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POWER AS
A DIMENSION OF
DENTISTRY

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- 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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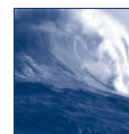
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power in order to
deal with it.

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FROM THE EDITOR

THE MONEY STRUCTURE OF DENTISTRY

The enormous pachyderms in the operatory are all dollar-denominated and will be for several decades to come.

The biggest challenges in dentistry today are not technical innovations, evidence-based practice, the new biology, or even access to care. The enormous pachyderms in the operatory are all dollar-denominated and will be for several decades to come. And we have to have the discussion, an honest one. The results could possibly redefine what it means to be an oral health professional.

The two large questions about money in dentistry are how should oral health be allocated given constrained resources and how will profits be distributed? The traditional answers to these questions are the ones I would support because they have been remarkably effective for almost 100 years. They would certainly be the best way forward if the world continued to be as it has been in the past.

Patients pay about 40% of their dental costs as services are used. The rest comes from “insurance”: partial patient prepayment plans and large infusions of employee benefits from industry and government benefits. Except for government funding, these sources have gone flat since 2005 and may even be declining. The cosmetic dentistry bubble proved to be susceptible to general economic trends, and as

wealth in America coagulates at the top, the number of patients seeking high-end care is shrinking. Between 1998 and 2012 the patient-to-dentist ratio decreased by 15%, while the number of adults who attended the dentists during the previous year declined by 7%. The market is unlikely to support more dentists who cater to the well-off and eschew insurance. This constriction in the dental market began in 2005 or 2006, before the recent general recession.

The second challenge concerns who can participate in the financial rewards of dentistry. It is a basic tenet in economics that markets correct themselves by encouraging the entry of new competitors when there are “excess” profits or exits in difficult times. Dentists are in the top 97th or 98th percentile of earners in America and thus they control attractive markets. The traditional protections against profit-induced competition in dentistry are the tiny delivery systems in the solo practice model and barriers to entry represented by licensure and practice regulations. Group practice arrangements are on the rise and legislators and lawyers are incentivized to break down barriers that may appear to be self-serving. Dentistry has allowed conditions to arise that are attractive to corporate models.

This year, the Academy of General Dentistry prepared an *Investigative Report on the Corporate Practice of Dentistry* that is valuable because it clarifies to some extent what corporate practice consists of, because it brings to light some new information about

factors that are driving this phenomenon, and because it identifies some of the dangers in the model.

One reason the profession has been slow to respond is that there is no clear understanding about what constitutes corporate practice of dentistry. The AGD report is helpful in this regard. The academy spoke with representatives of six prominent corporate operations and enumerated their characteristics. On the basis of this work, they identified three archetypes.

In the Dental Service Organization (DSO) model, the owners are all dentists who provide care in their practices and cooperate on management matters. In the DMSO-1, Dental Management Services model with no outside equity ownership, practice groups have a management services agreement with a common third-party organization for providing management, marketing, purchasing, staffing, and other services not directly related to clinical care. These services are purchased on a contractual basis. The third model, DMSO-2, involves management services that take an equity position in the practice network. The outside “owners” are often not dentists, and their primary interest, it must be assumed, is profit maximization. This external interest is *prima facie* an external standard, distinct from oral care.

The AGD investigation did not explicitly consider the uniformed services of the U.S. government, faculty dental

service arrangements in dental schools, and community charity clinics and FQHCs. I would suggest that these be added as a DMSO-3 model where the defining characteristic is that management services are provided by outside agencies that have nonprofit status.

In my opinion, dentist’s earnings and patients’ oral health are guided by the values of the ownership and the dangerous model is DMSO-2. Here money flows from dentists to non-dentists and commercial norms flow into the provision of oral care. At least one of these transactions is intolerable on moral grounds.

The AGD report takes an ethical position. “Regardless of who holds the responsibility for business decisions, dentists hold the responsibility for their clinical and ethical decisions, whether before a state dental board, a court of law, or the court of public opinion.” That is a brave statement and one I am happy to see. But can it be left at that? I would prefer to see a statement that *anyone* who benefits from providing patient care is responsible for both the upside and the downside of what happens at the chair, including what damage results from failure to provide appropriate care.

Finally, the AGD document provides some useful information about professional factors that may be driving practitioners toward corporate models. There is very little evidence for the prevailing wisdom that large education debts are tempting today’s young men and women to sell their professional

ethics. In the first place, relative to average private practice incomes, the cost of dental education has not increased much in several decades (the cost of purchasing a practice, however, remains several times educational costs because of the increasing number of recent graduates and senior dentists postponing their retirement). If organized dentistry wanted to reduce the debt burden on young practitioners, they would be lobbying strenuously to restore some of the recently curtailed state aid to dental schools. According to ADA data, 13% of practitioners in large groups are between 30 and 39 years of age and one-third are over 40. The motivation for dentists to go with groups is relief from management responsibilities.

The AGD report is available at www.agd.org/manage-your-practice/career-tools/corporate-dentistry.



LETTERS TO THE EDITOR



To the Editor:

I write to disagree with the essay claiming ethical superiority of dentists versus auto mechanics (Dentists vs. auto mechanics: Are there ethical differences? by Crystal Riley, 2013, 80 (2).)

My auto mechanic is my ethical equal in every way. He operates his business using all business ethical standards, charging fees that correlate with the mechanical problem and his time. He gives me value for my money and teaches me how to judge that value. In fact, he charges a fair fee without having to subject his fee to some regulatory board that Dr. Riley recommends.

Frankly, I find the premise of this essay elitist and embarrassing.

Donna B. Hurowitz, DDS, FACD
San Francisco, CA

Author's reply:

I would like to thank Dr. Hurowitz for her comments and offer some clarification. Both dentists and auto mechanics are true professionals. Auto mechanics are responsible for the safety of their customers by providing high-caliber mechanical services. Dentists are equally responsible for their patients' oral health

and its implications on systemic health. Both must complete rigorous training prior to licensure. Despite these similarities, there are significant differences. Dr. Hurowitz's mechanic obviously provides true informed consent, using excellent communications skills so that Donna can value the service. Dentists also provide informed consent to their patients. The difference, however, is that dentists are ethically and legally obligated to provide true informed consent; mechanics are not legally obligated to do so.

The two professions also differ as a function of their business models. The normative model in dentistry is an interactive one, which is based on the patient/client-focused relationship. In some other professions, a commercial model is the norm. The impact of this on the "client" is directly related to the integrity of the "professional." In dentistry, our integrity guides us, but we are also answerable to our licensing bodies. It is this element of oversight that helps maintain the standards of our profession, the trust of our patients, and subsequently our 'social contract'.

The essay was not meant to claim ethical superiority but to highlight the greater levels of legal responsibility that go hand-in-hand with dentists' ethical responsibilities. In my opinion, raising the professional bar should not be construed as elitist.

Crystal Lynn Riley, DDS
Boston, MA

Editor's note: Dr. Riley's paper has been subsequently republished in PEAK, the journal of the Royal College of Dental Surgeons of Ontario, November/December 2013.

Dear Dr. Chambers,

This letter is in response to the "Writing off copayments" article in the Fall 2013 *JACD* by Roberto Amato. The core issue is whether it is ethical for a dentist to waive the copayment of a patient's insurance plan.

The *ADA Code of Ethics* states that such a waiver is overbilling if it is not disclosed to the insurance company that the patient's portion will not be collected. The claimed essence of the "deception and misrepresentation" is that it "makes it appear to the third party that the charge to the patient is higher than it actually is" (*ADA Principles of Ethics and Code of Professional Conduct*). As noted below, the problem is not avoided by informing the insurance company.

No ethical duty is more important than to help the present patient as best we are able. One shining beacon is the American Medical Association. They conclude: "Physicians commonly forgive or waive copayments to facilitate

patient access to needed medical care. When a copayment is a barrier to needed care because of financial hardship, physicians should forgive or waive the copayment” (*American Medical Association Code of Ethics: Current Opinions*). They do not state how they expect to waive copayment legally. We should oppose unjust laws, and not support them with our ethical rules.

Another good signpost is the federal government, which is a third-party payer comparable to an insurance company. The Department of Health and Human Services has also recognized that “practitioners may forgive the copayment in consideration of a patient’s particular hardship. This hardship exception, however, must not be used routinely; it should be used occasionally to address the special financial needs of a particular patient.” (<http://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html>).

The ADA position is not rational. If as suggested the dentist were to inform the insurance company paying 80% of the dentist’s fee that the \$20 copay of a \$100 fee was not going to be collected, then the insurance carrier would be expected to pay \$64. But, that is only if the dentist agrees to have the patient pay \$16. If the process were continued, the dentist would finally be paid zero.

In sum, the ADA position, carried to its ethical conclusion, would result in free dentistry. Second, professional courtesy causes many of the same negative results. So does providing free dentistry to the dentist’s family. Third, given that the insurance industry got us into this quagmire, we should not expect that they will relinquish it voluntarily. Fourth, the same types of damage occur when an insurance company requires a 20% waiver of fees to steer insurance patients to the dentist. It is called managed care, and suddenly many of the criticisms stated in the article seem to become less important, because now the insurance carriers are satisfied. Fifth, the problems with insurance fraud and perjury for signing the claim form come from the insurance industry and their lobbyist-inspired legislators, not from any ethical principles.

Arthur Schultz, DDS, FACD
Manhattan Beach, CA

Author’s reply:

It was never my intention to imply that compassion for patients should not be taken into consideration. My original paper dealt with a principal dentist who routinely wrote off copayments for each and every patient with dental insurance, regardless of the circumstance. In Canada, for patients where money is an issue, there are numerous avenues

No ethical duty is more important than to help the present patient as best we are able.

When we believe that a regulation or policy or contract is wrong, we should work to change it.

available (www.fptdwg.ca/English/e-access.html). Jumping to the immediate conclusion to simply write off the copayment to help a financially struggling patient may initially seem justifiable yet overlooks many of the issues I originally discussed.

When dealing with patients who do not qualify for such government programs, their financial and oral health status should be assessed separately and on an individual basis. Possible solutions to circumventing writing off copayments include, but are not limited to: payment plans, deferred payment, discounts, and alternate treatment plans.

As dentists we must work within the confines of the law and find proper solutions if we disagree. The fact remains that writing off copayments in Canada is professional misconduct for dentists, and we are therefore subject to legal action according to the Dentistry Act of 1991 under RHPA. We have worked hard to obtain our professional status and if we are not careful society

will take this title away. Committing professional misconduct under the guise of saving the patient money is not, in my estimation, a proper solution.

Roberto Amato, DDS Candidate 2014
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London, Ontario, Canada

Editor's Note: The Summer 2011 issue of JACD (volume 78, number 2) contained a discussion by three dental ethicists concerning writing off copayments and the subsequent issue included several letters on the topic.

FORUM

WHAT WE OWE THE NEXT GENERATION

When we were all younger, Americans were confident that the core values that served our nation well in the past would guide it in the future. These values were expressed in homey statements such as “honesty is the best policy,” “respect your neighbor,” and “get involved in your community.” Today, we worry that the core values may be shifting and that sentiments expressed are different: “it’s only cheating if you get caught,” “I gave at the office,” and “don’t get involved.” Too many worry about “me” at the expense of “we.”

Society needs people who can think well and act wisely. We are a society that is being redefined by accelerating technological change; a society in which the stabilizing presence of families, communities, and organizations have been diminished, and in which human values and ethics have been subordinated to the pursuit of individual self-interest. It is time for a wake-up call. The profession must nurture individuals that can relate across multiethnic and multicultural points of view and who can collaborate in the pursuit of common goals; professionals who know how to build community; and professionals who have strong human values and personal ethics.

This wake-up call places a burden on the shoulders of the men and women across the spectrum of the profession.

No one is immune from making a contribution. It will require rethinking our assumptions and reinventing many of the ways of doing business. The primary challenge for dental schools is to graduate clinically competent practitioners and intellectually prepared scientists and healthcare providers. But the schools and the profession share the challenge of ensuring that those entering the profession are individuals of character, sensitive to the needs of the community, and continuously competent to contribute to society. Schools can reward graduates with the “credentials” to begin working toward full professional status. Only the profession can provide the prestige and satisfaction of serving the public in the company of skilled and caring colleagues.

The work begun in schools to build people, and to place a premium on the development of humanistic models that emphasize the importance and value of the individual must be carried forward and finished by those already in the profession. The humanistic model, loosely defined, places intrinsic value on everyone; develops a high feeling of self-worth; provides an environment that is motivating and inspiring; and places a very high premium on the integrity of each individual in an environment of mutual trust and respect. Each and every dentist is a teacher who passes on the best of the profession, or sometimes less than the best. Those entering the profession have their sense of self-worth and the career

aspirations influenced by those who have gone before them. In fact, no one has greater influence on young dentists than do their senior colleagues. Those who are motivated, inspired, and treated with a high degree of individual respect by those they look up to will become the leaders of the profession in a few years.

Beginning their practices, when in the formative years of their careers, dentists usually identify a few special senior colleagues who made a difference in their intellectual and personal development. A positive and lasting experience of this type depends upon a close relationship that transcends traditional roles. The new person entering the profession will not embrace the values of those who have built this profession if they are regarded as “competitors” or “strangers.” If the young men and women who aspire to be part of the profession we have so carefully nurtured cannot say, “Wow, this really is the best experience of my life—motivating, inspiring, challenging, and I would do it over again in a heartbeat,” we have failed. ■



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LET'S DISCUSS THE FUTURE

Kenneth Kalkwarf, DDS, MS, FACD

ACD PRESIDENT-ELECT'S ADDRESS

October 30, 2013

New Orleans, Louisiana

Good morning. I must start my remarks by congratulating the new Fellows of the American College of Dentists. You are being recognized by your peers for your accomplishments. I feel that is the highest accolade that a professional can receive. I welcome you to your day of celebration.

I would like to reflect for a few moments on what having you join us means to the College. Spencer Johnson, author of the best sellers, *Who Moved My Cheese* and *The One-Minute Manager*, created a small philosophical book that inspired the saying:

Yesterday is History

Tomorrow is a Mystery

Today is a Gift—that's why we call it the Present

Today is your opportunity to celebrate the gift given to you for your historical achievements and leadership. Enjoy the day!

But for a moment, I want us to think about the mystery of tomorrow. Mark Twain said, "Predictions are notoriously difficult to make, especially when they involve the future," and he was correct! I would not try to predict everything that will happen within our profession, but I am confident in predicting that we will face significant challenges.

Why would I say this? It would appear as if our profession is in a great position. Our use of technology and

materials, including digital imaging and impressions, lasers, and hybrid composites, has significantly increased the quality and the efficiency of our care. We continue to be looked to across the world as the benchmark for technical dentistry. We have reduced the prevalence of oral disease in U.S. children to an all-time low. The public's perception of our trustworthiness remains very high. Baby boomers, the individuals that have been our biggest supporters over the past 30 years, are retiring, with their teeth intact, with discretionary financial resources, and they continue their quest to be the healthiest, most attractive, and most eternally youthful creatures on earth. Why am I concerned?

Let me digress and go back over a century—to the early 1900s. Railroads were at an all-time business high. They had a virtual monopoly on the transport of people, mail, and goods that needed to move across the country. Their leaders were unimpressed with the upstart efforts of the Wright brothers and their heavier-than-air machines or Henry Ford's efforts to mass-produce a horseless carriage. A few individuals, including the writers of the 1908 Republican Party platform, were beginning to ask questions about lack of competition in the transportation



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industry, but they were written off as “radicals.”

The railroad owners gave no credence to what some may have seen as threats to their future. I will not bore you with a historical review of what transpired over the following three decades. We all know the outcome.

Were the railroad owners bad leaders? Of course not, they were financially successful and served a very important role in the evolution of this country. However, they failed the ultimate test of a leader—they listened only to each other and developed a biased perspective of their future. They saw their business as railroads—society was interested in transportation. Society wanted better transportation, more cost-efficient transportation, and more access to transportation.

Many feel that dentistry is reaching a decision point similar to that faced by the railroads. I would like each of you to take a moment and form a mental projection of what you feel the practice of dentistry will be like in the year 2033 (20 years from now). I can almost guarantee that each of you has created that image without great difficulty. You have the background, you understand the profession, and you have probably spent some time thinking about the question. Now I want to go to the next step—are you willing to bet your life savings that your projection will be correct? Why not?

The reality is that we can project only one thing about the practice of dentistry in 2033—it will be different. The science that drives decision making will have discovered new and different information. Disease patterns will continue to shift. The technologies that help us deliver care will be different. We have already seen an increased awareness by employers that healthcare benefits are an economic concern, and consumerism has moved to a dramatic new level. Alternatives to the traditional system of delivering oral health care are being assessed. The list of variables goes on and on—and some of them will be dramatically different from what exists today. The environment surrounding our profession will be altered, requiring us to change. Change is difficult and it requires strong leadership.

True leaders focus on long-term, as well as short-term, objectives and consider society's welfare in addition to their own. They seek information to help them lead, both information that agrees with their current stance and information that appears to run counter to their view. They ask questions of those with different perspectives and they listen carefully. They seek out factual discourse from writers who present balanced dialogue. They become involved in the discussion. We need you

We must remember that most leadership skills are not acquired by listening to stories; they are learned by modeling behavior.

They failed the ultimate test of a leader—they listened only to each other and developed a biased perspective of their future.

involved in dentistry's discussions: you are the leaders of our profession. You are the ones that others look up to.

Over the past several years, I have come to understand that the American College of Dentists is best defined as a facilitator of discussion about our profession, its future, and its commitment to society—a discussion, with people joining and departing from it, but continuing uninterrupted. One of the sustainers of that discussion is the *Journal of the American College of Dentists*, which does a remarkable job of laying thought-provoking information before us. The purpose of the College and its *Journal* is not to take a political stance and declare a philosophy or an idea right or wrong. The purpose is to stimulate reflection so the profession's leaders, in conjunction with society, can choose the best directions for the future.

I charge you, as recognized leaders in dentistry, to stay engaged in the discussion, make sure all sides of the issues are carefully considered, and ensure that society benefits—for as we know, by the things they do, the things they buy, and the people they elect, they will ultimately decide the future.

You must also make sure that the discussion does not develop an insider bias or become based upon a specific

dogma. Insiders are typically deeply invested in their success and perceive dramatic change as a threat to that investment. They also face tremendous peer pressure, and internal bias often prevails.

History shows that internally biased discussions may lead to conclusions that do not stand up over time, such as when these notable individuals spoke:

- Robert Millikan, in 1921, two years before he won the Nobel Prize in physics: "There is no likelihood that man can ever tap the power of the atom."
- Harry Warner, in 1927, head of Warner Brothers: "Who wants to hear actors talk?"
- Bill Gates, 1981: "640K ought to be enough for anybody."

When we bring individuals from outside of dentistry into our discussion, some will say it is crazy. This is a normal response—typically, outsider's views are rejected because they are perceived to lack credibility or they challenge an unwritten precept. However, outsiders have nothing to lose, and often bring a fresh perspective to the discussion. Howard Head, an aircraft engineer, retired and decided to take up tennis. After the first lesson, he asked a question: "Why aren't these things bigger?"—leading to the creation of the Prince tennis racket.

We are all here because we stood on the shoulders of others, and my next charge to you as a leader in our profession is to bring younger members

into the discussion. As pointed out so well by Eric Curtis in last May's *AGD Impact*, younger dentists have different views. Their views are not necessarily worse or better than ours; just different. In just the same way, our views were dissimilar from those of generations before us.

Most young dentists entering the profession this year were born in the late 1980s. They have always known the United States and the Soviet Union as partners in space and China as a market-based economy. They do not remember when "cut and paste" involved scissors. American Motors has never existed in their world, and, as far as they are concerned, smoking has never been permitted on U.S. airlines. We must have their thoughts and ideas as part of the discussion. *They* are the future.

