

TRANSITIONING
FROM PRACTICE

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Journal of the American College of Dentists

A publication advancing
excellence, ethics, professionalism,
and leadership in dentistry

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It is the communication policy of the American College of Dentists 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. The College is not a political organization and does not intentionally promote specific views at the expense of others. The positions and opinions expressed in College publications do not necessarily represent those of the American College of Dentists or its Fellows.

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

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Cover photograph:
There are no ends,
only transitions that
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FROM THE EDITOR

LEADERSHIP—MORE, PLEASE

Let's look a little more closely at the part about "potential." Fellows are expected to continue their leadership following induction.

Leadership is one of the strange virtues. No one is criticized for having too much. Aristotle's list of virtues came with a warning about the "golden mean." There was danger in excess courage, pride, benevolence, and even justice as well as in too little.

We escape the threat of excessive leadership when we recognize that it is not actually a characteristic of those who are given titles. It is about a relationship between some of us and the rest. I use the term leadership to mean a capacity to get others to work together effectively to accomplish something very important to them. Having the title does not make one a leader, having the responsibility does not do the work either. Surprisingly, truckloads of charm, devastating interpersonal skills, oodles of resources to trade for cooperation, and having one's name on the letterhead are all nice, but not proof of leadership. It has been said cynically that a leader is someone who knows where he or she is going and has followers. Having followers who are better for the leader's behavior is the key point.

You are a leader. That is how individuals get into the American College of Dentists. You will find the following language on the inside front cover of every issue of this journal: among the

objectives of the college is to "recognize meritorious achievements and the potentials for contributions to dental science, art, education, literature, human relations, or other areas which contribute to human welfare."

Let's look a little more closely at the part about "potential." Fellows are expected to continue their leadership following induction.

The regents have been exploring the meaning of leadership potential for about three years. It is critical to the future of the college. They asked me to survey the leadership trajectories of fellows, and then, based on these results, they asked for information about whether fellows of the college exhibit any different career leadership path than other dentists do. Here is what we found in studies of almost 200 fellows and 700 dentists who graduated from four representative schools in the United States who are not fellows of the college.

The first two accompanying graphs on page 3 show the extent of leadership engagement in dentistry, education, and scholarship of fellows and non-fellows over ten-year segments in their careers. Figure 1 reflects holding any leadership positions—from social chair in a component society to member of the editorial board of a prestigious journal to president of the ADA. Figure 2 adjusts leadership by weighing positions for the size of the constituency and the level of the office.

In both graphs ACD members are more likely to hold leadership positions,

to hold more influential positions, and to hold them longer than are other dentists.

There was also a question on the survey asking about the most important characteristics of leaders. Across the board, leaders can best be distinguished by the extent to which they embody ethics in their public lives. And fellows in the college are more likely to call out this virtue than are other dentists.

But there is a cloud hanging over these data. Although leadership accomplishment is clearly visible as early as dental school, leadership only gradually increases until about age 45-55, and then it drops precipitously about age 65. The average age of inductees into the college is 55. For more than a decade, the average age at induction has increased one year every three years. We are picking more of the fellows who have passed the peak of their active leadership in dentistry. Obviously, this pattern is not sustainable.

In the first issue of the *Journal of the American College of Dentists* in 1934, there is a statement of intent with regard to selection of fellows. Two paths to fellowship are laid out: one for “leaders in the community” and one to “stimulate young men [and it is hoped women as well] to engage in advancing the profession.” There is a minimum of ten years to establish eligibility for recognition under the first category, but not under the second, where the term “young” appears to intentionally signal early selection for fellowship.

FIGURE 1. Percentage of any leadership participation (rate of leadership involving) across career segments for fellows of the American College of Dentists and for a sample of non-fellow graduates from four dental schools.

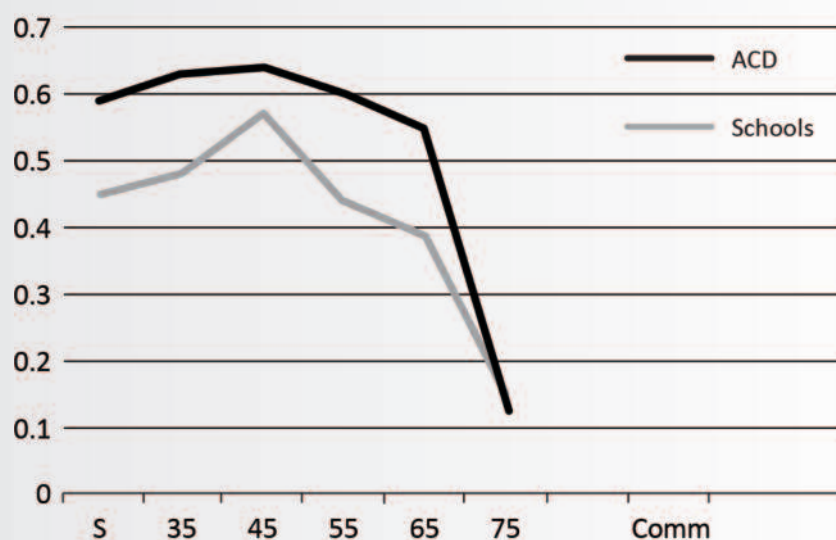


FIGURE 2. Extent of leadership involvement (weighted participation) reflecting number of activities, level of responsibility, and size of constituency across career segments for fellows of the American College of Dentists and for a sample of non-fellow graduates from four dental schools.

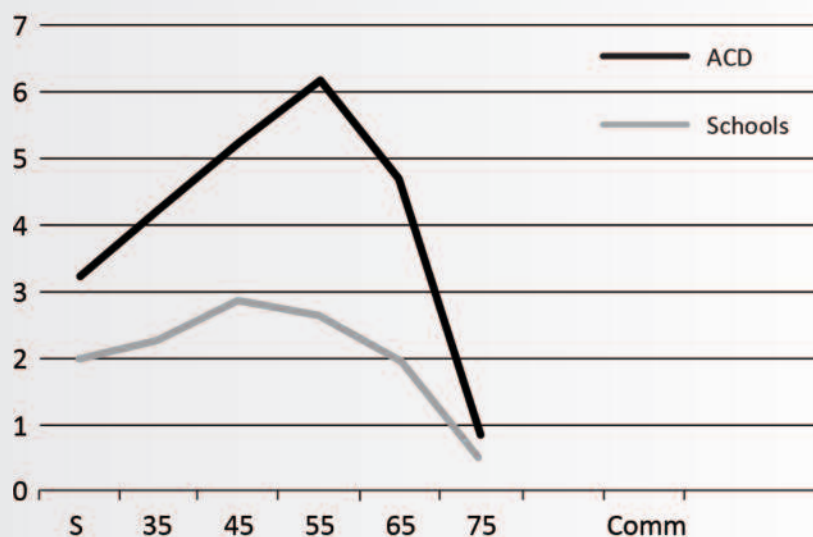
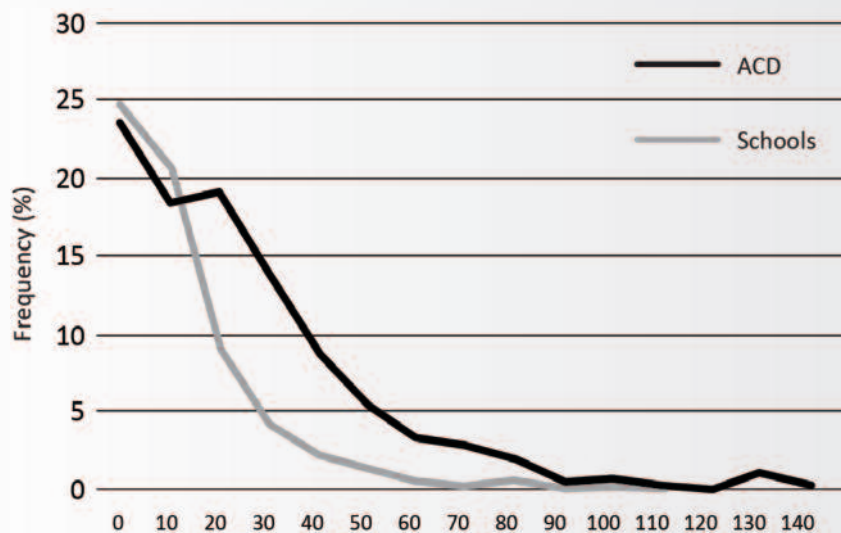


FIGURE 3. Frequency distribution of weighted participation in leadership for fellows of the American College of Dentists and for a sample of non-fellow graduates from four dental schools.



Our greatest resource is a strong and active leadership core that we share with other parts of the profession.

Figure 3 speaks to the distribution of ACD inductees in these two categories. Fellows of the college are clearly over-represented, compared with dentists generally, among those who hold 20 to 60 leadership positions over their lives, and there are some in the right-hand tail who are awe-inspiring models with more than 100 such career contributions. But there are also about a quarter that have almost no leadership contributions to the profession. They have entered the ACD on the strength of their many years of service to their communities.

The American College of Dentists is most effective by setting the standard or ideal for the best in dentistry and by making an ethical model known throughout the profession. Ethics is contagious. And it works best by transmission from leaders in the college to leaders in all other organizations. Our greatest resource is a strong and active leadership core that we share

with other parts of the profession. The strength of the college can be measure by the leadership *potential* of the fellowship. We grow in strength as more fellows come in that have a future of active leadership positions in related organizations in front of them.

“But how,” it might be asked, “can we be sure that younger members of the profession will be leaders until we see what they did?” A better question might be “how soon are there actionable indications that leadership potential is there to help the profession?” The answer is surprisingly simple: There is a very strong and statistically significant association between leadership in dental school and the first years of practice to predict who will become the profession-changing leaders at the peak of their impact around age 50. That is why the founders of the college established a minimum of ten years for the “good citizen” path to fellowship and there is no minimum age requirement for fellowship through leadership in the profession.

The college needs individuals who have the potential for getting the profession to work together to accomplish what needs to be done. We have not yet identified all of those who fit that criterion.

Dr. W. Johnson

LETTERS TO THE Editor



To the Editor,

Regarding the spring and summer 2014 issues on dental students and charity dental care, I would like to make the following observations.

It seems to me that professional ethics dictate that we as health care professionals live a life of giving right from the initiation of becoming a dental student. After 47 years of practicing, it is clear to me that there is never a time when we are perfect in our abilities, skills, techniques, or services. That must be why the professions have always been “practiced” rather than “performed!”

To assume a posture of perfection in all we do is inviting the impossible as a requirement. Perfection is a dangerous taskmaster. On the other hand, those who set goals and achieve even lofty goals, without the necessity of “perfection in all,” often set glowing examples for others to follow.

People often “give” what they no longer need. They consider used but still of value in context. Used handpieces, dental instruments, sterilizers, dental lights, compressors, generators, and

vacuum units still can function to save the dental health of many underserved, underprivileged peoples of this world.

Some of the ideologues of our dental profession demand perfection on the mission field or else not go. How unconscionable! Why would one deny the people of the undeveloped and underserved world *any* care just because it is not possible to provide USA private dental office equivalent care on the mountains, valleys, and plains of human dental need outside our smug USA world? Ideologues in their ivory towers bemoan the plight of poor humanity at the hands of dentists, dental students, staff, and volunteers on mission trips.

Reject the ideologue who delights in making dental students, staff, volunteers and practitioners feel dirty and mean spirited for helping others in desperation who walk miles and days for care, who sit quietly and patiently for hours just to be seen by someone with compassion and skill greater than anyone they know or ever have known or may ever see again! Reject the assuming ideologue who has not walked in the shoes of those generous and selfless dentists, dental students, staff, and volunteers who provide care to the helpless of

this world. We need more of the missions-minded dental personnel and fewer of the “expert” critics!

Having provided care for many people in such desperate settings for over 38 years, I applaud others who have done the same all over this world. It is time to speak up for the thousands of dentists and dental students who sacrifice time, money, and pleasures on spring break and other brief occasions in serving the world as best they know how.

The profession of dentistry owes a huge debt to our “giving” volunteers for their service to mankind through missions, both at home and abroad. Why don’t you join the chorus and sing praises to someone you know who does dental missions. Maybe you could join their team and become a real “giver” yourself. That can mean some lasting joy and job satisfaction plus a possible cure for the ideologue and perfectionist.

T. Bob Davis, DMD, FACD
Dallas, Texas

THERE ARE SOME PROBLEMS THAT REQUIRE OUR IMMEDIATE ATTENTION

Jerome B. Miller, DDS, MSD, FACD

ACD PRESIDENT-ELECT'S ADDRESS

October 8, 2014
San Antonio, Texas

Thank you for allowing me this opportunity to share my ideas about the college and my vision of its mission during the coming year. It is with a great deal of humility and pride that I will serve the college as your president for the coming year.

We have never been in a better time for dentistry than we are today. There has never been a greater demand for dental services. We have more opportunities to do things for our patients with new materials and techniques than ever before. We are extremely fortunate in our profession that in the past we have enjoyed high respect from the public and we have been basically autonomous with only minimal intrusion into our treatment of patients. This has made dentistry a most desired profession.

All this being said, the profession currently faces a number of problems and potential dangers. It has been said that change is not optional—it is inevitable. Change is now rapid and ever-present for us. We are seeing student educational and practice start-up debt continue to escalate. There is experimentation with new delivery models, many of which are administered by business interests that do not follow ethical principles. Government regulations and restrictions place barriers between patients and those seeking to serve them. Well-intended affordable health care laws have had unintended consequences. Shifts in patient and dentist demographics, issues

of social media, and drifting social values affect each of us, but seem bigger than anyone can control.

I believe all of these issues or problems, if you wish to call them such, are fixable or at least can be managed. But there is one factor that can and will sink us as a profession and could cause us to lose our autonomy. I am referring to the public's changing perception of the dental profession. In recent Gallup polls, dentistry is now fifth or sixth as the most trustworthy and ethical profession. Dentistry now ranks lower than physicians, pharmacist, nurses, and even engineers. How can we as a profession and as leaders of the profession maintain our position of public trust and halt the erosion of our professional image? This is an interesting and profound question!

This is where the college—the American College of Dentists—can and is making a difference. No other organization or body in dentistry is as dedicated to doing this as is our college. The college has always sought and maintained a reputation as being the conscience of dentistry, with ethics and leadership as our principal goals and objectives. The college is and has been working hard to promote ethics in dentistry. Other organizations profess ethics as an objective, but the American College of Dentists has made it our prime objective.



Dr. Miller maintains a private practice limited to pediatric dentistry in Oklahoma City, Oklahoma; jbmillerdds@yahoo.com

The college has developed a number of programs, many of which are interactive, that encourage and emphasize the importance of ethics in dentistry. These resources are free, engaging, and are readily available online. More than 47,000 of these courses have now been completed for continuing education or course credit. In this way, the college is influencing and encouraging the ethics of the practice of dentistry for many at the grassroots level. We, as college fellows should inform our colleagues of these programs and encourage their participation.

You might ask, what can a fellow of the college like me do as an individual to promote ethics in the profession? Certainly the first step is to recognize there is a problem out there. We all know or suspect colleagues that do things that seem a “little shady” to us. Should we just ignore them and go on our blissful way or should we try to change such behavior? We know for sure that the one thing that an unethical individual fears is “the light of day.” Unethical individuals and unethical practices hate to be exposed to the public and their peers. This does not mean you have to make public announcements of unethical transgressions, but if the purveyor of such behavior knows he or she is going to be exposed, it proves a powerful deterrent. To expect this will stop the intransigent unethical individual is a little misguided. To turn the other way is to be misguided in a major way. If we can curtail or in some cases alter such unethical behavior, then

we are going down the path to create a better ethical environment in the profession. I content that if unethical individuals know someone is watching there will be fewer of them.

During our Board of Regents meeting in San Antonio this week, we learned that an anonymous donor has pledged up to one million dollars as a matching gift for all of those who give to the college for the next 12 months. Your donations will be used to support a special project of the ACD—something that has never been attempted before. We plan to prepare a comprehensive report on the current state of ethics in the dental profession and what is needed to keep it strong. This study will be modeled on the famous 1926 *Carnegie Report on Dental Education* written by William Gies. The project is expected to take up to three years and to be comprehensive and fact-based. I encourage you to give to this worthwhile project. Your donations will be tax deductible if given through our foundation. Embrace this project as though it mattered a great deal to the future of the profession—it does.

An exciting development in furthering ethics in dentistry has been occurring in recent years at our dental schools. Most of you know many dental schools now have dental ethics clubs established within the dental school—not formally established or sponsored by the school, but organized and managed by students

But there is one factor that can and will sink us as a profession and could cause us to lose our autonomy. I am referring to the public's changing perception of the dental profession.

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themselves. These clubs are called SPEA—Student Professionalism and Ethics Associations. They have become very popular, and we now have clubs in most dental schools in the United States. The American College of Dentists and its members have been and are active in supporting these clubs. The facts that dental students realize that ethics are important to them and their future profession is a great sign.

A perception held by many for too long is that the ACD is made up of a bunch of “old gray-haired men” that are out of touch with the marketing and delivery of modern day dental care. That was never true, nor should we let it become the case.

In recent years, the last ten or so, we as a college have come to realize that we need younger leaders to be college fellows with demonstrated potential to make a difference to the profession. How much better to engage them before their leadership prime has past. If we at the college are about leadership, ethics, and professionalism, then we need these young professionals who already have the respect and admiration of their peers to join us. In this way they can serve as examples for others. So the college has and is placing emphasis on identifying young leaders earlier and nominating them for fellowship sooner. I encourage every fellow to identify at least one qualified candidate and sponsor him or her for fellowship this next year.

