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PRACTICE
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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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Cover Photograph: Consultants can help a practice get to the next level.
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FROM THE EDITOR

SOME NEW MATH FOR PHILANTHROPY

The law of division of fixed benefit applies when too many try to get their hands on the good works of philanthropy. When the charity dollar takes a long walk from the donor to the recipient, it gets worn out and shrinks.

In 1863 Reuel Gridley lost his bid for election as mayor of Austin, Nevada. He also lost a bet with his rival and had to lug a fifty-pound sack of flour around town to the accompaniment of a crowd and a band. This resourceful man then declared his intention to auction the burden, with proceeds to go to the Sanitary Society (such groups had sprung up in many states to raise money for wounded Union soldiers in the Civil War).

Gridley must have been a born fundraiser as he worked the price up to \$250 in gold—and the flour was donated back for immediate resale. By the end of the day, 300 citizens had purchased and

re-gifted the flour and \$8,000 had been raised. But that was just the beginning for the famous “National Sanitary Flour Sack.” Over the next months, the leading lights of Gold Hill, Silver City, Dayton, Carson City, Virginia City, and then San Francisco and St. Louis had momentarily held the bag, and it had been sold for something in excess of \$150,000. Reuel Gridley died in Stockton, California, in 1870, but the magic of multiplying the loaves of charity lives on.

We have a bottle of wine like that in Sonoma, California. It is probably vinegar now, but it might be reaching a Guinness record for the number of silent auctions it has attended. The multiplicative law of charity is not based on physical properties but on generosity which is extremely elastic.

Regrettably, there is a complementary law in charity; the law of division of fixed benefit. This rule works when too many try to get their hands on the good works of philanthropy. When the charity dollar takes a long walk from the donor to the recipient, it gets worn out and shrinks.

Here is an example. The foundation of a large national association recently announced competition for a cash award to promote innovation in dental education. A major winner of the award was another national association. That group has its own award program for improving dental education and has recently made awards to consortia and other groups that further allocate funding. So far, three or four recipients of charity have managed the same dollar and won some

public relations points. But the dollar has not done any work yet. A common characteristic of the foundation boards I serve on is that more than half of the requests for donations received come from organizations that also raise their own funds. This means the same dollar is actually going back and forth looking for a definitive application.

Everyone knows it costs money to raise money. But we underestimate how much it costs to spend it. I recently participated in an international foundation board meeting where a group of twenty-three professionals discussed the allocation of about \$15,000 among several very worthy community outreach projects. Making a few assumptions about the value of professionals’ time and some staffing expenses, I estimated that the cost to disperse the funds was equal to about 40% of the funds dispersed. (And that says nothing about the cost on the applicants’ side.)

In another example at the state level, a group of volunteers such as me reviewed forty-one applications last year for community outreach projects to meet oral healthcare needs of the underserved in California. The applications totaled two hundred and thirty-six pages, and in my case it took seventeen hours to read and I passed on the all-day board meeting in Southern California. The total moneys requested by the applicants was \$1 million in round numbers; the estimated need for oral health services that the organizations

were trying to meet was set by them at \$7 million. The funds available for dispersal were \$65,000. All organizations applying for funds had nonprofit status, and although they varied considerably in size, several had very large fundraising programs of their own. The average annual operating budget of the organizations requesting the \$65,000 (that information is required on the applications) was \$63 million.

In addition to the lengthening of the giving chain, another force is degrading the value of our charity dollars. Harvard professor Peter Frumkin calls it the “professionalization of the volunteer sector.” About 10% of services for Americans in need is now provided by tax-exempt organizations and, beginning in the 1970s, the U.S. government delivers more service through volunteer organizations than it does directly (further lengthening the chain). In 1990 there were 6,500,000 “tertiary” organizations registered as 501-c-3 groups. The term is Robert Putnam’s (of *Bowling Alone* fame) way of characterizing charitable, lobbying, and social interest groups whose members’ only involvement is to send money.

Not-for-profits can no longer afford to be run by volunteers. The legal requirements and competitive pressures have forced charitable groups to employ individuals with college degrees and advanced training in full-time, paid positions. There is a certifying program for executive directors (you may have noticed CED after names, something like the DDS). The forty-one grant applications

I reviewed for the California Dental Association Foundation were monotonously outstanding, although only one mentioned that dentists would be volunteering services. It is almost as though each organization had used a professional grant writer and downloaded a template from the Web. These not-for-profit professionals command reasonably high salaries, and they all pay taxes (draining funds from the charity chain).

On top of it all is legislation that further drives up the cost of doing good. Research done in dental schools is subject to Institutional Review Board scrutiny, where organizations volunteer to police the safety of research and pay hundreds of thousands of dollars annually in additional costs to do it right. A nonprofit organization that receives federal support is subject to the Davis-Bacon Act that requires, among other things, that construction workers be paid at prevailing wage (often 10% to 15% above market) and that labor costs cannot be donated. Bonds, permits, licenses, etc., can make volunteering very expensive. In California, labor unions bring suits against church and other volunteer groups engaged in cleanup activities on grounds that it denies paid employees a fair wage. Putnam estimates that 30% of the budgets for charitable organizations that actually have no active members goes to recruiting and advertising. I recently applied for a small grant based on the Web pages of three organizations that tout their service

through philanthropy. Two of them did not even acknowledge my application.

Reuel Gridley would have been discouraged to learn that in 1863 there were serious riots in New York City. A dozen people were killed protesting the draft for the Civil War. What was so annoying about this was that the financially well-off could pay \$300 (about the price of the first sale of the National Sanitary Flour Sack) to an agent who would secure a draft substitute. The government eventually dropped the practice—not because it was a moral foul, but because the agents took too much for themselves and delivered such inferior goods.

America is the most generous nation in the world, and dentists are among the most philanthropic of all. The ADA estimates that fifty cents of every \$100 in oral health care is donated. When dentists do this with a handpiece, it is truly praiseworthy and represents a form of caring that no one else can duplicate. When it is done with a credit card, it loses some of its dignity. As the chain of spending charity dollars grows longer and is managed by professionals, it also loses an increasing amount of its impact.



My PASSION

Amy Morgan

ABSTRACT

There is a tension between the technical skills of dentistry that most practitioners are good at and enjoy and the business aspects of managing a successful practice. Inattention to the business side of practice can rob dentists of the success and satisfaction of their work. Fortunately, dentists can be trained to be effective leaders of their practices. The increase in commercialism will make that increasingly imperative. The CEO of Pride Institute explains her passion for teaching and coaching dentists to create and implement their visions.

More than thirty years ago, our late founder, Dr. James Pride, presciently observed an essential piece missing in the training of dentists. Although they developed excellent clinical skills, they were weak in another vital area, namely, in the skills needed to run a business. After seeing many clinically talented dentists struggling with business issues that undercut their success, Dr. Pride established Pride Institute to bridge the gap between excellence in technical dentistry and entrepreneurial success. Because Dr. Pride is such a respected leader in the dental community, Pride Institute carries that same respect and awareness into the new millennium.

Today our role in the dental community is multifaceted. First, we are incredibly proud of our increasing presence in the dental schools. We are finally educating the students on entrepreneurial management so that they can balance their clinical preparation with advanced business training and thereby graduate as true professionals on all levels. We are now teaching comprehensive practice management curriculums to over eight hundred graduating dental students per year, spanning eight dental schools. And it is not traditional practice management, which can often be reduced to processing payroll, setting fees, and collecting bills. Our expanded practice management includes leadership skills, establishing strong patient relationships, staff management, community service, assimilating new clinical skills and

technology, as well as achieving profitability, productivity, and efficiency. Second, we have our core competency, which is coaching dentists on all of these skills after graduation and delivering what we consider to be an MBA in dentistry, putting dentists and their teams in control of the practice, rather than having the practice control them.

Here is a funny story about how I came to this work. Over twenty-five years ago, I began my career as a consultant with a new and interesting specialty in the medical and dental field working in cash-flow crisis intervention. My job was to deal with bankruptcies, cash-flow shortages, embezzlement, and other emergencies causing physicians and dentists to be less than successful. When dealing with dentists throughout my tenure as a crisis consultant, I would hear the same cry over and over: Why didn't they teach this to me in dental school, and why can't I just be a dentist? I quickly realized that the panicky decisions that dentists made as untrained business people very often affected the quality of the clinical work they could perform and the quality of life they could enjoy.

The obvious cure for this ailment was to train the dentist to be not only a competent clinician but also a competent business person. I began looking for



Amy Morgan is the CEO and lead trainer of Pride Institute, a firm helping dentists improve their lives and practices by learning entrepreneurial management. She may be contacted at 800-925-2600 or visit www.prideinstitute.com.

organizations that actually provided this kind of training for dentists when, in the early '90s, I stumbled on a course from the Pride Institute, called "The Dentist as Entrepreneur." This was the first program I had ever encountered that actually taught basic, hard-core business skills applied specifically to the dental practice. I loved the course so much that I referred all my clients to it. That was how I met Dr. Pride and his team at Pride Institute. Around 1992, I interviewed with Dr. Pride, and he made me an offer I couldn't refuse. He asked, "How would you like to get to the dentists before their hair is on fire?" I eagerly said yes, and I've been with the company ever since, rising from consultant to senior consultant to senior lecturer to CEO and now to owner—and I've never looked back.

Being a seminar leader, I love getting to interact one-on-one with the people in the audience. It has been really fun to see my seminar voice come through in written form as well, allowing me to reach a much broader audience. Many articles I've read in dental and general business magazines are pretty dry and cookie-cutter. My goal in writing is to entertain, amuse, and, most importantly, influence and inspire people to embrace management solutions to reduce their chaos and stress.

Pride Institute's, as well as my own, contribution is that at our core we have always combined training and consulting. Consulting by itself can almost be an addiction. It leaves the dentist and team no further equipped for self-management and therefore always requires them to

seek further consulting to solve their problems. I'm very proud of the fact that through our training, Pride Institute teaches dentists and their teams to fish for themselves. This, of course, means we work ourselves out of our consulting jobs because the practices we train ultimately steer their own destiny, but that is what we are proudly all about.

I believe that dentists want to use the one-stop shopping approach to gain the advice and counsel they need. Whether it is dental supplies, financial planning, advanced clinical training, practice management, marketing, or other services, these components can and should work together to provide the very best advice and counsel in a less competitive way. To accomplish this, Pride Institute has been developing internally, and we have also been reaching out to form alliances with others to provide more integrated training opportunities consistent with our vision and values. This year, for example, we are doing a seminar with Pankey Institute to approach the new-patient examination from an advanced clinical and an advanced managerial perspective.

We have twenty-six full-time Pride alumni dentists in clinical practice who have been trained to co-teach Pride's material across the country and to become respected mentors for other dentists in their communities. We recently added marketing and transitions divisions to address dentists' concerns in those

Dentists, arguably more now than before, know they must reach out for a systems solution, rather than a clinical solution, to be viable as a modern business.

areas. Through our education seminars we are now working with companies like Pankey Institute, Dentrix, CareCredit, and others to provide that one-stop shop we feel is essential. Working together with other specialists in providing something bigger than any one of us alone can offer allows us to give dentists the best expertise in all areas.