We must also help them recognize that every opportunity requires significant action from the recipient. And we must remember that most leadership skills are not acquired by listening to stories but learned by modeling behavior. We were wise because we watched those leaders ahead of us, observed successful behaviors, and adopted them. The next generations are watching us.

We must also learn from them. I believe the younger generations are doing a much better job in prioritizing

the intertwining and complex aspects of life. They must have listened to the physics professor teaching philosophy that I will now quote in detail:

"The physics professor started the class on volume with a large glass jar sitting on his desk, filled to the brim with golf balls and asked the class if the jar was full. Everyone answered 'yes.' He then reached under the desk, brought out a box of small pebbles and proceeded to gently pour the pebbles into the jar, where they rolled between the golf balls. He again asked the class if the jar was full, and again, everyone answered 'yes.' He brought forth a box of sand and gently shook the sand into the jar where it filled the remaining spaces. He again asked the class if the jar was full and while some were leery, everyone answered 'yes.' The professor reached back under the desk, removed a glass of wine and poured it into the jar.

"I want you to recognize that this jar represents your life,' the professor said. 'The golf balls represent the important things in your life: your family, your health, your faith, your friends, and your passions. The pebbles are the other things that matter, like your job and your house. The sand is everything else—the small stuff.

"If you fill the jar with the sand first, there is no room for the golf balls. The same is true of your life. If you spend your time and energy on the small stuff, you will never be able to make room for the important things. Pay attention to

the important things in your life: Play with your kids and grandkids, set aside the time for a periodic medical check-up, take your spouse to dinner.

"Don't worry, there will still be time to wash the car or play tennis. Take care of the golf balls first.'

"One of the students raised her hand and asked about the wine. The professor just smiled. 'I'm glad you asked. It just demonstrates that there's always time for a glass of wine with a friend.'"

In closing, I remind you:

Yesterday is History

Tomorrow is a Mystery

Today is a Gift—that's why we call it the Present

Celebrate it! ■

LETTER of CONGRATULATIONS from OKLAHOMA GOVERNOR MARY FALLIN

Mary Fallin
Governor of Oklahoma

Inclement weather prevented Governor Fallin from reaching New Orleans. This letter was read on her behalf during the convocation ceremonies by Regent Linda Niessen.

Congratulations to the new fellows who are joining the American College of Dentists today! These are outstanding dentists who have been chosen because of their leadership and their commitment to their profession and their communities.

My thanks go out to the American College of Dentists and all its members for working to promote dental health as well as general health. Your work continues to remind Americans of an important truth: that good health care must include oral care. Failure to adequately care for your teeth, gums, and bite can result in the development of medical conditions far more serious than gum disease or tooth loss.

I am especially proud of the many dentists in Oklahoma who take part in the annual Oklahoma Mission of Mercy. The Mission of Mercy is a two-day, free dental clinic designed to treat the most pressing needs of patients that are either uninsured, underinsured, or would normally not have access to dental care. At the event, patients undergo medical and dental triage to identify their needs and then be routed to the appropriate areas of treatment: oral surgery, extractions, restorations, pediatrics, and hygiene. More than 2,000 patients are taken care of during the course of the event.

This is just one example of the many kinds of service and leadership shown by dedicated dental professionals such as yourselves.

Thank you again for inviting me to attend the Annual Meeting and Convocation. I am sorry I was unable to be there today, but I wish you the best at this conference and in the future!



Mary Fallin
Governor of Oklahoma

2013 ACD AWARDS

ETHICS AND PROFESSIONALISM AWARD



The Ethics and Professionalism Award recognizes exceptional contributions by individuals or organizations for effectively promoting ethics and professionalism in dentistry through leadership, education, training, journalism, or research. It is the highest honor given by the College in this area. The American College of Dentists recognizes the **New York Academy of Dentistry (NYAD)** as the recipient of the 2013 Ethics and Professionalism Award.

The New York Academy of Dentistry was founded in 1921 by a prestigious group of 19 dentists who represented the leadership of the dental profession in New York. For more than nine decades, the Academy has consistently carried out its mission by pursuing its targeted goals in all areas. By its choice of topics and lecturers, the Academy has continued to provide an outstanding educational forum for its fellowship.

The Academy remains committed to the ideals of its founders. The ideals of promoting ethics, fostering education,

enhancing the profession, and communication of scientific information can never be dismissed if dentistry is to remain in high public trust and esteem. It is the goal of the New York Academy to help bring about constructive changes and to make its impact on the profession a positive force for continued growth in the future.

The Academy began an exploration into developing ethical programs in the New York area dental schools in the early 1990s. Dr. Joe Rowan who was the president of the NYAD and a Fellow of the ACD met with the deans of New York University and Columbia University dental schools. Numerous meetings were held and both schools decided to allow the Academy to develop and participate in their ethics curriculum. NYU had an existing course on ethics. In 1994, NYAD Fellows began working as facilitators of ethical scenarios with the first-year dental students, choosing the ethical dilemmas that were discussed. NYU has expanded the ethics program through the four years. The Fellows of the NYAD currently work with second-year students. To date 4,000 dental students have been exposed to the program. In 1996 a Fellow of the Academy began a course in professional ethics with the postgraduate prosthodontics residents. This course has expanded to the advanced programs in prosthodontics at NYU, the Manhattan VA Hospital, and New York Hospital Queens.

Columbia College of Dental Medicine also initiated an ethics program as a result of the NYAD efforts. The program is a series of lectures as well as facilitated

discussions for the third- and fourth-year dental students. It is co-directed by NYAD Fellows who have total control of the course content and scenarios. In addition, the NYAD has provided the financial support for the course by providing the textbooks since the inception of the program. Approximately 3,000 students have benefited from the program.

Stony Brook School of Dental Medicine began its ethics program in 2009 as the result of the NYAD. Again, the NYAD helped develop the program and provides both the textbooks and facilitators. In the past four years 200 students have gone through the program. Stony Brook has expanded its program to include third-year students as well as a fourth-year ethics elective.

The most recent addition to the NYAD ethics program is University of Medicine and Dentistry of New Jersey. The NYAD involvement with this program will begin this year. Funding for textbooks and facilitators will be provided by the NYAD.

Lastly, the NYAD has provided ethics education to the dental community. The Academy has provided ethics courses at the New York County Dental Society, the Ninth District Dental Society, and the Greater New York Dental Meeting.

The NYAD has had a significant positive impact over the last 20 years through its support of ethics programs. Course directors, lecturers, and facilitators have all benefited and over 9,000 dental students and dentists have

been exposed as a result of their efforts. The New York Academy of Dentistry is a most deserving candidate for the ACD's Ethics and Professionalism Award.

Accepting the award for the New York Academy of Dentistry is Dr. Amy Ludwig, President.

The Ethics and Professionalism Award is made possible through the generosity of The Jerome B. Miller Family Foundation, to which we are extremely grateful.

William John Gies Award



The highest honor the College can bestow upon a Fellow is the William John Gies Award. This award recognizes Fellows

who have made broad, exceptional, and distinguished contributions to the profession and society while upholding a level of leadership and professionalism that exemplifies Fellowship. The impact and magnitude of such contributions must be extraordinary.

The recipient of the 2013 William John Gies Award is **Dr. Dushanka V. Kleinman**. Dr. Kleinman is widely recognized for her impressive accomplishments and far-reaching achievements that have benefited dentistry, dental education, oral health care, and society. Her record is superlative and she is held in highest regard by her peers. Her achievements and contributions include:

- First woman dental officer to achieve the rank of Rear Admiral and to serve as Chief Dental Officer of the United States Public Health Service
- Rear Admiral and Assistant Surgeon General (retired), United States Public Health Service Commissioned Corps

- Deputy Director, National Institute for Dental and Craniofacial Research, National Institutes of Health (NIH)
- President, American Association of Women Dentists
- President, American Association of Public Health Dentistry
- President, American Board of Dental Public Health
- Board Member, Commissioned Officers Foundation for Public Health
- Member, Santa Fe Group (a prestigious "think tank" promoting systematic change in dentistry and dental education)
- Founding Board Member, U.S. National Oral Health Alliance
- Co-Executive Editor, *Oral Health in America: A Report of the Surgeon General*
- Recipient of honorary degrees from the University of Detroit Mercy and the University of Southern California
- Recipient of the Distinguished Service Award of the American Association of Public Health Dentistry
- Recipient of the Jack Hein Public Service Award of the American Association of Dental Research
- Recipient of the ADA Distinguished Service Award
- Recipient of an ADEA Presidential Citation
- Recipient of the Carl M. Schlack Award of AMSUS
- Recipient of APHA John W. Knutson Distinguished Service Award in Dental Public Health
- Recipient of the Lucy Hobbs Taylor Award of the American Association of Women Dentists
- Recipient of the Callahan Memorial Award, Ohio Dental Association
- Recipient of the Gold Medal Award of the Pierre Fauchard Academy
- Recipient of Distinguished Alumni Awards from the University of Illinois at Chicago College of Dentistry, Boston University Henry M. Goldman

School of Dental Medicine Alumni Association

- Awarded the USPHS Surgeon General's Medallion and Distinguished Service Medal
- Associate Dean for Research and Professor, School of Public Health, University of Maryland

HONORARY Fellowship

Honorary Fellowship is a means to bestow Fellowship on deserving non-dentists. This status is awarded to individuals who would otherwise be candidates for Fellowship by virtue of demonstrated leadership and achievements in dentistry or the community except that they are not dentists. Honorary Fellows have all the rights and privileges of Fellowship except they cannot vote or hold elected office. This year there are three recipients of Honorary Fellowship.



Mr. Peter A. DuBois, Esq. is the Executive Director of the California Dental Association (CDA) and in this capacity has directed

its day-to-day operations for over ten years. He has nearly 30 years of leadership, management, and policy experience across a wide spectrum of health care venues. He is widely recognized for his expertise and contributions. Highlights of his accomplishments and credentials include:

- BA with honors in American Studies, Amherst College
- JD, Harvard Law School, Harvard University
- Executive Director, California Dental Association
- Member, CDA Executive Committee and Board of Trustees
- Vice Chair, Board of Directors, The Dentists Insurance Company
- Vice Chair, Board of Directors, TDIC Insurance Solutions

- Board Chair and Chief Executive Officer, CDA Holding Company
- Vice Chair, Board of Managers, CDA Presents
- Vice Chair, CDA Foundation Board of Directors
- Vice Chair, CalDPAC Board of Directors
- Member and Past President, American Society of Constituent Executive Directors
- Member, Santa Fe Group (a prestigious “think tank” promoting systematic change in dentistry and dental education)
- Executive Committee member, Californians Allied for Patient Protection
- Member, California State University Foundation Board of Governors
- Former Executive Director, UCSF Medical Group
- Former founding board member, California Children’s Specialty Care Coalition
- Former Chief Executive Officer, University Children’s Medical Group, Children’s Hospital Los Angeles
- Former Chair and board member, California Children’s Lobby
- Former Deputy Assistant Director, Department of Mental Health, County of Los Angeles
- Former Executive Director, California Mental Health Association



Dr. Jack L. Ferracane is Professor and Chair of Restorative Dentistry, Oregon Health Sciences University (OHSU).

His distinguished career is replete with numerous high-level positions of importance and correspondingly significant accomplishments. He is well-known and highly respected for his expertise, both nationally and internationally. Dr. Ferracane’s record of accomplishments is summarized below:

- BS in biology, University of Illinois at Urbana-Champaign
- MS and PhD in biological materials, Northwestern University, NIH training grant
- Chair, Dental Materials Science, Oregon Health Sciences University (OHSU)
- Professor of Biomaterials and Biomechanics, OHSU
- Honorary Professor, School of Dentistry, University of Birmingham, United Kingdom
- Chair, Department of Restorative Dentistry, Oregon Health Science University
- Mentor and faculty advisor to over 80 predoctoral and graduate students and postdoctoral fellows
- Completed one-year sabbatical, University of Birmingham, United Kingdom, sponsored by an F33 Senior Fellowship grant from NIH
- Presented nearly 300 invited courses and lectures in 20 countries
- Authored or co-authored nearly 200 scientific published articles; published his first manuscript in the *Journal of Dental Research* in 1981
- Member of the editorial boards for over 12 dental publications
- Received over \$8 million in research grants and contracts
- Former Assistant Professor, Dental Materials, Baylor College of Dentistry
- Former President of the Academy of Dental Materials
- Former Associate Dean for Academic Affairs, OHSU
- Former President, Dental Materials Group, International Association for Dental Research
- First Place in the Young Investigators Research Award competition, American Association for Dental Research, Chicago Section
- Honorary member, Omicron Kappa Upsilon, Honorary Dental Society, Delta Chapter

- Recipient OHSU Faculty Senate Award for Outstanding Leadership
- Recipient, Wilmer Souder Award of the Dental Materials Group, International Association for Dental Research
- Honorary member, Oregon Dental Association, one of only five in the association’s history
- Recipient, OHSU Faculty Senate Award for Outstanding Research



Ms. Karen Matthiesen, or just “Karen” as she is known to Fellows, has expertly served the American College of

Dentists for nearly 30 years. She has spent the last 28 years as Executive Assistant and Office Manager. In this capacity she set high standards for employees. Her work has been characterized by her outstanding performance, attention to detail, unmatched people skills, and love for the College. Karen has also been an important stabilizing influence over many years having become the “corporate memory.” She has provided wise counsel in many critical and difficult situations faced by the College. Karen’s record of accomplishments is summarized below:

- Executive Assistant and Office Manager, American College of Dentists for nearly 30 years. Over the term of her employment the ACD underwent a period of significant growth, including going from 37 to 51 Sections; increasing in membership from 4,614 to 7,323; expanding from total ACD assets of \$385,363 to over \$2,040,000 and from total ACDF assets of \$64,184 to over \$5,856,000.

- Served under three ACD Executive Directors: Drs. Gordon H. Rovelstad, Sherry Keramidas, and Stephen A. Ralls
- Served with three different ACD Editors, Drs. Keith P. Blair, Robert E. Mecklenburg, and David W. Chambers
- Publication Manager, *ACD News*
- Attended and helped coordinate 29 different ACD Annual Meetings and Convocations
- Attended and helped plan nine ACD Summer Conferences
- Staff liaison for the *Campaign for the 90s* and the purchase of the three contiguous condominiums that serve as the office for both the ACD and ACDF
- Staff liaison for two ACD Executive Director search committees
- Chair, Board of Directors, Southeastern District, Lutheran Church Missouri Synod (LCMS) for nine years; she was the first woman to serve as chair of a district in the LCMS
- Member, Pastoral Leadership Institute, LCMS
- Member, Ablaze for God's Mission Steering Committee, LCMS
- Branch Secretary, Aid Association for Lutherans, LCMS, for 31 years
- President, Lutheran Women's Missionary League, Chesapeake District, (LCMS), for four years
- Member, Board of Directors, Lutheran Church of Saint Andrew, Silver Spring, MD
- Chair, numerous committees, Lutheran Church of Saint Andrew, including Parish Fellowship, Stewardship, Social Ministry, and Church Celebrations
- Member, numerous activities, Lutheran Church of Saint Andrew, including Youth Group Leader, Care Ministry, Communion Assistant, Vacation Bible School, and Sunday School Superintendent and Teacher
- Driver and Visitor, Meals on Wheels
- Chair, Montgomery County Extension Sewing Program for low income residents
- Volunteer, Shepherd's Table and Greentree Shelter for Abused Women
- Past President, Junior Women's Club of Rockville, Maryland
- Recipient, Junior Woman of the Year Award, General Federation of Women's Clubs, Montgomery County

SECTION NEWSLETTER AWARD

Effective communication is a prerequisite for a healthy Section. The Section Newsletter Award is presented to an ACD Section in recognition of outstanding achievement in the publication of a Section newsletter. The award is based on overall quality, design, content, and technical excellence of the newsletter. The Ontario Section is the winner of the Section Newsletter Award for 2013.

MODEL SECTION PROGRAM

The purpose of the Model Section program is to encourage Section improvement by recognizing Sections that meet prescribed standards of performance in four areas: Membership, Section Projects, ACD Foundation

Support, and Commitment and Communication. This year the Oklahoma Section earned the Model Section designation.

LIFETIME ACHIEVEMENT AWARD

The Lifetime Achievement Award is presented to Fellows who have been a member of the College for 50 years. This recognition is supported by the Dr. Samuel D. Harris Fund of the ACD Foundation. Congratulations to the following recipients:

Richard V. Brunner
James V. Burnett
Vance L. Crouse
James L. Dannenberg
Charles W. Fain, Jr.
S. Sol Flores
Sidney S. Friedman, Jr.
James D. Harrison
Theodore R. Hunley
James M. Reynolds
Edward P. Rogers
Robert S. Runzo
Bernard S. Snyder
Olin B. Vaughan
John D. Wilbanks
James L. Wyatt, Jr.

2013 Fellowship Class

Ahmad Abdelkarim <i>Jackson, MS</i>	W. Leandra Best <i>Vancouver, BC</i>	Blase P. Brown <i>Lyons, IL</i>	Nicholas R. Conte, Jr. <i>Lewes, DE</i>
Guy D. Alexander <i>Baltimore, MD</i>	William D. Bethke <i>Eau Claire, WI</i>	Richard L. Brown, Jr. <i>Tulsa, OK</i>	Allan Coopersmith <i>Westmount, QC</i>
Arwa Ali Al Sayed <i>Riyadh, Saudi Arabia</i>	Michael J. Biasiello <i>Park Ridge, IL</i>	William Buchanan <i>Brandon, MS</i>	Theodore P. Corcoran <i>Arlington, VA</i>
James S. Allen <i>Saint Joseph, MI</i>	Peter Birek <i>Toronto, ON</i>	William A. Burn III <i>Irmo, SC</i>	Roslyn M. Crisp <i>Burlington, NC</i>
William V. Argo, Jr. <i>Macon, GA</i>	David A. Bitonti <i>Gaithersburg, MD</i>	Gordon B. Burnett <i>College Park, GA</i>	Arlene Dagys <i>Toronto, ON</i>
Paul A. Averill <i>Williston, VT</i>	Mark D. Bochinski <i>Edmonton, AB</i>	Howard Buschke <i>Newark, CA</i>	Josephine D. Danna <i>Plano, TX</i>
Joseph V. Baldassano <i>Inverness, IL</i>	Robert K. Bogart <i>Abilene, TX</i>	R. Greg Carr <i>London, ON</i>	Rachel Anne Day <i>Lafayette, IN</i>
Heather H. Barker <i>Greenville, SC</i>	Alice G. Boghosian <i>Niles, IL</i>	Scott W. Cashion <i>Greensboro, NC</i>	Marcos del Valle Sepulveda <i>Ponce, PR</i>
Justin L. Beasley <i>Oklahoma City, OK</i>	Matthew D. Bojrab <i>Carmel, IN</i>	Jorge R. Centurion <i>Miami, FL</i>	Mark B. Desrosiers <i>Columbia, CT</i>
Douglas Beaton <i>London, ON</i>	Michael L. Bolden <i>Ossining, NY</i>	Jung-Wei Chen <i>Corona, CA</i>	Larry G. Dober <i>New York, NY</i>
Lisa E. Bentley <i>Mississauga, ON</i>	Peter J. Boswell <i>Jackson, MS</i>	William W. Cheung <i>Hong Kong, China</i>	Robert G. Donahue <i>Washington, DC</i>
Gregory A. Berger <i>Jasper, IN</i>	Carl H. Boykin <i>Jackson, MS</i>	Mark L. Christensen <i>Murray, UT</i>	Michelle M. Dorsey <i>Merritt Island, FL</i>
R. Robert Berube <i>Augusta, ME</i>	Robert D. Bradberry <i>Marietta, GA</i>	Kenneth Blake Clemes <i>Palmerstown, ON</i>	Jean-Jacques Dupuis <i>Paris, France</i>
Jed M. Best <i>New York, NY</i>	Edmund Braly <i>Norman, OK</i>	Barry L. Cohan <i>Baltimore, MD</i>	Timothy M. Durham <i>Lincoln, NE</i>
	Scott Breazeale <i>Gulfport, MS</i>		Scott A. Edwards <i>Memphis, TN</i>

