home to two of the five poorest counties in the U.S. Meeting the need for dental care for the poor was one of Dr. Peralez' priorities, even as he was taking the plunge into practice ownership.

"It was tough to get a loan," he said. "As senior dental student, all the banks in San Antonio were offering us all loans, but I thought it was important to go with a local bank. Then when I was ready to start a practice from scratch, the local lenders said 'Sorry, buddy, you've got \$80,000 in student loans!'"

Ultimately, the young dentist was successful in getting a Small Business Association loan and launched his own solo practice, with his wife Geena serving as his office manager. The same year, dentists in the Rio Grande area launched a group called "Dentists Who Care." Dr. Peralez was on the original Dentists Who Care board of directors.

"In 1997, a group of dentists got together to talk about the huge need for dental care, especially emergency dental care for the indigent. So we got a loan from the Department of Agriculture for \$225,000 to buy a start-of-the-art mobile clinic. It's all digital, and we had a lot of donations from dental suppliers.

"We've grown now and have about a hundred and forty dentists who give their time in the van in their own communities," Dr. Peralez explained.



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“We provide over \$500,000 worth of free dentistry every year.”

Recognizing that not all dental needs can be met in the mobile van, Dentists Who Care also provides vouchers for care to be redeemed in the dental office, which are distributed by school nurses in the area. According to Dr. Peralez, the average fees for the dental care given in exchange for a \$100 voucher is \$230.

Not surprisingly, Dr. Peralez swiftly came to the attention of his older colleagues early in his dental career.

“In my area of Texas, we have about a 94% participation rate in ADA membership. ASDA does a great job in our dental schools, so the first thing most new graduates do is go to a local ADA meeting,” said Dr. Peralez. “As a new dentist, I know that we migrate towards each other, we want to know what others are doing. It dovetails mentorship with leadership!”

Because of his early involvement in organized dentistry and visibility on access to care issues, Dr. Peralez was tapped early to play an active role in government affairs for the Texas Dental Association.

“Getting to know your state legislators on a personal basis is important,” he explained. “It’s not just giving them checks to support their campaign.”

With a good relationship established, Dr. Peralez is successful in getting the ear of legislators on topics like Medicaid and managed care. “We have to beat the drum,” Dr. Peralez explained, “because Medicaid, the indigent, and oral health care are not priorities in this state. Our dental budget is less than 1% of the

entire Medicaid budget. That tells you where oral health is on the totem pole.”

In recognition for his community involvement and activism in organized dentistry, the Texas Dental Association nominated Dr. Peralez for the American Dental Association’s Golden Apple Award for New Dentist Leadership. Among a field of well-regarded nominees, he was awarded the Golden Apple in 2005.

He is modest about his recognition.

“In our region and our state, we are interested in volunteerism. The older dentists set a good example. When you see the involvement of others, it’s contagious. As Vince Lombardi said, ‘Good habits are contagious and so are bad ones.’ We have people who really help you establish good habits here.”

In fact, that is his advice to older dentists regarding their younger colleagues. “Take an active role and get new dentists involved,” he said. “Put yourself out there. Invite a new dentist to lunch.”

But are Generations X and Y really interested in involvement? Dr. Peralez says yes. Despite the financial pressures of high student debt, the stress of establishing a practice, and the typical family growth—the Peralez family grew from no kids to three girls ten years of age and under—he is confident.

“Part of what sets our profession apart is that we are not selfish people! If we set a good example for new dentist involvement, and we will have a good next fifty years of dentistry coming our way.” ■

“As a new dentist, I know that we migrate towards each other, we want to know what others are doing. It dovetails mentorship with leadership!”

MENTOR SAYS LEARNING IS A TWO-WAY STREET

Karen Burgess

ABSTRACT

This year's winner of the ADA award for Individual Achievement in Mentoring, **Dr. Ronald Stifter** explains how opportunities exist for established dentists to mentor students and young practitioners. In a changing professional world where competition, debt, and diversity have grown, the guidance of a mature dentist is a valuable way to invest in the future of the profession.

Ask Dr. Ronald Stifter what his protégés receive from his mentoring, and the discussion quickly turns to the personal benefits of mentoring. "Mentoring really keeps you on your toes," he explained. "You want to keep the students shooting for high levels of achievement. So it forces you to do the same thing in your practice."

Dr. Stifter, the recipient of the American Dental Association's Golden Apple for Individual Achievement in Mentoring in 2005, has been involved in mentor relationships throughout his dental career. He started young, as a dental student at Marquette University, when he worked part-time as a dental laboratory technician for an area dentist who became his own personal mentor. After graduation from dental school in 1967, Dr. Stifter completed a three-year tour as a captain with the Army Dental Corps in Germany, and came back to Milwaukee as an associate for his mentor, taking over the practice when the dentist retired. As he began his private practice career, Dr. Stifter also came on board as an adjunct faculty member at Marquette, working hands-on with students learning fixed prosthodontics.

"My entry into mentoring was really an outgrowth of my teaching experience," he commented. "As a part-time faculty member, I was in the perfect position to help students both in the school setting and in the practice setting. It's a natural way to interact with the students."

Letting the students set the agenda for their conversations is important,

according to Dr. Stifter. While discussion topics often address how things are done in a real-world practice, interacting with patients, financial issues, and ethics, Dr. Stifter explained, "I like to let the questions evolve. Once some of these important questions come up, you can expand on them, letting students see the multiple sides of the issue involved. I try not to force my own opinion, but let students discover their own."

In his thirty-five years of practice and on the faculty of the dental school, Dr. Stifter has noted some changes in dental education and in the dental profession. "The cost of dental education is high; many students are graduating with \$180,000 to \$200,000 or more in student debt. This puts financial pressure on the students. It was a lot more common for dentists to go directly into practice ownership after graduation when I went to school. There wasn't as much competition out there and financially it was not as difficult to set up a practice," said Dr. Stifter. "Today, I encourage my protégés to try an associateship or to take a general practice residency and get that extra year of experience under their feet. For those that do take a GPR,



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I recommend they consider a residency elsewhere—getting a different group of teachers can broaden their scope.”

Another change in the last thirty-five years is the diversity of dental school students. The biggest change is one of gender. “When I was in school, there were three women in our class. Recently, we had a class that was more than half female, and my expectation is that there will be just a few more men than women in general,” he said. According to Dr. Stifter, dual career couples are common, as are “dental couples”—where both the man and the woman are dental students, and later, dentists. “It’s a natural outgrowth,” he said. “There are simply more women there!”

Dr. Stifter has also noted another change: getting into dental school is more competitive today than ever before. “The number of applicants for Marquette has really increased. Most recently, we had 1,800 students applying for 80 spots, and 500 to 750 of them are really serious about the school. These days, almost everyone who is accepted to Marquette enters school there. In the past, we would have a number of people who would apply, be accepted, but ultimately select another school.”

Helping mold these young, inquisitive students—the dentists of tomorrow—is exciting for Dr. Stifter, and he recommends getting involved in a mentor program to any established dentist with an interest. Many state dental societies sponsor programs.

“I’ve been involved with the Wisconsin Dental Association program—which is cosponsored by the Pierre Fauchard Academy, Marquette School of Dentistry, and the Greater Milwaukee Dental Association—since 1995, the year it was established. I usually get one protégé per year,” Dr. Stifter commented. “The program offers structured opportunities to interact with students, like the Give Kids a Smile program, Head Start projects, and social events like our annual mentorship dinner and Marquette basketball games.”

In addition to the intangible rewards, many established dentists find the answer to a common dilemma through mentorship: expanding their practice or selling it in preparation for retirement. “When you get involved, you get to know the students, and you may just find someone to bring in as an associate or sell your practice to. It’s a huge advantage to know the students well,” Dr. Stifter said.

The key to a good mentor-protégé relationship? Consistency. Dr. Stifter explained, “Dental students’ lives are hectic and they won’t always reach out. As the mentor, you need to be the one to initiate contact and make the effort to make it work. It’s kind of like being a parent!” ■

“It was a lot more common for dentists to go directly into practice ownership after graduation when I went to school. There wasn’t as much competition out there and financially it was not as difficult to set up a practice.”

Clinical Licensure Exams: The UNRuly GATEKEEPERS

Timothy W. Oh

ABSTRACT

A dental student approaching graduation reflects on concerns over initial licensure examinations. Among the issues that have been recognized but remain unaddressed are ethical treatment of live patients, unfair treatment of candidates, excellent reliability among examiners on any single case but poor consistency across testing, lack of validity, and no evidence of protecting the public. The licensure system would be improved by paying attention to issues of mobility and continued competence.

As graduation day approaches our thoughts turn to hunting for the first job, that first paycheck, and the dream office with the exotic fish that will fill the waiting room aquarium. However, there is one last hurdle beyond the world of clinic requirements, competencies, projects, and grade-point averages. Licensure—the piece of paper that says you are qualified to be let loose on the public, to hang a shingle and do dentistry.

