TEACHING ETHICS IN DENTAL SCHOOL

ETHICAL MARKETING FOR DENTISTRY
The Objectives of the American College of Dentists

The American College of Dentists in order to promote the highest ideals in health care, advance the standards and efficiency of dentistry, develop good human relations and understanding and extend the benefits of dental health to the greatest number, declares and adopts the following principles and ideals as ways and means for the attainment of these goals.

(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, stimulate and promote research;

(d) Through sound public health education, to improve the public understanding and appreciation of oral health service and its importance to the optimum health of the patient;

(e) To encourage the free exchange of ideas and experiences in the interest of better service to the patient;

(f) To cooperate with other groups for the advancement of interprofessional relationships in the interest of the public; and

(g) To make visible to the professional man the extent of his responsibilities to the community as well as to the field of health service and to urge his acceptance of them;

(h) In order to give encouragement to individuals to further these objectives, and to recognize meritorious achievements and potentials for contributions in dental science, art, education, literature, human relations and other areas that contribute to the human welfare and the promotion of these objectives — by conferring Fellowship in the College on such persons properly selected to receive such honor.

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ETHICS AND PROFESSIONALISM

—They Have To Be Taught

Like good manners, ethics and professionalism have to be taught. They are not automatically acquired in the growing up or maturing process of an individual. They must be specifically included as a part of the educational process of each person in the health professions.

Ethics is knowing right from wrong. It means honesty, trust, good behavior and conforming to an accepted standard of conduct.

Professionalism concerns personal integrity and moral right. It is placing the well-being of the patient foremost. It is personal character, dedication, honor, commitment and responsibility. The teaching of professionalism in professional schools has always been necessary.

Health professionals are supposed to develop a different philosophy in life and to think differently than people in business where the goal is to get the edge on the competitor and to make as large a profit as possible within the law. It is necessary for dentists to also be good businessmen, but professionalism should always take priority over entrepreneurship. In health care, the most important consideration must be the best interest of the patient.

It is a matter of record that students have been graduated from professional schools in recent years with very little instruction in either ethics or professionalism. However, there are a number of dental schools that have already recognized the current moral void in dental education and are searching for ways to improve the curriculum regarding student attitude and behavior. These schools are to be commended.

Perhaps it is the name “ethics” that sounds so old-fashioned and distasteful to some people. A different term like “personal integrity” or “professional conduct” might make the subject more acceptable in the professional schools. Regardless of what we choose to call it, however, we must be firm in setting ethical standards for students, as well as technical and scholastic requirements.

It is certainly not the fault of the dental schools that some of their students do not acquire sufficient training in basic ethics before arriving at the schools. On the other hand, if we are to teach our dental students to be professionals, the dental schools must try to see that dental graduates have a commitment to high ethical standards and that they develop professional attitudes. The entire image of the dental profession is judged by the conduct of individual dentists.

Dentistry must provide Society with graduates who exercise professionalism as well as good technical training. The professions have a responsibility to the public which looks for quality and excellence in products and services, and it particularly wants quality health care. The public deserves and expects personal integrity, high principles and professional demeanor in its health professionals, as well as technical excellence.

We certainly hope that the dental schools will again include the teaching of ethics and professionalism as essential requirements in a dentist’s education.

They are subjects that have to be taught.

Keith P. Blair
The American Association of Dental Schools has elected W. Robert Biddington of West Virginia as its new president. William E. Brown, Oklahoma, was named president elect. Don L. Allen of Houston, Texas became the Immediate Past President.

William F. Ford, Winnetka, Illinois, recently received Northwestern University’s Alumni Service Award. A diplomate of the American Board of Orthodontists, Dr. Ford has served Northwestern in many capacities.

Loyola University Dental School of Chicago has honored several distinguished alumni with special awards: Frank M. Amaturo was presented with the Centennial Alumnus Award for exemplary accomplishments and service to Loyola. Robert M. Unger, 8th District Trustee to the ADA, was selected as Alumnus of the Year. Walter E. Dundon received the Harold Hillenbrand Distinguished Service Award for contributions and services to the profession. William P. Schoen was recognized for outstanding contributions to dentistry in the field of dental literature and journalism with the Charles N. Johnson Memorial Award. Harold Hillenbrand, Executive Director Emeritus of the American Dental Association, received the William H. G. Logan Memorial Award for distinguished contributions to the international development and advancement of dentistry. Donald E. Bentley, President-Elect of the American Dental Association, was recognized for his service to the profession. William J. Sisson, President of the Loyola Alumni Association, for services to the University. Richard A. Kozal, Immediate Past President of the Loyola Dental Alumni Association, for services to the University.

The American Association of Endodontists has named Donald E. Arens of Indianapolis as its new president, Herbert Schlider of Boston as vice-president, Michael A. Heuer of Chicago as Secretary and Irving J. Naidorf of New York City for his 5th year as Editor for the organization. Elected Directors were Milton Siskin of Memphis; Frank B. Trice, Houston; Herbert F. Spasser, New York City and Nguyen T. Nguyen of San Francisco. Manuel I. Weisman of Augusta, Georgia was elected Vice President of the Endowment and Memorial Fund and re-appointed research director.
W. Neal Newton, Webster Groves, Missouri, has been selected as the 1983 recipient of the Distinguished Alumnus Award of the Washington University Dental Alumni Association. In recent years he established the highly successful “Big Brothers Program” in which alumni and senior dental students interact. A pedodontist, Dr. Newton is a past president of the Missouri Dental Association and a past chairman of the St. Louis Section of the American College of Dentists. His father was a dentist, one of his sons is a dentist and another son is a registered nurse.

Robert W. Baker of Ithaca, New York was recently made a Trustee of Ithaca College. He is a diplomate of the American Board of Orthodontists and a senior clinical associate at Eastman Dental Center at the University of Rochester.

Robert L. Lasater of Golf, Illinois, who has been in practice more than 62 years has received Northwestern University’s Alumni Merit Award. The award is given to alumni who have distinguished themselves in their profession so as to reflect credit upon their alma mater. An inventor, he patented the Toothmaster Electric Toothbrush and has done substantial research in dental materials, oral biology, diet, stress, biochemistry and periodontia.

Edward Bressman, Maplewood, N.J., has been appointed Director Emeritus in the Department of Periodontics at the Newark Beth Israel Medical Center at Newark, N.J. Dr. Bressman is a Diplomate of the American Board of Periodontology and Clinical Professor of Periodontics at Fairleigh Dickinson University.

Melvin A. Noonan of Oakland County, Michigan was the recipient of two public relations awards in recognition of his service to the dental profession, one from the Oakland County Dental Society and the other from the Michigan Dental Association.

Seymour L. Nash has retired after completing 10 years as Executive Director of the Dental Society of the State of New York.
Washington—British Columbia

Section Chairman Fred P. Barnhart announced that the Section had created the office of Editor-Correspondent.

The recipient of this year’s Ferrier Scholarship Award, given to the student most proficient in operative dentistry, will go to Mark F. Erickson, a third year dental student at the University of Washington. In 1984, the Award will be given to a student at the University of British Columbia.

The speaker at the annual meeting was retired Major-General John W. Barnes, U.S.A. who spoke on the Republic of China (Taiwan).

Charles V. Farrell

Western New York

Chairman Bernard Tofany conducted the annual meeting held at Rochester.

Dr. Tofany announced that the recipient of the Section Award, not yet named, would be a student from the State University of New York at Buffalo. The awardee would receive an honorary certificate in recognition of this accomplishment, plus a check for $200 from the Section.

During the meeting it was suggested that the Section sponsor a local seminar in each metropolitan area in Western New York for the new dentists starting practice, with a speaker or speakers on practice management and professionalism. No action was taken on the idea.

Warren M. Shaddock

Carolinas

Gordon H. Rovelstad, ACD Executive Director, reports to the Section on current College activities.

James B. Edwards, former U.S. Secretary of Energy and current President of the Medical University of South Carolina, addresses the Carolinas Section Meeting.

Carolinas Section Officers, left to right, Chairman Franklin B. Hines, Jr.; Vice-Chairman R. Jack Shankle; Secretary-Treasurer Larry A. Williams and John O. Bumgardner, incoming Secretary-Treasurer for the Section.
Alabama

Wesley O. Young Dies

Birmingham, died May 19 of injuries sustained in a fire at his home.

A diplomate of the American Board of Dental Public Health, Dr. Young was the only dentist ever named recipient of the John J. Sippy Memorial Award, given by the Western Branch of the American Public Health Association for meritorious service.

Dr. Young was a past president of the American Society of Dentistry for Children and the American Board of Public Health. He published over 50 scientific papers and co-authored the book, Dentistry, Dental Practice and the Community, the standard text for undergraduate dental students.

In his memory, the Alabama Section has made a donation to the American College of Dentists Foundation.

Gray Carter

Colorado

The annual meeting was conducted by Section Chairman William E. Cody at Denver.

Awards were given last year to the outstanding graduating student at the dental schools located in Rangely, Colorado; Sheridan, Wyoming and Pueblo Colorado. Steps have been taken to include the dental school at Albuquerque, New Mexico in the future.