Daniel G. Ehrich <i>Liberty, MO</i>	Neil J. Gajjar <i>Mississauga, ON</i>	James Michael Hatchett <i>Jacksonville, TX</i>	Lucien S. Johnson III <i>Orlando, FL</i>
Paul M. Eisner <i>Oakville, ON</i>	John L. Gibbons <i>Poulsbo, WA</i>	Eric R. Hatfield <i>Yarmouth, NS</i>	Joyce M. Johnson <i>Ridgewood, NJ</i>
Nagwa H. El-Mangoury <i>Beachwood, OH</i>	Thomas M. Gilbert <i>Fort Wayne, IN</i>	William Hawrysh <i>Mississauga, ON</i>	Harry E. Jones <i>Chattanooga, TN</i>
Andrea B. Elenbaas <i>Pass Christian, MS</i>	Shauna L. Gilmore <i>Centennial, CO</i>	Michael A. Hazey III <i>Bridgeport, WV</i>	Blair A. Jones <i>Lewes, DE</i>
Ross T. Enfinger <i>Orlando, FL</i>	William A. Gitlin <i>South Bend, IN</i>	Curtis B. Hill <i>Palm Bay, FL</i>	Arthur W. Jordan <i>Lufkin, TX</i>
Jeryl D. English <i>Pearland, TX</i>	Daniel A. Givan <i>Helena, AL</i>	Michael S. Hipp <i>Des Moines, IA</i>	Michael J. Kanellis <i>Iowa City, IA</i>
Catharine A. Enright <i>Atlanta, GA</i>	Gary D. Glassman <i>Toronto, ON</i>	Eric Hodges <i>Omaha, NE</i>	James A. Katancik <i>Portland, OR</i>
Edgardo F. Enriquez <i>Fairfield, PA</i>	Mark A. Goedecke <i>Mount Pleasant, SC</i>	Howard Holmes <i>Toronto, ON</i>	David C. Keim <i>Kalispell, MT</i>
Drew W. Fallis <i>Helotes, TX</i>	Felicia L. Goins <i>Columbia, SC</i>	Edward J. Hooton <i>Monroe, LA</i>	Irvind S. Khurana <i>New York, NY</i>
Daphne C. Ferguson-Young <i>Nashville, TN</i>	Robert S. Goldberger <i>Brooklyn, NY</i>	Jerald Kyle House <i>Hood River, OR</i>	James G. Kinard <i>Henderson, NV</i>
Michael T. Finnern <i>Bartlett, TN</i>	Richard G. Gray <i>New York, NY</i>	Stephanie Z. Houseman <i>Jerseyville, IL</i>	Michael A. Kincaid <i>Broken Arrow, OK</i>
Scott R. Firestone <i>Smithtown, NY</i>	E. Mitchell Greenstone <i>New York, NY</i>	Sarah A. Hulland <i>Calgary, AB</i>	James R. King <i>Mount Vernon, NY</i>
Stephen J. Frame <i>Hato Rey, PR</i>	Brad T. Guyton <i>Evergreen, CO</i>	Brent B. Hutson <i>Dallas, TX</i>	James E. King <i>WPAFB, OH</i>
Karen E. Frazer <i>Austin, TX</i>	Steven E. Haas <i>Coral Springs, FL</i>	Gabriel B. Ingraham <i>Charleston, SC</i>	Lloyd K. Klausner <i>New York, NY</i>
I. Jay Freedman <i>Roslyn, PA</i>	Theodore Halatsis <i>Laval, QC</i>	Amarilis A. Jacobo <i>New York, NY</i>	Ulrich Klein <i>Aurora, CO</i>
Michael S. Frey <i>Fenton, MI</i>	David S. Hale <i>Dallas, TX</i>	Samira Jaffer <i>Toronto, ON</i>	Raymond G. Koeppen <i>Friendswood, TX</i>
Mari Cynthia Fukami <i>Phoenix, AZ</i>	Violet Haraszthy <i>Niagara Falls, NY</i>	Lucien S. Johnson II <i>Orlando, FL</i>	Paul A. Kolman <i>Zionsville, IN</i>
	Jeffery D. Hartsog <i>Jackson, MS</i>		Robert S. Kozelka <i>Park Ridge, IL</i>

Peter A. Krakowiak <i>Lake Elsinore, CA</i>	Mark N. Librach <i>Toronto, ON</i>	Joseph S. Modica <i>Williamsville, NY</i>	Lise M. Payant <i>Quebec, QC</i>
George M. Kushner <i>Louisville, KY</i>	Jun S. Lim <i>Chicago, IL</i>	Edward H. Moody, Jr. <i>Morristown, TN</i>	Thomas J. Perrino <i>Cincinnati, OH</i>
Wilson J. Kwong <i>Vancouver, BC</i>	Steven J. LoCascio <i>Knoxville, TN</i>	Cheryl Mora <i>Vernon Hills, IL</i>	Jonathan T. Perry <i>New York, NY</i>
Kurt J. Laemmer, Jr. <i>Bradford, PA</i>	Vincent Mack <i>Traverse City, MI</i>	Anna B. Moreau <i>Alexandria, LA</i>	Ove A. Peters <i>San Francisco, CA</i>
Ernest W. Lam <i>Toronto, ON</i>	Simon R. MacNeill <i>Kansas City, MO</i>	Oscar Morejon <i>Daytona Beach, FL</i>	John D. Pitts <i>Little Rock, AR</i>
Claude Lamarche <i>Montreal, QC</i>	Steven C. Maller <i>San Antonio, TX</i>	Rory E. Mortman <i>West Palm Beach, FL</i>	David J. Psutka <i>Mississauga, ON</i>
Kevin C. Lauwers <i>Coquitlam, BC</i>	Walter R. Manning <i>Albany, OR</i>	Steven M. Murata <i>Salem, OR</i>	Eric Pulver <i>Highland, IN</i>
Alan S. Law <i>White Bear Lake, MN</i>	Anthony V. Maresca <i>Stony Brook, NY</i>	John J. Nasca <i>Williamsville, NY</i>	Rocio B. Quinonez <i>Durham, NC</i>
William D. Layman <i>Clearwater, FL</i>	Ana Karina Mascarenhas <i>Fort Lauderdale, FL</i>	Mary E. Neill <i>Norfolk, VA</i>	Daniel Quon <i>Jackson, MS</i>
Ryan S. Lebster <i>Holland, MI</i>	Suzanne U. McCormick <i>Encinitas, CA</i>	Cindy B. Nichols <i>Seneca, SC</i>	Antonio Ragadio <i>San Francisco, CA</i>
Arlene Lee <i>Marina del Rey, CA</i>	Danette C. McNew <i>Rockwall, TX</i>	James D. Nickman <i>Lino Lakes, MN</i>	Nathan Reynolds <i>Denver, CO</i>
David H. Lee <i>Greenville, MS</i>	Geralyn M. Menold <i>Hollister, CA</i>	Keith A. Norwalk <i>Genoa, OH</i>	James E. Richardson <i>Surrey, BC</i>
Elizabeth H. Lee <i>Memphis, TN</i>	Michael C. Meru <i>Draper, UT</i>	Allan R. Nowakowski <i>Muncie, IN</i>	Charles S. Ricks <i>Visalia, CA</i>
Rebecca C. Lee <i>Porter Ranch, CA</i>	Erik J. Meyers <i>San Antonio, TX</i>	Wilhelmina F. O'Reilly-Hill <i>Madison, MS</i>	Kathleen L. Robinson <i>Atlanta, GA</i>
Steve M. Leighty <i>Auburn, CA</i>	Mark J. Mihaló <i>LaPorte, IN</i>	Timothy W. Oh <i>Ellsworth, ME</i>	Julio H. Rodriguez <i>Brodhead, WI</i>
Sebastian J. Lentini <i>New York, NY</i>	Evan N. Miller <i>Charlotte, NC</i>	Paul A. Palliser <i>Cary, IL</i>	Kathleen A. Russell <i>Halifax, NS</i>
Jack M. Levine <i>New Haven, CT</i>	Mark W. Mitchell <i>New Port Richey, FL</i>	Sharon K. Parsons <i>Columbus, OH</i>	Abdi Sameni <i>Los Angeles, CA</i>
	Vipin Mithia <i>Mississauga, ON</i>		Mark A. Scantlan <i>Sullivan, MO</i>

Mark Schaefer <i>Port Washington, NY</i>	Alan E. Sloatsky <i>Pompano Beach, FL</i>	Bradley A. Trattner <i>Owings Mills, MD</i>	Michael A. Webb <i>Charlotte, NC</i>
Michael J. Scheidt <i>Westminster, CO</i>	Stanley W. Smith <i>New Rochelle, NY</i>	John R. Ukich, Jr. <i>Coeur d'Alene, ID</i>	Larry T. Weddle, Jr. <i>Westminster, CO</i>
Brian K. Schenck <i>Hixson, TN</i>	Robert M. Sorin <i>New York, NY</i>	David V. Valauri <i>New York, NY</i>	Jay Weinberg <i>Cranford, NJ</i>
Mark A. Schlothauer <i>Gering, NE</i>	Andrew I. Spielman <i>New York, NY</i>	Donald Vander Linde, Jr. <i>Grand Rapids, MI</i>	Jesse G. Welch <i>Houston, TX</i>
Patricia Seagriff-Curtin <i>Yorktown Heights, NY</i>	W. Frederick Stephens <i>Pasadena, CA</i>	Philip J. Vassilopoulos <i>Vestavia Hills, AL</i>	Preston Q. Welch <i>Fort Belvoir, VA</i>
Robert J. Seltzer <i>Boca Raton, FL</i>	Denice C. Stewart <i>Portland, OR</i>	Nicholas J. Vittoria <i>Islip Terrace, NY</i>	Susan E. Whiteneck <i>Norman, OK</i>
Marybeth D. Shaffer <i>Leetonia, OH</i>	Marie T. Stiles <i>Gaithersburg, MD</i>	Merlyn W. Vogt <i>Lincoln, NE</i>	Robert E. Wiggins, Jr. <i>Abilene, TX</i>
David E. Sheinkopf <i>Pleasantville, NY</i>	Kelly R. Suchman <i>Lee's Summit, MO</i>	Arthur R. Volker <i>Sunnyside, NY</i>	Robert D. Williams <i>Richmond, IN</i>
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LEGISLATIVE ACTION IS A SOPHISTICATED ENTERPRISE

Robert J. Hanlon, Jr., DMD

ABSTRACT

Backroom deals and cash payoffs are fine depictions of political power in the movies. But they are ineffective in today's highly complex interaction between oral health and public policy. Three recent examples of the work of the California Dental Association's Government Affairs Council demonstrate the range of approaches that are needed to be successful. A mass-action campaign drew attention to the needs of underserved Californians and demonstrated dentists' willingness to help. Education, including visiting model programs, provided information legislators require to understand complex issues. Tightly niched grass-roots contacts from key constituents demonstrated not only interest but informed engagement.

How do you get someone to take notice of your concerns? How do you get someone to champion your cause when no one else will take the lead? How do you get others to take your side when they are facing extreme pressure from those that disagree with you?

These are the questions you must answer in the world of legislative advocacy. Public officials start their careers with a certain area of expertise in issues they are passionate about, but soon they find themselves inundated with pleas from every direction on just about every issue imaginable. They face conflicts over what interest groups, colleagues, friends, neighbors, family members, and various constituents are all advocating.

Having spent several years now involved in organized dentistry and having served as Chair of the California Dental Association's Government Affairs Council, I have come to know that there is no silver bullet or magic formula for effective legislative advocacy.

Power in the legislative arena comes from maximizing the number of tools at your disposal, knowing what tools are appropriate for each particular issue, and being adept at using each of them. You have to find the right combination of strategy and tactics for each situation. This involves not just direct advocacy but also creating external pressure. You have to find unique ways to make the significance of your policy initiatives stand out and that make elected officials see the value of latching on to them.

You can also maximize the long-term impact of your efforts by engaging with public officials early in their careers or before their service actually begins.

Expertise, persuasive influence, charisma, status or position, well-organized and well-coordinated operations, and resources all come into play. All are needed at one time or another and in certain combinations.

MASS MOBILIZATION TO ATTRACT ATTENTION

The California Dental Association's legislative program has demonstrated how to adapt advocacy approaches based on the situation in order to exert as much influence as possible. CDA makes itself effective in the legislative arena by having a strong command of its many resources and knowing how, when, where, and who to mobilize.

Limited access to oral health care is a significant problem in California. Approximately ten million people (30% of the state's population) face barriers to dental care and over seven million people are eligible for the state's Medicaid program for low-income individuals, known as Medi-Cal. Unfortunately, chronically low



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reimbursement rates for providers make it economically unfeasible for most dentists to treat Medi-Cal patients (California Dental Association, 2011).

Access became even more limited in 2009 when the financial collapse hit and the state had to make drastic budget cuts. California eliminated dental benefits from the Medi-Cal program (Denti-Cal) for most adults, leaving more than three million poor, disabled, and elderly Californians scrambling to find a way to receive oral health services.

In response to California's worsening oral health access problem, an idea was born at CDA for what came to be known as "CDA Cares," two-day clinics in which volunteer dentists, other dental professionals, and community volunteers would be recruited to provide dental services at no charge to thousands of patients at large venues (e.g., fairgrounds) across the state.

The clinical philosophy of the program would be to establish individual treatment plans with the goal of relieving pain and infection. In addition to providing a public benefit, CDA would be highlighting the need for an adequately funded dental safety net and a comprehensive plan from the state to improve access to dental care. The program would be a unique opportunity to educate policymakers, particularly about the immediate need to restore adult Denti-Cal benefits. CDA Cares would generate media coverage as well, which would raise the public's awareness of the access problem.

This endeavor would be a massive undertaking to organize and would require mobilizing thousands of people.

Thanks to extraordinary organization, coordination, and initiative, the CDA

Cares program was a success from the start. The first CDA Cares clinic took place in Modesto in May 2012. More than 1,250 volunteers, including more than 500 dentists, dental hygienists, and dental assistants, provided 7,200 procedures to 1,650 people, some of whom had camped out overnight waiting for the doors to open. More than 60 CDA staff members participated. Several elected and other government officials attended. The Modesto clinic received praise from the head of the America's Dentists Care Foundation, who said it was one of the most well put together, first-time clinics (California Dental Association, 2012).

This was a great first step in the right direction and a precursor to a major breakthrough that occurred at the next CDA Cares, which was held in Sacramento three months later.

The leader of the California State Senate, Darrell Steinberg of Sacramento, was one of eleven elected officials in attendance to see an even larger turnout of volunteers and patients than in Modesto. The experience had a profound impact on Steinberg, who said he was stunned by what he had seen. "I will never forget the sea of people—the endless lines of low-income Californians—some of whom had waited overnight," he said. "I saw people who had lost all their teeth because they can't get preventive dental care" (California Dental Association; Legislature approves restoring Adult Denti-Cal; www.cda.org/NewsEvents/Details/tabid/146/ArticleID/1296/Legislature-approves-restoring-Adult-Denti-Cal.aspx).

He decided to make it his mission to restore adult Denti-Cal benefits in the next state budget. As Steinberg began budget negotiations this year with the governor and other legislative leaders, he fought for the funding, and he succeeded. Governor Jerry Brown signed a budget that restored Denti-Cal coverage

for preventive care, restorations, and full dentures.

The CDA Cares program had provided an opportunity to show how legislative action could help with the access problem, which led to a positive legislative result.

While it is not difficult to convince someone that dental care for the disadvantaged is important, the extreme pressures on California's budget in recent years have made any kind of additional funding hard to come by. Chronic budget shortfalls, court-mandated spending, and voter-approved ballot initiatives have severely limited the legislature's flexibility. Plus, legislators typically have more than one issue they consider to be a priority and they must choose among them. So it can be easy for legislators to throw up their hands and say they would like to help but that the money just is not there, no matter how worthy the cause.

CDA Cares gave Steinberg a reason and an opportunity to prioritize Denti-Cal benefits. Thousands of his constituents had lined up at a two-day clinic because they cannot access dental care. As their state senator, there was pressure on him to do something about this and he wanted to do something about it. CDA Cares helped Steinberg justify why Denti-Cal benefits had to take priority this year over other needs. Restoring Denti-Cal benefits would help address a critical statewide problem that had just been highlighted in a major way in his district. Steinberg got to be the champion on the issue, and both he and CDA got a legislative victory. It was a win-win.

The CDA Cares program is an example of both strength in numbers and mass mobilization, which was effective for the Denti-Cal benefits

issue. Seeing thousands of people line up, in pain, looking for help, provides a deep understanding and appreciation for the access problem in a way that cannot easily be matched.

Preparing and executing a program like this requires all hands on deck. CDA continues to host two CDA Cares clinics each year to highlight the many access issues that remain, and altogether there have been 4,559 volunteers that have participated, treating 5,878 patients—equal to \$4.4 million in dental services (CDA Foundation; CDA Cares Community Impact; www.cdafoundation.org/give/volunteer/cda-cares-volunteer-dental-program). CDA has to mobilize dozens of staff members, it has to mobilize its members and its healthcare partners to volunteer, and it has to mobilize donors for funding.

When all of that successfully falls into place, the result is not just an exceptional public service, but also a powerful advocacy tool.

INFORMATION TO DECISION MAKERS

In some cases, the kind of mass mobilization used for programs like CDA Cares may not be sufficient or may not be the best approach to achieve certain legislative goals. This is often true when dealing with issues that are more complex. A more targeted approach is required to provide the necessary education on the issue. You have to rely more on the power of expertise and personal dynamics to persuade.

The need for public officials that are adequately informed on complex issues also makes it important to engage with them as early as possible in their careers. CDA begins this process during

candidate interviews well before the candidates are elected. There is also extra focus on freshmen legislators, particularly now that California recently altered its term limits to allow legislators to spend 12 years in either house (previously the limit was six years in the Assembly and eight in the Senate). This can help them develop the expertise they need to become long-term champions for dentistry.

A policy priority for CDA that requires more focused education is securing funding for a comprehensive statewide oral health program managed by a state dental director who would lead an office of oral health. Currently there is a lack of capacity within California's government for supporting, coordinating, and pursuing funding for oral health programs. The state does not have an oral health plan or evaluation of oral health programs. There is no capacity to provide consultation and support for local jurisdictions, health professions, or school-based health centers.

For example, when funding was eliminated in 2009 for the Children's Dental Disease Prevention Program (CDDPP), California was left without any organized program to deliver essential preventive services to California's neediest children.

There is also a lack of ability to apply for and manage federal and other grant programs to support oral health. Significant amounts of federal money that the state could draw upon are left on the table. Offices of oral health in other states take advantage of federal funds, help integrate oral health into the state's broader health programs, and help coordinate the efforts of policymakers, government agencies, local organizations, community groups, and professional associations.

The CDA Cares program is an example of both strength in numbers and mass mobilization.

They saw that they could be at the forefront of rebuilding California's oral health infrastructure.

This is a complex issue with a number of layers. It requires some concentrated education for those who have no prior knowledge of the state's oral health system to understand the history and how such a model works.

Other states that have established this type of oral health infrastructure demonstrate how this can work in practice. New York's Bureau of Dental Health, in particular, stands out as a model.

This year CDA strategically selected a small group of key legislators, most of them freshmen, to travel with CDA leadership and senior policy staff to New York for an "Oral Health Education Forum" to learn more about it. The legislators spent time with the director of New York's Bureau of Dental Health and learned how the structure of New York's oral health programs, with strong leadership at the top, has produced results. For instance, the proportion of children with teeth in excellent or very good condition is 25% higher in New York than in California (U.S. Department of Health and Human Services; National Survey of Children's Health 2011/12; www.childhealthdata.org/learn/NSCH).