Currently, almost every state requires new graduates to pass a clinical licensure examination to obtain initial licensure, the notable exception being New York and those following suit by recognizing a PGY-1 year of education option. This crucial step in the process of obtaining one's license has been under scrutiny for some time. In March of 1997, the ADA drafted an Agenda for Change with objectives developed at the Invitational Conference for Dental Clinical Testing Agencies. This document, still posted on the ADA Web site, called for all involved entities to work together to "facilitate improvement in the clinical licensure process." Outlined in this text are twelve objectives meant to effect positive change in the process of initial licensure. Some of these goals have been met, but many of the concerns are still salient today. Nearly ten years later, four of the top five objectives for initial licensure have not been met: standardization of all exams for content and methodology, creation of a common exam, minimal

use of human subjects, and procedures to make clinical licensure examinations more candidate-friendly. The ADA, the dental schools of North America through ADEA, and the ASDA have all called for change in the methodology of U.S. clinical licensure exams and how the results are used. The consensus has been achieved; in 2003, 96% of leaders in dental education that responded to a survey by ADEA felt that there needed to be a change in the licensure procedures at a national level. It is time now for action.

The concerns of the new dentist and soon-to-be new dentist (the dental students) are that the exams in their current format are not uniform, do not validate competency or protect the public, are of questionable ethical soundness, and create barriers to geographic relocation.

Few could argue that there are different skills or knowledge required for practicing dentistry in Florida or California, Hawaii or Maine. Yet, there are different clinical exams with different standards that are administered to obtain licensure across the country. At last count, there were over a dozen different clinical licensure exams currently in use either in state-specific (10) or regional (5) formats. We have created national standards for accrediting dental schools and for the NBDE exams. Shouldn't we



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also have a single criterion for assessing a student's clinical competency?

Competency is important. The bottom line is that we do need competent dentists—competent when they graduate and competent five, ten, twenty, thirty years down the road. The public must be protected. That is why the ADA stipulates guidelines for accrediting U.S. dental schools and why the laws of every state require dentists to be certified by an accredited dental school. But who should be the judge of competency for the new dentist?

We students sometimes pay in excess of a quarter million dollars to be taught the skills, knowledge, and values to be competent dentists. Why then are these same schools seen as unfit to assess the outcomes of the training process? The dental community allows schools to judge competence in coursework. Many boards refer dentists who have proven to be incompetent in practice to schools for remediation—and accept the school's word that these questionable practitioners are fit to practice. The two-part NBDE examination is developed with the ADA by the dental education community and practicing dentists. Why then is the testing of clinical dentistry skills currently outsourced to licensing agencies and state boards with minimal control or, on occasion, with outright disregard for input from the dental education community or even the ADA?

How can a one-shot clinical examination on a live patient complicated by all the high-stakes variables, minute scrutiny by strangers to both the practitioner and the patient, be seen as a valid measure of overall competency? Do not teaching schools with a more complete picture of the abilities of each student have a better grasp as to the overall com-

The concerns...are that the exams in their current format are not uniform, do not validate competency or protect the public, are of questionable ethical soundness, and create barriers to geographic relocation.

petency of each student? Dental schools should be ultimately responsible for mandating clinical competency of their graduates relative to a national standard created in cooperation with the dental education community and the dental profession as a whole.

One of the primary functions of the clinical licensure examinations is purportedly to protect the public from incompetent dentists. Yet when we examine what infractions by dentists lead to censure by state boards, we see the overwhelming majority of complaints center around ethical issues. These include lack of communication, informed consent, insurance fraud, and impaired practitioner, and substance abuse. Very few licenses have been revoked in the U.S. for a one-time overextended Class II prep.

If we really want to protect the public, we need to focus on teaching proper ethical behavior, focus on peer review, and begin immediate creation of continued competency systems for practicing dentists. Who is more dangerous to the public: the new dentist freshly trained and acquainted with the cutting edge of the profession by having been immersed in dental education for years, or the "cottage dentist" isolated in a solo practice who has not systematically upgraded the skills learned in school and only signs up

for CE courses that happen to coincide in location with the annual ski trip?

The irony in all this is that we are trying to protect the public from "problem" (unethical) dentists by using an exam that is arguably unethical itself.

Many have suggested that the clinical licensure examinations, in their current format of using live patients, raise significant ethical concerns. Chief among these issues are:

- Students are forced to delay treatment of "ideal" lesions and periodontal disease until testing day arrives. Are patients being harmed by being denied treatment when they need it as students "save"—or at worst "grow"—their best lesions/patients for the clinical exam?
- Are patients offered comprehensive care when they are treated for one procedure alone and this procedure may be out of sequence from a treatment plan or may be performed in the absence of any treatment plan?
- Are examination candidates, who are cutting teeth and performing irreversible procedures on patients without being able to ask questions, seek advice, or receive help, practicing dentistry without a license?
- There is an incentive to pass the exam rather than treat the patient. Many times the imposed time limits cause a candidate to rush to complete work. The resulting restorations may meet exam specifications but not the standard of care that could have been provided.
- What recourse do patients have when their candidate fails the exam? Have they been harmed in any way by receiving care from a candidate deemed "officially" incompetent to practice dentistry?

Besides these possible ethical infractions in patient care, there is also concern over the ethical treatment of candidates. Of course there is the issue of the fairness of basing licensure on a test vehicle that is inherently variable. Candidates are not evaluated equally if there is no uniformity of the exam. Fortunate candidates are able to find patients with “ideal” carious lesions, and then have these patients show up the day of the exam. Other candidates must be tested on additional skills and knowledge such as proper methods of preparation extension and judgment in the placement of bases and liners. Any dentist can attest to the variability of cases between patients. A similar procedure can be

With the realities of life in the twenty-first century, graduating dentists need to be able work upon graduation and must be free to relocate between states and regions.

extremely difficult on one person yet very easy on another. How then is this test standardized?

The use of live patients leads to other problems. Is it really a fair exam if your “test” can stand up in the middle of the process and demand \$1000 cash to stay the rest of the time? Should a student who has trained for four years and done well by every other standard be judged incompetent if the patient fails to show up, or stands in the wrong line to be graded? What other type of exam requires you to reimburse your “test” for their time or, worse yet, fly your test subject across country and pay lodging and meals? To definitively remove the ethical concerns regarding patients and create a test that is fair to the candidates, the use of live patients in clinical licensure examinations must be eliminated.

Finally, we must look at the validity of the results of the existing examinations. One must also look at whether there is a correlation between student’s clinical exam score and other measures of clinical competency. Several published studies have indicated that a single “snapshot” exam of a candidate can yield results incongruous with other measures of competency utilized during dental training. The reliability of the exam is also questionable when failing candidates are able to pass either the same or a similar clinical licensure exam within weeks of the first exam. Is a student who passes WREB but fails California boards more or less competent than a student who passes California boards but fails WREB? Sometimes the answer depends on which side of the street you stand on in Tahoe. Licensure bodies have worked hard to improve the reliability of the ratings given by examiners, and they should be acknowledged for that. Concern remains, however, over the lack of reliability from one testing situation to another and especially over

lack of consistency between testing and practice performance.

Of all the players in the dental community, it is the students, those in the first stage of their career, that stand to gain or lose the most. The marketplace of dentistry has changed, and with the realities of life in the twenty-first century, graduating dentists need to be able to work upon graduation and must be free to relocate between states and regions. The current lack of a national standard impedes the free market and the ability of dentists to relocate. It is true that states and their dental boards need to regulate at some level the professionals in their state, but medical doctors can apply for license in all 50 states after passing their national standardized three-part exam. A young professional who by bad luck has a board patient who fails to show or a lesion that is rejected can lose more in income than the entire cost of a dental education.

The process of licensure needs to be fair, ethical, and effective. Currently, the clinical licensure exams in use in the United States do not fulfill these standards, nor does the ADEX exam or any other clinical test using live patients that is currently being investigated for consideration as a national clinical examination. The current debate has descended into squabbles over turf and details, losing sight of the big picture. Politics, millions of dollars, and conflicts of interest are fueling discussion about minutiae when few are looking at the real issues surrounding licensure exams. The dental education community, and dentistry as a whole, must take responsibility for ensuring competency and ensuring that a degree from a dental school in the United States is a respected sign of excellence. ■

VISIONS AND VIEWPOINTS: PROMISES AND REALITY

Kenneth D. Jones, Jr., DDS, JD

ABSTRACT

The immediate past chair of the ADA Council on Ethics, Bylaws and Judicial Affairs, who is also an attorney, explains why, after a thirty-year absence, he went back to treating Medicaid patients. It is easy to identify the social, political, bureaucratic, and financial shortcomings of our imperfect system. But how else, besides participating, can one educate patients so the dentist and the patient can both accept responsibility? How else can the profession make a difference except one patient at a time?

Hi. My name is Ken, and I'm a Medicaid provider. Three years ago, after a hiatus of twenty-seven years, I again started taking Medicaid patients. And, although I often think about quitting again, I take being a provider one day at a time.

Most of you have heard the Biblical exhortation, "Let he who is without sin cast the first stone." Ladies and Gentlemen, in my dental, legal, and council career, I have seen enough stones to make a rock garden. Now, I'll admit, I'm not entirely without sin. Even so, today, you may hear me drop a rock or two into the abyss of access.

So, let me tell you my story, the tale of a general dentist trying to cope with conflicts of time, money, commitment, and conscience.