The Colorado Section “Man of the Year” Award was presented to Dr. Ralph Lopez of Albuquerque, who was also guest speaker. Dr. Lopez spoke on “Dentistry: Yesterday, Today and Tomorrow.”

The Section will join with the International College of Dentists for a combined breakfast program at the Colorado Dental Association meeting.

Roy H. Reger
Metropolitan Washington D.C.

The Metropolitan Washington D.C. Section makes its annual contribution to the American College of Dentists Foundation. Presenting the check is Section Chairman Bernard Yanowitz. Accepting for the College is ACD Treasurer Robert W. Elliott, Jr., while ACD Executive Director Gordon H. Rovelstad, right, looks on.

Oklahoma

The annual meeting was held in Tulsa. Section Chairman James Berry reported that the Section is currently awarding a plaque and a $100. check to the outstanding senior dental student at the College of Dentistry at Oklahoma University. He proposed that the Section make an identical award to a student at Oral Roberts University. His proposal was accepted and the Section will be making the award to each school in the future.

Chairman also recommended that the Section make an effort to nominate qualified colleagues for Fellowship in the College. A.C.D. membership is concentrated in the two major metropolitan communities in Oklahoma and qualified dentists should be considered throughout the State.

Walter E. Dilts

Southern California

The annual meeting was held in Los Angeles under the leadership of Section Chairman, William Molle. The speaker was Dr. Duane Paul, Chief Economist for the Bank of America, who spoke on the Economic Outlook for '83 and '84.

Again this year, members voted to contribute $500. to the American College of Dentists Foundation. The Section is establishing an awards program for a senior dental student in each of the three dental schools in Southern California. Criteria for the awards was approved. An appropriate plaque will be presented, along with a cash award.

The Section members were honored to have in attendance Dr. Keith P. Blair, Editor of the College Journal, and Immediate Past Regent, Dr. Leon Ashjian.

An additional Section Vice President has been elected—Dr. Richard Geyer of Yuma, Arizona. It is our desire to initiate College activity in the Yuma-Phoenix-Tucson area. The initial event will be a breakfast meeting in Phoenix during the next session of the Arizona Dental Association.

Leo E. Young

Michigan

Again, this year, the Michigan Section annual program was divided into two events—a Special Session/Business Meeting on Sunday morning and the annual banquet on Monday evening. It is felt that the Special Session provides a forum for the membership and allows the Section to provide speakers of interest who might not be appropriate at the banquet. This year, the new Dean of the School of Dentistry at the University of Michigan, Dr. Richard Christiansen, keynoted the Special Session, speaking on "Future Challenges in Dental Education."

Dr. Christiansen addressed the changing nature of the dental profession and changing student attitudes. He felt the need for students to have more background education in economics and business management.

Section Chairman Edward D. Atwood presided over the meeting. Guest speaker for the banquet was Dr. Dan Roche, former covert CIA agent who spoke on espionage throughout the world.

Claude L. Raby, Jr.

Upper Midwest

The special event at this year's Section Meeting was the hosting of Minnesota Dental Association past presidents and their spouses who were invited to attend the breakfast meeting. Twenty-three past presidents and twenty-two spouses attended.

Section Chairman Daniel E. Waite introduced distinguished guests, including ADA President Burton Press, Minnesota Dental Association President Edgar Ziegler, American College of Dentists President Odin Langsjoen and others. President Langsjoen was the main speaker.

Chairman Waite gave a progress report on the Section project for Professional Responsibility Teaching in the Dental Curriculum and indicated the participation and contributions made to the program by Fellows in the area. He introduced Dr. Muriel Bebeau of the University of Minnesota, Director of the Program on Professional Ethics. President Langsjoen informed the gathering that the American College of Dentists Foundation had approved a continuing support of the Minnesota Project and had approved a $3,500. grant for this year.

Anna T. Hampel
Thousands of words have been written on the subject of professional ethics. Numerous articles on the subject have appeared in this publication. Many authors have defined ethics and elucidated the areas of concern. Professionals have been admonished to do certain things, but not others, to be considered ethical. However, one can be highly professional and simultaneously be unethical. The converse of this is also possible. Thus, professional behavior and ethical behavior are not synonymous, even though the terms are occasionally used interchangeably. Because a person exhibits one of these behaviors, it does not necessarily follow that he or she can also exhibit the other.

One dentist, for example, may be a continuous student who upgrades his technical skills as advancements occur. It can be said he is up to date in knowledge and ability. He can offer patients a wide range of treatment modalities which he can deliver with competence. He is, however, known to routinely deliver the services to his patients that are the most lucrative for him. Several of his colleagues, who are aware of this, question his ethics. None of these same dentists question his professional competence.

Another dentist similarly located is considered a good dentist yet he rarely attends a continuing education course, only does a little reading in a few journals and has not been known to take a hands-on course to upgrade his skills. This dentist renders advice and treatment based on what he considers to be in the best interests of his patients. Several of his colleagues, who are aware of this, question his professional competence but do not question his ethical behavior.

Most dentists fall somewhere in between these two examples. So what is it that creates the climate for considering that a practitioner is professionally competent and/or ethical?

It was G. V. Black who made the pronouncement that a professional has no right to be other than a lifelong student. Hippocrates was aware that a professional should place the best interests of his patients first. Thus, the Hippocratic Oath was developed to place professionals on record as stating publicly that they would uphold that belief.

In considering the two dentists described above, the question arises: Are the best interests of the patient being served when one’s professional knowledge and skills are not up to date? It is true that treatment in dentistry is not often a life or death matter in the sense that medical practice is. However, a tooth can be lost and/or a dentition crippled if the latest knowledge and highest skill is not made available to the patient. Undesirable physical consequences can follow which may not be life threatening but can adversely affect the quality of life for an individual.

One could conclude that only those who work at keeping their knowledge and competence at a high level can ultimately be called ethical practitioners. This, however, is not necessarily true. A professional who recognizes his abilities or lack of special knowledge can refer the patient to another practitioner or a specialist—thus serving the best interest of his patient.

The practitioner who receives a referral must carry out the chain of events by treating the patient with knowledge and skill of the highest rank—again serving the best interests of the patient. The practitioner

Robert H. Griffiths*
who received the referral is further obligated to inform the referring practitioner of his findings and recommendations. Since patients

That which dentists consider to be acceptable ads are generally termed ineffective by ad agencies; and what ad agencies consider effective ads are generally believed by dentists to be superficial, cosmetic, degrading or self-serv

frequently return to the original practitioner to discuss the treatment, all parties involved need to be informed to best serve the patient's interests.

Today one of the foremost questions before the profession is, "How does a practitioner inform the public of his competence and skills while maintaining his professional and ethical reputation?"

Advertising seems to be an appropriate item for discussion at this point. The Supreme Court of our land has declared advertising to be legal for professionals. The Federal Trade Commission labeled Codes of Ethics which restricted advertising as anti-competitive in nature. The American Dental Association Code has been adjusted to reflect the law of the land. So, a dentist may now legally advertise as long as he does not do so in a "false and misleading manner, in any material respect." I had the impression that

HMO's, large group practices, dental facilities in retail centers, and some younger dentists, were the most likely to advertise in the media and phone books. There are some notable exceptions to this which I became aware of during my years as President-elect and President of the American Dental Association.

Some members in the profession of dentistry believe it is unprofessional and unethical to advertise in the various media. A significant number of dentists do accept advertising by their professional organization if it is educational in nature and does not serve any individual to the exclusion of others.

I have been involved in the debate on the organizational approach to advertising for some time. Having heard many dentists fears, concerns and requirements, I have come to some conclusions about this type of advertising. That which dentists consider to be acceptable ads are generally termed ineffective by ad agencies; and what ad agencies consider effective ads are generally believed by dentists to be superficial, cosmetic, degrading or self-serving. Therefore, devising an effective, yet acceptable, ad is very difficult, if not impossible.

Complicating the issue is the fact that dentists attitudes about advertising vary considerably in different parts of the country. What is acceptable in one area may not be acceptable to another. It is therefore almost impossible to devise a national advertising program acceptable to all dentists. The profession realized this and elected to curtail its one attempt at national advertising under A.D.A. sponsorship. Further complications were presented by different groups within the profession who wanted their area of practice emphasized. So, what can be done to arouse more demand for dental services and still satisfy professional and ethical considerations?

In September 1979 the idea for access programs was first proposed. Population studies were done to identify any people that were being underserved. Five basic groups were recognized as having significant barriers to care.

The American Dental Association developed access programs for use by constituent, component and local dental societies to make access to care possible, thus increasing demand for dental services. The first program was designed to reach and assist the elderly. The second group to re-
ceive attention was the handicapped and home bound. Work for the third group, the psychologically impeded, was started in 1982. These three population groups constitute a significant percentage of the underserved population. The philosophy behind these access programs was to help and encourage dentists to help people to obtain dental services. The two-fold goal was to help people to better dental health while increasing demand for services—a professional and ethical approach.