Additionally, a visit to the cutting-edge nursing-dental collaborative program at NYU's College of Dentistry provided valuable lessons for the group about the link between oral health and overall health and how systemic issues affect the delivery of dental care.

Just as CDA Cares is a unique experience that leaves attendees with a special appreciation for a policy issue,

the education forum in New York was a unique experience that left the participants with a special understanding of a policy issue and an eagerness to address it. They saw that they could be at the forefront of rebuilding California's oral health infrastructure. CDA is planning education forums like this to help more elected officials see the need for a solution.

The fact that a state office of oral health and a dental director would help address the access problem is also part of the CDA Cares message, but this concept requires putting policymakers in front of the experts and allowing them to go back and forth. You must create an intellectual foundation for your case. There is nobody with more expertise and credibility on New York's model oral health program than the state's dental director. So CDA organized a forum that would allow policymakers to interact with him, other dental leaders, and its policy staff in a setting where they could see first-hand why that state is a model.

The education forum provided an opportunity to have a captive audience of policymakers focused entirely on dental issues for multiple days. This is a targeted approach that involves a small group of people and is most useful with a smaller audience. Everyone needs to have a chance to dive deep into the issue. You want to maximize personal interaction and let the persuasive impact of knowledgeable people take effect.

A powerful influence can be exerted when this kind of experience is combined with the human impact on display at CDA Cares.

GRASS-ROOTS POWER

Another key element of exerting influence in the legislative arena is advocacy from the grass-roots level. There is valuable credibility that comes with being a legislator's constituent who

is dealing with public policy issues first-hand in the community. Dentists should have opportunities for constructive dialogue with their legislators on policy issues to tell them about the role they and other dentists are playing in their communities and lay the groundwork for future interaction and relationships with those officials.

Grass-roots advocacy can involve mobilizing large numbers of people, but what is most important is ensuring quality advocacy from the participants. These are people who do not do this every day and they need to know how to advocate effectively.

A popular practice among interest groups in Sacramento is an annual “lobby day.” Hundreds if not thousands of members from organizations gather for a day or two in Sacramento, get briefings from their organization’s policy staff, and then meet in the Capitol to discuss their legislative priorities with the legislators who represent the districts they live in.

The largest of these programs are very effective at drawing attention from the Capitol and the media because of their scale. Rallies are often included and dozens of people may try to visit a legislator’s office to show how important an issue is to constituents from that district. This is the strength-in-numbers approach again.

CDA has adopted a slightly different approach to the advocacy day concept. Rather than mobilizing grass-roots activists all at once, CDA is organizing individual advocacy days designed specifically for its component dental societies in the state (there are 32 statewide). Four or five dentists are selected from a component to either come to Sacramento for a day or to take

part in a regional advocacy day meeting with legislators in their home districts.

This tactic uses a small group of participants allows for concentrated education and preparation on the current policy issues, strategy, and grassroots advocacy in general. The participants and CDA policy staff get to interact extensively and certain policy issues require this. The participants, in turn, can then confidently and persuasively communicate with elected officials and their staff.

The battle over California’s Medical Injury Compensation Reform Act (MICRA) offers a nice illustration of effective grass-roots advocacy from CDA as well as many other healthcare groups. This year, the top legislative priority for CDA and many of these groups was thwarting an attempt to raise MICRA’s limit on non-economic damages in medical malpractice cases. Opponents of MICRA, namely trial lawyers, announced they would be pursuing a ballot measure if the legislature did not raise the limit from \$250,000 to \$1.1 million during this year’s legislative session (Consumer Watchdog: Victims Of Medical Injustice Announce Initiative To Adjust 38 Year Old Damage Cap If Sacramento and Governor Do Not Act; <http://www.consumerwatchdog.org/newsrelease/victims-medical-injustice-announce-initiative-adjust-38-year-old-damage-cap-if-sacramento>).

MICRA has a long history and there is obviously a lot of emotion around the medical malpractice issue. MICRA’s opponent’s lobby was very aggressive and presented tragic stories about medical errors. Countering this requires spending the necessary time to properly educate and prepare grassroots advocates so they have a strong grasp on the background and the facts surrounding malpractice insurance costs. They need to be able to deliver a compelling case for how such a change

would impact liability costs, making it harder for medical providers to stay afloat and provide care to all the Californians that need it.

Even with an aggressive campaign from a powerful opponent and the threat of a ballot measure, no bills were introduced in the legislature this year that would raise the MICRA cap. This demonstrates how effective the advocacy efforts have been from CDA and other members of the coalition working to protect MICRA. Combining the efforts of professional advocates in Sacramento and people at the grass-roots level across the state that deal with medical liability first-hand has produced so much support for MICRA in the Capitol that not a single legislator thought it was worth even introducing a bill to try to change the law.

The MICRA issue also speaks to the power of coalitions, particularly when thousands of supporters across the state are eager to demonstrate the local, on-the-ground perspective on a policy issue. The MICRA coalition is made up of physicians, dentists, hospitals, community clinics, health centers, nurses, emergency responders, police officers, local governments, labor unions, women’s health advocates, and more. It is very difficult for elected officials not to see the value of MICRA when so many people from the grass-roots level on up coordinate to show how supportive they are of the law. The MICRA coalition shows legislators that supporting MICRA means they are on the side of all these valued members of the community.

Combining the efforts of professional advocates in Sacramento and people at the grass-roots level across the state that deal with medical liability first-hand has produced much support.

Conclusion

These are some of the concepts that can make a legislative agenda stand out and maximize influence over public policy. Having persuasive and charismatic professional advocates with policy expertise and political savvy to pursue one's goals full-time is very valuable. What puts the organization over the top are the programs that complement these efforts—from the awe-inspiring, large-scale programs like CDA Cares that draw media attention and raise public awareness, to smaller-scale, strategic educational opportunities and early outreach to candidates, to grass-roots advocacy that requires mobilizing large numbers of people but in a targeted way.

What is important is to recognize which approach is best for each particular issue and how to use these tools to advantage. One should always be striving for unique ways to make an issue one that elected officials will want to seize on and make them see the benefits of being a champion for it.

There are many elements to this kind of comprehensive legislative program. One needs charismatic leadership at the top to rally an organization or coalition around the

cause and approach. One needs enthusiasm up and down an organization, especially when trying to recruit volunteers and grass-roots supporters. One needs talented managers to execute programs well. One also needs strategic thinkers to make sure your advocacy is targeted, timely, and efficient. All of these efforts require significant financial investments.

This is the path for dental organizations looking to make a powerful impact on public policy, and it is a path that can lead to a much better legal environment for dentists to practice in.

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CAN POWER BE SHARED?

William S. Ten Pas, DMD, FACD

ABSTRACT

Dental insurance began with a partnership between dental service organizations and state dental associations with a view toward expanding the number of Americans receiving oral health care and as a means for permitting firms and other organizations to offer employee benefits. The goals have been achieved, but the alliance between dentistry and insurance has become strained. A lack of dialogue has fostered mutual misconceptions, some of which are reviewed in this paper. It is possible that the public, the profession, and the dental insurance industry can all be strengthened, but only through power-sharing around the original common objective.

Over 50 years ago, the precursor to today's dental insurance began on the West Coast. The Dental Associations of Oregon, Washington, and California commenced coverage of the longshoremen's children. As time went on and more groups purchased dental insurance, the associations formed dental service organizations (DSOs) to administer the benefits. Slowly, the DSOs and the associations drifted farther apart. Today, the power for maximally effective oral healthcare delivery is divided.

BASIC CONCEPT

Dentists and insurance companies have both common and unique "customers." Dentists believe their primary responsibility lies with the patients, although there are obvious mutual relationships with others. A clear example is any relationship created by voluntarily signing a contract that creates responsibilities for both parties. Insurance companies have four "customers": (a) agents and brokers, (b) employer groups, (c) patients, and (d) dentists. Insurance companies also have a primary obligation to patients to ensure that they have the coverage which they purchased or which was purchased on their behalf by their employers. Agents and brokers represent the employer groups when groups are looking for coverage for their employees. They expect the insurance companies to

administer benefits that the groups have purchased. The employer groups, not the patients, determine the benefits and pay for them. Dentists want a fair reimbursement for their services and are free to pick contracts (or avoid all contracts) that optimize their practice options.

Insurance has made dental care more accessible and affordable to people. It also has permitted third parties—those who purchase benefits on behalf of patients—to influence the practice patterns of dentists who elect to enter various contractual relationships.

Businesses today are transitioning away from higher paying manufacturing jobs and looking for savings wherever they can find them. The recent recession amplified this trend. This has happened at a time when dentistry has been hit with higher expenses. Student indebtedness, technology, new materials, advanced techniques, and increased costs for materials and supplies have put dentists in uncomfortable situations



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much like those facing the companies that purchase dental insurance benefits.

Codes

The American Dental Association owns, and garners considerable royalties from, their Code on Dental Procedures and Nomenclature (CDT). When the ADA decided to change the makeup of the Code Revision Committee (CRC), the committee responsible for the codes, it caused a greater chasm between the ADA and insurers. The ADA had the right to do this, but in doing so it significantly increased the number of codes and the frequency of infrastructure changes from every two years to every year. These changes added to the cost of administering dental insurance, a cost the insurance companies have been reluctant to absorb on their own. The change is viewed with distrust, even less buy-in, and it has created more codes that may or may not be reimbursed. Many dentists believe that if there is a code, it will be reimbursed regardless of the benefit package purchased by employers.

Dentistry needs to transition from procedure codes to diagnostic codes as medicine has. The ADA and insurers can do this jointly. There is a possibility, however, that mistrust between the ADA and the insurance industry will cause ownership of new codes to be vested in

an outside entity rather than jointly between the parties that have the greatest knowledge of and the most at stake in fair reimbursement systems. Non-covered services became an issue because of competition for customers within the insurance industry. If insurance companies require dentists to accept a fee for benefits the insurers cover, it would be even better if the insurers would require dentists to accept a fee for a benefit that was not covered. This would allow insurers the ability to give more for less. It also requires dentists to do more for fees that may not be adequate for their practice and to hold the patient harmless. This increases the distrust between insurance companies and dentists and has led to legislation in 33 states limiting or doing away with the concept.

MUTUAL INFLUENCE

A definition of power is “strength or force exerted or capable of being exerted or relating to political, social, or economic control.” In the social sciences, power refers to the capability to influence the behavior of others. There is certainly a mutual power relationship between dentists and insurance companies.

The effects of this joint power relationship are obvious. Dentists connect declining reimbursement with dental insurers. It is natural that the insurance industry will attempt to pass the constraints caused by employers being less munificent on to dentists. But that certainly does not explain the full impact of dentists’ recent declining incomes. The soft earnings have several explana-

tions, chief among these being falling utilization. Dental utilization started falling as early as 2002 and bottomed out around 2008. Another factor influencing decreasing reimbursement is the increased use of government programs for children. These programs consistently pay less than the commercial plans.

Dentistry accounts for approximately five cents of every healthcare dollar, yet there is extreme pressure on dentistry because of the high cost of medical coverage. Fully insured dental programs that allow for higher payments to “premier” networks are being rapidly replaced by Preferred Provider Options (PPOs) and other products that have required greater discounts to dentists and shifted more financial burden to the patient. Large businesses pay insurance companies to administer their dental benefits for a fixed or decreasing rate.

Insurance companies are either freezing or decreasing fees paid to dentists. This is done with little or no notice to the dental community. Also, benefits are being moved from the restorative category to the major category. This is done either at the request or with the knowledge of the employer groups in order to hold costs in check. Regardless of the cause, it does transfer costs to the patient. This is exactly the policy pursued by much of American business and by some holding political office.

For its part, the dental community has power in that only they can deliver the benefits that employer group’s

purchase. Insurance fraud is a reality. Perhaps it is counterintuitive, but insurance administrators have a bad reputation resulting from the fact that fraud is concentrated in a small fraction of the profession. It would be unethical for insurers to ignore such practices and become complicit in transferring benefit funds from the worthy many to the abusive few. Without knowing who the bad actors are in advance, the insurance industry must establish workable qualification and review mechanisms. These are understandably interpreted by ethical practitioners as unnecessary (for them) intrusions. These are costs for both practitioners and insurance companies.

Insurers see dentists doing more unbundling of procedures to increase revenue. They also watch dentists sign contracts that allow lower reimbursement. Dentists usually do this out of fear of losing patients if they do not sign. They do not realize that contracts they sign have clauses in them that allow the dentists to be leased to other networks without their knowledge or approval. Most dentists do not understand the demographics of business, of different networks, and of patients that make up their practice. Without this information, decisions are made that may not be in the dentists' best interests. Insurance companies point to this as a lack of business acumen, and dentists point to this as the insurance companies taking advantage of their practice.

COMMON INTEREST

How did we arrive at the posture of distrust and an apparent expectation that either the profession or insurance must make up for shortfalls others experience during difficult times? We got here because of a lack of understanding of each other's business and a lack of constructive dialogue.

Can we move beyond our growing divisiveness? This may be difficult to achieve in the short term. Each side seems to have invested a great deal in rhetoric with a view toward solidifying its member base. We have allowed ourselves to be suckered into a "zero-sum game" with its expectation that there are only winners and losers.

Progress is unlikely to begin until we can bring into view three common understandings. First, the dental profession and the dental insurance industry are in the same boat. Generally, what hurts one damages the other. Second, we share a common goal—improving the oral health of those in this country. Every rise in oral health will naturally be accompanied by growing strength in both groups. Third, we are not the only players in the game. American business and our government make decisions to move huge amounts of resources and promulgate rules and regulations that have significant impact on our common future and the health of Americans. Generally they make these decisions with little input or concern for our interests. A common voice would increase our power where it is most needed. ■

Insurance has made dental care more accessible and affordable to people. It also has permitted third parties to influence the practice patterns of dentists who elect to enter various contractual relationships.

POWER, ETHICS, AND CORPORATE DENTISTRY

M. Alec Parker, DDS, FACD

ABSTRACT

The North Carolina Dental Association recently sought to place clear statutory limits on the influence of corporate, nondental interests over dentists' practices' decision-making. This report describes the two-year legislative battle with well-funded and politically connected parties that ultimately resulted in laws that protect patients' rights to be treated by a dentist free of outside commercial interests.

On July 19, 2012, Governor Bev Perdue signed into law Senate Bill 655 (SB 655), Dentistry Management Arrangements, culminating more than a year's work by the North Carolina Dental Society (NCDS). Passage of the bill reconfirmed longstanding North Carolina law that prohibits corporations from owning or controlling dental practices.

A DECADE OF LITIGATION

For years the North Carolina State Board of Dental Examiners (NCSBDE) had been involved in investigations of dental management corporations over alleged violations of a provision of the North Carolina Dental Practice Act that states only a licensed dentist can own, manage, supervise, control, or conduct any enterprise that includes any of the ten elements that are deemed the practice of dentistry. The NCSBDE had been engaged in lengthy and expensive litigation with dental management corporations over issues related both to the statute and to the Management Arrangements Rule that provided clarification relative to the operations of a dental management corporation. The dental management corporations claimed that the rules were vague and that they were misinterpreted.

In an effort to put the issue to rest, the NCDS drafted legislation that spelled out what actions were allowed, with the intent of providing further guidance

to both the dental management corporations and to the dentists who contracted with them.

We recognize that dental management corporations provide valuable back-office services to dental practices and in many cases free the professional dental staff to concentrate on patient care rather than on payroll, IT issues, and other administrative functions. And we are in support of the right of nondentist-owned dental management corporations to operate in North Carolina as long as their business practices conform to the Dental Practice Act. But we are concerned about the actions of some dental management corporations that appear to be crossing the line into de facto ownership and clinical decisions.

We are also increasingly aware of abuses occurring in other states as dental management corporations have gained popularity, and we want to protect the best interests of patients as well as those dentists in North Carolina who elect to become affiliated with dental management corporations. Therefore, the NCDS introduced legislation in March 2011, during the North Carolina General Assembly's "long session."

It is worth noting that in 2010, Democratic control of the North Carolina General Assembly had been overturned



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after more than 100 years of power and now Republicans enjoyed strong majorities in both houses of the legislature. We filed companion bills in the North Carolina House of Representatives and in the North Carolina Senate April 6 and April 19, 2011, respectively.

OUR OPPOSITION REACTS

The fierce and furious response by the dental management corporations caught us by surprise. Within hours of the bill filings, our lobbyists called and asked for reinforcements, saying that the dental management corporations had more than a dozen lobbyists engaged. We hired two additional contract lobbyists to join our team, but even with these additions we were outmaneuvered. At the height of the battle, our opposition employed 18 lobbyists to our four.

Faced with such strong opposition, we gathered our leadership and lobbying team to plan our strategy. Meanwhile, our opposition had connected with their supporters in the House, who immediately sent our House bill to the Rules Committee where it languished.

OUR SENATE STRATEGY

This move actually had little effect on us because our strategy was to move the Senate bill. We had strong support in the Senate including an influential legislator who held positions on several high-ranking committees. We knew we could count on his support to advance the bill in the Senate.

Our grass-roots team was mobilized and concentrated their efforts on

contacting every senator we knew, asking for support of SB 655. Thanks to the efforts of our contact dentists across the state, the Senate version first passed the Senate Health Committee and then a full floor vote by a sweeping margin in June 2011.

TURNING UP THE HEAT

The day after the Senate vote, the opposition began a full-scale advertising campaign opposing the bill, thinking we would seek to advance the bill in the House before the end of the legislative session. Their target was conservative House Republicans whom they urged to stand up for free-market principles, protect private-sector jobs, and oppose excessive big government regulations.

Our opposition had misjudged our strategy. We had no intention of scrambling to pursue a House vote in the final days of the long session and instead planned to pursue the bill in the House during the short session that would begin the following May. As the long session wound down, the opposition essentially spun its wheels and hemorrhaged advertising money hoping we would make a move. Instead, we used the time in the interim before the short session to prepare for the fight we knew was coming in the House.

We recognize that dental management corporations provide valuable back office services to dental practices and in many cases free the professional dental staff to concentrate on patient care rather than on payroll, IT issues, and other administrative functions.

GRASS-ROOTS STRENGTH

We assembled a team of political and marketing consultants to help us plan and execute our strategy in the House. While we could not compete with our opposition's campaign coffers, they could not compete with our grass-roots members swarming members of the General Assembly with phone calls, e-mails, and faxes. All but one of the corporations that made up the coalition were headquartered outside of North Carolina, and they did not have the long-term personal relationships with the legislators that our members enjoy. Our members were the strongest weapon we had, so we made grass-roots education and mobilization the backbone of our plan. We supplemented our grass-roots advocacy with narrow, targeted advertising efforts.

In the fall of 2011, the member companies of our opposition banded together more formally under an umbrella organization they named the Alliance for Access to Dental Care. The alliance was run by an influential lobbyist who had recently held the position as head of the North Carolina Republican Party. In addition to its lobbying efforts, the alliance raised significant amounts of money from its members as well as other dental management companies not doing business in North Carolina, that enabled it to launch and maintain a robust advertising campaign and support its PAC efforts.

THE GLOVES ARE OFF

In March 2012 both sides came out fighting. The Speaker of the House had directed the creation of a special

committee to study the issue, and the House Select Committee on Dentistry Management Arrangement Limits held its first meeting March 7. During our opponent's testimony, it quickly became apparent that they had an agenda that reached far beyond the proposed legislation. The opposition falsely accused the NCDS and NCSBDE of protectionism, resisting the creation of the new dental school at East Carolina University, and ignoring the request to ease the portability of dentists into North Carolina. They challenged the NCDS's commitment to charity care and implied that organized dentistry in North Carolina was not concerned about access to dental care. They positioned the dental management corporations as the protectors of access. Finally, they questioned the way the NCSBDE operates, accusing it of overreach, labeling its relationship with the NCDS incestuous, and calling for changes in the way members of the NCSBDE were selected.

