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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 graduate studies and continuing educational efforts by dentists and auxiliaries;

D. To encourage, stimulate and promote research;

E. To improve the public understanding and appreciation of oral health service and its importance to the optimum health of the patient;

F. To encourage the free exchange of ideas and experiences in the interest of better service to the patient;

G. To cooperate with other groups for the advancement of interprofessional relationships in the interest of the public;

H. To make visible to professional persons the extent of their responsibilities to the community as well as to the field of health service and to urge the acceptance of them;

I. To encourage individuals to further these objectives, and to recognize meritorious achievements and the potentials for contributions to dental science, art, education, literature, human relations or other areas which contribute to human welfare — by conferring Fellowship in the College on those persons properly selected for such honor.

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FROM THE EDITOR

Form and Function in Editorials

I have heard speakers start recently by mentioning Elizabeth Taylor and the reassurance she reportedly gave all her husbands, "Don't worry. I won't keep you long." Such comments in the preamble to a speech make me worry: has the speaker really thought through what he or she is supposed to be doing? A controversy is developing over how many words an editorial should contain. I think that's silly. So start counting. I promise to make this one brief, no matter how long it takes.

Those who argue for word counts or short editorials generally may have in mind the limitation imposed by a familiar publication. There is also the view that modern readers belong to the "now" generation and are too busy to be detained over anything longer than a few sound bites. They would have us believe that a condensed version of the Bible makes sense in these times because most of us can only handle five commandments anyway. Brevity is merciful when the writing is bad, but good writing is the best remedy. The length of an editorial should be determined by the format of the publication, respect for the reader's intelligence, and the nature of the topic addressed.

Sometimes the format of a publication influences the length of its editorials. In the newsletter format, care must be taken to avoid the orphan paragraph that completes the editorial and is buried on the fifth page. Some journals have a tradition of fitting an editorial on a single page — allowing room for a pull quote or photograph and some white space to give the layout visual texture. Journals that carry advertisements or short notices are better served with editorials of one and an half pages in order to leave natural settings for the shorter material.

Many of the issues facing the profession today are complex, and short editorials must either ignore them or treat them superficially.

It is also necessary to consider how the art of reading differs from that of listening, for example, to an after dinner speech, a cassette recording, television programs, or any other time-bound medium. Writing honors readers by allowing them to adjust the time they spend with the copy, permitting everything from skimming to full and careful study, and even reading in random order. Normally, reading behavior is determined by an interaction between the content and style of the text and readers' interests.

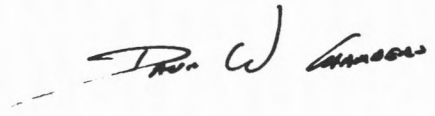
Good reading is dynamic. It hardly matters how quickly the eyes are moving; what really counts is the extent to which the brain is engaged. The practical limit on comprehension is whether the reader can sort the words efficiently and find meaningful places to put them. It is not a supply issue, it is a capacity problem. In dentistry, I consider it unethical to offer only an abbreviated treatment plan on the prejudice that a patient of apparent limited means could not afford the dental care they really need. In the same manner, it would be at least presumptuous for editors to offer less than a full presentation of the topic because of a prejudgment that their readers lack the time, interest, or capacity to understand it.

The worst part about determining the length of an editorial before considering its content is the way this limits the topics that can be presented to the profession. Architects and individuals in business share the maxim that "form follows function." If we concede that dentists' reading will be limited to snatches, glances, and the occasional six paragraphs about something they already agree with, we create a self fulfilling prophecy. Many of the issues facing the profession today are complex, and

short editorials must either ignore them or treat them superficially.

A good editorial thrives on the challenge of trying to develop important ideas so readers can understand them. The writer must usually build up familiar concepts as a foundation for novel perspectives. Almost by definition, if the leaders of the profession are to realize its future, they must learn to see the world anew — an unlikely result of a diet of the brief and the familiar. I am reminded of the recommendation for timid souls facing the prospect of a task as difficult as jumping across a six-foot ditch. "Break it down into manageable segments," the traditionalists urge. "Try three comfortable, two-foot jumps."

Abraham Lincoln was a tall man for his time. A boy once asked him, "Mr. Lincoln, how long *should* a man's legs be?" The future president answered "Long enough to reach the ground." And that should be the proper length for an editorial as well — long enough to get down to something solid.



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

Letters to the Editor

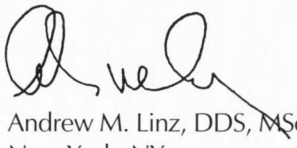
To the Editor:

Dr. Jules M. Hoffman's position (letter, Spring 1996, *Journal of the American College of Dentists*) with regard to solving educational gaps by merely changing the current dental curriculum and his comments concerning postgraduate training are disturbing to me. He implies that the aim of training dental students for today's practice can be accomplished by emphasizing clinical training in restorative dentistry. This view fails to recognize that a good many technical procedures in restorative dentistry could be performed by properly trained and supervised technicians, which will likely occur in the near future in this era of "managed care."

In order to preserve dentistry as a profession, the dental curriculum needs to be augmented by emphasizing the study of basic sciences and medically oriented clinical areas. As a former director of two major hospital dental departments and training programs, it has been my experience that too much of the residents' time is currently spent making up for their lack of educational exposure in these areas.

Dr. Hoffman suggests that a year of postgraduate training would not be necessary if the proper changes could be made in the dental curriculum. My position is that a postgraduate year should be a requirement for licensure. A mandatory year of postgraduate training for licensure would also help eliminate the archaic practice of clinical testing for initial licensure. Dentistry is the only major health profession with such a requirement now.

It has been ninety-five years since the first dental graduate was accepted for internship training in the United States, and it is about time that every dental graduate receive the educational benefit of such a requirement, as medical graduates have.



Andrew M. Linz, DDS, MSc, FACD
New York, NY

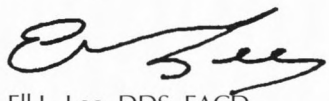
Dear Editor:

The fall issue of the *Journal of the American College of Dentists*, while providing much thought provoking material, struck its loudest note in "Ethical Checklist for Dental Practice" by Rinchuse, Rinchuse, and Deluzio.

While I support the general premise and have for many years espoused the need for ethical re-evaluation, I must take exception to one aspect of the article. That area is professional courtesy. As an oral and maxillofacial surgeon, I consider it one of the highest compliments when a dental or medical colleague or a family member chooses me to provide their care.

For over twenty-five years I have been privileged to treat many members of our health care "family" and continue to do so at no charge. I consider this an act of respect, not a gift. Do I get additional referrals? — perhaps. Do I get personal satisfaction? — absolutely!

Sincerely,



Ell L. Lee, DDS, FACD
Green Bay, WI

Dear Editor,

I recently read the article by M. S. Rubin ("The Changing Marketplace: Informed Choices; Safe Action," Spring 1996, *Journal of the American College of Dentists*) about the regulated environment in the dental marketplace. In it the author makes reference to a Far Side daily calendar page. The cartoon illustrates a large dinosaur, with a small head, speaking to his colleagues. He states, "The picture's pretty clear, gentlemen... The world's climates are changing, the mammals are taking over, and we all have a brain about the size of a walnut." This got me thinking about my own specialty — periodontics.

Some large managed care operators are now beginning to control our fee schedules as well as our patient loads. They not only pay much reduced fees, but control the number of specialists allowed on their panels in a geographic area. General practitioners are not busy enough due to the residual effects of fluoridation and an oversupply of practitioners. Therefore they try to keep

the patient in their offices, relegating the prospective periodontal patient to the hygienist. Changing treatment patterns are altering the traditional roles of periodontists.

Recently, the American Academy of Periodontology has queried some of its members about advertising directly to the general public. If this proposal is acted on, patients who ask their dentist whether they should see a periodontist would be told, "Yes. I have a periodontist coming to my office every Wednesday. I will put you in the schedule for next week." That would make periodontists unique among health care professionals with doctor's degrees as the only itinerants. It would further destroy the base of patient referrals, although the concept of referral has already been eroded severely by the recent practice of just picking a name from the "provider list" of an insurance panel.

In terms of solutions, I have two suggestions. One would be to pressure insurance companies to reimburse for periodontal surgical procedures based on the qualifications of the surgeon. Second, there should be no restrictions on the number of specialists in a geographic area. Both these restrictions are disservices to the patient and the professional alike. Neither care nor patients should be rationed.

I feel sorry for the postgraduate student now. Periodontics is not only a three year program, but when the graduates finish, they will be getting only half the fee I was charging five years ago. This does not take into account the high cost of their additional education nor the three years of lost income. It is also a matter of fact that none of the recent graduates of the program where I teach part-time have opened their own offices. I continue to worry about how many postgraduate periodontal programs will be in existence and be viable after the turn of the century.

Respectfully,

Dr. Harold I. Sussman

Harold I. Sussman, DDS, MSD, FACD
New York, NY

Dear David,

Thank you for another great issue of the *Journal*. Your ability to attract great writers with important information is outstanding. My letter relates to the article by Mark S. Rubin, "The Changing Marketplace: Informed Choices; Safe Action." I appreciate his effort to give us some positive steps to accomplish in our individual and collective efforts to provide an alternative to signing up for managed care plans. I hope that everyone reads his message of hope and acts to control our future.

One area where I think we should tread very lightly, however, is in the formation of IPAs. I agree that dentists in specific locations who are faced with do or die options from overwhelming managed care operations should consider banding together as an IPA in order to have some negotiating strength. However, I think urging dentists to consider IPAs as a method of resisting managed care actually plays into the managed care industry's hands. One of the frustrations the managed care industry has with the dental community is the fact it has to negotiate with each individual dentist in order to sign up enough practitioners to become a viable alternative to the independent dentists in a community. The medical community wasn't quite so difficult because it tended to be composed of large groups or its members were associated with a specific hospital that had a managed care contract with its patients. Once the managed care company signed up either the hospital or a couple of large groups, the rest were forced to fall in line or lose all their patients.

If dentists joined IPAs to negotiate the best deals with managed care companies, they may enjoy the short-lived pleasure of finding the contracts quite generous. I'm reminded of a fellow dentist who was tickled to find a managed care program what would accept his current fee listing. He signed right up. He now complains that he hasn't been able to raise his fees in recent memory, and when he complains, he's reminded that the large group of patients he is seeing for this company can be transferred to a more willing provider at any time.

Managed care companies would love to find large groups of dentists who speak with one voice. These groups

could be offered generous reimbursement levels in exchange for losing control of their patient populations. Once they have sold the rights to these patients, they give up their major bargaining tool. When the remaining dentists in the community see the IPA sign up the major employers in the community, they'll run to sign up before they get left out. The scenario has been played out in communities all over the United States by physician groups and hospitals.

Dentistry has prided itself in its independence and dedication to patient care. Dentists' overheads are high because they are trying to give outstanding quality care in an intimate and comfortable environment. By banding together into IPAs (large targets), they give up that independence and begin the process that leads to cost cutting, service cutting, and less involvement with their patients. I think that, except in rare instances, dentists should follow the rest of Mr. Rubin's suggestions and leave the grouping tendencies to physicians.