In 1982, this philosophy was expanded-upon with Operation Ident which is a program for marking the dentures of nursing home residents. This project was designed to help the nursing home administrators and patients by providing easier identification of oral prosthetic appliances. Another aim was to help dentists recognize how large this underserved group is. Hopefully, this project would result in an access program to break down the barriers to care for these people. Thus the goal of better dental health for these people and increasing the demand for dental care would be realized.

In summary, one can say that the philosophy fostered for the past three years by the American Dental Association has been one to help dentists to help people have the opportunity to increase their demand for dental services.

That philosophy has now been set aside for a marketing effort voted in by the A.D.A. House of Delegates. This program is divided into segments. For the purpose of this paper I will consider only the segment for the individual practitioner. The program is available to dentists and is carefully outlined. It details an office program of marketing. A real “how to” manual is supplied to the dentist. Included in the program are some time-honored methods of professional and ethical approaches to building a practice. There are also some new ideas which may not appeal to all.

The purpose of the marketing program is to give dentists a potpourri of approaches from which to choose. The segment for individual dentists is geared to mesh with component and constituent society programs.

The American Dental Association, in the marketing program, would act as a warehouse for materials to help dentists implement whatever approach they may elect to use. In one respect this program parallels the philosophy of the previous three years; that is, to be effective it depends upon the efforts of the individual dentist. However, the marketing program essentially broadens the approach to stimulating demand for services. It deviates from the prior philosophy of helping people to help themselves by emphasizing a more direct appeal to increase demand for services.

To bring all this together, let me point out that ethical and professional behavior ultimately depends on the desires and actions of the individual dentist. In our local, state and national organizations we discuss and solidify the feelings and desires of the individual. We gain strength and courage from each other to personify our mutually agreed-on Code of Conduct.

Since the greatness of our profession depends on the individual there are some basic questions each dentist must answer: Am I keeping up in knowledge and competence? Am I offering my patients treatment of the highest order and referring them when I cannot? Are my decisions always based on what is best for my patients? Do I always treat my patients with respect and thoughtful care? Do I conduct my life in a manner which generates respect? If you can answer “yes” to all these questions you are exhibiting professional and ethical behavior in your practice.

When the vast majority of the dentists answer “yes” to these questions we can justify the status of a profession. △

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THE ETHICAL MARKETING OF DENTISTRY: IS IT A MISNOMER?

Paula Perich*

There's a rumor going around that you are actively engaged in the marketing of your practice. In fact, they say you're involved in some rather sophisticated target marketing—making your services more attractive to certain population groups than to others.

Is that true? Are members of the American College marketing their practices? Yes. All dentists market. And all dentists engage in target marketing because—consciously or not—they make it easier for some classes of people to visit their practice based on office hours, location, fee arrangements, etc.

All dentists market. The only differences are in how effectively and how ethically the marketing is done.

Can marketing be done ethically? Certainly. However, not marketing—particularly if you deliver a professional health service—might be considered unethical. Consider this working definition:

Marketing: A system of activities which identifies and satisfies consumer needs and wants.

Do not ethical dentists seek to identify patient needs? ... identify patient wants? and satisfy patient needs and wants?

What is it that a dental patient needs? Most would agree that they need professional treatment. But what they want is not so easily determined. Some may want surcease of pain; some, the peace of mind a good checkup brings; some want the cosmetic benefits of a clean, healthy smile; some want to live in a state of wellness; some want attention; some want their dentistry done during convenient hours. This identification as to what a patient really wants from dental treatment is one of the key determinants as to how effectively a practice is being marketed.

*Director of Marketing, California Dental Association.

Paula Perich

is currently the California Dental Association Director of Marketing and is responsible for implementation of the Marketing Program throughout the state.

She has held other positions with CDA: Director of Communications and Managing Editor of the CDA Journal.

Paula has spent eight years in health care public relations and marketing both for the dental association and as p.r. director for Hospital Affiliates International. She has a B.A. from California State University, Los Angeles and a Professional Designation in Public Relations from UCLA.

This article is intended to promote the concept of efficient marketing for the ethical dentist. To quote Dr. Burton H. Press, ADA President, “Marketing is not a dirty word.”

Why Now?

Historically dentistry has contented itself with treating—on a regular basis—the 50 percent of the population that seek dental services regularly. Why this sudden emphasis on expanding that patient
pool? Because the 1980's represent a different marketplace for the profession of dentistry, for several reasons:

1. **The Economy**
   A 1979 study by the ADA revealed that 11 percent of respondents were postponing or avoiding dental care because of inflation. We don't have a similar study since, but we can speculate that if it was 11% in 1979, it was probably far higher in the 1982 economy.

2. **Less Need for Treatment**
   Dental health education and the stress on prevention over the past 20 years has paid off. We've reduced the amount of restorative work necessary. Fluoridation of water supplies has reduced caries.

3. **Increased Productivity**
   Enhanced technology and expanded use of auxiliaries has almost doubled the dentists' productivity in the last 30 years.

4. **Fewer Visits**
   Between 1977 and 1979, there was an average decrease of 1.5 dental office visits per dentist, per week, across the country.

5. **Greater Population Transience**
   Between 25 and 50 percent of the U.S. population change dentists every five years.

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**Why Marketing?**

Of the 50 percent of the population that don't go to the dentist regularly, they have three primary reasons for their avoidance.

*They can't afford it.* Obviously there are some population groups that simply cannot afford regular dental services and their needs must be met by special access programs at the national, state and local levels. However, many of the people who say they can't afford it, can afford winter ski vacations; can afford expensive stereos; and can afford new wardrobes and cosmetics. What they mean when they say they can't afford it is, they don't consider it a priority. Dentists don't compete with other dentists nearly as much as they compete with alternate forms of discretionary spending.

Dentistry is the most *affordable* health care available—the average office visit is $36. What the consumer *can't* afford is *neglect.* Marketing can address that.

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**It's painful and/or unpleasant**

Most people will admit that dentistry's no longer painful but they view it as vaguely unpleasant.

There is nothing inherent in the dental visit that needs to be unpleasant. In fact, the opposite is true. In an age where futurists decry the lack of interpersonal communications, dentistry delivers its services in a most personal environment—we are giving individual, professional attention. We need to position ourselves as a highly desirable, pleasurable experience.

Marketing can address that.

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**No need to go**

Of the 50 percent that don't go regularly, 63 percent named this as the reason—they felt no need to go. In the world of marketing and public relations, perception is reality. If they perceived no need—that's as good as no need at all, to them.

Marketing can address that.

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**How?**

Before you can like someone, you usually have to
Before you can embrace a particular concept, it helps to be somewhat familiar with its particulars. A brief introduction to the marketing mix follows, it includes:

- **Product**
- **Price**
- **Place**
- **Promotion**

This traditional marketing mix relates to products and must be translated somewhat, when relating it to professional services:

- Product becomes the professional health service;
- Price becomes the professional fee;
- Place becomes the professional office; and
- Promotion is still how you let people know that you're there, delivering that service.

Many dentists tend to think only of promotion when they think of marketing—and only of advertising when they think of promotion. But this is inaccurate. Advertising *can* be a part of promotion, although it certainly is not always; and promotion is one of the four aspects of the marketing mix. **Advertising And Marketing Are Not Synonymous.**

Promotion is external marketing. Product, price and place are all aspects of internal marketing which should be addressed first. Aggressive external marketing should be undertaken only when the marketer is assured that product, price and place are mutually reinforcing and functioning smoothly.

This principle has some far-reaching ramifications—particularly for professional services—because in service marketing, the product and the distribution channel become virtually indistinguishable. In other words, the crown that the dentist has just seated is not judged solely for clinical quality; instead the patient is satisfied, dissatisfied or enthusiastic about the dentistry delivered based on characteristics of the distribution channel which can be:

1. condition of the parking accommodations,
2. decor of the reception room, or
3. dress and demeanor of the staff.

**The How To's of Marketing a Practice**

If a dentist did embrace the concept of marketing, how would he/she approach the marketing of his/her practice in an efficient manner?

There are basically six steps in the development of a marketing plan for the dental office. They are listed and briefly described below. The American Dental Association has published a workbook which guides the practitioner through these steps in explicit detail. It's entitled "Dental Marketing Planner" and can be purchased for $34.95 from the ADA.

**Prepare Fact Sheet**

This is merely an attempt to define and describe the current situation. It would more accurately be referred to as "marketing research" but to many doctors that phrase connotes the need for statistical analysis, sophisticated research methodologies and data processing. Actually, the preparation of the fact sheet should be a logical, straightforward analysis of how the individual practice is faring in the marketplace, and a look at dentistry's status in the marketplace (which would include your specialty's status, if you are a specialist.)

**List problems and opportunities**

For example, 1) are you in need of more *new* patients; or 2) do you just need to improve recall and acceptance of treatment plans for patients of record; or 3) does your practice cater primarily to lower middle class patients in a neighborhood rapidly assimilating a foreign-language, upper-middle class population?

These problems will begin to define themselves based on the information uncovered in the fact sheet. And each problem presents an opportunity; problems are just opportunities in work clothes.

