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Women: The Changing Face of Dentistry
An introduction to the issue.
Debra S. Finney, RDH, MS, DDS, and Cindy Lyon, RDH, DDS, EdD

California Women in Dentistry: A Look Back
This manuscript offers a profile of a diverse selection of female dentists from California with different professional career paths.
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This manuscript discusses the history and data that appear to support the notion of a developing pipeline toward greater numbers and strength of women in dental education.
Cindy Lyon, RDH, DDS, EdD, and Jessie Vallee, DDS

Does California Project the Future of Dentistry?
This commentary discusses how the majority of U.S. dental students will soon be women and examines gender differences in the labor supply of dentists.
Marko Vujicic, PhD; Bradley Munson, BA; and Brittany Harrison, MA

Women in the Boardroom: Reflecting the Changing Gender Demographics of Dentists
This article discusses that while more women are in the workplace today, there are still relatively few women who hold leadership positions. Interjected throughout are the perspectives of one young female leader.
Natasha Anne Lee, DDS, with personal experiences from Irene Marron-Tarrazzi, DMD, MS
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Some Things Change

Kerry K. Carney, DDS, CDE

n the 19th century, Jean-Baptiste Alphonse Karr was the editor of Le Figaro. He was also a cynic. You can argue whether cynics make good editors or good editors become cynics. (Just as you can argue whether obsessive-compulsive behavior makes for good dentists or good dentists become obsessive compulsive … I digress.)

Karr was an editor and a cynic. His famous quote, “plus ça change, plus c’est la même chose,” is usually translated as “the more things change the more they stay the same.” It is a good epigram, but its applicability depends on the frame of reference.

If your frame is close in on the individual, a change may seem very pronounced. But if you zoom back out, the change may be drowned out by mitigating factors.

In 1920, the United States federal government granted women the right to vote. Zoom in and universal suffrage was a huge change for women. It was public recognition that they had the intellect to make decisions and the public presence to deserve respect. However, zoom out and adding women to the electorate has not changed the tenor of political campaigns.

The presidential election of 1800 and that of 2016 are not dissimilar. In both elections, each side believed that the election of the other would mean the ruination of the country. One newspaper proclaimed that the election of Jefferson would mean that “murder, robbery, rape, adultery and incest … [would be] openly taught and practiced, the air will be rent with the cries of the distressed, the soil will be soaked with blood and the nation black with crimes.”1 Jefferson was attacked as an infidel who had no respect for the beliefs of Christians.

Adams was attacked from within his party by Hamilton, who described Adams as having “great, intrinsic defects” in his character.2 He was attacked by the opposing Jeffersonian Republicans who were spreading rumors of a plan by Adams to establish an American dynasty by marrying one of his sons to a daughter of George III. Plots, intrigue and betrayals resulted in an election that Congress eventually decided for Jefferson after 35 tie votes with Aaron Burr.

This year’s campaign was just as nasty and vile as the one in 1800. The inclusion of women in the electorate has made no difference; the uncivil level of campaign discourse has stayed the same. Though some things may stay the same, there is no progress without change. One would think that we could agree that progress is good, but even progress has its detractors. Ogden Nash said, “Progress might have been all right once, but it has gone on too long.”3 We get tired of having to progress, always having to stay on top of new regulations and new demands, always moving forward. The past always seems like it was simpler, easier, less taxing, predictable. It is easy to look back and think that some earlier time was better. The sepia tones of our recollection lend nostalgia to images of the past.

Despite Mark Twain’s position that he was in favor of progress, it was change he didn’t like. Change is a constant. It is inescapable and though not always comfortable, it is not necessarily bad. Change can happen on any level. Change can be trivial or fundamental.

Increasing ethnic diversity and the feminization of the profession will not distort the underlying, fundamental relation between the doctor and patient.
out and the change in child-rearing practices reflects a change in societal norms, an increased value placed on that time devoted to parenting, especially by fathers. It is hard to see how such a change could be bad for anyone. It reflects progress by reinforcing the underlying importance of the parent-child relationship and increasing flexibility in a father’s child-rearing role.

But change is hard. It does not occur in a vacuum, and it does not usually happen spontaneously without some impetus.