The NCDS had long-standing relationships with several of the committee members. We were confident that the Select Committee would issue a favorable report on the bill, which would go a long way in ensuring broader support when the bill reached committee and floor votes. Unfortunately the alliance had reached the same conclusion and it used its power to convince the House leadership to bypass the Select Committee and render its work impotent. Over the next several months, the alliance successfully employed stalling techniques to stop the bill from moving forward.

IN THE SPOTLIGHT

It also was around this time when SB 655 attracted national attention. Our legislation had made North Carolina a bellwether for the nondentist-owned dental management corporation industry. Dental management companies and their financial backers—private equity

firms—were watching our fight closely, and they were determined to win. Private equity firms stood to earn substantial profits from the dental industry and were not about to watch their business model be threatened.

The alliance engaged well-connected Republican political operatives, influential lobbyists with both Democratic and Republican ties, and a national PR firm to help them. Some state and national Republican leaders contacted Republican members of the North Carolina House encouraging them to support free-market principles and stop government overreach by opposing the bill.

The national news media also took notice of our legislation, and we began to see a series of articles that catalogued fraud and patient abuses in practices owned by dental management corporations, many of which concentrated on delivering care to the Medicaid population. Investigations by reporters exposed the private equity firm connection, where profits seemed to take precedent over patient care. These revelations attracted attention and generally were supportive of our side of the issue. But while these may have helped us in a public media relations battle, the real war was being waged within the walls of the legislative building.

THE LOWEST DEPTHS

As the battle raged on, our opponents continued to reveal the lengths to which they would go in order to stop our legislation. In early summer, we ran a television ad that featured a local dentist who spoke about the importance of protecting quality patient care and keeping decisions in the hands of a licensed dentist rather than a for-profit

corporation. In arguably the lowest point of our battle, we received a communication from one of our opponents advising us to stop running the ad or risk having the dentist's professional reputation sullied. We knew the threat was real, so we pulled the ad.

All the while, our member dentists were continuing to barrage members of the House leadership with the message: "Please allow our bill to be heard." We knew we had enough support for our bill to pass if it reached the House floor. In the final weeks of the short session, the Speaker called the two sides together and announced that both groups would participate in mediated sessions in an effort to reach a compromise on the legislation.

TENSE NEGOTIATIONS

Moderated by a prominent House legislator, representatives from the NCDS and the alliance, along with their attorneys, began a series of meetings and iterations of the bill surfaced daily. The versions advanced by the NCDS maintained many of the tenets of our original legislation. The versions put forward by the alliance contained language so foreign, and so contrary to anything the original legislation sought to achieve, that it was ludicrous. Several versions would have eliminated virtually any restrictions on dental management corporation control of dental practices and proposed sweeping changes to how NCSBDE board members were selected.

At one juncture we seriously considered withdrawing our bill rather than allowing an egregious version to advance through the House. But as both sides vied for position, we noticed that the solidarity of the alliance was crumbling. It became clear that not all of the alliance members were in agreement with the bill's language but had their

own priorities to advance based upon their respective business models.

REACHING A COMPROMISE

Late one night, after a particularly arduous session, the tenth and final iteration of the legislation was advanced and agreed upon by both sides. Absent from the legislation were several provisions that would have strengthened the NCSBDE's jurisdiction over dental management corporations, but the bill retained components critically important to the dental board: it clarified definitions related to dental management arrangements, validated existing rules prohibiting non-dentist ownership, and provided the NCSBDE safeguards and enforcement tools. While the legislation did not accomplish everything the dental society had sought, neither did it grant any additional control or concessions to the dental management corporations. The final version of SB 655 quietly advanced through the Health and Human Services Committee and to the House floor where it received a unanimous vote of support.

The fact that the NCDS prevailed in this legislation has important national ramifications in the ongoing debate between those who believe that dental practices should continue to be owned and controlled by dentists. Other states, such as Texas, have also begun to examine the activities of nondentist-owned dental management corporations. In June 2013, the staff of the U.S. Senate Committee on Finance and Committee on the Judiciary released a 1,517 page report entitled "Joint Staff Report on the

We believe that the debate will continue and that its eventual resolution will have critically important implications for all of us—those who provide dental care and those of us who receive it.

Our members were the strongest weapon we had, so we made grassroots education and mobilization the backbone of our plan.

Corporate Practice of Dentistry in the Medicaid Program.” The executive summary contains the following statements which relate to the ethical challenges that seem to be inherent in some dental management corporations.

Across the country, there are companies that identify themselves as dental management companies. These organizations are typically organized as a corporation or limited liability company. They work with dentists in multiple states and purport to provide general administrative management services. In late 2011, whistle-blowers and other concerned citizens came forward with information that some of these companies were doing more than providing management services. In some cases, dental management companies own the dental clinics and have complete control over operations, including the provision of clinical care by clinic dentists. While there is no federal requirement that licensed dentists, rather than corporations, own and operate dental practices, many states have laws that ban the corporate practice of dentistry. In those states where owners of dental practices must be dentists licensed in that state, the ownership structure used by some dental management companies is fundamentally deceptive. It hides from state authorities the fact that all rights and benefits of ownership actually flow to a corporation through contracts between the company and the “owner dentist.” These contracts render the “owner dentist” an owner in name only. Notably, these clinics tend to focus on low-income children eligible for

Medicaid. However, these clinics have been cited for conducting unnecessary treatments and in some cases causing serious trauma to young patients; profits are being placed ahead of patient care.

In one case, the corporate structure of a dental management company appears to have negatively influenced treatment decisions by overemphasizing bottom-line financial considerations at the expense of providing appropriate high-quality, low-cost care.

SERVING TWO MASTERS?

Due to the potential profits available to investors in corporate-owned dental practices, we have every reason to believe that our legislative fight in 2011-12 is just the first round in an ongoing debate as to whether a corporation, whose primary responsibility is to increase profits and shareholder value, can coexist in a business model whose principal employees are dentists and other dental auxiliaries who are ethically bound to make treatment decisions based upon the best interests of the patient. We believe that the debate will continue and that its eventual resolution will have critically important implications for all of us—those who provide dental care and those of us who receive it. ■

LEGAL DIMENSIONS OF POWER IN THE DENTAL OFFICE

Sue Ann Van Dermiden, JD
Alex Sperry, JD

ABSTRACT

Hostile workplace environments and sexual harassment depend on unequal power. It is the legal responsibility of the employer (the dentist practice owner) to protect against, investigate, and take appropriate action to prevent the abuse of power in the office. This article discusses harassment by dentists, staff members, and patient, vendors, and other third parties. Six direct steps for managing this issue are presented.

It is 6:17 a.m. You unlock the etched glass doors to your dental office. You make your way to your desk, throw down your keys, and settle into your chair. As you pick up the day's schedule you begin to crack a smile. Eighteen patients, half of whom have been in the practice for 15 years or more. Today's lineup: Several extractions. Multiple fillings. Four crowns, three bridges. Many denture repairs. You get this. This is why you went to dental school, why you still get up early, and why you still strive to learn new technology and skills.

But wait. A 4:00 p.m. "Meeting with Dental Assistant?" You do not recall scheduling that meeting. Hmm. What could be the purpose? Eighteen-some patients later, you find out.

Your newest dental assistant says she was groped last week by a long-time patient—the one who holds a powerful position at the high-tech company in town. The same patient who introduced you to the mayor last year and who invited you to his yacht party this summer. Your dental assistant also tells you this was the second time this has happened. She says that you were in the room when this patient grabbed her breast the first time, and that you pretended not to notice. She then begins telling you about the patient's lewd comments toward her when he left the chair...and about the racy texts he sent to her last week. Your heart sinks. You don't get this.

Dentists, like other employers, are accountable for harassment against their employees. This is true for acts perpetrated by co-workers, but also for inappropriate conduct by patients, vendors, customers, consultants, or anyone else with whom your employees connect in the course of their work responsibilities.

First, let's briefly review the basics. Then we will address your role and responsibility in the above hypothetical case.

AN ONGOING ISSUE

Despite years of awareness and laws centered around preventing sexual harassment (Clarence Thomas, Anita Hill, and the infamous "Coke can" Senate confirmation testimony happened over 20 years ago!), it still occurs in workplaces throughout the country. It is something about our human nature, and how we interact with others, and social views on sexual matters, that keeps these issues alive. According to a



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Harassment is often interpreted to mean that the conduct unreasonably interfered with the individual's work performance or created an intimidating, hostile, or offensive working environment.

2010 Society for Human Resources Management poll, nearly one-fourth of organizations reported an increase in the number of sexual harassment claims brought in their organizations within the prior 24 months. Nearly 20% of organizations reported that sexual harassment claims were brought forward equally by male and female employees.

However, not all lewd conduct at work amounts to sexual harassment. To be unlawful sexual harassment, plaintiffs must prove that they were subjected to offensive, unwelcome conduct of a sexual nature that was sufficiently severe or pervasive to be abusive. This is often interpreted to mean that the conduct unreasonably interfered with the individual's work performance or created an intimidating, hostile, or offensive working environment.

So, you might ask, what does this mean for your dental office?

EMPLOYER LIABILITY

For starters, if a supervisor commits unlawful harassment, the employer may be automatically liable when the harassment has resulted in a "tangible employment action" such as, for example, a demotion, an undesirable assignment or a discharge.

If a co-worker, or a supervisor with no authority over the complaining employee (often referred to as the "complainant"), commits unlawful harassment, the employer may be liable if the employer knew, or should have known, of the harassing conduct but took no action to stop or correct it. In

such cases, the employer may be able to limit liability by showing that there was no knowledge of or way of knowing of the harassment, or if it can show that immediate, appropriate corrective action was taken.

If a customer, vendor, visitor, or other third party commits harassment, the rules are similar to co-worker harassment. However, courts will also consider the degree of control that the employer had over the third party's misconduct.

HARASSMENT BY DENTISTS

As the dentist in the office (aka "The Boss"), it is best that you not engage in any harassing conduct yourself. Of course, right? It sounds simple. However, let us mention a cautionary note: sexual harassment, when it comes to supervisors, is often as much about *power* as it is about conduct of a sexual nature. According to some experts and studies, sexual harassment is inextricably linked with an abuse of power. This abuse may be directed at males or females, by males or females. This is why courts recognize same-sex harassment, even in the absence of sexual attraction.

Do not give in to age-old stereotypes that sexual harassment is a form of flattering sexual attention for women. When the recipient of sexual harassment has no choice in the encounter, or has reason to fear the repercussions if he or she protests, the interaction has moved out of the realm of "welcomeness" and

into the arena of an abuse of power, intimidation and, perhaps, unlawful harassment. Thus, a seemingly harmless flirtation with a dental assistant, when coupled with the power dynamic of the dentist, can have unintended legal ramifications.

Because an employer has strict liability for supervisor harassment, keep this simple ethos in mind: Just don't do it. You will be respected for it, and the glass doors will stay open. Be professional and above reproach in your interactions with staff. With your power comes great responsibility—and liability, if misused.

In reality, though, it is more likely that others—not you—are a greater source of concern.

HARASSMENT BY THIRD PARTIES

As The Boss, you also have the responsibility to protect your employees from harassment at work, even when done by your patients or others. Why? Because you have the power to do so.

When it comes to harassment by third parties, courts look to the degree of responsibility the employer has over that third party. As the dentist, you seemingly have a great deal of control over the patient. You can institute certain safety measures to ensure a patient is not alone with your staff. You can have a discussion with patients about their behavior. Ultimately, you can refuse service to a patient or terminate the relationship entirely. Yes, it may mean a loss of business, but juries will not be persuaded by your loss of revenue if that is what it takes to provide a safe

working environment for your staff, particularly if it only means the loss of one of several hundred patients.

SOME SIMPLE RULES

With all of that said, the practical reality is that all employers should institute programs to prevent and correct workplace harassment. For those of you who like checklists, such a program looks like this:

- Maintain a clear, detailed policy that outlines your office's position against sexual harassment.
- Correctly interpret and consistently follow that policy.
- Conduct periodic supervisor training and employee awareness programs about the office's policy outlawing sexual harassment.
- Implement a complaint procedure that requires employees to come forward with harassment complaints and prohibits retaliation against those who do so.
- Identify a designated individual with authority to oversee the complaint process.
- Adopt an investigative strategy that protects the parties' privacy interests to the extent possible, but do not promise absolute confidentiality.

By following these best practices, you can establish a comfortable workplace for your employees and shield your practice from costly sexual harassment claims.



As The Boss, you also have the responsibility to protect your employees from harassment at work, even when done by your patients or others. Why? Because you have the power to do so.

DENTAL STUDENT INDEBTEDNESS

WHERE DID IT COME FROM AND WHERE WILL IT LEAD?

Gary L. Stafford, DMD, FACD

ABSTRACT

Today's dental school graduates are burdened by an ever-increasing amount of student loan debt from both their undergraduate and predoctoral educations. Although considered to be multifactorial in origin, this article explores the microeconomic theory of supply and demand as a source for rising tuition costs and subsequent educational debt. The historical context for the cost of a dental education is provided, and serious questions are posed about how this indebtedness might impact the future of the profession.

In 2013, college students in all fields graduated with an average of \$35,200 in student loan debt from their undergraduate education, with 39% of these graduates stating that they would have made different choices related to planning for college had they understood the total cost of an undergraduate education. An astonishing 50% of those surveyed were unaware of the amount of undergraduate student debt they had accumulated (Fidelity Investments, 2013). These same college graduates, once matriculated into dental school, will face a staggering average student loan debt load of \$221,713 upon graduation (American Dental Education Association, 2013b). Yet the prospect of entering a profession whose educational costs continue to escalate has not deterred potential candidates from applying for what remains a highly coveted seat in an entering dental school class.

Based upon current and future demand, job satisfaction, and earning potential, a 2012 *U.S. News and World Report* special report on the 100 best jobs ranked dentistry as the number one occupation in the United States (Graves, 2012). With the U.S. Bureau of Labor Statistics reporting a projected 25,000 new openings in the next eight years, high job satisfaction, and the potential to earn a median salary of \$145,240 dollars per year (U.S. Department of Labor, 2012), it is little wonder that dentistry is viewed as an attractive career choice

and that there is such a high demand to gain admittance to dental school.

For undergraduate students who are contemplating dentistry as a career, these types of reports place dentistry in a very positive light. However they do not provide a complete picture. In the *U.S. News and World Report* special report, no mention was made as to the cost of attaining the education necessary to become a dentist, nor was there any mention of the long-term financial impact of servicing the accumulated educational debt that the new graduate will have. A report commissioned by the U.S. Department of Health and Human Services Health Resources and Services Administration in 2005, concluded that the costs of acquiring a dental education now far exceed the resources of the vast majority of U.S. families (U.S. Department of Health and Human Services, 2005), and this inability for families to help fund their children's education places more pressure on the student to personally accept larger educational loan debt. Without a thorough understanding of the cost of their education and the sacrifices that must be made in order to satisfy their student loan repayments, applicants for admission to dental school might not have a realistic expectation about their true net earnings as they begin their



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careers. One could rightfully assume that any misconception about this economic reality could have a negative effect on overall job satisfaction.

The purpose of this article is to present a working hypothesis about how one specific causative factor (the micro-economic theory of supply and demand) might play a role in contributing to the burgeoning amount of debt that confronts our next generation of dentists than has been previously thought. In addition to exploring a variety of more commonly accepted internal and external causative factors, serious questions will be raised about the consequences that this student loan-related debt could have on the future of our profession.

WHERE DID IT COME FROM?

To state it simply and directly, the increase in student loan debt mirrors the rise in overall tuition costs. Myriad internal and external factors are commonly cited as sources for the steep rise in dental educational costs; therefore, an argument could be made that the concomitant rise in student loan debt is also multifactorial in origin. However, upon closer inspection, several of the internal and external causal factors that give rise to increased tuition and fees have elements that can be connected to the issues of supply and demand.

INTERNAL AND EXTERNAL FACTORS

Among the most commonly accepted internal and external factors, and one of the primary drivers of increased tuition,

has been the gradual decline in funding for higher education which had formerly helped colleges keep an education more affordable. Over the course of the two decades preceding the Great Recession of 2007-09, loss of institutional federal support, declining state appropriations, and limitations on student-generated clinical revenue resulted in a greater reliance on tuition and fees. This steady decrease in support was further exacerbated by the Great Recession, which led to further, more drastic cuts in state higher education funding (Johnson & Ostern; *The student debt crisis*; www.americanprogress.org). The need to rely more heavily on tuition and fees for institutional operations rather than funds from the federal and state level, naturally led to a notable rise in student borrowing which has been a major contributing factor in adding to a dental student's burden of debt.

The Great Recession also played a role in the ability of schools to distribute grants and scholarships from their endowments, a vital way to help offset students' educational costs. At institutions with large endowments, endowment spending contributes significant resources toward their operating budgets. In some cases, it is the largest source of revenue for the institution. Thus, endowment spending helps to keep tuition below the level that would be necessary if tuition alone paid

To state it simply and directly, the increase in student loan debt mirrors the rise in overall tuition costs. Myriad internal and external factors are commonly cited as sources for the steep rise in dental educational costs.

the true cost of educating a student. During the Great Recession, the Dow Jones Industrial Average declined by over 50% in its value, and this drop in the valuation of colleges and universities' endowments meant that there were fewer resources available to provide for their students, once again necessitating a greater reliance on students attaining financing from other sources.

The government has always played a role in postsecondary education in the United States, from land grant universities to state-subsidized colleges, to public grants and subsidized loan programs (Klobuchar, 2013). Federal loans made up 39% of student aid received by undergraduates and 69% of total graduate student aid in 2011. Federal grants constituted 27% of grants on which undergraduates relied and 2% of graduate student aid. Tax credits added another material portion of aid. Thus, the federal government provides more than two-thirds of the direct aid to all postsecondary students (Baum & Payea, 2013). Unfortunately, beginning July 1, 2012, Subsidized Federal Stafford Loans, which made up 35% of all new loans in 2011-12 (Klobuchar, 2013), became available only to undergraduate students forcing those in graduate or professional schools to seek other sources of assistance, such as unsubsidized Federal Stafford Loans. These loans, which are sponsored by the U.S. Department of Education, made up 40% of all new loans in 2011-12 (Klobuchar, 2013). However the federal government does not pay the interest accrued while one is in school, during a grace period, or during a deferment. This recent change allows interest to accrue while a student is in dental school and then be

capitalized into the principal amount, therefore compounding the interest and adding to the overall student loan debt upon graduation.

Private lenders such as banks, credit unions, and Sallie Mae created mechanisms to help students finance their education as a result of demand from those who exceeded their Federal Stafford Loan limits, as well as a way to generate profits from the increased enrollment in institutions of higher learning. A key distinction between federal student loans and private student loans is interest rate risk. Today, all federal student loans have fixed rates. Many private student loans are variable-rate loans with risk-based pricing, where rates vary based upon an assessment of the creditworthiness of the borrower. These loans, much like the subprime mortgages that led to the housing crisis, are fueled by investor appetite for asset-backed securities and have much looser lending standards (Consumer Financial Protection Bureau; *Private student loans*; www.consumerfinance.gov). This has resulted in many students borrowing more than required to finance their education with the additional dilemma of having less flexibility in handling deferments, forbearance, or debt forgiveness should repayment become a concern.

