AVROM E. KING on The Future of Orthodontic Practice

Avrom King is a founder of The Nexus Group, a professional association committed to the refinement and survival of fee-for-service dental practice. He has written and lectured extensively throughout the United States and Canada, and JCO is fortunate to share his thinking about the future of orthodontic practice. *ELG*

GOTTLIEB You have a unique view of what is happening to the dental profession and to orthodontics which I would like you to share with our readers.

KING Everything that we think we know about dentistry today indicates that the profession is rapidly evolving into three separate professions which we have described as Tier I, Tier II, and Tier III.

GOTTLIEB Please give us a quick definition of the three tiers and then we can discuss them in greater depth.

KING By Tier I, I am referring to the delivery of dentistry through involuntary closed panel and contract programs. Involuntary is the key to this tier. Our mathematical simulation models indicate that, within 15 years, about 25% of the dentists in the United States will be employed in the delivery

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of Tier I dentistry. Tier II involves the retail merchandising of dentistry. Here the emphasis is on voluntary participation, often through open panel and contract programs, but also through less structured entrepreneurial sources of supply. By the mid-1990's, I think that well over half of all the dentistry in America, perhaps 55%, will be provided by various retail merchandising concepts. As you can readily see, The Nexus Group is projecting that 80% of the dental profession will soon be involved in delivery of either Tier I or Tier II dentistry. The remainder will be practicing in Tier III, which I would define as the independent private practice of fee-for-service professional care through what we are calling a "wellness model of delivery", rather than the traditional "sick care model" which dentistry has historically derived from medicine. Most of Tier II will also involve fee-for-service, but the Tier II practitioners will have a very different economic rationale, behavioral dynamic and philosophy of practice. More about this in a few minutes. I might add that in describing these tiers, I neither endorse nor deplore this development. I am merely describing what I think will be.

GOTTLIEB As a matter of fact, are we not already beginning to see ample evidence that this separation is beginning to happen?

KING That is correct. We are beginning to see an impetus for Tier I medical and dental care in the contract negotiations of municipal workers—specifically, teachers, sanitation workers, firemen and policemen. But, much more significant than that is the growth of Tier I type of delivery mechanisms that are corporate-owned within large corporations. The classical example today is what is happening at the R.J. Reynolds' health care facility in Winston-Salem, North Carolina. We know that about one hundred of the Fortune 500 companies are now actively evaluating the possibility of a corporate-owned health care facility. Some have already approved prototype installations for evaluation purposes. These include IBM, John Deere, General Motors in some divisions, Ford in some of its divisions, and probably International Harvester.

GOTTLIEB What do you perceive is the motivation of business in doing this?

KING The primary reason for corporate involvement in health care delivery is that it represents a significant cost saving for the corporation that provides it. It is a dollar-efficient solution. If I had to define the theme of Tier I in one word, it would be "efficiency". In 1977, General Motors spent more money on health care insurance than on any other outside purchase. Its expenditure for health care surpasses the dollars it spends for steel or coal or paint or plastic or rubber or any of the products which it uses in the performance of its business. GM and other corporations are seeking a dollar saving, and they will find it through a new type of bureaucratic organization.

GOTTLIEB And having their own health care facilities will reduce that cost enough to warrant getting into the delivery of health care?

KING To give you an example, let's establish a hypothetical company, Acme Widget Corporation, and let's assume that Acme employs 10,000 people in a centralized facility. Typically, the cost per employee in a medical and dental program could be $100 per month. 10,000 employees at $100 each equals $1,000,000 a month or $12,000,000 a year. Independent studies, including ours, seem to agree

that large insurance programs generally require 20-30% of the premium dollar for general administrative and overhead costs associated with the program. Thus, Acme Widget Corporation would spend $2,400,000 to $3,600,000 administering such a program and subsidizing related overhead costs. However, since a corporation employing 10,000 people already has sufficient staff, facilities, and equipment for the self-administration of a comparable program, these administrative and overhead costs can be reduced, usually by a quarter, often by a third, and occasionally by a half.

If the overhead and administrative costs of Acme's program are $3,000,000 and the company is able to save only 25% of this amount by incorporating a self-administered program within its corporate structure, the saving is the equivalent of $750,000 a year. If Acme were to build and equip its own health care facility at a cost of $1,000,000, the cost of the facility, exclusive of salaries, would be returned in a little over a year, without taking into consideration the tax benefits to Acme of depreciation and other balance sheet considerations.

With average industrial profits at 5-7%, Acme would have to add $12,500,000 of annual sales in order to realize comparable bottom line benefits. What would a $12,500,000 increase in annual sales mean to the company in terms of cost of materials, the risks of increasing sales, marketing support, field support, etc., compared to the relative ease of operating its own health care facility. If you were the treasurer of Acme Widget Corporation, what would you recommend?

GOTTLIEB And R.J. Reynolds is doing this with a much larger corporation?

KING R.J. Reynolds is able to provide medical and dental services for 40,000 employees plus their families in a cost-efficient facility that greatly reduces the expense to the company. A company that employs 40,000 workers at a centralized location can probably spend upward of $5,000,000 in developing a health care facility and recapture that within 18 months. Now it is becoming clear why R.J. Reynolds is so enthused about their corporate-owned health care facility and why over 150 corporations from all over the world have visited that facility in the first few months of its operation.

GOTTLIEB What about smaller corporations?

KING Companies employing 4-5000 people are unquestionably going to be able to provide Tier I health care through the use of highly sophisticated diagnostic and treatment equipment and the use of paraprofessionals. Even much smaller companies, employing 500-1000 people, will have the opportunity within ten years of providing Tier I health care on much the same basis as they presently have lunchroom facilities. You can call Automatic Canteen and tell them the nutritional balance and calories you want, whether you want a hot meal and what you want it to cost. They will do everything else. That is going to be happening in health care, with the provider renting or buying space from the corporation.

GOTTLIEB You are estimating that by the year 2000, 25% of the dental profession will be engaged in Tier I dentistry. Now let's talk about Tier II, retail dentistry. What is the basis for thinking that dentistry can be retailed?

KING The failure of traditional dentistry to provide effective service for the majority of the population is what has created the opportunity for Tier II den-

tistry. Dentists complain that there are too many dentists. Perhaps dentists should consider the possibility that they are attracting too few patients. Sears looks at the same data as the dental profession and concludes that not since the introduction of television have retailers had a comparable opportunity to generate profit.

GOTTLIEB Profit is the key motive of Tier II dentistry. What about the quality of the service?

KING Tier II is being developed by marketers, not dentists. The Tier II marketer argues that the clinical needs of most people can be satisfactorily met by ordinary clinical achievement; that extraordinary clinical achievement is needed only by a few. Both for economic efficiency and quality of care, the Tier II marketer ideally would be able to identify those who have exotic needs and send them elsewhere for treatment, probably to a Tier III dentist. For the Tier II marketer, the Tier III dentist has a compulsive need to provide a level and quality of dentistry that most people do not need, most people do not want, and most people cannot afford. Certain departments in the retail department store chains — Sears, Ward's or Penney's — historically generate the most profit per square foot of floor space. These include the optical department, the credit department, the extended warranty department, and the automobile service department. These are all service-related profit centers. This seems to indicate that dentistry offers a huge potential for profit in retailing for the mass marketers who have demonstrated excellence in helping consumers create wants and then assisting them in translating these wants into needs.

GOTTLIEB Dental offices in department stores today merely lease their space and operate independently. You believe that is going to change?