In summary, dentistry has a very bright future, one full of opportunity. But there are some significant challenges. The good news, and it is good news indeed, is that the steady hand guiding the profession is yours.

Remain active; speak boldly about ethics; recruit and mentor the next generation of leaders. Do not let anyone else do this. I believe the problems we face today are all resolvable.

The one challenge facing the profession which could doom us as a respected profession is the loss of public trust and confidence. If we continue to see erosion in the ethics and professionalism in dentistry, the public could and should rightfully take away our autonomy. We could become a publicly operated trade with little or no professional guidance or control. If we want the public's trust we must act in an ethical and professional manner, always doing what is best for the patient. We must all understand that you do not demand or command trust, we earn it.

Our job as the American College of Dentists, with the reputation of being the conscience of dentistry, is to ensure that we as a profession earn and deserve the public's trust. The dental profession is at a tipping point. Since our inception in 1920, the American College of Dentists has met many other such challenges, and we can and will make the difference in this effort.

I know many of you personally, and I have watched with profound admiration year after years as each fellowship class steps forward. I know for certain that your colleagues, your patients, and the public at large respect you personally and what you stand for. Do not let that gift remain a closely guarded personal attribute. Share it. It is needed, now. ■

2014 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 the area of ethics. The American College of Dentists recognizes **Healthy Smiles, Healthy Children (HSHC)**, the Foundation of the American Academy of Pediatric Dentistry, as the recipient of the 2014 Ethics and Professionalism Award.

- Founded in 1987, HSHC is the \$14.9 million charitable arm of the American Academy of Pediatric Dentistry (AAPD).
- HSHC's mission is to support community-based initiatives providing dental homes to children from families who cannot afford dental care.
- Since 2010, HSHC has provided more than \$1.8 million in Access to Care Grants and commitments to 48 organizations in 18 states, and grantees have helped provide dental homes to more than 118,000 children.
- In 2014, HSHC made \$1.1 million in Access to Care Grants, including

multiyear Access to Care Grants of \$375,000 each to organizations in Pennsylvania and Texas.

- In 2013, HSHC introduced its first annual "Dental Home Day," an event where AAPD members and affiliated volunteers provide dental care for underserved children in the host city of the AAPD Annual Session. HSHC supports care during the day-long event and also provides grant support for the continued care of participating children.
- In November, HSHC teamed with the American Dental Association's "Give Kids a Smile" (GKAS) initiative in partnership with 3M ESPE and NASCAR. GKAS conducts school-based oral health education programs during race week. HSHC is sponsoring the GKAS program in Phoenix and has issued a one-year Access to Care Grant to a Phoenix clinic that will provide dental care to underserved children participating in the GKAS school education program.
- HSHC invests in kids by cultivating future dental leaders through two tiers of intensive university-based leadership training.
- The AAPD and HSHC collaborated in creating a program that will allow dental leaders to better service their patients, their staff, the dental profession, and their communities.
- The Leadership Institute at the Kellogg School of Management at Northwestern University is a three-

year program for 30 students attending on-campus courses over four days each December. The fourth Leadership Institute convened in December 2014 and more than 120 individuals have completed the required coursework since the program began in 2004.

- The Advanced Leadership Institute at the Wharton School at the University of Pennsylvania builds upon the Leadership Institute curriculum, challenging students to apply Kellogg and new Wharton experiences to issues facing child oral health. Advanced Leadership Institute sessions convene every three to four years with a yearlong program featuring two on-campus sessions, remote group work, and final presentations to the AAPD Board.
- Leadership Institute and Advanced Leadership Institute graduates are sought-after candidates for leadership roles within the dental profession and the public sector. Currently, 18 Leadership Institute graduates serve on HSHC committees, including 10 who serve as HSHC Trustees. Many more have applied their Leadership Institute and Advanced Leadership Institute learning to their community efforts, both in and out of dentistry.

Accepting the award for Healthy Smiles, Healthy Children is Dr. Beverly Largent, 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. This year there are two recipients of the William John Gies Award.



The first recipient of the 2014 William John Gies Award is **Dr. Patricia L. Blanton**. Dr. Blanton is recognized for her

extraordinary record of leadership and accomplishment in dentistry and her community. She is held in the highest regard throughout the profession. Dr. Blanton has been a driving force in dentistry, and she is widely recognized as one of the profession's key leaders. Her accomplishments are substantial and far reaching, and she has made an indelible positive impact on dentistry. Highlights of Dr. Blanton's record include:

- DDS, Baylor College of Dentistry
- PhD, in human anatomy, Baylor University
- Diplomate, American Board of Oral Medicine
- Professor emerita, Department of Biomedical Sciences, Baylor College of Dentistry/TAMUS
- Volunteer clinical professor, Department of Stomatology, MUSC
- Chair, Department of Gross Anatomy, Baylor College of Dentistry
- President, Dallas County Dental Society
- President, Texas Dental Association
- President, Texas Society of Periodontists; past president, Southwest Society of Periodontists

- Vice president, American Dental Association
- Member, American Dental Association, Council on Scientific Affairs
- Delegate, American Dental Association
- President, American College of Dentists
- President, American College of Dentists Foundation
- Consultant, American College of Dentists Foundation
- Chair, Texas Section, American College of Dentists
- Member, Board of Directors, Baylor Oral Health Foundation
- Patricia L. Blanton Library, Baylor College of Dentistry
- Recipient, Lucy Hobbs Taylor Woman Dentist of the Year, American Association of Women Dentists
- Recipient, Dentist of the Year, Dallas County Dental Society
- Recipient, Lifetime Achievement Award, Dallas County Dental Society
- Distinguished alumna, Baylor College of Dentistry
- Distinguished alumna, Advanced Training Program in Periodontics, Baylor College of Dentistry/TAMUS
- Distinguished alumna, Hardin-Simmons University
- Invited presenter, numerous national and international dental venues



The second recipient of the 2014 William John Gies Award is **Dr. Arthur Ingram Hazlewood**. Dr. Hazlewood is recognized

for his truly exceptional leadership and accomplishments in dentistry, dental public health, education, humanitarianism, care to the underserved, dental advocacy, and global outreach. He has worked tirelessly to address health care needs and care for the less fortunate. His record is extremely impressive, and he is held in the highest regard by his

peers, nationally and internationally. Dr. Hazlewood's achievements and contributions include:

- DDS, College of Dentistry, Howard University
- MPH, School of Public Health, Columbia University
- Diplomate, Board of Special Care Dentistry
- Assistant commissioner of health and director, Bureau of Health Care Administration, Nassau County Health Department, New York
- Founding faculty member, New York State Dental School at Stonybrook
- Adjunct professor, Department of Community and Preventive Medicine, New York Medical College
- Director, Planning and Program Development, New York City Health and Hospitals Corporation
- Director of dental affairs, New York City Health and Hospitals Corporation
- Medical director and director of dentistry, Morrisania Neighborhood Family Care Center
- Co-chair, Joint ADA and Health and Hospitals Corporation Task Force on Dentistry
- President and chair, American Association of Hospital Dentists
- Regional vice president, American Association of Hospital Dentists
- Member, Executive Committee, Federation of Special Organizations in Dentistry
- Chair, New York Section, American College of Dentists
- President, National Academies of Practice
- Member, Governor's Advisory Task Force for New York
- Recipient, Outstanding Service Award, American College of Dentists
- Recipient, Physician of the Year, Our Lady of Mercy Medical Center, New York

- Recipient, Award of Distinction, Academy of Dentistry International
- Recipient, Distinguished Alumnus Award, Howard University, Washington D.C.
- Recipient, Larry Chasko Award, American Association of Hospital Dentists
- Recipient, Distinguished Fellow, National Academies of Practice
- Recipient, Humanitarian and Service Award, Guyana Consulate
- Provided consulting and advisory services to Republic of Guyana, Hamilton Ontario, Ghana, Barbados, Peru, United Nations Development Program, Health and Human Services, National Institutes of Health, and advisory services to Dongyang Peoples Hospital, China

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.



The first recipient of Honorary Fellowship is **Dr. Robert E. Boose**. Dr. Boose is the executive director of the Massachusetts Dental Society and in this capacity has directed its day-to-day operations for over 12 years. He has more than 40 years of exceptional leadership experience covering a variety of positions and responsibilities. Dr. Boose is widely respected by his peers. He is a true visionary who is able to effectively

address the demands of a dental society in the twenty-first century. Highlights of his accomplishments and credentials include:

- EdD, vocational business education, Temple University
- Executive director, Massachusetts Dental Society
- Vice president, Endicott College
- Dean, School of Graduate and Professional Studies, Endicott College
- Executive director, New Jersey School Boards Association
- Commissioner, Maine Education and Cultural Services
- Executive director, New Jersey County College Association
- Superintendent of schools, Mercer County, New Jersey
- Deputy assistant commissioner, intergovernmental relations, New Jersey Department of Education
- Adjunct graduate school professor positions, Rutgers University and College of New Jersey
- Certified teacher of hearing impaired children, Pennsylvania School for the Deaf
- Major, Adjutant General Corps, U.S. Army inactive reserve



The second recipient of Honorary Fellowship is **Ms. Grace Deshaw-Wilner**. Ms. Deshaw-Wilner is currently managing vice president of professional affairs for the Michigan Dental Association. In that capacity she has helped guide thousands of Michigan dentists through the peer review process. She has unselfishly provided educational programs on ethics and professionalism for both dental and non-dental groups. Ms. Deshaw-Wilner has worked tirelessly to establish a unique working relationship with the

state's Board of Dentistry to benefit both Michigan and the profession. Ms. Deshaw-Wilner's accomplishments include:

- BA, psychology, Michigan State University
- Managing vice president of professional affairs, Michigan Dental Association; she was formerly responsible for the Departments of Ethics, Peer Review, Human Resources, Board and House of Delegates, Care and Well-Being, and Practice Management/Legal
- Interim executive director, Michigan Dental Association
- Special consultant to the Michigan Dental Foundation
- Certified association executive (CAE), American Society for Association Executives
- Member, American Dental Association-TRIO teams' committee
- Presenter, various ADA conferences and sessions
- Member, secretary, chair-elect, chair of the board, and immediate past board chair, and various committee leadership positions, Michigan Society of Association Executives (MSAE)
- Recipient, MSAE Chairman's Gavel Award in 1997 and MSAE Key Award in 2009
- Author, multiple *Journal of the Michigan Dental Association* publications and the magazine of the Michigan Society of Association Executives



The third recipient of Honorary Fellowship is **Dr. N. Karl Haden**. Dr. Haden currently serves as president of the Academy of Academic Leadership, an organization he founded. He has a superior record of impressive contributions and accomplishments on the most compelling issues facing dental education through the

American Dental Education Association and the Academy of Academic Leadership. Dr. Haden's impact on the profession has been profound and long-lasting. He is held in the highest regard by his peers. Dr. Haden's accomplishments include:

- PhD, philosophy, University of Georgia
- Founder and president, Academy for Academic Leadership (AAL)
- Since founding AAL in 2005, has worked with more than 100 universities in the United States and abroad
- Has engaged more than 3,000 faculty members through AAL's professional development programs in teaching, learning, leadership, and career development
- Associate executive director for educational policy and research, American Dental Education Association (ADEA); while at ADEA, provided chief staff support for the ADEA Commission on Change and Innovation, which has been a leading change agent in instituting new accreditation standards, the move toward a new model for National Board examinations, and curriculum change in dental schools across the United States
- Helped initiate the ADEA Leadership Institute in 1999; still directs this flagship leadership program that has over 300 alumni, including 14 current dental school deans
- Helped design a similar leadership program for the American Association of Colleges of Pharmacy, the Academic Leaders Fellowship Program, that also has more than 300 alumni, among whom are a number of pharmacy deans
- Works collaboratively with a number of dental organizations, including a partnership with ADEA to provide four highly successful faculty development programs such as the ADEA/AAL Institute for Teaching and Learning, now with more than 500 alumni; other partners provide scholarships, including the ADEA Gies Foundation, the American Academy of Pediatric Dentistry, the American Association of Endodontists Foundation, the American Association of Periodontology Foundation, the American Association of Oral and Maxillofacial Surgeons, and the American Association of Orthodontists
- Author or coauthor of more than 80 articles and monographs in educational policy, including several articles that are among the most cited in the history of the *Journal of Dental Education*
- Peer reviewer, *Journal of Dental Education*, *Journal of the American College of Dentists*, *Journal of Healthcare for the Poor and Underserved*, and *Medical Sciences Monitor*

SECTION ACHIEVEMENT AWARD

The Section Achievement Award recognizes ACD Sections for effective projects and activities in areas such as professional education, public education, or community service. The 2014 recipient of the Section Achievement Award is the New York Section in the area of professional education. The New York Section is honored for its Mentoring Lecture Program that encourages dental students and residents from the New York Metropolitan area hospital programs to lecture, teach, and become future leaders of the profession.

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 Michigan Section is the winner of the Section Newsletter Award for 2014.

MODEL SECTION DESIGNATION

The purpose of the Model Section program is to encourage section improvement by recognizing sections that meet specified standards of performance in four areas: membership, section projects, ACD Foundation support, and commitment and communication. This year the Indiana Section, Ontario Section, and West Virginia Section earned the Model Section designation.

LIFETIME ACHIEVEMENT AWARD

The Lifetime Achievement Award is presented to fellows who have been members 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:

F. Carl Cerine
John J. Cunat
W. Howard Davis
H. Martin Deranian
Marvin L. Fishmann
Haskell Gruber
Alex J. McKechnie, Jr.
Marie U. Nylen
Harold Perry
H. M. Stebbins
Marvin A. Tuckman

2014 ACD Fellowship Class

Alaa I. Abdelhamid
Qassim, Saudi Arabia

Kenneth Abramovitch
Loma Linda, CA

Anita Aminoshariae
Cleveland, OH

Christopher L. Andrews
Columbia, SC

Nikola Angelov
Missouri City, TX

Travis J. Antholz
Lincoln, NE

Krishna Aravamudhan
Chicago, IL

Mark H. Armfield
Augusta, KS

Melodee Armfield
Augusta, KS

Carrie K. Arquitt
Springfield, MO

Douglas C. Ashman
South Jordan, UT

Joshua A. Austin
San Antonio, TX

Evis Babo
Atlanta, GA

R. Mark Bailey
Waldron, AR

Amy M. Batten
Goldsboro, NC

John W. Baucum
Corpus Christi, TX

Todd M. Baumann
Dallas, TX

Douglas Beckham
Birmingham, AL

Todd Belfecker
Revere, MA

R. Bryan Bell
Portland, OR

Tobin Bellamy
Coquitlam, BC

Andrea Beltzner
Portland, OR

Steven D. Bender
Plano, TX

Daniel A. Bills
Sicklerville, NJ

Markus B. Blatz
Chester Springs, PA

Winifred Booker
Owings Mills, MD

Suheil M. Boutros
Grand Blanc, MI

Ryan Braden
Lake Geneva, WI

Roger A. Briggs
Scottsdale, AZ

David R. Bright
Tyler, TX

Kristin C. Burch
Palm Harbor, FL

Angela K. Burns
Loundon, TN

Yvette L. Burns
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Mark A. Camp
Longview, TX

R. Claire Campbell
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Shelley L. Canada
Houston, TX

Natalie J. Carr
Riverview, FL

Mara Catey-Williams
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Mark S. Chaney
New Orleans, LA

Edward H. Chappelle, Jr.
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Angela C. Chi
Charleston, SC

Nicholas Chiovitti
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David P. Christie
Victoria, BC

Norman R. Chu
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Brian Clark
Tillsonburg, ON

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Skillman, NJ

Scott H. Coleman
Houston, TX

Daniel H. Cook
Tacoma, WA

Terry L. Cotterell
Oklahoma City, OK

Christopher J. Couri
Peoria, IL

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Naples, FL

Julio V. De Jesus-Gomez
San Juan, PR

Christopher N. DeTure
Ft. Lauderdale, FL

Eric J. Dierks
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Sarah C. Donner
Lincoln, NE

Larry D. Dormois
Germantown, TN

James C. Douthitt
Amarillo, TX

David J. Dowsett
Portland, OR

Katrina Y. Eagilen
Los Angeles, CA

Robert M. Eber
Ann Arbor, MI

Leity P. Erickson
Bedford, NS

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Alex Fleury <i>Dallas, TX</i>	Jose M. Gonzalez, Jr. <i>Laredo, TX</i>	Michelle M. Henshaw <i>Boston, MA</i>	Donald A. Jones <i>Clarksville, TN</i>
Gary W. Fong <i>Lethbridge, AB</i>	Albert L. Granger <i>Garden City, NY</i>	Brian N. Hockenberger <i>Norton, OH</i>	Sherry R. Jordan <i>Cumming, GA</i>
Richard McKinnon Forbes <i>Boone, NC</i>	Charles F. Grannum <i>Brooklyn, NY</i>	Scott J. Hodges <i>Hasting, MI</i>	Parag R. Kachalia <i>San Francisco, CA</i>
Ashraf F. Fouad <i>Baltimore, MD</i>	Joseph P. Graskemper <i>Bellport, NY</i>	Charles R. Hoopingarner <i>Houston, TX</i>	Michael J. Kastner <i>Toledo, OH</i>
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Benetta M. Gadegbeku-Bell <i>Columbia, SC</i>	Christina A. Gregory <i>Bensalem, PA</i>	Johanna A. M. Huijssoon <i>Washington, DC</i>	Ahmed Khocht <i>Redlands, CA</i>
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Wayne T. Kinney <i>Indianapolis, IN</i>	Michelle L. Mazur-Kary <i>Auburn, ME</i>	Peter Nkansah <i>Toronto, ON</i>	Michele C. Ravenel <i>Charleston, SC</i>
G. Thomas Kluemper <i>Lexington, KY</i>	Kevin S. McCurry <i>Sheridan, WY</i>	Randy J. Norbo <i>Roanoke, VA</i>	Clive B. Rayner <i>Orange Park, FL</i>
Stanley L. Kogon <i>London, ON</i>	Mark D. McOmie <i>Chattanooga, TN</i>	Karen F. Novak <i>Houston, TX</i>	Ali A. Rezai <i>Oakland, CA</i>
Matthew F. Krische <i>Lawrence, KS</i>	Alton G. McWhorter <i>Dallas, TX</i>	Kalu U. Ogbureke <i>Houston, TX</i>	Ronald D. Riggins <i>Moline, IL</i>
Victor Kutcher <i>Burlington, ON</i>	Amir Mehrabi <i>Little Rock, AR</i>	David K. Okano <i>Rock Springs, WY</i>	Philip J. Rinaudo <i>Rockville, MD</i>
John E. Lagner <i>East Northport, NY</i>	Mark C. Mehrali <i>Camarillo, CA</i>	Erica R. Oliveira <i>San Antonio, TX</i>	Thomas H. Risbrudt <i>Phoenix, AZ</i>
Stephen A. Laman <i>Houston, TX</i>	Mary B. Mellard <i>San Antonio, TX</i>	Roger E. Oppenheimer <i>Sherman, CT</i>	Brian T. Robinson <i>Rockville, MD</i>
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Tad R. Mabry <i>Iowa City, IA</i>	John F. Monticello <i>Grand Rapids, MI</i>	Frederick T. Philips <i>Corpus Christi, TX</i>	Melissa Rozas <i>Coppell, TX</i>
Alastair MacDonald <i>Glasgow, Scotland, UK</i>	Rex C. Moody <i>Mission Viejo, CA</i>	Erin F. Phillips <i>Indianapolis, IN</i>	Christopher J. Salierno <i>Huntington, NY</i>
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	Samson Ng <i>Vancouver, BC</i>		Barry Schwartz <i>London, ON</i>

Congratulations to
all new Fellows.