The demographics of dentistry are changing. A profession that was predominately male and white has been slowly morphing in ethnic diversity and gender. In the last 15 years, the practicing women dentists’ share of the U.S. practicing dentists market increased from 16 to 28.9 percent. The number of women graduating from dental school continues to climb. This feminization of the profession may lead to changes that increase creativity and flexibility in the practice. Some of these changes may be used by both male and female dentists to improve the life-work balance.

At the close-up level, we may see changes in practice models and changes in the dental career trajectory. We may see changes in modes of care and in the use of technology to facilitate different practice modalities. All these changes may help both male and female dentists have professional lives that are fulfilling, successful and well integrated into a healthy personal life.

While all these changes may occur, the most important element in the dental profession will remain unchanged. Zoom out and we will still see the doctor-patient relationship as the most important factor in the calculus of dentistry. Increasing ethnic diversity and the feminization of the profession will not distort the underlying, fundamental relation between the doctor and patient. That relationship will continue to be based on trust and the duty of care. That doctor-patient relationship will stay the same: Plus ça change, plus c’est la même chose.

REFERENCES

The Journal welcomes letters
We reserve the right to edit all communications. Letters should discuss an item published in the Journal within the last two months or matters of general interest to our readership. Letters must be no more than 500 words and cite no more than five references. No illustrations will be accepted. Letters should be submitted at editorialmanager.com/jcaldentassoc. By sending the letter, the author certifies that neither the letter nor one with substantially similar content under the writer’s authorship has been published or is being considered for publication elsewhere, and the author acknowledges and agrees that the letter and all rights with regard to the letter become the property of CDA.
The October 2016 Journal, Sugar in the Spotlight, had several great articles about sugar in the relationship to fatty liver disease, type 2 diabetes, soda taxes and label warnings. However, essentially nothing was said about sugar’s role in dental caries or the prevention of dental caries. Most adults know that sugar causes decay, but for most people, their ideas of prevention are very limited. Prevention of dental caries is challenging, but diet modifications can have a tremendous effect.

Because sugar will not be eliminated from our society, what should patients be aware of for the prevention of dental decay? While oral hygiene is important for oral health, we as dentists must also emphasize how diet affects the process of caries disease. As a pediatric dentist, I always stress three variables: frequency of sugar exposure, food consistency and timing of food intake.

For exposure frequency, I use Life Savers candy as an example. If you eat one piece of candy, acid will be produced for about 30 minutes; if you eat the whole pack at once, acid will still be only produced for 30 minutes. However, if you eat the whole pack throughout the day, acid will be produced for about five hours. Reducing the frequency of sugary foods is very important.

With food consistency, sticky foods can stay on teeth for a prolonged time and acid is continually produced. Dried fruits, such as raisins, stick to the teeth and acid is produced. Avoid sticky foods.

For the timing of food intake, not eating before bedtime can be tremendously valuable. We stop salivating during sleep, and decay-causing food left on the teeth at bedtime will produce acid for a prolonged period. Never eat before bedtime.

Another great prevention means is the opposite of not having food on teeth before sleep, i.e., having fluoridated toothpaste on the teeth during sleep. The last thing to touch teeth before bedtime should be a toothbrush with a fluoridated toothpaste (different amounts for different ages). Tell children to expectorate, but not to rinse with water after brushing. If children start this practice at a young age, it could continue for life.

This excellent issue discusses the purpose and means of reducing the volume of sugar intake. If we as dentists could reduce the frequency of sugar, we would have the added benefit of reducing the total sugar volume intake and promoting health.

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The nub:
1. Meaningful work can be divided into isolated and perfectible tasks and (sometimes) reassembled into efficient wholes.
2. Efficiency is not effectiveness.
3. Defining dentistry in technical terms may damage it.

David W. Chambers, EdM, MBA, PhD, is professor of dental education at the University of the Pacific, Arthur A. Dugoni School of Dentistry, San Francisco, and editor of the American College of Dentists.

The Well-Taylored Dentist

David W. Chambers, EdM, MBA, PhD

Every MBA student learns about Frederick Winslow Taylor, although he is no longer held in great respect 100 years after his heyday. Taylor wrote the book on how to get the most out of workers. It was titled *Principles of Scientific Management*.

The Industrial Revolution had only gone so far in standardizing interchangeable parts in the assembly-line process. It was Taylor’s contribution to standardize the worker. Taylor was the original “time and motion” guy. Famously, he determined the ideal size and shape of a shovel to maximize the amount of coal a worker could move in an hour. It has taken the health professions years to catch on to the notion. Until the professions caught on recently, consultants did well pointing out “best practices” one office at a time.