History: The last Medicaid patient I had seen was in 1975. That was when I got a letter threatening legal action for making a denture for an ineligible patient and accepting payment for it. (They ignored the fact that the patient had, at every appointment, a valid card issued by their mistake.) I returned the \$177 to the State of Ohio, and never took another patient.

Recent history: In a column I wrote, I made the observation that: "If we really want to increase access for the needy population, then every dentist must participate. In today's world, that will happen only if it is required for licensure." I stand by what I said. Total participation will occur only if forced.

And having opened my mouth, I thought that maybe I should walk the

walk as well as talk the talk. I needed to find out if my perception of today's problems of taking Medicaid patients was the same as it was thirty years ago. I decided, once again, but on a limited basis, to take "the card."

First, I had to find out if my provider number was still valid. It took eleven long distance calls to have someone tell me I had to make a new application. I did, and I waited for a reply. And waited. And waited. Three silent months later, it only took seven long distance calls to find someone who could and would tell me that my original number was still good. Then I had to fill out a W-9 and a direct deposit authorization. That was acknowledged in only...well, actually, never!

OK, what about claim forms? And how much does Medicaid pay? For what services? And what needs to be

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preauthorized? Back to the phone, only now I had a name and a number to contact in the Ombudsman's Office. He was immensely helpful in directing me to the Web sites that had all that information. Don't even try to get it by mail.

Turns out, I no longer needed a special typeface or Medicaid claim form. A standard ADA form is OK. Special directions for the blanks to fill in are online, too. Simpler, and less info needed, than a normal insurance claim. So far, so good. How about electronic submissions? Well, that department was a little grumpier when I called. I decided to forget that for the time being.

Shortly, the first day's first call for the card came in. Within three days, there were fifteen patients on the books and the phone kept ringing. At that point, I stopped booking until I determined whether any submission and payment problems might occur. You know, let's make sure we get paid and that the payment gets into the right bank account.

Soon, I tried to access the automated phone system to check on the status of overdue claims. Nightmare! Long introduction to every keypress. Disconnects at every turn. No live help that I could find. Another call to the Ombudsman's Office got me switched to a Provider Assistance Operator, who was the nicest, most patient, and most helpful government employee who ever had to deal with me. She answered my questions, checked my math, and walked me through every step of the voice system. Then she took twenty minutes to show me the key sequences and timing it took to bypass all the time consuming garbage on the system. She deserved a raise.

So, why did I put up with the hassles that remain and continue as a Medicaid provider? Well, here were my initial observations after several months:

- These are the same mix of good and bad patients as the rest of my practice.
- They had a very high rate of sealants placed. But four of five teeth had sealants that appeared poorly done and had recurrent decay.
- Two-thirds of these patients needed at least one endo. Two-thirds needed at least one extraction.
- There was a much higher rate of recently done, poor quality work than the average population, some bordering on awful.
- Most adults had at least one job. None with kids were married. Only one had established a two-parent household.
- Many were more appreciative of my time and effort to treat and educate them than the average dental population.

But why do some of us continue and some not? Well, I have some opinions why some of us do and some of us don't, and why some of us say we should, and some of us say they won't.

The very real issue of access to dental care is a complex one. In many ways it echoes the complexity of societal changes I've observed over the last third of a century I've been in private practice. These are things we need to discuss. We need to discuss priorities, not only of dentistry, but also of dentists and of society in general, even if it's not politically expedient or politically correct.

My era of dentists made a commitment to their communities. Ninety percent ended up in solo practices, with few progressing to groups of more than two. Their patients could trust that they would be there to take care of their needs. Many of today's young dentists seem to lack that sense of future com-

mitment. To them it's "a job" that they can move on from, if and when their spouse gets a better job or their income doesn't hit six figures quickly enough. I ask students "how many did not put on their personal statement when they applied to dental school that they wanted to help people." No one raises their hand. They knew what it takes to get into dental school. They also know what it takes to get out. It would be interesting to see, after a few years, the commitment to "help" those who can't afford fillings, let alone crowns, endodontics, periodontics, or implants.

Some of the students I speak with are from poor and disadvantaged backgrounds themselves. I am told that few return to their roots; to the communities that need them; to the youngsters that need a positive role model. I hope that is not true, but more than one educator has said the same thing.

The seeds of social ethics cannot be planted in dental school and be expected to take root. That attitude is one that is either there or is not, long before the prospective student arrives in the fertile fields of higher education. However, an already bountiful harvest can be nurtured by our dental educational system, but it only works when done on a daily basis. My challenge is this: Can our dental schools find those prospects that are not only bright and talented, but have the ethical commitment to make a difference from day one? Do we need less emphasis on who has the class with the highest GPA and a little more on whose class will remain true to that personal statement that said, "I want to help people"?

And it's not just students and educators whose priorities may need revamped. I look at the topics of our CE speakers, including our ADA speakers—given the choice, at the same fee, between another course in practice

management, implants, makeovers, esthetics, or ethics, who would choose ethics? Few, since that doesn't increase the personal prestige or the bottom line.

In our *ADA Principles of Ethics and Code of Professional Conduct* (ADA Code), we speak of the "Qualities of compassion, kindness, integrity, fairness, and charity [that] complement the ethical practice of dentistry and help to define the true professional." We proclaim that "The ethical dentist strives to do that which is right and good. [And that] the ADA Code is an instrument to help the dentist in this quest."

We declare to all that, "Under [the principle of Justice], the dentist's primary obligations include dealing with people justly and delivering dental care without prejudice. [And i]n its broadest sense, this principle expresses the concept that the dental profession should actively seek allies throughout society on specific activities that will help improve access to care for all.

Do we really believe that? Or are the new car, bigger house, second home, country club membership, shorter hours with higher fees, and a "makeover" practice what you really meant you wanted to do when you applied to dental school? Is helping people something that only others should do?

In spite of some peoples' attitudes about our Code of Ethics and our approach to access, we are doing things now to improve access to care. Granted, not enough, but steady progress. We need more of these programs, and more individual dentists who care. We will not solve society's ills in a day, a week, or a year.

I cannot deny that there are barriers to be faced, every day. Reimbursement is poor, but you can adjust your way of

practice to do well. In many states, the built-in aggravation of working with government-funded bureaucratic programs, though less than in the past, is still a factor for many of us. And though it is not often politically expedient to discuss, as professionals, we are expected to deal with society's changing priorities as well. And those priorities, both within and without dentistry, are not only those of the needy. For example: I see a widespread loss of commitment to the family. Family used to care for family. Now, it's seen as the government's job. The clients who call my law office most often, asking how to make sure their parents can qualify for Medicaid so the estate is not used up when they head for the nursing home, are well-to-do professionals.

There was a loss of stigma when we dropped the term "welfare" and replaced it with "Medicaid eligible." Folks used to work to get off the welfare roles. Now Medicaid is often seen as a right.

We need to acknowledge the morass of misguided societal priorities that exist, and not stick our heads in the sand. They should not be used as an excuse to exclude segments of the population from our offices. We need to use them as an opportunity to educate our patients. We need to help them separate the "wants" from the "needs." We need to help teach them that the necessities of life and support of family are different, and much more important, than optional luxuries and poor lifestyle choices. We need to help make them aware, that not only can we help them, but that they can help themselves.

We owe a duty and an obligation to society and to dentistry, as a profession and individually, to use our best efforts in resolving, to the extent we can, the disparity in access to dental care. We must educate our members about society's expectations and dentistry's obligations.

We must educate our leaders to understand that the access problem is not all our fault; that we will help, but that we will not, and can not, solve it alone. We must educate our patients, not only about dentistry, but also about their taking responsibility for their actions. We must make them aware that if they expect more from themselves, they will get more by themselves, and we should take that same advice, expecting more and letting them know it.

**My challenge is this:
Can our dental schools
find those prospects that
are not only bright and
talented, but have the
ethical commitment to
make a difference from
day one?**

We cannot fulfill those obligations by turning them away.

That's why I continue to treat the underserved. If I can change a patient's life here or there—and I know I can't change them all—then I can sleep better at night, knowing that I have done my best to fulfill my obligation to my profession, to my family upbringing, to my patients, and to a society that says that what I do matters.

In a nutshell, my vision and my viewpoint, my promise and my reality all boil down to this: my name is Ken, and I'm a Medicaid provider. Maybe I can make a difference, one day, one appointment, one parent, and one patient at a time. ■

ISSUES IN DENTAL Ethics

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WHAT DOES THE FACT OF ADVERTISING CONVEY TO PATIENTS?

Ashi Adamjee, David Alfi, Divya
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Chan, Marshall Chey, Hyung Cho, and
Christopher Choi

A cab driver once told me on a ride home from a late night of studying that “dentists are thieves.” He expressed a dark side of the profession about which I was naïve. In knee-jerk reaction, I adamantly defended dentistry, saying how his experience was atypical and did not reflect the profession as a whole. Yet he ranted on and likened dentists to car mechanics, complaining that his dentist had done unnecessary work for the sake of profit. As I gave it some thought I became partly sympathetic. Recently, I had entrusted a mechanic to fix my car transmission and he had refused to explain in detail what he had done to justify the expensive price, not that I would have understood anyway. It was then that I realized that patients might go through the same vulnerable process, defenseless to all types of unethical activity.