Scott W. Searcey
Oklahoma City, OK

Theodore Sewitch
New York, NY

Kathy J. Shafer
Litchfield, IL

Timothy G. Shaughnessy
Marietta, GA

Craig A. Shepherd
Greenville, TN

Joan A. Sheppard
Bloomington, MN

Robert G. Sherman
Honolulu, HI

Roger W. Sjulson
Fosston, MN

Harold A. Smith
Indianapolis, IN

Lindsay A. Smith
Tulsa, OK

Kristi M. Soileau
New Orleans, LA

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Yuma, AZ

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Laurence H. Stone
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Holly, MI

Barry R. Svec
Windsor Heights, IA

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Las Vegas, NV

M. David Tillman
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Ivan Torres-Nazario
Mayaguez, PR

Charles S. Travagliato
Hamburg, NY

Aaron Tropman
Wake Forest, NC

Victoria A. Ursitti
Arlington Heights, IL

Pilar Valderrama
Dallas, TX

Samuel V. Veltri
Clarksburg, WV

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Wichita, KS

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Eugene, OR

Martha H. Wells
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Erich M. Werner
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William F. West
Tupelo, MS

Russell A. Wicks
Collierville, TN

Brad Wilbur
Henderson, NV

Jon W. Williamson
Cedar Hill, TX

William A. Wiltshire
Winnipeg, MB

Wendy S. Woodall
Las Vegas, NV

William B. Wynn III
McAlester, OK

William B. Wynn IV
Tulsa, OK

Rex R. Yanase
Torrance, CA

Dagoberto Zapatero
Virginia Beach, VA

James W. Zimmerman, Jr.
Toledo, OH

Stefan Zweig
San Marino, CA

Posthumous

George A. Bullock
Doylestown, PA

Mary L. Mariani
Davenport, IA

WHAT IS THE ARD?

Neil S. Hiltunen, DMD

ABSTRACT

Until as recently as 100 years ago, the concept of retirement had almost no meaning. Now it is a formal stage of life with its own privileges and responsibilities. We are living longer and learning more about how to take full advantage of the opportunities this provides. The Association of Retiring Dentists is an organization intended to make that a rich experience for all.

The Association of Retiring Dentists (ARD) is a growing organization of over 475 dentists in 43 states and five countries. We are connected by the commonalities of being dentists and desiring to learn about the later stages of our careers and lives. We seek to share experiences and explore opportunities.

Our vision is to create and maintain a global organization of resources through education and the exchange of experiences on both sides of retirement. We picture the association bringing mature dentists together in a variety of venues to make the most of retirement. These venues can be from local to international in scope. They can take place in small offices, on cruise ships, at convention centers, or in remote or local clinics. Information can be disseminated through individual conversations, mentoring, meetings, internet, or publications such as a newsletter or magazine.

We believe that the latter stages of dentists' careers can be the most fulfilling and enjoyable of their entire lives, using their lifetimes of accumulated resources for the benefit of themselves and others. The wisdom of experts is also sought to add depth and understanding to the many facets of this new venture. There is no other single resource available to dentists to gather this information, and dentists by their education and other resources are uniquely positioned to experience a fulfilling retirement when properly planned. The ARD offers information and support targeted toward dentists in their profession.

BACKGROUND

We live in an unprecedented time. Never before in human history have there been so many older people on the planet. Many of us are seeking guidance and insight into what to expect in this uncharted frontier. Unfortunately, there is not much help available as we are truly pioneers exploring a new age.

A long period of retirement is relatively new to the human race. It used to be that in an agrarian society a person would work up to his or her ability. A farmer would lift the hay bales until he could do it no longer, and that task would then be done by a younger, stronger family member. Gradually, with aging, the older person would be valued more for experience and wisdom than for physical strength.

The current paradigm of retirement began in 1889 when Chancellor Otto Von Bismarck instituted a retirement plan in Germany. Benefits started at age 70 when the average life expectancy was 45 (partly due to high infant mortality). Our current Social Security System originated in 1935 under President Franklin D. Roosevelt with a retirement age of 65 when the life expectancy was 62 (*The Economist*, 2009).



Dr. Hiltunen is co-founder of the Association of Retiring Dentists; neil@retiringdentists.com.

It was these social programs that created the mindset that at some age we stop working and receive money that we had entrusted to others to put aside for us. There was no consideration for ability to work. Rather retirement was age-based. Age 65 was selected by President Roosevelt's Committee on Economic Security because actuarially it was determined that the system would be self-sustaining. In fact, there is no biologic or other scientific basis for using age 65 as a defining point for the beginning of old age. Yet it has become accepted as such regardless of a person's physiology or abilities.

In the late 1940s and early 1950s things began to change, and people began living longer and longer. "Life expectancy after age 65 to age 90 tripled between 1940 and 1980. In 1940, only 7% of Americans had a chance of living to the age of 90; by 1980, that percentage had risen to 24%" (Butler, 2008).

For healthy persons today at age 65, there is a 50% chance of living beyond age 89 for males, age 90 for females, and for couples, at least one spouse may live to age 94 (Securian Financial Group, 2013).

Neurolinguistics tells us that how we view the world depends on the words we use to describe it. The broad social acceptance of 65 as the start of retirement age relates to how we define "retire" or "retirement." In dictionaries we find such words as, "withdraw, leave, giving up, permanently stopped, ending, seclusion, privacy, retreat, withdrawal, moving away from something difficult, dangerous, or disagreeable, and pullback." All these words have a negative connotation.

So too we can change our paradigm of retirement by using more positive

words to create a new vision of the future. One can choose such words as, "freedom, joy, liberation, or happiness, recreate, begin anew, enjoy, change, renewal, rejuvenate, grow, or contribute," to change our view of retirement.

"Retirement" is a noun, meaning endpoint; it is a condition. "Retiring" is a verb, an action, the ability to move, to do something. That is why we are the Association of *Retiring* Dentists. We hope to promote later years that are active, productive, and meaningful.

"Aging" has an even greater problem with a negative perception than "retiring" and is inextricably linked to retirement. No one retires without aging, and virtually no one wants to age because it is associated with being "decrepit."

Chronic disease can sap our productivity, is costly to treat, and reduces mobility and enjoyment of life. In fact, chronic disease contributes to an estimated \$369,000 healthcare cost (including insurance premiums) for a 65-year-old male through the remainder of his life (Insured Retirement Institute, 2012).

Coupled with concern about chronic disease is depression, commonly seen in our older population. If not planned well, retirement and aging can precipitate gerontophobia that can result in suicide. More than 20% of suicides are committed by people 65 and older (Butler, 2008).

Factors playing a role in this sad statistic include loneliness, depression, hostility, and a sense that life has no purpose. In addition to the potential for suicide, these conditions create stress with the physiological release of the hormone cortisol. Chronic elevated levels of cortisol impair the immune system, making a person more vulnerable to infection and a downward spiral of deteriorating health. The relation between depression and mortality was studied and confirmed: "high levels of depressive symptoms are

an independent risk factor for mortality in community-residing older adults" (Schulz et al, 2000).

This is the environment in which we live and are retiring. At the same time we do not need to let this environment dictate our view of the future. Our perspective has been based on a time and history very different from that in which we currently live, and "we should not regret growing old; it is a privilege denied to many."

WHAT'S DIFFERENT ABOUT DENTISTRY?

Having a positive outlook may be easier for dentists as we reflect on the gifts many of us have received and accumulated over the years. As dentists, we generally have good reason to be optimistic about our transition to a new life. We have skills in dentistry that can benefit every human being. We can improve self-esteem, relieve pain, help people eat, and even save lives. Also, people with a higher level of education tend to live longer (Montez et al, 2012), and people with higher incomes also tend to live longer. "Mortality is negatively associated with lifetime income" (Duggan et al, 2006). Dentists tend to fit into both of those categories.

Dentists can often choose how they want to retire, when, and where to transition their lives. We have no mandatory age to stop working. Over the years, we have developed networks of patients, family, and colleagues that can be tapped to help us pursue our passions. Often our financial situation can also support these passions.

Today it is reasonable for us to think of our lives as divided into thirds. The first third—to age 30—is preparing. We learn values and skills at home, college, dental school, and in the first years of our careers. The second third—to age 60—is producing. We refine our skills and grow our families and practices. During

this middle third we accumulate knowledge, clinical skills, social and professional networks, as well as a reservoir of funds for the future. Over these 60 years, our activities have been focused on, and limited by, commitments to education, family, and practice. Priorities have competed for available time.

The last third is becoming all we can be. During this period, many of our other responsibilities have diminished, providing extra time, a new resource. When discretionary use of time is added to the previous resources, the potential is staggering, not only for the dentist but also for our broader community. Baby boomers in their later years could be net “givers” to society, not the fiscal drain that is widely supposed (Dychtwald & Kadlec, 2009). Also, “Seasoned men and women,” said David Walker, U.S. Comptroller General, “are the most underutilized asset in America.” The economic potential is significant. “If those who retire are encouraged to volunteer, it could add another 5% to the gross domestic product” (Dychtwald & Kadlec, 2009).

ARD AS AN ORGANIZATION

For dentists, the ARD can help create a new positive view of retirement and provide the resources to do so. The ARD as an international organization can connect dentists around the world for travel and education, and for providing dental treatment and cross-cultural understanding. Already we have member dentists from the United Kingdom, Australia, South Africa, and Canada, in addition to the United States.

The ARD recognizes the enormous potential of our demographic, and the obvious question arises: “How do we achieve our potential?” There is no model. There is no school. The Japanese proverb comes to mind, “None of us is as smart as all of us.” Sharing our experiences with others can be of

great help. We are aware of no other organization like the ARD, and the vision for the future is bright, the potential huge.

For most of us, dentistry is a strength since we have been performing it for decades. So it makes sense to consider dentistry as part of retiring. Martin Seligman (2002) says, “I believe that the highest success in living and the deepest emotional satisfaction comes from building and using your signature strengths.”

What will it take to bring this organization and vision to fruition? The organizational models of the International College of Dentists and the Pierre Fauchard Society are examples. However, what the ARD can do will be much more than connect like-minded, well-respected dentists doing valuable work. The ARD can add an entire new dimension to dentists’ visions of retirement.

We need energetic, retired dentists looking for something meaningful to do. We need funds to employ full-time administrators and employees. Funds can come from sponsors and advertising, as well as membership dues. We need an editorial board to review articles submitted for publication. We need people skilled in marketing, internet technology, and social media. We need travel and leisure time experts to create, market, and conduct tours or coordinate trips for dentists to explore the world. We need people to gather information about, evaluate, and coordinate local and global volunteer opportunities. We need personnel to help connect buyers and sellers of practices as well as to help identify opportunities for temporary work. We need access to the best minds for providing information about the

“Retiring” is a verb, an action, the ability to move, to do something. That is why we are the Association of Retiring Dentists. We hope to promote later years that are active, productive, and meaningful.

Our perspective has been based on a time and history very different from that in which we currently live, and “we should not regret growing old; it is a privilege denied to many.”

psychology of retiring, financial planning, estates, retirement living options, health, medical care, and aging.

Membership in the ARD is limited to dentists. Applicants for membership have credentials checked to be reasonably sure that they are or have been a licensed dentist. By doing this, we hope to provide a trusting environment in which dentists are free to share their thinking without being a target for sales persons.

There are growing industries, such as financial and estate planning, housing, and travel to name just three, that are targeting the baby boomers to buy their products. The information, products, and services can vary in quality and reliability. The ARD hopes to be able to sort through this tsunami of information and possibilities so that member dentists will have a reliable source for exchanging feedback on products and services.

Not only can the ARD be of value to those close to retirement, but also to those just starting their careers when the vision and mind set about retirement are being formed.

The ARD attempts to identify some of the complexities of retirement and blend the broad resources and experiences of colleagues and experts to help us make the best of this unusual opportunity for us, our profession, and society. Retiring is our last best chance of making something meaningful of our lives. We are blessed to enter a period in our lives that generally has not been available in human history. ■

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EVERY RETIREMENT IS AS PERSONAL AS EVERY PRACTICE

Bruce Valentine, DDS, FACD

ABSTRACT

Selling a practice is not like selling a car; many lives are bound up in the transaction. This is a personal narrative about career planning and circumstances. Without the author's succession of detailed plans, he never would have been sensitive enough to the need for nearly continuous adjustments. In the end, the true value of the practice was not measured in dollars.

To understand my experience transitioning out of dental practice, it will be helpful to travel into my past. The year is 1962; I had graduated from high school; I had decided on a career in dentistry. My father sat me down for a discussion on money and my future. He began by stating that he would pay for all of my living and education expenses up to my graduation from dental school, as his father had done for him. The caveat that followed was that I had to promise both him and my grandfather that I would do the same for my children. I promised and I fulfilled my promise. Secondly, he stressed I needed to learn to live on a budget, borrow money only for real assets (home, professional office, and autos), plan on funding a retirement beginning year one of my practice, and have no debt at retirement date. I have done those things as well.

Now let's skip forward to 2004, and our youngest daughter informing my wife Grace and me she wanted to get her PhD in criminology. We calculated the earliest I could retire and still honor the first promise I made to my father would be 2010. Never had I thought in 1962 I would be responsible for three masters' degrees and a PhD. We calculated on the second issue of debt, we were under control and we would be debt free by 2006. We made the year 2010 our goal and I would be 65. So I began a plan to take CE courses on practice transitions and completed 50 hours of CE by 2008.

Also, during that time I would attend CDA Presents conventions and interview informally those brokers present.

In 2008, the great economic recession hit! In our area, it was a depression! Stanislaus County, California, was the epicenter of the economic meltdown. City and county governments laid off 30% of their employees. Housing starts fell from 4,500/year to 178/year. Homes lost 66% of their value. Unemployment surged to 18.8% (today it remains high at 11.3%). Modesto's reputation received a ton of bad press in national statistics: top 10 in foreclosure activity, top 10 in unemployment rates, and top 10 in the number of car thefts. Children in the schools under Title I (less than 200% of the poverty level) surged to 70% of those enrolled.

At the same time our practice was beginning to experience changes. In 2006, Delta Dental was selling the Delta Preferred Option in our area. As we were Premier members, economic calculation showed at our level of production and expenses, my practice would not be financially viable at the fee schedule under the Delta Preferred Option. As a result, the number of young families entering our practice began to decline significantly! In fact, in the ten years



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beginning in 2000, the average age of our patients increased by ten years.

The recession hit our area hard in 2008. The number of new patients decreased by 50% on a monthly basis. The number of patients returning for re-care appointments decreased by 20% on a monthly basis. Production and collections failed to grow for the first time in 39 years. The number of families moving to other states increased to an average of five families a month. Managing the practice became very stressful! Our youngest daughter's education was going to take two more years than we had planned. 2008 became my most difficult year!

Now I needed another plan. I met with my eight long-term and highly valued team members (at the time of retirement in 2014, their average tenure with my office was 22 years), and together we developed a plan to maintain and increase production, reduced and changed hours, and increased efficiency in expense control. For two years we put a hold on salary increases, and agreed that after those two years raises would be tied to a certain percentage of collections. Everybody, including me, would receive the same percentage increase. I began to spend more of my free time managing the practice. The one good event of the 2008–2010 period was that building costs decreased significantly (50%) and from cash reserves we rehabilitated the outside of the office, replaced carpets, and updated our home that we had lived in for the last 26 years.

