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the editor's corner

Dentists in many parts of the country are actively seeking to reverse a recent trend toward permitting dental auxiliaries to perform expanded duties under various shades of supervision by a dentist. The impetus for this action is apparently the fear that less well-trained people will assume the tasks traditionally reserved for professionally trained people, especially in large closed-panel clinics and in independently operated auxiliary practices. This is not an unreasonable fear, considering the speed with which such facilities are coming to pass.

Various government agencies have expressed a similar thought — that the use of expanded duty auxiliaries is part of the solution to the limited distribution of dental care; the limited availability of dentists; the "high cost" of dentistry; the barriers to entry into the dental profession posed by licensure laws which have high educational requirements and limit access to practice dentistry in various states. These agencies have called for changes in state dental practice acts to greatly expand the duties permitted to auxiliaries.

Orthodontists were among the first to favor the use of expanded duty auxiliaries and, in many states, sponsored changes in the dental practice acts to broaden the permissable duties of auxiliaries. This action was taken in the face of large numbers of child patients and relatively small numbers of orthodontists. It was a move that was aimed at increasing the orthodontist's productivity. It was accompanied by a side effect which kept ortho-

dontic fees at relatively low levels for a long period of time. A consequence of this has been that, as the child population has declined and as the increase in adult patients in the average orthodontic practice has been relatively slow, the size of orthodontic fees plus reasonable fee increases have not been able to maintain the orthodontist's purchasing power.

Most orthodontists probably need the use of expanded duty auxiliaries, along with measures to reverse the trend of decline of numbers of patient starts in the average practice, in order to maintain or restore productivity. The consequence of limiting the use of auxiliaries in orthodontic practice, either by law or by orthodontist inclination, is to limit the orthodontist's income or potential income. One orthodontist with one pair of hands has limitations placed on the number of patient starts he can handle, even if plenty of patients were available to him. This is demonstrated in practices in states which still have very restrictive regulations with regard to dental auxiliaries and in which the orthodontist observes the letter of the law. This may well have contributed to the figure that showed up in the AAO survey of orthodontists, that the average orthodontist would feel comfortable starting 128 cases a year. If that is about the limit that one lightly aided orthodontist could start, it is not strictly relevant to the question, that the average orthodontist is not now starting that many cases.

The problem for orthodontists lies in the fixing of the limit at any relatively low level. That means that the orthodontist has only two mechanisms with which to try to keep up with growing inflation and increasing costs and that would be in raising fees and lowering practice costs. Since lowering practice costs is not, on the average, an effective way to cope with the problem and since most orthodontists cannot raise fees annually to keep up with the level of inflation and increased costs that we have been experiencing, somewhere along the line, sooner or later, it has to catch up with him.

The Department of Health, Education, and Welfare (now divided into the Department of Health and Human Services and the Department of Education) has had a problem estimating the future use of dental auxiliaries. In one report it is predicted that there will be less use of auxiliaries, for economic reasons, and that dentists will be doing more of the tasks and working longer hours. On the other hand, HEW has expressed the expectation and supported the concept that there will have to be greatly expanded use of dental auxiliaries. No doubt we will see both of these happening, depending on location and the nature of individual practices. It would be surprising if there were an about-face on the question of expanded duty auxiliaries and measures taken to reverse the recent liberalizing trend and revert to severe limitation of auxiliary duties.

While continuation of expanded duty auxiliaries is presently favorable for most orthodontic practices, it would be unwise to ignore the possibility that, somewhere down the road, we may be faced with intrusion into the traditional structure of orthodontic practice of a call for independent orthodontic auxiliary practice, as we are now seeing the implementation of independent auxiliary practice changing the nature of general dental practices with independent practice by denturists, by hygienists and expanded duty auxiliaries in preventive practice, and a call for the independent practice of EDDAs in operative dentistry. □