Sincerely,

Bill vanDyk

Bill vanDyk
San Pablo, CA

Changing the Law: How Boards of Dental Examiners Influence the Legislative Process

Don-Neil Brotman, DDS, FACD

A Board of Dental Examiners functions in three areas: discipline, licensure, and legislation. This article deals with the legislative elements of the board.

Although the policies of the board often determine the vigor with which segments of relevant codes are enforced, all statutes, rules, and regulations are intended to be uniformly applied to licensees.

Few dentists understand how the board works and its complexities until they have served on a board of dental examiners. Those who do serve must gain expertise in the Dental Practice Act and applicable law.

The board's counsel, from the Office of the State's Attorney-General, advises the board members on the legal interpretation and meaning of applicable statutes, many of which are not part of the Dental Practice Act.

When legislation is proposed to alter the Dental Practice Act, it usually emanates from the dental board, the state dental association or society, the dental hygiene association, or a legislator who has a constituent with an unusual interest. However, the introduction of legislation does not assure its enactment. When there is organized opposition to a proposal, its passage is unlikely. Various factions within the profession and society must be willing to endorse a proposal before it can become law. Therefore, boards usually seek the help of other dental organizations when attempting to modify a statute.

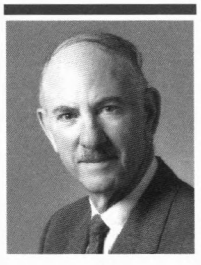
Legislation

Changing the law requires introducing a bill into the legislature's House or Senate and, after hearings, approval by both houses and signature by the governor. However, while a proposal is being considered, many amendments may be introduced and attached. What seemed to be benign legislation sometimes becomes a horror story.

Consider a *hypothetical* situation: the Centers for Disease Control and Prevention (CDC) determine that periodontal disease is communicable and can be spread by the organism that causes dandruff, *P. Ovale*. As a result of this finding, the State Board of Dental Examiners, in its infinite wisdom, decides dentists must shave their heads and cannot sport mustaches or beards. Since no existing law addresses the situation, the General Assembly must create statutes before the board will be able to reduce the spread of hair borne diseases (HBD).

A bill is planned requiring licensed dentists to have their heads shaved at least twice a week. Although the proposal is disfavored by both male and female long-haired dentists, the board receives the endorsement and cooperation of the state dental association for the public good.

The HBD bill is introduced, read before the Senate and hearings are held by the assigned committee, the Senate Committee on Commerce. Favorable testimony is provided by a representative of the board, as well as by the lobbyist for the state dental association. The committee receives further testimony from a representative of the barber's union, who requests an amendment requiring head shavings to be accomplished only by licensed barbers. A further amendment requiring dental assistants and dental hygienists to have shaved heads is proposed and adopted



Dr. Brotman has served as President of the American Association of Dental Examiners and the Maryland State Board of Dental Examiners. He is currently a member of the ADA Council on Dental Education and the Northeast Regional Boards of Dental Examiners. His practice is at 1101 N. Calvert Street, Baltimore, MD 21202.

by the committee. This brings the concurrence of the beautician's and cosmetologist's unions, whose legislation committee chairperson recommends that eyebrows and eyelashes also be removed.

The ACLU provides testimony in opposition to the bill.

Ultimately, the Commerce Committee approves the proposal by a vote of nine to three along with an amendment permitting hairpieces to be worn by dentists and their employees when not doing surgical procedures.

The bill is forwarded to the full Senate and approved. Next, the HBD bill is sent to the House for its consideration. In the House Committee on Health and Insurance, amendments are added permitting those who can prove that they are descendants of Samson to apply for and receive a waiver on religious grounds so they might retain their hair and strength. However, each exempt person would be required to wear a barrier to guarantee that no hair borne organisms could reach the oral cavity of a patient.

After the House approves its changes in the bill, a joint committee of House and Senate members reconciles the proposal by compromising on the provisions that differ between the versions passed by the two bodies. Both bodies approve the final draft.

When the Governor receives the bill he vetoes it. One of his cousins, a dental assistant, has beautiful red hair which is truly her crowning glory. She called the governor's wife and told her why she felt the bill was objectionable.

The Senate's proponents are unable to gather enough votes to override the veto. Therefore, status quo is maintained, at least until the following year when the legislature reconvenes.

Rules and Regulations

When the statute contains words addressing an issue, provisions clarifying it are possible through administrative procedures which are often complex, usually require open hearings and must have many authorization signatures before becoming official. The rules and regulations detailing the ordinance have the same effect as statutory law but do not require the action of the legislative bodies.

The communities of interest are usually involved in the development of rules and regulations so that thorough consideration is given to different points of view. As a result, few unanticipated challenges to the proposals occur when hearings are held on the proposed rules and regulations changes.

Several years ago, the Maryland law changed so that it became mandatory for licensees (dentists and hygienists) to participate in continuing education to reregister their licenses. However, the law was generic and vague, and it required fleshing out.

The board president appointed a committee of board members that included dentists, hygienists, and consumers to evaluate and recommend appropriate rules and regulations regarding continuing education. The chairman of the committee invited the Maryland State Dental Association; the Maryland Dental Society; the Maryland Dental Hygienists Association; the Maryland Academy of General Dentistry; and the Baltimore College of Dental Surgery Dental School, University of Maryland to each appoint a representative to participate in the committee's deliberations.

Copies of the continuing education requirements of other jurisdictions were obtained, distributed, and studied. Many issues were discussed and debated, including:

- ☐ Minimum number of hours per reregistration interval
- ☐ Acceptable course sponsors
- ☐ Acceptable subject matter
- ☐ Record keeping
- ☐ Validation of participation
- ☐ Monitoring of licensees for compliance
- ☐ Costs involved with monitoring
- ☐ Failure to comply
- ☐ Substitutes for continuing education
- ☐ Initial date of requirements
- ☐ Mandatory courses (infection control, CPR)

Ultimately, the committee reached consensus; the board was apprised of the committee's recommendations, which were approved with modifications. The proposed rules and regulations were sent to the State Secretary of Health and Mental Hygiene, who introduced them into the promulgation process.

An open hearing was held after public announcement of the hearing, as required by law. Subsequently, the Office of the Attorney General reviewed the proposal for legal sufficiency. Then, the material moved across the desks of various functionaries and bureaucrats who needed to attest to the codification, appropriateness, and format of the document and affix their signatures. More than a year passed before the process was completed and the proposal was adopted.

This paper is intended to provide some insight into the realities of the legislative elements of a dental board's activities. Although there are variations from state to state, the format described approximates actuality.

Initial Licensure in Dentistry: How Boards of Dental Examiners Test Candidates for Licensure

Robert T. Ferris, DDS, PhD, FACD

No more controversial nor contentious subject exists in dentistry than initial licensure. The term usually means a series of examinations conducted over several days by a state or regional board or agency. Candidates are not allowed to practice in a state unless they have passed the state's board or a board given by another state or by a testing agency recognized by the state. The purpose has always been to ensure the competency of the person who seeks to practice dentistry in that jurisdiction. And yet, almost everyone agrees that "holding a license in a particular profession does not guarantee competency."[1]

Why, then, does the dental profession continue to hold on to the outdated paradigm? Some say it is because certain clinical procedures are valid "markers" of clinical competency.[2] Others say it's the only entry-level mechanism available to assess the outcomes of predoctoral dental education. And still others believe it is the only approach that is politically acceptable to all of the communities of interest. If this is true, why is everyone in the process so unhappy with the system? One would think that a system with so many and varied detractors and opponents would be discarded and replaced with something more effective and modern.

Multiple Perspectives

As a Past-President of the American Association of Dental Examiners, I once characterized our initial licensure process as an eighty-year-old answer to a ninety-year-old question which no longer should be asked! The initial clinical examination for licensure was appropriate at a time when dentistry was struggling for recognition as a health profession. It was necessary when dental education was not standardized, or accredited, and was largely unregulated. None of these conditions exist today.

On the other hand, many other problems of equal importance plague us today, but the initial licensure process does not address these issues. Problems of ethics, professionalism, substance and sexual abuse, fraud, and exceeding one's scope of competency are reviewed only after a license has been granted. Most interpretations of law view a license as a property right, making the suspension or revocation of a license an exceedingly difficult, almost impossible action by regulatory authorities. As an eight-year member and Chairman of the Florida Board of Dentistry I know this is a fact of life in the nineties.

Many conflicting points of view on the need for an initial licensure examination are raised in dental forums. Boards of dental examiners are said to be political appointees with little or no expertise in valid and reliable examination. This may be true, but these same appointees usually have no special background in substance abuse counseling or rehabilitation either. Would any of us rather face the Federal Drug Enforcement Agency than our own peers on a

Dr. Ferris practices periodontics at 475 Maitland Avenue, Altamonte Springs, FL 32701. He is a Past President of the Florida Board of Dentistry and the American Association of Dental Examiners and has served on the ADA Council on Dental Education.

state board regarding the retention of our license to practice? Which of us would rather be judged by a Federal District Court or a criminal court than by a jury of our professional colleagues on allegations of insurance or Medicaid fraud? While we might end up facing both, only the licensing agency can revoke the license to practice dentistry.

I once characterized our initial licensure process as an eighty-year old answer to a ninety-year-old question which no longer should be asked!

It is often said that, since all dental schools are accredited now, the schools should certify candidates for licensure. This may sound reasonable, but aren't these the same schools and educators who told us that outcomes assessment was the proper role of licensing boards? Don't we rely on outside audits of the safety and soundness of financial institutions by banking regulators before we leave our money at the teller windows? As a member of the ADA Council on Dental Education and Commission on Dental Accreditation, I recently have seen the nation's dental schools beginning to develop and strengthen programs in outcomes assessment. These efforts are at an early stage, however, and they have yet to give great confidence to the profession that all graduates are predictably competent.

In fact, one of the most significant charges against the schools today is they have not been accountable for the competency of all graduates. The argument goes as follows: The board exams are primitive and have not changed enough over the years. If this is so, and if the failure rates have risen at a time when the numbers and qualifications of applicants to dental schools sharply declined, it appears that the schools may be graduating less competent candidates for licensure. Dental educators may deny this, but the syllogism is intact: same types of board members, same types of exams, but different results, i.e., higher failure rates. The only variable in the equation is the skill level of the applicants.

That is one perspective, but it may not be realistic. It may be that the schools have changed their focus in recent years, emphasizing biomedical, medical, and behavioral sciences, with less stress on traditional areas. An obvious response would be that the schools and boards should work more closely, to parallel their efforts to teach and to test more compatibly. As stated by Past President of the ADA, James Gaines, "All parties are qualified to become legitimate participants" in the effort to improve licensure and its examination component.[3]

For the time being, that is a reasonable response to the current anxiety over the licensure process. On a long term basis, however, this is only "tweaking" the current (and I believe inappropriate) system. A modern approach, with many more advantages than our present licensure process, follows.

A Fresh Look

I propose replacing initial licensure with an initial permit to practice general dentistry under the general supervision of a licensed consultant-dentist or dentists assigned by the state board. The *permittee* would be able to practice in areas of competency in general dentistry certified by the school which granted the degree. The consultant would periodically review patient and financial records for appropriateness and quality of care. Required participation in continuing education programs would strengthen quality assurance and also could include credentialing in areas and technologies not typically possessed by entry-level candidates, if the permittee wished to expand the scope of his or her practice. Periodic screening for alcoholism and illicit drug use would be under the direction of the licensing board.