From continuing educational classes on dental practice transitions, I learned that associate buy-in sales were very financially successful. During the 1980s and 1990s, I had tried the associate

experience two times for a total of nine years. Both had failed for various reasons, including issues I had with the attempts and issues the associate dentists brought with them. I had concluded from my own poor experiences and the flat business environment that the associate buy-in option was not possible. I began to feel the most comfortable with the direct sale of the practice, with immediate transition into retirement while remaining in Modesto. During the period of 2008–2010, I built a relationship with a dental practice broker who had deep connections with the University of the Pacific School of Dentistry, as I had. Mike and I had several discussions during annual UOP Alumni Meetings. By late 2010, I had decided I would use his company to broker the sale of the practice.

As part of the restructuring of the practice in 2008, I set a goal that I would list the practice for sale in September of 2012. As 2012 neared, the practice had stabilized and begun to grow slowly. With the help of my dental team, we reduced hours by 10%, controlled expenses, increased production, and increased profitability. Our practice was doing much better, yet I knew intuitively that it was time to sell the practice. I was tired, stressed, and not the positive person I had always been. I knew the time was right, and down deep inside a voice said it is okay to let go.

The practice was appraised in September of 2012 and listed. The appraisal was slightly higher than where I thought it would be, my team was on board, and I was ready to go. During the next six months, only two dentists looked at the practice and neither made an offer. I was frustrated. I met with my financial and legal team as well as the broker, and we decided to decrease the sale price by 20%. Mike continually assured me I had a great practice, the value was great, and in time the practice will sell.

Almost immediately, interest spiked! Over a three-month period 35 dentists reviewed the financials and showed significant interest in the practice...and yet no offers. The broker contacted the interested dentists and nearly every time the answer for being no longer interested was that they did not want to live in Modesto. This is the town I grew up in, the town where I raised four children, the town where I had become very successful. How could they not see?

In late June, 2013, we received a full-price (the reduced price) offer from two dentists, one twelve years out of school and the other one year out of school, who were in partnership. Events were looking great; a preliminary purchase agreement was signed with a financing contingency. Another setback developed. Because of debt issues involving the other practice they owned, and a \$350,000 educational debt with the younger dentist, the financing institutions would only loan a third of the purchase price, and I would have to carry the other 66% of the purchase price debt. I was struggling with: "What should I do now!" During this period the practice remained for sale, yet, we received no other contacts from interested parties.

Returning to my financial, legal, and broker team, I asked the following questions: "What should we do, and, if we decide to proceed, how should the sale and financing be structured?" Seller financing was very difficult for me to accept, and went against the information shared in numerous CE classes. After much discussion with my team and my wife, deep thought, prayer, and introspection, I decided to proceed with the sale. I was ready to retire and a little voice told me to do the deal! In joint meetings with the legal and financial teams, the final deal was structured as follows: a one-third down payment, loan

#1 was for an additional one-third with a one-year fully amortized note of 6%, and loan #2 for the final one-third was for three years, interest-only for the first year, and fully amortized during the final two years at an interest rate of 7%. As I owned my building, a competitive ten-year lease was negotiated and signed. In year four, the new owners of my practice have a first right of refusal to purchase my office building. My financial plan has the building selling in 2017.

Escrow closed November 16, 2013. A most bittersweet period. I missed my patients and my dental team greatly! Most of my patients were friends whom I knew well, my dental team was the best. I felt I was going through eight divorces. For a reason I had yet to discover, down deep within my soul I knew I had made the right decision, but I was really struggling inside!

As I write this story, the buyers have made every payment on time on both notes. My practice continues to provide the new owners with 55% of their combined practice income. During the four months after the close of escrow, I was very busy with collection of account receivables, payment of bills, rollovers of retirement plans for all eight team members and myself (more work than I ever imagined!). I was volunteering for an increasing number of community and professional activities. I was even learning to say no! April 2014 arrived, and I was nearing completion of all the details in the sale of the practice. I knew I had made the right decision, but what justification do I have for saying that?

One of the defining motivators of my life was a quotation I learned while I was a student in English 1A in my undergraduate education. I have based many of my life's decisions in my 45-year career on several meaningful

quotations. This one means very much to me and today even more. In Pericles's speech to the families of the Athenian war dead he said: "What you leave behind is not what is engraved in stone monuments, but what is woven into the lives of others."

In April 2014, I received a phone call from a younger colleague whom I respect and trust. Mike, the father of three children in high school and college, a man with a wonderful wife, and a very good dentist, shared with me the news that his melanoma had returned. The cancer was now Stage IV metastatic melanoma, and he was beginning additional rounds of chemotherapy. Another UOP grad and I worked and cared for Mike's practice. I worked two and a half days each week and my friend worked almost two. Events did not go well for Mike, and he passed away last June. His death created sadness and shock for his patients and his dental team. I took over managing the practice and continued working. On August 16, the practice was sold, and I finished my last patient today, August 21. Both my colleague and I worked pro bono with the net income going to the family. We maintained and increased the practice's production and collections by 5%, worked with and ministered to a deeply heartbroken dental team, preserved an asset for a grieving family, and cared for Mike's wonderful patients.



Perhaps, the sale of my practice was not the way I had wished or envisioned it to be. And yet, today I know why I felt good deep inside at the time of my sale. The practice sale gave me an opportunity to weave my life into the lives of others and make a difficult time for many a little bit better.

PRACTICE TRANSITION WITH INTELLIGENCE AND GRACE

Marcia A. Boyd, DDS, MA, FACD, CM

ABSTRACT

Viable practices change with the professional and personal needs of dentists and with trends in society. There is no single way for transitioning out of practice—concluding a direct sale, remaining as an associate, and even purchasing a new practice to better match one's more mature lifestyle and practiced preferences. Changing ratios of dentists to patients currently favor a seller's market and emergence of corporate models provide new options. An analysis is given of the Canadian practice market. Planning advice is also offered.

Change requires response. Sometimes the change in dental practices is generated internally by the dentist matching details to personal life stages and goals. Sometimes it is influenced by environmental factors such as the economy or demographics. Talk of practice change is dominated by new technologies, office expansion, and growth in efficiencies and business models. But the transitions toward reduced time at the chair and to leaving practice entirely can be done with varying degrees of intelligence and grace. Such transitions require the same sort of planning and judgment that are needed for successful practice expansions.

All the Ways of Selling

Dentists decide to retire for one of three reasons: they are sick, they are sick and tired, or they have achieved financial freedom.

Currently the banks continue to be very supportive of dental practice purchases and often will provide 100% funding, or even more, for the purchase of a dental practice. The interest rates for borrowing are also very low. Given a seller's market and a purchaser's ability to get "cheap" money, it is a "win-win" purchase-sale situation!

Meanwhile landlords know and appreciate dental practice tenants. Dentists are excellent tenants, and typically the vast majority do not move their offices. This seems to give the

landlords an extra power boost, and they will often play that card when negotiating a lease renewal or a reassignment of the lease to a new owner. Given the cost of moving—loss of leasehold improvements, the price of the move itself, plus further leasehold investments—the landlords often hold the dentist in "golden handcuffs" where there is nothing to do but to pay the additional rental renewal option.

Selling a practice that is a cost-share among several dentist-owners or that has associates can be challenging. Often the well-functioning and successful "partnership" relationship is found with those who have graduated together, have been friends, and share the same education and practice philosophy. Selling "the whole" is easy and often greater than the sum of the parts. Not so when one wants to sell and the other does not. Consider the potential purchaser who is usually not the same generation and may have conflicting ideas about moving the practice forward. "We've done just fine with things as they are; there is no need to spend any extra money to upgrade." For the potential



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purchaser it is like marrying someone you don't know! The risk is great—on both sides. This negotiation requires a lot of open, honest communication about future plans and expectations.

Here is another potential misalignment of career plans. The associate has been in the practice for three years but is not ready or does not want to be an owner. There may be a very thoughtful and valid reason for not wanting to be an owner. However the optics are not good. Potential purchasers will ask, “Why doesn't the associate want to purchase the practice? Read: “They have test driven the practice for three years and must know that there is something wrong here because they don't want to purchase it.” An undeserved “stigma” on the practice will make it more difficult to promote and move toward a sale.

Many vendors stay on as associates to allow a gradual exit and a smooth transition for patients and staff. They are not only very helpful in every way with patients, staff, and mentoring the new owner but also very productive and therefore able to assist the new owner with meeting their financial obligations.

It is an unnecessary and limiting constraint to think in terms of selling a practice to a younger version of oneself. The value of the practice depends on what the new owner dreams of and what he or she can do with it. One prosthodontist, in the final year of graduate school, wanted to take a non-traditional approach for entry into the marketplace. He said, “I don't want to

just “hang out my shingle” and then go cap in hand to the dental community begging for referrals. What I want is to purchase a “high end” restorative practice which will provide immediate cash flow and then evolve the practice into a specialty office.” That having been accomplished, his approach has proven to be extremely successful. The owner remained in the practice as an associate until the purchaser graduated and has continued in a part-time associate position since. Everyone is happy.

Another established orthodontist was “thinking out of the box” as well. He wanted to expand his practice quickly. He found a pediatric dentistry practice owned by an older specialist who was thinking about retirement. The beauty of this transaction was that the owner referred out all of the orthodontics and the internal orthodontic referral became a condition of the purchase agreement. The pediatric dentist associated for two years to establish the relationship and provide the internal referral pool within the merged practices. Instant growth!

LARGER TIDES of CHANGE

The law of supply and demand will prevail, and it will continue to be a seller's market. This is most apparent in the major cities and their suburbs. Rural areas still struggle to engage younger or “investor dentists” in the purchase of those practice opportunities even though

Dentists decide to retire for one of three reasons. They are sick, they are sick and tired, or they have achieved financial freedom.

A DENTIST GOES RURAL

I think that the seed to sell my practice was planted when I had an unplanned lunch with two colleagues who both worked part time within organized dentistry and encouraged me to think about doing the same. I realized that I had been working as a dentist for over 30 years, since I was 24 years old, and hadn't given any consideration to doing anything else. The work they described appealed to me and I wondered if there was a way to keep practicing but also indulge some other interests. Getting involved at an instructional level, teaching at the dental school, was also something that I had considered but never had found the time to contribute.

The more I thought about selling, the more justification seemed to appear. I had done a renovation in the office five years previously, and I was starting to worry that, by the time I was ready to sell, the office might, again, have become old and tired looking. My office was situated in an older building that I had often thought might be torn down before I was ready to retire. All of these factors seemed to indicate that selling sooner rather than later might be a good idea.

Finally, in talking with other dentists, it seemed that a large number were nearing or on the verge of making the same decision with respect to their practices. I wondered, if I waited, would I be putting my practice on an already congested market. I spoke with a friend and colleague who was a broker and asked if she felt that the time might be right. I indicated that I would prefer to stay on as an associate as I had no intention of walking away from the clinical side of dentistry any time soon.

After listening to all of my concerns, she confirmed that it was, indeed, a good time to sell and felt that it was definitely a seller's market. She indicated that, not only were selling prices at an all-time high, but also many buyers were keen on keeping the older dentist around. My older style, recall based, patient-centered practice was of particular interest to potential buyers. Almost before I knew it, the practice had been listed, ten or twelve offers accepted for review and a final offer accepted and acted upon—all within four months! Three years later, I'm in the process of signing a new three-year associateship agreement with the dentist that bought my practice, working part-time in organized dentistry, and helping run a student study club in conservative gold restorations at the dental school.

Regrets are few. As a solo practitioner for the last 18 years before I sold, I hadn't realized how much control I had over the patients' experience from the time they entered the office to the time they left. I think it's this loss of control that is the most difficult thing with which to deal. However change brings change and there have been some positives as well. Moving forward with technology had always been a problem for me and the new owner had nudged us into the twenty-first century. He has been incredibly accommodating to my working hour needs as well as my practice philosophy.

Trusting your own intuition is a hard thing to do sometimes but with seasoned advice and a methodical approach, selling your practice can be the next best thing to starting one.

they are excellent practices and outstanding investments. In these locations, it is a buyer's market.

Sale and purchase prices have increased in the desirable urban areas. Banks, however, are now, more than ever, scrutinizing these younger, less experienced professionals more closely as they may not be as proficient as the vendor and therefore may not be able to comfortably service their purchase loan and other living expenses.

Rural centers may be more difficult to manage. More recently dentists wanting to start in practice or perhaps be more entrepreneurial and purchase a "satellite" or expand their practice base have come to see the benefits of being located outside the major urban centers. They, in consultation with their trusted professionals (accountants, lawyers, and bankers), have "sharpened their pencils" and realized the value added that can be realized in rural practices—population-to-dentist ratios are huge and a large patient base, with plenty of treatment demand covered by insurance as well as lower overhead result in greater cash earnings at the end of the day. So there is now interest in these rural offices, which often have real estate available as well. As a bonus, the residential housing market is significantly more friendly, the neighborhoods are safe, and the schools are excellent.

One young practitioner did his due diligence. He was able to purchase a thriving rural practice for about half the cost of a similar practice in a city setting. Six months into his ownership he was doing so well he wanted to purchase yet another rural practice of the same magnitude or greater! He was a happy young man working hard and realizing his dreams.

Deregulation and the attendant rise of "corporate" models are evident in dentistry as well as other professions—

pharmacy, real estate brokers, business brokers, optometrists, law, and so forth. All have seen or are going to see less regulation in both ownership situations and owner privilege. Still in dentistry anyone can buy and run a practice as long as a licensed dentist is involved in the management (ownership share).

Some owners who are in the mid-career stage of their careers and have built successful practices but are tired of management have decided to sell their offices for an excellent price in return for “freedom of management!” They suffer from “management fatigue” and are happy to return as an associate for a transition period. They see an opportunity to pay off their loans, be debt free, have some years of freedom, and have extra cash that they could use, if they wanted, to buy and build another practice.

Established practices are now being regularly approached by “dental corporations” wishing to purchase the practice and have the vendor stay on as an associate for a period of time. Oftentimes these owners have built very successful practices and want to slow down, reduce the number of days in the office, and ease their way into retirement. However these purchase agreements usually require that the office production keep pace with previous revenues, so there is really no room to slow down. Reading the fine print is always required!

Some advantages cited for such arrangements include: dentists can focus on patients rather than management; the corporation can afford to invest in new technology and provide a support team for new technology and CDE; there is economy of scale for purchasing; it is a good start for new graduates and a secure avenue for those not skilled in management or others who want to retire or make a transition.

The sobering fact is that sellers must understand that anyone is replaceable! Also, they are only one of the reasons why patients attend the practice, albeit a very important one! Patients also come to the office because they like the staff, they know the office policies and procedures, which they accept, they like the location, and people just don't want to change. Therefore they will give the new owner a chance to prove himself or herself. If a transition is done well, patient attrition can be as little as 5%. This would include those patients who have travelled long distances, perhaps after a personal move, to stay in the practice with that particular dentist. If transitions are thoughtfully done, they can be successful for patients, staff, and all other parties involved.

In my humble opinion, there is room in dentistry for both the “investor” multiple-office corporate model and the private practice office. Individual characteristics will dictate which suits a particular dentist. Some would prefer to be their own boss while others would prefer the freedom from management. All can be successful.

Picture yourself in the position of having just sold your practice but staying on to assist with the transition of the practice. Transitions can be tricky for everyone. In a full sale, you have relinquished your right to manage the practice. The new “kid” is now in charge. You are staying on for a specified period of time. This often creates confusion with the staff who want to defer to you, the previous owner, although you are not “the boss owner” anymore. More often than not the new owner will do things that are different from the way you used to or believe they should be done. This can create tension within the office and with the staff who are working to assist with patient retention and a successful transition. Your patient base does not want to be transferred to

So there is now more interest than ever in these rural offices, which often have real estate available as well.

THE RIGHT PERSPECTIVE MATTERS

	Great Moves	Stumbles
<i>Vendor</i>	A professional practice appraisal	Stays too long as an associate in the transition
	CYA! Call Your Accountant	
	Doesn't have staff employment contracts	It's not always about money, but rather a good "fit" for self, staff, and patients
<i>Purchaser</i>	Be respectful	Terminates staff who are critical to a smooth transition and patient retention
	Keep the practice as much the same for one year before "branding" it your own	

the "new" dentist and would rather wait for the opportunity for an appointment with you during the limited number days you are in the practice. Again, this creates issues with the booking of patients and the fact that the new dentist now has ownership of the operation and "owns" the patient base.

The vendor-purchaser transition is not always positive. Sometimes vendors stay too long as associates and then tension and stress in the office increases. Here is an all too familiar scenario. The previous owner wants to exit because the patient or practice management is now not to his or her liking. The new owner wants to be respectful but would rather that the previous owner leave. Not a happy situation for anyone in the office. The staff feel the tension. The best

way to avoid this and have everyone "save face" is to sign incremental associate agreements. In other words, sign on as an associate for nine to twelve months transition, with six-month increments thereafter by mutual agreement. That way when the time comes, for either of the two, the relationship can be terminated without great embarrassment and with respect and dignity for both parties. A much happier ending for everyone!

THE CANADIAN PERSPECTIVE

The United States and Canada enjoy reciprocal recognition of graduates of accredited dental programs through a mutual agreement between the Commissions on Dental Accreditation in the respective countries. The reciprocal agreement means that graduates from an accredited school in either country are eligible to take the certification examinations required in the other country—the same licensing examinations performed by dental graduates of that jurisdiction. Canada

has recently established mutual recognition agreements with Australia, New Zealand, and Ireland.

In addition, not the profession but the provincial and federal governments have demanded that there be a "challenge exam" for foreign-trained (non-accredited) graduates in order to provide an alternative pathway to licensure in Canada beyond the two-year Qualifying or Degree Completion Programs currently available in Canadian dental institutions. This process was introduced in 2010 (www.ndeb.ca).