KING To date, dental departments are leased, with dental services provided by both commercial and professional corporations which, in effect, have a franchise with a particular store. However, by the mid-1980's, we anticipate that department stores will have sufficient experience to begin owning their own dental departments and their own dental labs and supply houses and, in some cases, their own equipment manufacturing facilities. Most states do not presently permit commercial corporations to own an interest in professional practices. That will change. At least four states that prohibit commercial ownership of professional service corporations are now being heavily lobbied by groups seeking legislation which would place certain types of contract dental programs under the state insurance commissioner rather than the Board of Dental Examiners.

GOTTLIEB What evidence is there that all these groups are on the right track in wanting to change traditional dentistry?

KING The orthodontist and the dentist cannot persist in believing that the old ways still hold. Most of us, when confronted with new ways, do what Drucker has called "devil advocacy", We find a devil to explain the problem—the Supreme Court Decision or the Federal Trade Commission or Senator Kennedy or the ADA. You can fill in the name of your own private devil, but the situation is far too complex to admit this simplistic cause and effect explanation. Court decisions, regulatory agencies, and political leaders are both cause and effect. Tier II dentistry is an aspect of the broad social and cultural changes that are occurring in all segments of our cul-

ture. The devil theory will not explain away what is happening in Tier I and Tier II. The devil theory is only an obstacle to our understanding of what is happening.

GOTTLIEB We now have various types and qualities of department stores. Do you expect that this will result in a variety of quality levels available in department store dentistry?
KING Yes, I do. During the next five years, we will begin to see segmentation of department store dentistry, just as we have seen segmentation of department stores. We now have examples of discount department stores operating profitably in the same community with a Nieman-Marcus or a Lord & Taylor or a Saks Fifth Avenue. It is plausible that some day these fine stores might offer cosmetic dental services within the store in a way that is consistent with the character of the store.

GOTTLIEB So, Tier II dentistry may take a variety of forms?
KING Yes. For example, there will undoubtedly be one or more national franchise organizations in Tier II dentistry. They will be organizations very much modeled on a merger of the Century 21 promotional concept and the MacDonald's hamburger chain organizational concept. Each participant will own his own practice and, perhaps, his own building, but share a national identity in the franchise, heavily supported by extremely sophisticated advertising and other promotional activities. In addition the franchise could provide educational materials, factor receivables, arrange intra-franchise transfers of customers, offer cooperative purchase of equipment and supplies at reduced rates. This is going to happen and I anticipate that it will have a major impact, far exceeding that of "pure" department store dentistry.

GOTTLIEB And what is the combined impact of the two?
KING I think that by the year 2000, 55% of the profession will be involved in some form of retail dentistry. If you add the 25% for Tier I and 55% for Tier II, you see that only 20% of the profession remains. That 20% will be practicing what we call Tier III dentistry, which will have a level of sophistication and a breadth of definition that far exceeds the traditions of dentistry. Nevertheless, Tier III dentists will probably have to recognize, as the Tier II marketers already do, some emphatic shifts in the habit patterns of the population, which are helping people become more assertive in demanding a range of options for themselves. They may not accept professional advice and judgment without question and they may desire ready access, quick convenience, longer office hours, and the ready availability of multi-purpose shopping.

GOTTLIEB How do you visualize the working conditions of dentists in these tiers?
KING Organizationally, Tier I is going to be derived from what I call an administrative bureaucracy. A prototypic model of an administrative bureaucracy is the United States Post Office. Everything we can say about a career position in the United States Post Office will essentially apply to the Tier I dental practitioner. There will be high job security, adequate reward, advancement based primarily on seniority, relatively low challenge, and slow and largely predictable change. In an administrative bureaucracy one is not rewarded for being extra-ordinary. One is rewarded for being ordinary. The more nearly one conforms to the median line of the bureaucracy's expectation, the more secure one is.

That contrasts markedly with the Tier II practitioner. Tier II is essentially derived from an entrepreneurial bureaucracy. The prototype of the entrepreneurial bureaucracy is IBM. In the entrepreneurial bureaucracy, one is rewarded for extraordinary performance consistent with the value system of the bureaucracy. IBM, Sears Roebuck, General Motors do not reward people for being average. They reward people for being beyond average—extraordinary. A Tier II orthodontist or dentist will have all the rewards, potentially, that IBM offers as compared to the United States Post Office, as well as all the potential risks. Many dentists will develop sophisticated behavior strategies appropriate to this Tier, which will give them great satisfaction and high financial reward.

The organizational model for Tier III dentistry is non-bureaucratic. It is derived from principles of participatory and developmental management with long-term interrelationships among dentists, staffs, and clients. Tier III will be marked by voluntary, active participation of clients, not patients or customers. The Tier III practitioner and staff are going to have a much broader range of needs, involving true helper relationships and the opportunity for great spiritual and monetary rewards.

GOTTLIEB How much orthodontics do you think will be done in Tier II?

KING There is a strange irony here. There is no more discretionary form of dentistry than orthodontics and, in addition, all the population factors should mean that orthodontics is on the wane. But marketers and systems engineers see great opportunities in orthodontics and we think that orthodontics will be the object of heavy promotional effort. In New York State, we are beginning to see large, very well respected, ethical specialty practices in orthodontics, endodontics, and oral surgery contracting with both Tier I and Tier II providers to provide specialty services at a favorable fee for customers of a Times Square store or to an employee closed panel program.

GOTTLIEB This is on a referral service basis, with the practitioner working in his own office?

KING Yes, a referral service. The Times Square store does not really aspire to provide orthodontic care, if a more efficient and economical model can be found. Thus, a Board certified orthodontist may be in an administrative position or providing services to Tier I and Tier II, or will establish a Tier III practice.

GOTTLIEB Wouldn't it seem that by the nature of their personality, interests, and training that many dentists would find it hard to fit into Tier I or Tier II?

KING We know a good deal about the personalities of dentists. For example, if you ask a group of practitioners to name two or three of their colleagues whom they consider superior practitioners, whom they would offer as role models to young dentists, and then profile the personalities of that group, you find that it is different in some very important characteristics from a randomly selected sample of dentists. We also know that freshman dental students tend to resemble the random profile and, as they go through dental school, they move farther away from the peer selected profile. So, the ways in which dental schools have selected students has correlated negatively with high achievement in dentistry and dental school training has tended to exaggerate that negative correlation. What we may see is that dental schools and graduate programs will take on the characteristics of the three

tiers. Thus, one residency program may become acknowledged as a Tier III program and another as a Tier I or a Tier II program. That will reflect the choices of the faculty and may also be influenced by funding.

GOTTLIEB What about the dentists already in practice? How will they fit into Tier I and Tier II?

KING As I go about the United States and Canada, talking with dentists about the three-tier concept, one of the questions which I frequently find is this: "Where is Sears Roebuck or a closed panel program going to get their dentists? All they are going to have are old rummies and young kids who can't afford to start their own practice." My observation is that this is just not true. A dentist friend of mine who is very well regarded by his colleagues, thought of as a gifted dentist, who has been almost compulsive in his need to improve himself by his participation in continuing education, joined a closed panel program a few years ago, much to the dismay of many people. I saw him recently and he said to me, "I have never been happier. I have hired my last staff person. I have fired my last staff person. I have conducted my last staff meeting. I have collected my last bill. I have hassled my last insurance carrier. I have filed my last preauthorization. I am now working 32 hours a week. I never worked so few hours in 11 years of private practice. This year I will earn more than I earned in any year of private practice. I also get $100,000 of whole life insurance coverage, two weeks of paid vacation, ten days of continuing education anywhere in the United States with all travel, tuition, and per diem paid. Next year, I will be entitled to 15 days of continuing education. After five years, six weeks of paid vacation. When I was in private practice the thought of being away for a week frightened me. The financial consequences scared me so, I couldn't enjoy the week I took. The administrator of my program does not interfere with the quality of care that I aspire to give. My wife loves me again. I'm seeing more of my kids. It is a professional rebirth for me." His situation and his needs are not unique. In effect, he was saying, "I now get to do all of the things I really enjoy in dentistry and have little or no responsibility for all the things that stress me." Behaviorally, we know that this dentist could achieve the same goal in other ways. For example, in an astutely managed group practice. But, the Tier I program will be more readily available, because Tier I will utilize managerial strengths of non-dentists. In the corporate sector, these strengths tend to be valued and developed. In dentistry, the same strengths tend to be deprecated and, therefore, undeveloped.