At the five- to eight-year level, after successful completion of a written (or electronic) diagnosis and treatment planning exam, a license would be granted. Re-examinations for relicensure would occur at intervals determined by the licensing board. For instance, medical specialty boards routinely use a seven- to ten-year time frame. Failure to succeed in a relicensure exam would not suspend the license, but the licensee would remediate in deficiency areas in a manner prescribed by the board. In fact, many boards now have experience in remediation, as a result of disciplinary proceedings in quality of care infractions.

Most interpretations of law view a license as a property right, making the suspension or revocation of a license an exceedingly difficult, almost impossible action by regulatory authorities.

In the case of specialists, the statutes of the relevant state would govern, but one could envision that diplomate status by an ADA-recognized certifying board which has recertification requirements, would be sufficient for relicensure. Non-boarded specialists would have an additional incentive to become

boarded, similar to the current hospital staff model which provides a strong economic incentive to become certified. Therefore non-certified dental specialists either could become diplomates or they could comply with the process proposed above for general dentists.

I propose replacing initial licensure with an initial permit to practice general dentistry under the general supervision of a licensed consultant-dentist or dentists assigned by the state board.

Chambers describes a model of "authentic evaluation" to replace one-shot testing for licensure evaluation.[4] This has the advantage of examining when the dentist is ready, and performance can be evaluated over time, instead of "a single, high-stakes moment of possible failure."[4] The initial license would also be provisional. Periodic re-examination for relicensure could be scheduled with flexibility that would permit the licensee to retest when ready.

Dental schools and dental societies would, of necessity, have a major role in the ongoing professional education of all dentists. The institutions and organized dentistry would have a significant economic interest in the continuing competency and relicensure of all dentists. The schools would have greater income from continuing education programs, and dental organizations might see more success in their recruitment and retention efforts.

The greatest impediment to this system is it would be DOA (dead on arrival) at the state legislatures due to opposition by existing licensees. However, the American Board of Oral and Maxillofacial Surgery (ABOMS) found an acceptable approach by specifying a date in 1990, after which all new diplomates would be retested in order to retain certification by ABOMS. Thus, after a certain time this proposed model could be applied to all new applicants for licensure, thereby eliminating the objections of existing licensees.

One of the principal attractions of the proposed system is that it answers virtually all of the logical objections to licensure by credentials, endorsement or reciprocity. To be specific, proponents of licensure by credentials argue that the lack of disciplinary action by a board against a licensee, the so called "blemish-free record," indicates that a dentist must be practicing in a safe and competent manner. This assertion must be weighed against the current passive status of dental boards which may only react to complaints against licensees. In other words, dental boards are not generally permitted by law to be proactive, except where probable cause exists that a violation has occurred.[5] This is as it should be in a democracy. But, the well known paucity of funds for investigation and prosecution, and the reactive nature of board regulation gives no confidence that our system assures competency.

A proactive, continuing competency, assurance-based system would furnish contemporary proof of both safety and competency, to the extent that we can currently evaluate such qualities.

On the other hand, a proactive, continuing competency, assurance-based system would furnish contemporary proof of both safety and competency, to the extent that we can currently evaluate such qualities.

The current financial resources of state boards are slim, but the money saved by eliminating initial testing could be directed toward more important activities. My state board experience consistently showed that the majority of quality of care problems were with older practitioners, decades after they passed a state board clinical exam. The largest group of substance abuse and fraud cases came from the younger licensees, who had succeeded in passing their clinical exam in the recent past. I believe that the boards are testing the wrong people for the wrong things. A system that periodically evaluates clinical competency and provides office audits would go a long way toward focusing our resources on the problems most likely to occur. Education and enforcement are more likely to succeed in this proposed model than in the current system, which assumes too much and evaluates too little.

Students fear the system. Dental educators generally decry the system. Many leaders in organized dentistry are critical of the system and its purported negative effect on recruitment and retention. And state and regional board members, well-meaning and professional as they are, are tired of being blamed for the inequities of a system that they try valiantly to defend and to improve. Isn't it time for a change?

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A Voice in National Policy: How Boards of Dental Examiners Affect Education and Practice

Joel F. Glover, DDS, FACD

State dental boards are thought of as being independent and apart in actions from each other, the dental practice community, and the dental educational community. Historically the board was created with the specific mission of protecting a state's citizens. It is a state's right to license the dentist in a way the board sees as practical to assure that a dentist is capable of providing safe care.

Over the years, state boards developed policies that directly impacted methods of licensure in other states. Board policies also affected the educational and the practicing communities. State boards have a strong voice in influencing national dental policies in licensure, education, and practice. This is due to an ever increasing communication network among dental board members, educators, and practitioners. By working together, these three communities have the ability to improve the licensure process for all states.

Common Committee Membership

All board members belong to the American Association of Dental Examiners (AADE), a national organization that meets twice yearly. The AADE provides a common ground for dental boards and dental examiners to share ideas, discuss problems, and exchange thoughts concerning current issues.

The earliest examples of board influence is the long-standing relationship between board members and practitioners and educators on the American Dental Association's (ADA) Council on Dental Education. The Council is composed of twelve members: four members from the American Association of Dental Schools (AADS); four from the American Dental Association (ADA); and, four from the American Association of Dental Examiners (AADE).

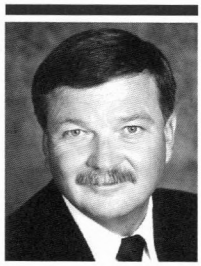
The Council on Dental Education also participates in the Commission on Dental Accreditation, augmented by eight other persons. The commission accredits all dental education programs.

A long standing policy of state dental boards is to allow graduates from dental schools accredited by the ADA's Commission on Dental Accreditation the right to be examined for licensure. Many jurisdictions allow only ADA commission accredited graduates to sit for their licensure exams, while a few permit foreign-trained dentists to sit for the examination after passing the National Dental Board Examinations and a practical, bench test without patients.

The ADA, AADE, and AADS diligently worked together to develop and improve the National Board's Dental Examinations. Today, all state licensing boards accept this ADA set of examinations in lieu of taking individually state sponsored written tests. However, some states require additional written examinations, such as those covering state dental practice acts.

ADA leadership for many years appointed AADE members to work on select committees charged with developing research studies, policies, and standards for dentistry. For example, AADE developed the "Guidelines for Valid and Reliable Examinations," which it applies to its own tests.

Dental boards have also been instrumental in making continuing education a requirement for relicensure. Advanced education programs and specialty licensure are new areas being considered



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by dental boards. In some jurisdictions, specialty examinations are now being offered for specialty license.

Regional board testing agencies have evolved to develop licensure examinations for member states. Today, only a few individual state boards continue to administer their own licensure examination. The consortia of states comprising each of the four regional testing agencies develop and consequently accept a single examination for all member states. This is beneficial, as a dental candidate, upon successful completion of the regional examination, is eligible for licensure in several different states. The member states of regional boards have also cooperated in an exchange of ideas and policies. Shared ideas resulted in state policy change such as licensure by credentialing.

Ultimately regional testing agencies working together and supporting mutual goals to develop better examinations and licensure procedures may influence state, regional, and national policy.

Today, there is increasing interest in dentistry to pursue new and innovative means to examine candidates for licensure. Many are calling for a national examination, freedom of movement, and continuing competency. The Dental Interactive Simulated Computer (DISC) examination is under development by several regional testing agencies, state dental boards, the ADA, AADS, the AADE, and other dental organizations.

State boards have a strong voice in influencing national dental policies in licensure, education, and practice.

Studies such as the Pew Foundation report on the future of dentistry and the Institute of Medicine report, *Dental Education at the Crossroads,* made some novel and, in some cases, controversial suggestions on licensure and credentialing.

Keeping the Mission in Focus

The dental boards' primary mission and task is to protect the dental health of the citizens of their states. Yet, through organizations such as AADE, regional boards, and integrated work with the Council on Dental Education and Commission on Accreditation, the dental licensing agencies will continue to have an influence upon and affect national policies concerning licensing, education, and private practice.

The author wishes to express thanks to Ms. Molly Nadler, Executive Director of AADE and Dr. Lillian Bashman, Immediate Past President of AADE for their contributions to this paper.

License Without Examination, The Washington State Experience: How Boards of Dental Examiners Might Alternatively License Dentists

Bruce P. Kinney, DDS, and Lisa Anderson

In 1989 the Washington State Legislature created an alternative pathway to licensure for dentists seeking to practice in Washington. This program — License Without Examination (LWOE) — is often confused with licensure by credentials or endorsement. The effect of this law is to make dentists eligible for licensure in the state of Washington if they currently hold license in another state with a *substantively* equivalent practical licensing examination.

In the United States, restriction of the practice of dentistry to those formally judged to be qualified began in Alabama in 1841. By 1907 every state had a statute providing a board of licensure in dentistry.[1] This formal process evolved into a system using practical clinical examinations to assess competency for licensure to practice in the dental profession.

In recent years, there has been strong sentiment to change this system, specifically to allow licensing of dentists by credentials, endorsement or reciprocity. In 1975, the ADA House of Delegates adopted a resolution encouraging state boards to establish criteria by which dentists could be licensed by credentials. Today, dental boards in twenty-nine states plus the District of Columbia can grant a dental license to a dentist licensed in another state jurisdiction without further examination.[2]

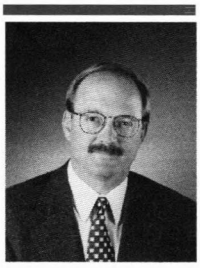
Some argue that a credentialing path to licensure leads to greater freedom of mobility for dental professionals. It is also thought to lead to increased competition and movement of dentists to areas of need, while maintaining quality standards to protect the public.

Dental licensing agencies have the ability to screen and evaluate the "credentials" of a practitioner, but the screening must be done source by source. Unlike the medical profession, there is no one entity or databank providing historical, educational, and practice data on dental practitioners.

This paper is not intended to argue the merits of such a system of licensure. Graduates of an accredited school of dentistry may have a reasonable expectation to practice where they choose without restriction. However, states have a vested interest in protecting citizens from less capable practitioners. Requiring a practical clinical licensing examination may well serve this function.

Licensure in Washington State

Prior to 1990, all persons seeking dental licensure in Washington state, whether practicing general dentistry or in a specialty area, were required to successfully complete a written and clinical examination. The process was the only "standard" by which to obtain dental licensure. Whether judged as good or



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bad, the examination process was a way to generally observe and select out practitioners who could not demonstrate minimal competency in providing the examined dental services. An often criticized fact was the state statute only provides for issuing a general dentistry license; dentists limiting their practice to a recognized dental speciality were required to pass a general dentistry clinical examination.

Presently, Washington state is a member of the Western Regional Examining Board (WREB) and contracts with WREB for the practical clinical examination.

In 1989 the Washington State Legislature passed legislation allowing a non-clinical examination path to dental licensure. When the LWOE program was passed, it was a last minute amendment tacked onto a bill supported by the Washington State Dental Association. There was little time to analyze the potential effects of the proposed change to existing licensure laws. As is often the case, the law had impact beyond the intentions of its authors. This law permits active dental professionals licensed in other states to apply for licensure without examination, provided that the other state's licensing standards are "substantively equivalent" to the licensing standards in Washington state.