Dental professionals are not always perceived as ethically competent. For example, some offer “free consultation,” but charge a hefty fee for associated radiographs not mentioned in advertisements. Orthodontists may quote a fee without mentioning the cost of the retainers. The patient is not referred to a specialist as the dentist convinces the patient that they can perform the required procedure even though they

might not be able to provide the best of care. Misleading advertising is used in order to induce patients to come to the dentist with unjustified expectation. In some cases the dentist may advertise the treatment records of a patient in order to attract new clientele, disregarding patient record confidentiality.

This paper considers ethical issues associated with truth-telling in dentistry, specifically in advertising. It addresses how advertising in dentistry affects the profession and the public with respect to integrity, autonomy, veracity, non-maleficence, and beneficence.

Marketing in dentistry has never been more prominent—television commercials, magazine ads, journal advertisements, billboards, “free lunch” lectures, etc. Consumers and dentists are being pounded with information regarding brighter smiles, healthier gums, and straighter teeth. Dental businesses are luring in patients with attractive offers and promising results, but are they truthful?

“What Does the Fact of Advertising Convey to Patients?” was written by junior students at the Columbia University School of Dental and Oral Surgery. “Changing Perspectives on Dental Advertising” was written by senior students. These papers were selected from among projects submitted by students in the ethics program supported by the American College of Dentists at the school. The papers were submitted by Drs. Henry Chalfin and Robert Miner of the College.

A bright smile is desirable in American culture and many dental claims are now made for whiter teeth. By looking exclusively at the ingredients and claims, it may seem entirely convincing that whitening products should perform as they promise. Nevertheless, there is no sound evidence that they are any better than a whitening dentifrice. The claims mislead the consumer, giving the wrong impression that their teeth will be as white as if a dentist professionally did it. Perhaps this explains why no whitening toothpaste or over-the-counter gel has applied for or received ADA acceptance for a whitening claim. Such acceptance would require the product to meet the same safety and efficacy standards as the professional gels.

Whether the claims are misleading or not, the profession is paying a price for advertising. As David Ozar and David Sokol note in the book *Dental Ethics at Chairside*, "To any audience reasonably cynical about the contents of advertising and marketing language...the fact that dentists employ any kind of language or imagery that resembles standard advertising "puffery" suggests that they are not communicating with their clients literally and carefully in terms linked to scientific fact. This suggests that they are willing to place a 'sale' ahead of meeting the patients need." This argument is in harmony with the one the cab driver mentioned: that dentists prioritize selling a product or service over all, including the best treatment. Thus, aside from the conventional complaints that advertisements can be misleading or even deceptive, the very act of marketing in dentistry does influence the public's attitude towards dentists. Perhaps this provides some insight to a recent Gallup poll concerning the public's assessment of honesty and ethics of

various professions that the average rating of dentists is 53%, a lower rating than other healthcare providers such as nurses, medical doctors, veterinarians, and pharmacists.

Ozar and Sokol identify several models for the relationship between dentists and patients. In the "Commercial Model," advertising could play a significant role. Both the practitioner and the patient are active participants. The dentist has the same obligations as any tradesman. The patient's needs and well-being play a secondary role in determining the dentist's course of treatment; the primary motivation being that which will benefit the dentist to the greatest extent in terms of factors such as time and money. The patient is seen as a homo economicus, the rational consumer, who weighs all the elements of cost and benefit relevant to a given exchange and chooses the available product or service that yields the best combination of these.

However, most patients are not trained in dental science and are unable to play the role of a rational consumer. Another problem is that the patient and the dentist are regarded as co-equals in this model, yet patients who suffer an illness often feel a decrease in their ability to direct their lives and experience of loss of autonomy. They do not enter the relationship on equal footing with the dentist.

This trend toward the commercialization of dentistry is due to a combination of social and economical factors. In the 1960s and 1970s there was an increase in the number of students admitted to dental schools, but there was no concurrent increase in the user population. In fact, there was a relative decrease in the need for dental treatment due to factors such as fluoridation. The 1980s saw the emergence of insurance companies and their attempts to control healthcare costs as well as an increase in the tuition of dental students who were now graduating with a greater total debt. There have also

Whether the claims are misleading or not, the profession is paying a price for advertising.

been certain social changes, such as a switch from a manufacturing economy to a service-oriented economy and an increase in consumer education. In 1979, the ADA prohibition of competitive advertising was eliminated resulting in a surge of competitive advertising.

When an individual decides to enter the dental profession, an agreement is made to fulfill the obligations of this profession toward the maintenance of the well-being of the community. It is through the fulfillment of this commitment that trust is gained. However, if we deviate, we lose this trust. With the increase in competition in our profession, some forget that our primary obligation is to serve the patient and the public at large and that a professional's primary concern is service, not prestige or profit. The dentist's financial gain should always be secondary. ■

CHANGING PERSPECTIVES ON DENTAL ADVERTISING

Richard Fernandez, Connie Gao, William Genkin, Toral Ghandi, Roseanna Graham, Judy Hou, Eugenia Hsu, and JungSun Hwang

Nothing gets the conversation going at conventions, continuing education seminars, and parties quite as quickly as the topic of advertising in dentistry. Every dentist has an opinion on the topic, and each opinion is typically a strong one. Many dentists feel that advertising should be unnecessary, going so far as to call it harmful to the profession. And yet by our profession's very nature we are in direct contact with our customers without a middleman or a large corporation to stand behind, making us all too sensitive to public opinion. This public opinion is heavily influenced by advertising.

The court concluded that bans on advertising are grounded in etiquette, not ethics, and such habits are not the proper basis for restraint of business in modern society.

THE PAST

It all started out so simply with regulation of advertising grounded in dental ethics. A winter 2000 paper by Laurance Jerrold and Hengameh Karkhanehchi published in the *Journal of the American College of Dentists*, "Advertising, commercialism, and professionalism: A history of the ethics of advertising in dentistry," traces the development of the profession's views toward advertising. The 1866 code of dental ethics devoted a single sentence to advertising:

"It is unprofessional to resort to public advertisements, cards, handbills...calling attention to peculiar styles of work, lowness of prices...or to claim superiority over neighboring practitioners...to go from house to house to solicit or perform operations, to circulate or recommend nostrums or perform any other similar acts."

And in 1899, an addendum to the above code permitted dentists to "modestly" advertise their location, hours of operation, absence from or return to business, and allowed posting a fee schedule for the public to see.

The years 1924 through 1927 saw great changes to the code, specifically the itemization of eight evils: 1) advertising of personal superiority, 2) advertising of fixed prices, 3) deliberate deception of the public, 4) advertising under the name of a corporation, 5) advertising peculiar practice modalities, and 6) testimonials.

The golden fifties were ushered in by new regulations stating: "The dentist has the obligation of advancing his reputation for fidelity, judgment and skill

solely through his professional services to his patients and to society. The use of advertising in any form...lowers the public esteem of the dental profession."

Almost all advertising stopped. Business cards and letterheads were permitted to exist only in a framework consistent with the "dignity of the profession and customs of the community". In 1956 Procter and Gamble launched Crest, the first toothpaste containing stannous fluoride. The ad campaign used to promote the toothpaste had a tremendous impact on dentistry in the United States. "Look mom, no cavities!" the caption under Norman Rockwell's paintings read. The paintings themselves featured huge-toothed, smiling kids returning from their dental checkup. Procter and Gamble's praise of the dental profession was the sole voice heard by the public.

In 1975 a legal case completely unrelated to dentistry set the stage for the changes to come. *Goldfarb v. Virginia State Bar*, having gotten to the Supreme Court, received a ruling stating that "all learned professions are subject to antitrust laws." Furthermore, the ruling stated that this was because the learned professions were engaged in commerce as defined by the law.

A second case in the mid 1970s, *Virginia State Board of Pharmacy v. Virginia Citizens Consumer Council*, received the ruling stating that advertising was protected under "free speech protections" of the First and Fourteenth Amendments. These two rulings were applied to the Bates case, and in 1976 the Federal Trade Commission claimed that the ADA ban on advertising violated antitrust and freedom of speech laws.

The Supreme Court held that:

- 1) If it is legal to disclose fees of services in the office, that it must also be legal to do so in advertisements.

- 2) Public disclosure of basic services fees can be disclosed because these services are typically not custom tailored.
- 3) Some information is better than no information.

The Supreme Court stated that a greater utilization of professional services would actually lead to reaching pockets of the population that failed to seek professional services. Also stated was the idea that advertising primarily benefits the new practitioner's entry into the business, as personal contacts and word of mouth take a long time to establish and favor the established professional. Finally, the court concluded that bans on advertising are grounded in etiquette, not ethics, and such habits are not the proper basis for restraint of business in modern society.

PERSPECTIVES ON ADVERTISING

Public opinion of individuals, businesses, and industries arise in many ways: the type of work professionals do, the image they put forth as a group, etc. But in any business field, advertisement is considered to be useful tool to modify the public's attitudes, behaviors and perceptions.