In response to the increased demand from high school graduates who wish to pursue postsecondary education, many universities have modified their infrastructure in order to recruit the best students by adding more extravagant amenities such as dorms, gyms, or cafeterias. These projects, which significantly increase the universities' operational costs, are eventually passed on to the student in the form of higher tuition and fees and perhaps to the various schools or colleges in the form of an operational tax. Although some dental schools operate independently with no support from their parent

university, others must contribute to their parent universities' budgets. Increased taxation by the parent institution to help with their operating budgets will decrease any margin of profit by the dental school or force the dental school to experience a larger deficit, ultimately resulting in a tuition and fee increase to cover the shortfall. At many institutions the overall budget is designed so that the more financially lucrative programs and schools help subsidize the less financially viable programs (American Dental Education Association, 2013a). Dental schools, with high student demand for acceptance and a stream of clinical revenue may appear to be more financially viable than other areas with less student demand or those that produce no revenue stream other than tuition.

Dental education is beginning to observe some of the ramifications of the Great Recession that led to a dramatic rise in undergraduate enrollment during the economic downturn. Many of these same students, due to a sluggish economy, are reluctant or unable to settle into full-time careers, so they look to graduate school to stay out of the workforce by seeking advanced training in sectors of the economy that continue to exhibit growth. When studying their options, they often look to careers within those sectors that will provide the greatest job security, income, and job satisfaction, with each of these attributes exerting a great deal of influence on their decision-making process. The attractiveness of the dental profession has driven prospective students to apply for admission and has created a demand that is in excess of our current ability to supply.

Observing that demand plays such a key role in several of the commonly accepted causal factors that have contributed to higher tuition, and thus

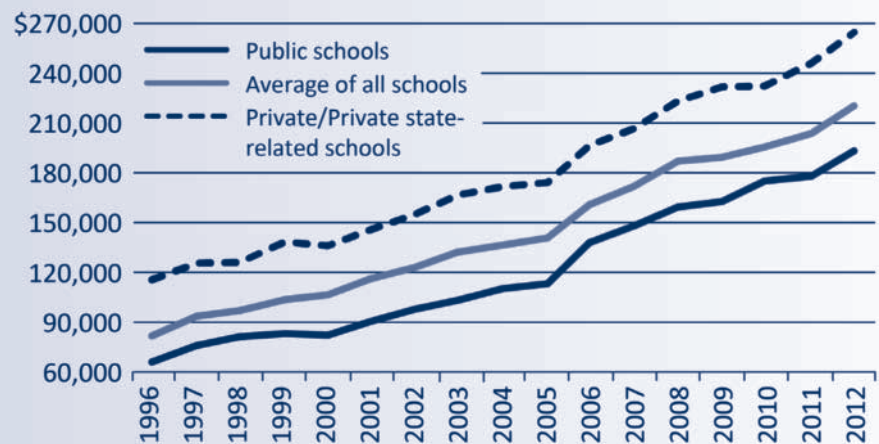
higher amounts of student loan debt, led to the working hypothesis that the microeconomic theory of supply and demand may be a major factor in the problem.

MICROECONOMIC THEORY of Supply AND DEMAND

Supply and demand is one of the most fundamental concepts of economics and is the backbone of a market economy. This microeconomic theory states that, in general, the greater the supply and the lower the demand, the lower the price will be. Conversely, if there is a low supply or a high demand for a good or service, the price for that good or service will be higher (Rittenberg & Tregarthen, 2012). With a 37% increase in applicants since 2000 and only a 23% increase in enrollees, demand for a dental education remains higher than can currently be supplied (American Dental Education Association, 2012b).

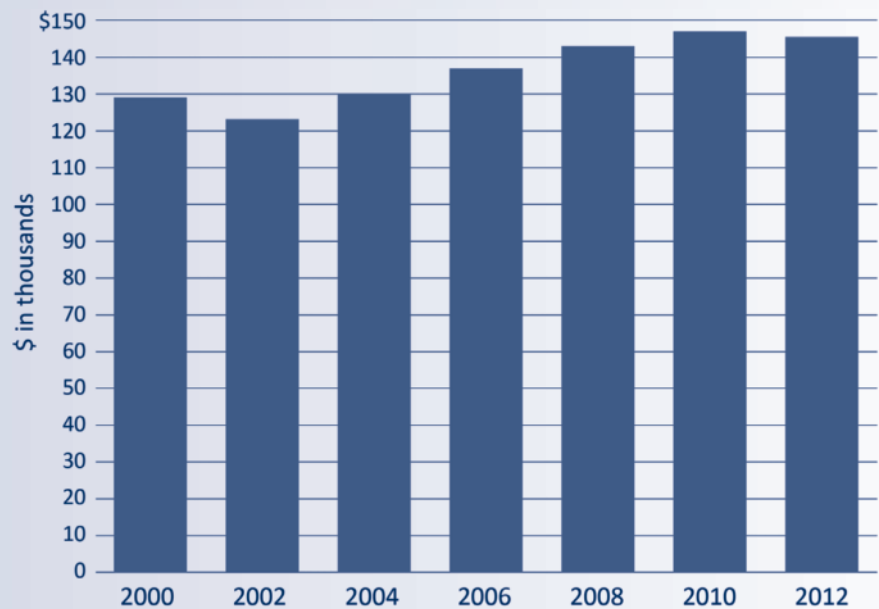
While the demand to gain admittance to dental school over the last 13 years has been high, this has not been the case historically. Decreasing applicant demand for dental school admission occurred over the course of 14 years, beginning in 1975, when there was a historic high of 15,734 applicants and 5,763 first-year matriculates for U.S. dental schools. That high-water mark was followed by a decline in applications that ended in 1989 with 4,964 applicants for 3,979 positions. This small applicant pool (decreased demand) for the available seats (supply) could be considered at least partially responsible for a series of school closures between 1986 and 2001. Beginning in 1986 with Oral Roberts University in Tulsa, Oklahoma, seven dental schools closed their doors over the course of 15 years. Dr. James Winslow, Vice President of

FIGURE 1. AVERAGE EDUCATIONAL DEBT* AMONG GRADUATING STUDENTS WITH DEBT BY TYPE OF SCHOOL, 1996-2012



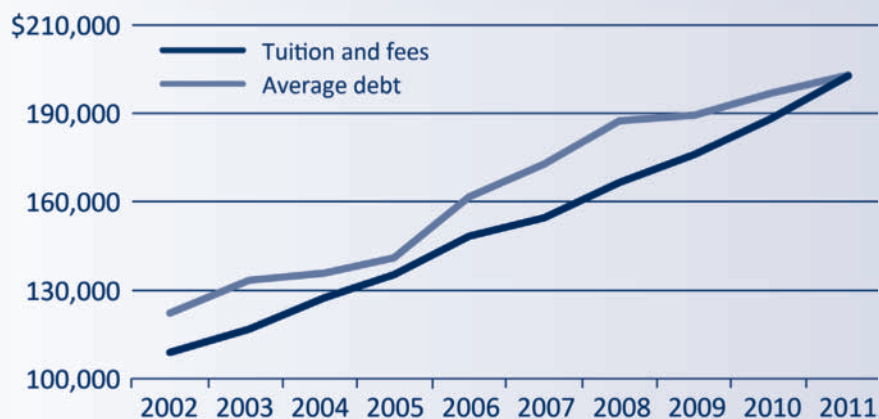
*Educational Debt is the sum of undergraduate debt and dental school debt of only those respondents who have debt.
Source: American Dental Education Association, Survey of Dental School Seniors, 2012 Graduating Class, (Current Dollars).

FIGURE 2. GENERAL DENTIST'S MEDIAN AVERAGE ANNUAL SALARIES, 2000-2012



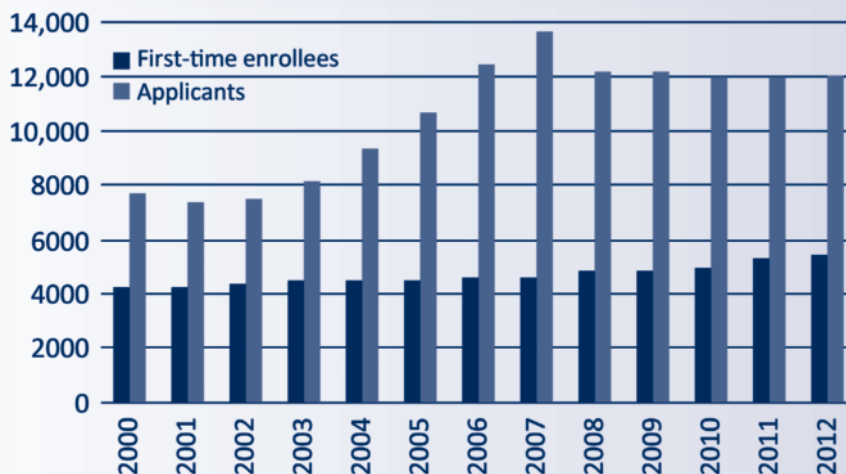
Source: Bureau of Labor Statistics.

FIGURE 3. AVERAGE EDUCATIONAL DEBT* AMONG GRADUATING STUDENTS WITH AVERAGE TOTAL TUITION AND FEES, 2002-2011



*Educational Debt is the sum of undergraduate debt and dental school debt of only those respondents who have debt.
Sources: American Dental Education Association, Survey of Dental School Seniors, 2011 Graduating Class, (Current Dollars); American Dental Association, 2010-11 Survey of Dental Education, Average Total Resident and Non-Resident for All Four Years.

FIGURE 4. DENTAL SCHOOL APPLICANTS AND NEW FIRST-TIME ENROLLEES, 2000-2012



Source: American Dental Education Association, U.S. Dental School Applicants and Enrollees, 2012 Entering Class.

Student Affairs, stated that the closure of the Oral Roberts University School of Dentistry was linked to student indebtedness and students' subsequent inability to fulfill the mission goals of the university. The debt load of the graduates dictated that they go into private practice, which precluded their performing their mission work, a central goal of the Christian school (*Tulsa World*, 1985). Other economic factors such as the inability of private institutions to compete with public dental school tuition rates, and the desire of parent institutions to use highly valuable real estate for more profitable enterprises such as medical research, forced six other schools to follow suit. In 1995, during the peak of these dental school closures, the Institute of Medicine (IOM) published *Dental Education at the Crossroads: Challenges and Change* (Field, 1995). This comprehensive assessment of dental education provided a thorough review of workforce models, projections, and underlying assumptions. The committee found "no compelling case, at this juncture, that the overall production of dentists will, in the next quarter century, prove too high or too low to meet public demand for oral health services. Accordingly, it found no responsible basis for recommending that total dental school enrollments should be pushed higher or lower."

The committee also recommended that it was best to leave the decision for increasing or decreasing dental school enrollment to "active surveillance and monitoring of developments that could change trends in supply, demand, or need."

Twenty years after the peak of dental school closures, we are witnessing an expansion in dental education due to a change in demand, both from those interested in entering the profession as well as the recognition that there is a

need to increase access to affordable oral health care for a large segment of the population. In 2000, there were 55 dental schools in the United States and by 2015 it is anticipated that there will be 67. Since 1997, one school has closed (Northwestern University), nine schools have opened, three schools began enrollment in the fall of 2013, and one plans to matriculate its first class in 2015 (American Dental Education Association, 2012c; Fox, 2011).

Even with these new educational facilities and with several other schools increasing their enrollment, demand continues to outpace supply. In fact, with the increase in applications over the last 13 years, the competition to gain admittance to dental school has only made it more difficult for an applicant to be chosen for acceptance. This is true despite 1,249 new seats having been added in U.S. dental schools since 2000. With no apparent decrease in interest by applicants applying for admission in conjunction with a somewhat limited supply, the economic theory of supply and demand dictates that we should logically see a rise in tuition costs.

Daniel Lin (*Why is higher education so expensive?* www.learnliberty.org), an economist at American University, postulates that two primary factors have acted as drivers behind this increased demand for those who choose to enter postsecondary education generally: job prospects and government subsidies. Taking a closer look at how these two drivers have specifically contributed to an increased demand for admission to dental school may help to illustrate why they have also led to increasingly higher debt loads for graduates.

Job PROSPECTS

There are a multitude of internal forces on campuses that drive tuition upward, but they are less important in setting the price of an education than is the

conviction that college is an unbeatable investment for a better life (Lemann; *The cost of college*; www.newyorker.com). The evidence indicates that almost without exception, each successive level of higher educational attainment yields additional economic benefits (State Higher Education Executive Officers Association, 2012), so it should come as no surprise that so many college graduates want to enter the dental profession. As noted in the 2012 *U.S. News and World Report* special report as well as in reports by the Bureau of Labor Statistics, those who enter the dental profession have a high degree of certainty in finding gainful employment, enjoying a stable employment future, and earning a comfortable salary. When compared to the unemployment rates of high school graduates, those with some college education, and college graduates, dentistry provides a very high level of job security. In fact, with an unemployment rate of 0.7%, dentistry is one of ten occupations that has the lowest overall rates across all U.S. occupations. Not only do dentists enjoy very high employment rates but their job opportunities have been projected to grow by 21% between 2010 and 2020, faster than all of the other occupations in the U.S. economy (United States Department of Labor, 2013). This growth virtually assures that not only will a job be available once a student graduates from dental school, but opportunities should continue to present themselves for the foreseeable future.

Along with this bright employment picture, salary data show that dentists have the potential for earning an exceptional income when compared to other occupations. In the 2012-13 edition of the United States Department of Labor's *Occupational Outlook*

Handbook (2013), the government's premier source for career guidance, dentistry held five of the top ten highest paying occupations, with general dentists ranking sixth out of all occupations in the U.S. economy. It is no surprise that potential income and highly positive current and future job outlook projections are major factors in driving the demand by college students who choose dentistry as a career path.

GOVERNMENT Subsidies

The second factor that has led to an increased demand not only for dental education but also for higher education in general relates to public policy. Government subsidies through student loans, grants, and tax credits were instituted to help students fund their education with the thought that an educated workforce would create a beneficial social return. In essence, it is a value proposition for policymakers and the general public that achieving this goal will lead to social and economic benefits for individuals, states, and the nation. The commitment from the U.S. government in providing these subsidies is made evident by the fact that the Department of Education will provide over \$38.5 billion in awards from the Student Financial Assistance account in 2014-15, which is almost double the amount from 2009-10, when there was \$19.4 billion available for awards (Office of Management and Budget, 2008; 2013).

These statistics direct us back to the matter of supply and demand, where a strong argument can be made for a direct correlation between applicant demand and rising tuition costs. Thanks in part to these government subsidies; more and more Americans have sought out higher education due to the belief that education is more affordable. Universities have responded to the availability of federal dollars by doing

Universities have responded to the availability of federal dollars by doing what subsidized industries usually do, which is to raise prices (tuition) to capture the subsidy.

what subsidized industries usually do, which is to raise prices (tuition) to capture the subsidy. Ordinarily, such upward pressure would be restrained by consumers' willingness and ability to pay, but as government subsidies have helped absorb tuition increases, the public's budget constraint has been lifted (Edwards. & McCluskey, 2009; Vedder, 2004).

Over time, this public policy has helped to create a vicious circle of economic events. As more college students express a desire to pursue a dental education, more students compete to gain admittance, and this increase in demand has eventually contributed to higher tuition costs. Simply put, when something is subsidized, it is cheaper for people to consume, so people consume more of it and demand rises. According to the economic theory of supply and demand, a rise in demand will usually be followed by a rise in costs (Daniel Lin; *Why is higher education so expensive?* www.learnliberty.org). Since many dental schools or parent institutions have lost federal and state level appropriations, they are eager to capture funding in other ways, most notably through the student via federal student loans. In the long run, these federal student loan subsidies are actually detrimental to the student borrower for the simple reason that with any rise in tuition, there is political pressure to increase the very subsidies that were designed to provide assistance to the students. Subsidies function not only to make higher education less affordable but also to create a situation where students pay higher tuition and are ultimately burdened with a higher debt load.

INCREASED DEMAND

With this rising demand by applicants, three alternatives present themselves to the parent institution. Maintaining the

status quo in terms of class size and tuition costs, where admission standards rise and the school or parent institution forgoes an increase in revenue is the first and perhaps most unlikely option. Secondly, an increase in enrollment could occur, but for many institutions this is not a realistic option due to space limitations on the number students that can be enrolled. Lastly, with the present demand fueling higher tuition for a slowly increasing supply (seats), schools or parent institutions could enhance their revenue stream by increasing tuition and passing the added cost on to the students who are able to receive federal dollars to help subsidize their education costs (Daniel Lin; *Why is higher education so expensive?* www.learnliberty.org). This option appears to be far more likely and certainly fits the microeconomic theory of supply and demand.

Support for this theory can be found in data from the American Dental Association. Between the 2000-01 and 2010-11 academic years, total costs to students through the entire predoctoral dental education program increased 101.6% for in-state residents and 92.5% for nonresidents. Resident total education costs increased by an average of 7.3% annually while nonresidents increased by 6.8% annually. To illustrate how educational costs have risen faster than most other goods and services, during this same period of time the consumer price index (CPI), which measures changes in prices paid for a representative sample of these goods and services, increased by an average annual rate of 2.4% (United States Department of Labor, Bureau of Labor Statistics; *Consumer price index*; www.bls.gov).

These trends, which certainly could be considered warning signs for dental education and the profession as a

Table 1. CHANGES in DENTAL Schools, 1986-2015

<i>Year</i>	<i>Closed</i>	<i>New, open</i>	<i>New, planned</i>
1986	Oral Roberts U, Tulsa, OK		
1988	Emory University, Atlanta, GA		
1990	Georgetown U, Washington, DC		
1990	Fairleigh Dickenson, Rutherford, NJ		
1991	Washington U, St. Louis, MO		
1993	Loyola University, Chicago, IL		
1997		Nova Southeastern, Fort Lauderdale, FL	
2001	Northwestern U, Chicago, IL		
2002		U of Nevada, Las Vegas, NV	
2003		A.T. Still U, Mesa, AZ	
2007		Midwestern U, Glendale, AZ	
2009		Western University, Pomona, CA	
2011		East Carolina U, Greenville, NC	
2011		Roseman U, South Jordan, UT	
2011		Midwestern U, Downers Grove, IL	
2012		Lake Erie Osteopathic, Bradenton, FL	
2013			U of New England, Biddeford, ME
2013			A.T. Still, Kirksville, MO
2013			University of Utah, Salt Lake City, UT
2015			Bluefield College, Bluefield, VA

Source: American Dental Education Association.

whole, were predicted in a 2001 study conducted by the American Dental Association, which came to an ominous conclusion: "Education is expected to undergo dramatic changes within the next 15 years. The cost of dental education, probably the highest of all the major academic offerings, threatens to price dentistry out of the education marketplace" (American Dental Association, 2001).

WHERE Will It Lead?

Today, most students enter dental school with a bachelor's degree and a sizable undergraduate debt load. With 85% of graduating seniors responding to the

Class of 2011 ADEA Survey of Seniors, on average, they reported entering dental school with \$35,670 in undergraduate debt (American Dental Education Association, 2012a). This undergraduate debt, combined with the financed costs of four years of dental school, leaves our new graduates shackled with a large monthly obligation that will remain with them for the life of the loan.

A certain degree of speculation is required when predicting how rising tuition costs and the subsequent mounting debt will affect entry into the profession. Although dentistry has not felt the aftershocks of the Great Recession of 2007-09 to the extent of many of the other sectors in the U.S.

economy, one should not assume that the profession is immune from any of the future consequences that may arise as a result of our new graduates shouldering such a large financial burden as they begin their professional careers in a sluggish economy.