The LWOE method of licensure is often mistaken as a credentialing or endorsement program. While the dental education and practical experience of the practitioner is considered, the main premise of this law mandates successful completion of a general dentistry practical examination in another state that is "substantively equivalent" to the dental examination administered or subscribed to by Washington state. This premise, while well intended, is not how the law was written. The law grants licensure to a practitioner based on the examination given by a state, not the examination taken by an individual practitioner. It is the current licensing standards of the state where the applicant became licensed by examination that is the predominant focus under the LWOE program. In some cases, when the current licensing standards in a state are not equivalent to those in Washington, the applicant may be able to document, on an individual basis, that the examination he or she took was a "substantively equivalent" examination at that time.

This law permits active dental professionals licensed in other states to apply for licensure without examination, provided that the other state's licensing standards are "substantively equivalent" to the licensing standards in Washington state.

Since the Washington State Board of Dental Examiners (the Washington State Board of Dental Examiners and the Washington State Dental Disciplinary Board were combined to form the Washington State Dental Quality Assurance Commission in 1994) fully implemented the program in 1990, it has become the most common method of licensure for dentists seeking to practice in Washington state. In 1995, 102 licenses were issued by the LWOE program versus 86 by examination. The program, despite initial uncertainties, has not resulted in an influx of new dentists into Washington. Of the 676 licenses issued from October 1990 to present, only 305 are known to currently reside in the state. An analysis of complaints received against individuals licensed under the LWOE program versus complaints against those licensed via the state examination determined complaints were received on about 7% of dentists licensed under each method.

Implementation of License Without Examination

The board considered a number of issues in implementing the LWOE program, including:

- Formal identification of Washington's existing examination and licensure framework.
- Defining "substantively equivalent."
- Surveying all other states and testing agencies for examination criteria. This is still done on an annual basis.
- Limitations placed by the statute relating to the definition of "state." Under the statute, there was no provision to consider practice experience obtained in provinces, territories, possessions, commonwealths, or districts.
- Many states (including Washington) were unable to provide historical data related to the examination processes or content.
- Projections that dentists would flock to the state creating an oversupply of practitioners and increased disciplinary activities.
- Issues related to verifying practice history and disciplinary reporting of other states.

The task of drafting rules and establishing eligibility criteria, application procedures, and licensing examination standards began once the initial licensing framework was set and state information was gathered. The rule-making process took many months and the hearings were unparalleled in attendance by the public and special interest groups. In the formal hearings, there was emotional testimony, and threats of potential antitrust lawsuits plagued board members.

With the rules framework in place, the board surveyed all state and regional licensing entities to request information

Somewhere I heard the definition: "Good quality health care is that which is beneficial to the patient; properly done; given with compassion; based on correct diagnosis; respectful of the well-being and dignity of the patient; and compatible with available resources." Add ethical conduct, integrity, fairness, and accountability and it's a good mix with which to discuss the age-old question, "What makes a good dentist?"

The board tries to use prevention and intervention when practitioners appear to be headed for trouble. In fairness, some patient and employee complaints about quality of care are actually signals the dentist needs help more than discipline.

The foregoing definition of quality covers most of the common problems the state board sees regarding complaints of quality of care: over-diagnosis and concomitant over-treatment, missed diagnosis and concomitant under-treatment, incompetence, negligence, insurance fraud, physical abuse, and drug abuse.

It must be noted, the board tries to use prevention and intervention when practitioners appear to be headed for trouble. In fairness, some patient and employee complaints about quality of care are actually signals the dentist needs help more than discipline. It may relate to drug or chemical dependency, in which case we try to get the dentist into our diversion program. If it relates to lack of knowledge, we try to counsel and direct the dentist to remedial education and training. Often, this is all that's needed to re-establish acceptable quality of care.

Within the past five years, the state board has been a strong influence in dental offices with its adoption of infection control regulations. Backed by legislation authorizing its Cite and Fine Program, the board has upgraded the sterilization and disinfection techniques in many offices, improving the public's health, safety, and welfare. In a few extreme cases of non-compliance, the state board revoked the practitioners' licenses. That is the most draconian way the state board can influence the "form" of the practice.

In California, the Department of Corporations requires dental plans under its purview, such as Delta Dental Plan of California, to have formal programs of quality assessment. Within those programs, the state board regulations comprise a significant part because quality assessment usually involves examining the structure, process, and outcome of dental services — the three vital elements of a practice — regardless of its "form."

The state dental board may be relieved of many of its administrative burdens related to the various forms of delivering dental services.

Structural assessment includes reviewing the physical elements of the facility and dental equipment, its accessibility, emergency procedures and equipment, administration protocol, sterilization techniques and infection control. A number of state board regulations are woven into the makeup of these integral parts of a dental practice.

The process and outcome of care are assessed by reviewing how a dentist documents the care provided: taking the health histories, recording examination and radiographic findings, planning and providing appropriate treatment — all properly recorded in progress notes — and finally, monitoring the outcome through periodic recall visits and preventive services. Again, state board regulations are involved in many of the routine procedures during the "process" of a dental practice.

End of the Tunnel?

Lest all the foregoing dampen the enthusiasm of practitioners with a future before them, it should be noted that in November 1995, Governor Pete Wilson sent a directive to all regulatory boards and commissions to thoroughly review all their regulations and weed out those that may be negatively affecting the state's business climate.

The dental board, in cooperation with the state dental association, started the process to comply with the governor's directive. To reinforce his directive, in April 1996, the governor announced his Competitive Government plan for getting the state government slimmer and trimmer to face the challenges of the 21st Century. Using the example of how he used his emergency powers — after the 1995 Northridge earthquake — to cut bureaucratic red tape, the governor cites how the world's busiest freeway was rebuilt in just sixty-six days.

The new plan, a three-year effort, puts a priority on results over process, innovation over regulation, and merit over mediocracy. It recommends abolishing many boards and commissions; consolidating and streamlining occupational licensing functions; sunset-reviewing all regulations every five years; contracting out many state services to the

private sector; enacting a constitutional cap on the overall cost of regulation; and concentrating on essential functions such as public safety and public education.

The first step will be to hold hearings throughout the state so that small business owners can identify regulations which they feel need reform.

If this giant project succeeds, there is no doubt that the dental "business" will be affected. The state dental board may be relieved of many of its administrative burdens related to the various forms of delivering dental services. It will then be allowed to concentrate on its prime mission: to protect the public.

It'll give us something to reminisce about at our 80th class reunion.

Think, Reason, Respond

Olin D. Thompson, DDS, FACD

It is an honor to share with you some thoughts and to challenge you to deeper levels of thinking. One of my favorite radio personalities, Earl Pitts, concludes his early morning commentary with the following, and I paraphrase, "Wake up, Dentists. You may hear something that will turn your pathetic lives around."

Although I am currently president of the Georgia Board of Dentistry, I do not want to address you as a representative of the board. Rather, I wish to address you as a free thinking, independent minded, hard working general dentist who is genuinely proud of our profession and deeply committed to it as a bastion of our free enterprise system. I am not ashamed of the level of prominence and financial reward that our profession has afforded me and all of you. I will draw from the experiences my service on the board has exposed me to and from the time I spent working with many of you on matters of the Georgia Dental Association. These experiences have changed my way of thinking and for the past ten years the pattern has become clearer and clearer: Think, reason, respond.

To aid the thinking process I decided I must know what my core values are. I began by writing them out and meditating on them until I was as sure as I could be what my value system reality is. To reason meant that any change I might make must be congruent with my core values. Otherwise I would be in conflict and therefore would not be able to adapt to change. I became interested in what other free thinking men and women might add to my reservoir of knowledge. I read much, I listened to speeches of men and women talking in small groups, workshops, and round table discussions. One certain conclusion emerged: the axioms of economics, business, and the health care professions must be viewed in light of history.

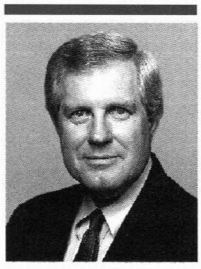
Alvin Toffler, in his book, *The Third Wave,* demonstrates to us a new age — the age of technology, the microchip age, the age of unprecedented communication and information assimilation. Because of this we must have a clear set of values that we can understand, articulate, and communicate or we will be reduced to constantly reacting rather than being ready to respond. Reactionary change will lead to the destruction of a wonderful profession. If we think and reason, the changes we make will be congruent with our core values. Thereby, we will preserve the free enterprise system of the practice of dentistry and retain the ability to earn the financial rewards of our profession.

With this as a backdrop allow me to paint a scene of history, of present, and future, remembering that yesterday is already history; today is the day we really have, and tomorrow will almost be a blur because of this high tech age we are living in.

This is an exciting opportunity for those who will think, reason, and change. For those who want to go on with the status quo, I am fearful this is going to seem like a sad future, one without hope for the remainder of our generation of dentists and outright despair for the future generations. I refuse to accept this, and I will continue to think, reason, and speak out for the values I hold so dear, for the profession I love, and the relationships I have with my patients through my practice.

In a few generations dentistry in the United States has evolved from the back of a wagon — where men such as Painless Parker used an American Indian doing a war dance to attract crowds — to the back of a barber shop where teeth were extracted, crude dentures made from vulcanized rubber, or an occasional gold swaged crown was crudely fitted over a hardly prepared tooth.

The "office" moved to over the drug store where I, and many of you, experienced dentistry for the first time and it changed very little, in regard to equipment and instrumentation when we entered dental school. We continued using rubber bulb chip blowers to clear the field and would squirt a little water on the tooth with another rubber bulb. We used the same belt driven hand pieces to grind on a tooth. Then, the great Borden hand piece changed the course of dentistry and literally propelled us into a new age.



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Looking back on our early training, one can hardly believe we learned the art of dentistry in such an environment. Yes, we learned both the art and science of dentistry in spite of those crude instruments. We learned it because we had an abundance of patients, dedicated professional educators, and part-time instructors who sacrificed their time to teach us.

The Historical Perspective

Look into the history of dentistry. If you do not own it, I recommend purchasing *Dentistry — An Illustrated Story*, by Melvin E. Ring. Ring traces dentistry throughout the Orient and into Western Europe with France becoming the dominant role player in developing the profession. I will quote Ring extensively because of the importance he places on Pierre Fauchard:

"Modern dentistry owes its greatest debt to this remarkable Frenchman who was trained as a military surgeon and who synthesized what was known in the West about dentistry. In the edict of 1699, the French Parliament established the first Board of Medical Examiners to protect the people from harmful mistreatment by quacks, and it was Fauchard who spoke out that this commission lacked a skilled and experienced dentist. That his practice was crude was due to his times, that it was scientific and comparatively superior and successful, was due to himself.

"Although France had been the cradle of modern dentistry, during the nineteenth century leadership in the field passed to the United States. The Revolution temporarily suspended advancement of the sciences in France. While the spirit of inquiry took hold in the United States upon the establishment of a popular democracy, the opportunity for personal advancement and monetary gain lured to American shores some of the most able dental practitioners of the Old World and this fostered the development of a generation of thinkers and inventors. However, until about 1850 almost all prominent dentists were medical doctors who had chosen dentistry rather than general medical practice as their vocation. Others (known as itinerants) had little if any professional training, having drifted into the trade for want of anything better and because the constant demand for dental treatment assured them of a steady income. They extracted teeth, sold tooth powders and other nostrums, and occasionally filled carious teeth with questionable results. Anyone could buy a key or forceps and hang out a shingle even though he lacked the most elementary knowledge of anatomy or therapeutics. Nevertheless, skilled, properly trained dentistrs, the leaders of the profession, exerted a great deal of effort to inform the public that there was a large difference between the quacks who preyed on them and trained operators."