With advances in technology that can make people's heads spin (mine in particular, because I remember when flossing was first introduced!), dentistry will continue moving into what I call its Renaissance period. Despite worries over shifts in the economy and demographic impacts on baby boomer dentists, the profession—now more than ever—offers a much needed and wanted array of services. As new technology moves into the practice, dentists are requiring budgets for their advanced computer systems, state-of-the-art clinical skills, and other innovations. These new opportunities make dentists realize the tremendous importance of having a financial budget and a business plan in order to afford to have the Renaissance practice. This makes our job at Pride Institute easier. Dentists, arguably now more than before, know they must reach out for a systems solution, rather than a clinical solution, to be viable as a modern business. I consider this progress.

It is fairly clear that commercialism is increasing in dentistry, and I think that is good. Certainly, when you watch

the Extreme Makeover shows, they spotlight dentistry as a solution, and a relatively easy solution compared to the bandages and bruises of the other surgeries. At the same time, these shows have made dentistry look like a relatively instant solution. Commercialism puts the spotlight on dentistry, and getting a lot of publicity and promotion is desirable. However, now it is up to the dental community to use that attention for good.

That means maintaining ethical integrity. The cosmetic advantages of dentistry need to be joined by as much education and focus on function and long-term oral health solutions. Dentists need to band together and be the professionals they have been trained to be. This means that when a patient comes in and asks for a crown on every tooth, a competent and confident dentist can look that patient in the eye and expand the focus to a discussion about health, wellness, and function. Dentists need to influence and inspire patients to do not only what is best esthetically but what is best for their long-term oral health. So I say that commercialism is fine, just always use it in the most ethical manner.

The skills that distinguish a highly successful dental practitioner from a less successful one include: having a practice vision, focusing on one's vision and goals, never giving up, being creative in developing not only clinical solutions—but also business ones, building lasting relationships with patients and teams, and having a strong set of foundational values that guide one through the challenges of owning a business. The

unsuccessful dentists I encounter blame their problems on the economy, the region, the staff, or the patients. Blaming external factors for their difficulties puts their problems beyond their control to correct. I highly recommend that those dentists look in the mirror. Successful dentists believe that they are the most important factor in bringing about success or failure. The advice we give dentists at Pride Institute is: "If it's going to be, it's up to me."

Unfortunately, over 55% of dental offices in America are in chaos, which means that they make day-to-day decisions by the gut. If a doctor doesn't know his or her statistics and doesn't have black-and-white systems and clear expectations for the staff, then the only way to manage is by the stomachache. Anytime you hear a dentist say, "I can't tell you why, but I just feel that somehow my systems, my staff, and my production could be better," this is management by subjective judgment and perception, which is 99% wrong. The only management decisions that should be made are through management by facts and statistics. If you "feel" as if a staff member isn't doing his or her job, what situations have you observed that lead you to that conclusion? And what statistics, benchmarks, or goals is the staff member failing to meet? That is how you need to make decisions—backed up by facts.

I think dentists are happy when they are in the operatory, and they are confused and upset when they have

to step outside it. That gets into the “E-Myth,” which best-selling author Michael Gerber discusses in his address to Pride dentists. The E-Myth is the mistake that many small-business owners make, namely they think that their success in a small business comes from being a good technician within that business. Dentists, trained in clinical excellence, often make the mistake that their technical skill is all that is required to run a successful dental enterprise. However, we know that the roles of entrepreneur (the visionary) and manager (the organizer) are also absolutely essential. Many dentists endure an unhappy, stressful work life because they are conflicted between just wanting to do the dentistry and being overwhelmed by all the other factors necessary to manage the business. We find that when dentists just buckle down and learn how to train, coach, organize, set goals, delegate, etc., they can relieve their stress and actually spend more time in the operatory than the time before they organized their business. Happiness comes from having a plan, feeling competent in who you are and where you are going, and knowing you’ve got the tools to get there.

In my own case, I would say coaching dentists to get out of their state of denial is the biggest challenge I face. It is very frustrating to see practices in which doctors and teams are perpetually struggling with situations that really have solutions. Many dentists are in denial about how practice-management solutions can help them

become successful. This concerns me because the average baby-boomer dentist is fifty-two years old and has accumulated retirement savings of only \$225,000—which is woefully inadequate. So my frustration comes from how to get the word out to struggling dentists that there are tried-and-true, consistently proven solutions to the dilemmas they face, if only they would open themselves up to them.

But my frustrations are balanced by the great satisfaction I feel in front of a group of people, teaching material that people can use and seeing their eyes light up. That is my passion. No matter how many thousands of airline miles it takes to be out there delivering courses on leadership, staff management, team motivation, or statistical interpretations, changing people’s lives is what it’s all about. After two days of teaching, when I look out at an audience and I genuinely know that they have learned something important to them that they never knew before, then I have accomplished my vision. And that’s the way my entire team at Pride Institute feels. One of the things I’m most proud of is that I have twenty-eight full-time staff members who share this passion, whether they are consultants, sales persons, receptionists, accountants, or whatever. I have a team that shares the vision and gets tremendous personal satisfaction from achieving their goals. This is what gives me fulfillment: my work, my team, and the dentists and dental teams we touch. ■

As new technology moves into the practice, dentists are requiring budgets for their advanced computer systems, state-of-the-art clinical skills, and other innovations. These new opportunities make dentists realize the tremendous importance of having a financial budget and a business plan in order to afford to have the Renaissance practice.

PRACTICE MANAGEMENT CONSULTING: HOW TO BUILD A BETTER PRACTICE THROUGHOUT YOUR CAREER

Roger P. Levin, DDS, FACD

ABSTRACT

Practice management consulting focuses on placing a sound business system under the technical expertise of dentists. Dentists should spend almost all of their time at chairside where they can add greatest value to their patients. The good practices of business can be learned and implemented just like the good practices of dentistry can. Consulting may be necessary for any practice that is having issues; it is also recognized as an opportunity to raise any practice to higher levels.

After all, the goal of dentistry is to provide optimal oral health care to patients. What does practice management have to do with that? You have a practice. Patients come in to your office. You treat them. And they return for their next appointment. Sounds pretty straightforward, right?

Unfortunately, in the real dental world, there are usually a few “bumps in the road.” Patients fail to show up or cancel at the last minute. If they do show up, they arrive late, wreaking havoc on your schedule for the rest of the day. Or, in a worst case scenario, maybe there are no patients for the first appointment or the second one, or the one after that.

Over the years, I have met many dentists who were on the verge of leaving dentistry due to the overwhelming stress of owning and operating a practice. How can this be? How can highly skilled and talented people end up being miserable in a profession they used to love?

The answer is relatively simple. Dental schools teach and train dental students to be excellent clinicians—not practice owners. In this country, we have the finest colleges and universities in the world, where dentists and specialists receive outstanding clinical education and training. It is not the clinical side of the practice where most problems occur. It is the business side. While dental students receive training on the latest clinical techniques, most dental colleges and universities provide very little educa-

tion in the way of practice management. Fortunately, that is slowly changing. But even one or two business courses are not enough to prepare dentists to successfully manage a multi-million-dollar business over the course of twenty or thirty years.

At Levin Group, we believe that practice management consulting provides our clients with the business skills necessary to operate a successful and profitable dental practice throughout their careers. Just as we all hire advisors such as accountants and lawyers to guide us in important matters, the practice management consultant has the expertise to advise dentists on significantly improving the business side of their practices. Levin Group has found time and time again that implementing effective business systems often reignites a dentist's original passion for dentistry. The right consulting experience lets dentists rediscover the enjoyment of practicing dentistry and regain control of their practices.

It's NOT THE DENTISTRY... It's EVERYTHING ELSE

My goal when I started Levin Group twenty-two years ago was to improve the lives of dentists. If you are not enjoying your practice, it is doubtful you are enjoying a high quality of life. How much time do you spend in your practice? And how much time do you



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Consulting is all about getting the dentist back to where he or she belongs—chair-side—while building the practice to reach its full potential.

spend thinking about your practice when you are out of your office? If things are going poorly at your practice, you are consumed with how to make things better. Practice management consulting, when done properly, gives you back the control over your practice and your life.

As a third-generation dentist, I can say that dentists are like no other professionals in the world. Unfortunately, part of our uniqueness is also what makes us vulnerable as the leaders of our businesses.

The truth is that most dentists (including myself) are very linear, focused people. We are taught very specialized skills. It takes a great deal of energy and focus to master those skills. That type of concentrated effort is the very nature of dentistry. Few dentists have ever worked in other business fields or held other jobs. As most business professionals reach their late twenties, it is likely that they have worked several jobs in high school and college and have held several full-time positions in the business world. They have worked with dozens of managers, been exposed to perhaps hundreds of different co-workers, and dealt with any number of differing office policies. By contrast, a dentist tends to be very focused on his or her practice and the world of dentistry.

Few dentists start a practice with any detailed knowledge of how to operate a business. More than 64% of dentists are solo practitioners who have an average of six or fewer employees. During the first few years of practice, this lack of

business experience is not always a large obstacle. When practices expand, however, dentists soon realize that running their practice is more involved than they previously thought. The day-to-day management of the practice becomes more complex, and dentists find they cannot deal with it as easily as before. The dissatisfaction with their situation will continue to escalate until they realize significant changes need to be made.

Many practitioners come to me saying, “I went into this to be a dentist, not a businessperson.” They say this because they find themselves spending less and less time chair-side and more time managing the practice. Consulting is all about getting the dentist back to where he or she belongs—chair-side—while building the practice to reach its full potential.

ONE DENTIST, TWO ROLES

Dentists typically play a dual role as both main producer and practice owner. To use a sports analogy, the dentist is like a player-coach. As the main producer for the practice, the dentist is like a quarterback or point guard generating offense for the team. As the practice owner, the dentist must manage the other team members. Without the proper systems in place, many dentists experience a high level of frustration with trying to juggle the often conflicting responsibilities of both roles. Frustration on the part of the dentist translates into increased stress for the team. A high-stress environment often results in conflicts among staff, poor customer service, decreased production and disappointing profitability.

Leading a dental practice is incredibly challenging. To operate a dental practice successfully, the dentist must excel as a player and as a coach. Just as a manager or coach in professional sports has assistant coaches, dentists may need to call on other experts or advisors to get their game up to speed. The practice management consultant can serve as the assistant coach to help the dentist identify and execute his or her various roles and responsibilities.

THE TIME CRUNCH

The lack of business training is not the only factor hindering dentists from reaching their true potential. Time, or the lack thereof, also prevents dentists from fulfilling the duties of practice leader and owner. Dentistry is a labor-intensive profession. When dentists are chair-side, they are focused on one thing and one thing only—providing superior patient care. They are not in position to lead the team, monitor practice performance, or design new marketing strategies.

Levin Group recommends that dentists should spend 95% of their time chair-side performing dentistry, which leaves precious little time for anything else. That is why consulting provides a much needed service for so many practices. Why go through the stress and frustration of trying to grow your practice and become more efficient when there are experts who can help

you begin the process of transforming your practice immediately?

As the main producers in their practices, dentists have little time to manage their team or the practice. Business is not simply about financial comfort, nor is it about showing up every day, getting through the day, and getting out. Business is about implementing well-defined systems that lead to long-term success.

Most practices can be significantly more profitable, with very little stress and higher levels of enjoyment, if they

The truth is that most dentists (including myself) are very linear, focused people.

implement documented systems that allow the practice to run optimally on a daily basis. Constant fluctuations in cash flow, stress, communication, and profitability all indicate that a practice is not being managed properly. Practice management consulting allows a dentist to implement high-performance systems that encompass areas such as scheduling, customer service, collections, communications, and case presentation, among others.