Taylor would have approved of CDT codes but been uneasy about the concept of oral health. The job of the boss was to discover which products sell at the greatest margin, break tasks into components and optimize them, move each task to the lowest paid worker possible and market and perhaps resell the package.

One can certainly imagine that Frederick Taylor would endorse corporate dental practice — but not the idea of a dentist or group of dentists contracting with a DSO to handle the backroom tasks of payroll, billing, compliance with regulations and the like. Taylor would have favored the corporate model with nondentist equity interests that treat professionals as production units.

Owner-managers of corporate practices have insisted that they do not interfere with technical dental work. That is correct. They make a good case for demanding technical acceptability of all work performed by employee dentists. But, dentistry is more than technical procedures, no matter how well done. Decisions such as which procedures are rewarded, what equipment and staff are available for various procedures, where practices are located and what hours they are open, and comprehensive care from a dentist who has a long-term relationship with patients are all part of dentistry, even though they are not “technical” in nature.

The true battle developing in dentistry is over whether dental care can be defined in isolated technical segments. I agree with William Sullivan of the Carnegie Foundation that the gradual death we are witnessing across all professions is due in significant part to the professions defining themselves in strictly technical terms rather than patient service.

The term “scientific management” was not coined by Frederick Taylor. He borrowed it for the title of his book. The first use was made by Supreme Court Justice Louis Brandies in his ruling on the Eastern Rate Case in 1910. The unions were suing the railroads that were pulling in large profits by repackaging the work of employees into commercial bundles of isolated technical units. Brandies ruled that, that was nothing but good “scientific management.”
Older Adults Affected by Gene Mutations When Taking Multiple Medications

Older adults who take multiple medications, also known as polypharmacy, may have increased hospitalizations because of gene mutations affecting drug metabolism, according to a recent study published in *Pharmacogenetics and Personalized Medicine*. Researchers at the Center for Bioinformatics and Data Analytics in Oral Health at the Columbia University College of Dental Medicine carried out pharmacogenetic testing on six older adults who went to the hospital a minimum of three times in the last two years and six older adults who had gone less frequently. The average age of the adults was 77 and they were taking approximately 14 medications. What they found was that in “the higher hospitalization group, each of the participants had at least one of the mutations and half had more than one. None of the controls had any of the mutations.”

Joseph Finkelstein, MD, PhD, is director of the Center for Bioinformatics and Data Analytics in Oral Health at the Columbia University College of Dental Medicine, associate professor of health informatics in dentistry at Columbia University Medical Center and lead author of the paper.

“Although this was a very small pilot study, the findings suggest that routine testing for these gene variants could improve health outcomes for older adults taking multiple medications,” Finkelstein said. “In dentistry, for example, pharmacogenetic testing could be part of a personalized approach in which clinicians select pain medications that are most effective and least risky for each patient.”

The result isn’t conclusive, however, because of the small sample size. The study’s abstract elaborates on this.

“The pilot data supported the hypothesis that pharmacogenetic polymorphism may represent an independent risk factor for frequent hospitalizations in older adults with polypharmacy. Due to small sample size, the results of this proof-of-concept study cannot be conclusive. Further work on the utility of pharmacogenetic testing for optimization of medication regimens in this vulnerable group of older adults is warranted,” the abstract stated.

A press release about the study states that nearly 40 percent of Americans who are over the age of 65 take at least five or more medications. Not many studies have been performed to analyze the individual genetic risk factors for adverse events related to drugs in this specific population.

For more information, visit jct.sagepub.com.

Behavioral Therapy Resource Tested for Children’s Dental Anxiety

A new, guided self-help cognitive behavioral therapy resource has proved to reduce dental anxiety in children, according to a study conducted by the International and American Associations for Dental Research (IADR/AADR). Details of the therapy were recently published in the article titled “Development and Testing of a Cognitive Behavioral Therapy Resource for Children’s Dental Anxiety” in *JDR Clinical & Translational Research*. Researchers at Sheffield Hallam University studied children between the ages of 9 and 16 by utilizing a mixed “methods design where within phase one, a qualitative ‘person-based’ approach informed the development of the self-help CBT resource. Guidelines for the development and evaluation of complex interventions were also used. Within phase two, children ages 9 to 16 who had elevated self-reported dental anxiety and were attending a community dental service or dental hospital were invited to use the CBT resource,” according to a press release.