These two circumstances have resulted in a supply and demand balance that has and will continue to impact the purchase or sale of dental practices. Baby boomers were expected to exit the marketplace earlier, but they have become "Houdinis," have disappeared and have not been selling their practices due to economic upheavals and real financial losses over the last decade. With the influx of more qualified practitioners, this delayed sale is not likely to tip the balance in favor of the dental practice purchaser but rather reinforce the seller's market in Canada as it has been for several years.

The number of dentists eligible for licensure in Canada in 2014 is estimated to be approximately 940 (Personal Communication: Dr. Jack Gerrow, Executive Director and Registrar of the National Dental Examining Board of Canada). Canadian dental schools graduate about 450 (48%). Adding the "international"/non-accredited dental graduates who return to dental school to gain qualification adds an additional 90 (10%) graduates to the total. Those coming to Canada under the reciprocal agreements (United States, Australia, New Zealand, and Ireland) number another 200 (21%) while the success

rate in the NDEB Equivalency Process is estimated at 200 (21%).

As dental faculties expand the number of graduates in the coming years (both domestic and foreign trained), in addition to the NDEB Equivalency Process “graduates,” there will be an increase in the number of buyers in the marketplace. Therefore the more buyers, the greater the increase in the value of the practice sale.

Women in the profession have literally “changed the face” and the demographics of dentistry over the last two to three decades. They practice as their male colleagues do with some exceptions. Many work part-time, preferring to work no more than a short distance from home, and the vast majority practice in urban/suburban settings. Their tendency is to gravitate to part-time associate positions. However there are many who are full-time entrepreneurs and continue to impact this demographic and demand.

SUMMARY

One dentist summed up his “retirement” experience this way: “Although the decision to transition from practice owner was a difficult soul-searching experience, for the most part, it has gone rather smoothly: from part-time associate within the practice for two years and now as a coach and associate elsewhere. Three years into the journey I still have no regrets and my professional direction and goals remain unabated. Yes, there was the initial shock of no longer being “emperor,” but it was, after all, my decision to sell my beloved practice. And what fun it has been having all those dental auxiliaries and vendors still being nice to me! I was replaceable, but not entirely.

What has made my dental journey as pleasant as it has been so far? I muse the following:

- Loving family support
- Well thought-out future professional plan (why, what, how?)
- Realistic expectations
- Age...I am not getting any younger

If you are looking to make a professional move of the exit strategy variety, be it with trepidation or bravado, plan well. Keep your head down and spirits high!”

Many dentists, after the fact, say they should have retired sooner. What they actually mean is that they should have planned sooner. Too short a time means sacrificing enjoying a long, meaningful, and rewarding time after their career and missing the chance to make an exit from strength and dignity. Begin by having a professional practice appraisal completed so that you can learn from it to realize the return on your investment. Acting upon the data provided by the appraisal will allow you to prepare your practice for a successful and profitable sale.

Planning is the key—and it cannot happen too soon as we get a “reality check” in so many aspects of our lives as we grow older. Talk with other colleagues who have made the transition and learn from them as they share their own “do’s” and “don’ts.” Be sure to speak with those who have expertise in critical areas: accountants, lawyers, estate planners, bankers.

As practicing dentists, with a view to future retirement, we depend on the ability to adapt to change—in the office, in the marketplace, and at home. If we can learn to anticipate, we can turn change to our advantage and plan for an incredible future. ■

It is an unnecessary and limiting constraint to think in terms of selling a practice to a younger version of oneself. The value of the practice depends on what the new owner dreams of and what he or she can do with it.

THE ROAD BACK TO DENTAL SCHOOL

Kenneth Namerow, DDS, FACD

ABSTRACT

It is not unusual for dental practice to be book-ended by being a student on the front end and a faculty member on the back end, sharing one's accumulated experience. Dr. Kenneth Namerow shares his story of trading in his visions of an RV after endodontic practice for a second career as an educator.

You would think, perhaps, that after more than three decades in a demanding profession, even one that was financially rewarding, one would have earned the right to sit back and rest, to travel, to hang one's hat wherever it felt comfortable. That was my assumption, too, as the turn of the millennium approached—an auspicious time, it seemed, to leave everything about dentistry behind. The year 2000 seemed right on all levels.

The plan my wife and I came up with involved purchasing an RV and exploring lots of highway. We were going to travel the country and enjoy all the things we may have missed during the 32 years I worked in a busy clinical practice as an endodontist in Ridgewood, New Jersey. There were three endodontists, including myself, with 12 employees spread over two practices. My buy/sell agreement meant the practice—and our patients—would not be disrupted.

Things did not quite turn out as planned.

A NEW PATH OPENED FOR ME

It was wintertime when my retirement commenced, so we came to Florida first. In Fort Lauderdale, I knew that Nova Southeastern University had started a new dental school in 1997. This new school was the first private dental college to be established in Florida and the first to open in the United States

since 1975. This was a time when dental schools were closing, not opening, so I sent a congratulatory note to the dental college's founding dean, Seymour Oliet.

The next thing I knew, I had been invited to teach at the new school on a part-time basis. At first, that meant one day a week, then two and a half days a week. Soon I found myself spending more and more time at the university and less and less on anything that could reasonably be thought of as retirement.

I had discovered a second career.

They gave me an office. I became post-graduate director, then chair of the department. In 2010, I became a full professor, and now I serve as division chief of surgical sciences and section chair of endodontics. It has been 14 very rewarding years.

I always loved teaching. Even when I had a full-time practice, I taught one day a week at Columbia for a few years and then a half day a week at Fairleigh Dickinson University. That was a perfect load for the circumstances.

There is nothing like the interaction with students. If you can make a difference, that is immensely satisfying. In private practice, there is a significant financial reward, but in academia you receive something even better, the



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gratitude of past students and future practitioners.

For example, two of my former residents recently invited me to lecture to approximately 200 dentists on endodontics versus implants in Montreal. Afterward, they sent me this note: “You are a prince. Thanks for everything. We will cherish this week forever.” Appreciation from one’s practice patients is wonderful; from one’s peers and soon-to-be colleagues is even more special.

When I was growing up in northern New Jersey, I knew I wanted to go into medicine or dentistry. My mother was in real estate, and my father owned a local candy store. I loved biology and chemistry. In the end, I felt that becoming a dentist suited my personality better. I like working with my hands, for one thing, and apart from becoming a surgeon, dentistry offers more opportunity for that. I also felt dentistry would allow me more of a family life. And as it turned out, I went into a dental specialty that, other than oral and maxillofacial surgery, deals more frequently with emergencies than any other dental field.

My choice of endodontics as a specialty was influenced by a two-year stint in the U.S. Army, in the mid-1960s. I was a preventive dentistry officer at Fort Bliss, in El Paso, Texas. This was during the build-up to the Vietnam War, and I was very lucky not to be chosen to serve in Southeast Asia.

I was also very lucky to have a commanding officer who let me rotate among the different specialties, including endodontics and periodontics. A lot of commanding officers were not so accommodating, leaving dental officers just doing restorations. But I was encouraged to do everything, and, in the end, I discovered that what I loved was saving teeth.

After my Army stint was over, I entered Columbia University to study endodontics. I was fortunate, once I graduated, to practice in a great area. In northern New Jersey, the dental IQ is very high. I first became an associate and then a partner with an excellent practice with excellent mentors.

One of the things in my first career that pointed the way toward the second was public service. I joined the American Association of Endodontists, in which I became very involved. I served as chair of the Public and Professional Affairs Committee and as a director on the board for the American Association of Endodontists. I also served as president of the New Jersey Endodontic Association.

In these capacities, I met many people who had a great influence on me, especially educators. I came to see how important it is to give back to education. I saw the shortage of full-time educators, which bothered me. I felt that because this specialty had been so good to me,

There is nothing like the interaction with students. If you can make a difference, that is immensely satisfying. In private practice there is a significant financial reward, but in academia you receive something even better, the gratitude of past students and future practitioners.

We need great practitioners and we need the great teachers to inspire and educate them. In dentistry, there is no need to choose only one or the other.

and I was financially able to afford it, when the time came to leave my practice and take up this second career in education, I did not hesitate.

OPENING A NEW PATH FOR OTHERS

Educators, in my opinion, should be honored. Professors in dentistry make a major financial sacrifice compared to what they could earn in practice. That kind of devotion demands respect because it makes what we do in private practice possible. The American Dental Association should honor educators any way they can, especially those who sacrifice the lucrative rewards of practice for the satisfactions of academia.

With all these things in mind, I decided to make it easier for young faculty members to choose teaching over practice. I began by raising the funds for an endowed professorship in endodontics. A practicing endodontist can easily earn three times what a dental college professor is paid. To balance these numbers, I set a goal of \$500,000 for an endowed professorship. The income from a \$500,000 endowment is about \$25,000.

We not only reached the goal in short order, we overshot it by \$65,000, with another \$250,000 in pledges still outstanding. The strategy was simple. I personally called and spoke with alumnae, and they responded just as I knew they would. The American Association of Endodontists Foundation has stepped up.

We certainly need quality professors to attract the best students possible. Dentistry in general and endodontics in particular has entered a time of extraordinary technological advances. I also have been fortunate to work with several colleagues who had been on a similar path as myself—full-time clinicians who transitioned into full-time dental educators as well.

THE BEST OF BOTH WORLDS

We need great practitioners and we need the great teachers to inspire and educate them. In dentistry, there is no need to choose only one or the other.

I'd love to see more endodontists in my situation, with 25 or 30 years of practice behind them, realize the advantages of giving back by becoming educators. Those still practicing might consider teaching one day a week. Those who have accumulated a lifetime of practice experience could do more.

For now, the purchase of an RV remains a distant dream. Every once in a while my wife will ask if I am ready to start traveling. After a tough day, I admit, it is sometimes an attractive idea. But I am loving my second career. The RV will have to wait a bit longer. I have found a better road. ■

PRACTICE TRANSITIONS—PAST, PRESENT, AND FUTURE

Ronald I. Prokes, DDS

ABSTRACT

Until the 1960s, the value of a practice upon the retirement of the dentist was considered to be nil. In the next several decades, the value of a practice as a going business concern was recognized and formulas based on productivity were used to establish the sales price of “walkaway” practice transitions. Increasingly creative means, such as pre-sale, deferred pre-sale, shareholder process, incremental practice sale, and practice mergers have been created to make practice transitions more flexible, thereby maximizing the financial value of transitions. Dentists at the beginning of their careers will have an increasing range of opportunities in the future, with various combinations of financial security, freedom from management concerns, control over the practice, and accumulation of equity. Those in the 45- to 55-year age range should be planning in detail for their transition. Those older than 55 should begin exercising their plans since the future will involve much longer transitions.

In the clinical areas of dentistry, the silicate restorations of the 1950s, 1960s, and 1970s eventually gave way to the advances of multiple generations of composite resins and the dental materials of today. In the area of crown and bridge, it is now possible to fabricate a quality crown chair side, and it is possible to “scan” images to labs for preparation of crowns without ever having to take an impression. This advanced technology is created with the ideas of improved benefits, ease, and comfort both to dentist and patient. Similarly, the next generation of practice transitions is evolving with the same concepts of increased benefits to both buyers and sellers. Practice transitions, which basically involve the sale of part or all of a dental practice from one individual or entity to another, are undergoing dramatic changes.

The field of practice transitions, like dentistry itself, is undergoing many changes—new and innovative approaches to an increasingly important part of the dental business cycle. For many years, a practice transition was basically confined to the sale and purchase of a practice, generally culminating in a walkaway deal (in which the seller would leave upon signature of the contracts or shortly thereafter). Over the years, that simplistic approach has been modified and refined, evolving into much more creative approaches in recent years. With the current and continuing changes in the business of

dentistry, we will inevitably see even more creative means of transitions over the next decade.

PAST

Practice transitions have evolved greatly over the past several decades. In the 1950s and early 1960s, a practice transition basically involved a dentist closing his doors and walking away into retirement without any compensation in return, other than the possible sale of used equipment to a colleague. Patient records were either disposed of or passed along to a new dentist in town. The thought of compensation for goodwill and restrictive covenant was about as foreign to dentistry of that era as was the term “adhesive dentistry.”

With the advent of third-party involvement in the form of dental insurance, changing socioeconomic patterns, inflation, price controls, etc., the profession began to evolve more into a business, and as such, recognition was given to value for a dental practice in the form of compensation for developing a business rather than merely having a career job. The advent of compensation for the business value of a practice



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created an entirely new market in the late 1960s and 1970s—the market of practice transitions. Since it was still relatively easy for new grads to start up their own practices and be financially successful without having to purchase existing practices, placing high values on dental practices was still not the norm during those years. It was not uncommon in those years to value a practice at 100% net or 50% of gross, plus the fair market value of the equipment. However, in the case of some specialty practices, such as orthodontics, some practice values were placed at the equivalent of one year's gross receipts.

During the 1970s and 1980s, the transition of dental practices evolved into an ever-expanding market. Dental practitioners began to see that they had more than just a lifelong job producing an annual income. They realized that they also had a transferable business and that residual value for that business awaited them when they were finished practicing, thus allowing them to transition a practice (generally at retirement age) and receive substantial income in return. Around the early 1970s, a new field emerged as well as an ancillary service to the dental profession—practice brokers. The early brokers were frequently dental supply personnel who used their many field contacts to put dentists together for compensation, though in reality, they had been doing similar pairings without compensation for years. As the business of dentistry evolved, so did the brokering of practices, luring people of varying backgrounds into the field. Unfortunately, these people often looked more toward closing a deal for their own compensation than to determining the needs

of the dentists involved and completing a transition for the best interests of the principals.

PRESENT

From the mid-1980s through most of the 1990s, practice transitions created a major impact in the business of dentistry, with literally tens of millions of dollars of practices transitioned annually. In order to fulfill the needs of the dental clients in practice transitions, many of the “new generation” practice brokers were professionals with backgrounds in dentistry, law, accounting, or business. During the last 12–15 years, many creative means of practice transitions were created, although the commonplace walk away sale still exists even today. The needs, especially the financial and emotional needs, of the dentists were finally taken into consideration. Programs were developed to allow a seller to get 100% equity out of the value of the practice and yet stay on in the role of a well-compensated clinician, in order to maintain an income flow, for up to ten additional years following the sale. When control was an issue, the same results could be accomplished by a “deferred pre-sale,” whereby contractual and financial commitments were made immediately by the purchaser but the seller retained title to the practice, as well as control of the practice, for the first several years of the transition, at which time the roles would then reverse. In general, practice transitions became more based upon the needs of the buyers and sellers.

During this time frame, urban area practices would generally sell for 65–80% of the weighted three-year average receipts, with a sale generally completed in the time frame of a year or less. For rural area practices, the value was generally less (maybe 60–70%) and the time frame generally longer (maybe one to two years). There were, of course,

exceptions to the above, with some practices selling for over 90%, and some “geographically challenged” area practices selling for less than 50%.

Thus, over the years, dentists recognized and ultimately received very fair values for their practices. This became exceptionally important, since ADA surveys as recently as the late 1990s showed that almost 75% of us depend upon the proceeds of the sale of our practice to fund part of our retirement. Of course, those dentists who looked at their various options, determined their own needs as well as considered the needs of the other party, and used competent and knowledgeable advisors (attorneys, accountants, and consultants skilled in the area of dental practice transitions) generally received the greatest value for their practice. Ultimately, they also had the most successful long-term post-transition relationships with the successor dentist as well as their former patients and employees.

FUTURE

Now with 2015 upon us and recognizing that according to the ADA publication in August 2013 that there is a “new normal” in dentistry, practice transitions in 2015 and beyond are likely to become even more complex, creative, and important to both the emotional as well as the financial needs of dentists. The changes in the transition market include conditions such as: purchase price as a percentage of gross annual receipts, length of time to transition practices, changes in supply and demand of practices as baby boomer-aged dentists enter the preretirement stages of their professional lives, market competition from the DMSO segments and other nontraditional practice environments, changing demographics in both the

general patient base at large as well as the practicing dentists and enrolled dental students, and certainly, the economic downturn created by the recent “great recession.”

Although there are many interpretations of practice transitions, over 25 years of experience in working with thousands of dentists has led me to my own definition, which equates to quality of life—working on who you want, when you want, where you want, if you want! First and foremost, however, all practice transitions should be based upon needs of buyers and sellers, with the goal that the needs of the seller, which in turn create an opportunity, are complementary to and met by the needs of the purchaser. For a prospective seller/shareholder, the questions to be addressed in considering his or her needs are:

- Do I need (or want) to continue working for financial reasons?
- If so, is it full-time or part-time, and how many days/weeks for how many years in the future?
- Can I give up (or at least share) control, and what exactly does control mean to me? (It is interesting to note that a potential seller will often tell me that he or she is willing to relinquish control, but when I look to the spouse, the spouse’s head is vehemently saying, “No.”)
- Is the spouse’s input supportive or not?

For a prospective purchaser/shareholder, the questions to be addressed in considering his or her needs are:

- What are my economic needs during the first year into the transition?
- What are my economic wants at five to seven years into the transition?
- Am I willing to assume control of the practice and do I have the business skills to do so?
- What are my geographic desires?

- Is the opportunity more important than geographic considerations, or is geography more important than opportunity?
- Are there relevant spousal input and considerations?

Too often, parties enter into an arrangement out of convenience, as when a well-intentioned supply rep matches two parties as associate/host, or buyer/seller. Though the intentions are always good, the outcomes of convenience-based transitions typically result in failure.

TRENDS IN TRANSITIONS

What’s next in dentistry and practice transitions? For a practicing clinical dentist, this decade should probably be the greatest time ever to be a clinician. The new concepts, products, and treatment modalities have made our profession much more enjoyable, profitable, and productive. From the standpoint of practice transitions, however, the many changes coming in this decade are likely to make practice transitions much more difficult, require greater amounts of time to complete, and potentially be less profitable for the sellers of dental practices. This should be of greatest concern to any dentist 45 years of age or older, and shall be potentially most rewarding to the young dentists of this decade.