**State Specific Objectives**

In addressing the problems identified above, specific objectives might emerge, such as: 1) increase new patient referrals by existing patients; 2) increase percentage of patients responding to recall notices; or 3) hire one bilingual staff person.

**Develop Strategy**

This step should involve as many specifics as possible. For example:

a. **Revamp Recall Procedure**
   1. Alice to obtain samples of new recall cards and their costs by April 15.
   2. Sharon to do informal survey of other dental offices and their recall systems by April 15.
Establish Budget

There is no figure that is the right amount to spend on the marketing of your dental practice. Retailers typically spend between five to seven percent of gross on marketing. That's a fairly significant percentage, particularly if you've budgeted nothing in the past. Your 1984 marketing budget will be best determined by a careful analysis of your fact sheet and a prioritization of those elements of the marketing plan most critical to your practice now.

Projected Outcome

The marketing plan should have a projected outcome for every objective to be addressed in a given year. If the objective is to increase patient volume, the hoped-for result should be stated specifically, e.g., number of increased patient visits per month or percentage increase in patients to be attracted in a given time period.

When an objective is met, celebrate!

Whose Job Is It?

Whose responsibility is it to market the dental practice? I believe we can follow the lead of for-profit corporations in an approach that involves a delegation of responsibilities between the parent corporation (dental association) and the individual marketer (dentist). McDonald's corporation provides an excellent example.

McDonald's advertising urges customers to enjoy the quality of life available to them if they purchase McDonald's products. They rarely advertise the products themselves, but the benefits to be derived from frequenting their place of business. They don't advertise the location or the features of one particular franchise or location either; they leave it up to the individual franchise owners to get their share of the market via their own promotional efforts and the quality of their marketing mix—product, place and price.

This approach can work equally well for dentistry. In January 1982, the California Dental Association implemented a statewide marketing program. The integrated design of this program does include television and radio advertising done by CDA for its member dentists. These ads remind patients that the best time to see their dentist is before they have to.

Fifteen months into this campaign, dental office visits were up 3.6 percent in California and down 1.5 percent in the rest of the United States. The American Dental Association is investigating the possibility of this approach nationwide and the issue will be discussed at the ADA House of Delegates in October 1983.

But the California Dental Association doesn't presume to do the whole job—their program puts a strong emphasis on the role of the individual in promoting his/her own practice. Since the inception of the CDA campaign, over 10,000 dentists and dental auxiliaries have attended full-day marketing seminars, learning how to get their fair share of the market via their own promotional efforts.

These seminars stress the importance of a team approach to practice promotion and delineate the responsibilities in terms of what the auxiliary can do and what the dentist can do. Auxiliaries are asked if they would feel comfortable pursuing promotional activities such as:

1. Having individual business cards printed and distributing them in the community.
2. Contacting and cultivating other receptionists and office managers of dentists' and physicians' offices in the building or neighborhood.
3. Offering pertinent dental health brochures to ob/gyn., pediatric and/or plastic surgery offices.
4. Making personal visits to the answering service and maintaining open communication with them.
5. Contacting referring doctors' offices when new patients appoint.
6. Volunteering to participate in component community outreach programs, including dental health presentations at schools, hospital maternity teas, and for community groups.
7. Joining Soroptomists, professional women's business groups, or Toastmistress clubs for exposure in the community.
10. Making a thank you call or sending a note to patients concerning a good child patient.
11. Writing thank you on the back of checks before endorsing.
12. Telling people they work for Dr. ________ and are PROUD OF IT!
13. Recommending their office to friends and family.
14. Giving out copies of "How to Select a Dentist" to friends needing a dentist.
15. Contacting local preschools and arranging a “fun” tour of the office for 3-year-olds and their mothers.
16. Bringing up the subject of their office at the beauty shop, drug store, shoe store, or fitness center in an enthusiastic manner, without appearing to be high-pressure selling.

Doctors are also asked to examine their own role in practice promotion and to develop a realistic community outreach plan as part of their annual marketing program. Such a plan might include:

1. Making a commitment to be actively involved in two organizations during 1984—one civic, one dental.
2. Speaking positively about the profession in all social situations.
3. Asking family members to play a role by being active in the community and offering pertinent dental health information.
4. Encouraging staff to become community involved by planning flexible lunch hours for monthly meetings of Soroptomist, Toastmistress, Business Women, etc.
5. Volunteering to participate in component community relations programs such as tours for preschool and elementary students; oral hygiene presentations for junior high; or team dentist duties for the high school football team.
6. Involvement in sports activities. This puts the dentist in touch with people interested in physical fitness and marketing research indicates these people are predisposed to be regular users of dental care.
7. Becoming actively involved in a dental study club or specialty organization.
8. Making one contact a month (luncheon or dinner date, if appropriate) with a local physician, pharmacist or referring dentist.
9. Calling all patients the evening of significant treatment.

Towards What End?

Marketing is not a panacea; nor is it as glamorous as most people would have it. But it does provide the practitioner a means by which he/she can evaluate the marketing needs of the practice; develop a plan that addresses those needs; implement the plan in appropriate and affordable stages; and evaluate its effectiveness.

Perhaps the biggest misconception in the marketing of dentistry concerns what the dentist thinks the patient is buying. As stated earlier, rarely is the patient buying the crown, or the prophyl or the filling. They lack the expertise by which to judge the quality of dentistry done in their mouth. But they evaluate your service, nonetheless, based on the condition of the office parking lot, the decor of the office, the way the staff dresses and the quality of the interpersonal relationships that the patient observes. For in service marketing, the product and distribution channel become virtually indistinguishable. In short, they’re buying the doctor, staff, office and location first, dentistry second.

The perusal of one article obviously will not make someone a marketing expert but dentists are usually pleased to discover what a common sense approach the marketing discipline dictates.

A good, first-step is the attendance, of the entire staff, at a dental marketing seminar. If this is impossible, selections from the reading list accompanying this article should be assigned to various staff members with follow-up staff meeting discussions. These should lead into the six-step developmental process described earlier.

Peter Drucker had said that in today’s environment, no business can succeed without “… an essential redefinition in terms of markets, products, services and processes.”

I invite you to engage in such a redefinition. I believe you’ll find it enlightening and, hopefully, most beneficial as well.

Reading List

American Dental Association “Dental Marketing Planner,” 1983
Donnelly, James H. and George, William R., Marketing of Services, American Marketing Association, 1981
Neeley, D.D.S., Michael J., “How to Get More New Patients”

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Each of us is faced with the inevitable task of doing some financial planning, whether or not we have any interest in it or any knowledge of it. It becomes increasingly confusing when we are faced with changes in the tax laws which complicate an already difficult subject. This article reviews some of the more common financial mistakes that are made so as to enable you to more adequately face your financial future. The purpose of this article is not to emphasize the negative, but rather to make you more aware of the kinds of mistakes that professionals do make so that you might avoid these common pitfalls.

1. Failure to set goals. All successful people set goals for themselves, be they financial or other types of goals. Your goals should be written down and put into the order of importance and priority. Specific dates should be written down for each goal to be achieved and any obstacles that you face should be identified and techniques decided on how these obstacles may be overcome. Common goals include education of one’s children, purchase of a retirement home, retirement planning, etc. The process of goal setting also applies to your practice of dentistry and will enable you to grow in your practice as well.

2. Faulty thinking about insurance. One of the greatest sources of wasted dollars in a dentist’s portfolio is money that is spent for insurances. Purchasing insurance is like purchasing any commodity—purchase only that which you need and get the best buy that is available. It is imperative that every dentist has firsthand knowledge of all the insurances that he/she needs in practice and life, which include the following—life, disability, medical, malpractice, automobile, home, etc. The use of whole life insurance in both estate and financial planning has been overemphasized and should not be a major part of one’s net worth. Term insurance adequately meets your needs for income protection for your family in the case of your death and is available at minimal cost. One of the best buys in term insurance is the ADA Group Life Insurance, which is one of the least expensive insurance programs in the country. The amount of insurance that is needed on your life is three to six times your net income after taxes. Keep in mind also that any funds that have accumulated in any retirement plans are used to reduce the amount of life insurance you need since this money will pass directly to your beneficiary upon your death. If planning is done properly, life insurance should be eliminated between the ages of forty and fifty, as enough other assets would have been accumulated to replace the life insurance.

Before purchasing any disability insurance, you should determine what your benefits are from social security as well as the benefits from your own retirement plans, including IRA, Keogh, and pension benefits. All of these plans are payable upon disability and reduce your need for disability insurance. A further means of protection is to establish a group of five dentists who will cover for one another in the event of one of them being disabled. This serves to keep your practice functional during your time of disability as well as providing a means to extend your waiting period for disability payments, thereby lowering your insurance premiums.