The children studied also filled out questionnaires assessing their anxiety and health-related quality of life before and after using the resource. A total of 85 children were invited to participate and 48 completed it.

“Having launched this year, *JDR Clinical & Translational Research* provides a unique opportunity for oral health research leaders to publish their research and effectively translate their findings to those who need the information to deliver evidence-based prevention and care,” said Jukka Meurman, president of IADR. “On behalf of the International Association for Dental Research, I am pleased that the authors of this study contributed their research to this publication.”

For more information, visit jct.sagepub.com.
A new study shows that dental sealant programs in schools are a cost-effective way to protect at-risk children from tooth decay. The study, titled “Evaluation of School-Based Dental Sealant Programs: An Updated Community Guide Systematic Economic Review,” is slated to be published in the American Journal of Preventive Medicine this spring. Researchers from Kennesaw State University in partnership with the Centers for Disease Control and Prevention Division of Oral Health studied the cost-effectiveness of the programs by analyzing the results in children with and without sealants and how many cavities those children experienced over a four-year period. The results found that “the cost savings from future cavities and productivity losses from parents leaving work to take their child to the dentist outweighed the costs of running school-based dental sealant programs.”

Christina Scherrer, a professor of systems and industrial engineering at Kennesaw State University and part of the research team, said the team is confident the programs are good investments of public health funds. “A dental filling for a cavity costs several times as much as a sealant, so this is a situation where the preventative sealant program could save money and avoid the pain and inconvenience of tooth decay,” Scherrer explained.

She also pointed out that school-based dental sealant programs reach many students in low socioeconomic areas with little access to dental care. “We looked at how much these sealants will save in later medical reimbursements,” Scherrer said. “Students without access to dental care may show up at an ER with tooth pain, needing a root canal or extraction, which in turn might be billed to Medicaid.”

Sealants are most effective in reducing cavities in children with newly formed permanent teeth, according to the “Sealants” resource available on cda.org. In fact, all children should have their molars evaluated for sealants soon after they erupt. For more information on the study, visit news.kennesaw.edu.

Some medications aid in the integration of dental implants, according to a new study at the McGill Faculty of Dentistry. The researchers analyzed data on dental plant integration from more than 700 patients operated on between 2007 and 2015. Results were then confirmed on rats.

Professor Faleh Tamimi teaches in the McGill Faculty of Dentistry and is the senior author on several papers on the subject. “Because some medications affect bone metabolism and the way that bone cells heal and multiply or die, they can have an important effect on the success of implants,” Tamimi said.

The study concluded that drugs that aid integration of implants are beta blockers and drugs that impeded integration of dental implants include heartburn treatments. The study’s abstract states, “Propranolol-treated rats presented smaller cortical defects with more bone volume/tissue volume compared to saline-treated rats. Propranolol also enhanced osseointegration as propranolol-treated rats presented higher bone-implant-contact and peri-implant bone volume/tissue volume than saline-treated rats.”

Tamimi said scientists already knew that drugs for heartburn reduce calcium absorption in bones and increase the risk of bone fractures and that is why the researchers wanted to examine how it affects the integration of implants and bone healing after this type of surgery. “But we didn’t expect to find that the negative effects of these type of drugs would be as great as they are. Further work will need to be done to find the appropriate dosages and time periods that people should take or avoid these medications,” Tamimi said.

For more information on the study, view the abstract at onlinelibrary.wiley.com.
Cellulose Nanocrystals ‘Offer Promising Approach for Bone Regeneration’

A new way to restore sufficient bone volume may have been discovered by researchers at the National Institute of Standards and Technology (NIST). Researchers, through an agreement with the National Institute of Dental and Craniofacial Research of the National Institutes of Health, looked into a model using cellulose nanocrystals to regrow bone. What they found was the ability to “disperse the nanocrystals in scaffolds for dental regenerative medicine purposes.”

Martin Chiang is the team leader for NIST’s Biomaterials for Oral Health Project. “When we cultivated cells on the cellulose nanocrystal-based scaffolds, preliminary results showed remarkable potential of the scaffolds for both their mechanical properties and the biological response. This suggests that scaffolds with appropriate cellulose nanocrystal concentrations are a promising approach for bone regeneration,” Chiang said.