WHO NEEDS CONSULTING?

I think that in many dental circles there is a misconception about what kind of practice needs or wants consulting. Traditionally, it was believed that consulting is only necessary if a practice is having issues. While practices in this position should certainly seek consulting, they are not the only ones availing themselves of consulting services from professional consulting firms. In fact, there are many top-producing practices that place an even higher priority on consulting as a way to reach the next level of success. These practices understand that there is nothing wrong with seeking outside help. They are keenly aware of the value of consulting, and they believe their consultant is a significant factor in helping them reach their potential.

One reason why successful practices gravitate toward consulting is that they understand that consulting is not just a one-shot deal. Because we build strong relationships with our clients and deliver results, dentists often choose to continue the consulting experience by accessing other services offered through Levin Group's Life Plan Alliance. These services are designed to serve the needs of dentists throughout their careers.

WHAT CONSULTANTS ARE AND AREN'T

In some dental offices, the very word "consultant" has a variety of interpretations. It may bring to mind someone whose sole purpose is to come into the practice and fire people. This view is often reinforced by the media. In movies and television programs, consultants are typically portrayed as clueless individuals who wreak havoc on an office with foolish firings and ridiculous promotions. Employers see these depictions as satire. Employees, on the other hand, view them as fact. Consequently, dentists may doubt the effectiveness of hiring a consulting firm if staff members become defensive. Yet there is a reason so many Fortune 500 companies routinely rely on consulting—because it works.

FINAL THOUGHTS

Every dentist is unique. Every practice is different. Developing a comprehensive plan enables dentists to reach their ultimate potential by providing them the tools necessary to build sustainable growth and long-term success. These tools include high-performance systems, proven methods, customized solutions and other critical services, including financial planning, recruitment and transitions. It's not just about your practice; it's about your life! The right consulting experience can improve both.

WHO HAS THE RIGHT TO HOLD YOU BACK FROM YOUR IDEAL PRACTICE?

Cathy Jameson

ABSTRACT

Dentistry is growing in complexity, both technically and as a business. Dentists regularly and wisely seek help in developing their technical skills and should do the same in the area of business systems. Often the key to fulfilling practice is a team that shares the dentist's values and supports the functions that make the office efficient. The key to building such teams is communication.

I am the founder and CEO of a practice management coaching firm with clients throughout the United States, United Kingdom, Europe, Africa, and the Caribbean. We are dedicated to improving the lives of dentists, their team members, and their patients by establishing, administering, and monitoring the business and clinical systems of a dental practice.

As we work on developing the management systems, we coach the team on ways to improve communication, since communication is the bottom line to success—no matter what a person's role in the practice. Teamwork and a cooperative, healthy work environment are critical to the ultimate success of the practice. In addition, we provide coaching in the clinical arena—how to purchase, use and integrate technology, how to fully develop the hygienic department, OSHA and HIPAA compliance, ergonomics, and clinical efficiency.

We provide comprehensive coaching with the goal of improving practices. We go to dental offices and teach one-on-one through a method of individualized instruction. We do not believe that any two practices are exactly the same, and so we individualize our method to fit with the doctor, their team, facility, and patients.

The goal of practice management is to develop efficient, effective systems that lead to and support a well organized, productive, profitable practice with a team of leaders working cohesively in

the pursuit of a commonly established set of goals. Carefully established and maintained systems—both business and team systems—lead to stress control. In an environment where systems are in place and the team is synchronized, a practice is able to move toward a clearly defined vision. That is when fulfillment and joy evolve within the profession of dentistry.

My love for dentistry began with a potential dental student when we were in undergraduate school at Oklahoma State University. My husband, John Jameson, and I were married while in undergraduate school, so I, then, helped put him through dental school at Creighton University. From there, I helped him establish his practice, worked with him in both clinical and business roles, learned how important all systems are in the establishment of a practice, and sought information about new technologies and financing programs until we mastered them within our practice. Then I became a consultant in other practices, a writer, and a professional speaker. I have lectured in twenty-six



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countries and in every state in the U.S. and we have now coached more than two thousand teams.

I am a constant learner and a “forever student.” I am inspired by what I learn and enjoy recording new learning, insights, and experiences. By writing for dental journals, I am able to teach the methods of management that we have found to be so effective. It is a way for me to stay in constant contact with the industry, sharing what we have proven to work.

We offer one-on-one comprehensive coaching, meaning that we go into the practice to teach personnel, business, management, teamwork, communication skills, clinical systems (including all hygienic programs), technological integration, and marketing. By “comprehensive coaching,” I mean offering everything from skill development to personalized instruction and coaching in all aspects of the practice to bring the dentist and the team to maximum potential.

We work with practices of all types. This is possible because instead of showing up to present the same single curriculum to every practice we coach, we teach proven systems in a variety of ways and introduce them to each practice just when they need it most. It is all focused on their goals and their individual needs, strengths, and challenges.

We provide coaching for all kinds of dental professionals—students; residents; doctors, not only in their beginning years, but also in their most productive years; those who want to focus on a certain kind of dentistry such as cosmetics or implants; all specialists; those integrating an associate into the practice or preparing for a partnership or transition; and everything in between.

Just as dentists would not diagnose dentistry without performing an analysis

of a patient’s oral health, we would not diagnose or carry out coaching without a thorough analysis of what the practice needs. We have a great team of experts at Jameson who analyze the practices and develop a treatment plan or plan of action for the individual practice and team. Our success is based on the success of each practice. Our consultation must start with a clearly defined analysis of the present status of all systems and a clear understanding of the goals set forth by the doctors.

I have taught communication skills since 1975 and believe communication to be the bottom line of success. Our team has seen this truism unfold repeatedly; therefore they are great at integrating good communication skills throughout everything we teach. From the enhanced management and communication skills, we find that more potential patients are attracted to the practice and more of those patients will say yes to the treatment once it has been presented. The fulcrum of the practice is excellent new patient experiences, comprehensive diagnosis, and outstanding consultations where patients can see—clearly—what is going on in their own mouth and can—clearly—understand why the doctor’s recommendations will be a benefit to them. This fulcrum is solidly based in quality communication—on the part of all team members.

Another area of expertise that we bring to our consultations is our commitment to teach dentists how to collect what they produce (which is the title of a book I have written on the subject). Our average increase in production is 35% by the end of the first phase of our consultation. We also believe that hygiene is the lifeblood of the dental practice, so we can offer a full enhancement project of clinical expertise, as well as management. Our increase in hygiene productivity averages 59%. And, again, with these substantial increases in production there

must be a coinciding increase in collections. Careful management systems will lead not only to increased production but also to increased profit. Net profit and increasing margins are essential for a healthy business.

We make a lasting impact because we believe in the power and importance of every role in the dental team. We nurture and help maximize the potential of each member of the team so they can pool their energies and talents as they watch the lid come off the practice!

Dentistry is becoming more sophisticated every year. With the commitment to comprehensive care, huge acceptance of implant dentistry as a long-lasting, conservative restoration, increasing interest in aesthetic dentistry for people of all ages, and the continued movement toward high tech dentistry, advances are moving at an exceptionally high rate of speed.

This is another reason why excellent and sophisticated practice management is so critical. Progressive movement up the ladder of clinical expertise must be accompanied by a like movement of management expertise. Frustration comes when a doctor knows how and wants to do excellent clinical dentistry but does not get to do that kind of dentistry. One of the reasons behind the inability to do the kind of dentistry in the way dentists want can be a lack of understanding, low support, or lack of enthusiasm from the team. Another barrier can be poor management systems.

For example, I spoke with a doctor from the East Coast recently who has gone through major hands-on training with one of the world's finest clinical instructors. However, he is not doing the kind of dentistry he has been taught because "I'm too busy. My team thinks this is too time-consuming. I don't have the support of my team." Even if dentists

improve their clinical excellence and fail to improve their management skills, they see no result from their diligently earned knowledge. Our purpose is to help doctors manage their practices well enough so that they get to do the kind of dentistry they want to do and know how to do and get to provide that dentistry in the way they want to provide it.

The American Dental Association's most recent surveys identify the fact that the third major reason people do not come to the dentist is that they do not know a good dentist. Half do not go to the dentist on a regular basis.

So, if people are not coming to the dentist on a regular basis and a major reason is "not knowing a good dentist," practitioners have a huge job to do—and a huge opportunity! Doctors must help people understand the value of oral care and to be exposed to the opportunities available in dentistry today.

I think quality, ethical, patient-centered marketing is excellent and necessary. We need more and better media exposure; more and better marketing so the community can be introduced to the excellent professionals who can give them the care they need. Marketing is not a negative thing, but a means of educating patients about who is practicing and what options are available. I believe in this type of patient/consumer education. I also believe that all media exposure needs to be done with unquestionable ethics, just as a dental practice must be managed with unquestionable ethics.

In the sophisticated world of dentistry today, a dentist cannot stand alone. He or she needs to be surrounded by professionals of essential knowledge and training. A successful team must be receptive to a network of outside resources. This network may include patient financing programs, financial planners (including tax accountants) that understand dentistry, practice transition experts, clinical experts, human

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We make a lasting impact because we believe in the power and importance of every role in the dental team.

resources experts, lab experts, product experts, and certainly business and personal management experts. The business of dentistry is complex. We recommend that a doctor surround himself or herself with people who focus their time and attention on the various requirements for an excellent practice, as mentioned above. Then, the doctors can do the things that only doctors can do and can focus confidently on what they love the most—the dentistry.

To expand a bit on how important this can be, especially in times of practice transition, it takes excellent management to get your practice in good order as a

saleable entity for a partner or buyer. For any kind of a transition, whether integrating an associate, contracting with a partner, or buying or selling a practice, a doctor must get the practice in order and then assess the talents and abilities of professionals who focus on practice transitions. The transition needs to be good for the buyer and the seller. Since there are more doctors retiring each year than are graduating, it is a buyer's market. It is imperative that a practice be as clean and smooth-running as possible, not only for peace of mind of the seller, but also so that it is prepared for and appealing to a potential buyer.

Dentists make numerous decisions every single day. Most decisions are related to patient care because this is the area in which the dentists feel most comfortable. However, since most dentists lack formal training in business and personnel management, fear and pause set in when making other kinds of decisions. And so many doctors delay or do not make these kind of management decisions. Most have what Zig Ziglar calls “paralysis by analysis.” Decision making is a major challenge.

Good decision making is based on skill development. Leadership and decision making are not inherent qualities, but skills. Because these are skills, they can be learned. In our leadership courses, we teach people how to make decisions as the CEO of their business. In the end, that's exactly what a doctor must do—make decisions that are good for the organization and those decisions may not always be popular.

Often, dentists don't make a decision, put it off, ask the team, ask a spouse... or just ignore the question or concern at hand. Their decision is, in essence, a

decision to not make a decision. Problems only get worse when not addressed and opportunities can be missed.

If the practice is perfect already, great. However, I have yet to see a practice that could not advance exceedingly with excellent coaching. If a team says, “Oh, don't have them come in; we can do this ourselves,” then I have to ask, “If they can do this themselves, why haven't they? And how much money are you losing every day that you wait to take your practice to the next level?”

I often ask the question, “How does anyone get the right to hold you back from having your ideal practice—whatever that means to you? How does anyone get to tell you what you can or cannot do with your practice? Why would you settle for anything less than your best?” Maybe that is one of the reasons why 66% of dentists say they would not choose dentistry as their profession if they could do it again, according to the ADA.