Dental education has, and will continue to be absolutely imperative to the progress of our profession.

The following is a statement by one of these leading dentists, Shearjashub Spooner. "One thing is certain, this profession must either rise or sink. If means are not taken to suppress and discontinue the malpractice of incompetent persons who are pressing into it merely for the sake of its emoluments, it must sink, — for the competent and well-educated men who are now upholding it will abandon a disreputable profession in a country of enterprise like ours and take their attention to some other calling more congenial to the feelings of honorable and enlightened men."

Yes, there were many ups and downs, yet dentistry survived, and thrived, and grew because there were free thinking men of vision and integrity who came forward and fought for the best for the profession.

Facing the Issues

So How Should We Then Live? This is the title of one of my favorite books by theologian and philosopher Frances Schaeffer as he writes about the obstacles and missed opportunities in the rise and decline of Western thought and culture. What are some of the obstacles and opportunities we face today in dentistry? I certainly cannot share them all in this time, but allow me to mention some in hopes of stimulating you to think, reason, and respond.

Dental education has, and will continue to be absolutely imperative to the progress of our profession. Are there some things happening today that we should be mindful of, situations that pose potential obstacles to us as free thinking individuals and practitioners? I believe so. I am not referring to an individual or an institution, but of a mind-set, a national trend that permeates every aspect of our educational system, whether it be primary, secondary, graduate, dental, or medical. And that mind-set is that we abdicate the role of education to the educational elite.

Daniel Bell, professor of sociology at Harvard University writes in the *Coming of Post-Industrial Society*, in the chapter entitled "Who will rule," that the university — or some other knowledge institution — will become the central institution of the next hundred years because of its role as the new source of innovation and knowledge." He says that crucial decisions will come from government but, increasingly the decisions of both business and government will be predicated on government-sponsored research, and "because of the intricately linked nature of their consequences, the decisions will have an increasingly technical character." Society thus turns into a technocracy where the determining influence belongs to technicians of the administration and of the economy. Bell sees that in the final analysis the whole

state — its business, its education, its health-care, its government, even the daily pattern of the ordinary man's life — becomes a matter of control by the technocratic elite. They are the only ones who know how to run the complicated machinery of society and they will then in collusion with the government elite have all the power necessary to manage it. Then, add to this thought the statement of John Kenneth Galbraith in his book *The New Industrial State:* "There will be an elite composed of intellectuals, especially the academic and scientific world plus the government."

So what is happening in dental education today? All the old proprietary schools have closed, gone out of business, and have been replaced with either private or state university schools. Is this necessarily bad? No, because these privately run schools became economically too expensive to keep open. They could not provide research facilities nor compete for research grants to do so, and we must have research to continue to develop new materials and methods necessary for the ongoing growth of the profession. So some schools that once educated classes with 90 or more students with a full-time faculty of 15 or 20 may now have full-time faculties of 80 to educate classes of 50 students. The students find the pool of available patients coming to the school drying up and it often takes an extra quarter, or more, to complete their basic requirements. Many of the faculty who would like to teach full-time are having to do research, publish, and do intramural practice in order to keep their jobs. They have less time to devote to the student and are more apt to be thinking of their research than demonstrating clinical procedures to these students. It takes many more administrative faculty than ever to keep the school going and in compliance with government regulations and paper work.

In addition, the dental schools are likely to be under the Medical Center President, who is most likely a physician, and he sees things through the eyes of the medical community. In medicine they have few problems with patient availability, they have a mandatory year of internship after graduation for additional clinical excellence, they have hospitals which oversee the credentialling and ongoing competency of the practitioner, and they occupy the places of prominence in organizations like the Institute of Medicine and the Pew Foundation.

There is an agenda to have a single core national clinical examination. Should we wait to see what the outcome will be or do we get actively involved in shaping the outcome?

What are these elites doing, what are they saying? They are publishing reports on *Dental Education at the Crossroads* which would draw us back into a model of medical education, even though the report denies this. They advocate the elimination of entry level clinical examinations administrated by dentists in private practice, opting instead for licensure upon graduation from an ADA accredited dental school.

We are hearing about the ethical dilemma of using live patients for clinical examinations. Some are even questioning the ethics of using live patients for educational purposes. There is an increasing use of high-tech mannequins for preclinical training, and these are already in place in many schools for this stated purpose This is fine, if this remains the purpose. But, one wonders, given the current state of patient availability how long it will be until the mannequins are used for more clinical training.

There are those who would like to eliminate an entry-level clinical examination and replace that with a schedule of periodic competency evaluations. This has gone so far that the models for such evaluations have been accepted and a committee of the American Association of Dental Examiners is preparing to present the "how to" for implementation. For example, one model would stipulate that, on a five- or ten-year cycle, examiners would enter the dentist's office and check random samples of his or her patient's records. In another scenario, the dentist would submit one or more patients to demonstrate his or her continued competence.

Some states are facing elimination of licensure boards as we now know them and their replacement with a mega-board of some title like, Board of Public Health. The majority of members on such a board would represent a cross section of health care providers, consumers, and maybe one dentist, *maybe* one. Georgia considered establishing a board with this title. What would their future role be — long term? Is this board to be made up of the "elite" of our state? Keep your eyes and ears open.

A bill was introduced in February that would eliminate a clinical examination for one who is licensed in another state, has a clean record, and has been practicing five or more years. One who meets such qualifications could be eligible for licensure in Georgia. So the government will decide because they have the advice of the elite of education. Is this possible?

Two prestigious organizations, the Institute of Medicine and the Pew Foundation have spawned several committees from various groups. From committees of these organizations come recommendations and resolutions like *Dental Education at the Crossroads.* (I have suggested it should be *Dental Education at the U-turn.*) One must ask the question, do we in dentistry wish to be drawn back into medicine and be recognized as a sub-specialty?

Then there is an ADA report, referred to as the "2020 Report," which lays out specific tiers of auxiliary support in the dental practice: clinical dental assistant, restorative dental assistant, preventive dental assistant, dental hygienist, and dental health practitioner. Very recent history shows us how this can lead to serious problems. The physician has practical nurses, registered nurses, nurse practitioners, and physician assistants. Each have regulatory boards, and are seeking legislation for expanded duties. Could we see "quackery" raise its head again in the near future? We still have quackery in dentistry, with the illegal denturist in Georgia.

The Pew Foundation recently recommended cutting back on the enrollment in medical schools by as much as 20%. Who will fill the gap, if one occurs in medicine? Could it be a nurse practitioner or a physician assistant? Have you been to a medical doctor lately? How much time do you spend with the physician compared to the time you spend with a nurse or PA? How close are we to having individuals, once again, practicing many aspects of dentistry who are not the well trained, competent dentist we know today? Should we expand the duties of our auxiliaries or go any farther with the role of hygienist? These are questions that must be answered through informed thinking and reason.

There is an agenda to have a single core national clinical examination. Should we wait to see what the outcome will be or do we get actively involved in shaping the outcome? How are dentistry and the public best served if it is inevitable that we will some day have a national clinical examination? We could abdicate the decision to those with an agenda that may adversely impact the future quality of dental care, or to the "elite" of a socialist leaning or we could step up and actively shape a change consistent with our core values, whereby we adapt without conflict and still preserve the best for the profession.

So How Should We Then Live?

It is hoped that this article is sufficient to stimulate you to think, to reason, and to act so that the changes we make can be adapted without loss of our esteem, our financial rewards, our profession. The decisions we make now will determine how we will be practicing dentistry tomorrow. Do not deceive yourselves into believing there is a lot of time. We are living in the technological age where things happen in nanoseconds. Please, let us be ready to respond with a sound mind, prepared by thought and reason to preserve the free enterprise system in the practice of dentistry.

I would like to close with the following quote from Winston Churchill: "Among our socialist friends there is a great confusion about private enterprise. Some see it as a predatory tiger to be shot. Others as a cow to be milked. Only a handful see it for what it really is — the strong, and willing horse that pulls the whole cart along.

"I do not believe in the power of the state to plan and enforce. No matter how numerous are the committees they set up or the ever-growing hordes of officials they employ or the severity of the punishments they inflict or threaten, they can't approach the high level of internal economic production achieved under free enterprise. Personal initiative, competitive selection, the profit motive corrected by failure and the infinite processes of good housekeeping and personal ingenuity, these constitute the life of a free society. It is this vital creative impulse that I deeply fear the doctrines and policies of the socialist government have destroyed. Nothing that they can plan and order and rush around enforcing will take its place. You may destroy wealth and find that all you have done is increase poverty"

You may say he was talking about a situation that does not exist in the United States today. Really?

Dentists at War

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The Marquis de Lafayette was not the only significant French volunteer in George Washington's camp. Two dentists played a part as well. Jacques Le Mayeur emigrated to serve as Washington's dentist during the American Revolution, and Jacques Gardette, who went on to help establish dentistry's preeminence in America by publishing the first scientific dental article, volunteered as a surgeon with the infant American navy. But it wasn't until 1844 that Washington, D.C. dentist Edward Maynard, who also invented the Maynard rifle, first suggested that dentists formally serve with the nation's military. St. Louis practitioner Henry J. B. McKellops petitioned Congress in 1858 to provide for dental services in the armed forces. During the Civil War, although the South regularly assigned dentists as medical surgeons to hospitals and combat regiments, such appointments were unofficial. By war's end, neither the Union nor the Confederate armies had made any provision for dentists.

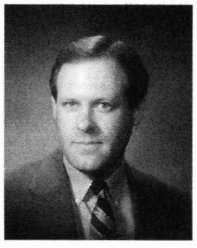
Ironically, at the same time the vicissitudes of war gave dentistry a status boost. The U.S. government's incessant search for new sources of revenue for the war machine in the 1860s increased the pressures on many dentists. Excise taxes were levied, and dentists had to take out a license costing ten dollars. Some tax collectors insisted that the preparation of dentures was a manufacturing operation instead of a service and tried to collect an additional ten dollar fee, plus a three percent assessment on the value of the output. A ruling obtained by local dentists from the Philadelphia Collector that dentistry provides *services*, not products, and hence was not subject to additional taxes, was an important victory for the establishment of dentistry as a profession.

But it took until 1901 to establish the first Dental Army Corps, which consisted of thirty contract dentists without rank who were attached to the Medical Corps. In 1906 the ADA formed a Committee on Army and Navy Dental Legislation to improve the status of military dentistry. In 1911, congressional legislation led to the founding of the Dental Corps of the Army. Dentists joining the armed forces would receive a lieutenant's commission with regular Army pay, allowances, and retirement benefits. The Navy Dental Corps was created by an act of Congress in 1912.

By June 1915 more than five thousand dentists were commissioned in the Army Reserve Corps. The National Defense Act of 1916 permitted dentist promotions to captain and major. The next year a Dentists Bill was passed by Congress granting dental students the same exemptions allowed medical students. Soon thereafter the War Department drew up plans for a full complement of military dental surgeons. A Student Army and Navy Training Corps would be conducted at all dental schools approved by the Surgeon General.