The cellulose nanocrystals model was developed at American University by Douglas M. Fox, an associate professor of chemistry at American University who has submitted a patent for his work. The method involves a “simple, scalable method to improve their performance.” That method, according to an abstract of the study, goes like this: “By using an ion exchange process to replace Na+ with imidazolium or phosphonium cations, the surface energy is altered, the thermal stability is increased.”

“Plastics are currently reinforced with fillers made of steel, carbon, Kevlar or glass. There is an increasing demand in manufacturing for sustainable materials that are lightweight and strong to replace these fillers,” Fox said. “Cellulose nanocrystals are an environmentally friendly filler. If there comes a time that they’re used widely in manufacturing, cellulose nanocrystals will lessen the weight of materials, which will reduce energy.”

“Plastics are also working with the Georgia Institute of Technology and Owens Corning to study the benefits of replacing glass-reinforced plastics used in airplanes, cars and wind turbines. “As we continue to show these nanomaterials are safe and make it easier to disperse them into a variety of materials, we get closer to utilizing nature’s chemically resistant, strong and most abundant polymer in everyday products,” Fox said.


‘SWAT Team’ of Immune Cells Explained as Reason for Low Infection Rate After Cleft Lip Surgery

Low infection rates in babies following cleft lip and palate surgery has long been a mystery, but new research points to a “SWAT team of immune cells” as the reason.

In total, the lip tissues of 13 babies were examined at the Children’s Hospital of Georgia (CHOG). The study “found innate lymphoid cells, or ILCs, a type of immune cell that functions like a natural antibiotic to recognize and attack invaders like bacteria. In the average mouth, where hundreds of types of bacterium have been documented, there is plenty to target,” according to a news release.

Babak Baban, PhD, is an immunologist in the department of oral biology at The Dental College of Georgia and in the department of surgery at the Medical College of Georgia at Augusta University.

“ILCs are newly discovered as one of our immune cells, but they are really old. We had just missed them,” Baban said.

Jack Yu, MD, chief of pediatric plastic surgery at the Medical College of Georgia and director of the Craniofacial Center at CHOG, has been performing cleft lip and palate repair for almost 25 years.

“Their presence helps explain why we don’t have more surgical site infections than we do,” Yu said.

Cleft lip and palate are the most common birth anomalies and occur in about one in 700 births, according to a news release.

Researchers plan to continue comparing cell numbers in both young and old mice and the roles these cells can play in gum and other diseases.

For more information, visit eurekalert.org.

Unmodified nanocrystals clumped and turned brown (left disc). Using modified nanocrystals, there was no clumping, and the composite is nearly as transparent as the pure polymer. (Courtesy Douglas M. Fox.)
Benefits of Using Lasers in Dental Treatment Validated

The benefits of using lasers for dental problems have been validated by a new study conducted by researchers at the New York Institute of Technology. The objective of the study was to “define the laser parameters that optimize pathogen destruction and depth of the bactericidal effect.” The study, using computer simulations, found that diode lasers can kill off bacteria buried 3 mm in the soft tissue of gums. In addition, the lasers limited the amount of heating of the tissue around the gum, which helps the area heal more quickly. Three different types of lasers were utilized and two types of bacteria colonies were studied.

Lou Reinisch, PhD, is associate provost for academic affairs at New York Institute of Technology and co-author of the study. “The findings are important because it opens up the possibility of tweaking the wavelength, power and pulse duration to be the most effective for killing bacteria,” Reinisch said. “The doctors will look at this and say, ‘I see there is a possible benefit for my patients in using the laser.’”

David Harris is also a co-author of the study and director of Bio-Medical Consultants Inc., which specializes in medical laser product development. “When you do this treatment, you remove an infection and allow tissue to regenerate. Getting rid of the infection means the tissue can heal without interference,” Harris said. “The model is a great tool for making predictions of what can happen in the tissue. Our study confirms its use as a way to determine the most effective laser parameters to use clinically.”

Harris also noted that at least 25 percent of dental offices in the United States have the capability of utilizing lasers for periodontal treatment in accordance with their study. The authors suspect that physicians and surgeons will benefit from the research as well for procedures on vocal cords and dermatological treatments. The study, published in *Lasers in Surgery and Medicine,* includes video of the computer simulations where readers are able to view the soft tissue heat up and cool off.