In my opinion, each and every doctor has the right and the opportunity to have the ideal practice (whatever that means to the individual). It is my hope that you do not look back on a day, a week, a month, a year, a career, a lifetime with regret wishing you had done something that you did not do. Rather, it is my hope that you get to the end of each day, week, month, year, career and your life and look back with joy that you did what you wanted to do and that you accomplished that which you hoped to accomplish. ■

PASSION, PROFITABILITY, AND POSITIVE ATTITUDE

Bill Blatchford, DDS

ABSTRACT

Many dentists work for their practices, experiencing frustration and lost enthusiasm. Their vision of the possibilities of their practices has been limited. They no longer see their practices as the result of choices they can make. Coaching can help overcome this narrow perspective. The commercial opportunities of Web marketing, new services such as implants and sedation dentistry, and large CE programs should be embraced by dentists to continue the recent trend of dentists earning more than physicians.

A young female dentist with two preschool children and a supportive husband found herself the owner of a large practice with fourteen staff members, including several associates, as the previous owner had an accident injury. She was beside herself with worry and concerned she was going broke while missing her children's growing-up years. We caught each other at the right time. With coaching and direction, she became the leader she envisioned and formed a team. She instituted strong systems of booking and collecting and mastered sales skills. She is now a solo dentist producing \$1.6 million with a net of 50%, enjoying her team of three, and working three and a half days a week.

THE NEED

This is my job as a dental practice management coach and why I am so passionate about the journey and the results for these doctors. If you choose to be a dentist early on, I want there to be great support for you to make the profession a fun, rewarding, and continually interesting part of your life.

Dentistry is the best profession in America right now because of independence and freedom from control, increased profitability, ability to differentiate one's practice in the marketplace, lifestyle choices for vacations and hours working, plus the greatest satisfaction in changing people's lives by helping them to enhance and keep their smiles.

Dentistry net income surpassed physician net income in 2000 and the dentist's work week is far lower than the eighty hour work week of physicians. We avoided the managed-care pitfall of physicians and have made insurance work for dentistry and the patients. With licensure by credentials in nearly all states, we are much more mobile than ever before.

Yet any profession has plateaus or downturns and this is why I am involved in the business of dentistry. Dentistry can become very routine with similar treatments and working in the same small environment with the same small number of people. Dentistry is a challenge physically; the clock is not always your friend. A dentist can work very hard and still not produce much income. A dentist is not only the leader but also a full-time player, so training the team is important. A dental education is very specific and does not lend itself to corporate hiring or other venues. You could feel stuck.

With these various challenges, dentists can become frustrated and continue to view the smaller picture of life and practice. They find their overhead can be in the 80% range and ask "Why me?" This is especially true if last night was



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Dentistry is a challenge physically; the clock is not always your friend.

the local dental society meeting and there was some braggadocios sharing their highest monthly gross ever, rounded up to the nearest ten thousands. As a young dentist, we do not stop to differentiate between gross and net. Psychologically, dentists can lose their focus and enthusiasm for the profession. I have coached dentists near the end of their careers who ask, "Where were you when I started? I love this stuff and may never quit."

Choices

When someone is frustrated, there are choices to make and one feels immobilized and afraid to make a decision for fear of making a wrong move. Frustration builds and apathy may result. Some dentists continue to practice when there is no passion, no new classes or ideas, and they basically drop out but still go to the office every day. How sad!

This, then, is my passion: to help my profession regain the dreams, goals, and focus, to get back in the game and keep moving forward. Each dentist is different and unique, which is why I have developed a custom coaching program throughout which I personally address each doctor's unique picture. Through national and international speaking, plus regular articles in dental journals, I have become known as the doctor's coach. The only person who will be there from start to finish is the doctor. Therefore, if we can coach the doctor to create his or her dream, put strong systems in place, and learn communication skills, a strong team will form to support the vision.

I worked with one doctor's practice from the start, helping her to select a location, team, marketing, and deepen her direction for leadership. Today, she is producing over \$2 million as a solo dentist with a highly niched cosmetic and reconstructive practice.

In my twenty years of practice and mixing with other dentists in continuing education courses, I found a wide variety in levels of profitability, case acceptance, enjoyment of practicing, and staff that surround the dentist. Often dentists work hard and consider working hard (long hours and possibly multiple locations) a must for making more money. For me, it is not about working harder but working smarter.

As a dental business consultant and pilot, I feel my unique perspective is having worked now with over 1,900 offices, I can see the doctor and practice from 35,000 feet. I can help the doctor envision possibilities and own a bigger picture of future success.

I am always studying and observing what the future trends in dentistry are. Presently, I am encouraging dentists to look at sleep apnea, CRP for physician referrals, cosmetic dentures, implants, and IV sedation. I help them acquire the competency skills. Cosmetics were popular about fifteen years ago and now everyone is a "cosmetic dentist." What makes you different? How can you be branded as different?

Dentists were told in dental school, "Put out your shingle and patients will come." It is not that easy. To be successful in dentistry, one needs to study a location choice, to discover one's unique path to dental happiness with leadership vision and goals, and to develop communication skills not only for patients but for teamwork, too. Dentists must keep up both technically and in the area of business. They must know and understand their numbers and how to change them. For example, they choose their target for overhead and it does not need to be the national average of 83%. I work with a doctor who produces nearly \$1million and her overhead is 49%.

In my observation of doctors, I see that it is important to show them that they have choices about their lives and practices. For dentists, frustration sets in

when they feel they are continually pulling the wagon with staff jumping on and off. They feel dentistry is hard work and wish they could choose something else. If I can give them a feeling of leadership and organization to restore their happiness and feeling of being needed and wanted, this is victory to me. We saved another dentist and he or she found happiness.

In a few cases, I find money is not the motivating factor. However, when a practice is organized well with leadership and systems in place, there is more profit and the dentist takes notice. Staff participates in a fair bonus, so money is a motivator, too. One of our dentists did not care about the money but wanted to form his practice so he could work just three eight-hour days a week with four full days off. He now produced \$1.6 million with a team of five. He was willing to study sales skills and be a strong leader. He was already an excellent dentist and efficient operator.

Leadership in a practice is a continual challenge. Dentists were selected for dental school based on science scores, not political or communication abilities. To create a successful practice, one needs to become the leader and make decisions based on one's own practice vision. Leadership and decision making are a continual challenge for most dentists.

Day-to-day decisions are made in successful practices because of clear and committed leadership and vision. Teams form because they buy into the practice vision. They all want the same things to happen for the practice, patients, and themselves. When the vision is clearly articulated by the leader, team members can make their own decisions. We eliminate the micromanaging that vexes so many dentists. Hiring the right people and being a strong leader with vision helps the team to carry that vision as their own.

FUTURE OPTIONS

A young, ambitious dentist joined our coaching program with great cosmetic skills. He wanted to define his practice as cosmetic, yet as he looked around, everyone was a cosmetic dentist, some with great skills and some mediocre. I coached him to look at branding himself with additional skills and today he has his IV sedation certification and has mastered implants. He is producing \$2 million a year. He is looking for an intern to do single teeth and fillings.

This then leads to the topic of commercialism in health care. The world has changed and we are overloaded with information. Yet, our manner of selecting services and goods is largely based on personal referral, plus awareness in the media, including the Internet. Without the media and advertising, dentistry becomes a commodity as the public perception would be "all dentists are the same." Dentists are not the same and your excellent margins are not what attract patients to you. Yes, you must be an excellent clinician, yet just as in any retail store, it is the relationship, trust level, and ability to emote caring that attract patients to you.

Today, I think it is imperative for dental practices to be on the Web and this level of commercialism is good for dentistry and good for patient choices. When a doctor shares pictures of the team and office, this starts to create a relationship and trust. Completed after pictures and testimonials build confidence and reinforce a positive impression. Web sites are moving into video with astute marketers. Change is happening fast.

The future of dentistry is very positive. Our oldest daughter is a second-year dental student and she is thirty-five years old with two bachelor's degrees preceding this. She sees the profession as one to satisfy her need to be an independent

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Some dentists continue to practice when there is no passion, no new classes or ideas, and they basically drop out but still go to the office every day. How sad!

leader, to feel needed, and to make choices about profitability and services offered.

We started working with a husband-wife dental team eight months before they opened their practice. We coached them on vision, leadership, location, practice goals, and dreams. They continued working in high-volume clinics as the office took shape. They were so ready with marketing, sales skills, and systems they had patients calling even before the office was complete. They averaged \$65,000 a month for the first three months. In their first calendar year, they produced just under \$1 million with one staff member.

Dentistry in America is strong and healthy. Dentistry has become recognized by physician students-to-be as a better choice than medicine due to lifestyle choices. Dentists can work a regular work week and not be on emergency call yet dentistry can still be a technical challenge and change people's lives. The joke for medical students will soon become, "Oh, you couldn't get into dental school, either?"

Dental incomes surpassed physician income in 2000. The demographics of dentistry are changing rapidly from the former all-male profession with spouses who were either teachers, nurses, or secretaries who could find work anywhere. Today, nearly half of dental students are women and their spouses are professionals who find work in large urban areas. At this point, we are seeing about one-third of female graduates who do not own their own practices but work part-time. Some are not re-entering the field after child rearing. The field of veterinary medicine discovered these choices forty years ago.

My top producers are female dentists surrounded by female teams. Dental schools are selecting candidates who

have a variety of experiences, some older students, and the result is a more right-brained, caring leader who has communication skills and leads with a bigger picture. There is striving for perfection mixed with joy and comfort. Add this to the demographic change from graduating nearly 6,000 dentists in the 1970s and 1980s to today's yearly graduation of 4,300, and it is significant. Also, America's population has moved from 200 million to 300 million, and the demand increases. The predictable result is that metro areas will be even more crowded with healthcare providers and the rural areas will be underserved.

Another significant factor is the way continuing education is now delivered. When cosmetic and bonded dentistry came into the field, private organizations became the teachers of new techniques and skills. There have been excellent three-day huge extravaganzas where twenty different clinicians speak to whet the appetite for their particular contribution. These gatherings have made dentistry exciting and inviting. Organized dentistry has noted the format and made a real effort to boost the motivation and enthusiasm at their meetings. I give great credit to those clinicians who ventured out on the skinny branches to develop teaching centers for interested dentists.

I love what I do. I am able to help dentists receive the emotional and financial rewards. Best of all, I love helping dentists to become pleased with the great profession they selected and helping them to continue to enjoy its challenges and rewards. ■

PERFORMANCE MEASUREMENT APPROACHES TO MORE PRODUCTIVE DENTAL PRACTICES

Richard E. Workman, DMD

ABSTRACT

Although the trend is changing, most dentists work along. This means a major impediment to improving practice productivity is lack of benchmarks against which to judge outcomes. The example of treating periodontal conditions based on population baseline parameters is used to illustrate how practices can become more successful with the help of organizations that provide performance measurement consulting.

Dentists today provide more complete and comprehensive care for our patients than ever before. New technology, diagnostic tools, materials, and procedures assist us in our ability to focus on early detection and therefore perform more conservative or less invasive procedures. Dentistry is becoming more sophisticated and with that comes a higher need to use evidence-based measurement tools to ensure that we remain objective versus subjective. In doing so, it is essential that all processes have compelling scientific research to support the beliefs at the foundation of these measurement tools. In dealing with hundreds of dental practices in the U.S., Canada, and the Caribbean, we at Heartland Dental Care feel we are privy to a broad spectrum of dental practices. What we consistently find is substantial variances between what a doctor and team say they believe in regard to the care they are delivering in their practice and the actual patient care results that are occurring. Without objective measurement tools, the dentist and team are left with the inevitable stew of human nature and subjectivity.