The cost of carrying medical insurance is constantly increasing. Accordingly, every effort should be made to reduce this cost. One means of doing this is for the dentist to pursue a medical policy with a deductible as well as a copay feature. In this manner, the dentist is responsible for a specified deductible, as well as a certain percentage of the maximum cost.
INVESTMENT PROFILE

10–15%
RISK
DOLLARS
(Oil, Gas,
Cattle,
Low Income Housing,
and other tax shelters)

20–25%
SEMI-RISK DOLLARS
(Common Stocks, Preferred Stocks)

50–60%
FOUNDATION DOLLARS
(Money Market Funds, Municipal Investment Trusts,
Municipal Bonds, Treasury Bills, Corporate Bonds,
Certificates of Deposit)

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It towards the entire bill. As an example, a standard policy would be a $1,000 deductible with a 20/80 co-pay feature on the first $5,000. In this case, the dentist would be liable for 20% of the first $5,000 of the bill in addition to the $1,000 deductible. The cost of such a policy is usually 50–80% lower than the standard medical policy. Deductible policies are also available in both higher and lower limits.

3. Not enough diversification in our investment. Many of us get carried away with "get rich quick schemes" and over-commit ourselves in one investment area. Always keep in mind the investment portfolio, as demonstrated in Figure 1, showing triangulation of your investments. Whenever thinking about a new investment, you should examine this triangle and determine two things—where the new investment fits in in terms of risk, semi-risk, or foundation dollars and if you do commit those dollars to that particular investment, does it change the portfolio significantly. By adhering to this triangulation principle, you will not get rich quick. However, you will get rich. Your investment mix, of course, should change as our economy and times change. It does no good whatsoever to look backwards on our investments. Proper planning and diversification will allow us to face the future securely and with a great degree of optimism.

4. Not utilizing tax shelter retirement plans. It is surprising to find that approximately 50% of the dentists in the country do not make any contributions to any retirement plans at all. Every dentist finds him/herself in a high tax bracket and, accordingly, it is in your own best interest to fund tax sheltered plans as much as possible. Since the government assumes half of the cost for these investments, it becomes a very lucrative medium. The opportunities available to the dentist, of course, include the Individual Retirement Account (IRA), Keogh, and corporate retirement plans. Even with the recent changes in the tax law, the professional corporation still provides the dentist with the opportunity of sheltering the greatest amount of income. I believe it is our own responsibility to provide for our retirement as social security will in no way come close to providing the standard of living to which we have become accustomed. Therefore the dentist should read all the literature available and make the necessary commitments to fund retirement plans as soon as possible. Incorporation, in my opinion, is still beneficial and offers many advantages over not incorporating, in addition to the retirement plans. Keep in mind there is no "magic number" of dollars in which incorporation is indicated. Instead, the decision should hinge on careful evaluation of the benefits of setting aside at least 25% of your income tax-free in your retirement plan and still having enough money to live on. Other benefits of incorporation include shifting of income into another calendar year, interest-free corporate loans, and other.
corporate benefit plans in addition to retirement plans. At the present time, it is estimated that 35% of the dentists in the country are incorporated. If the other dentists were aware of the many benefits, the number would increase tremendously.

5. Failure to properly plan for our children’s education (shifting of income). The cost of obtaining a college education is increasing dramatically every year. Accordingly, it is necessary to set aside substantial sums of money to fund our children’s education. It is absolutely ludicrous to attempt to save this money in our own name since we are taxed on the earnings. Accordingly, it makes sense to transfer funds to your children’s names, either permanently or temporarily, so that any earnings on these funds will be taxed in their tax bracket, which is obviously lower than your own.

The ways of transferring money to your children include outright gifts, Crown loans, Clifford Trusts and trusts. Under the Economic Recovery Act of 1981, it is now permissible to give $10,000 per year per recipient, with no lifetime maximum. Therefore, parents can give their children $10,000 each per year ($20,000 per child), with no gift taxes. Keep in mind that under the gift law this money is permanently transferred and cannot be returned. An alternative to this is the Crown Loan which is a non-interest bearing demand promissory note made to a member of the family where the earnings of the money would, therefore, be taxed to the recipient, but the donor (the parent) may ask for the money back at any time. The money may also be transferred through a trust mechanism, the shortest time for which is ten years and one month (a Clifford Trust). After that time, the assets may be returned to the donors (the parents) with no gift tax or capital gain tax liability. Utilizing either the trust arrangement or the Crown loan, the parent retains more control over the assets. All of these alternatives should be considered and the best one utilized in your case. One of them should definitely be utilized, however, in your planning for your children’s education.

6. Not leveraging your home or trading up. One of the main advantages of home ownership is the fact that interest payments on the mortgage may be written off against our current income. This results in a savings of 50% or more, depending upon the nature of the state taxes where you reside. The advantage of the lower interest rates, in addition to the fact that real estate has appreciated in recent years, result in an excellent investment opportunity for you besides providing shelter. You should be spending at least 25% of your gross taxable income on your home mortgage. This sounds like a large amount of money, but from a financial planning standpoint as well as a tax savings standpoint, it makes tremendous sense.

7. No estate plan. Under the Economic Recovery Act of 1981, it is now possible to transfer your entire estate to your spouse with no estate taxes. You should amend your will to read that your entire estate is transferred to your spouse and vice versa. Additionally, under the new tax law there is a unified estate tax transfer to beneficiaries other than your spouse. The amount of this transfer for 1983 is $275,000 and increases to $600,000 by 1987. The property that is being transferred under the unified estate tax must be specifically noted in your estate plan or will in order to receive this credit. Therefore, you may transfer this money to other beneficiaries, such as your children, grandchildren, etc. and pay no tax on it. This is in addition to the rest of your estate going tax-free to your spouse. However, upon the death of your spouse, there are still estate taxes, which start at 18% and increase to 50%. Therefore, it is imperative that adequate planning be done in regard to your transferring your assets. You should consult with an attorney and determine the way you would like your assets distributed upon the death of you and your spouse. Failure to do this will result in additional and unnecessary estate taxes.

8. Sloppy personal record keeping. Good record keeping is an integral part of financial planning. Adequate records must be kept in your dental practice as well as in your financial planning if you are to meet with success. You will always be faced with the possibility of IRS audits, as well as being able to adequately check your progress. Therefore, you should develop good habits in keeping records and maintain them in a safe place so that they will be available when you need them.

On balance, I have provided you with an opportunity of examining some mistakes that are more commonly made by professionals today, as well as suggestions for overcoming mistakes. Remember that you are responsible for your own financial planning, even if you hire a financial planner. You need to know what your desires are, when you would like to have achieved your goals, and how adaptable you are to not achieving them. The financial planning that you do today will determine tomorrow. △

References

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PROFESSIONAL RESPONSIBILITY CURRICULUM REPORT

AMERICAN COLLEGE FELLOWS SERVE AS EXPERT ASSESSORS

Teaching Ethics at the University of Minnesota

Muriel J. Bebeau*

Upper Midwest Section Chairman Daniel Waite and Past Chairman Ronald Geistfeld have been instrumental in implementing a project for their section that exemplifies the ideals and objectives of the American College of Dentists. "The ethics of the profession has always been a major concern of the American College of Dentist," commented Geistfeld during a September 1981 seminar for University of Minnesota dental faculty involved in the development of a Professional Responsibility Curriculum for their school. "In fact, cooperating with other groups for the advancement of interprofessional relationships... and making visible to the professional the extent of his or her responsibilities to the community... and urging acceptance of them, are two of the objectives of the College," added Dan Waite.

These comments were prompted by a seminar discussion of the issues and problems in implementing a professional responsibility curriculum. In earlier seminars, data had been presented which clearly established the need for the curriculum. The faculty began to realize that even advanced students had difficulty in identifying ethical issues and developing well-reasoned solutions to common ethical problems. In subsequent sessions, measurable goals and objectives had been defined, concerns about whether ethics could be taught were thoroughly explored, and effective instructional strategies had been identified.

One potential negative outcome was identified. By implementing discussions of ethical issues, the faculty may inadvertently be reinforcing a common perception of students—that of an idealistic educational institution far removed from the realities of the practical life. Survey data from a quality assurance curriculum project had already confirmed that many students see the practicing community as a place where ethical and technical standards are relaxed. On the other hand, by making a more concerted effort to promote the development of a professional responsibility curriculum, the faculty was likely to garner the support of the profession. Faculty has been sensitive to criticism by members of the profession who often see the educational...

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institution as a place where the ethical standards for admission aren’t high enough or where standards aren’t enforced when there is evidence of unethical conduct.

"We must strengthen the link between the educational institution—which has responsibility for influencing the ethical development of professionals—and the practicing community that must maintain the professional standards," concluded Waite, Geistfeld, and other seminar participants. Based on a recognition of mutual needs, the American College Upper Midwest Section Executive Committee and Directors of the Curriculum Project began a series of discussions which resulted in a project presented to the Upper Midwest Section of the American College in April 1982 and implemented in the fall of 1982.

The purpose of this article is to describe 1) the ethics curriculum developed at the University of Minnesota, 2) the assessment processes being designed for that curriculum, 3) the role of members of the College as expert assessors, 4) the involvement of the Upper Midwest Section, and 5) the future needs and possibilities for involving other ACD Sections and the national organization of the American College of Dentists.