For more information on the study, view the abstract at onlinelibrary.wiley.com.

Those Who Get Migraines More Likely to Have Nitrate-Reducing Microbes in Mouth

Those who suffer from migraines are more likely to have a mouth full of more microbes with the ability to modify nitrates than those who don’t get migraines, according to a University of California San Diego School of Medicine study published by *mSystems.* Researchers studied 172 oral samples and 1,996 fecal samples. The abundance of genes that encode nitrate, nitrite and nitric oxide-related enzymes in the oral samples appeared more frequently in those who experience migraines. Researchers “used a bioinformatic tool called PICRUSt to analyze which genes were likely to be present in the two different sets of samples, given the bacterial species present.”

Embiette Hyde, PhD, was one of the researchers. “We know for a fact that nitrate-reducing bacteria are found in the oral cavity,” Hyde said. “We definitely think this pathway is advantageous to cardiovascular health. We now also have a potential connection to migraines, though it remains to be seen whether these bacteria are a cause or result of migraines or are indirectly linked in some other way.”

Next steps for the researchers are to identify more defined test subjects and whittle down the types of migraines experienced. This will allow them to “determine if their oral microbes really do express those nitrate-reducing genes, measure their levels of circulating nitric oxide and see how they correlate with migraine status.”

Many of the 38 million people in the U.S. who experience migraines report a connection between consuming nitrates and bad headaches, according to a news release.

For more information, view the study’s abstract at msystems.asm.org.
Women: The Changing Face of Dentistry

Debra S. Finney, RDH, MS, DDS

Women go into dental hygiene ... honey.” Those were the crushing words I heard from my predental college advisor in 1972. I had worked in a dental office for two years before entering college and thanks to the mentoring of Dr. Aubrey Stephens, I decided that I wanted to become a dentist. At that time, dental school classes typically had only one or two women, but growing up in Alaska, that didn’t faze me. I heeded the advice of my counselor though and applied to dental hygiene programs. It would be 10 years before I met a dental school recruiter who asked me why I wasn’t in dental school and handed me an application. What a change 10 years had made! When co-editor Cindy Lyon, RDH, DDS, EdD, and I entered the University of the Pacific, Arthur A. Dugoni School of Dentistry in 1983, there were 34 women in a class of 134. Times were changing as noted by the authors of this issue. The period between 1970 and 1980 saw a nearly 20 percent increase in women entering dental school and a similar increase occurred in the following decade.¹ We are currently approaching gender equality in entering dental school classes.

Women have traditionally filled allied positions on the dental team, and it has been a challenging road for women dentists to break the mold. Brian K. Shue, DDS, CDE, and Harriet F. Seldin, DMD, MBA, CDE, in their article, “California Women in Dentistry: A Look Back,” begin in 1866 when Lucy Hobbs Taylor became the first woman to earn a dental degree. She was initially denied admission to dental school because she was a woman. Their paper chronicles the history of female pioneers and “outlaws” in dentistry with a focus on California. Don’t miss the list of references with such gems as “Women Who Wield the Forceps,” Los Angeles Herald 1897.

The challenges and accomplishments of early female dentists provide an interesting historical perspective as we project future trends. Marko Vujicic,
PhD, et al. with the ADA Health Policy Institute (HPI) have written a valuable piece compiling data on future trends in dentist labor supply and looking specifically at projections for California. As they point out, the differences in practice styles and patterns of female dentists are well documented. What is not as well understood is the effect that the increase in the number and percentage of female dentists will have on the labor supply. With women often working fewer hours than male counterparts, will an increase in the percentage of female dentists decrease the labor supply available for patient care? The authors summarize the available data and emphasize that further study is still needed. For instance, what is the public perception of female dentists and is that a factor in choosing a dentist? The dental literature is void of contributions on this and even a search of the perceptions related to women in medicine is sparse. In both dentistry and medicine, women favor certain specialties such as public health, pediatrics and obstetrics.

A recurring theme among the authors in this issue is the importance of role models and mentors. Dr. Lyon and Jessie Vallee, DDS, emphasize mentorship in their paper examining the changes to the number of women entering dental education. They address the role that a greater pipeline of women in the dental profession has had on the number of female faculty, administrators and researchers. As they point out, that “mentorship is invaluable” at every level. Perhaps even more so for women in organized dentistry, as pointed out by Carol Gomez Summerhays, DDS, and Natasha Anne Lee, DDS, in their articles relating both personal experiences and data substantiating that the number of women in leadership does not universally reflect the percentage in the profession. Irene Marron-Tarrazzi, DMD, MS, interjects her perspective as a young leader and offers tools that would be beneficial for helping new dentists succeed.