Measurements And Performance Systems (MAPS) is the comparative analysis mechanism Heartland has been using and constantly updating to correlate with current dental knowledge over the past fifteen years. The doctor and team members, our partnership offices, and our coaching clients have access to over two hundred hours of training during their first year alone.

Through this rather intensive interaction and explanation of current standard of care and emerging trends, technologies, and protocol we develop a collaborative clinical philosophy and reach agreement on how to implement our processes and approaches, while consistently and objectively measuring our results against these held beliefs. Our goal is to share our perspective and hopefully to enhance the current understanding of general practice across the United States.

Dentistry is expanding beyond the cottage industry of yesterday where dentists yearned to “work alone” while experiencing the responsibilities and risks of ownership. According to an October 16, 2006 *ADA News* article, percentages of 2004 graduates that own their own practices ranged only from 11% to 38%. We have entered an era where the majority of graduating dentists will never own or build their own practice due to education debt, cost of buying a dental practice, and the responsibilities and risks of ownership. We believe the new generation of dentists will emerge as individuals who desire to gain fiscal stability in their practices and personal situations, as well as being an integral part of a more highly



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What we consistently find is substantial variances between what a doctor and team say they believe in regard to the care they are delivering in their practice and the actual patient care results that are occurring.

collaborative process. The results of this collaboration will ultimately benefit our patients as well as our profession and dentists individually.

At Heartland we work with a broad spectrum of dentists in every stage of their careers. We are in a unique situation that allows mentoring and growth for new graduates by our more experienced doctors, as well as collaboration between our doctors as a whole. This safe environment allows for increased clinical, business, and leadership expertise for all involved. Aside from what we are learning about what new dentists want, we have learned that many seasoned dentists have a strong desire to gain freedom from day-to-day management and business decisions, while securing the equity in their practices before they retire.

We exist to support all generations of dentists with their clinical and leadership development, as well as business and operational knowledge. We believe our practices should be patient-centered and clinically focused on what is best for the patient. We refer to our clinical philosophy as "Lifetime Care." Lifetime Dental Care is a philosophy of care that applies the highest standards of care available to maintain the patients' oral health over their entire lifetimes. In simplest terms, it is offering the same level of care to our patients as we would our friends and loved ones. We have

found most dentists, too, subscribe to this philosophy and want to offer the highest standard of care possible to their patients. Most dentists consider themselves quality-oriented and continue to look for ways to offer and deliver the best standard of care possible by using the information and systems they employ in their practices. They tell us they get frustrated because they lack the tools and systems necessary to achieve this. Once these tools and systems are shared, dentists often tell us, "If I only had known this was available, I would have used this a long time ago!"

Our most obvious example pertains to periodontal therapy. When we ask a group of dentists what percentage of the adult population has periodontal disease, we hear from 20% all the way up to 80% or more. If we were to only count Type 2, 3, or 4 periodontal disease and we only use 20% as the annual prevalence, it could be projected that out of the next one hundred adults coming into the practice, approximately twenty patients would need four quadrants of scaling and root planing. This would amount to approximately eighty quadrants of scaling and root planing and a remaining eighty adult prophies, which would be a 1:1 ratio of scaling and root planing to adult prophies. We may not be qualified to suggest that this should be the accepted standard, but please make note that recently a well known practice management consultant shared his belief that the recommended amount would be eighteen adult prophies were done on

average for every one quadrant of scaling and root planing. It is my opinion that our 1:1 ratio mentioned above certainly does not reflect current indications of the prevalence of periodontal disease, but is a place to start. When evaluating their periodontal programs, many dentists find that there is a statistically significant opportunity to increase the periodontal care in their practices.

The most compelling information we could hope to share in this article is that dentists lack exposure to a broad database of clinical benchmarks and information. This is information that when shared and applied has helped scores of our affiliated dentists give the care that is reflective of current clinical information. This information helps them “beg the question” of themselves, their teams, and other similar practitioners and has ultimately helped them improve the care they offer their patients. Certainly a side effect of this improved care is increased economic outcomes, but it is the improved clinical care that truly enhances our providers’ satisfaction within our profession.

The example of the prevalence of periodontal disease and subsequent treatment is only one example of the comparative analysis utilized in our MAPS, individual office trend analysis and collective rankings reports. We delve past the traditional measurements of collection, production, new patient flow, and number of crowns done in a practice. We use over one hundred metrics and formulas that have been collaboratively defined as benchmarks based on current

beliefs and standards of care based on current clinical and business knowledge. This approach gives us a consistent and standardized approach to the quality of care we deliver to our patients.

The study of benchmarking data allows us to create systems and protocols that are predictable, repeatable within a single dental practice, and consistently transferable to other practices. Consistent collaborative training on these protocols is necessary for all involved to understand the dentists’ philosophy on Lifetime Care and carry that out on a day-to-day basis in the form of the patient care delivered in each doctor’s practice.

Information and technological advances continue to increase the sophistication of our profession. Dr. W. Edwards Deming once said, “If you can’t measure it, you can’t manage it.” Dentists now and in the future are in need of intuitive measurement data as well as resulting systems that are consistently repeatable and transferable in dental practices across our country. At the end of the day, we all want to experience peace of mind in providing care that our patients need and desire, while concurrently experiencing professional and personal success. We at Heartland hope to be a part of the realization of this goal within our profession. ■

We have entered an era where the majority of graduating dentists will never own or build their own practice due to education debt, cost of buying a dental practice, and the responsibilities and risks of ownership.

ISSUES IN DENTAL ETHICS

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THE EVOLVING RELATIONSHIP BETWEEN SPECIALISTS AND GENERAL DENTISTS: PRACTICAL AND ETHICAL CHALLENGES

Barry Schwartz, DDS, MHSc

ABSTRACT

As dentistry evolves, so has the interrelationship between specialists and dentists, in many cases to maintain a full office schedule amidst changes in patient needs and practice philosophies. This essay will consider the ethical implications as well as the enablers and disablers of relationships between specialists working in a general dentist's office. Dentists need to consider all of the ethical implications before embarking on new relationships between dentists and specialists in order to best maintain patient trust and to provide enhanced patient care.

Phyllis has just attended Dr. Smiley, her general dentist, for an examination and she is informed that her four unerupted wisdom teeth need to be removed. Because this will involve surgery, Dr. Smiley is going to arrange for an appointment with an oral surgeon. An oral surgeon comes into Dr. Smiley's office to work on his patients every Monday. Phyllis is very happy to have a dentist who can arrange all of their family's dental care in the one office. Her husband's recent root canal was done by an endodontist who comes in on Thursdays while her daughter's orthodontic treatment is done in Dr. Smiley's office on Fridays. Last year, Phyllis had her gum surgery done by the periodontist who comes in on Tuesdays. According to Phyllis, "Dr. Smiley takes great care of her family's dental health.

We never have to go anywhere else. More dentists should be as thoughtful as Dr. Smiley!"

Dentistry has evolved over the years due to technological advances as well as through increased patient education, resulting in patients requesting more sophisticated treatments. Until recently, general dentists had their schedules full simply keeping up with treating carious lesions and providing continuing care appointments. In that era, most dentists would refer oral surgery, endodontics, periodontal surgery, and orthodontics, and many would refer a number of their child patients as well, so they could concentrate their efforts on what they enjoy and do best. Those patients were referred for procedures requiring greater specialized expertise than most general dentists possess, or simply because the dentists preferred not doing certain procedures.

But filling a general practice office's schedule has become more complex and patients, or many of them, have changed as well. As the population has become better educated and especially with the Internet and with the impact of professional advertising, information



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about oral health care is more easily accessible. Dentist-patient relationships have therefore evolved. Dentists must deal with more demanding consumers of their services. With so many changes in dental practice, it is not surprising to see that relationships between general dentists and specialists are also beginning to change and that some general dentists are inviting specialists to provide their services in the general dentist's office.

This essay will consider the ethical implications as well as the enablers and disablers of the relationship between specialists and general dentists in the general dentist's office. Many of the trends and patterns of practice referred to in this essay have not yet been carefully researched. Where research has been available, it has been used and duly referenced. In other respects, the author has depended on his own informal research and observation of trends and patterns. The practical and ethical importance of these changes in practice patterns suggests the need for careful research about them.

THE CHANGES IN PRACTICE

With fluoridation, better preventive dental education, and proliferation of third-party insurance coverage for more advanced dental procedures, dentists have found that they need to offer additional services to fill their schedules, since their patients have fewer cavities. Many newer practitioners are attempting to do all of the periodontal, endodontic, and oral surgery treatments that they had been trained to do in school rather than referring these patients to

specialists. Others have responded to the increased demand for orthodontic treatment that has paralleled decreasing levels of childhood caries (Marshall, 1998). Unfortunately, general dentists sometimes find themselves overwhelmed by the difficulties that they encounter (Graham & Harel-Raviv, 1997; Spear, 2005).

But dentists clearly have a duty to refrain from harming the patient and to recognize their limitations. According to the *ADA Code of Ethics* (ADA, 2005), this includes that they "seek consultation, whenever the welfare of patients will be safeguarded or advanced by utilizing those who have special skills" (Section 2B). Hindsight may always be 20/20, but knowing just when that appropriate time is can be very difficult to determine consistently.

As an alternative, a number of general dentists have found specialists who not only provide required care right in the general dentist's office but also serve as mentor, assisting in the development of interdisciplinary care and upgrading of the general dentist's skills should the dentist wish to eventually take a more active, albeit selective, role in future cases.

Consider the case described at the outset. One might judge this to be the ideal situation for a patient, for there are many positive reasons for a general dentist to have specialty treatments provided in his or her own office:

- Developing a close professional relationship with a specialist who

With so many changes in dental practice, it is not surprising to see that relationships between general dentists and specialists are also beginning to change and that some general dentists are inviting specialists to provide their services in the general dentist's office.

shares similar values in patient care, infection control, pain management, etc.

- Better communication between the dentist and specialist since any questions regarding diagnosis and treatment can be carried out face-to-face, thus enhancing continuity of care for the patient.
- Ensuring a comfortable and familiar environment for the patient, thus reducing patient stress.

While the potential benefits of this arrangement for the patient noted above are genuine, they cannot justify manipulating the patient or withholding needed information from the patient to keep their work in the office.

- Ease of access, parking, and paperwork with greater consistency for the patient.
- Enhancing the patient's conviction that the dentist is overseeing all aspects of the treatment as a case manager, thus enabling greater patient trust and loyalty.

THE CHALLENGES OF THE NEW ARRANGEMENT

But there are complicating factors as well. Some reasons why a general practitioner might not want to have specialty treatments provided in his or her own office are practical patient care issues. For example, the office would have to be prepared to deal with patients in recovery after heavy sedation after the specialist has left the office, including possible complications whose management the general dentist and his or her staff may not be familiar with. Or the more general issue of whether the general dentist's staff will need additional training to assist the specialists, communicate effectively with patients about the specialists' work, etc.

Even more important are subtle aspects of the relationship between the general dentist and the specialist practicing in his or her office. For example, some general dentists complain that some periodontists take over the patient's regular scalings and the patients then expect the periodontists to also check their entire dentition. Some of these patients never see the general dentist until advanced carious lesions necessitate a "referral" back to the general dentist. So developing a clear understanding of who does what will be essential and will involve careful give and take, especially among professionals who do not already

know each other well and, especially, know each others' work.