Knowing that successful practice transitions are based upon complementary needs, that dentistry is becoming more of a business and less of a profession (it is just reality—does not make it what we want), and that one of the purposes of any business is to eventually sell it at a profit, the

During the last 12-15 years, many creative means of practice transitions were created, although the commonplace walk away sale still exists even today.

Trends in practice transitions should be of greatest concern to any dentist 45 years of age or older, and shall be potentially most rewarding to the young dentists of this decade.

following are some considerations that will likely influence the future of practice transitions.

DENTAL MANAGEMENT SERVICE ORGANIZATIONS

There is increasing competition from the dental management service organizations (DMSO), entities that offer young dentists career opportunities as employees rather than as equity owners. The young dentists today are typically around \$200,000 to \$250,000 in student loan debt and are, at this point in their careers, most interested in income and experience. Since they often are uninterested in equity or control or issues affecting them more than five years in the future, the DMSO opportunity looks very attractive to them. After all, why should they consider taking on another \$300,000 to \$800,000 of debt to acquire practice equity when they can have a job with regular hours, no management responsibilities, and guaranteed salaries of \$125,000 to \$150,000 right out of school?

What the young dentists frequently fail to realize, or at least care less about at that point in their careers, is that they have little or no control in practice management policies. Ultimately, many of these young practitioners have left or will leave employment in a DMSO for the more traditional ownership of a fee-for-service practice. Personally, I have talked to more than one individual in the above situations willing to sacrifice \$100,000 or more of annual income initially to enter the private practice equity environment and have control.

From the seller's perspective, DMSOs offer an alternative approach to traditional buyers. The DMSO offers a seller the opportunity to reduce manage-

ment responsibilities and maintain clinical income. We work with many different models and philosophies of DMSOs, but the one common factor is that they universally see dentistry as either an income stream while they own the practice or as a big payout when they sell their multiple of practices. The DMSO model offers to a seller either cash (100% of the sales price upfront, or part upfront and part based upon future performance), equity in the DMSO (as stock), or some combination thereof. The more creative and aggressive DMSOs are now offering the possibility of a return of roughly 300% of a year's gross receipts if the seller is willing to take some risk with an equity position in the company. Thus, for a practice with \$1,000,000 in receipts, these latter entities may eventually pay a seller \$3,000,000 for the practice as opposed to the current likely return of \$700,000 to 750,000. Do you have the stomach lining and heart muscle to gamble on such a return, or are you risk adverse and comfortable with the more traditional returns for the sale of a dental practice—typically 60–80% of a three year weighted average of receipts?

CREATIVE PRACTICE TRANSITIONS

In the past, and still present today, the most common form of a practice transition was the “walkaway.” Today, however, we have an endless variety of practice transitions, all of which are based on the needs of the individuals involved. It may not be possible in the future to receive maximum value without the use of some creative strategies in certain transition scenarios. In past practice transitions, a value was established, an agreement entered into, money exchanged and contracts signed, and title of the assets as well as responsibility for care of the patients transferred from the seller to the purchaser—all in a relatively straightforward and simple

manner. While this approach will still be successful in certain situations, it is becoming increasingly evident to many in the practice transition field that there is a need for more creative programs to achieve maximum value and optimal efficiency.

While it is impossible to list and define in detail all such creative strategies in the scope of this limited space, several creative concepts can at least be alluded to in a very cursory manner. Strategies to benefit both purchasers as well as sellers will be referenced superficially with the goal to instill in your minds that nontraditional concepts to benefit both purchasers as well as sellers exist today and will continue to evolve. Thus, what follows will be a very brief summary of some of the variations for a practitioner to consider over the next ten years or so.

Pre-Sale

This is a process in which the seller of a practice immediately gives up financial responsibility, managerial control, and ownership of the practice to the purchaser, but then remains as a full-time or part-time clinical provider in the practice for up to seven years post-closing. Benefits to the seller are that he or she: (a) receives payment for the practice equity (thereby converting it from a non-interest-bearing asset into an interest-bearing asset); (b) maintains clinical income as a provider; (c) relinquishes managerial control; and (d) has security in the event of death or disability of having received maximum value for the practice. If you are in your late 40s or older, this should be a serious consideration for you.

Deferred Pre-Sale

Many young dentists initially look for income and experience and later move

into commitment and equity. Many middle-age or older practitioners look to maintain current income and control for several more years.

One transition option to meet the needs of both parties is the deferred pre-sale in which the parties commit financially and contractually immediately, but for a pre-defined period (typically two to five years), the seller retains practice ownership, financial responsibility for and managerial control of the practice, and after the pre-defined time period, the roles reverse. If you are considering the sale of 50–100% of your practice in the next five to seven years, this concept may be of interest to you. In fact, transition programs of an ingenious nature have been created in which to sell a practice for as much as 120% of a year's gross receipts

Conversely, for the young dentists considering the purchase of 50–100% of a practice in the next several years, the above paragraph must be pretty depressing. However, for those young dentists potentially interested in purchasing a practice, what if a program were designed which allowed him or her to name their own price to buy a practice? If 100% or 120% of a year's gross receipts is too much to pay, how would 65%, 55%, or even 50% of a year's receipts be? Any prospective purchasers interested in buying practices for less than current fair market values? If so, then realize that such possibilities may now be available. If a potential seller could offer these options in one package and yet earn even greater than 100% of a year's gross receipts for a practice, we would truly have a win-win situation. With the creative practice transition strategies now available, both concepts are possible: sellers may receive 100–120% and purchasers might pay only 50–55%, potentially.

These creative concepts revolve around the use two strategies. First is the use of a deferred pre-sale. Second is

the use of the “earned equity” concept in which the young purchaser “earns” credits towards the purchase price. These credits can be based upon certain levels of production requirements or time requirements in determining credits or can even be calculated retroactively in cases where two dentists are already practicing together. The credits earned can be partial or full, thus earning credits for up to the entire purchase price of the practice.

Shareholder Process

For those dentists desiring to enter into a “partnership” whose intent is for the younger dentist to eventually purchase 100% of the practice over a 10–20 year period of time, the shareholder process may be the solution. This program lets the entering dentist buy the first 50% of the practice with pre-tax dollars, allowing for a substantial savings of income taxes. It also allows the flexibility that if the personal or professional relationship does not succeed, the two dentists can terminate the professional relationship and have two separate practice entities in the same geographic area.

Incremental Practice Sale

Of increasing prominence and popularity is a program in which two professionals and their corporations unite in a practice transition as buyer and seller and create a management LLC, which then becomes the “practice.” All income is received by the management LLC and all expenses are paid by the management LLC, including provider compensation to each partner's dental corporation, based upon his or her personal productions/

collections. This program provides tax efficiency for both buyer and seller, as well as potentially allowing the seller to receive additional sale revenues based upon growth of the practice while the two dentists are together—typically 10–15 years. (Caution: if the seller's corporation was in effect between July 25, 1991 and August 10, 1993, be sure to check with your CPA to see if Anti-Churning Rules may apply). It can be demonstrated that use of a deferred incremental sale strategies may result in about 250% of the net sale proceeds of a dentist who uses the old-fashioned walkaway sales strategy.

Practice Mergers

Would you like annual economic returns of 25% or more without investing any money of your own as well as the ability to thoroughly understand what you are investing in. Are we talking options, leveraged buyouts, lotteries, or what? In fact, we are talking dental practices! Yes, you can purchase another dental practice, merge it into your own practice, and return 25% or more, investing in what you know best (dentistry) and using 100% of somebody else's money.

Dentistry has two basic categories of expenses in practices—fixed and production. Fixed expenses are those that remain relatively constant whether you produce \$100,000 a month or \$100,000 a year. These include categories such as rent, utilities, insurances, accounting fees, software support, equipment leases, and to a degree, staff. Production-related expenses, however,

are those that remain relatively constant in terms of percentages, but will have total dollar amounts very different for a \$100,000 per month practice than those of a \$100,000 per year practice. These include expenses such as lab, dental supplies, office supplies, staff salaries to a degree, and some miscellaneous expenses. Although there is a range for each category, for purposes of illustration, we will assume that lab expenses average about 10% of your annual income, clinical supplies about 7.5%, office supplies about 3%, and miscellaneous expenses about 2.5%. We will also assume another 15% of annual income for additional staff expenses as the practice grows.

Therefore, if we have an “average” practice grossing \$800,000, for every dollar of growth beyond that, our fixed expenses remain constant, but our production-related expenses increase only by 38% ($10.0 + 7.5 + 3.0 + 2.5 + 15.0 = 38$). This requires the assumption that we can do all the additional production ourselves. Thus, if we add \$400,000 in revenues, our additional net income increases by almost \$248,000 ($\$400,000 \times 62\%$). However, if you do not have the patient base to increase your gross receipts by \$400,000, you will need to consider a practice merger. Now, you have two additional expenses to consider—the debt service and paying somebody to do the dentistry if you are unable or unwilling to assume the additional production. Debt service will typically range from 10–15% of the annual production. In order to pay somebody to do the added production, you will need to add an additional 30% or so for provider compensation.

Therefore, if you purchase a practice, merge it into your own, and do all of the dentistry, your return is 47% (100% minus 38% for the above production expenses and minus 15% debt service).

Now for every dollar added to your current production, you will net about 47%. Therefore, if you merge a \$400,000 practice into your own and do all the dentistry yourself, your additional net income will be almost \$200,000 ($\$400,000 \times 47\%$). If you elect or need to pay somebody to do the additional dentistry, your return is reduced by 30% “provider compensation,” resulting in about a 17% return—all without ever touching a high speed HP! In other words, by merging a \$400,000 practice into your own, leveraging the buyout 100%, and delegating the work, your potential return is \$75,000–80,000!

This, of course, is the logic of most DSMOs.

Miscellaneous Strategies

Other creative practice transition strategies may include some of the followings: incubator programs—developing a practice for a new dentist via the excess of patients of an existing dentist who does not want to sell a practice nor take in an associate but would like to be compensated for his or her excess patients; two-stage closings—in which a young dentist can begin to immediately amortize some of the practice assets with little or no money exchanged and the seller can defer taxes on the practice sale until a later date in which he or she may be in a more favorable tax bracket; and present value/future value transitions—in which an above current fair market value can be created in order to maximize transition receipts for a seller.

SUMMARY

The above and other creative practice transitions are now available for consideration and use in situations where needs are only met by creative

solutions. While you must be cautioned that not every practice will meet the requirements for such creative strategies, you must also be aware of at least the possibilities. It will be necessary for purchasers, sellers, and shareholders/partners to use the services of knowledgeable, ethical, creative, and experienced advisors—practice transition consultants, accountants, and attorneys.

In fact, any practice transition involves three basic concepts: (a) determination of the needs of a prospective buyer, seller, or shareholder; (b) a match of parties with complementary needs in the opportunity at hand; and (c) use of consultants with the experience and expertise to navigate you through the sometimes tortuous fields of practice transitions. In the future, traditional transitions will continue to be available, but creative transitions are likely to become used more often.

Will all the time, effort, and money spent by dentists of the last several decades in developing a business be wasted, with little or no compensation upon retirement, as was the case of our predecessors? The answer may be a resounding “Yes”—if we do not accommodate and modify. Just as there were “gloom and doom” projections for our future relative to changes caused by insurance, managed care, OSHA, HIPAA, third-party involvement, etc., there will be similar doomsayers predicting the downfall of practice transition values. However, as dentists, we are a creative, energetic, analytic, and adaptable group. We evaluated and overcame the above obstacles to be stronger than ever. With the same resourcefulness, aided by the input and assistance of competent professionals in the area of practice transitions, we will retain an environment whereby we still will receive fair and reasonable compensation for the efforts extended in creating a successful business.

The most important changes are likely to include: a need to be much more creative, extensive planning and preparations, and thinking in longer time frames. It will no longer be adequate to put a practice up for sale and expect to get fair compensation and completion in a short period of time and then just walk away from the practice. Although there will be many challenges, changes, and modifications to existing practice transitions, as well as the evolution of new and different transition modalities, the primary responsibility will be with the individual dentist to plan properly.

Just as the future of clinical dentistry is bright, the future of the business of dentistry, as related to practice transitions is equally bright! It will, however, require changing paradigms from the historical transition approaches. In part due to the increasing number of DMSO entities, it is anticipated that the traditional solo practice model will decrease by about 7.0% annually. Proper planning, creativity, increased time frames, determination of each party's needs, and advisors to implement those needs with the proper programs will allow for continued and even improved practice transition returns in the future. For the young dentists, tremendous transition choices and opportunities will be present in this decade. For dentists in the age range of 45–55 years, it is important to start the planning process at this time. For dentists over age 55, it is important to begin implementing plans immediately. To assure your future, plan now to take advantage of that which you have created in the past! ■

Non-traditional concepts to benefit both purchasers as well as sellers exist today and will continue to evolve.

THERE ARE A LOT OF WAYS TO GO

William van Dyk, DDS, FACD

ABSTRACT

There is much more to transitioning well out of dentistry than maximizing the economic value of the practice. The full spectrum of professional and personal values, and where each dentist is in his or her life, must be considered. The same is true for the staff and the patients, especially for mature family-oriented practices. A case is worked out in detail, showing that the wisest thing to do in some cases is to gradually wind down a practice and stop without selling at all.

There are a significant number of baby boomer dentists who are contemplating the end of their dental practice career. Like baby boomers in general, the size of the group will affect the decisions of those involved.

The 2008 Great Recession has had a dampening effect on the decisions of many of these dentists. They put off the inevitable due to financial and other concerns, but many factors are forcing their hands. The most obvious one is their own decreasing capability to continue working. The ability to continue to see patients is affected by illness, disabilities, and mental wear and tear—all of which increase with age. In addition, many eager young dentists are waiting in the wings for the opportunity to take over practices. The pressure to move out of the way continues to weigh on senior dentists. Plus the changes in modern dental practice, whether new equipment and techniques, or the general pressure of decreasing returns and increasing overhead, have a negative effect on the willingness of aging dentists to take on yet another battle. Finally, patients begin to make the decision on their own that their dentist will be retiring. The number of new patients decreases. The willingness of patients to sign on for major treatment slows. Patients boldly ask when their dentist will retire. They are protecting their own future dental health.

As all these factors come into play, there is an understandable desire to delay the decision as much as possible.

The dental practice has become home away from home. It gives meaning to a long and productive life. It provides the opportunity to do something important for mankind, saving teeth, maintaining oral health, and allowing patients to enjoy eating, talking, smiling throughout their lives. It is filled with first patients and then friends as time goes by. And the members of the team are like family. Moreover, it has rewarded years of training with a constant comfortable income. Retiring means giving up all these positive aspects of a life well lived.

With all of this in mind, dentists 50 years old and over have to start thinking about the transition. Ideally a dentist will begin in his or her early 50s to create a practice environment that can introduce an additional, much younger dentist into the business. Over a long period, the practice slowly drifts from the senior dentist to the younger dentist and an inevitable transfer of all the patients and facility moves to the younger dentist and the senior dentist leaves. There are many practices where this happens and all of the parties—the senior dentist, the junior dentist, the staff, and the patients—are comfortable with the transition. But too often the opposite is the case. No planning is done. The senior dentist works until a disability forces retirement. The patients are dropped in the lap of a young dentist



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who comes up with the money to buy the practice. Or no one offers to buy the practice and the patients are left to find their way toward a new, unfamiliar dentist at a time when they can no longer handle significant change comfortably.

WHAT ARE OUR OPTIONS?

Is there an alternative to the ideal or the opposite? The rest of this piece will discuss the options. The most important thing to remember is that the earlier the planning begins, the better the possible outcome. And the best outcome is for the senior dentist to move into a comfortable retirement with sufficient funds to live out his or her remaining years in enjoyable activities. The practice sale provides part of that success. At the same time a young dentist gets to step into business ownership with a practice that runs well, a staff that is supportive, and an ability to continue to keep the practice successful. And finally the patients are happy with the transfer and are willing to continue their support of the practice. Proper planning can make this all happen.

PLANNING IS ESSENTIAL

For the senior dentist, planning consists of first facing the reality of the situation. Personal internal evaluation of his or her desires and needs comes first. Can the change to no practice be handled? Is there a clear road after retirement to other productive activities? Will the family adapt to the change in a positive way? Are there investments and savings sufficient to maintain a comfortable lifestyle? Before any move is made to transition, clear answers to these

questions must be developed. Disaster strikes when the first move is to hire a broker or practice transition specialist. It is similar to hiring the architect first, then trying to think about what you need in the house. You end up getting what the architect thinks you should have. Transition consultants/brokers are excellent adjuncts to accomplish the dentist's goals, if the goals are well formulated.

One of the biggest problems involves money. Too many dentists have not saved adequately for retirement. Other dentists have found seemingly adequate savings dissolve through changes in the economy or local environment. Planning needs to take personal and family financial requirements into account. This might mean planning to delay retirement or slow the process by making sure there is an opportunity to continue working at some level even after the practice changes hands.

Second, the senior dentist needs to decide how to involve the staff in the transition. In a few instances staff are involved from the beginning and make the transition smooth. But it is important to remember that each employee sees the world from his or her perspective. As loyal as each seems to the dentist and the practice, their first priority is to themselves and their family. Learning of an upcoming transition may be the stimulus to take a job closer to home or with better hours, etc. If at all possible it is important for all involved that the staff stay on through any transition.

For the senior dentist, planning consists of first facing the reality of the situation.

Patients often relate much better to team members than they do to the dentist. A consistent front desk person with long years in the practice can make the change in owners of the practice appear seamless.