World War I proved to be a productive testing ground for dental officers. The western front, as Massachusetts dental historian Martin Deranian points out, was even the setting for a dentist's development of a new medical specialty. Varaztad Kazanjian was head of Harvard Dental School's prosthetic laboratory when he was named chief dental officer to a Harvard medical unit organized in 1915 to care for casualties of the British Expeditionary Forces. Kazanjian arrived in France to discover that battle inflicted facial wounds were routinely left untreated. Combining his interest in dental and maxillofacial prosthetics with new surgical reconstructive techniques on facial wound patients, Kazanjian eventually treated three thousand cases—and emerged from the war to be hailed as the father of modern plastic surgery.

Then, after a generation of silence, the bombs fell at Pearl Harbor. With newspaper headlines screaming above photos of smoldering wreckage, the United States declared war. In the rush to mobilize, however, government officials were shocked to find that many of the people they tried to put into uniform flunked their physicals. The reason was not bad backs or weak hearts. It was teeth. "Dental defects" topped the list for rejecting military recruits. Selective Service regulations required the nation's draftees to have at least six op-



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posing teeth in each jaw — meaning only three sets of matching incisors and three pairs of posterior teeth. Some ten percent — by some counts double that — couldn't qualify.

It became obvious to everyone from the Surgeon General to the local draft boards that dentists also would be needed to fight the war. But because of dentistry's development and subsequent tougher entrance requirements for dental schools, and doubtless abetted by the economic sluggishness of the depression, the population of dentists in the United States in 1939 had decreased by 8,000 since the boom of the 1920s. Yet even with the acute need for dentists and dentistry's distinguished military performance in the first world war, at the onset of World War II dentists were drafted as privates again. The reason for the demotion was financial: the federal government was reluctant to furnish commissions to all dentists. Not for long. The Army Specialized Training Program (ASTP) and the Navy's V-12 Program soon allowed dental students to be inducted as enlisted personnel with the assurance of commissions on graduation.

Worried about providing enough dentists for the civilian population, the government also asked various schools to accelerate their curriculums. One such school was the College of Physicians and Surgeons of San Francisco (P&S), forerunner of University of the Pacific School of Dentistry. As the nation committed itself to a second world war, P&S Dean Ernest Sloman committed the school to support the war effort. "This year, nineteen hundred forty-two," he announced, "finds a group of young men, highly trained in a special branch of the healing arts ready to take its place in a world vastly changed during the past six years. Our government has seen fit to grant deferments from conscription to this group — looking ahead to the time it could call upon it to fulfill a vital need. The time has come — the need is great. Our work is well defined — the maintenance of the dental health of the armed forces of our nation. As a group we stand ready to meet this obligation, setting aside our well laid plans of a few short years ago."

In July 1942, the school converted to a four-quarter, year-round, three year program, with new classes entering in July instead of September to supply the American military with the dentists it needed to fight the war. "Dentistry and dental education are just beginning the greatest task we have ever contemplated. We must recover the salvageable men lost through dental neglect," Sloman vowed. "[We must have] healthy soldiers and a healthy people providing the wherewithal to fight. If one dentist rehabilitates one rejectee a month for one year he will have served his nation twelve times better than he could have by shouldering a gun." The accelerated curriculum produced two graduating classes in 1944, the four year program designated the class of 1944A, and the three year class of 1944B.

Some tax collectors insisted that the preparation of dentures was a manufacturing operation instead of a service...

In 1943 and 1944 P&S itself was drafted, as Army Specialized Training Unit 3932. One hundred fifty-eight out of the 160 dental students enrolled at the college accepted Army and Navy Commissions. Military officers even took up residence in the building.

Academic instruction was mingled with military classes and drills. "Whatever effect uniforms and military discipline may have on our students of dentistry, we hope they will never forget for one moment that they are members of our institution, one of that great triad of Faculty, Alumni and Students, a member of one of which we shall ever be," the school magazine, *Contact Point,* cautioned in June 1943. "It is still our school, our alma mater, and we shall revere her just as loyally, and feel as much one of her family, whether we wear the plain clothes of the civilian or the blue or khaki of Uncle Sam."

Amid the strangeness and stress of the rapidly shifting circumstances, anecdotes abounded about dentistry at the front lines. A popular wartime story told of a dentist about to remove a tooth while under siege. When the dentist and patient hear the whine of a falling bomb, the patient raises his hand. "Stop," he says. "It may not be necessary."

Although a surprising amount of treatment was rendered on the battlefields, by 1943 Sloman was worried about the war's impact on the quality of dental care. "Our graduates, during the last decade or more, have been educated in comprehension and trained in ability to render kinds of dental services for which there can be little call in military life," he wrote. "The danger ahead for these and for dentistry is in the likelihood of forgetting concepts and techniques not usable in the war effort. The tremendous backlog of dental defects created by traditional neglect and tremendously aggravated by a costly depression makes it impossible for the dentists of the military forces, even with the highly desirable ration of one dentist to five hundred enlisted men, to render services other than those that can be performed with necessary regard for time."

While dentists in the military faced a dilemma—how to adequately treat all the soldiers in their care without compromising their standards—their civilian counterparts faced a bonanza. How would they have time to see all those patients? Back home, dentists and patients alike felt the pressure to do their part. A 1944 *Contact Point* advertisement profiled a girl at State Teachers College in Whitewater, Wisconsin, who sold enough hogs and poultry to buy $1,400 worth of war bonds. "That's enough to buy 70,000 .45 caliber cartridges!" pro-

claimed the copy. "How is your bond buying record?"

Many military dentists in World War II ended up pursuing conspicuously non-dental tasks. Dentists served as medical officers, communications officers, electricians and quartermasters, and even captained boats. "The lay public is quite surprised to learn that commandos and rangers have dentists in their units, as also do the paratroops," the P&S alumni magazine *Contact Point* pointed out, "although they do not plan on immediately placing Class II amalgams on landing in enemy territory. As our local shopkeepers constantly remind us — this is war."

Even though perhaps not able to fully perform the functions for which they were formally trained, in war the American dentists held their own. Military dental historian Irene Bober-Moken has shown that fifty-three U.S. military dentists, for example, were captured in the first six months of the Pacific war. Eight were subjected to the Bataan Death March in the Philippines. Many were held for the duration of the war in the Cabanatuan prisoner of war camp.

The other POWs at Cabanatuan, on the orders of their senior officers, went to their dentists. Although one dedicated officer managed to floss by meticulously unraveling threads from his clothes, most men had no recourse to such oral hygiene amenities as toothbrushes. Cleanings were in great demand. Using handmade wooden chairs with adjustable headrests and handmade instruments, and writing their records on the reverse side of labels peeled from six-ounce evaporated milk cans, POW dentists logged over fifty thousand appointments in thirty-three months.

Dental defects topped the list for rejecting military recruits.

Conditions were bleak. Surgical instruments were boiled in the kitchen only once a day. Nevertheless, the camp dental officers displayed tremendous ingenuity. At least one dental engine was fashioned from purloined sewing machine parts and powered by an enlisted man pumping a foot treadle. Amalgams were made by mixing mercury raided from syphilis medications in the medical supplies — mercuric chloride powder heated in mess kits with fifty percent hydrochloric acid yielded a usable form of the liquid metal — with shavings from smuggled silver coins. Some of the resulting makeshift restorations, monitored after the war, were documented lasting well into the 1980s.

Ultimately, the dentist in World War II emerged as a popular symbol of power. Various cartoons and illustrations circulated through the military and around the nation, showing the American GI as a dentist pulling the teeth of cowering Axis soldiers. The Allies would prevail, and so would their dentists.

This article was adapted from *A Century of Smiles*, by Eric Curtis, a history of 20th century American dentistry filtered through the experience of University of the Pacific School of Dentistry. *A Century of Smiles*, hardbound, 120 pages, illustrated, is available for $25 from UOP School of Dentistry, Department of Public Relations, 2155 Webster Street, San Francisco, CA 94115.

The Report

It was one of those strange conversations that take place at meetings of state dental association councils; three members who are only acquaintances arrive twenty minutes early and all there is available is coffee and small talk.

"What do you think of the Foghorn Commission Report?" ventured Bernard. "Well, I wasn't entirely impressed," volleyed Martha. Charles added, "Yea, well, you know the definition of a committee..." Long silence and searches for non-dairy creamer.

Finally Charles took up the topic in earnest. "I'll tell you what I really think about that Foghorn thing; I think somebody's nuts. The whole thing is arrogant. It's out of touch with real dentists. The idealism may be a nice touch in dental schools or big organizations, but it sure as heck doesn't meet my needs. It's obvious to me that there must have been some people on that commission who don't have to practice dentistry for a living."

Bernard and Martha looked a bit shocked. Finally Bernard answers, "Well one thing you'll have to give them — their position on continuing education is right on the mark. I have been saying for years that this is the biggest blight on the profession. Finally somebody had the nerve to step up and name the problem and suggest some practical solutions."

"Now I'm confused," said Martha. "I haven't read the report, but I have seen a number of editorials. To tell you the truth, I can't tell from those editorials just what is in the report, but I haven't seen anything about CE." "Well, what do you think the reference to non-traditional educational settings is about anyway if it's not CE?" shot back Bernard. "I tell you, if you throw away the whole report and just keep this one part, that commission has done an invaluable service to the profession in pointing out this widespread evil."

Charles is now at his cynical best. "You wish. I haven't read it either, but a lot of my friends have warned me about it. I understand that nontraditional educational settings refers to unaccredited dental programs, probably including illegal functions for auxiliaries as well. It never should have happened in the first place, and the best thing we can do now is bury this thing and take control of our own destiny."

"I don't mean any offence, doctor, but it seems narrow minded to throw the whole thing out just because you don't like part of it. As I say, the legitimization of the CE problem is sufficient justification to take this seriously. This is the key to our profession's future."

Now Martha seems a bit superior as she muses. "You're both taking a rather naive view, as I see it. One of you hasn't read it but seems to have found enough evil to have it burned. The other probably read it from cover to cover and only found one possible confirmation of a previous personal view. This is what I hate about dental politics. And you've convinced me, from now on I won't even read the editorials."

The American College of Dentists has taken a leadership position in dental ethics and professionalism. Part of its responsibility in this role involves placing before Fellows and others practical ethical issues for analysis and discussion. Ethics is neither a private matter not an academic one. Several Fellows responded to the case of *The Report*, you are invited to comment on the second case.

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We usually think of ethics in terms of patient confidentiality, the treatment of AIDS patients or how a dentist advertises. These are issues that typically involve our relationships with our patients or with the public generally. We usually do not think of political issues involving our profession as having "ethical" connotations; that they are free of the ethical boundaries that we place on ourselves when we join our profession. "The Report" gives us an intriguing example of the ways in which we can become distracted from viewing an issue from the perspectives of fairness and justice which form the basis of the ethical practice of our profession.