Note that there is an important ethical issue embedded in the creation of this relationship; namely, in regard to competent practice. To work this closely together, the generalist and specialist must respect each other's particular skills or they will be constantly dealing with the ethical challenge of sending patients to a dentist of doubtful or uncertain competence, right there in the same office! As an extreme example, the author has encountered some specialists who have recommended to their patients that they have their general dentistry work done by someone other than the "referring" dentist.

In addition, there are the obvious complexities of identifying the proper financial arrangement between the general dentist and the specialist. These will be discussed more fully below.

This topic takes the discussion to the most complex of the specifically ethical issues raised by such practice arrangements. There is a very important ethical concern whether patients are getting proper informed consent in the referral process. It could be very tempting to adopt a practice in which important information is not given to patients who use the in-house specialist. But patients need to be able to decide on the caregiver they should see for the work they need, and they need sufficient information to do this; otherwise, the patient's autonomous choice would be unethically restricted. Since there would be some guarantee of a minimal number of patient referrals to make the specialist's coming to the office profitable, the dentist might be tempted to apply subtle pressure to the patient to not go elsewhere. While the potential benefits of this arrangement for the patient noted above are genuine, they cannot justify manipulating the patient or withholding needed information from the patient to keep their work in the office. One can

also imagine that the desire to keep the specialist busy could affect the dentist's criteria for removing wisdom teeth so that surgery is recommended for patients who are asymptomatic or have a lower possibility of future complications.

In addition to this potentially harmful conflict of interest for the "referring" dentist, who is now profiting from the work of a contracted specialist, there could also be subtle pressure on the specialist to help the general practitioner keep busy.

On both sides of the arrangement, we find ethical challenges not too distant from the ethical questions that arise in regard to gift giving and receiving. All health care practitioners are obligated to act in the best interest of their patients, but a professional's ability to do this can be compromised when gifts are being given or received within referral relationships. Even when dentists may feel that there is no harm in the conflict of interest involved in a gift, there can still be the perception by the patient of an inappropriate influence on the professional's judgment (Davis, 1998). (Also see the *Royal College of Dental Surgeons of Ontario Conflict of Interest Guidelines* available at www.rcdso.org/pdf/guidelines/conflict_interest.pdf.)

Ethical problems occur when dentists do not realize that their referral patterns may be subconsciously influenced by such gifts (Wazana, 2000). Regarding gifts, Hasegawa suggests that one way to assure the preservation of ethics is to refuse giving and receiving them as a matter of office policy (Hasegawa, 2001). So, when the gift giving and receiving takes place within the same office, there is no other resolution but to stop the arrangement.

How should these conflicts of interest be handled to make sure they are not harmful to the patient? They must be

addressed through transparency with the patients (Ozar, 2004). Clearly a failure to disclose the arrangement would interfere with the patients being able to weigh their choices and decide if the conflict of interest is harmful to their interests or not. So this needs to be something carefully addressed by the dentists involved when the arrangement is set up. (Such arrangements fall into the gray area as far as regulations are concerned, because there are no specific guidelines and/or regulations regarding such activities.) If the general dentist informs the patient of the pros and cons of this referral process, and if the patient is allowed to and encouraged to choose freely, then there is no harm in the conflict of interest. Thus, in the example scenario, giving the patient a choice of attending another oral surgeon, as well as informing the patient that the oral surgeon does pay the office a percentage, would be the ethical approach to take.

DEVELOPMENT OF DENTIST-SPECIALIST RELATIONSHIPS

In order for optimum patient-centered care to occur, general dentists must know what their limitations are, and have a close professional relationship with a number of specialists so that their patients can receive the care that is required. Establishing an open level of communication between the patient, the referring dentist, and the specialist is essential for optimum patient care. This three-way openness is often difficult to achieve when the specialist is not in-house because the specialist, who must be mindful of continuously nurturing the relationship of the referring dentist, may find it difficult to honestly answer patients' questions when less than ideal treatments have been performed by the general dentist present or the two dentists have differing approaches to managing a patient. (Goldenberg, 1997) Examples of this occur frequently when

patients are referred to endodontists to complete or redo a complicated endodontic procedure that the general dentist had been unsuccessful with, or an oral surgery case that is referred with broken root tips remaining, or with a sinus perforation (Kress, 1995). Specialists are often taxed to honestly answer questions without fear of being cut-off from future referrals lest they be construed as having bad-mouthed the qualifications and capabilities of general dentists and being viewed as "ungrateful for the referral" (Glick, 1997; Holloway, 1985; Ozar & Sokol, 2002).

These ethical tensions are likely to be much greater in the situation where the specialist is practicing in the general dentist's office. The two dentists must establish a bond of mutual trust and open communication if such close collaboration is going to benefit their patients and have any degree of staying power.

But achieving this level of trust and communication may be very challenging, given the adversarial relations of some specialists towards general dentists and vice versa. Of course, many specialists have become actively involved in organized dentistry and in dental societies in order to develop closer ties with general dentists. By sharing their expertise in organized talks or being available to offer consultations on specific cases, many specialists have been able to forge better professional relationships with general dentists. But there are numerous articles and letters in the journals by the national specialty organizations in North

America critical of general practitioners who offer the services of a specialist in their offices, suggesting that specialty care should be left to specialists in the specialist's office. According to one general practitioner, this has contributed to "twenty years of a consistently negative campaign" against general dentists which has not benefited patients, dentists, or specialists (Kennedy, 1990). So creating a stable collaboration will depend on a high degree of trust and active communication by both parties at the outset and as the arrangement continues through time.

Facility Fees

When a specialist works out of a general practicing dentist's office, there is a financial agreement between the parties to cover overhead expenses. Typically the specialist would pay a facility fee of 50% of the specialist's billings in exchange for a constant supply of patients who require specialty treatment. Because of the potential for conflict of interest harmful to the patient, it is important to weigh the facility fee against the standard of an appropriate fee for use of the office to provide services, but the fee may not include a benefit to the general dentist simply for the referral.

According to the *Royal College of Dental Surgeons of Ontario Guidelines on Conflict of Interest*, a dentist may split a fee with another dentist who comes to their office to provide services to patients; however benefits obtained as a result of a referral itself are to be avoided.

The ethical question about the size of the fee paid by the specialist thus centers on the actual costs involved, both direct and indirect, and whether the referring dentist profits financially for the referral in addition to the actual costs. One could also compare this situation with the sale of dental appliances or the dispensing of drugs, as situations involving similar conflicts of interest that are assured of being ethical and not harmful to patients through care and equity in the financial arrangements themselves and transparency with the patients (Ozar, 2004).

Conclusion

It is a fact that dentistry has evolved in many elements of patient care. Many of these changes have resulted in better care for patients. The evolution of the specialist-generalist relationship may benefit patients in some degree. But it also has the potential to harm the trust element that is a cornerstone of the dentist-patient relationship if the conflicts of interest that inevitably exist in the financial relationships of general dentists and specialists are not carefully examined and dealt with in such a way that they are not harmful to patients. In the case described at the outset, Phyllis sees many advantages to the new relationship. Unfortunately, other patients may not share this outlook and could consider the dentist's actions to be shaped by monetary concerns and self-interest unless transparency with patients enables them to see the relationship as ethically appropriate. Dentists should consider all of the ethical implications before embarking on these new relationships between dentists and specialists. The traditional relationship between dentists and specialists has contributed to the maintenance of patient trust and should only evolve to provide enhanced patient care, and not evolve based on financial pressures. ■

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Small Ethics

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ABSTRACT

Traditionally, ethics in the professions has focused on big problems that could be found on other peoples' back porches. Small, habitual, frequent, and personal lapses get little attention. In this essay, the literature on opportunism is applied to dentistry with a view toward bringing matters of "near ethics" within reach. Examples of small lapses are discussed under the headings of shirking, free riding, shrinkage, pressing, adverse selection, moral hazard, and risk shifting. The conditions that support opportunism include relationships with small numbers of transactions and uneven access to information. Practical limits on understanding all the consequences of agreements and the costs of supervising others and enforcing corrections of breaches are inescapable aspects of opportunism. Opportunism may not be accepted by all as the subject matter of ethical, but curbing it is a worthy goal and understanding the causes and management of opportunism casts some light on the ethical enterprise. Four suggestions are offered for addressing issue of opportunism.

Perhaps the dental profession has not been well served by grounding its approach to ethics in classical theory such as normative principles, virtue ethics, and utilitarianism. Perhaps we are spending too much time tussling over big issues such as managed care and commercialism and looking for some bad guys who justify our use of high rhetoric. Through attention and money we might be able to reduce the number of high profile ethical breaches in the profession by 10% or more. But surely it would be better to stop one lapse each day in every dental office.

This is an essay about small ethics. What we need is some way of talking about the very common miscalculations, cases of negligence, sharp dealing, "self first this time because I deserve it," "those who can work the system do," and "don't kill myself if I don't have to" patterns of behavior that have become rationalize habits. And we need a way of talking about this without having to label ourselves as unethical people.

Opportunism is a term sometimes applied to this kind of "near ethics." There is a small literature in the field. Some good work can also be found under the headings of agency theory or organizational economics. Consider the examples in the sidebar.

Perhaps some readers will be annoyed with this list of opportunistic actions in dentistry. Perhaps the list was only scanned after the realization that "near ethics" means close to us, not

approximation to traditional ethical theory. Each of the examples has an odor of not being quite right, but they come perilously close to common practice. No one is necessarily damaged irrevocably; we might bellyache about some of these examples in a general sort of way if we can make the case that someone else is doing the deeds. But anyone who puts down his or her productive work to make a campaign to stop these practices would be thought quixotic. Probably, no one would do jail time for any of these behaviors, even if engaged in habitually. But students at several dental schools were recently and very publicly disciplined for the counterparts of the practice indiscretions mentioned in (c), (q), (r), and (t) in the sidebar. Maybe we could agree to call these examples of "near ethical violations" but we cannot agree to disregard them.

Opportunism does not mean ignoring the posted speed limits on the highways—almost none of us do. It means knowing when to obey the speed limits—almost all of us do. The remainder of this essay will take up four topics: a) exploring the major categories of opportunism; b) attempting to define opportunism and how it relates to ethics; c) discussing why opportunism arises and how it is managed; and d) suggesting what might be done with this insight to improve the daily practice of dentistry.

EXAMPLES OF OPPORTUNISM IN DENTISTRY

SHIRKING

- a. Dental students start reducing patient treatment after they meet their “requirements” or skip recalls because they need crowns.
- b. A certain clinic is known for its shoddy work – the fee for a poorly done crown is the same as the fee for one of high quality.
- c. Dentists sign in for CE credit but leave early or don’t stay at all; the questions for the free CE in the journal are filled out while reading the article or with the help of a few fellow practitioners.

Free riding

- d. A faculty member basks in the reputation of a prestigious dental school without contributing to that reputation.
- e. A dentist accepts an invitation to sit on a prestigious board but misses many meetings and fails to do his homework.
- f. A student puts his name on a group project and earns credit for it despite doing almost none of the work.

SHRINKAGE

- g. The new Vita EasyShade device is permanently borrowed from the school’s clinic; six carpules of anesthetic are on the bracket tray just in case.
- h. Staff helps themselves to the photocopy machine, phones, computers, and “company time” for personal uses.
- i. A very liberal definition of business expenses is used in preparing income tax returns.