GOTTLIEB How many orthodontists do you anticipate will be operating Tier III practices?

KING At the present time, we do not see too many. Orthodontists have not yet shown any marked degree of a capacity to accommodate to change. While I think that more and more people are going to be availing themselves of orthodontic care, the Board certified orthodontist is in danger of providing less and less of that growing amount. Our data indicates that, presently, about half of all orthodontic procedures are initiated by dentists without orthodontic certification.

GOTTLIEB Will that be related to a decline in dentist referrals?

KING Yes, in part. There is increasing evidence of growing antagonism on the part of general dentists toward orthodontists; and many orthodontists stand aloof from the general dentist.

GOTTLIEB Aloofness from the general dentist is certainly not in the orthodontist's best interest.

KING Well, orthodontists and periodontists usually see themselves as the intellectual elite of the profession. By virtue of the way in which all aspects of dentistry seem to converge in their chosen specialties, orthodontists and periodontists tend to have a much higher integrative ability—what psychologists call Gestalt—the ability to perceive the whole of something when only a portion is readily visible. I think that is one reason for the aloofness. A second may have to do with Orenstein's concept of right and left hemisphere skills. The orthodontist is an extraordinary example of left hemisphere or highly analytic skills, oftentimes with a very low integration of right hemisphere intuitive skills. That means that the orthodontist is often not a very sensitive person humanistically. He does not perceive human needs very readily. We know that he can help himself to do better in this regard, but he has had a whole lifetime of rewards in emphasizing left hemisphere skills. A third reason for the aloofness that is becoming more and more dominant is pure economic competition. We are seeing more and more general dentists and pedodontists doing more and more orthodontics.

GOTTLIEB Everyone speaks about comprehensive high quality care and yet, in Tier I, I can envision limitations on the basis of a menu of services that would be allowable; in Tier II, I can envision a limitation on the basis of the potential for profit; and in Tier III, I would say that limitations may be those of the practitioner. How does quality evaluation and quality control enter into the 3-tier concept?

KING The primary difference among Tier I, Tier II, and Tier III is a philosophic one. They have a different economic model, a different procedural dynamic, a different ethical construct. Tier I does not aspire to provide superior care in any comprehensive way. Tier I is concerned with disease, not health; and disease can be quantified, measured. You cannot measure a feeling of well-being. Tier I is concerned with the efficient restoration of normal parameters. We know disease exists, because we have a statistical profile representing upper and lower limits; and we say that anything that falls between those limits is health, and Tier I is not concerned with that. Everything that exceeds those limits constitutes disease, and Tier I actively intervenes with disease to restore normalcy.

GOTTLIEB That sounds like the indexes of malocclusion that keep cropping up in orthodontics.

KING Yes. However, Tier I care is not going to be concerned with sophisticated aspects of occlusal relationships. Tier I is going to be concerned with gross deviations from normal and how quickly a normal relationship can be restored.

The Tier II marketer — who may or may not be a dentist — says, "In dentistry as in life, most problems have rather ordinary causes and are susceptible to rather ordinary solutions and do not require extraordinary or heroic efforts, which most people do not need, do not want, and cannot afford." Marketers recognize what I have come to call the hole-in-one complex in dentistry — the need to create the most perfect case. The Tier II marketer is saying, "Wait a minute. Most of what people need is not very complicated, does not call for extraordinary diagnostic or clinical skills, does not depend on highly esoteric competency,

and we can make a lot of money if we recognize the few that do and refer them out."

Tier III dentistry requires high self esteem on the part of the client as well as the practitioner, a high capacity for desiring a wholeness of body image, an evolving concept of health that is qualitative, not quantitative. Tier III is elitist relative to attitude, not income. Almost anyone can afford almost anything that is truly desired. That's why "poor" college students spend a remarkable percentage of available funds on expensive jogging shoes, art books, cameras, and stereo equipment.

GOTTLIEB With the variation in quality and quantity of dentistry available in the three tiers, how much movement might one expect to see of patients from tier to tier?

KING There is a percolation effect that we are already beginning to see. People who have had no experience with dentistry or who have had only negative associations with dentistry are being exposed to the services of dentistry by reason of Tier I care. Some percentage of those, and it is much too early to know what that percentage might be, are going to want greater choice than Tier I offers them and they will seek out some Tier II alternative. Some percentage of those who migrate into Tier II, or whose initial experience is in Tier II, will come to desire a level and quality of care which Tier II cannot provide and they will move on to Tier III.

GOTTLIEB The implication from this is that an important market for the Tier III dentist and orthodontist is going to be created by the mobility of people from Tier I and Tier II to Tier III as their health aspirations and expectations change.

KING It should become a major market and the mathematical simulation models that we used in developing these predictions indicates that, barring something quite cataclysmic, the 20% of the dental profession who are able to establish Tier III practices are not simply going to survive in private practice, they are going to thrive. We believe, at least for the intermediate future, that there will be many more people who come to aspire to Tier III care than there will be practitioners able to deliver it.

GOTTLIEB When you say "able to deliver it", what does that mean for the orthodontist who aspires to be a Tier III practitioner?

KING It means that he is going to have to assume self-responsibility for some very significant and countercultural change. He must recognize that orthodontics is a discretionary purchase and that the orthodontist is not really competing with other orthodontists and with GPs and pedodontists who practice orthodontics as much as he is competing with automobile dealers, realtors, travel agents, TV stores. Orthodontists compete with anybody who sells any product or service which somebody wants. For the orthodontist, the problem is a behavioral one. Is it that there are too many orthodontists, or are there too few people who want orthodontic care? Are we going to close down our school programs because there are too many orthodontists, or is the individual orthodontist going to accept responsibility for developing ways within his own community to attract more people into his practice?

Not only must the orthodontist recognize that he is providing a highly discretionary service, but that he is providing it oftentimes in a behaviorally difficult environment. Leaving

aside the adult orthodontic patient for a moment, at the very time when the adolescent orthodontic patient is most sensitive to peer relationships, most threatened by developing heterosexual interests, most intimidated by body image, most beset by psychodynamic insecurities which are a normal part of the developmental process, that is the point at which the orthodontist traditionally begins his work. That calls for an extraordinary behavioral sensitivity on the part of the orthodontist and his staff. In dealing with child patients, the orthodontist occupies the position of the dog food manufacturer, in that the recipient of the service is different than the purchaser. Dog food manufacturers have known for a very long time that the kind of food that your dog wants to eat, you won't buy. The kind of food that the dog wants to eat is rather gray in color and is obnoxious to our nose and eye. So, dog food looks like your food, smells like your food, and you are invited to make human associations with it. Rich brown gravy means a great deal to you. It doesn't mean very much to your dog. When my son or daughter is in your practice, who is your client? I am your client because I am paying for it. On the other hand, everything that we know about how our culture works indicates that that child is a miniature broadcasting station. When Ford introduced the Mustang, they spent almost three million dollars on public relations efforts directed at young people who were not old enough to have drivers' licenses, because Ford recognized the ability of these young people to create demand in the adult culture. For this reason — and because your relationship with my kid importantly determines the outcome of the case — the child is also your client; and, I argue, your primary client. My feelings about you are significantly influenced by how I perceive the attitudes of my child toward you.