Advertising modalities typically fall under three categories:

- *Institutional*: These are advertising campaigns done by professional societies on a national or regional level. They do not advertise any group or single practitioner; rather they increase awareness about the profession, improve the profession's image in the public eye, or educate the public about their needs and how the profession may help. These ad campaigns, while having the power to do a great deal of good for the public by reaching the underutilizing population and changing attitudes

of the public about a profession, are typically the most rare.

- *Disclosing*: This is the type of ad that the ADA would like private dentists to use. This type of advertisement states the doctor's name, location, and hours of operation. This ad is a "competition neutral" ad since it gives the patient no apparent competitive advantage of the advertising professional over another. These ads do not reach the underutilizers, though they have been shown to increase utilization among those already inclined to do so. Also interestingly enough these ads often prompt the client to go to the professional they have most history with, rather than the one paying for the advertisement.
- *Persuasive*: These claim superiority in quality, pricing, etc. These are the types of ads using testimonials, brand name recognition, etc. Such advertisements have been shown to reduce pricing on the products they advertise, to force businesses to use new systems simply to stay alive, and to prevent price fixation.

Whether one considers advertising to be ethical is typically more an argument of definitions rather than of ethics. One needs to determine the kind of advertising and the kind of business model this advertising is done under. Consider dentistry to be the classical guild model of the 50s, in which the professional acts as the benevolent community leader who dispenses aid or relief; in which the patient is in acute distress and does not have time to shop around for the best deal based on colorful ads; in which the provider-to-population ratio is such that fierce competition is unnecessary for survival (everyone can have their share). Then, perhaps, no advertisement is necessary at all. Simply having the word "dentist" displayed over the door of a business is sufficient. There is only one dentist, and everyone knows what a

dentist is like.

On the other hand, if we choose to adopt a commercial model of the profession, in which the client is expected to shop around and in which the client dictates the course of treatment, then we have a model in which brand loyalty (previous experience with a dentist) is important, a model in which the patient is not in acute pain but seeks aesthetic or domestic improvements that are not a health issue per se. This is a model that is starting to sound all too familiar in modern dentistry. Then we see that advertising is not only ethical but expected and necessary for survival.

The ADA claims that because dentistry is not a commercial but a professional activity, advertising should be unnecessary. The FTC claims that dentistry should abide by the same rules of the game as everyone else. In reality, the truth lies somewhere in the middle. While we are a part of commerce, we do heal patients and carry a heavy ethical burden to do no harm whether it is by negligent treatment or by unprofessional advertising campaigns. This is probably why the current climate does not frown on "institutional" and "disclosing" advertising.

Now we move to the issue of advertising that grants one a competitive advantage over one's professional colleagues. Until the 1979 revision of the ADA code, many elements of this type of advertising were strictly forbidden. Only recently specialization dentists been allowed to advertise their education. The latest revision of the *Code of Professional Responsibility* in 1998 still frowns on most elements that would allow a patient to differentiate one practitioner from another.

If the most entrepreneurial dentists come out on top, it is also highly probable that they will not be working on patients at all (working on your business instead of in your business is the first rule of entrepreneurship). The clinical work

The ADA claims that because dentistry is not a commercial but a professional activity, advertising should be unnecessary. The FTC claims that dentistry should abide by the same rules of the game as everyone else.

will be done by their employees who will, in all likelihood, be excellent clinicians. After all, it is only reasonable to reduce overhead by having less redos, credits, bad accounts receivable, etc.

Big business creates highly specific systems to control the processes it engages in. These systems would allow a uniform and supervised standard of care. Treatment that is below the standard of care would be quickly recognized and dealt with (something that may go unchecked for years in private practice).

The only danger is that the procedures with higher overhead may be discontinued in lieu of more profitable ones that are less beneficial to the patient in the long run. Unfortunately current dental trends are showing signs of this without any involvement of

economies of scale. Fewer and fewer dentists are doing onlays and other gold work (which, in theory, can last a lifetime and has greatest biocompatibility). More dentists are using resin-bonded ceramic restorations, which fail within seven to ten years, and posterior composites, whose material properties are worse than amalgam, let alone gold. This trend is happening because of ease of placement and manipulation and patient's choice (commerce model) of aesthetic materials over ones with greater longevity.

BUSINESS INVOLVEMENT

Oral B high-tech plaque remover (tooth-brush) enters the market with the slogan "brush like a dentist." (What happened to "look mom, no cavities"?). Crest tooth-whitening strips will bleach your teeth in the comfort of your home, "no need to go to the dentist."

It seems that our profession, once held up by advertisements of the 1950s, has fallen out of favor with big business. Big business that seeks to make a profit selling products which replace our professional services. Big business that has enough money to run national advertising campaigns and reach each and every one of our clients. Big Business is not constrained to avoid persuasion ads or advertise under a brand name rather than an individual name.

Pfizer undoes our professional home care instructions by unambiguously advertising that rinsing is as good as flossing (an ad campaign approved by the ADA). Coca-Cola grants a million dollars to the American Academy of Pediatric Dentistry Foundation for "unrestricted research" in an attempt to promote "personal responsibility" for oral health despite increasing container sizes, making schools dependent on income from soft drink vending, and creating brand loyalty through school sales.

And yet some dental professionals still argue that having an advertising presence in the public eye is unethical. Dentists' ethical rights of autonomy and self-governance are quickly shrinking relative to business.

During these times our profession has begun to realize the advantage of "institutional advertising." It has the power to reach underserved groups, to educate patients about their options, to improve the professions standing in the public eye, and to raise awareness. And yet, despite this, the ADA House of Delegates all too rarely approves funding for these ads.

THE FUTURE

In the past, almost all restrictions on dental advertising were created especially to curb competition and ensure that everyone got a fair share of the practice: a sort of professional courtesy.

Most newly graduating dentists no longer consider "disclosing" ads to be inappropriate and agree that "institutional" ads are needed. But historically the ADA has revised the advertising section of the *Code of Professional Responsibility* more often than it has issued money for national advertising or public information campaigns.

If the dental profession fails to promote its image more aggressively, then someone else will do it. And the results may not be to the dentists' liking.

This profession must make a greater effort to stand as a unified front to ensure its future in the face of a changing economic and regulatory environment. Because if we do not choose where we want to go, we may not end up where we want to be. ■

GENERATIONS

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

ABSTRACT

Groups naturally promote their strengths and prefer values and rules that give them an identity and an advantage. This shows up as generational tensions across cohorts who share common experiences, including common elders. Dramatic cultural events in America since 1925 can help create an understanding of the differing value structures of the Silents, the Boomers, Gen Xers, and the Millennials. Differences in how these generations see motivation and values, fundamental reality, relations with others, and work are presented, as are some applications of these differences to the dental profession.

It is human nature to exaggerate our differences to promote our sense of identity. Individuals do it, so do groups, professions, and whole generations. We have always wanted to see ourselves as special and to make our own rules.

A mother was complaining to her daughter. “Why do you have to make everything an issue? I wasn’t so rebellious. What makes you so special?” The daughter shot back, “At least you didn’t have you for a mother.” Every generation has vigorously defended its right to challenge the values of its parents and just as vigorously claimed the right to stop its children from doing the same.

When this phenomenon comes in twenty or twenty-five year clumps, we call it generational differences. It’s a hot topic now because of the explosive power of media, large swings in population size between Boomers and Gen Xers, and targeted marketing. Different generations do respond to health care differently and the values and expectations of dentists of different ages are not the same.

THE PLAYERS

The current discussion generally recognizes four generations. The Silents were born in roughly the time period of 1925 through 1945. The Boomers came along between 1946 and 1964. Gen X was probably the group that started the conversation about generations because, for the second time in a short span of time, it was obvious that this group differed

significantly from their parents. Gen Xers were born between 1965 and 1976. They were followed by Millennials, those born between 1977 and 1999. (Our most senior group, those born before 1925, are generally known as the GI Generation; but they receive very little attention in the discussion.) Each book on the subject of generations offers variations on the labels; some authors identify five generations from 1900 until now while others find six; the length of the periods varies.

Fifty-eight million Americans were born in the two decades following 1925, making them by far the lowest birth-rate cohort. An average of 2.9 million Silents were born each year, with a century low of 2.3 million in 1933. The Boomers are so-called for the birthrate explosion during the post-Second-World-War prosperity. An average of 4.0 million Americans were born each year (4.3 million for the century high in both 1957 and 1958) for a cohort size of almost 80 million Boomers. Generation X is sometimes called the “Bust Generation” because there are only 34 million of them. This is because of a 15% decrease in birth rates and a shorter span of years, only about twelve instead of the traditional twenty, allotted to this group. There are more Millennials than Boomers; 83 million were born in the last twenty years of the century, plus a large upswing in immigrations. The

birth rate has returned to about 3.8 million per year. Even if there were no value differences across generations, the demographic patterns must be watched because of their effects on matters such as applicants for dental school, patient base, and talent pool for leadership positions.