Ethics Courses Required for Freshman and Senior Dental Students

Ethical problems that dentists are likely to encounter are discussed in small group seminars for first and fourth year dental students. These sessions are part of a new curriculum developed by the Minnesota School of Dentistry entitled, "Professional Problem Solving and Professional Responsibility." Each one-credit course consists of ten hours of discussion. The curriculum development work was supported by a grant from the American Fund for Dental Health.

The program's goals are to make students more aware of professional ethical problems and to give them the opportunity to deal with these problems under benign and relaxed conditions. Students discuss problems with peers and experienced professionals to learn about different opinions, to pool knowledge about likely outcomes and consequences, and to develop responses to situations that are the real challenges of the profession.

To ensure that students encounter situations that are life-like, a survey of 700 Minnesota dentists was conducted to identify the recurrent dilemmas of the profession. Based on that survey, the problems that students discuss include: conflicts between self-interest and the patient's interest; truthfulness in the patient-professional relationship; interactions with other dental professionals; conflicts between one's own moral code and the profession's rules; and conflicts between the patient's right to decide and the dentist's obligation to deliver quality care.

Many students see the practicing community as a place where ethical and technical standards are relaxed. Students find the experience valuable, e.g., one student said: "These experiences helped me take a broader look at a case that is presented. Various alternatives were suggested to situations where I thought there was no alternative. This was also an opportunity to think for ourselves and to be listened to. Our contributions were well-received and appreciated. Thanks."

A recent graduate wrote to express his appreciation for the course. "I just wanted to drop you a line and let you know how valuable the ethics course has been to me...I have had my office open a grand total of five weeks. In that time, I have encountered a great diversity in patients...Dentistry in the real world can be very disconcerting if the new dentist has not grappled with some basic philosophical and ethical questions. The ethics course did get me involved and thinking about some very difficult situations...[that] I am finding can, and do, occur every day. I am still developing my practice philosophy. I am grateful for the 'early start' in practice ethics."

Measuring Problem Solving Ability is a Distinctive Feature of the Minnesota Curriculum

Assuring that students can develop well-reasoned solutions to the problems that confront professionals and that they recognize the ethical issues is a major concern of the faculty. Much effort has been devoted to developing realistic performance tests. The basic approach has been to get students to come up with solutions to common problems. A series of the most important problems that dentists say they encounter were developed as dramas, which are recorded on audiotape. Students go to the Learning Resource Center, listen to these dramas, and are required to respond on the spot, as they think it would be best to do if they were actually in such a situation. Their response is recorded and later transcribed. The faculty read these responses and judge whether the student recognized the ethical issues and developed a well-reasoned response. Talking with the student afterward is an important part of the program.

Testing in any curriculum serves
two purposes: 1) to certify that the student is competent to practice, and 2) to diagnose deficiencies in skill which aid in planning remedial instruction. One major responsibility of the educational institution is to assure that the assessment procedure isn’t simply an arbitrary and subjective judgment of student’s ability. Most programs designed to teach professional ethics have not included performance tests because they have not been able to demonstrate adequately the validity and reliability of the tests. The Minnesota program has devised an innovative way of measuring problem solving ability, and preliminary studies of the validity and reliability are most encouraging, especially when compared with some of psychology’s previous efforts to measure related abilities, such as empathy. A research team at the University of Minnesota is currently seeking funding to carry out the kind of programmatic research which will eventually allow the faculty to establish minimal levels of competence as a graduation requirement.

In the near term, the procedure can be useful in helping students evaluate or diagnose their ability to identify and resolve ethical problems. Faculty could serve this function in the curriculum, but Geistfeld and Waite believe members of the professional community add validity to the evaluation if they play the role of expert assessors.

Having students talk with an experienced professional about the solutions to their problems would help students to see themselves as linked with a group of professionals and get them used to the idea of discussing ethical problems with experienced dentists. Also, it would help students develop a collegial relationship with an experienced dentist, one that might continue into professional life. Most of all, it would help students see that the faculty aren’t self-appointed zealots, isolated from practicing dentists. Rather, students would realize that many members of the profession earn the respect of their colleagues because of their own personal integrity. They would also learn that these professionals have achieved success by working out courses of action in dilemma situations that compromise neither self-interest nor the rights of their patients, their colleagues, or the community.

The Role of the Expert Assessor in the Assessment Center

The idea that shaped the American College project was borrowed from industry. An AFDH grant enabled the Minnesota faculty to bring in consultants to assist in developing the Professional Responsibility curriculum. During one of the three two-day seminars held to define the curriculum, consultants described an Assessment Center concept used extensively in industry. Decisions about hiring and promoting employees are based on performance measurements made at these centers. Judgments about an employee’s competence are based not only on ratings by an immediate supervisor but on the views of an outside judge. Applying this idea in dental education, students would go to a center for a performance evaluation following a course or series of courses in professional responsibility. Someone other than the course instructor would judge the student’s competence and talk with them about the evaluation. Members of the professional community are ideally suited to play this role.

Dr. Waite articulated the benefits of the American College involvement in the role of outside expert. Having students talk with an experienced professional about the solutions to their problems would help students to see themselves as linked with a group of professionals and get them used to the idea of discussing ethical problems with experienced dentists. Also, it would help students develop a collegial relationship with an experienced dentist, one that might continue into professional life. Most of all, it would help students see that the professional community.

American College Involvement

The Minnesota Area Fellows developed a slide-tape show to describe the assessment center concept and the potential role for members. With this show members of the College could become trained as expert assessors, and might then volunteer to spend two to three mornings a year working with students. In that role, assessors would review transcripts or videotapes of student performance. Later, they would meet with students individually to discuss the evaluation.

Since this was a new endeavor that required the member of the College to take on an unfamiliar role, orientation seminars were held to prepare the practitioner to evaluate and interact with students. In a seminar setting professionals:

- Reviewed the dramas. Since the dramas present rather complex issues, some time was spent in discussion of each case to develop a consensus on how the problems could best be handled. Participants noted that the best resolutions tend to develop through collaborative efforts as each professional brings unique insights and experience to the discussion.
- Reviewed and refined the criteria developed to judge student performance. The School of Dentistry faculty had spent considerable time developing criteria. Reactions from the professional community were not only helpful in clarifying and refining these criteria but reaffirmed the importance of the endeavor.
- Practiced techniques for interacting with students. Talking with students about ethical problems, especially if one must challenge a position taken by the student, is a new role for most practitioners.

As of this writing, seventeen members of the College have become trained as expert assessors.
and play a crucial role in the School's Professional Responsibility Curriculum. Though a systematic evaluation of the project has not yet been completed, each volunteer has expressed wholehearted support by his continued willingness to serve. Additionally, the Section Executive Committee will recommend that the project be continued at the local level and is asking the national organization to consider the current needs of the Minnesota Research Project and the future possibilities for extending and expanding the program.

**Future Needs and Possibilities**

In the last few years, there has been a resurgence of interest in teaching professional ethics, particularly in the health sciences. This has been prompted not only by greater social consciousness, but by the dramatic technological advances which force all professions to face new ethical and moral questions. As a result, professional schools are beginning to institute courses in professional ethics. Dentistry is no exception and the University of Minnesota is committed to providing that evidence. Unless we can demonstrate that these courses make a difference, the recent curricular changes are likely to be short-lived, especially in the present economic times. We must demonstrate: 1) that the ability to identify, reason about, and adequately resolve ethical problems are distinguishing characteristics of the competent professional, and 2) that criteria for judging this area of competence can be as rigorously applied as other areas, e.g., diagnostics, treatment skills, etc.

The University of Minnesota School of Dentistry has developed an extensive plan to demonstrate that a program in applied ethics can enhance the ethical development of professionals and that standards can be developed to protect the interests of society and the profession; perhaps not from all the unscrupulous but at least from those who act out of ignorance. The research dimension of the project does have application to other professions, and the research team, headed by University of Minnesota psychologist, James Rest, a national noted expert in moral development, is seeking foundation funding to expand the work to other professional schools. The continued support of the dental profession gives credence to this effort.

Dean Richard Oliver believes that dentistry's interest in supporting this kind of work is characteristic of a dentist's abiding commitment to the public. He feels that it's no accident that dentistry is held in such higher regard than other professions, and believes that the American College is to be congratulated for its interest and commitment to the ethical development of the student.

Most programs designed to teach ethics are based on intuition, rather than evidence of effectiveness. The U. of Minnesota ... is committed to providing that evidence.

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A TREASURY OF DENTISTRY

Early Offices Were A Dangerous Place to Practice

By Gardner P.H. Foley

Since the glorious years of 1839 and 1840 when dentistry was established on an ever-improving professional course by the creation of three foundations—the first national organization, the first journal, and the first college—the profession in this country has sought diligently and effectively to improve not only its quality of practice but also its equipment and protective devices with the aim of reducing or eliminating certain uncomfortable and often injurious facets of the dentist's office experience.

The dentists of today will undoubtedly be surprised to read accounts of accidents, sometimes fatal, incurred by their predecessors. The cases presented have been selected to illustrate various kinds of office accidents. Fortunately the powers of progress have led to a remarkable reduction in the incidence of injuries.