Dentists in private practice face a difficult dilemma. Most are in single person or small group practices, and unlike many other professionals, they do not operate in large organizational settings with considerable interactions with peers. Information often comes from organized dental groups which may already have an opinion. The comments of Bernard, Charles, and Martha illus-

trate some of the difficulties which can arise from such a situation. Bernard seems focused on the continuing education perspective, a personal issue for him, but it is unclear what the report actually had to say about it. Charles seems to have uncovered a conspiracy, but has not even read the report. Martha has at least read some editorials, but has concluded that she is not impressed by the report. We do not know what the report was or how valuable it may be, but we do know that these three individuals have formed strident opinions with what appears to be incomplete information.

Our ethical responsibility applies to all aspects of professional conduct, including our obligations to our profession. These principles include a sense of justice, of benefit, of do no harm. This includes keeping an open mind, evaluating new information fairly, and forming opinions with all of the data available. To me, the most compelling ethical principle is "above all, do no harm." We should be thinking about this ancient axiom in all of our dealings with each other, our patients, and the public. This includes the next Foghorn Report, the next claim of a manufacturer, the next rumor of a competing colleague's business difficulties, or any similar situation. We owe it to each other to ensure that what we say and how we say it are responsible and do no harm, either explicitly or implicitly.

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The Foghorn case which appeared in the 1995 winter issue got me thinking about being "open minded" about "closed minded" reactions.

The case presents three characters who react to an authoritative report in ways that I often observe myself and others reacting and find hard to accept. Yet, each of their reactions, taken together, gets to the heart of why ethics remains illusive.

Critical reasoning skills which are an essential part of ethics, require starting with facts and holding them up against well articulated values. When values conflict, we can either walk away or pick one value over another thus gaining a deeper understanding of what is important as we try to explain why we choose and think the way we do. This is especially effective when we do it with a few other people. Sometimes we even discover new ways of looking at things.

The first character in the case, Bernard, reads the entire report. He then admirably starts a conversation and tries to bring the group together over a common value. It's an effort towards solidarity, but he only uses portions of the report to reinforce a previous personal view. He doesn't look at all the facts or hear the other values at stake.

The second person, Charles, never reads the report. We don't know where the committee got its authority to make the report, but one can hear expressions of an appeal to subsidiarity (letting the smallest basic group decide what needs to be done before going to larger groups with restricted power to preserve the smaller group). He doesn't want to turn things into a "federal case" or "make a mountain out of a mole hill." Still, he bases his decision on comments from friends and not only condemns the committee's report, but the worth of all committees. In addition, because of his shocking communication style, he's unable to question the facts of the report and closes off any meaningful dialogue about the work of the committee as well as his or his colleagues' insights about the issues being explored. Instead, the conversation is now switched to the value of "discussions" — not to be confused with dialogue or debate.

The third individual, Martha, also didn't read the report, but did read editorial comments about it. She wants to be responsible, but also recognizes the futility of the debate between Bernard and Charles. She jumps to the conclusion that the report and all editorials are political exercises and not worth her time and effort.

This case is a gold mine of ethical riches. It raises all of the familiar questions around such values as autonomy, justice, authority, and truth. It also reveals less familiar ethical frameworks such as solidarity, subsidiarity, responsibility, and the need to make a distinction among (a) polemics and critique, (b) discernment and diagnoses, and (c) dialogue and debate. All of these are worthy of deeper discussion and should be explored at a later time.

The distinction between polemic and critique, however, is a good place to start because that's how Martha, the third character in the case, ends the conversation — by inappropriately collapsing polemics and critique under the general heading of dental politics.

Polemics tends to focus problems on people or groups of people who hold a particular view or value. Critique, on the other hand, focuses only on the strength of a particular view, value or argument.

Polemics is designed to be divisive. It encourages debate and conflict. Critique is designed to provide understanding and should generate community and dialogue. It's the basis of solidarity and discernment; and discernment is what an ethical dialogue is about. It's not a debate, not necessarily a dialogue to classify and solve a specific problem — just an exercise to gain better understanding and a better way of being human.

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The basic issue is three dentists are confounding, at best, misinformation from a commission report. It seems clear from the scenario that neither Martha nor Charles have even read the report. It appears Bernard has read it but apparently without the needed background to understand it, for example, he thinks the reference to non-traditional educational settings refers to CE.

Many misconceptions, misunderstandings, and false rumors are generated and spread among the dental community. Often this is done inadvertently by individuals who have not actually studied the material or data on which the subject they are discussing is based. There is a tendency to be authoritative, to support our bias relative to a given issue. To be honest and ethical, one should have the first-hand information about an issue before commenting about it. This is even more significant for those in respected and leadership positions at various levels in the profession.

We shouldn't take the way out expressed by Martha. She had not read the commission report and states that in the future she won't even read the editorials. We should take the opposite approach and become as well informed as possible about issues important to the profession.

The *Journal* invites comment on "Helping Others — Helping Yourself." Views should be 400-800 words and should be faxed to the Editor (David W. Chambers) at (415) 929-6435 no later than Friday, 6 September 1996. Submissions will be peer reviewed and edited to fit with other responses. The most useful combination of responses will be published in the December 1996 issue of the *Journal*.

Helping Others — Helping Yourself

It was a rather pointed discussion for two dentists who had been classmates and such good friends. "I have heard," said Ray, "that you have been claiming some very impressive results." (But his face showed skepticism bordering on sarcasm rather than admiration.) "The people who have been to your courses all claim great success, but I haven't heard anyone else talking about this new root canal paste."

"Well, you know how dentists are," answered Al. "I call it the NIH syndrome for 'not invented here.' If they didn't think of it themselves, there is a tendency to discount it. But this is really more sophisticated than people realize. That's why I have only licensed one company to sell the paste and I control the production very carefully. Otherwise quality would go to pot as industry tried to put profit above scientific integrity. And the extensive training at my workshops is necessary to prevent mistreatment by dentists who only understand part of the procedure. Unless they have been certified in one of my courses, there's no way the safety and efficacy of the treatment can be guaranteed."

Ray remained unconvinced. "I've read what's supposed to be in that paste, and I can't understand how it's supposed to have the effects you claim. And a friend of mine at the university said he read several studies that tried to replicate your results and they have not been able to do it."

"Of course they haven't," answered Al, almost victoriously. "Every so-called study has been flawed in at least one fatal fashion, often in several. Not one of the researchers has been certified by me as even being competent in the techniques. If you subscribed to my newsletter, you would see the evidence, much of it testimonial from hundreds of successful practitioners, but some of it comes from rigorous clinical trials as well, that supports this program."

Ray just scrunched his face like he was watching a car accident on television. Al interpreted his thoughts. "I'll bet you're worried about the risk, about trying something new on patients. Every honest professional is concerned about that. We all are concerned to 'do no harm.' But harm can be passive as well. I have no idea how many root canals were caused iatrogenically by excellent clinicians who insisted on the conservative treatment of gold foil."

"No," said Ray, "I wasn't thinking of that. I was just wondering how the scientific and professional aspects of this program you are promoting can be reconciled with the financial rewards that must be involved. And quite frankly, I am bothered by your use of FACD after your degrees in the advertisements I have seen. I don't begrudge anyone the success they deserve; I just don't know how you can draw the line."

"Oh, Ray. I'm a little hurt at this coming from you. In school you were the man with the golden hands. And everyone says you have a practice built on the highest standards of technical quality. I would be amazed to hear anything else. I also gather that you have done quite well for yourself besides. What's the difference between your profiting from technical acumen and my profiting from scientific skill? In both cases, our contributions to patients far exceeds our compensation.

"I just don't know how to answer you on the FACD thing. I know some people don't like it, but as far as I can tell, it brings honor to the College as well. There is nothing false or misleading in telling others about an honor that I have earned. I am quite comfortable with the place I have drawn the line between service to patients and personal reward. I see no necessary conflict here."

Strategic Planning

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

Strategos is Greek for "the art of the general" and the origin of our term strategy. There is an aura of strength, sweep, authority, and control in this word. It is assumed to be the mark of every well-managed organization, but especially of large, forward-thinking ones.

Strategic planning is taught in all the management programs. The height of its popularity was the late 1960s through the late 1980s when organizations, ranging from giant multinations to local churches, engaged in the process. Many firms developed strategic planning staffs, Management Information Systems to feed them, and half a dozen journals were launched to develop theory.

Today, the glamour has faded from the strategic planning enterprise. Many of the staffers are now consultants. It is fashionable in big business to retain the planning staffs but not take them too seriously. The collapse of the former Soviet Union, the greatest experiment in complete strategic planning in modern memory, certainly tarnished the hopes that strategy is sufficient to promote organizational excellence. Some well-respected business scholars even question whether it is necessary. The mantra of the objectivist, social engineering of the 70s (such as the Great Society) — "if you don't define where you're going, you might end up somewhere else" — now sounds as quaint as its comic-strip (Pogo) origin.

But we still have an abundant supply of generals and their art will certainly never die. We are in a transition. The strategic planning taught in college text books doesn't fit very comfortably on the organization of the 90s. It is too formal, too rational, too controlling, and too insensitive to multiple objectives, diversity, our highly educated workforce, and the rapid pace of change.

This column will offer some definitions as a common starting point, describe the classical approach to strategic planning, and then explore some contemporary alternatives.

Definitions

Mission is the statement of an organization's identity. What is its reason for existing? How does it differ from other organizations in the same environment? A mission statement for a dental practice might speak to technical quality, patient self-determination, or a friendly atmosphere. Good mission statements are short enough that group members can remember most of their content and distinct enough so that a knowledgeable outsider could match the mission statements with the organizations.

Goals (or objectives) are specific statements of what will be achieved and when. "Gross $350,000 next year," "retain 85% of new patients," and "implement a TQI system by February" are examples of goals; they are measurable targets (not necessarily in quantitative terms).

Policies control or channel action. They set expectations for how members of the organization should behave, but they do allow some flexibility. "The policy in this office is to take a full-mouth series of radiographs on all new adult patients." "We have a needle-stick protocol that we follow." Policy is one of the more under-used, powerful means of coordinating action and motivating behavior.

Programs are step-by-step plans for how an organization's objectives will be realized. "First we will hire a consultant to advise us on the recall system, then we will set milestones for progress we expect each quarter, next we will assign tasks to each employee, etc."

Budget is the allocation of resources to programs for the sake of accomplishing certain objectives. It is quite common to find organizations with articulate and admirable lists of objectives for which there are no programs and no, or insufficient, budgets. These are called "wish lists" and they have almost no value beyond perhaps some public relations function.

Environment is the context in which an organization functions. Much of the success of any organization depends on how well it fits with its environment. A practice that does not offer implants may be ill advised to gear up for this service if other dentists in town will be capturing the market while necessary training is going on.

Strategy is the planned integration of an organization's mission, environmental response, goals, policies, programs, and budgets into a consistent whole. Strategy is what holds it all together. It is the way an organization looks at itself and its context and decides how to function. Strategy is a posture.

Generally, these terms answer different questions about an organization:

Who are we (mission)? What will we do (goals)? Which actions are expected (policy)? How will we go about reaching our objectives (program)? How will we distribute the resources (budget)? What is our context (environment)? How do we coordinate all this (strategy)?

The Classical Model

The approach to strategic planning that grew popular in the 1960s heavily emphasized analysis, decomposition of the environment and the organization into components, quantitative measures, especially of goals, separation of functions among staff and managers, all with a penchant for rationality.