GOTTLIEB Considering the behaviorally sensitive environment in which the orthodontist is working, what steps can he take to maximize that environment?

KING In my estimation, you cannot have a behaviorally sensitive orthodontic practice if you are not able to maintain long term relationships with staff. The quality of the dentist/staff relationship importantly determines the quality and amount of dentistry which will occur in that office. The dentist/staff relationship is, in effect, a model of the dentist/client relationship. We have been able to document rather dramatically that the quality of the relationship that the dentist has with the staff largely determines the kind of patient who is attracted into the practice. And, we have some data which suggests that the difference between compliant and noncompliant orthodontic patients may pivot on the phenomenon called future-focusing.

GOTTLIEB Perhaps we should say what future-focusing is.

KING By future-focusing, we mean the ability to see yourself concretely in a future time frame, not necessarily realistically, but concretely. A youngster might reply to the question of what he wants to be when he grows up that he wants to be an astronaut, an artist, or a soccer player. None of these may jibe with the abilities that he has or is likely to have, but it is very specific and he can develop highly specific scripts involving himself in these roles in his daydreams. Similarly, you can ask a child in your practice how he plans to spend the Summer. One child may say, "I don't know." Another may say, "Well, we're going to be home until the middle of June because my

married sister is going to come and visit us, and then we are all going to drive to Oregon and camp out for two weeks, and when we come back, I am going to take swimming lessons." We think there are important behavioral differences between those children who have and those who do not have a capacity for future-focusing. The relative absence of this skill, for example, is a highly diagnostic indicator of antisocial behavior in children.

GOTTLIEB Can you teach a child to future-focus? Thus make a cooperator out of a noncooperator?
KING We think so. We do not have conclusive evidence, but we think that a sophisticated, behaviorally astute dentist and staff can provide extra measures of support and love and acceptance and, thereby, significantly help a child to develop future-focusing skills. This does tend to make a cooperator out of a noncooperator. But, there is a secondary, more selfish reason. These children influence the attitudes of other children toward a given orthodontist, and those children, in turn, influence the attitudes of their parents.

GOTTLIEB Orthodontists are not generally in the habit of looking to patients themselves as referrers.
KING They are a very strong, often overlooked, referral source. One child influences the attitude of other children who are about to undertake orthodontic treatment, and those children distinctly influence the behavior of their parents. Perhaps a child's general dentist says, "Well, I think you ought to see Dr. Smith. Tommy needs to have an orthodontic evaluation." But Tommy persuades Mom that Dr. Jones is the person he wants to see. So, mother calls up the general dentist and says, "One of Tommy's friends is having a really good experience with Dr. Jones. How do you feel about that?" The dentist says, "Oh, Dr. Jones is a fine man. Go right ahead." We think this happens in one version or another far more often than most orthodontists realize.

GOTTLIEB The converse is also important.
KING I know that happens.

GOTTLIEB It has come to my attention that a marked increase in the number of orthodontic patients with divorced parents is creating problems of cooperation in orthodontic practices.
KING There is a related phenomenon there. You can safely expect that orthodontists will have a disproportionately high number of adolescent patients from divorced homes, because rate of divorce correlates with income. Divorce is a discretionary expense and so is orthodontics. People who choose to get divorced have a value system which may encourage them to afford orthodontics. Most orthodontists fear that the financial problems which accompany divorce work against the initiation of therapy; but, we believe that this apparent obstacle is potentially an advantage. This is another reason why the orthodontist has to be behaviorally astute and propagate a high degree of behavioral competence with his staff, because this is another aspect of the discomfort that many adolescent patients are feeling.

GOTTLIEB Do you believe that a behaviorally oriented doctor and staff can set up a relationship with the patient that will overcome the problems that are created by outside situations?
KING That may be an overstatement. A behaviorally sophisticated dentist and staff can establish a personal rela-

tionship with an adolescent patient which represents affection and warmth at a time when the child's other relationships are very chaotic, and the child can learn to prosper personally in the practice.

GOTTLIEB Behavioral psychology according to Watson, I believe, taught that people tend to behave in a compartmentalized fashion. Is that still believed, and are you therefore setting up a compartment which is a relationship that the patient has apart from his other problems, which will permit him to deal with you on a basis of affection and cooperate with you in his orthodontic treatment because he likes you and likes your office?

KING More than merely affection, as important as that is, because in a behaviorally astute office the young patient is increasingly being encouraged to accept responsibility for his own care. This is, incidentally, a by-product of future-focusing skills. I don't know whether it makes dental sense, but behaviorally I encourage the orthodontists we work with to spend much more time with their young patients than is traditionally done, helping them to understand what is going to happen before it happens. I want the dentist and the staff to acknowledge the integrity of that young person. I would like the orthodontist to give a sheet of paper to the young patient and say, "John, this blue line represents your lower teeth and this blue line represents your upper teeth as they are today. When each of these blue lines overlaps with these two red lines, we are done." I would like the scale of that diagram to be such that even a miniscule movement is projectable, so that the child has a sense of accomplishment and can relate his cooperation to the rapidity of movement. Then, on a regular basis, a five-minute consultation by the orthodontist or a staff member should be scheduled with the child for this purpose. You treat the child as you would an adult and encourage him to grow to the point where he begins to take responsibility for monitoring progress back to you and you merely become the person who draws the lines. When the child reaches a point where he can say, "How come I've been doing everything you told me and there was less progress from here to here than there was from here to here?", now you are getting him involved in his own care and you have an opportunity to talk to him about things he wasn't interested in at all six months ago.

GOTTLIEB Communication is not confined to the patient though, is it?

KING I think it is tremendously important that there be some regular communication between the office and the parents. But, I would like to establish patterns in the office that permit the child to make the report to his parents. As I envision this, the dentist or staff person is present as support, but the child explains his progress to his parents. With divorced parents, particularly if one parent has visitation rights and is contributing to the orthodontic care or has an insurance program that is contributing, I think that separate parent consultations should be offered to the child. But, many times, a joint consultation is more appropriate.

GOTTLIEB What do you think is the preferred form of communication between the orthodontic office and patients and parents?

KING Whether it is by telephone or in person, the important thing is that it be unstructured and that it involve free two-way communication. We suggest the installation of an unlisted telephone line and printing wallet-size cards with the number on it to be given

to each child patient. This increases their sense of responsibility and permits us to say to them that any time they are worried about something or have a problem, here is a number to call. No one except patients like themselves has that number. One of us will answer this line. You can talk to me if need be. Maybe Mary or Susan will be able to answer, but this is your number. Carry it in your wallet. That is a marvelous nonverbal way of saying to the child, "You are important to me." I want him to know that he has access to me directly, not through his parents, that the outcome of the case and the rapidity with which it will be completed is importantly determined by him and we're here to help him.

GOTTLIEB If an orthodontist has not been in this helping mold, can the leopard change his spots?
KING The ability to be warm and empathetic is something that has largely been determined in childhood and there is not a whole lot that you can do as an adult to increase your latent potential. However, everyone can learn to recognize the limits of his or her behavioral competencies realistically and select staff members so that their skills and abilities can augment the dentist's skills and abilities.