A basic tenet of the writings on generations is that the environment during the formative years of one's youth—say ages five to twenty—significantly shapes the value structure of individuals. The argument runs that common pervasive or dramatic circumstances shape a collective identity for

Every generation has vigorously defended its right to challenge the values of its parents and just as vigorously claimed the right to stop its children from doing the same.

each generation. A typical example is that the Silents grew up with radio, the Boomers with television, Gen Xers had video games, and Millennials were immersed in the Internet. The extension of this observation is that Silents developed an imagination and a concern with news or what was happening in the world. Television is supposed to have created a generation with high expectations who crave entertainment and are “me-oriented.” Gen Xers are imaginative, high-tech, and self-sufficient. Millennials use the Internet to create mosaic worlds of vast and rapidly changing scope.

There are problems with this central thesis of generationally based identity and values. Certainly not all individuals born before 1945 prefer the radio to the Internet, and some of them share values and life patterns that are more typical of Boomers, Gen Xers, or even Millennials. Who decided that twenty years is the right size for meaningful differences? What about intergenerational differences? I am who I am largely because I am my father's son. William Strauss and Neil Howe have an interesting theory that the same set of four archetypical value patterns repeats itself every century and has for hundreds of years. The period of the 1950s through 1970s—with the GI Generation as elder statesmen, Silents in charge, raising Boomers—is a configuration that has recurred throughout history as a time of defiant rhetoric, weak families, cynicism, “me-first,” and inconclusive wars. The same generational interactions, clashes of values, and social issues seem to have existed in the Great Awakening in the last part of the nineteenth century (which included fragmentation of medicine with homeopaths, quacks, etc.), the Jacksonian Era (which saw the de-licensure of medicine), etc. Strauss and Howe define our current era—where Silents are the elder statesmen, Boomers the generative group, Gen Xers waiting (almost hopelessly) to take over,

and Millennials the bright new pennies—as an era of “culture wars.” We don't know what really matters as the oldest generation calls for compromise and fairness, the Boomers are fine with differences as long as they get what they feel they are entitled to, Gen Xers don't expect to get much, and Millennials wholeheartedly embrace diversity and plurality.

On the belief that there is much in the notion that significant shared experiences during the formative years can shape a generation's identity, the following look at our history might uncover some formative forces.

SILENTS

The childhood and youth of those born between 1925 and 1945 was dominated by the Great Depression and the recovery from it. Unemployment reached 40%, dentists' incomes dropped 40%, and fathers abandoned their families. The government ultimately re-established what America needed most—a sense of security (which is why the Silents overwhelmingly vote Democratic). Although the wars in Europe and the Far East helped pull the country together and out of economic depression, they further challenged the notion of rational political order. The average annual salary was \$1,400 and eggs cost 44 cents a dozen. Board games were big; “April in Paris” was a hit tune; people read *How to Win Friends and Influence People* and watched movies such as *The Thin Man* and *King Kong*.

BOOMERS

The Silent generation overcorrected the damage to the family they experienced while they were children and raised a cohort of privileged kids who turned on them as soon as they came of age. The suburbs were invented, church attendance

swelled, and television regularly portrayed an “Ossie and Harriet” and “Father Knows Best” view of the family. Age at marriage and birth of the first child was the earliest it has been for a hundred years prior or sense. Individual bedrooms for children and “family” rooms appeared. The average salary about doubled (to \$3,000) but so did the cost of a dozen eggs (72 cents a dozen). Pastimes centered on small groups and show—bowling leagues, Davy Crockett caps, Barbie dolls, and pizza; “Tammy” and “Jailhouse Rock” were the top tunes; *Lord of the Flies* was popular, but the best selling book was the *Holy Bible*; *The King and I*, *Gigi*, and *My Fair Lady* were popular movies.

GEN XERS

Those born between 1965 and 1979 were raised on a diet of depressing news, but unlike their Silent grandparents who witnessed, and overcame external and economic forces, Gen Xers grew up with unrelenting attacks on their values. Watergate, Jim Jones, and Three Mile Island were on the TV. We were told that the environment was being destroyed, but not how to fix it. Youngsters in this time saw their hippy parents shifting

rapidly from “don’t trust anyone over thirty” to “two-income families working eighty hours a week is the only way to get the prestige and possessions I am entitled to.” One in three meals was eaten outside the home, health foods and drugs elbowed out pizza, 40% of the children born in this period grew up in single-family households. This was the generation of latchkey children; self-help had replaced self-awareness. Our pastimes turned from what we could do together (Silents) and what we had (Boomers) to who we were—meditation, martial arts, skateboarding, disco, jogging. Gen Xers watched “Charlie’s Angels” and “Three’s Company” and sang “Bridge over Troubled Water” and “50 Ways to Leave Your Lover.” The price of eggs fell to 61 cents a dozen while averages salaries surged to \$7,500.

MILLENNIALS

The moral outrage of earlier times seems to have exhausted America by the late 1980s and the 1990s. Tanya Harding and O. J. Simpson, Desert Storm, Monica Lewinski—certainly they were wrong, but everyone who felt strongly about them had their say and then we moved

on. Political correctness (PC), a concept invented by Gen Xers, has given way to diversity and tolerance. One quarter of children were born to single mothers. Minorities and single-issue groups found cable television and the Internet and have overwhelmed us with alternatives. Immigration and integration are now distinct issues. School violence, video-game violence, and violence reported on television have established a right to exist. Personal bankruptcies were up 60% in a decade. And at the same time, privileged parents are now entrusting their children to professional coaches, tutors, and private schools. The average annual salary is \$23,600 and eggs cost a dollar a dozen (about ten times more affordable than they were when the Silent Generation was growing up). Pastimes reflect personal expression—body-piercing, Nintendo, chat rooms.

Differences

There are general differences across generational cohorts. Marketers, political parties, and sociologists certainly think so. The U.S. Army recruited for World War II with the slogan, “Uncle Sam wants you.” They went after Boomers

PATTERNS OF GENERATIONAL DIFFERENCES—MOTIVATORS AND VALUES

	SILENTS	BOOMERS	GEN XERS	MILLENNIALS
SOURCE	Legal, laws	Rights, liberties	Freedoms	Personal
RESOURCES	Scarce	Abundant	Out of reach	Temporary
WEALTH	Pay cash, save	Toys, manage debt	Poverty	
GUILT	Wrong is wrong	Negotiate penalties	No harm, no foul	No whistle, no foul
OWN REWARDS	Delayed gratification	Instant gratification	No gratification	Small pleasures
LIFE REWARDS	Duty	Recognition, status	Self-determination	Meaningfulness
DIVERSITY	Suspicion	A virtue	Expected	Demanded
QUALITY	To standards	Prestige	Value	Value
POWER	Paternal	Title	Expertise	Not an issue

PATTERNS of GENERATIONAL DIFFERENCES—How Things Work

	SILENTS	BOOMERS	GEN XERS	MILLENNIALS
CHANGE	Change is revolution	Manage change	Change expected	Fluid
ALTERNATIVES	True/false	Good/bad	Uncertain	Both/and
PACE	Very slow	Slow	Fast	Instant
INFORMATION	Broadcast	Rich media	On demand	Everywhere
AUTHORITY	Hierarchy	Flat organizations	Decentralized	Virtual
OWN WORK	Do it all	Do with help	Contract	Cut and paste

with the phrase, “Join the people who’ve joined the army.” “Be all that you can be” was the language aimed at Gen Xers. And what about the mosaic, quick-disconnect Millennials? “The power of one.”

The tables that accompany this article are meant to suggest trends; they are not descriptions about how individuals always behave based on the year they were born. But they might be useful on a personal basis for filling in the background behind why we behave the way we do and why somebody else behaves (surprisingly) differently. They might also suggest strategic differences in how organizations could respond to groups of individuals. Each generation is described as it exists in 2005. The characterizations of Boomers may be slightly out of focus as a description of their behavior in the 1960s; Millennials are depicted as ten- to twenty-five year olds without pretense regarding their nature twenty years from now.

WHAT MATTERS:

MOTIVATORS AND VALUES

Boomers challenged the system, but they did not destroy it or replace it. They negotiated a compromise with the Silent Generation so they could compete on favorable terms for what they valued most—things and status. Remember, the Silent Generation became the indulgent parents of the Boomers. While the older generation talked about “duty,” “responsibility,” and “rules,” hippies and yuppies were speaking a different language. They were the first generation in recent times to obsess about “rights,” having grown up with *Roe v. Wade* and *Brown v. the Board of Education*. But rights quickly became the right to colored TV, long hair, short skirts, and guaranteed success at whatever one put a hand to. Abundance should be distributed, not hoarded. Boomers are competitive—competition against each other is how things get sorted out; competition against the establishment is how more rewards are added to the pool; and competition against their own children was an unfortunate byproduct of the other competition. Gen Xers find themselves forced out of many jobs because their seniors are working longer and there are more of them. Silents take pride in craftsmanship, in a job well done, while their slightly junior colleagues take pride in the “deal,” the showmanship of their work, the recognition.

Silents accepted delayed gratification; they had to because of the Great Depression. They see resources as scarce, they often work out of a sense of honor or duty, and they accept paternalistic authority.