The most basic method became known as a SWOT analysis, an acronym which stands for Strengths, Weaknesses, Opportunities, and Threats. The heart of strategic planning in the traditional sense is to analyze the environment into categories of likely major changes that could be classified as threats or as opportunities for the organization and then to perform an organizational audit to identify the organization's strengths and weaknesses.

For example, a dentist might look at the demographic changes in the community where the practice is located, changing disease patterns, number and type of other dentists in the community, reimbursement plans, interest rates, availability of office space and reliable help, etc. This list would then be separated into forces that represent a potential challenge to the future practice — perhaps two new general practitioners moving in or a lease expiring. Potential opportunities would also be selected — a new factory coming to town with a good health plan. Large firms carry the environmental analysis to great length, hiring consultants, commissioning studies, and retaining staff members who assemble and organize detailed data sets. It has normally been assumed that quantitative data is superior and various mathematical and computer models are even developed by the most sophisticated planners.

The organization audit concentrates on the strengths and the weaknesses of the organization. Representative strengths in a practice might include great technical skills of the dentist, great social skills of the staff, good office location, convenient hours, a pleasant office, financing plans, etc. Weaknesses are those characteristics of the practice that are undesirable, for example, a heavy debt load, old equipment, lack of skill in certain techniques, and so on.

A threat to one organization may be an opportunity to another; historical strengths have a nasty habit of becoming weaknesses as the environment changes.

Against the background of the SWOT analysis, the leaders of an organization then map a strategy. This process involves using organizational strengths to protect against environmental threats or take advantage of opportunities. Perhaps a dentist who can provide a broad range of services or has convenient hours because of an office sharing agreement would be in a better position to compete for a closed panel contract. The combinations of environment and organization that make most sense are worked into measurable objectives and supported by budget in preparation for the implementation of the strategic plan. Such analyses are customarily performed on a regular basis, most often annually.

As useful as it might be for managers to steep themselves in the environmental and organizational analyses, a major shortcoming of the classical model is the vague nature of the process of actually converting the facts into strategy. There is no clear methodology for matching organizational and environmental features. Which combinations should the organization focus on? Further, it is often noted that what constitutes a strength or weakness, or a threat or opportunity may not be obvious. A threat to one organization may be an opportunity to another; historical strengths have a nasty habit of becoming weaknesses as the environment changes. The evidence, even from staunch advocates of strategic planning, is scanty that those who plan in the classical, formal sense out perform those who don't.

Contemporary Alternatives

Many large organizations retain a formal strategic planning function, but supplement it with other, more intuitive approaches. Four of them will be presented.

The Polling Approach. There is a trend now, especially in smaller organizations or not-for-profits, to use something like a SWOT analysis as a warm up and then to collapse the analysis phase entirely. This is the method of "aggregating expert opinion." Getting industry leaders to identify possible courses of action and place them in priority order is a new form of sudden strategy making. This can be as simple as brainstorming with or without a facilitator, with or without a computer, and with or without background information.

A more elaborate version of this process with a twenty-five-year history is the Delphi technique. In this method, a panel of experts is polled regarding their opinions on an issue. For example, they may be asked to identify a dozen significant research opportunities for the profession in the next ten years. The combined list is circulated again (usually to the same experts) who are asked to rank them. Items with very low priorities are eliminated and the list is circulated again and this time the priority ratings are to be accompanied by written commentary, especially if high or low. The new ratings and accompanying comments are distributed yet again with instructions to limit the voting to only a few top items. Usually, after three of four such iterations, a small list of pri-

oritized action items has been generated.

If any of the polling, voting or consensus building approaches to strategy are ever effective, it is largely because one or two powerful individuals serving as experts were already busy making certain the projects were being carried out anyway. The strategy researcher S. S. Cohen calls this kind of planning "decorative strategy." In its worst form, it is practiced in state and national legislative groups by law makers who develop policy with one eye on public opinion polls.

Contingency Approaches. Some strategists have developed their approaches based on the fact that the future is essentially unknowable. While planning for "the" future may be irrationally risky, planning for likely alternative futures has some merit. Three variations on this approach are scenarios, contingency planning, and options planning.

A scenario is a detailed description of a likely future set out in the order it is apt to unfold. A dentist might say, for example, "I intend to join a practice with one other general dentist and a specialist in endodontics and a specialist in periodontics. This is what my balance sheets will look like for the next five years; this is what my work schedule will look like on a daily basis; this is how the other dentists in the community will react; and so forth." In classical strategic planning, the emphasis is on projecting isolated historical trend data; in scenario planning, the project is to tell plausible stories and to illuminate interconnections. The most favorable scenarios (in the sense of best fitting one's self-image) are chosen for further development and resources are shifted in that direction.

Contingent means "depending upon" and contingency planning means that action plans are developed to be implemented depending on which futures actually occur. We often associate contingency planning with disaster preparedness. It is possible to work with contingency planning as a way to prepare for positive but essentially unpredictable events as well. For example, a private practitioner might look at what logical changes are necessary in his or her practice if a large new firm moves to town, if several older dentists retire, if all other dentists in town sign up for managed care, etc. It makes sense to plan for the events that are most likely to occur and those which would have a major impact if they did. By looking at a range of contingency plans, it is often possible to recognize a pattern of resources that would be essential for several contingencies. These are the ones prudent planners will develop.

A third variation on the contingency approach to planning is called options planning, and it takes a more active posture with regard to possible futures. A dentist involved in options planning would enroll in hand-on training in implants, test new dental materials, and literally take an option on purchasing a piece of property to develop a new office. This is more than hedging on the future; it is testing it out to see if it can be favorably influenced. Options planning proceeds by managing a portfolio of tentative responses toward alternative futures, some of them even contradictory with each other. As eventualities reveal themselves, some options are let lapse and others are invested in more heavily. The early, steep part of the learning curve is already past by the time the future becomes clear for options planners so they have a competitive advantage.

Logical Incrementalism Approach. James Bryan Quinn has combined the concepts of multiple initiatives and attention to timing into a comprehensive framework which he calls "logical incrementalism." The boss, or the dominant coalition in a larger organization, guides an assortment of hot prospects toward a more or less consistent vision of the future with an eye on the precipitating events in the environment. The creative responses and the energy to carry them out come from within the organization; the structure for coordinating their timing and their unity come from the top. For Quinn, the formal planning process is only one aspect of an organization's attitude toward the future. Good ideas and good opportunities do not appear on an annual schedule or because they have been called for. Quinn's strategic planner is a top line manager who steers the organization by means of the collective impact of daily decisions.

Vision Approach. The problem with classical strategic planning is clarifying that little miracle that has to take place between analysis and implementation. How is description turned into a direction?

In strategic planning, vision always means double vision.

By one name or another, the essential ingredient in strategic planning comes down to vision — the vision of an individual or the shared vision of an organization. In strategic planning, vision always means double vision. It is the ability to simultaneously see very clearly and in honest detail *what is* and at the same time *what could be.* All the great religions of the world accept the frailty of human nature while simultaneously calling for something higher. The utopias and systems built on idealism are momentary flashes.

A dentist, for example, might read the decline in dental caries as an opportunity to rebuild dentistry on a pro-health positive self-concept of patients. Seeing some colleagues begin to compete on price may open the way for other dentists to compete on care and service. An easy test of whether a dentist thinks in terms of vision is to ask what he or she sees when looking into the mouth of a new patient. Technicians see a list of procedures to be completed. Professionals see the damage of neglect, difficult challenges, problems of patient compliance and affordability — and superimposed over all this, a beautifully resorted mouth and a patient with renewed self-confidence.

Recommended Reading

Bowman EE, Hurry D. Strategy through the options lens: An integrated view of resource investments and the incremental-choice process. *The Academy of Management Review*, 1993, *18*, 760-82.

Based on the idea that people like to keep their options open in the face of an uncertain future, this theory shows how organizations explore alternatives, allocating and withdrawing resources from various programs as they read the unfolding future.

Classical texts which present the SWOT analysis and rather elaborate formal and rational treatments:
Ansoff HI. *Strategic management*. New York, NY: Wiley, 1979.
Lorange P. *Corporate planning: An executive viewpoint*. Englewood Cliffs, NJ: Prentice-Hall, 1980.
Steiner GA, Miner JB. *Management policy and strategy*. New York, NY: Macmillan, 1977.

Dalkey NC. *The Delphi method: An experimental study of group opinion*. Santa Monica, CA: The Rand Corporation, memorandum RM 5888-PR. 1969.

The literature on the Delphi technique is often inaccessible or found in secondary sources. This is the original report.

Ginsberg A, Venkatraman N. Contingency perspectives of organizational strategy: A critical review of the empirical research. *The Academy of Management Review*, 1985, *10*, 421-34.

Comprehensive but rather academic review of contingency approaches to planning.

* Mintzberg H. *The rise and fall of strategic planning: Reconceiving roles for planning, plans, planners*. New York: The Free Press, 1994. ISBN 0-02-921605-2; 460 pages; about $35.

A sweeping attack on strategic planning — more precisely a characterization of it as a formal, rational, staff function as perhaps practiced in large firms in the 1960s and 1970s. Often bitter, but very broad ranging and probing. Lays out the whole literature.

* Porter ME. *Competitive strategy: Techniques for analyzing industries and competitors*. New York: The Free Press, 1980. ISBN 0-02-925360-8; 395 pages; about $35.

A true classic. Many MBA students are familiar with the seminal concepts of generic competitive strategies, industry life-cycles, buyer selection, and strategic groups without realizing that one man introduced them together in a single book. This is a combination of economics, marketing, and business strategy. It explains how firms work. The book is packed with a wealth of material and the examples tend to be brief, so a basic familiarity with business is helpful.

* Quinn, JB. *Strategies for change: Logical incrementalism*. Homewood, IL: Richard D. Irwin, 1980. ISBN 0-256-02543-6; 222 pages; price unknown.

The purpose of the book is to show how strategic planning can (a) improve quality of information used for decision making, (b) coordinate various lead times of diverse projects, (c) manage personal resistance and political pressure associated with change, (d) build organizational awareness, (e) decrease uncertainty, (f) involve those having concrete information, (g) avoid premature momentum. It is influenced by the "limits to rationality" theorizing of the late 60s and early 70s and public policy, as opposed to business thinking.

Senge PM. *The fifth discipline: The art & practice of the learning organization*. New York, NY: Doubleday Currency, 1990.

Beautiful discussion of vision — the double vision of what things really are and what they can become — and the shared vision of an effective organization. (This book has been summarized earlier for the leadership column on the learning organization.)

Wack P. Scenarios: Uncharted waters ahead. *Harvard Business Review*, 1985, September/October, 73-89.

Not the first nor the most detailed presentation of scenario planning, but one of the most accessible and easy to understand.

Wildovsky A. Does planning work? *The Public Interest*, 1971, 95-104.

The answer is, no. Wildovsky is well known in the public policy and sociology areas. His critiques of the irrationality in government are famous, irreverent, and learned.

Editor's Note

Summaries are available for the three recommended readings preceded by an asterisk (*). Each summary is about five pages long and conveys both the tone and content of the book through extensive quotations. These summaries are designed for busy readers who want the essence of these references in fifteen minutes rather than five hours. Summaries are available from the ACD Office in Gaithersburg. A donation to the ACD Foundation of $15 is suggested for the set of summaries on strategic planning; a donation of $50 would bring you summaries of all the 1996 leadership topics.

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