In 1855 John S. Clark, of New Orleans, was using a lamp to warm some wax for an impression. When the lamp exploded, the flames ignited his clothes and burned him severely.

Apparently injuries sustained in the course of an extraction procedure were the most common of personal office accidents. In 1907 M.W. White, of Yorkville, S.C., in attempting an extraction, pressed so hard against his chair that he broke a rib.—Following his graduation from the Atlanta-Southern Dental College in 1906 Boykin Patton entered practice in Tuscaloosa, Ala. Early in his career he lost an eye while doing an extraction. However, despite this handicap, Dr. Patton became one of Alabama's best operators.—I quote from the New York City Mail of September 25, 1911: "While pulling a tooth Dr. Burr Bannister, one of the oldest dentists in Kalamazoo, was fatally injured. His patient turned to one side during the operation and tipped the chair over, pinning the doctor beneath it. One of the chair's arms struck him in the stomach, causing internal hemorrhage." The reference to Dr. Bannister's age could suggest that he was using an old-fashioned chair not attached to the floor.

In 1891 Francis M. Baab, a New York dentist, died as a result of having been bitten by a young woman upon whom he was operating.—Charles E. Monks, of New Britain, Conn., died from blood poisoning, contracted "in relieving a patient's suffering from a diseased tooth." He had plunged one of his instruments into the palm of his hand. Dr. Monks, 38 years old, was a 1901 graduate of the Baltimore Medical College Dental Department.

In 1884 Archives of Dentistry under the heading "A Warning to the Profession" reported several cases of injuries resulting from the use of the dental engine. The chief attention is given to Dr. A. W. Freeman's history of how he lost his right leg:

I had taxed the knee for years with the entire running of Green's then White's, dental engines (foot pumps) often with a feeling of discomfort which, it was supposed, was rheumatic. In retrospect I now consider the many thumps and the running of lathe and engine for over twenty years were preparatory aids, while the immediate cause of the primal inflammation was the severe blow, upon the crank of a Morrison dental chair, given a few hours before twinging pain began. A water motor, electricity, or an assistant should run the engine.

I found this reference to the "Gold Eye" in a 1905 issue of the American Dental Journal—but quoted from the New York Sun: "The 'gold eye,' recognized throughout this country as an ailment peculiar to dentists, is increasing. It is a form of eye strain incidental to the work of constantly plugging cavities in teeth with gold leaf and fine particles of gold. After a year
or two of such work dentists are obliged to wear glasses."

At an 1877 meeting of the New York Odontological Society, A.H. Brockway reported on an unpleasant experience he had had recently: "I caught one or two hairs of a gentleman's moustache in a corundum wheel, from which we both received quite a shock. It is my first experience of the kind, and I have often wondered why such accidents do not happen oftener. Had the rubber dam been on at the time the accident could not have happened."

There is also a class of accidents that do damage only to the office and other property. In 1903 the fountain spittoon in the office of a Salem, Mass., dentist overflowed during the night and caused $500.00 damage to the clothing stock on the floor below.—In 1889 David Genese, a prominent Baltimore dentist, gained a peculiar notoriety because of the very unusual nature of three fires that occurred in his office. Twice the office was set fire by a hand mirror. Another blaze was caused by a goldfish bowl. At that point in the progress of dentistry sunlight was commonly a welcome presence in dental offices, but certainly not for Dr. Genese.—I leave the vulcanizer, that explosive cause of many accidents, as a single subject of a future presentation.

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**Famous Inventor**

**Peter Cooper**

**Gives Testimonial**

For several reasons I am delighted to publish a letter (a.l.s.) written by a famous American to a New York dentist in which he expresses his warmly felt appreciation for the excellence of the dentist's services. The letter written by Peter Cooper to Dr. Dunn in 1879 is a valuable addition to the small collection of known testimonials to dentists in praise of not only the operator but also of the profession that afforded him the skills and materials to achieve the therapeutic results related by the patient.

The letter was presented to the late Dr. J. Ben Robinson in 1930 by Mrs. Mary Ford Dunn, of Brooklyn, N.Y. Peter Cooper (1791-1883) became nationally famed as an inventor, manufacturer, reformer, and philanthropist. He founded Cooper Union in New York in 1857, an enduring institution that he built and endowed to provide educational opportunities for the working classes.

Peter Cooper's comments on the materials used in the dentures mentioned in the letter and his testimony as to the contrasting therapeutic results obtained from wearing the two dentures make this letter one of historical importance to the dental profession.

No. 9 Lexington Ave.

Sep. 16th 1879

Mr. Dunn

Dear Sir

After some years experience in wearing gold and rubber plates I exchanged for your pure and beautiful mineral plates about four months since, and the change already effected is remarkable. My mouth was much inflamed and my tongue badly swollen. Now the inflammation has subsided and a natural healthy condition is restored by the change of plates. Then again the neatness and cleanliness of the pure mineral plates add amazingly to the comfort and satisfaction of wearing them. I trust that you may increase the health and happiness of the public by being able to bring these plates within the means of the poor people as well as those in more easy financial circumstances.

Peter Cooper
RETAIL DENTISTRY

Practice and Patient Characteristics

Judith F. Rosner,* Philip Yablons* Kenneth P. Maykow,* Michael C. Wolf*

The delivery of dental care in America has traditionally taken place in the office of a solo practitioner operating on a fee-for-service basis. Times are changing. Since 1977, when the Supreme Court ruled that professions may not be prohibited from advertising, a new mode of providing dental services emerged: the retail dental center.

The term “retail dental center” is a difficult one to define. Originally, it referred only to those dental facilities located in a retail department or drugstore. However, more recently the term is being used to refer to a specific philosophy concerning how dental practitioners choose to approach the public, i.e., like consumer-oriented businesses, as well as particular practice characteristics. These include such things as high visibility, easy-access location, use of extensive advertising, reduced fees, extended hours of operation, extensive use of auxiliaries, and availability of specialty dental services on the premises. Thus, retail dental centers may be found in malls, plazas, or freestanding buildings, not just in retail stores.

In contrast, the traditional American dentist works primarily in a solo-practice setting. Usually one or two auxiliaries complete the

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In recent years, dentistry has experienced the emergence of a new mode of dental care delivery—the retail dental center. This paper describes the practice and patient characteristics at two retail dental centers in New Jersey. Moreover, these findings are compared with those of a recent American Dental Association study of five dental centers in California.

Interview data were collected from patients in June, 1981 (N = 302) and from the owner/administrators of the two centers. The features of lower cost, convenient location and convenient hours attract patients to the retail dental center. However, there was no one type of retail dental patient. The socioeconomic characteristics of the patients frequenting the two centers were very different and reflected those of the geographic areas in which each of the centers was located.

Unfortunately, very little hard data has been gathered to date describing the various types of retail centers or the socio-demographic characteristics of the patients who frequent them. This need is addressed here; both the practice and patient characteristics at two retail dental centers are described in this paper. In addition, we will compare our findings with those of a recent American Dental Association (ADA) study of five retail dental centers in California where comparable data exist.

Both retail dental centers discussed here are in New Jersey. The Ocean County Center is located in a rural, coastal section of southern New Jersey in a small, strip shopping mall. It is rented by the owner and has its own entrance. In contrast, the Bergen County Center is located in a suburban community considered part of metropolitan New York City. It is attached to a discount store with which it carries a long-term lease; however, its entrance is separate—it cannot be reached from within the store.

The five retail dental centers studied by the ADA are located in...
California. All of them are found within the same chain department store and they are all operated by a single management firm.

Methodology

Our patient data came from interviews with 153 patients at the Ocean County Center and 149 patients at the Bergen County Center (N = 302). Dentulous patients over 18 years of age who had been to the facility at least once before were interviewed.

The interviews were conducted by two senior dental students from Fairleigh Dickinson University during June 1981. They interviewed patients at different times of the day and week to ensure as representative a sample as possible. The twenty-three-item interview schedule included both closed- and open-ended questions and took about ten minutes to administer.

To gather information on the practice characteristics of the centers, we interviewed the owner/manager of the Ocean County Center and the administrator/manager of the Bergen County Center. The data collection methods used by the ADA in their California study differed from ours in that their patient information came from questionnaires (N = 258), not interviews, and their information on practice characteristics came from a questionnaire completed by a representative of the management firm that runs them.

Findings

Practice Characteristics

1. Physical Layout

The Ocean County Center is a very large area (4,000 sq. ft.) housing seven semi-private treatment rooms, one private oral surgeon’s suite with two recovery rooms, and a commercial-type laboratory. (The laboratory owner is in partnership with the dentist/owner of the center.) Ocean County operates six days a week, 9-9 Mondays through Fridays and 9-6 on Saturdays.

The Bergen County Center has seven operatories (two are double units) and one emergency chair. There is no private oral surgery suite or commercial-type laboratory on the premises. Bergen County operates seven days a week, 10-10 on weekdays and 10-5 on weekends.