PRESSURE

- j. A student presents only the option of a crown to her patient (when a build-up would be perhaps more appropriate) because she needs her C&B requirements and then begins the prep before the instructor gives the final start check.
- k. As more dentists establish practices in a small community they reduce the number of days worked and increase fees correspondingly rather than accepting more patients at slightly lower fees.
- l. A practitioner shades informed consent to favor the procedures that are more fun to do or return higher income per time spent, or not giving informed consent at all.

ADVERSE SELECTION

- m. Dental schools are looked to as the safety net for welfare patients but are discouraged from competing with private practitioners for high-paying ones.
- n. Episodic treatment is rendered with follow-up and corrective care being “on the patients’ own.”
- o. Spa dentists and extreme make-over practices cherry pick the patients away from dentists providing comprehensive, continuous care.

MORAL HAZARD

- p. A dental student passes out business cards at church describing himself as “Dr. X.”
- q. A dentist retroactively updates the records on a few patients who have mentioned second opinions just to ensure proper form.
- r. Several dentists establish a Web site to share information to set maximal insurance charges and exchange tips on clever ways of documenting otherwise unreimbursable procedures.

Risk shifting

- s. Dental students complain when they are caught “cutting corners” in clinic and defend themselves by saying that practitioners do it all the time.
- t. Difficult partial bony impactions are up-coded to full impactions because the codes don’t reflect the true nature of the work done.
- u. Initial licensure examinations expose individuals who are not patients of record of any licensed dentist to treatment with no provision for follow-up care.

Types of Opportunism

There is no once-and-for-all comprehensive catalogue of opportunism. The following types cover much of the territory.

SHIRKING

Giving less than the expected or originally agreed-upon effort or quality is known as shirking. None of us always does his or her best, but there is something out of sorts if there is a pattern of performance that is generally less than we would claim if asked to publicly describe what we do or if that pattern is somehow related to monitoring by others or the potential for extra reward. Shirking is massive in dental schools that have requirement systems, and most dentists practicing today recall that. Capitation systems are prone to shirking for exactly the same reasons. Shirking will be lurking in any situation where reward is fixed and assured. Individuals who work for a salary are at risk for shirking. The first three examples in the sidebar can be classified as shirking.

FREE RIDING

Should everyone who works in your office get a productivity bonus based on practice outcomes or should all members of your group's organizing committee receive the same public recognition? If the answer is yes, there will be some free riders. Free riders are individuals who expect the same benefits from group membership that others receive without doing their share of the work. Some senior dentists are resentful that young men and women entering dentistry act "entitled" to the privileges of the profession that those who went before worked so hard to establish. There are dentists who grumble about organized dentistry's "failure to represent the

average dentist" although they have never served on a committee and may even be outside the tripartite structure. That is free riding with prejudice. Further examples appear in the sidebar.

SHRINKAGE

There is an old joke about the way communists negotiate: "What's mine is mine; what's yours is negotiable." This gets at the heart of shrinkage. It is human nature to use common resources for our own ends before resorting to expending our own resources. It is not uncommon for American organizations such as Wal-Mart, restaurants, or the post office to experience unaccounted reduction of inventory, small equipment, and breakage caused by unauthorized use in the range of 30%. Some of this just walks out the front door under someone's coat, but most of it is from employees making personal photocopies, "borrowing" the company car, or writing personal matters off as business expenses. The typical rationalization tends to include elements of "the organization is so big they would never miss this little deduction," "others are doing it all the time," and "I am owed this for all the extra things I do that go unrecognized." In some cases, each of these arguments is true, but in aggregate the books never seem to balance.

PRESSURE

I hate it when the car repairman says "In addition to the wuzits that you need to get this thing back on the road, you also gotta have a thingy and a gizmo." I don't know what thingies and gizmos do or why I should have one or more of them, but I always suspect that it is more valuable to the repairman to sell them than it is for me to have them. I am especially suspicious of lawyers, politicians, and regulators who want to create ideal worlds at the expense of folks like me who are satisfied with adequate ones.

Certainly thoughts such as these have flashed through the minds of a few patients during case presentations. It isn't opportunism if the patient really wants a lot more than the minimally acceptable amount of dentistry; it is pressure if the dentist presents the information on which the patient decides in a way that favors any of the dentist's interests (economic, ease of treatment, or satisfaction in doing big cases) or if some or all the relevant information is withheld.

ADVERSE SELECTION

This term may be familiar to dentists as one of the problems with insurance schemes that are not universal. The trouble is something like this. The benefit-to-cost ratio of participants in a pooled resource plan is not uniform. If costs are fixed, those who stand to receive the fewest benefits will opt out of the system, driving up the cost to those remaining. Managed care has reached a plateau for this reason—all the low-hanging fruit is gone. Dentists who treat Medicare patients (regardless of what they feel about social issues) usually report that the costs of treating such patients must be passed on to others in the practice. Dental school faculty understand that students in the bottom of the class receive many times more attention than do the typical students; state boards know the names of a handful of practitioners; and insurance carriers have some things to say about a small number of practitioners that make the things practitioners say about third parties seem polite. Unlike the other examples of opportunism, adverse selection is insidious because it is institutionalized, "forcing" individuals to act opportunistically.

At first glance, it may not be obvious that adverse selection is a problem of opportunism. The explanation appears in a well-known essay by G. A. Akerlof on lemons. The lemons in question are used cars that are not what they appear to be. Anyone who sells a lemon makes a surplus profit (and we can argue about whether this is honest or just good business). Akerlof's insight is that the cost of this practice generally is greater than what would be needed to offset the surplus profit. Certainly the buyer who cannot spell caveat emptor gets stuck with an excessive cost, but so do all buyers and sometimes sellers as well. The fact that hard dealing is known to exist in the used car business drives down costs generally as buyers are unable to identify lemons in advance so must assume there is at least some reasonable chance of getting one. Also a new market is created in order to absorb some of this risk in the form of mechanics that will test the car or agencies that sell "certified" used cars. Insurance companies, lawyers, and other intermediaries take their cut out of uncertain transactions, thus reducing the value available to the principals, and thus becoming institutional agents of opportunism. As a class, professionals especially suffer from this form of opportunism. Many dentists are prepared to explain this in detail with regard to the practices of lawyers and third-party carriers.

MORAL HAZARD

This form of opportunism is also common to the theoretical literature on insurance. In that context, an individual enrolls in an insurance plan without fully disclos-

ing existing risk factors or once enrolled elevates the risks. Failing to disclose a family history of an illness or signing up for a no-smoking policy and then taking up smoking are examples. We hear of associateships that fall apart just like marriages do because either the young practitioner misrepresented himself or herself or because the senior dentist turned out to be something other than what was represented. The bait-and-switch approach underlying "free" initial services and advertising pseudo specializations fall into this category. Other examples are listed in the sidebar.

Risk Shifting

When a student enters dental school, he or she can disclose documented handicaps under the Americans with Disabilities Act that then become the school's problem. The same is true for office employees in practice. A patient of record has claims on a dentist that individuals who are not patients do not enjoy. Dentists are normally entitled to favorable malpractice rates if they are members of a state association that offers such plans. In all these cases the form of opportunism is to shift at least some of the risk for adverse outcomes to others.

THE NATURE OF OPPORTUNISM

It may appear that opportunism is just testing the boundaries of what is acceptable in society or a group. But it is more. It is strategically exceeding the boundaries; it is knowingly bending the rules, taking more than one's due, staking out status or exemptions that would not be extended to others, and going back on one's commitments. A definition of opportunism is intentionally acting as if existing explicit or actual agreements had been renegotiated in one's favor. In shirking, the individual does less than expected because additional rewards are not possible. Free riding is helping one's self to benefits others have worked for.

In shrinkage, the individual takes a little something extra to make up for perceived inadequate compensation. Pressure involves making a new contract on terms that would not be agreed to if everything were known. In adverse selection, the original contract for protection against risk is adjusted by defection; in moral hazard, it is adjusted by deception. Risk shifting spreads initial potential downside outcomes to people who did not know they had them in the first place.

Is opportunism a class of ethical violation? By several tests it would appear to be. It is normally done "under cover of darkness," avoiding full and candid disclosure. It is always to some degree a reneging on original mutual expatiations. For these reasons, the normative principles of veracity and autonomy are violated. It certainly abridges the utilitarian test of the greatest good to the greatest number. Whether it could be willed as a universal on the deontological view is certainly debatable. It would alarm a Rawlsian who insists that the original just distribution of goods and rights should not be tinkered with after the fact for personal advantage. One who favors discursive ethics, as I do, would have to step back from any position that calls into question not only specific promises but the whole social apparatus of making promises as a way of grounding ethics. Perhaps only the casuists, who enjoy arguing a position until they make it work, would find anything to like about opportunism.

On the other hand, there are a few good arguments against considering opportunism under the heading of ethics. Some would stop short of calling a little rounding error on the taxes or insisting on one's rights under the Americans with Disabilities Act an ethical

lapse. Certainly the individuals who engage in opportunism have learned to blink at it. It seems to lack the pretense to high tone and principle that bolster our ethical righteousness. Overzealous searching for and punishing opportunism earns one the title of “prig.” And there is the knockdown argument that we all are opportunistic every day. Faced with this choice between admitting that we are unethical and throwing out the evidence is no contest, especially when it is lightweight.

We can still learn much of value about ethics by holding opportunism and ethics together for comparison without having to say that they are the same thing. And that is the purpose of the next section.

By way of preliminaries we need to note one more feature of opportunism. It is seldom regarded as “right or wrong” by those who engage in it. The more typical characterization is “acceptable, justifiable, defensible, entitled” and their opposites. The operational question is “can the original understanding be changed unilaterally in light of the present situation.” That is literally what opportunism means. The useful insight that opportunism opens for us is that the boundaries between right and wrong are not crisp and sharp. Even leaving aside the fluid nature of changing circumstances, human expectations of each other (and of ourselves) are inherently ambiguous and open to constant renegotiation. Perhaps this is as it ought to be.

CONDITIONS THAT LEAD TO OPPORTUNISM

Opportunism does not emerge when marriage vows are being exchanged, when a lease on an office suite is being arranged, or when the treatment plan is presented. It comes afterwards in the strategically advantageous enactment of the agreement and absence of any penalties for stepping over the bounds.

Opportunism does not grow under conditions of competent supervision with intent to enforce the original understanding.

Opportunism exists in relationships where one individual has better information than others do and a small number of highly complex interactions are transacted that would be costly to monitor and where it would be difficult to reestablish the original understanding. These are precisely the conditions for most ethical problems of interest, such as cheating, taking advantage of patients or partners, inappropriate commercialism, and lapses of professionalism. If we could better understand the conditions that promote or control opportunism, it may be that we can better understand the conditions that affect ethics.

Relationship

Generally, we do not speak of opportunism in open, competitive, and one-time situations. The stock market is not opportunistic (although your broker might be). Relationships are a precondition for opportunism because they imply an expectation of future interactions, a value to the relationship over and above the sum of the interactions, and actual or implied mutual promises and expectations. Relationships create value—sometimes enormous value—and it is this newly created common value that is an attractive target of opportunism. The understandings that existed as the relationship was being formed are thought to be open to reinterpretation, and opportunism is an attempt by one or several of the parties in the relationship to harvest some of that value without publicly renegotiating the relationship.