GOTTLIEB How does one go about doing that?
KING There are lots of ways. I believe that the PET program is a good beginning point.

GOTTLIEB Let's say what PET is.
KING PET stands for Parent Effectiveness Training, but it really doesn't have a thing to do with whether you are a parent or not. PET has to do with effective communications and interpersonal relationships and is not limited to parenting. The value of PET is that it provides a non-threatening, short-term, very effective way for dentist and staff to learn to better share feelings. This sharing probably represents the limit of sharing which patients will be able to do, since dentist and staff nonverbally establish — or fail to establish — the behavioral environment in which sharing does, or does not, occur.

GOTTLIEB How does one contact the PET program?
KING PET trainers can be contacted through the administrative office of public school systems. We have known many dental practices, including orthodontic practices, which have made arrangements singly or with several practices together so that the PET trainer could come into the dental office for a couple of hours every couple of weeks and work with the dentist and staff. Nexus conducts three-day workshops with groups of 12-15 dentists and staff.

GOTTLIEB Through these programs an orthodontist could not only acquire an understanding of the philosophy, but he could learn techniques of staff selection, staff management, and patient relationships which would bridge the gap to a behaviorally oriented practice?
KING Yes.

GOTTLIEB How much doctor time is involved in the average behaviorally oriented practice? Is he more involved with patients, or does that depend on his own attributes?
KING It is dependent upon his attributes. I am uncomfortable with many of the management consultant people

(CONTINUED ON PAGE 750)

ciencies. The second phase is a process by which people begin to accept responsibility for their own personal and professional growth. The third phase is to link achievement and reward. You cannot learn PM other than by doing it and there is that 6-month period of short-term risk. Then the rewards become manifest and the dentist and staff have a marvelous time with it.

GOTTLIEB PM is not a democracy is it?

KING No. It is not a democracy, because democracy means "let's vote". It does not involve delegation of authority because delegation implies that I, the dentist, get to delegate. At the same time, it does not mean absence of structure, because that is chaos. PM has a very high degree of structure and a very sophisticated structural form, which doesn't look anything like the traditional hierarchial model.

GOTTLIEB Would this be an example of an authoritarian action transferred to PM? Some orthodontists will time the performance of the staff in certain operations, punitively sometimes, but more usually to structure their scheduling and to set standards for new employees. As threatening as that might be to employees when imposed from the top, if the employees should get together and say, "Hey, we could do a better job if we knew how long it took to do the job and we could schedule much better", would that be an example of PM management bringing an idea like that from the bottom rather than imposing it from the top?

KING Precisely. PM is a way of involving people in the definition of problems and setting priorities so that they can own the solution.

GOTTLIEB Does this take a lot of time on the part of the staff and involve frequent staff meetings?

KING As a rule of thumb, I would say that an office that is serious about PM is going to be investing 4-6 hours a month in the process. If a dentist and staff are willing to give that amount of time, in a matter of just a few months the increase in their productivity makes the cost of that time trivial. There is a myth in dentistry that the only time you are productive is when you have spit on your hands. If you begin to define dentistry as involving behavioral and managerial competency, then that is not true and the time you spend at staff meetings can be highly productive, even in a purely financial sense.

GOTTLIEB Are the staff meetings structured and conducted by the staff rather than the dentist?

KING It is a shared responsibility. The reverse of this procedure is the passive hostility that is amply illustrated in dentistry, as in all authoritarian enterprises. The dentist attends a continuing education program and comes back all enthused and says, "All right, staff, I want to share with you something I've learned about a brand new way of appointment book control." And, he makes a little presentation sharing with them some of the material and some of his enthusiasm. He says, "The way I see it, if we do this it would solve this problem and help take some of the strain off of Jenny, and I think it is just great. What do you think?" Silence. "Well now listen, if any of you see any problems in this I want to hear about it." Silence. "Well, does anybody object if we try it for a few months?" Silence or, "Doctor, it's your practice. If you think it's the right thing to do. . . . " "All right, if nobody has any objections, we are going to try it for three months. Agreed?" Silence,

which is taken to mean assent. That's the passive part. Two or three weeks later comes the hostile part. At lunch one staff member will say, "This dumb system. What was the doctor thinking about when he put in such a dumb system?" The dentist, because he is a practicing authoritarian and because he consciously or unconsciously exploits the prerogatives culturally associated with the title "Doctor" with his staff as well as with his patients, creates a passive response in the staff. The fact that the staff doesn't choose to take the risk of sharing opinions doesn't mean that the staff doesn't have them or that those opinions won't surface as hostile.

GOTTLIEB Actually, the orthodontist or dentist would have to have the feeling that somebody he hired was going to be a person that he could respect for whatever they were and with whom he could share the concept of what the practice was trying to accomplish.
KING They would have to grow to that.

GOTTLIEB Can anybody grow to that?
KING Yes.

GOTTLIEB That is probably a rather sophisticated choice for a dentist who might not be a humanist by nature.
KING Fortunately, there are some easily accessible skills that can help the dentist greatly in the selection process.

GOTTLIEB How does that work with a dentist who is essentially authoritarian, but who can see the merits of a new approach to staff management?
KING I have observed many dentists who have become intellectually intrigued by humanistic, whole-person participatory management concepts, who find out that there is a set of tactics for identifying and hiring people with latent capacities in these areas, who hire such people but don't really change themselves or their offices, and find that these people don't fit at all. You cannot put somebody who wants to be warm and empathetic and accept responsibility into a highly authoritarian, degrading, routinized job and expect her to be happy. Such a dentist will conclude that the system doesn't work, that this was the worst employee he ever hired. That is why we feel that the first need is to help the dentist and the staff together to develop a philosophy of practice. While we think that people have tremendous capacity for growth, some people on the staff are not going to grow and some are going to come to the dentist and say, "I have an opportunity to go with the telephone company, and I think I want to take it." As that natural progression occurs, the dentist is ready to select on a more certain and sophisticated basis.

GOTTLIEB I imagine that the first thing that has to happen is that the orthodontist or dentist must recognize where he stands in this activity.
KING Yes. We are talking about a level and quality of activity that calls for some real maturity in producing situations which generate mature responses. If I am correct in my perception of what the orthodontic profession will be, the choice is to do this or risk losing your professional birthright. I don't think that the punitive kind of orthodontic practice has very much survival value in the next five or ten years.

GOTTLIEB By punitive kind of practice, do you mean approaches which say, "If you don't do this, your teeth are going to fall out" or "If you don't do this,

I am going to kick you out of my practice" or "If you don't do this, I am going to tell your mother" or "If you don't do this, it is going to cost you more money" or "If you don't do this, it is going to take endless time" or "If you don't do this, we can't get a proper result"?

KING Yes. That approach cannot survive.

GOTTLIEB Unless there are enough people who are attracted to a rigidly structured situation.

KING But, you see, there are going to be large marketing organizations which offer all that rigidity in structure and a whole lot more—including $700 fees.

GOTTLIEB Orthodontists who feel more comfortable with specifics rather than concepts are going to have to reach out.

KING One of the overwhelming problems of dentistry is that dentists, by reason of their personality and training, seek out tactics. The dentist tends to be always in search for the holy grail, for The Answer, The Way, the piece of equipment, the technique, the appliance. One of the reasons why Tier I and Tier II will attract dentists is because Tier I and Tier II depend on tactics and strategies. These are how-to-do-it tiers, never why. Tier III is going to be the rightful domain of those who are able to envision their opportunities and conceptualize about their problems so as to develop individual solutions. Because this is a rare skill in dentistry, the cadre of Tier III dentists will be small in number for a while.