In the early planning stage it is important for the dentist to build and maintain a high quality long lasting team. Any team members who are difficult or high maintenance should be gently replaced. Excellent team members should be rewarded to the point where it is difficult for them to leave.

TIMING OF IMPLEMENTATION

When to involve others in the transition is an individual choice. Most transition specialists recommend keeping the discussion private until a new dentist is chosen. Of course in the ideal setting, the associate dentist is thoroughly incorporated into the practice prior to the transition and the staff are comfortable with the slow, steady change. Where that is not possible, some specialists consider creating a contract with the staff, offering them a significant bonus if they will agree to stay for the first six months after the practice changes hands. It is in the best interests of the senior dentist to have the staff committed to stay on as far as the value of the practice is concerned. A bonus of \$5,000 per staff member can often be more than made up by the increased value of the practice. And it is in the best interests of the new owner to have the same team in place for at least six months to give him or her a chance to meet most of the active patients as they rotate through a usual recall schedule. It is often possible for both the seller and the buyer to agree to split the bonuses.

Lastly, the nuts and bolts of transition need to be decided upon. There are numerous possibilities. As

mentioned above, the ideal would be to bring in an associate and make a plan for the gradual transfer of ownership. Finding an associate who has the personality and dental skills to match the existing practice may take some effort and trial and error. Finding an associate who is committed to the area, whose family is committed to the area, and who is committed to the patient population in the practice is extremely important. Losing an associate after making a commitment to the transition can be devastating to the practice, the staff, and the patients.

ROLE OF THE NEW DENTIST

One of the most important aspects of transitions that involve associates is to get a commitment early on to the exchange. It is recommended that the transitioning dentist set the price of the practice within the first year of the relationship and make a plan for the purchase. Even if the associate is not prepared to immediately commit financially, it is important that he or she perceive that any effort they make to attract patients and build the practice will not increase the future purchase price. In addition as the associate begins to buy into the practice, it is important that the senior dentist makes it clear to staff and the community that the new dentist is a part owner and involved in the decisions and management of the practice. Often if the senior dentist does not make an effort to establish joint ownership, the staff and patients do not perceive the new dentist as anything other than an employee and the new dentist becomes disillusioned with the arrangement.

The next alternative is to sell the practice outright, either to walk away or to reverse the normal arrangement and become an associate in the practice. Of primary importance in this scenario is to make the practice as attractive as possible to potential buyers. As more baby boomers face retirement, it is felt

that the number of practices on the market should grow significantly. As that happens the potential of multiple choices for potential buyers will increase competition. To compete, it will be possible to lower the selling price to find a buyer. The alternative would be to make the practice very attractive to buyers. Just as realtors recommend that a home should be staged to attract buyers and get an excellent price, dentists should attempt the same strategy. With that in mind, it is important to perceive what a potential buyer might want. Obviously a going business with good systems in place, excellent cash flow, a steady supply of new patients, and a long-standing dedicated staff are essential. If they are not in place, it is important to create a plan to bring them up to a high standard before calling a broker to put the practice on the market.

But in addition to these basic necessities, there are other issues that should be addressed. A new dentist may look closely at the interior of the practice, but ultimately he or she and their family will also look beyond the walls of the practice. What does the building say about the practice? What about the local area? Is the town growing in another direction? And how about living conditions near the office and schools? As the seller, the senior dentist should serve as a one person chamber of commerce for the town. All the positive reasons that the practice has been successful need to be clearly communicated to the potential buyers and the buyer's family.

Lastly, the senior dentist needs to decide what kind of dentist he or she wants to take over the practice. If the patients have become friends and the staff have become like family, the person chosen to carry the practice forward should demonstrate the same qualities of care and concern for patients and staff. The better picture the seller has of

the type of dentist that will fit into the office, the better the success rate of the transition.

DO NOT FORCE A “Fit”

There are an infinite number of possible hybrids of the above scenarios. In each instance the success will depend on the preparation of the transitioning dentist and willingness of the buyer to make sure that the practice in question is one that fits his or her needs and those of the family. The buyer must make sure that he or she has thoroughly evaluated what is needed as far as income, patient type, services offered, staff, and support for their family. A practice that has declining income and few opportunities for new patients may seem like an inexpensive opportunity, but if it cannot provide enough income to pay student loans, the practice loan, and the needs of the family, it will only lead to frustration.

As a last possibility, a dentist contemplating retirement might decide to do nothing. That can also work. Take a dentist at age 65 who has not done the proper planning and does not want to now rebuild the practice or face the number of eager young dentists who would want to take over the practice but cannot demonstrate that they are willing to give the same care to the patients/friends in the practice. This dentist is still pretty healthy and would like to take advantage of that. Some parts of dentistry and seeing many of patients are still rewarding. This dentist decided to get an appraisal of the practice and finds that it could possibly be sold for \$300,000.

Let's look at it this way. If the dentist worked until age 70 (five more years), the income would amount to \$300,000 by earning only \$60,000 per year. This level of productivity can easily be managed working only one to two weeks per month. The dentist would go into half-retirement, spend two weeks a month in Hawaii and get the money expected from a current sale. At the same time, there is no more worry about

new patients, providing dentistry that is no longer enjoyable to do, spend more time with patient-friends, stay involved in the profession, be prepared to increase work if a family crisis demands it (full retirement is very difficult to reverse), and at age 70 either continue to work on a limited basis or refer patients to a young dentist in the community selected to provide the type of care that they deserve. Sure, the overhead percentage goes up, but it does not matter as long as the salary requirements are met. Staff may be an issue, but the number of baby boomer staff members who would like to retire part-time is also growing.

In an actual scenario I am familiar with, a dentist put the practice on the market for \$300,000 but over the next two years got no offers. During that time he earned \$400,000 working full-time. It dawned on him that had he sold the practice immediately after putting it on the market, he would have lost \$100,000. Now he has gotten all he needs from the sale and can walk away, leaving his patients in the hands of his excellent partner.

Transitioning out of the dental profession is the dream of a few dentists, but for most dentists the exercise is fraught with land mines. Where do I begin? How do I find the right dentist to take over? What will I do afterwards? This article attempts to break the process down into simple steps. Start as early as possible. Do a personal search first to answer the questions about what is personally important to achieve in the transition. Take the time to get the practice in fine working order so that it is attractive. Then find professional help to make the transition run smoothly. Or, do not do anything, but do it wisely! ■

If at all possible it is important for all involved that the staff stay on through any transition. Patients often relate much better to team members than they do to the dentist.

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AN ASSESSMENT OF FACULTY AND DENTAL STUDENT DECISION-MAKING IN ETHICS

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ABSTRACT

This study reports and compares dental student and dental faculty scores to national norms for the Defining Issues Test 2, a measure of ethical decision-making competency. The findings showed that dental students and faculty tend to make decisions that promote self-interest, paralleling the ethical orientation of business professionals. Differences associated with gender, language, and norms from previous studies were observed. The findings underscore the importance of raising dental faculty and student awareness of their own ethical decision-making approaches. More importantly, the findings highlight the need to ensure that dental faculty have both the knowledge and skills to train dental students about the central role that ethical decision-making must play in patient care.



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Increasingly, healthcare practitioners are expected to become socially responsible to deal with widespread disparities in overall health and access to health care (Asch et al, 2006; Frist, 2005; Schoen & Doty, 2004). In the recent Institute of Medicine report, it was suggested that oral health professions and physicians have similar requirements regarding the improvement of access to oral health care for vulnerable populations (Institute of Medicine, 2002).

In response to demands for change in dental practice, the Commission on Dental Accreditation (CODA) standards for predoctoral dental and dental hygiene educational and programs now specifically address these issues:

Students should learn about factors and practices associated with disparities in health status among subpopulations, including but not limited to, racial, ethnic, geographic, or socioeconomic groups. In this manner, students will be best prepared for dental practice in a diverse society when they learn in an environment characterized by, and supportive of, diversity and inclusion. Such an environment should facilitate dental education in: basic principles of culturally competent health care; recognition of health care disparities and the development of solutions; the importance of meeting the health care needs of dentally underserved populations, and; the development of core professional

attributes, such as altruism, empathy, and social accountability, needed to provide effective care in a multi-dimensionally diverse society.

Furthermore, predoctoral dental education programs are required to create a learning environment that promotes critical thinking: “Graduates *must* be competent in the use of critical thinking and problem-solving, including their use in the comprehensive care of patients, scientific inquiry, and research methodology.” The skills of ethical decision-making—one indicator of social responsibility—and critical thinking are also important in achieving improvements in the United States healthcare system, as articulated by the Institute for Health Improvement, where the “Triple Aim” calls for: (a) improving the quality and satisfaction of patient experiences, (b) improving the health of populations, and (c) reducing the per capita costs in health care (Berwick et al, 2008).

The specific need for improved social responsibility as evidenced by ethical decision-making in dental practitioners is exemplified by recent studies showing a somewhat negative attitude in dentists towards the poor and underserved (Catalanotto et al, 2011; Logan et al, 2013). While bias could be an explanation of negative attitudes toward the poor and underserved, ignorance may also be a function of or cause of poor ethical decision-making. Not being aware of social determinants of disease and the difficulties of low income/low oral health literacy patients in accessing oral health care and practicing appropriate prevention may lead some to

ignore the ethical obligation of dentists to practice the ethical principle of justice (treating all fairly). In other words, the negative attitude may stem mostly from ignorance rather than prejudice.

In order to promote social responsibility and critical thinking, dental school faculty need to demonstrate that they have the requisite knowledge, attitudes, and skills to effectively teach students. The Health Resources and Services Administration (HRSA) has funded a series of grants directed towards dental educational programs that promote these aims. In 2010, HRSA funded grants in predoctoral training in general, pediatric, and public health dentistry, and dental hygiene (HRSA-10-262) with a goal of enhancing the oral health workforce’s ability to meet the needs of underserved populations in the United States.

Undertaking this type of curricular and instructional initiative requires considerably more thoughtfulness and planning beyond merely adding or revising course content and modifying instructional strategies. Knowing what ethical decision-making skills and beliefs faculty and students hold is pivotal in determining what support they will need to acquire these new competencies, or even whether training is required. The use of measurement tools can also

Knowing what ethical decision making skills and beliefs faculty and students hold is pivotal in determining what support they will need to acquire these new competencies, or even whether training is required.

assist educators in identifying currently held notions of ethical decision-making competency and in identifying areas where expanding individual breadth of knowledge and awareness are needed. Aside from collecting baseline data for our own program, the authors became interested in comparing our faculty and student scores to national norms.

In order to achieve our goals, this study had the following aims: on a widely used standardized measure of level of moral reasoning, (a) compare University of Florida dental student and dental faculty group scores to national norms, (b) compare the scores of dental student to faculty members, and, (c) investigate variables that might be related to scores among dental students.

Methods

Faculty and students were sent a pre-invitation letter explaining the purpose of the study. Data were collected using the “professional” level of SurveyMonkey, which allows for better data security through SSL encryption. Cohort groups of students and a sample of convenience of faculty members were used.

The newly revised Defining Issues Test (DIT2) assesses respondents’ ability to apply moral principles when developing a solution to a general dilemma that illustrates a social problem. Participants read five brief vignettes about a social problem and decide what is important in responding to that problem by indicating their initial position on a dilemma. Next they rate and rank the arguments they considered important in deciding what should be done. The way that partici-

pants respond is felt to be based on personal cognitive schemas, preexisting underlying organizational patterns or conceptual frameworks that provide the basis by which individuals relate to the events they experience.

Research shows that among adults, arguments generally cluster into three groups. These include arguments that appeal to: (a) Personal Interests (PI), or making decisions in which promoting self-interest is the primary guidance; (b) Maintaining Norms (MN), or making decisions that are consistent with what society expects; and (c) Post-Conventional thinking (P), or making decisions based on ethical principles related to the good of humanity, that promote the societal good rather relying on social conventions, expectations, or legal contracts. An additional dimension is N2, a newer index that tends to show stronger construct validity than P (Maeda et al, 2009). N2 scores are calculated by comparing participants’ ability to discriminate between Post Conventional items and lower ethical reasoning level items that are designated by PI and MN norms. The Defining Issues Test has been extensively used in many fields and it is accepted that PI or personal; interest represents a low level of ethical development (almost the only one used by children), while P is the highest level of ethical reasoning.

Using a national database, Dong reported the DIT2 schema scores of 53,261 college and graduate student standards from 2005 to 2009 to develop national norms. Dong also compared schema scores by gender. The DIT2 means from the Dong study were used to compare our sample to national norms. These norms are available at <http://ethicaldevelopment.ua.edu/files/2014/03/Norms-for-DIT2.pdf>.

All dental school faculty members, including clinicians and basic scientists ($n = 82$), and all first-year dental students in two classes ($n = 166$) at the University

of Florida dental school were invited to take the DIT2. Overall, 173 individuals completed the survey (35 faculty and 138 students); a response rate of 70%.

The mean age of dental student and faculty participants was 23.8 ($SD = 3.4$) and 53.8 ($SD = 9.5$), respectively. Fifty-seven percent of the faculty were male compared to 48% of the students. In the dental student group, 80% spoke English as their primary language and 35% self-identified as underrepresented minorities (URM) during the dental school admissions process. URM refers to ethnicity, including American Indian, Black, Hispanic, Native Hawaiian, Pacific Islander, or any Asian other than Chinese, Filipino, Japanese, Korean, Indian, or Thai.

Data were checked for missing values and distributional form. Summary statistics were computed for numeric and categorical variables. Univariate t-tests were used to compare the means in samples to national norms.

Results

Table 1 compares normative and sample mean scores for DIT2 variables: PI (Personal Interest), MN (Maintaining Norms), P (Post-Conventional), and N2. The combined faculty and students scored significantly higher on PI ($p = 0.020$) and significantly lower on P ($p = 0.008$) and N2 ($p = 0.001$) in comparison to the national norms reported by Dong. Faculty and student scores on PI and MN were comparable to each other. Students scored higher than faculty on P, though these differences were not significant. The students scored significantly higher than faculty on N2 ($p = 0.01$).

Table 2 presents results for students only, showing comparisons across sex, minority status, and speaking English as a native language. Male students

Table 1.

Comparison of faculty and student scores on the Defining Issues Test for level of ethical reasoning with a national norm and comparison of students' scores to faculty scores at one United States dental school.

Table values are means with (standard deviations) shown in parentheses.

	National Norm	Faculty & Students	p-value of Difference	Faculty	Students	p-value of Difference
N	53,261	173		35	138	
Personal Interest (PI)	20.61 (11.46)	22.69 (11.66)	0.020	23.37 (8.95)	22.51 (12.27)	0.642
Maintain Norms (MN)	34.07 (14.36)	34.93 (13.22)	0.395	34.11 (12.50)	35.13 (13.43)	0.673
Post Conventional (P)	41.06 (15.22)	37.42 (14.68)	0.008	34.86 (15.25)	38.07 (14.51)	0.266
P Discrimination (N2)	41.33 (14.57)	36.76 (14.18)	0.001	31.49 (13.49)	38.16 (14.05)	0.010

scored significantly higher than female students on personal interest as a standard for ethical reasoning ($p = 0.032$) and significantly lower on P ($p = 0.004$) and N2 ($p = 0.001$). Status as an under-represented minority was unrelated to level of ethical reasoning. Those whose native language was English were more likely to interpret the vignette in terms of ethical principles ($p = 0.036$) and less likely to apply personal standards ($p = 0.076$), with N2—the measure of preferring higher to lower levels—showing this difference significantly ($p = 0.014$).

Discussion

In this study, comparisons among the mean scores of dental faculty and students were made to national norms comprising undergraduate and non-dental graduate students. It seems reasonable to expect that dental faculty and students would be similar to each other and, as professionals, would use less self-centered approaches to ethical

reasoning. However, the study's finding showed that dental faculty scored slightly higher than the dental students and Dong's national norms on the measure of PI which gauges self-interest, and lower on the higher levels of reasoning P and N2. This same trend was observed when comparing male to female students and native English speakers to non-native English speakers.

Since faculty members scored lower than dental students on P (Post-Conventional) and significantly lower on N2, it appears that students are using higher level ethical reasoning skills than are faculty members. Consistent with CODA standards related to ethics and a humanistic culture/learning environment, the dental school needs to ensure that faculty are knowledgeable and trained in how to teach and promote ethical responsibility and, in part, serving societal good, assuming this is

The more difficult task lies in engaging pre-professional students in a way that brings about reflection finding role model in the profession or changing the culture in which students function.

Table 2.

Student scores on the Defining Issues Test for level of ethical reasoning comparing females and males; underrepresented minorities (URM) and non-underrepresented minorities; and non-native English speakers (NNE) and native English speakers.

Table values are means with (standard deviations) shown in parentheses.

	Female	Male	<i>p</i> -value of Difference	URM	Non-URM	<i>p</i> -value of Difference	NNE	English	<i>p</i> -value of Difference
Personal Interest (PI)	19.97 (10.68)	24.60 (12.72)	0.032	21.71 (11.15)	22.94 (12.87)	0.559	25.77 (11.28)	21.20 (11.89)	0.076
Maintain Norms (MN)	34.42 (12.55)	35.55 (14.53)	0.639	33.54 (11.22)	35.98 (14.46)	0.275	33.77 (12.02)	35.26 (13.88)	0.587
Post Conventional (P)	42.30 (13.73)	35.16 (14.01)	0.004	40.46 (11.23)	36.80 (15.90)	0.119	34.23 (11.63)	40.08 (13.70)	0.036
P Discrimination (N2)	43.25 (12.02)	34.42 (14.06)	0.001	39.58 (15.40)	37.40 (11.11)	0.342	33.33 (12.44)	40.50 (13.70)	0.014

a value shared by faculty members. Ensuring that dental faculty have the appropriate training and skills is important because it is likely to enhance their ability to train students who can then make decisions that demonstrate social beneficence.