Boomers are more apt to point toward instant gratification and recognition and status. Thirty percent of the MacMansions being built today are for Boomers. They believe in abundance, even if that means running up the credit cards. Because of the size of this group and their spending habits, Boomers are the marketer’s dream. The rain on the Boomer’s parade is demographics. Their parents are living much longer than generations did before and their children, pushed out of the job market and out of the housing market by Boomers themselves, cannot afford to leave the nest. Increasingly, Boomers’ resources will be diverted to supporting the generations that preceded and followed them.

Gen Xers are sometimes accused of being cynical. To which they respond, “Whatever.” Boomer parents have been spending some of their latchkey children’s dream. The value outlook of the Gen Xers is a realistic reflection of the somewhat dimmer future they face. Rather than arguing with their parents or society as the Boomers did, Gen Xers

say “just leave me alone.” They value freedom more than rights; self-determination is an ideal. They prefer jobs based on expertise (computers, finance, even service positions) where there is some freedom in how the job is done and results count. The clash between tradition (Silents), title or position (Boomers), and expertise (Gen Xers) is more serious than occasional misunderstandings. It is a bedrock fight over whose standards would be used to judge what is good. Each generation understandably campaigns for the criteria that match its long suit. We do not know yet what base Millennials will claim for power.

Millennials share Gen Xers’ diminished prospects for economic success, but not their fatalism. They find small pleasures, invest across a wide portfolio of potentially satisfying experiences instead of putting all their hedonistic colored eggs in one basket, and are quite prepared to move on to the next thing when the current one ceases to be satisfying. They are much more likely than Boomers to find reward in the meaning of activities rather than in possession or in recognition. They volunteer in larger numbers than any Americans have this century—not for the recognition or the way it looks on their resumes, but because they find it meaningful to do so. They are not good at delayed gratification, but they are very good at moving along quickly to explore something that might give good intrinsic satisfaction.

The Boomers infuriated their Silent seniors by biting the hand that fed them. Gen Xers irritate their seniors because they set their own standards for success, often with low expectations that cause the Boomers some self-doubt, and Gen Xers carve out small, technical areas where they are much smarter than those just a few years older (e.g., computers). Millennials’ value structure is something of a mystery to the other generations as

well. There are multiple, short, interconnected paths to success that this group seems to have discovered, the secret of depending on its own resources for reward. How can their elders control the younger cohorts? They can’t, of course, and that is the lesson of generational studies—each generation defines essential values in their own terms, terms that allow them to compete given the hand they have been dealt.

A particularly instructive generational difference involves guilt. Breaking the rules entails shame for Silents; they feel the wrong involved in committing acts outside the rules. Boomers discovered that they could wind their parents around their fingers a bit and are prepared to negotiate the consequences of transgressions. They are the generation of executives who have perfected the consent degree (“we will pay damages but do not admit doing anything wrong”). “No harm, no foul” is the battle cry of the Gen Xers, and they have elaborate ways of defining harm. For Millennials, the issue is not harm but getting caught. If no one noticed, it doesn’t matter. This kind of intergenerational logic can contort Boomers unmercifully as they realize that “somebody” is supposed to catch these younger guys but it is not in their job description to do so. Joseph Conrad’s classic studies in guilt and shame, *Lord Jim* and *Heart of Darkness*, would probably not make sense to readers today.

How Things Work

Silents are structuralists; Boomers are systems thinkers; Gen Xers are looking for the segment of the world they can control; and Millennials work with mosaics or holograms.

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The all-encompassing reality of the Great Depression stamped Silents with a world view that external reality matters, it is fixed, and we struggle to understand and respond to it. Of the four generations discussed in this paper, Silents are the ones who would grab the title “realists.” Change means world war, fifteen years of recovery from the stock market crash, and fireside radio broadcasts from the president for reassurance and leadership. The alternatives were black and white—democracy or totalitarianism, right or wrong, true or false, guilty or innocent—them or us. The world works the way it does because of scientific rules and change is structural change—we should proceed with prudence.

Boomers assaulted their parents’ structure and found that they could shake it. They quickly learned the art of managing change. Deliberate innovation seemed to be reasonable. The true/false realism of the Silents was recognized as not being an inevitable given; it had a value dimension. It became the good/bad dichotomy of the Boomers. Organizations needed to be flattened to open more opportunities for success.

Groups needed to have a conscience—to stand for something. This, plus the fact that more and more people were choosing alternative sources of information to pay attention to, created the need for public relations firms. In the Korean War, General MacArthur hired a PR firm to manage his image. The good/bad dichotomy means that it is important to pay some attention to looking good.

Generation Xers watched their parents on this point and are a bit skeptical. Perhaps it doesn’t matter. Perhaps “60 Minutes” or some guy with a trash talk radio show can puncture any manufactured image. It happened to Nixon and a lot of established companies. It happened to the parents of the Gen Xers. Change and ambiguity (situations that admit multiple interpretations) are happening, but they may not be as easily managed as the Boomers would hope. The media have become rich and diverse, and they are driven by active users no longer satisfied with a passive, single-message approach. It doesn’t take much time before events are either too familiar or too confused to be worth paying attention to. The pace of change is accelerating.

PATTERNS of GENERATIONAL DIFFERENCES—RELATING TO PEOPLE

	SILENTS	BOOMERS	GEN XERS	MILLENNIALS
SOURCE	Fixed roles	Competitive teams	Ad hoc teams	Networks
AUTHORITY	Chain of command	Challenge authority	Self-control	Collaboration
FEEDBACK	Assume its okay	Formal, documented	Ask often	Expect instant
SHARING	Hard knocks school	Trade secrets	Help if asked	Glad to help
COMPETITION	Want to win	I win/you lose	Win/win	We win

Opinion making, work settings, and meaningful groups are multiple and decentralized. The ex cathedra voice is hard to discern.

Millennials are changing the logic of reality. Either/or seems like an artificially constrained world view. Either/both/neither seems more realistic. In recent years, the UCLA Survey of Freshmen, an annual, nationwide poll of students entering college, reports that young Americans placed high value on making lots of money and high value on service and volunteer work. Older Americans think they are lying (it has to be one or the other). Youth are having none of this logic chopping. They have seen in the news that few things are permanent, and the prospect of continuous flow rather than no change or even frequent change is exciting for the prospects it opens for new experiences. They have equipped themselves—by outlook and competency—to respond quickly, to embrace huge networks of contacts, and experience things at multiple levels. Think of today's wired technology. It is instant, everywhere, and virtual. That is the way the world works for those born after 1980.

An interesting way to look at the changes that have taken place in the logic of the world in the last half century is to consider cheating in college. In the 1960s, the dominant form of grade manipulation was to pay someone to impersonate you and take the written test on your behalf. A generation later, students didn't bother with that; they just challenged the grade given by the instructor. Gen Xers went online and bought their term papers. Now college students just cut and past from the Net. It is not that one generation is more or less honest than another; the meaning of reality and how we relate to it is evolving.

RELATING TO OTHERS

Silents accept the chain of command implied in traditional hierarchies, with their fixed roles, preassigned status, formal rules, and all this implies for how people should treat each other. They believe in "paying their dues." They are competitive, but often for the team or organization rather than for themselves. Dentists of this generation speak fondly of professionalism.

The type of competition Boomers embrace is different. It tends to slip over into the "I win/you lose" type of thinking. Boomers work in teams, but uncomfortably. They wonder whether their team is better than other teams are and whether they are a leader in their team and whether they are getting credit in proportion to their effort. They will challenge authority and they expect anything that is said about them to be documented and "fair." "Fair" may mean "according to due process" or it might mean "complimentary." Just try giving anything but a glowing performance review to a Boomer. No generation in recent history has produced more lawyers than has the Boomers. Not only is a lawyer a pretty good embodiment of the values of this generation, they are also quite useful to other Boomers in protecting their "rights."

Gen Xers are not as concerned with winning and losing. They are the generation that invented the win/win solution. They are at home in teams, including multiple and shifting teams. Their sense of portable expertise lends itself to situations where their skills are valued and used until they are no longer needed and then they move on. By contrast, they are not especially good committee members, if by committee we mean a group that exists and meets whether or not there is any specific task to be accomplished. Gen Xers would prefer to see themselves as exercising self-control and the freedom of inde-

pendent choice. They feel uncomfortable when work or social circumstances create long-term hierarchical relationships. These are precisely the conditions that Silents assume and Boomers work to achieve. Much intergenerational tension flows from this difference of view on how people should relate.

The newest generation shares the disinterest in formal structure but is less likely to be irritated by it because they see themselves as parts of large overlapping families rather than as freelancers. If a Silent or Boomer wants to be part of a Millennials' network, he or she is welcome. Authority is frowned on and collaboration is valued. Gen Xers often surprise those they work with by asking for feedback about their performance. They are not asking to be judged as people; they want specific information that helps them do the job better. Millennials insist that this kind of feedback be built into the task. Even the "I win/you win" dichotomy of the Gen Xers is being replaced now with a "we are in this together" attitude.

An easy way to distinguish among generations is to ask "How is important information shared?" Silents proudly display their diplomas from the School of Hard Knocks, not realizing that younger generations have found on the Internet that it lost its accreditation about twenty years ago. Boomers discovered the value of intellectual capital (and are ready to sue to protect it). They share information strategically. They want to know, for example, what is in it for them to mentor a junior colleague. Gen Xers are proud of their expertise and are usually willing to share it if asked.