GOTTLIEB Except that everybody visualizes himself as a Tier III orthodontist.

KING Yes, but not everybody is going to survive economically as a Tier III orthodontist. Formerly, you could practice any way you wanted to and were able to generate enough traffic flow to get away with it. In the future, those who aspire to be Tier III orthodontists, but practice an authoritative and punitive kind of orthodontics are simply not going to survive. You have to decide whether it is your personal and professional objective to provide usual and customary care. If it is, you ought to receive a usual and customary fee. If, on the other hand, you aspire to provide unusual and extraordinary care, then you are entitled to unusual and extraordinary compensation — monetary and spiritual. I know that when dentists develop sufficient self esteem and sufficient behavioral skills and are feeling good about themselves, they can say to the patient, "Yes, this can be done for $700. I wouldn't want it done in my mouth that way or in the mouth of my wife or child, and I wouldn't feel very good about doing that in your mouth. I don't think you have an ordinary, customary mouth. I think you are a very special person and we are going to aspire in this office to provide a very special kind of care. Since you were good enough to come to me and tell me about your hesitation, I would like to talk specifically about some of the differences." Then I would talk in a nonjudgmental, nonpunitive way about the differences, why this is a better way to do it. And when I am done, 99.99% of my patients are going to choose to have confidence in me rather than in a closed or open panel or in an anonymous carrier. It is hard to learn new ways, but it is no harder than witnessing your own failure as you stubbornly hold to old ways.

GOTTLIEB Orthodontists have felt threatened by the transient nature of their practice, that they have to start all

over again with new people all the time.

KING Compared to the oral surgeon and endodontist, the orthodontist has very long-term relationships with patients. In the first two years intensively and the next two years something less so, that person becomes a testimonial for the practice. For an orthodontist not to see himself as having long-term relationships with people, even in our highly mobile society, would be a big mistake. When I was 14 years old, I lived in Phoenix, Arizona and my orthodontist was Robert Dawson Payne. I understand that he is still practicing in Phoenix. I went away to college when I was 16 and I was still in appliances. I loved Payne. If he told me to hook those rubber bands over a chandelier and hang for an hour a day, I would have done it just because he said so. I really liked him. I don't remember the name of the lady who assisted him, but I really liked her. I felt very good about those people. When I went off to college, he referred me to a sadistic s.o.b. and I wouldn't do anything for him. He hollered at his staff and he hollered at me. He had temper tantrums so bad that sometimes he had to leave the treatment area for a while to compose himself, and returned very tense. Well, I got even with him. I didn't do anything. As a result, my arch never closed. There is no question in my mind that had I stayed in Payne's practice, I would have finished up with a fine result. I was his patient over 25 years ago and I still have a long-term relationship with him—at least in my mind.

GOTTLIEB On that score, dentists may be partly correct when they say, "Where is the great dissatisfaction with traditional dentistry?" They point to the high score for dentistry on the Harris poll and the Money magazine poll.

KING Well, the indisputable fact is that only about 20% of the total population fully utilize the services of dentistry; that another 40-50% utilize the service of a dentist only on an episodic or crisis basis and 75% of these see a dentist for any reason fewer than 12 times in an entire lifetime; and virtually one-third of the population go to their grave untouched by dentistry. So, when you conduct a Harris poll and tell me that dentists rank at the top, I have got to ask what percentage of the population uses dentists? Rather than quote a Harris poll, I propose we quote from Eric Hoffer. He said, in 1951, "The well adjusted make poor prophets. A pleasant existence blinds us to the possibilities of drastic change. We cling to what we call our common sense, our practical point of view. Actually, these are names for an all-absorbing familiarity with things as they are. The tangibility of a pleasant and secure existence makes other realities, however imminent, seem vague and visionary. Thus it happens that when the times become unhinged, it is the practical people who are caught unaware and are made to look like visionaries, still clinging to things that no longer exist."

GOTTLIEB It seems to me that orthodontists are going to have to look for solutions on an individual basis, rather than on any group action.

KING I would endorse what you have said, because all aspects of organized dentistry are bureaucratic. That is not pejorative. That's not to say they are evil. They are what they are, and we have come to know a good deal about bureaucracy. We know that it functions best during times of slow and sequential change. It tends to respond, rather than to initiate action. It tends to be self-perpetuating. It tends to depend on yesterday's behavior for anticipat-

ing tomorrow's needs. In all of these regards, bureaucracies are maladapted to confront today's problems. Not the AAO alone or the ADA alone, not the AMA, ABA, U.S. Air Force, U.S. government. We are dealing with bureaucratic responses to problems that are not bureaucratic. There are two marvelous articles that have not a thing to do with dentistry that appeared recently and that I would encourage your readers to secure and read. One appeared in January 1977 in Fortune magazine. The approximate title was "How General Motors Turned Itself Around". What you find in that article is that the Chairman of the Board of General Motors concluded that there was no way the company could survive by seeking bureaucratic solutions to environmental problems. He created a task force outside of bureaucratic lines of authority and reporting. A small group funded by the Chairman of the Board and responsible only to him set out to develop some of the definitions and solutions that we are now seeing in GM showrooms. An even more fascinating article appeared in Business Week magazine (April 9, 1979). It was about AT&T and the reason that it is even a better example is that AT&T is so much more like dentistry. AT&T was a company with an historic mission, highly regulated, a quasi-utility. The benefit it received for tolerating regulation was monopolistic protection. But now, like dentistry, AT&T is no longer being protected. The change occurring at AT&T is parallel to the change that is occurring in dentistry. AT&T has largely begun to recognize the need to redefine its function, since through a change in its historical mission, AT&T is now a marketing organization rather than a utility. If an orthodontist reads that article and does not see an overwhelming parallel between what AT&T had to do and is doing and what he has to do, he is not going to survive.

GOTTLIEB No orthodontist can look forward to practicing in the future as he is today?

KING It would be presumptuous for me to say that 20 years from now there will not be a single orthodontist practicing traditionally, but I do think there will be few of them. The environmental difference between 1990 and 1950 is every bit as great as the difference between the cloistered monk illuminating manuscripts before and after Gutenberg invented movable type. The quality of the change is that dramatic. I sometimes ask my audiences to imagine Brother John, a 14th Century monk who sat in a monastery illuminating manuscripts, being lifted up and brought to today. We show him phototype, a printing press, a xerographic process. Brother John is going to have one of only a few reactions. He's going to reject reality — a simple act of denial. He is going to say that this is illusionary, not really happening. It can't last. It won't last. It's the work of the devil. Or he's going to become despondent and withdraw. Apathetic. He's going to say, "My God, there is no place left for me." Or he's going to say, "Maybe I need to enroll in a trade school and learn more about this." Or he's going to say, "In an era when you can print 100,000 copies of my beautifully illuminated manuscript page in just a few minutes, what a great opportunity there is for someone with my unique talents." Or he may say, "Perhaps you'd like me to teach you how to do this handwork." In the same way, the orthodontist is going to feel hostility. Or denial. Or he is going to become apathetic. Or he is going to adapt. As Eric Hoffer said, the inclination of all people who have a heavy investment of time, money and energy

in learning one way of doing something is to hold to the old way. But, it is truly written — "Seeds of opportunity are carried by winds of change."

GOTTLIEB And, given the ability to recognize that, there is open opportunity for orthodontists in Tier III?