This is of high importance to dentists precisely because the profession is insistent that oral health care should be provided in the context of a trusting

Opportunism is strategically exceeding the boundaries; it is knowingly bending the rules, taking more than one’s due, staking out status or exemptions that would not be extended to others, and going back on one’s commitments.

Opportunism is episodic, even though it may be habitual. This is required in order to preserve the ambiguous nature of the action and to prevent detection through pattern recognition. Opportunism finds comparisons, norms, standards, and alternative means for others to satisfy their needs to be uncongenial.

relationship rather than as an open market transaction. The relationship is between professional and patient, not provider and customer. There is an expectation of continuing and growing trust into the future. The profession is right to be concerned about trends toward consumerism, piecemeal dentistry, patients who shop price, and the erosion of comprehensive care. These are examples of opportunism on a wholesale scale.

INFORMATION ASYMMETRY

There is an old story about two great samurais who met for a much anticipated showdown. They faced each other, calculating the attacks and counterattacks available to them and envisaged the replies of their master adversary. After several minutes they bowed simultaneously in recognition that neither could achieve a decisive advantage.

Opportunism requires uneven knowledge. Shirking employees need to know where to hide and how to look busy; students know more about cheating than faculty members do about catching cheaters; welfare recipients often know the applicable laws better than healthcare professionals do; those who game the insurance industry are quite sophisticated. Pressure, selling more than is needed, is especially dependent on asymmetries in knowledge. The same can be said of embezzlement. Normally, the original understanding is close to balanced in relevant knowledge, because of circumstances, vigilance, or advisors and brokers hired to ensure equality. Time passes; things change; and rather than openly renegotiating the understanding, one party helps himself or herself to some of the unguarded common goods.

Information asymmetry is expressly recognized as significant in professional relations. Codes of ethics exist, among other things, to alert professionals to the dangers posed by their superior knowledge and to block them from abusing it. The key elements in every professional code—confidentiality, patient interests, autonomy, and informed consent—are intended to neutralize or compensate for uneven knowledge.

SMALL NUMBERS

Opportunism is episodic, even though it may be habitual. This is required in order to preserve the ambiguous nature of the action and to prevent detection through pattern recognition. Opportunism finds comparisons, norms, standards, and alternative means for others to satisfy their needs to be uncongenial.

BOUNDED RATIONALITY

Philosophers have long been cautious about the relationship between facts and values. No card-carrying ethicist, for example, believes that multiplying facts, even very accurate ones, will ever reveal how humans should behave toward one another. The argument here is of a different sort. The opportunity for opportunism requires that it be impossible or impractical for us to fully understand the facts of most situations.

Nobel laureate in economics Herbert Simon first developed the theory of bounded rationality. In its simplest form, it holds that we intend to think things through, but have neither the equipment nor the opportunity to do so for all but the simplest of issues. Except for bounded rationality we would be able to spot bad initial understandings and recognize opportunism immediately. In fact, Simon says, we give up trying to get even our original understandings right in all their contingent eventualities and are satisfied to accept approximations with the tacit agreement that we will work

together to smooth out the wrinkles as they appear. Bottom line: there is no armor against opportunism. Human interaction runs out of intelligence and into trust very quickly and that trust must be constantly renewed. We are so constituted that ethics is a requirement for social life but not necessarily a guarantee of the one we want.

COST OF SUPERVISION

Opportunism is a calculated excess; it is neither an abnegation of the original understanding nor a gross excess. We can learn a lot by inquiring how far the opportunist is prepared to cross the line. And there is an answer. The first part of the answer is that the clever opportunist can accumulate undeserved common benefits up to an amount equivalent to the cost of making monitoring truly effective. There are economic, psychological, personal, reputation, and work flow disruption costs associated with supervision and watching out for opportunism. Opportunists know that those with whom they have understandings find it more effective to allow some opportunism than to try to prevent all of it. My wife and I, for example, plant a garden large enough to feed earwigs, slugs, squirrels, rabbits, and ourselves. In this view opportunism is a cost of having a relationship. Some of the benefit that comes from the common good will be lost to opportunism, but it makes no sense to spend more trying to prevent or punish that loss than the value of the loss itself.

There is even an “insult” cost associated with supervision that is perceived as being excessive. Students complain about excessive restrictions and supervision. And they are right to a certain extent. The message sent by

heavy-handed monitoring is that colleagues are not trusted and that the atmosphere of professionalism is being tainted. Lest any practitioner reading this disagree, let him or her ask how they feel about the monitoring that insurance companies do of their work. The insult cost of monitoring for opportunism is normally born disproportionately by those who do not engage in opportunistic practices.

COST OF ENFORCEMENT

There is a parallel argument concerning what is required to reestablish the relationship, with or without the opportunist. Sometimes it really is better to let a small transgression pass when it is recognized. That certainly seems to be the case among the highway patrol officers in my area, and I am grateful for it. As a first approximation we can expect smart opportunists or the average of all opportunism to approximate the combined costs of monitoring and enforcing excesses of the common understanding. It stands to reason that spending more than it is worth to maintain a relationship is a matter of principle rather than common sense.

This is precisely the point where some readers will say they have had enough of this sort of analysis and that they mean something by ethics that is different and superior to tradeoffs designed to maximize the common good. There is a strong tradition holding that ethics is a matter of principles and these are wholly right or wrong. There is no amount of cheating that can be tolerated. The argument usually has as its companion the position that rules are rules and any time they are bent only encourages further and more brazen transgressions. I would never try to talk a person who believes along these lines out of his or her conviction—it has never worked yet. Perhaps there are universals and absolutes where this

belief holds, but I have also never seen a person of this persuasion who was free of personal opportunism, at least selective opportunism.

The solution to the cost problem that seems to work best, and is built into some of our laws, is random monitoring, targeted monitoring with cause, and vigorous enforcement of clear transgressions. These approaches hold down cost (including the social cost of appearing to be Big Brother) and focus on known opportunists. Large but fair penalties for those over the line satisfy the requirements of retributive justice and change the calculus for would-be opportunists.

WHAT DOES IT ALL MEAN?

Can we use this understanding of opportunism to do some of the work we expect of ethical theory? In particular, are there some elements of opportunism that are helpful where classical approaches seem to be letting us down?

First, the net of opportunism captures many more questionable behaviors. Not only is the case of students colluding to reconstruct a test question set with answers cheating, so is the practice of dentists organizing to manipulate payments from third-party carriers. Holding one’s self out to be something one is not—as in selling a large reconstruction case with no more qualifications than having recently attended as course—is a concern that may not come under the traditional approaches to ethics. Little lapses—an unnecessary carpule of anesthetic, a sloppy health history, or a treatment plan motivated to some extent by the dentist’s ego—come before our attention, even if “no damage results.”

Holding one's self out to be something one is not—as in selling a large reconstruction case with no more qualifications than having recently attended a course—is a concern that may not come under the traditional approaches to ethics.

Second, the net of opportunism has fairly large holes in it which allow much questionable behavior to escape. In the traditional approach to ethics, we are primarily concerned with labeling actions as “right” or “wrong” either because we believe such recognition will substantially promote good and retard bad or because this is a precondition for punishing unwanted behavior. (We are not overly concerned with rewarding the good because doing good is its own reward and action for the sake of reward somehow removes it from being praiseworthy.)

We will have to think this through, but there may be some advantages in soft edges on ethical issues:

1. We can place more questionable actions on the table for discussion (generally and in very specific cases) if we are not first required to label them as “unethical.”
2. We can all learn from the analysis of opportunistic behavior, including learning about the circumstances that promote or permit it, if there are more alternatives than guilt and innocence and degree of retribution.
3. Fear of being wrong about whether another's behavior is wrong may promote doing nothing or worse, performing “trial by rumor.”
4. If we accept that ethical codes evolve or grow more perfect and useful, we must permit some flexibility at the margins.
5. Guilt and punishment are not the only appropriate responses to ethical breaches or opportunism. Rehabilitation, reconciliation, and forgiveness are high human virtues for a reason.

Third, the net of opportunism does not belong to individuals; there is only one common net for the group. The potential benefits of soft edges on ethical or opportunistic behavior mentioned above are not an argument for ethical relativism, That is the defeatist and damaging view that individuals or groups are responsible for setting their own standards. I do see, however, an advantage in judging opportunism “relative to” its overall effect on the parties concerned in a collective sense over and above the behavior in an abstract sense. This means there is also a common standard for what is appropriate behavior across the group.

Fourth, it is the responsibility of the members of the group to maintain the net. We have to talk a lot more about expected behavior than is our current practice. Ethics language sometimes slips into the judgmental and the preachy—not of course for those who are making the noise about taking the high road, but for those listening. There is much work to be done along the lines of “let's talk about the best ways to work out these problems.” This is professionalism.

One thought as you close the journal: failure to mend the net of professionalism by discouraging opportunism and speaking up to correct it is itself a damaging type of opportunism. ■

RECOMMENDED READING



Summaries are available for the three recommended readings marked 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 friendly competition; a donation of \$50 would bring you summaries for all the 2007 leadership topics.

Barney, J. B. and Ouchi, W. G. (Eds.)
Organizational Economics: Toward a New Paradigm for Understanding and Studying Organizations.*

San Francisco, CA: Jossey-Bass.
ISBN 1-55542-015-X; 493 pages;
cost unknown.

Organizational economics is the study of organizations and organizational phenomena using concepts taken from contemporary organizational theory, organizational behavior, and microeconomics. This is a collection of influential papers in the field that have been published previously, including some classics, such as Akelof's analysis of lemons.

Chisholm, R. M.

The agent as cause.

In M. Brand and D. Walton (Eds.)

Action theory.

Boston, MA: D. Reidel, 1975.

One of the few philosophical efforts to analyze agency as a concept in ethics. The emphasis is slightly off target for an understanding of opportunism, being an attempt to establish conditions for responsibility, thus blame.

Pratt, J. W. & Zeckhauser, R. J. (Eds.).

Principles and agents: The structure of business.

Boston, MA: Harvard Business School Press, 1985. ISBN 0-87584-164-3; 240 pages; cost unknown.

This is a set of papers on organizational economics invited to commemorate the fiftieth anniversary of the Harvard Business School. All of the presenters have a connection with Harvard and none are organizational behavior scholars. They look at the topic from the perspective of law, labor relations, accounting, etc.

Sharma, A.

Professional as agent: knowledge asymmetry in agency exchange.*
Academy of Management Review,
1997, 22, 758-798.

In traditional agency theory, opportunism (taking advantage of others in a relationship) on the part of agents while working on behalf of principals is balanced by principals writing contracts to align the agent's goals with their own or by monitoring agents' behavior or metering their productivity. These remedies are not readily available when the agents are professionals because professional agents have specialized knowledge, because supervising the professionals is costly, and because principals typically are co-producers of results along with their agents. Sharma proposes four other mechanisms that are operational in the case of professional agents: self control (a combination of self-interest and altruism), community control, bureaucratic control, and client control.

Williamson, O. E.

Markets and hierarchies: Analysis and antitrust implications.*

New York: The Free Press, 1975.
ISBN 0-02-935360-2; 286 pages;
cost unknown.

Williamson is the leading exponent of organizational economics, a theory that explains why certain economic transactions are more effectively carried on in organizations than through markets. Certainly, professional activities such as dentistry, fall into this category. Organizations imply relationships that promote efficiency, but they also create the conditions for opportunism.



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