All the centers in the California study reported having eight one-chair operatories. Only one center had on-premise laboratory facilities used only for prosthetics. Each center in the ADA’s California sample reported eight-hour workdays during the week, with office hours varying from 10 a.m. to 6 p.m. or from noon to 8 p.m. A couple of centers were open on Saturday, but all were closed on Sunday.

2. Personnel

The Ocean County Center employs seven full-time general practitioners and part-time specialists in oral surgery, orthodontics, and periodontics. The owner works at the center two days a week and spends the rest of the week at his “traditional” office in a small town nearby. Each dentist works with an assistant, and two hygienists are employed by the center. Office staff includes an office manager, a person who deals only with insurance, an accountant, and a secretary-receptionist. Eight full-time technicians work in the laboratory housed by the center.

In contrast, the Bergen County Center employs only three full-time dentists and nine dentists work on a part-time basis. Part-time specialists in oral surgery, orthodontia, and periodontia are also on staff. The owner does not work at the center, but a full-time dentist carries the title of “managing dentist”. As at Ocean County, dentists at Bergen practice four-handed dentistry. Bergen also employs a part-time hygienist. Office personnel include an office manager/administrator and a person who processes dental insurance forms. Dentists at both centers are paid on a commission basis and almost all are in their thirties.

Far fewer dentists are employed by the centers in the California
Each of these centers reported having only one full-time general dentist and two centers reported an additional part-time general practitioner. Four centers reported having a part-time orthodontist and one center had a part-time periodontist. No center employed an oral surgeon. All twelve dentists employed full- or part-time at the five centers were under 40 years of age.

Each of the centers differed widely in the average number of patients treated each week. At the Ocean County Center approximately 675-800 patient visits were reported each week; and at the California centers, an average of 90 patient visits per week were reported.

All centers try to see patients on an appointment rather than on a "drop-in" basis. However, most centers can accommodate non-emergency patients within two days and emergency patients on the same day.

Thirty percent of the patients at Ocean County have some third party coverage as do twenty-nine and a half percent of the patients at Bergen County. Both of these centers accept Medicaid patients, but both report negligible numbers in this category. Fifty-six percent of the respondents in the California study reported they have prepaid dental coverage and, of these, thirty percent said they purchased the reduced fee plan offered by the centers. Both centers we studied, as well as those studied by the ADA, accept major bank credit cards for payment of fees.

### 3. Advertising

The owner of the Ocean County Center told us he employs an advertising agency and that he spent between $70,000 and $80,000 on advertising during the first year of operation. He estimated that this sum may drop to $50,000 with "word-of-mouth" referrals. He found that the best response was to his radio ads (three spots a day on...
four stations). He also advertises in the Sunday paper and in senior citizens newspapers. This center is surrounded by senior citizen housing and retirement communities. Thus, advertising efforts, discounts, and lower prosthetic fees are all aimed at an older target population.

In contrast, the Bergen County Center, in operation three years longer than the Ocean County one, reported a lower advertising budget ($25,000). The Bergen Center also employs an advertising agency, but the core of its advertising efforts lies in newspaper ads, fliers, and the Yellow Pages. The radio is only occasionally used now, but was most important as an advertising medium during the first six months the center was open. Located in a metropolitan suburb, the Bergen County Center aims its advertisements at a solid middle-class clientele. Thus, the center's media messages stress "quality of practice" as well as lower cost and convenience.

The California study found that each of the five centers used the same variety of advertising methods: in-store promotions; the Yellow Pages; mail promotional brochures and store signs. The average annual amount spent on advertising per center was $1,520—a minuscule amount compared with what was spent by the two centers we studied in New Jersey.

4. Patient Characteristics

We had expected that most patients who frequented retail dental centers would be blue collar, lower-middle-class workers. We had some surprises. While the majority of all patients interviewed were blue collar workers, at the Bergen County Center over a third (34%) were found in white collar occupations and 16% and 11% were classified as professionals in the Ocean and Bergen Centers respectively (Table 1).

The educational backgrounds of the patients at the two centers differed dramatically—60% of those attending Bergen vs. 33% of those at Ocean had at least some college education (Table 2). The family income data (Table 3) also point to a higher patient socioeconomic status at the Bergen Center where 22% of the patients reported their family income as over $25,000. (The 17% in the lowest income bracket is most likely due to the student population found at the center; two colleges are located in the area.) The patients attending the Ocean County Center were overwhelmingly white; in contrast, 22% of Bergen's patient population was non-white. Most patients at both centers were married and the age distribution of those interviewed was about the same.

In general, it appears that the Bergen Center attracts a more solid middle-class clientele (consistent with its advertising efforts) and the Ocean Center attracts a larger blue collar population. Because we did not include denture patients in our study, we lost information on the number of older, retired patients living on a fixed income.
income—many of whom live close to the Ocean Center.

The ADA's findings were somewhat similar. Thirty-two percent of the patients treated at the five California centers were categorized as blue collar, 21% as white collar, and 13% as retired. The mean household income was $20,667 and 71% of the patients were white.

How did these patients learn about the centers? The most common sources for all patients were "friends or neighbors" and "newspaper or radio". Those attending the Bergen County Center were most likely to get a word-of-mouth referral, probably because it has been in operation longer than the one in Ocean County. In contrast, 50% of the patients in the California study said they learned of the dental services through store signs or brochures distributed in the store.

Most patients live no farther than a half-hour from the centers—with a majority (56%) at Bergen living within fifteen minutes of the dental service. This can possibly be explained by Bergen County's greater population density.

There was a great difference between the Ocean and Bergen patients regarding the last time they visited the dentist (Table 4). Bergen's patients were more likely than those at Ocean to be regular visitors to the dentist; this finding is consistent with the socioeconomic data discussed previously. Forty-four percent of the patients interviewed at the Bergen Center compared to only 13% at the Ocean Center said their last visit to the dentist was within one year. Nearly all the patients at both centers received care from private practitioners before coming to the centers and, interestingly, eight percent of Bergen's clientele previously received care at a dental school (likely Fairleigh Dickinson University School of Dentistry).

When those who had not been to the dentist for over two years were asked what kept them from seeking care sooner, the greatest percentage of patients at both centers said, "I didn't need care" (Table 5). However, over a third of those attending the Ocean Center contrasted with only 18% at the Bergen Center answered that they didn't go sooner because it was "too expensive." This might be explained by the lower socioeconomic status of patients at the Ocean Center.

Why do patients go to retail dental centers for care? (Table 6). Our patient responses were similar to those in other studies—cost and convenience (location and hours). However, while cost was the most frequently mentioned factor by patients in our study, convenient hours and convenient location were mentioned by a greater percentage of the respondents in the California study than was cost.

As expected, when asked what they found attractive about the dental center, most patients at both

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*Totals do not add to 100% because multiple responses were given.
centers mentioned "price" and "convenience" (hours and location), though the percentages were higher for the Ocean Center.

Only 43% of our respondents answered the question "What do you find unattractive about this dental center?" Patients attending the Ocean Center mentioned the attitudes of the staff, lack of confidence in the dentist, and lack of privacy during treatment as unattractive features. On the other hand, patients at the Bergen Center were more likely to check appointment problems and lack of personal attention as unattractive features.

The features of lower cost, convenient location and convenient hours attract patients to the retail dental center.

The Ocean County Center, on the other hand, attempts to attract an older population by advertising in senior citizens' newspapers and offering discounts on prosthetic care.

Thus, just as the demographic characteristics of the neighborhood surrounding the private practitioner's office in many ways determines the type of patient who knocks on his/her door, the same holds true for these dental centers.

Or, as the University of Iowa study found with regard to demographic characteristics, anyone from the general population may be a potential retail dental patient.6

Although this survey provides some insight into the practice characteristics and patient characteristics of retail dental centers, it asks more questions than it answers. Do patients use these centers for all or only some of their care? How many patients have left the retail centers and returned to private dentists? How satisfied are the dentists who work at these centers? How do the patient characteristics and utilization patterns compare to those of patients who go to private practitioners? These questions must be addressed in future studies in which a larger, more geographically representative sample of retail dental centers and their patient populations are queried and in which comparisons are made with patients receiving care at traditional practices. △

**Conclusions**

We found the features of lower cost, convenient location, and convenient hours attract patients to the retail dental center and that most patients are satisfied with the care they receive. Beyond this, however, it is difficult to make any generalizations about the patient population of these centers because: (1) of the relatively small size of our sample; (2) only two centers were studied; and (3) both centers are located in the same state and thus in the same geographic region of the country. However, what is clear from the data is that there is no one type of retail dental patient. Socio-demographic characteristics of the patients who frequent the two retail dental centers studied here reflect those of the geographic areas in which the centers are located.

Moreover, the centers gear their marketing and advertising campaigns to attract these different groups. For instance, the Bergen County Center decidedly gears its advertising to a middle-class audience, touting "quality of care" and "personal attention" in its brochures. The Ocean County Center, on the other hand, attempts to attract an older population by advertising in senior citizens' newspapers.

The features of lower cost, convenient location and convenient hours attract patients to the retail dental center.

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