KING Our bias and our commitment in Nexus is to Tier III dentistry. I continue to believe that the independent fee-for-service dentist has, potentially, a marvelous future and that there will be far more people desiring the level and quality of care and service which the Tier III dentist can uniquely provide than there will be dentists competent at offering Tier III services. Tier III dentistry requires technical excellence, behavioral skills, business management, judgment, self esteem, resiliency, courage, imagination and, particularly today, a sustaining sense of humor and a deep spiritual faith. These are attributes that are potentially in all of us. Those who wish to thrive in Tier III cannot do so by denying Tiers I and II or by establishing an adversary relationship with the dynamics of those tiers or the practitioners within them.

GOTTLIEB Would it be feasible to practice Tier III orthodontics a couple of days a week in one office and Tier II orthodontics a couple of days a week in another?

KING Reluctantly, I must tell you I do not think that will be practical or prudent. The likely result would be a very high level of personal stress and an averaging-out phenomenon that would impede the unique benefits of both practices. There would be a tendency for your Tier III practice to accept certain Tier II characteristics and an expectation that the Tier II practice would perform in some ways more suited to Tier III. Staff expectations would surely be different. The meaningful differences among the tiers involves personal philosophy — how I see me and, therefore, how I see others. Personal philosophy cannot be turned on and off. Philosophy would be reduced to tactics. To strive for excellence in two tiers would probably result in mediocrity in both. However, even those dentists who are familiar with the tripartite concept of dentistry continue to make what seems to me to be a fatal error. They take the economic rationale or the behavioral dynamic or the ethical construct of one tier and insist on applying it to another tier. That is simply not valid. The ten commandments are invalid if you are a monkey. Not because they are wrong, simply because they are not relevant. You cannot take the economic model of Tier I dentistry and use it to judge Tier II dentistry. You cannot take the ethical precepts of Tier III dentistry and apply them to Tier II.

GOTTLIEB Many practitioners, general dentists as well as specialists, are curious about the place of the specialist in Tier I and Tier II dentistry.

KING We anticipate that some specialists will function administratively in both tiers and that general dentists will be encouraged to develop specialized skills. Unquestionably, there will be some closed panel programs with specialists on the staff and the R.J. Reynolds' health care facility is a prime example. However, logic, economics, and what we are witnessing happen on Long Island, New York — unquestionably the current battleground of dentistry — suggests that there will probably be specialty practices that develop a referral relationship to large Tier I and Tier II components. In effect, they will become satellites of the Tier I and Tier II components. Remember that the prevailing Tier I and Tier II belief is that

most people only need and only want and will only pay for ordinary clinical skills. Even in specialized areas, general dentists who seek variety in their work will offer specialized services. But, the economics of Tier I and Tier II will most certainly dictate that those people who do require a level of specialized care which cannot be readily provided within Tier I and Tier II will be referred to specialty satellites. Keep in mind that in the next few years, the legal distinction between a specialist and a generalist will become blurred, largely as a result of FTC regulations. It seems clear that the FTC will not allow a dentist or dental organization to require or imply that Board certification is the sole acceptable criterion for specialty competence.

GOTTLIEB So, how do you read the future for those Board certified orthodontists?

KING Over the next few years, orthodontics will most dramatically display the decay of specialty functions. We believe that by the mid or late 1980's a significant number of today's Board certified orthodontists, perhaps 20-30%, will be wholly or partially involved in capitation programs and that 65-70% of all orthodontic cases will be treated by general practitioners with a special interest in orthodontics. There is probably no single area of dentistry that will be more affected by systems-centered concepts than orthodontics. When certain assumptions are made, the consequences of systems engineering on orthodontic production are mind boggling. Here are the assumptions. The orthodontist must have a huge case load. He must work 4-handed with two or three auxiliaries; he must have a superior nonclinical staff; and he must have a radial, systems-engineered facility. When these assumptions are valid, we think that it will be feasible for an orthodontist to provide or supervise more than one hundred orthodontic adjustments in a sixty-minute period. This configuration requires highly sophisticated support systems for traffic flow, materials preparation, record keeping and appointment making. In the judgment of most observers, an orthodontic practice of this size will require a very large Tier I organization or an extraordinarily successful Tier II marketing program.

GOTTLIEB The use of expanded duty auxiliary personnel seems implicit in orthodontics in all three tiers.

KING There will be extensive reliance on expanded duty auxiliary staff members. The present restrictions are largely supported by dentists who fear the economic consequences. However, nontraditional forms of dental competition — department stores, national franchises, and independent advertising dentists — will soon bring those fearful practitioners to the point of demanding EDA's as a means of securing their own livelihood. If we did not have the economic consequences of Tier II dentistry to contend with, the coming of the EDA would be much slower. It is also important to realize that expanded duties can refer to other than clinical responsibilities; for example, expanded behavioral duties or expanded administrative duties. Surely, the dentist will expand beyond his traditional duties, too.

GOTTLIEB Will this hasten the unionization of auxiliaries and dentists too?

KING One inevitable consequence of Tier I and Tier II dentistry is the unionization of dentists and staff. The American Federation of Teachers, which has been experiencing a declining membership as fewer and fewer children

are entering school, has already begun to recruit medical workers and beginning in 1980 will compete with the Teamsters and the Retail Clerks unions for the privilege of organizing some Tier I and Tier II dental groups. The notion of a single monolithic organization, such as the ADA, representing all of dentistry is antiquated. It is simply not compatible with the essential differences in the emerging three tiers. As a practical matter, most observers expect that the courts will soon require that the ADA abandon its requirement for membership in the national organization as a condition for membership in a local organization.

GOTTLIEB You mentioned the independent advertising dentist. How do you read that development in the future?

KING Research by the newsletter, *The Advertising Dentist*, showed that advertising dentists attract 2.7 patients who earn more than $14,000 per year for each patient who earns less than $14,000 per year. As a result, dentists who advertise tend to locate their practices in middle and upper middle class areas. The myth that the advertising dentist appeals only to the blue collar worker and old folks is untrue. While advertising is being hotly contested in dentistry today, there has been a 64% increase in telephone directory advertising in 1979 with the expectation that we will see a 100% increase in 1980; there are more than 3000 separate dental newspaper ads every week; about 2100 minutes of radio and television advertising every week. Advertising dentists are beginning to supplement the traditional appeal of price, credit, and pain-free dentistry with "we care about you" themes. Thus, the advertising dentist is beginning to strive for an environment which has been historically identified with the nonadvertising dentist. The independent advertising dentist and the dental retailers will, together, be responsible for the evolution of dental advertising into a highly sophisticated art and science.

GOTTLIEB Do you expect to see more group dental practices?

KING There is no question in my mind that we will see more dental groups in the coming years. The economics of post-industrial dental practice require better utilization of physical plant and equipment for longer hours for more days of the week. Various forms of shared associations, some of them organizationally innovative, are inevitable. One mode of this may be a turnkey concept in which dentists will be able to lease a facility with equipment, staff and accounting and billing services from a leasing company for a fixed hourly rate. This has been called the condominium principle.

GOTTLIEB The government seems to be committed to pushing the HMO type of group.

KING The primary claim of HMO's has been medical — less hospitalization and shorter hospital stays. But, competition in the marketplace is rapidly bringing virtually all HMO's to dentistry — and in a big way. There is now evidence of an organizational hybrid, the dental HMO which is often referred to as a DMO. This would be a closed panel capitation program under the federal enabling legislation or a state chartered organization administered by a state insurance commissioner rather than the Board of Dental Examiners. Physicians and dentists in a federally chartered HMO/DMO will be able to practice in any state without approval of state dental examiners. Under Public Law 93-222, the

HMO/DMO will enjoy significant marketing advantages.