First and foremost, escalating tuition costs and indebtedness may deter future dental school applicants from considering dentistry as a career, and in order to face any of the profession's future challenges, we must continue to attract the best and

Table 2. HIGHEST PAYING OCCUPATIONS: TEN OCCUPATIONS WITH THE HIGHEST ANNUAL MEDIAN PAY

<i>Occupation</i>	<i>2010 Median Pay</i>
Oral and Maxillofacial Surgeons	≥ \$166,400
Physicians and Surgeons	≥ \$166,400
Orthodontists	≥ \$166,400
Chief Executives	\$165,080
Dentists, All Other Specialists	\$161,020
Dentists, General	\$141,040
Judges, Magistrate Judges, and Magistrates	\$119,270
Architectural and Engineering Managers	\$119,260
Prosthodontists	\$118,400
Podiatrists	\$118,030

Source: U.S. Department of Labor, Bureau of Labor Statistics, *2012-13 Occupational Outlook Handbook*.

the brightest undergraduate applicants from a diverse applicant pool. These rising costs are especially troubling when attempting to attract minority applicants or those applicants who are economically disadvantaged. A lack of diversity in the dental workforce could have a profound negative impact on access to care for our most vulnerable, underserved populations, since minority dentists are more likely to provide dental care for minority patients (Mitchell & Lassiter, 2006).

High levels of student indebtedness make it increasingly difficult for recent graduates to start families, save for retirement, and take the risks that are associated with building a successful career. This high level of student indebtedness may be a determinate of

occupational choices, forcing many of these young practitioners to place undue influence on monetary priorities during the formative phase of their careers (American Dental Association, 2001). In a profession where the majority of dentists have historically practiced in a sole proprietor business model, high debt levels may delay or prevent our new colleagues from buying existing practices or from starting their own. Overall, there is a downward trend of those in solo practice, with 69.4% of dentists in 2010 practicing as sole proprietors in contrast to 76% in 2006 (Fox, 2012). With the driver of job prospects attracting applicants into the profession based upon statistics that are derived primarily from information supplied by solo practitioners, indebtedness that delays or prevents solo practice may eventually have a negative influence on this income data, which in turn could make the profession seem less attractive to applicants. Similarly, any delay or inability to enter solo practice may limit the future income potential of the new graduate, affect lifetime earnings or influence job satisfaction.

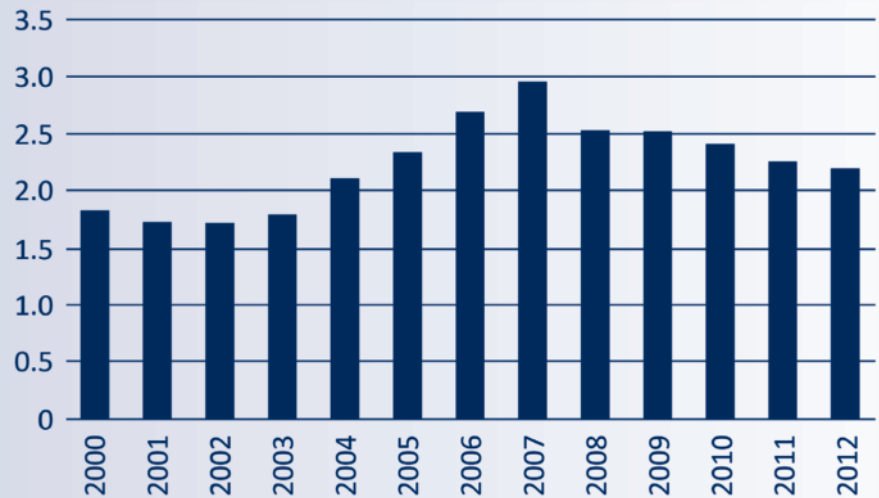
For some, facing the economic realities of student loan repayment might mean forgoing a career, either full- or part-time, in dental education. For others, it might mean choosing a type or location of practice that will provide a more immediate financial return while neglecting the growing needs of a large segment of the population. Career choices that are based on debt levels do not bode well for expanding access to dental services for underserved and vulnerable populations (Johnson & Ostern; *The student debt crisis*; www.americanprogress.org), since these new graduates may choose not to see low-income patients because of low reimbursement rates from

public assistance programs such as Medicaid (American Dental Education Association, 2013a).

A specious theory has emerged based on the presumption that if we enroll more students and graduate more dentists, we will be better able to address the critical dental needs of these underserved populations. This theory has been used as a rationale to increase class sizes of existing schools and for the opening of new educational facilities. Unfortunately, higher tuition costs and increasing student debt makes it difficult for entry-level practitioners to care for the very segment of the population that they are being trained to treat and whose dental needs demand the services they can provide. As long as it remains economically impractical for our recent graduates to either join existing practices or locate their new practices in underserved areas, policymakers will continue to investigate other delivery options in order to provide the necessary dental care to the populations in need. Increasing the number of practicing dentists, burdening them with more debt, and therefore making it difficult for them to help address access to care issues, may force public policymakers to dictate changes in how and by whom dental care will be delivered.

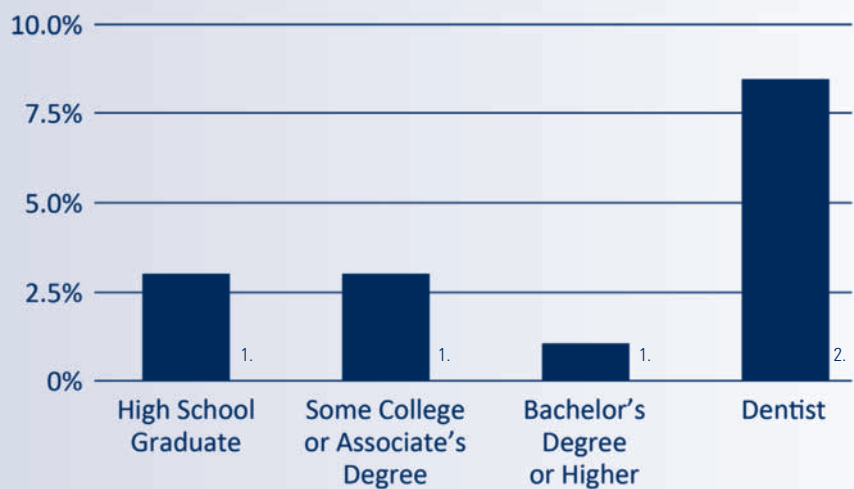
There appears to be nothing on the horizon to indicate that there will be a change in either dental schools or parent institutions from continuing to raise tuition costs and therefore add to the educational debt of their graduates. This increasing burden of debt is worrisome for dental students, their families, dental school faculty members, and policymakers alike, and without concrete solutions, we may be heading for a financial precipice that could only

FIGURE 5. DENTAL SCHOOL APPLICANT/FIRST-YEAR ENROLLEE RATIO, 2000-2012



Source: American Dental Education Association, U.S. Dental School Applicants and Enrollees, 2012 Entering Class.

FIGURE 6. UNEMPLOYMENT RATES



1. Source: www.bls.gov/news.release/empsit.t04.htm May 2013 Data.

2. Source: 2013 U.S. News Special Report—The 100 Best Jobs in America.

Career choices that are based on debt levels do not bode well for expanding access to dental services for underserved and vulnerable populations since these new graduates may choose not to see low-income patients because of low reimbursement rates from public assistance programs such as Medicaid.

be deemed to be precarious for the future of the profession.

Although the original intent of the following quote was to address access issues, it might also be considered appropriate when applied to the rising burden of dental student indebtedness. In the words of Henry S. Pritchett, President of the Carnegie Foundation for the Advancement of Teaching in 1926, "To set up a generation of physicians, of dentists, of nurses, whose service is so costly as to be out of the reach of the self-respecting man of modest means who desires to pay his way would be a dismal mistake." ■

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ETHICAL OBLIGATIONS AND THE DENTAL OFFICE TEAM

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ABSTRACT

A hypothetical case of alleged sexual misconduct in a practice with high employee turnover and stress is analyzed by three experts. This case commentary examines the ethical role expectations of an office manager who is not directly involved but becomes aware of the activities. The commentators bring the perspectives of a dental hygienist, academic administrator, and attorney; a teacher of behavioral sciences in a dental school; and a general dentist with many years of practice experience.

Continuing education credit is available online at www.dentaethics.org for those who wish to complete the quiz and exercises associate with this article (see Course 21).



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THE CASE

Ms. Stanley has been the office manager for Dr. Pruitt for 15 years. Over the course of time, several dental assistants have come and gone. Ms. Stanley is the one primarily responsible for hiring and managing the staff in the office. She has found that usually when dental assistants leave the practice, it is because "the office is too stressful a work environment." It is in fact a very busy practice.

Ms. Stanley hired Ms. Long, a personal acquaintance of Dr. Pruitt's, about 18 months ago and now even Ms. Long is exhibiting the telltale signs of office burnout: not getting her work done in a timely manner, coming to work late, and often calling in sick. Ms. Stanley really thought Ms. Long would stay employed in the practice for many years considering she knew Dr. Pruitt outside the office via their children's school. It seemed now that even she will be leaving at some point. It was just a matter of time.

Because Ms. Stanley has her own office space and deals mainly with paperwork issues, she rarely sees the interaction between the rest of the staff and Dr. Pruitt during working hours. In her 15 years at Dr. Pruitt's office, she has always thought him to be a good boss. If he had only one fault in her eyes, it would be that he

I believe the office manager does have a duty to act on the information, and the duty is derived from her role as assistant to a health care professional.

occasionally flirts with the women in the office after hours, but the interaction seemed harmless. After all, he is a happily married man with two children he adores.

One afternoon—after all the patients were treated for the day and Dr. Pruitt was gone—Ms. Long approached Ms. Stanley with some shocking news. Ms. Long told her that she and Dr. Pruitt had been having an affair for the last six months and that it was “totally stressing her out.” Ms. Long claimed that her husband was starting to get suspicious and she was feeling very guilty, so she told Dr. Pruitt that their relationship was over. She needed to get her life back on track and knew it was not healthy for the office either. She said that when Dr. Pruitt heard this he became very angry and told her that her “working days were numbered.” She needs her job to pay for her daughter’s college education, and she felt she needed to tell Ms. Stanley the truth in case Dr. Pruitt tried to fire her for invalid reasons.

Ms. Stanley was taken totally off guard with this news and was simply at a loss for words. She did not know what to believe. The thought did cross her mind, however, that maybe Ms. Long was not the first dental assistant to experience this “special treatment” by Dr. Pruitt. Maybe this is why they all left!

INTRODUCTION

Sexual conflicts and affairs are inevitably messy. News media are full of celebrity relationship scandals, and one only needs to look at divorce statistics to realize that relationship dishonesty and

conflict are commonplace in the United States. When such situations occur in a dental office setting among co-workers or between employer and employee, another dimension is added to the mix: patient care may be at risk and the fiduciary relationship between the dental profession and society may suffer.

One of the bigger questions that the case raises is this: How far does the ethical obligation of professionalism and professional conduct in a dental office extend to office employees? Should dental office staff or “auxiliaries” be held to the same standards as their dentist-employer? Are they simply an extension of the dentist’s obligations, undiluted and pure, or should they not be expected to maintain such standards? Should licensed dental office employees be held to a higher standard than those who are unlicensed? What if the dentist-employer is the one exhibiting the ethical lapse? How should office staff respond?

The following three case commentaries explore different aspects of the case. Professor Zarkowski examines the legal and ethical issues associated with the case. Dr. Donate-Bartfield explores professional obligations of dental office staff and also looks at the pitfalls of dual relationships. Dr. Patthoff delves into the nature of professionalism itself and ethical shortcomings.

What ethical issues are at play here? What should Ms. Stanley do now that she has this information? Does Ms. Stanley have an ethical obligation to take action?

COMMENTS BY PROFESSOR ZARKOWSKI

I believe all members of the office team should aspire to work in an environment that supports the ethical principles guiding oral healthcare delivery. Ms. Long’s autonomy is not being respected. It is unclear as to how she found herself in the situation of having an affair with

her employer. It is unclear whether the relationship was consensual or not. If it was not, the dentist has compromised the employee's professional autonomy. An additional issue is the situation Ms. Long finds herself in because her employer has now threatened to terminate her employment. The ethical principle of justice is being violated. If Ms. Long is telling Ms. Stanley the truth about the circumstances, the principle of veracity is being honored. At the same time, by being truthful to her employer, Ms. Long is at risk of losing her job. Nonmaleficence is also important in this case as Dr. Pruitt is doing harm to Ms. Long. She is under stress, fearful of losing her job, and now is telling a colleague about her circumstances. It appears that emotional, physical, and potentially financial harm will occur.

Ms. Long believes that she will be terminated because she no longer wants to have a relationship with Dr. Pruitt. Ms. Long may be in a situation which falls within the sexual harassment category of *quid pro quo*. *Quid pro quo* behavior involves expressed or implied demands for sexual favors in exchange for some benefit (a promotion, a raise, or a recommendation) or to avoid some detriment (termination, demotion) in the workplace. By definition, it can only be perpetrated by someone in a position of power over another. It appears that as long as Ms. Long maintained her sexual relationship with Dr. Pruitt she remained employed. When she indicated she wanted to end it, she has been threatened with loss of her job.

The affair may have also created a hostile work environment within the practice. This illegal condition exists when circumstances prevent employees from performing their assigned

responsibilities—the pattern of high stress and turnover noticed by Ms. Stanley. Hostile environment may also arise from unwanted conduct which is so severe or persistent that it creates an intimidating, hostile, or offensive educational or working environment. Conduct contributing to a hostile environment may be physical, verbal, or nonverbal.

As is found in most sexual harassment situations, Dr. Pruitt is very powerful in this situation and appears to be abusing his power as an employer.

I am offering the following suggestions as to what Ms. Stanley may consider. These recommendations are based on some of the ethical principles that have been discussed, as well as the legal issues.

1. She could provide advice to her employer to end the relationship and not take any other action that may appear to be retaliatory.
2. She could educate Dr. Pruitt concerning the sexual harassment categories of *quid pro quo* and hostile environment and the risks he is taking with his staff.
3. She could work with a consultant or expert to educate the office staff about their roles and responsibilities to create a work environment that is respectful, update a staff manual if appropriate to include then protocol for reporting inappropriate behavior, and take other measures to protect current and future employees and patients.
4. Depending on the state in which the practice is located, she could seek advice from the state dental association peer review committee or similar entity.
5. She could personally confront Dr. Pruitt, although the situation would become a matter of he said-she said and still may result in Ms. Long being fired.

6. She could advise Ms. Long to contact her local Equal Employment Opportunity Commission (EEOC) for advice about the situation.
7. The state law where the practice is located most likely has laws protecting the civil rights of employees, under which sexual harassment would be included. She could educate her employer about the protections afforded employees within the state.
8. If Ms. Stanley is a valued member of the dentist's team, she may have enough status to sit down with Dr. Pruitt and Ms. Long to work out the situation.
9. If Ms. Stanley is concerned that other staff has been the victims of harassment, she may want to contact them. Often individuals who have left a situation will not talk about the reasons. But if she wants to gain additional insights this action may be helpful. As far as the EEOC is concerned, there is usually a time limit as to when an employer can be reported. However, if Ms. Stanley discovers this has been a pattern of behavior by her employer, data gathering may assist her in determining how she approaches the next steps. She may determine she does not want to work in an environment where such activity occurs.

It should be said that any actions Ms. Stanley takes may put her in harm's way as her employer, Dr. Pruitt, may terminate her as well.

I feel that Ms. Stanley has been made aware of a potentially discriminatory action her employer may take with one of his employees. She has worked in the office for a number of years and may

have been unaware of the actions of the dentist. She is now aware of at least one situation. To honor the principles of justice, do no harm, and beneficence, she should address the situation as outlined in some of the recommendations noted above. I do not believe her status as an office manager diminishes her responsibilities as a colleague and employee.

I also wish to emphasize the point that it should be irrelevant that Ms. Stanley is an “auxiliary.” She is described as the office manager, which in my mind makes her an employee, a colleague, and someone with specific job responsibilities. The term “dental auxiliary” combines a number of different dental professionals into one category which is not reflective of their education, licensure, certification, and scope of practice. I recognize the intent may not be to categorize everyone under one umbrella title, but I feel obligated to draw attention to this. I think the case would make more sense if it asked whether any employee is obligated to do something about such a situation that has been brought to attention. The proposed framing seems to imply that a dental office manager practices under different ethics or may not even be obligated to act ethically.

COMMENTS by DR. DONATE-BARTFIELD

Ms. Stanley, a dental office manager, just learned that Dr. Pruitt, her employer, may have had an affair with a member of their dental team, Ms. Long. In addition, Dr. Pruitt may have threatened to fire Ms. Long when she ended the affair. Ms. Stanley can decide that this is a personal matter and none of her business, thus avoiding an uncomfortable conversation with Dr. Pruitt that could

result in her losing her own job. Deciding not to intervene would be an easy choice, especially because discussing Ms. Long’s accusations could potentially hurt both Ms. Long’s and Dr. Pruitt’s families if they learned about the allegations.

Does Ms. Stanley have an obligation to act on the information she has just been given? Does Ms. Stanley, Dr. Pruitt’s subordinate on the dental team, have a duty to confront Dr. Pruitt on these allegations?

I believe the office manager does have a duty to act on the information, and the duty is derived from her role as assistant to a healthcare professional.

Healthcare professionals have a societal agreement to serve the public. Their services are needed to support important public functions (such as providing necessary health services), and their professional role is sanctioned and protected by the public (Welie, 2004). Licensing laws support this agreement by restricting the practice of professional services to members of the profession. In addition to being competent, patients expect that dentists will put their own self-interest aside to care for them when they are in a vulnerable state (Ozar, 2002). Trust is important in a professional relationship because patients cannot judge the quality of the interventions being made. These expectations are reflected in the profession’s code of conduct.

We need to be able to trust professionals, among other things, to safeguard our personal information, to act in our best interests, and to respect our autonomous decisions—even when we make poor ones. We also trust that dentists’ professional and ethical obligations are reflected in their business practices. This can be seen in a team approach where the office staff and dentist work together to meet each patient’s needs. As a professional, Dr. Pruitt has been charged with the well-

being of his patients and his professional code calls for “...a workplace environment that supports respectful and collaborative relationships...” (American Dental Association, 2012). When considering this case, it is important to note that Dr. Pruitt’s employees are charged with helping him fulfill these professional obligations.

Professionals do not work alone. Every day, medical records clerks safeguard data, dental assistants sterilize and care for instruments, and research assistants carefully code data. No professional could provide these services without expert support. While it is the job of the supervising professional to select appropriate tasks for supporting staff and make sure they are properly trained and supervised, once duties are delegated, supporting staff members acquire corresponding professional and ethical responsibilities for the part of the professional service that they provide. This means that they too must be worthy of patient trust by acting responsibly in their roles and completing their duties in a way that honors the values and obligations expected of the profession. Thus, a medical records clerk should never violate confidentiality, even when tempted to gossip about what is learned at the job, dental assistants sterilize every instrument as if it would be used in their own mouths, and research assistants check and re-check data with the knowledge that careless errors could affect published results that influence patient care.

In this case, I am assuming that, as office manager, Ms. Stanley’s contribution to honoring these professional obligations is to provide leadership for the business aspects of the office. It also appears that she is involved in some human resources functions as

part of her job. Proper execution of her duties affects both staff and patients. This includes making sure that there is adequate staffing, helping set appropriate performance expectations for employees, and enforcing office policies that provide a safe and supportive working environment. Importantly, the moral pressure to carry out these duties—and to act on information that may have a negative impact on the office setting—is not lessened if others in the office, even her employer, are not honoring their obligations. It also does not logically follow that Ms. Stanley's responsibilities to the practice, the employees, and ultimately, the patients the practice serves are negated if the problem threatening the work environment is caused by the supervising professional who employs her. In fact, it may be that she is even more obligated to act in this situation, since she is likely the person in the practice who is best positioned to manage the problem.