Research has shown that medical school students score higher on P and N2 compared to students in business and other academic majors (Maeda et al, 2009). We expected dental faculty and students to be similar to other health care students with high P scores, but they were not. Instead they were more similar to conventional business practitioners and non-healthcare students. In our study, these findings showed that our dental faculty members

and students were significantly higher on PI and lower than P and N2 compared to Dong and Maeda et al. (2009) national norms.

Previous research has shown that there are differences associated with geography, gender, and professional school type. In this study, female dental students scored significantly higher on P when compared to male students, a finding that is consistent with Bebeau (2002) who noted the same among female students in medicine, veterinary medicine, and law (Landsman & McNeel, 2004; Self & Baldwin, 1998; Self et al, 1995). During the time covered by the Maeda study, there was resurgent interest in medical ethics, perhaps demonstrating that the medical schools' commitment to teaching about and measuring moral judgment was reflected in student response. It could also be true that medical and dental school students differ along these dimensions.

It is important to point out the limitations of our study. For example, there are inherent problems in self-report measures, such as the potential for social desirability bias (although the bias appears to be trending in the wrong direction). The small sample size of faculty ($n = 35$) was another limitation. Further, there is no way to separate the more frequent mention of low-level ethical reasoning schema by non-native English speakers as resulting from cultural differences in background or as resulting from unfamiliar use of English terminology.

Although we have discussed measures of ethical decision-making competencies, there are several other relevant issues. These include context, stage in professional training, and interpersonal skills needed to implement ethical reasoning.

CONCLUSIONS

The conclusions point to a relatively poor performance by the faculty and students as compared to national norms. This study found that native English speaking students and females used higher level ethical reasoning skills than did male and non-native English speakers and faculty members. Bringing this information to forefront provides opportunities for current dental faculty and students to become aware of their ethical decision-making practices, inclinations, and effects.

In the spirit of offering evidence-based findings, the study results were reviewed at a schoolwide faculty assembly and at several committee meetings including clinic team leaders, faculty development sessions, curriculum, and with department chairs and administration. Teaching ethical decision-making principles is essential; the difficulty lies in creating realistic classroom discussions and exercises that promote critical thinking in future dental practitioners. Students can repeat in the classroom the instructors' theories on veracity, respect for autonomy, beneficence, and other principles involved in making decisions in the classroom. The more difficult task lies in engaging pre-professional students in a way that brings about reflection finding role model in the profession or changing the culture in which students function.

These findings present an opportunity to evaluate the efficacy of didactic courses, clinical learning, patient-provider interactions, faculty hiring, and related efforts aimed at promoting ethical decision-making across the curriculum and dental school community. The notion that dentistry is one type of commerce is a highly debated sociopolitical issue (see Peltier & Giusti, 2008). The notion that the oral healthcare providers' views on social responsibility are primarily dominated

by economic imperatives causes a discord between policies and access to care (Logan et al, 2013; Shafik et al, 2007). This study points out that it is critical for schools to consider curriculum revisions and faculty interventions to address these findings. All of this, of course, requires faculty members who are competent and appropriately oriented to teach social responsibility. The current research implies that dental faculty members need help in this area. We cannot assume faculty competence in ethical reasoning. Changes are required if we expect them to properly educate dental students.

In dental practice, challenging the status quo on social responsibility requires practitioners to make individual decisions that take into account the economics of dentistry, political and structural factors, and, moreover, the needs of patients and professionalism. The ability of faculty to make informed decisions is essential in combating oral healthcare disparity for marginalized groups throughout the nation. Issues of social justice may also be an important objective of faculty development programs aimed at ensuring that the profession meets societal demands. ■

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The notion that the oral healthcare providers' views on social responsibility are primarily dominated by economic imperatives causes a discord between policies and access to care.

We cannot assume
faculty competence in
ethical reasoning.
Changes are required
if we expect them to
properly educate
dental students.

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SUPREME COURT RULING MAY DETERMINE THE FUTURE OF STATE-BASED PROFESSIONAL LICENSING

David J. Owsiany, JD, FACD

ABSTRACT

The U.S. Supreme Court heard oral arguments this fall in a case involving the North Carolina State Board of Dental Examiners that could have a dramatic impact on how states license and regulate professionals in America. This paper briefly describes the facts of the case and the history of professional licensing in America and then discusses and evaluates the potential impact of the various legal arguments presented by the parties in the case.

The U.S. Supreme Court recently heard a case that could have a significant impact on how states license and regulate dentists and other professionals across America. The case emanates from North Carolina, where the Federal Trade Commission (FTC) took action against the North Carolina State Board of Dental Examiners (NC Dental Board) for prohibiting non-dentists from providing teeth-whitening services to the public.

CASE HISTORY

Beginning in 2006, the NC Dental Board sent “cease and desist” letters to non-dentists who were providing teeth whitening services to the public in North Carolina. In 2010, the FTC issued an administrative complaint against the NC Dental Board charging it with violating federal antitrust laws by excluding non-dentist teeth whiteners from the marketplace in North Carolina. Following a series of administrative proceedings, the FTC issued a final order against the NC Dental Board, directing it to stop restricting the provision of teeth-whitening services by non-dentists.

The NC Dental Board then appealed to the U.S. Court of Appeals for the Fourth Circuit, which issued a written opinion in 2013 upholding the FTC’s order finding that the NC Dental Board had acted in violation of federal antitrust laws. The NC Dental Board then sought review by the U.S. Supreme Court,

which accepted the case and scheduled oral arguments for the fall of 2014. A decision in the case is expected in 2015.

BRIEF HISTORY OF STATE-BASED PROFESSIONAL LICENSING

State-based professional licensure has a long history in America, beginning with the licensing of physicians. According to David Johnson and Humayun Chaudhry’s book *Medical Licensing and Discipline in America*, the regulation and licensure of physicians date back to the Colonial Era in America when certain colonies, recognizing the danger to their citizens of unscrupulous or unqualified medical practitioners, adopted medical licensure requirements. In the 1800s, many states called for the formation of medical societies to examine and certify or license candidates for the practice of medicine, following a specified number of years of medical study.

The Jacksonian Era (1828-1840) ushered in an anti-regulatory climate that led to a collapse of medical regulation and licensure in the United States; but with the onset of the Civil War in 1861, states began reconsidering and eventually reestablishing the regulation of physicians. America’s Civil



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War involved unprecedented levels of casualties of soldiers and civilians, many of which were attributable to medical illnesses and unsanitary medical practices, not necessarily the direct result of the armed conflict.

Advances in modern medical science by 1880 led to newer and more successful treatment of diseases and injuries, requiring higher levels of professional knowledge and skill. As a result, states saw the need to set licensure requirements to ensure healthcare providers were educated and competent in medical science. Moreover, scientific discoveries that keeping wounds and surgical instruments clean would dramatically reduce deaths due to infection, further encouraged states to license and regulate health care practitioners.

These same considerations led to the licensure of dentists. Advances in the understanding and treatment of dental disease, accompanied by an expansion in the number of dental schools, including many that were university-based and not just private proprietary schools, helped turn dentistry into a respected profession. Alabama is believed to be the first state to license dentists in 1841. The rest of the states followed in the ensuing decades. Most of these laws created state boards of dental examiners that worked with the state dental societies to administer examinations and certify those dentists who passed the exams. By the early 1900s, most states had enacted some kind of dental and medical licensing regulations.

From 1900 to 1930, states expanded licensure to other professionals, including lawyers, accountants, architects, nurses, and pharmacists.

Today, many states have expanded licensure even further to other trades and professions, including plumbers, florists, and hair braiders. This recent expansion of licensure has led to criticism from some commentators and economists who question whether licensure is now designed to protect the public from harm or merely to protect licensees from competition.

OVERVIEW OF THE LEGAL ISSUES IN THE NORTH CAROLINA CASE

The principles of federalism animate the U.S. Constitution's design by dividing government authority between the federal government and the states. The federal government's authority is limited to those powers enumerated in the Constitution while other authority is reserved for the states.

Consistent with this constitutional design, the U.S. Supreme Court has long-recognized the states' primary role in professional licensure. In 1889, the U.S. Supreme Court held that the "power of the State to provide for the general welfare of its people authorizes it to prescribe all such regulations as in its judgment will secure or tend to secure them against the consequences of ignorance and incapacity, as well as of deception and fraud." The court also noted that "due consideration, therefore, for the protection of society may well induce the State to exclude from [medical] practice those who have not such a license, or who are found upon examination not to be fully qualified." Similarly in 1923, the U.S. Supreme Court held that a state may "prescribe that only persons possessing the reasonably necessary qualifications shall practice dentistry" and that the state legislature may "confer upon an administrative board the power to determine whether an applicant

possesses the qualifications which the legislature has declared to be necessary."

Pursuant to its constitutional authority to regulate commerce, the U.S. Congress passed the first American antitrust law—the Sherman Act—in 1890, prohibiting every contract, combination, or conspiracy "in restraint of trade," and any attempt to "monopolize" commerce. The U.S. Supreme Court has held that the federal antitrust laws are a "comprehensive charter of economic liberty aimed at preserving free and unfettered competition as the rule of trade." The Supreme Court has upheld the use of federal antitrust laws to restrict private anticompetitive activities, including private agreements to fix prices or create monopolies in certain markets.

The Supreme Court has also recognized that in our dual system of government, consistent with the principles of federalism, the states are "sovereign" and that there is nothing in the language and history of the federal antitrust laws that indicates an intent "to restrain a state or its officers or agents from activities directed by its legislature." The Supreme Court has applied this so-called "state action" exemption from the federal antitrust laws in various settings, including in upholding the actions of a state supreme court in denying an applicant admission to the state bar.

The North Carolina case presents a clash of these two competing legal principles: the federal pro-competitive norm that is reflected in the antitrust laws and the principles embodied in federalism that states are protected from federal interference when they act to protect their citizens from harm through professional licensure. In determining how these principles apply to the actions of the NC Dental Board, the U.S.

Supreme Court will also likely be setting the standards for state-based licensing boards across America.

Pursuant to North Carolina statute, the NC Dental Board consists of eight members: six licensed dentists, one licensed dental hygienist, and one consumer member. The dentist members of the board are elected by North Carolina's licensed dentists, and according to the statute, any dentist elected to the NC Dental Board must possess a license to practice dentistry in North Carolina and actually be engaged in the active practice of dentistry.

Analysis

The U.S. Supreme Court could take one of at least three different approaches in the North Carolina case, each of which is discussed below.

The first approach America's highest court could take would be to follow the FTC's lead, which essentially holds that because dentists (i.e., market participants) make up a majority of the NC Dental Board, the board is a private actor, not a state actor, and therefore is not entitled to state action antitrust immunity unless it can show that the state is actively supervising the board's actions. In essence, the FTC found that the NC Dental Board is a collection of independent practicing dentists who were acting collaboratively to prevent competition from non-dentist teeth whiteners.

Notwithstanding the FTC's ruling, the fact that the state of North Carolina chose to have dentists on the board that licenses and regulates dentists is not surprising or unique. All states have some type of professional licensure laws, and they regularly set up systems with individuals from the regulated profession participating on the regulatory boards. This makes sense since market participants have the expertise to determine qualifications, set standards, and assess competence. Moreover, active practicing

professionals are likely to spot emerging threats to the public—especially in dynamic fields like dentistry and medicine—much faster than government bureaucrats or state legislators can.

The FTC's approach would have a significant impact on how states license professionals. In fact, 23 states joined in an amicus (friend of the court) brief filed with the U.S. Supreme Court in support of the NC Dental Board, pointing out that each of the states uses active professionals on regulatory boards overseeing their own respective professions, including physicians, dentists, chiropractors, nurses, pharmacists, optometrists, lawyers, architects, funeral directors, and accountants. Similarly, the National Governors Association and the National Conference of State Legislatures also jointly filed an amicus brief arguing that the level of supervision required by the FTC places an "impractical burden on States that depend on hundreds of boards to carry out regulatory and policymaking functions."

The second approach that the U.S. Supreme Court could adopt would be to follow the Fourth Circuit's reasoning, which arguably considered two factors in determining that the NC Dental Board is a private actor. The Fourth Circuit not only focused on the fact that a majority of the board members is made up of market participants but also the fact that these dentist board members are elected by the state's licensed dentists. The Fourth Circuit concluded that the NC Dental Board is more akin to a private actor than a state actor because, in the court's view, the dentist board members are more accountable to North Carolina's dentists who elect them than to the state. The Fourth Circuit

Today, many states have expanded licensure even further to other trades and professions, including plumbers, florists, and hair braiders. This recent expansion of licensure has led to criticism from some commentators and economists who question whether licensure is now designed to protect the public from harm or merely to protect licensees from competition.

The North Carolina case presents a clash of these two competing legal principles: The federal procompetitive norm that is reflected in the antitrust laws and the principles embodied in federalism that states are protected from federal interference when they act to protect their citizens from harm through professional licensure.

concluded that since the NC Dental Board is a private entity, in order to be exempt from federal antitrust law, the board needed to show that the state actively supervised its actions in prohibiting non-dentists from conducting teeth whitening activities, which, according to the court, the NC Dental Board could not do.

This approach may present somewhat less of a burden on the states than the FTC's approach, since the states could continue to have market participants serve on licensing boards as long as the board members are not elected by the licensees. However, the Fourth Circuit's approach would still be a significant intrusion upon the states' long-held discretion of designing licensing boards that meet their respective needs and desires related to setting appropriate professional standards, public safety, and accountability.

States employ many different mechanisms for board appointments, including some that rely upon regulated professionals in the selection process. The most common method is for states to give the governor broad authority to appoint board members. Other states require the governor to make appointments to certain boards from a list of nominees submitted by the regulated professionals. In some states, as is the case with the NC Dental Board, certain board members are directly elected by the regulated professionals. These varying methods of appointment reflect the broad discretion that states have traditionally exercised in the area of professional licensing. By adopting the Fourth Circuit's approach, the U.S.

Supreme Court would undermine that long-held discretion and impinge upon the principles of state sovereignty and federalism that the state action antitrust exemption was designed to protect.

The third way that the U.S. Supreme Court could rule would be to reject the FTC and Fourth Circuit's approaches and make clear that the NC Dental Board's actions are exempt from antitrust scrutiny. Traditionally, the courts have given state actors exemption from federal antitrust laws when their actions are pursuant to a clearly articulated policy to displace competition with regulation. North Carolina statutes, as passed by the legislature, provide the following: (a) the NC Dental Board is "the agency for the State for the regulation of the practice of dentistry in this State"; (b) anyone practicing dentistry must have a valid "license duly issued by the North Carolina State Board of Dental Examiners"; and (c) the practice of dentistry includes anyone who "removes stains, accretions, or deposits from the human teeth." These statutory provisions clearly demonstrate that the NC Dental Board is a state actor, not a private actor, and that the board was acting pursuant to a clearly articulated state policy when it prohibited tooth whitening by non-dentists.

By taking this approach, the U.S. Supreme Court would protect the primary role that the states have enjoyed in the area of professional licensing since our nation's founding. Moreover, it would preserve the states' ability to design professional licensing laws that meet their respective needs in protecting the public, including preserving their ability to use the skills and expertise of professionals who have active knowledge of the professions they are asked to license and regulate.

CONCLUSION

This third approach—making clear that state licensing boards are exempt from federal antitrust scrutiny—is superior to the first two approaches outlined above because it satisfies the dual objective of ensuring that the states will continue to have the ability to design professional licensing and regulatory systems that best protect the public while also preserving the principles of state sovereignty and federalism. Those critics who are concerned with the laws related to professional licensing in their own respective states can still take their concerns to the state legislature where such policy discussions belong.

William J. Gies wrote in his famous report to the Carnegie Foundation in 1926 that serving on a state dental board is an “altruistic endeavor” that requires the dentist board members to show the “highest personal and professional character” and to act with “conscience and public fidelity.” He recognized the significant danger to the public and the dental profession if dentists serving on their state licensing boards did not act with disinterest and integrity.

Gies’s words were directed at state dental boards in the 1920s but they are equally applicable to any state professional licensing board in the United States today. If the U.S. Supreme Court issues a ruling permitting states to continue to use market participants on licensing boards free from federal interference, these board members ought to heed Gies’s words. The public, which they are charged with protecting, deserves nothing less. ■

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Similarly, the National Governors Association and the National Conference of State Legislatures also jointly filed an amicus brief arguing that the level of supervision required by the FTC places an “impractical burden on States that depend on hundreds of boards to carry out regulatory and policymaking functions.”

2014 MANUSCRIPT REVIEW PROCESS

In addition to the 27 published theme papers and three articles reviewed by the American Society for Dental Ethics, eight unsolicited manuscripts were considered for possible publication in the *Journal of the American College of Dentists* during 2014. One was returned without peer review because the topic did not fit the communication mission of the journal. Two manuscripts were accepted for publication with minor revisions. Two were returned for major rewriting, and one of these has subsequently been published in *JACD*. Three were determined by the reviewers as not meeting publication standards.

Thirty-five reviews were received for the seven manuscripts reviewed, for an average of 5.8 reviews 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 0.77, 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 six requests from others to republish articles appearing in the journal received and granted during the year. This is a 16% republication rate.

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 2014.

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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 the 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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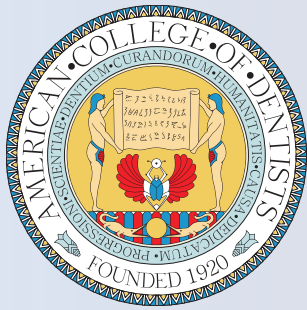


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