GOTTLIEB What is the impact of Tier I and Tier II going to be on third party dental insurance programs?
KING The effect will be profound. Realizing this, some carriers are establishing consulting services to offer managerial support, particularly actuarial services, to Tier I and Tier II organizations. Some carriers may buy into these tiers. We expect large Tier II organizations, emphatically including Sears and probably most major national franchises, to offer both individual and family health care insurance. Sears already has the Allstate subsidiary. Apart from Sears, the other major retailers and national dental franchisers can be expected to purchase programs from established private carriers and market these under their proprietary name, very much as petroleum marketers do with gas and oil additives. This will be a tremendous source of revenue for private carriers and more than compensate the more successful ones for the loss of premium income due to corporate-owned health care facilities.

GOTTLIEB What do you expect to happen to the Delta dental plans?
KING My Tier III bias leads me to look upon the Delta dental plans as dentistry's mistake and I have strongly encouraged the profession to suspend its occasionally heroic efforts to resuscitate this moribund concept. Our data suggest that over the next five to ten years, the Delta programs will not be commercially viable in Tier I and Tier II environments. So, the advent of Tier I and Tier II effectively marks the beginning of the end for Delta in this segment of the market. It is already clear that the philosophy of Delta is totally incongruent with Tier III dentistry. You cannot have "usual and customary" community standards applied to unusual, not customary quality of care. Even the staunchest defender of the Delta concept will be forced by economic circumstances to reevaluate his position within the next few years. I am delighted to see this happening, but regret that it is not happening as a result of intentional action by the dental profession.

GOTTLIEB Do you see a national health plan in the near future?
KING I have not seen any evidence in our modeling studies which gives me reason to anticipate any comprehensive national health plan at least for the next 5-6 years. There are many reasons for that, primary among them is that nobody wants to be president when the Social Security system goes bankrupt and the federal government, whatever party is in power, has all it can do to keep Social Security afloat. I do think we will see some medical catastrophe insurance and I do think we will see an expansion of dental care for indigents, perhaps within a national health corps. I also anticipate that there will probably be an expansion of certain school dentistry programs in the primary grades, centered on topical fluoride, flossing and nutrition instruction. But we don't see any national health program in the next six years or so.

GOTTLIEB How does orthodontics fit into the concept of holistic health care?
KING Very much so. Holistic health care, as I understand it, involves one's evolving sense of body wholeness and that is what orthodontics is concerned with. If I come to your office with a gross deformity or feeling grossly deformed, that is one kind of a problem. But my guess is that most people who

come to an orthodontic office, adolescents as well as adults, do not have that bad a tooth problem and what you are dealing with is a sense of body integrity, a sense of perfection. That's an evolving idea and cannot be separated from stress control, from nutrition, from all other aspects of health. Tier III is focused on what can be, not what is. On health, not disease. Any person who has had a successful experience with nutrition or physical fitness or biofeedback or natural childbirth has learned about self-responsibility in the achievement of health. Such a person is seeking, potentially, a holistic dental practice.

GOTTLIEB I am wondering about the fragmentation of this idea of holistic care. Does it work with the dentist having one aspect of preventive care, including restorative and preventive, and the orthodontist having his responsibilities? They frequently might be working at cross purposes.

KING We are talking very much about the future and no one has been to the future. We are going to have to learn together. My thinking is that the Tier III orthodontist and the Tier III dentist, by reason of their own maturity and commitments, are going to have much higher communication skills and much more willingness to communicate with each other. I think they will integrate their respective services — probably in a highly individualized way.

GOTTLIEB Will it be a satisfactory enough conception of orthodontics to straighten teeth? If the orthodontist views himself simply as a tooth straightener do you think he can be replaced?

KING He will be replaced by another tooth straightener who works in a different kind of delivery system. Surely.

GOTTLIEB How should the orthodontist be viewing his job in the future?

KING He has to regard himself as being behaviorally adept, at least in Tier III. He will be contributing to a sense of body wholeness in a sense larger than just dental. I am not suggesting that he needs to be a consulting psychologist. I'm simply saying he needs to have a deep feeling for the needs of people and to be able to respond appropriately to those needs. I think that the orthodontist will increasingly be concerned with other related health services, nutrition for example. Eating well isn't going to straighten teeth or keep them straight, but the fact is that an involvement with orthodontics has significance that goes beyond occlusal considerations. Relative to personal growth, orthodontics is, potentially, a peak experience, a global experience.

GOTTLIEB All of this is coming along at a time when the population statistics are in a state of flux as well.

KING The numbers are interesting and provocative. But I am more challenged by the cultural attitudes which surround these numbers. In a male-dominated profession which is heavily dependent upon female staff members for economic success, these attitudes are surely pertinent. The mindset of Mommies, historically the key parent in an orthodontic relationship with a child, is rapidly deviating from the traditionally expected, male-perceived norms. We know, of course, that fewer children are being born. That the average age at which a woman conceives her first child has risen nearly 4.5 years over the last quarter-century. That the size of families has shrunk significantly. That we are witnessing massive population shifts from the Northeast and Midwest to the South,

West and Northwest. That central city urban living is being revitalized at precisely the time we are able to document heavy population flow into small towns and rural areas. That American culture is rapidly developing *new* characteristics which are being derived from the *new* value systems of a burgeoning over-age population.

These trendlines are quantifiable, and many of their consequences are already socially indelible. But demographics, a statistical science, must be interpreted within an attitudinal frame of reference. *There are shifts in how we perceive qualities of life which are at least as important as what we can measure by our nose-counting techniques*. For example, cultural attitudes toward what constitutes health. Or the new insistence of more and more people that the individual can influence his or her biological destiny. The ways in which females are seeing themselves and, therefore, the ways in which females are seeing others and the world which contains the human family. Consider just one expression of the emancipation — the attitude of women toward work. The reasons why women work are becoming less and less confined to economic necessity and more and more related to fulfillment, recognition, and personal autonomy. Last year, nearly 40% of married women whose mates earned more than $30,000 a year were employed for more than 1,000 hours during the year. In 1979, females purchased six billion dollars of automobiles on their own credit. Between 1974 and 1979, United Arlines saw the number of female passengers rise from 4% of the total to nearly 20%. During the same period, female American Express cardholders increased from 750,000 to 3,000,000. The insurance industry found that 40% of the non-group new life policies issued during these five years were on the lives of females. Etc, etc, etc.

Let me say it this way. Counting noses is important, but incomplete. The orthodontist has an urgent need to become an astute observer of the culture. Otherwise, the numeric calculations are mindless impediments rather than useful stepping-stones.

GOTTLIEB This is especially true in light of the growing number of adult orthodontic patients.

KING We have some preliminary data about adult orthodontic patients. They tend to go into orthodontics because they have reached, or are reaching for, a new level of self acceptance. Show me an adult orthodontic patient and I will show you someone who slightly before or slightly after the beginning of orthodontic therapy has become involved in all kinds of other activities. The adult enters your practice and says, "You know it may sound silly, but I've been bothered by this ever since I was 14 and now I want something done about it." Almost without exception, no adult begins orthodontic therapy in isolation. That decision either is a consequence of other decisions or is prompting the making of other decisions, and these decisions together have a spiritual union that relates very much to a holistic concept of health. I deeply believe, by the way, and this has nothing to do with birth rates, that adult orthodontics has got to be one of the great, exciting growth areas for your specialty. Not because of the fact that there are not as many children around any more, but because adult orthodontics involves a truly voluntary decision by an economically self-determining individual to accept a purely discretionary service. The opportunity for satisfaction on the part of the client as well as on the part of the orthodontist and staff is overwhelming. □