Could this situation have been avoided? In hindsight, there were issues that should have been red flags that not all was well in the office: a certain amount of staff turnover is expected, but lots of staff turnover suggests work environment issues that needs to be addressed. Similarly, hiring friends such as Dr. Pruitt hiring Ms. Long, is a questionable practice that needed to be addressed at the onset of Ms. Long's employment. It should have been recognized that hiring friends and family may invite problems with dual relationships (such as causing problems with overlapping roles because of the blurring of work and personal boundaries) and can create staff issues because of the appearance of favoritism towards the friend-employee. This blurring of appropriate boundaries can become a slippery slope, and that is particularly relevant here, because

boundary violations are always present in sexual harassment. Finally, despite a description of Ms. Long's tardiness, absenteeism, and problems getting her work done, her work performance issues do not seem to have been addressed. There is no mention of performance standards, discussions of job expectations, or a performance improvement plan in place for Ms. Long's work difficulties. This laissez-faire approach to addressing performance issues adds to the problem of role conflicts and boundary violations. Taken together, these practices would make the work situation problematic, even without her report of an affair with Dr. Pruitt.

But perhaps the most concerning red flag for Ms. Stanley should have been the "occasional flirting" Dr. Pruitt engaged in with team members after hours. While this behavior may indeed have been "innocent," it is inappropriate in the workplace, and may have been experienced as unwelcome by employees who, because of their subordinate relationship with Dr. Pruitt, may not have felt comfortable expressing discomfort with this type of interaction. Such unsolicited sexual innuendo or banter, which is how this "flirting" may have been perceived by the staff, can constitute sexual harassment. This ethically problematic behavior was apparently commonplace and accepted in Ms. Stanley's workplace.

The ADA code calls for respectful and collaborative relationships, and sexual harassment represents the antithesis of these interactions. In addition to being illegal, sexual harassment involves an abuse of power by the professional that can create an atmosphere that dehumanizes the victim of the

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harassment. This environment harms the climate at the workplace and can result in an atmosphere of intimidation and shame for victims. Role expectations are violated, and appropriate workplace interactions are replaced by a breakdown of professional and personal boundaries. The deleterious effects of these interactions would be experienced by the entire team, affecting employees' performance in the practice, and ultimately their interactions with patients. If the inappropriate “flirting” created a hostile environment for women at the office (and Ms. Stanley admits she is not in a position to observe what goes on at the practice, so this is a possibility), a legal and ethical line was crossed. Ms. Stanley, in her role as office manager, needs to honor her professionally ascribed duties. She needs to take actions to assure a psychologically healthy work environment for the team, act in accordance with the ADA code which calls for respectful work relationships, and confront these pernicious behaviors.

It is unfortunate that Ms. Stanley did not act earlier because prevention can be useful in reducing the potential for harassment (Levin, 2010). In retrospect, Ms. Long needed to have a discussion with Dr. Pruitt long before her afternoon meeting with Ms. Stanley. As office manager, it would have been within her job responsibilities to point out the need for an office policy about appropriate behavior, to create an office manual that clearly outlined a procedure for handling issues of this sort, and to educate everyone, including Dr. Pruitt, about the types (quid pro quo and hostile environment) and legal consequences of sexual harassment. Likewise, the wisdom of hiring a friend should also have triggered conversation

about the potential problems with dual relationships (Donate-Bartfield & D'Angelo, 2000) and preventive actions to manage the potential problems caused by dual relationships in the work settings should have been initiated.

If true, Ms. Long's report that her job was threatened because of her unwillingness to continue a relationship with Dr. Pruitt would constitute quid pro quo sexual harassment. But the situation may be complex. While Ms. Stanley may have her suspicions about Dr. Pruitt's relationship with Ms. Long, and Ms. Long is in the subordinate position of power with respect to Dr. Pruitt because of her employee status, Ms. Stanley still needs to distinguish what she knows from what she suspects; she does not know for sure that Ms. Long's accusations are true. Moreover, Ms. Long's job performance has been problematic and it is possible that Ms. Long may be distorting facts to save her job. Since there is a need for more information to decide a course of action, and since resolution of this conflict could benefit everyone—by preventing Ms. Long's victimization and potentially keeping Dr. Pruitt from becoming involved in costly legal actions—Ms. Stanley is obliged to have an uncomfortable conversation with Dr. Pruitt about his relationship with Ms. Long (Chambers, 2009).

With Ms. Long's permission, Ms. Stanley needs to talk to Dr. Pruitt and hear his side of the story. Depending on Dr. Pruitt's response, Ms. Stanley should inform him of the potential consequences of his actions (including the need for possible legal counsel), the need for education, and creation of an office policy for employees on appropriate office relationships. If Dr. Pruitt denies the allegations, some actions to remediate the situation are in order: training for the staff, a performance improvement plan for Ms. Long to document performance

deficiencies and to assist her in meeting job expectations, increased awareness on Dr. Pruitt's part of the impact of his behavior on his employees and the need for appropriate professional boundaries with subordinates, along with written office policies to institutionalize these understandings. Referral to an employee assistance program, which can bring in a trained and objective mediator to deal with both workplace and personal fallout from workplace situations, can be of great value in helping in situations such as these, and Ms. Stanley can request consultation and make appropriate referrals.

On the other hand, if Dr. Pruitt admits to being guilty of the behavior Ms. Long has accused him of, Ms. Stanley is faced with a painful choice—she needs to hold herself to a professional standard that she acquired because of her association with Dr. Pruitt's professional obligations. This is a standard that the dentist is not honoring. This paradox places her in a situation similar to that of the “whistle-blower.” She needs to stand up for what is right, even though it will come with some costs. As evidence of this, her conversation with Dr. Pruitt may threaten her own employment, paradoxically placing her in a similar situation to Ms. Long.

Stumbling on a difficult moral problem that one has not created, while having to manage and suffer the consequences, feels like being in an accident. In some ways, Ms. Stanley is a victim. But what serves the principle of beneficence is clear: Ms. Stanley cannot support proper professional services for patients while tolerating illegal actions such as quid pro quo sexual harassment and cannot direct an office where inappropriate dual relationships and

corrosive work place behaviors are sanctioned without violating professional standards. Like any professional, she is honored to work in a setting that has the primary goal of improving peoples' health and eliminating their pain. She now has to act on the obligation that goes with that privilege.

COMMENTS by DR. PATHOFF

Like a wound ball of string, the nature of ethics and habits are such that pulling on any loose end will trigger a change elsewhere. Finding and identifying what will maximize values for all, though, are still ethical questions. If we listen carefully to these complex ethical issues through the theme of restorative-justice (a theory of justice that emphasizes repairing of harm through cooperation of all stakeholders), the proposition eventually surfaces that ethical deliberations ultimately should center more on care-and-love (not just rules-and-regulations). That said, rules-and-regulations and care-and-love are hard habits to nurture.

As a dental auxiliary, does Ms. Stanley have an ethical obligation to take action? Any proposal for Ms. Stanley will be influenced by natural habits. Habits grow from years of guidance and practice (desirable and undesirable), our own experiences (failure and success), and our observations of others. Any number of ethical decision-making frameworks (such as principles, virtues, rights, and casuistry) would accordingly be useful aids to some, if not all, of us.

Relevant laws regarding sexual harassment, if available, could also be referenced. The *ADA Code of Ethics* (2012) Section 3.E. Abuse and Neglect as well as Section 4, Justice and Fairness, offers professional guidance. Together, these raise further concerns about

criminal implications and possible reporting obligations or whistle-blowing.

Ms. Stanley may not, though, see herself as a professional, serving in a true professional practice. Professional practices fully integrate the well-being of the patient, society, and the profession as a first priority. She may not have a reasonably ranked set of professional core values to help her (and the others involved) to collaboratively identify any violations of verbal promises or any other moral, legal, business, or professional obligations. If Ms. Stanley held an adequate sense of any authentic professional reality—one that gets past the either-absolute-or-relative dichotomy—she could find a path for structured reasoning and a foundation for sound judgment.

Because Ms. Stanley is an office manager, working in a professional office, her actions may require professional obligations in addition to those of normal civil rights or fair-trade practices. Though she is not a licensed professional, she is a person who must act professionally because she represents, and is an extension of, a particular dental professional and a licensed profession. Her “boss,” however, may not model or articulate professionalism. Her professional acting role, nevertheless, can be comforting and consoling to Ms. Stanley. A sense of professionalism will make public any over-dependence on individual judgments, those marketplace judgments and reactions that tend to supersede the reality that we also live in community; we depend on each other, and an Other for our very being and our daily survival.

The central challenge to dentists as professionals—and to dentistry as a profession—is the problem of submergence of professionalism in marketplace values and motivations. Our marketplace's dependence on individual judgments tends to override our continuing need to apply recognized expertise to serve the patient's needs. Professional ethical challenges for dentists and their offices ultimately concern prioritizing professional values and commitments over marketplace values and motivations. Professions have three distinct social and ethical characteristics: professional expertise, professional authority, and professional ethics (Patthoff, 2007).

These characteristics transfer to Ms. Stanley. What professionalism looks like in a dentist's competent and ethical practice and consequently, the interactions of the rest of the office staff with patients, with the dentist, and with one another is detailed elsewhere (Patthoff & Ozar, 2012). Staff should perform assigned tasks competently, respect the competence and contributions of co-workers, interact with patients in a respectful manner (consistent with the dentist's ethical goal of an ideal collaborative relationship with every patient). They need to understand dentistry's central practice values and make them primary in their work (Ozar & Sokol, 2002). These values are for the sake of patients; the reason dentistry is a profession in the first place (Patthoff & Ozar, 2008a; 2008b).

Some staff members directly focus on office efficiency or the market success of the business. The professional-patient interaction, however, is profoundly

different from the seller-consumer interactions in the marketplace; this needs to be reflected in everything the office does. This involves direct patient interactions and, in different ways, administrative situations like those faced by Ms. Stanley.

Any habit of professional virtue is the culmination of a process. It begins with recognition, by an individual and—in the case of an office—by a group collectively, that a certain way of acting is valuable enough that all ought to learn to do it habitually. A conscious effort to act this way over and over should ideally follow, and then, every time this pattern of action fits. A desired way of acting needs to be adapted as called for and, simultaneously, reinforced as a habitual response to pertinent situations. Offices may not be proficient in novel situations. With time, though, less conscious attention is required to produce a predictable response. These responses need to be continuously reevaluated, however, for appropriateness and effectiveness.

Even when a desired habit becomes unconscious, the process is incomplete. Full development of a virtue also requires that:

- The virtuous action happens every time it is appropriate—and usually with little effort and minimum attention.
- The person or group becomes spontaneously aware of circumstances that frequently challenge or inhibit the desired virtuous action and learns a collection of responses that ease the decision-making process.

Addressing “shortfalls” is not primarily about the initial learning process—for instance a new member who knows little about professionalism. Most dental offices, presumably, have many habits of professionalism already established for every staff member. Ms. Stanley's focus is on how her office

can take the next step towards full development of professionalism through consistent competent and ethical conduct.

This brings us to shortfalls—occasional shortfalls and systemic shortfalls from perfect professionalism. Systemic shortfalls imply that an office may not have ample real habits of professionalism, and obviously would be facing a great deal of remedial work. It is hoped that this is not Ms. Stanley's situation. Until more is known, then, we should first consider the occasional shortfall.

Competent practice and ethical conduct has four general kinds of occasional shortfalls: (a) a common situation arises but what professionalism calls for is not deemed important in the situation; (b) a common situation arises but a person is uninformed what professionalism concretely calls for or how to do it; (c) a common situation arises but other concerns so burden a person that what professionalism calls for gets pushed aside; and (d) something totally unexpected or out of the ordinary makes it hard to decide what professionalism calls for or how to do it.

In an ideal professional dental office, the first two shortfalls are unlikely, except for a few new staff members. Respectful education, by the dentist or another staff member (depending on the situation) is obviously what is called for when such shortfalls occur.

The third type of shortfall happens because busy offices are not always running smoothly and peacefully. Dentists and staffs need to take careful note, then, of the third type of situation and work out ways to address them. This is like an individual learning how to avoid enticements that sway away from a true or desired virtue. Some patterns of shortfall may be preventable with appropriate foresight, others may

not. By noting their patterns, the office will not be blindsided. Everyone involved will be aware that extra care and generosity, not only towards patients, but towards one another in the office, is essential to acting their professional best in spite of special circumstances.

The fourth type of shortfall, by definition, does not follow a pattern. It cannot. This does not mean, though, there is nothing an office committed to professionalism can do. In some situations, time can be made to consult with the dentist or other staff to help decide what professionally ought to be done and how to respond. If there is no time for this, the person must then make a best professional judgment and proceed. The situation can at least, then, be examined by the dentist and staff after the fact. In this way, whatever is done can become, either at the time or after the fact, something that is “owned” and affirmed by the whole office team. Others might disagree with what a person involved judged best; a respectful conversation though, affirms the good will and best intentions of the person involved (affirmation for trying one’s best does not need consensus). Everyone’s efforts to practice dental professionalism can still be mutually honored.

A shared desire by every member of the office—professionals and non-professionals—to grow together towards fully developed professionalism in the office requires a shared recognition that every individual’s efforts in this matter at hand needs to be respected and supported by every other member. This is a lofty goal. It requires a special kind of honesty and humility on the part of

all (professionals and nonprofessionals) alike. It is uncertain how many office managers can rise to this level of discussion. Ms. Stanley and others face the real risks of losing their jobs and struggling with the process of wrongful discharge claims. If we are looking at what “should” be done, nonetheless, this points the way.

What Should Ms. Stanley Do? Ms. Stanley could approach Dr. Pruitt, perhaps with the support of Ms. Long (if she desired) or with a trained restorative justice mediator, to simply say something like this:

We want this to stay confidential and fear we should have spoken out sooner. I’m concerned about this practice and my role in it, especially regarding the revolving employees. I have sensed something less than professional in the comments of our team about our office interactions and relationships ever since I have been here. Given the new legal climate, I am concerned I may no longer have a job. Before I became an administrator with you, I had some sense of what dentistry and the profession are and what my role in this ought to be. Over these past 15 years my appreciation and pride has grown. I’m in a situation, though, where all of that is being challenged.

I think we can be better than we have been. To do that, though, we need to review our agreements about what professionals and professional practices are and what they should do and be. We can start with what we are already doing and, equally, perhaps change a few things that are not getting us there. A few important things need to change if I am to stay here. I am responsible for keeping our busy office running smoothly and I want to start with why Ms. Long, who was

The office manager needs to take actions to assure a psychologically healthy work environment for the team, act in accordance with the ADA code call for respectful work relationships, and confront these pernicious behaviors.

The office manager cannot support proper professional services for patients while tolerating illegal actions such as quid pro quo sexual harassment and cannot direct an office where inappropriate dual relationships and corrosive workplace behaviors are sanctioned without violating professional standards.

once a great employee, now seems so depressed. I am beginning to think she may need medical help and that I am not being responsible about the health of our staff. She looks sick and is not seeing a doctor. I think she's afraid of letting us down but sense she still wants to work here.

CONCLUDING COMMENTS

Sexual conflicts and deception in relationships will always stir strong emotions from those involved and those looking in. In a professional setting, such scenarios become even more complex as professional duty and responsibility are challenged. In this case Ms. Stanley's personal and professional ethics are tested. All three authors agree that some action is required.

Specific recommendations for action vary somewhat from expert to expert. All three agree that professional obligations supersede the impulse to either withdraw from the fire or feed it. The professional ethics at work in a dental office are there to protect the public as well as the profession. These duties, as articulated in this case analysis, do not only belong to the owner-dentist but to all those who are employed in that office. When the owner dentist is the offending party, these obligations do not end; in fact, those who must pick up the pieces and carry on may be forced to exhibit moral courage at the highest level. ■

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2013 MANUSCRIPT REVIEW PROCESS

Five unsolicited manuscripts were received for possible publication in the *Journal of the American College of Dentists* during 2013. Three were sent for peer review. One manuscript was accepted for publication; one was returned for extensive modifications; and one was not accepted. Twelve peer reviews were received for these manuscripts, an average of 4.0 per manuscript. Consistency of reviews was determined using the phi coefficient, a measure of association between review recommendations and the ultimate publication decision. The phi was .482, where 0.00 represents chance agreement and 1.00 represents perfect agreement. The College feels that authors are entitled to know the consistency of the review process. The Editor also follows the practice of sharing all reviews among the reviewers as a means of improving calibration.

Instructions for authors and instructions for reviewers can be found on the Web site of the College. Journal reviewers are encouraged to use a sequential set of standards in evaluating

manuscripts. The first concern is that the manuscript presents a topic of significant interest to our readers. Those that meet this criterion are evaluated for absence of bias in the presentation. The third standard is clarity of presentation.

The Editor is aware of three requests to republish articles appearing in the journal received and granted during the year. There were no requests for summaries of recommended reading associated with Leadership Essays.

The College thanks the following professionals for their contributions, sometimes multiple efforts, to the dental literature as reviewers for the *Journal of the American College of Dentists* during 2013.

Marcia Boyd, DDS, FACD
Vancouver, BC

R. Bruce Donoff, DMD, MD, FACD
Boston, MA

Brook Loftis Elmore, DDS
Leander, TX

White S. Graves, DDS
Monroe, LA

Peter Greco, DMD, FACD
Bryn Mawr, PA

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East Lansing, MI

William A. Van Dyk, DDS, FACD
San Pablo, CA

James Willey, DDS, FACD
Chicago, IL

Stephen K. Young, DDS, FACD
Oklahoma City, OK

Submitting Manuscripts for Potential Publication in JACD

Manuscripts for potential publication in the *Journal of the American College of Dentists* should be sent as attachments via e-mail to the editor, Dr. David W. Chambers, at dchambers@pacific.edu. The transmittal message should affirm that the manuscript or substantial portions of it or prior analyses of the data upon which it is based have not been previously published and that the manuscript is not currently under review by any other journal.

Authors are strongly urged to review several recent volumes of *JACD*. These can be found on the ACD Web page under “publications.” In conducting this review, authors should pay particular attention to the type of paper we focus on. For example, we normally do not publish clinical case reports or articles that describe dental techniques. The communication policy of the College is to “identify and place before the Fellows, the profession, and other parties of interest those issues that affect dentistry

and oral health. The goal is to stimulate this community to remain informed, inquire actively, and participate in the formation of public policy and personal leadership to advance the purpose and objectives of the College.”

There is no style sheet for the *Journal of the American College of Dentists*. Authors are expected to be familiar with previously published material and to model the style of former publications as nearly as possible.

A “desk review” is normally provided within one week of receiving a manuscript to determine whether it suits the general content and quality criteria for publication. Papers that hold potential are often sent directly for peer review. Usually there are six anonymous reviewers, representing subject matter experts, boards of the College, and typical readers. In certain cases, a manuscript will be returned to the authors with suggestions for improvements and directions about conformity with the style of work published in this journal. The peer review process typically takes four to five weeks.

Authors whose submissions are peer reviewed receive feedback from this process. A copy of the guidelines used by reviewers is found on this site and is labeled “How to Review a Manuscript for

the Journal of the American College of Dentists.” An annual report of the peer review process for *JACD* is printed in the fourth issue of each volume. Typically, this journal accepts about a quarter of the manuscripts reviewed and the consistency of the reviewers is in the phi = .60 to .80 range.

Letters from readers concerning any material appearing in this journal are welcome at dchambers@pacific.edu. They should be no longer than 500 words and will not be considered after other letters have already been published on the same topic. The editor reserves the right to refer submitted letters to the editorial board for review.

This journal has a regular section devoted to papers in ethical and professional aspects of dentistry. Manuscripts with this focus may be sent directly to Dr. Bruce Peltier, the editor of Issues in Dental Ethics section of *JACD*, at bpeltier@pacific.edu. If it is not clear whether a manuscript best fits the criteria of Issues in Dental Ethics, it should be sent to Dr. Chambers at the e-mail address given above and a determination will be made.

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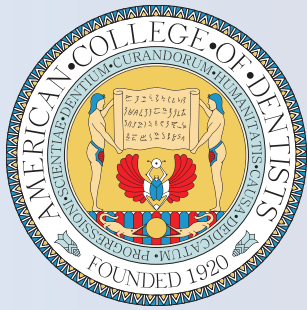


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