How can their elders control the younger cohorts? They can't, of course, and that is the lesson of generational studies—each generation defines essential values in their own terms, terms that allow them to compete given the hand they have been dealt.

Among the youngest generation, it is a norm that knowledge is freely available and readily passed to those who could benefit from it, and in turn benefit others. Opensource software, common access knowledge bases such as online encyclopedias, and blogs are examples of the storage and access to information that Millennials grew up with.

Work

Silents work to the rules of the organization or standards of the profession, take pride in doing their assigned task well, aspire to leave a legacy, and expect to earn retirement as a deserved reward. There is a bit of a stigma associated with interrupting one's career.

By contrast, Boomers work to impress the boss or peers and see their assignments as opportunities to advance their careers. Retirement is not a certainty, or it may be something that is postponed or eased into, and it is a time for retooling for other life activities. A career interruption is regrettable because it puts one behind.

Gen Xers work on what matters most to them while serving the client. Their jobs are valued if they develop portable skills, because one's career is expected to be a succession of positions, perhaps even a succession of careers. Retirement is a sabbatical, a timeout during one's career for refreshment and reorientation.

We can only guess at the career patterns of Millennials. Probably they work to provide value to clients (rather than perform tasks, impress others, or serve the client) and they feel quite comfortable saying "no" at work. Their careers will be a succession of jobs or work in different fields, but unlike the Gen Xers, Millennials will overlap their work. The concepts of retirement and

interrupting work do not make sense. All of adult life will be a pulsing, alternating, overlapping mix of work, rest, and renewal.

IMPORTANCE TO DENTISTRY

Dentistry, as a self-regulated profession, is not immune from the effects of generational differences. Patients of different ages expect different things from their dentists. Young dentists will practice differently from their seniors. The profession will experience internal tensions as leadership passes from one generation to another, but we expect that there will always be differences of value across generations—there always have been.

For example, older dentists, especially those who serve as examiners on licensure examinations, are monotonous in their complaints that the technical quality of young dentists' work is not what it was in former times. (Actually, pass rates on boards have been constant for decades, suggesting that somebody complained about them just like the established dentists are complaining about their juniors.) But generational studies help us to understand that Silents are more apt to focus on the technical nature of work as part of dentistry, while younger dentist are more likely to focus on service and value to the patient. Certainly the nature of dental care has become more complex and more patient-focused. In a related fashion, younger dentists will become increasingly concerned over mobility as their career patterns become more irregular.

The fastest growing form of dental practice is one dentist working for another, as an associate, employee, or independent contractor. This reflects economic realities and generational trends. Young dentists, especially Gen Xers, want opportunities to apply focused skills and freedom of career movement. We can predict that dentists

PATTERNS OF GENERATIONAL DIFFERENCES—Work

	SILENTS	BOOMERS	GEN XERS	MILLENNIALS
CAREER	Work, then retire	Retirement uncertain	Succession of jobs	Simultaneous jobs
Good work	Legacy	Career	Portability	Parallel careers
WHAT MATTERS	Work tasks	Value to worker	Serving client	Value to client
AUTHORITY	Work the hours	Impress the boss	What matters to self	Okay to say no
RETIREMENT	Deserved reward	Time to retool	Sabbaticals	Perpetual recycle
CHANGE jobs	Stigma	Get behind	Necessary	Normal

working for dentists will continue to become a preferred form of practice arrangement. As such practices grow, there will be more chances for misunderstandings that stem from differences in values. Obviously, the same is true with regard to other hired staff members.

The difficulty some senior dentists are experiencing in finding young dentists with similar values to buy their practices, especially in some specialties, can be expected to continue. This is partially a matter of the numbers in the demographics. It is also a generational issue. Fewer young dentists will want to make the long-term commitments involved in purchasing a practice. This will be especially damaging to Boomer dentists who tend not to fully fund their retirements.

Workforce planning for the profession will become more complicated. Simple headcounts of graduates will become increasingly less accurate as a measure of the capacity of the profession to serve the oral healthcare needs of the country. Young dentists, both men and women, will interrupt their careers, overlap their work in dentistry with other activities such as teaching, and even move out of the profession entirely. Young practitioners will be more open to the prospect of working in teams, at least opening the possibility that additional members of

the delivery team may be added in future.

There are differences across generations in attitudes toward and capability to use technology. This is deeper than who buys computers and digital cameras first. We can predict, for example, which types of technology younger dentists will prefer—that which brings them closer to patients, systems that connect team members in the office and spread the workload, and open-source arrangements. The same conclusions apply to all technology, not just the electronic variations.

Organized dentistry, as with other organizations, has a long history of dealing with generational differences. The red flags are out currently for practices based on “paying one’s dues,” committees that don’t do anything, offices that are mere titles—anything that appears patronizing or paternalistic—rigid and one-size-fits-all structures, and task forces that recommend future task forces. Perhaps more use could be made of networks, assignments based on expertise rather than seniority, prototypes rather than study groups, and opportunity based on interest rather than political status.

Quite possibly we will see a change in continuing education and professional development. Already lectures from experts are losing ground to hands-on formats. As the practice of the profession becomes more complex, courses will need to cover more skills, including some for which no CE credit is currently

given such as patient communication. Learning will also become more just-in-time and just-where-needed, and the dentist will become more of a partner in designing his or her learning.

There will be more pro bono work, and it will change in nature. The tension between doing well and doing good will abate, and access will take on a different meaning from its current connotation of getting more paying patients into dental chairs.

Strauss and Howe, in the book *The Fourth Turning*, predict that America is poised for a cultural shift. We have just about finished the culture wars, they say, where everyone pushes his or her own agenda and no one can see the way forward. We will enter a crisis where the country will allow leadership to be effective. There are some who would just as soon skip the crisis, but most would welcome some effective leadership. By emphasizing the ways in which generations can contribute as a team to dentistry, rather than harping on the differences, we could move that way.



RECOMMENDED READING



Summaries are available for the three recommended readings preceded by asterisks. Each is about eight pages long and conveys both the tone and content of the original source through extensive quotations. These summaries are designed for busy readers who want the essence of these references in fifteen minutes rather than five hours. Summaries are available from the ACD Executive Offices in Gaithersburg. A donation to the ACD Foundation of \$15 is suggested for the set of summaries on generations; a donation of \$50 would bring you summaries for all the 2005 leadership topics.

Hicks, Rick and Kathy (1999).

Boomers, Xers, and Other Strangers.*

Wheaton, IL: Tyndale House.

ISBN 1-56179-677-8; 370 pages; about \$20.

Christian, family perspective on generational differences. Detailed analysis of each of the decades from 1920 through 1990. Description of GI and Silent generations, Boomers, Gen Xers, and Netsters is presented primarily in terms of value differences. The husband and wife team of authors are involved in campus ministry.

Lancaster, Lynne C. & Stillman, David (2002).

When Generations Collide.*

New York: CollinsBusiness.

ISBN 978-0-06-662107-4; 355 pages; about \$16.

The goals and approaches to work exhibited by Traditionals, Baby Boomers, Gen Xers, and Millennials are explored with regard to work behavior and meaning, recruiting and retention, evaluation, training, and etiquette. The authors emphasize the strengths of each generation and argue that there is no universal approach—each generation must be managed in its own terms. Lynne Lancaster is a Boomer and David Stillman is a Gen Xer. They worked together at a major consulting firm and discovered that generational differences were a moderating factor in the management advice they were giving. They formed a company to explore such differences related to work. The book is easy to read and clever.

Strauss, William & Howe, Neil (1997).

The Fourth Turning: An American Prophecy.*

New York: Broadway Books.

ISBN 0-767900046-4; 382 pages; about \$26.

Generations are seen in the context of regularly repeating cycles of history (each “turning” of the four-phase cycle lasting about twenty years). The Silents, born in the forties and fifties, are artists who seek to find meaning. Boomers are prophets who challenge meaning. Gen Xers (whom Strauss and Howe call the 13th generation) are nomads who struggle with conflicted values. And the Millennials are heroes who must recreate meaning. “The prophet, born in the High, seeks vision; the nomad, born in the Awakening, seeks realism; the hero, born

in the Unraveling, seeks power; and the artist, born in the (past or current) Crisis, seeks empathy” (322). Unlike many other generational analyses, the one by Strauss and Howe develops a rich analysis of the ways generational archetypes change over lives in response to the cycle of time and roles with respect to other generational groups. Although well-written, the thesis is complex and occasionally forced. After nearly four hundred pages, one is surfeited with detail. Howe is a historian and economist, Strauss is a founder of the Capital Steps, a political satire singing ensemble. Both are denizens of inside-the-beltway think tanks.

For Gen Xers, Millennials, and their fellow travelers:

www.ccl.org

(Center for Creative Leadership, does it all)

www.creativetrainingsolutions.com
(training specialists)

www.jobtrack.com
(information resource)

www.gentrends.com
(full-service speaking and consulting)

www.moatskennedy.com
(a popular keynoter)

www.stats.bls.gov
(Bureau of Labor Statistics)



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