As I sit as the only female on the American Academy of Periodontology Board of Trustees, I wonder, what progress have we made to encourage and facilitate women in leadership roles? The California Dental Association in particular has made a concerted effort to diversify leadership at every level. Even with greater acceptance of women in leadership roles, it often remains challenging for women to serve due to commitments with family. Dentistry must continue efforts to change in this regard. British clergyman Willard Pollard (1828–1893) is credited with the quote, “To change is difficult. Not to change is fatal.”

As discussed by Dr. Lee in the article “Women in the Board Room: Reflecting Changing Gender Demographics of Dentists,” the changes to the dental workforce are not limited to gender but also include cultural and generational diversity. These demographics are increasingly represented in leadership across all aspects of corporate and organizational business. The ramifications of this diversity are proving to be quite valuable. For example, a publication titled “Companies with More Women Board Directors Experience Higher Financial Performance” reports “Fortune 500 companies with the highest representation of women board directors attained significantly higher financial performance, on average, than those with the lowest representation of women board directors.” The report also points out that a stronger-than-average performance was achieved by companies with three or more women on the board.

Volunteer organizations will need to consider changes in governance structure, meeting styles and even meeting physical facilities to compete for members and leaders in the future, as noted by Dr. Lee. Perhaps the most convincing sign that change is needed — an iPad app called Gender Diversity on Corporate Boards! In natural systems, as diversity increases, so does stability and resilience. Cultivating diversity, in all of its forms, is an indispensable strategic investment in the future of our profession.

REFERENCES
California Women in Dentistry: A Look Back

Brian K. Shue, DDS, CDE, and Harriet F. Seldin, DMD, MBA, CDE

ABSTRACT California’s female dentists have experienced many professional and societal challenges. Their earliest achievements and successes are examined, including their history in the early California schools of dentistry and dental societies, their service and professional practice. A diverse selection of female dentists from California with different professional career paths is profiled.

When women in the 19th century began to choose the profession of dentistry in the United States, sensational headlines and commentaries like this quote from a San Francisco newspaper were not uncommon.

“There is both a new charm and a new terror in civilization. She is the woman with the forceps.”

In writing about the history of California’s female dentists, it is important to mention earlier struggles that occurred elsewhere in the U.S. for context.

In 1866, New York-born Lucy Hobbs Taylor became the first woman to earn a dental degree. She, herself, noted that her goal to become a dentist initially “struck terror into the hearts of the community, especially the male part of it.” After a long search for a mentor who would teach a woman, she found Cincinnati dentist Samuel Wardle and gratefully served as his apprentice. Hobbs Taylor then applied to the Ohio Dental College, but it “shocked the professors” and “of course they refused” admission. She practiced first in Ohio and later Iowa, but still desired to attend dental college. To that end, Hobbs Taylor attended the American Dental Association meeting in Chicago with her supportive Iowa Dental Association, which made a “formal demand” on her behalf to the dental schools to admit her.2
In 1873, Pennsylvania’s Annie Ramborger and two female European classmates were expelled from the Pennsylvania College of Dental Surgery after completion of the first year because of complaints from a minority of the male students. The college’s board reversed this decision; Ramborger finished her education and became the first U.S. woman to earn a dental degree by taking a full curriculum. She had a successful practice in Philadelphia for many years and, in 1893, became licensed in California. Here, she practiced in Los Angeles using her married name, Annie Hammell.

Much discussion about women and dentistry occurred during this period. Some said Hobbs Taylor had “so far forgotten her womanhood” and “her place was at home, taking care of the house.” Faculty complaints about female dentists and dental students focused on physical demands and coeducational discomfort. Though female dental students might have had unsupportive professors or antagonistic classmates, many accounts showed that they ended up winning their fullest respect, honor and appreciation.

A Los Angeles newspaper heralded, “The most startling innovation is the woman dentist.” In 1870, of the nation’s 7,839 dentists, 24 (0.3 percent) were women. The U.S. Census reported the percentage of female dentists increased to 0.5 percent in 1880 and 1.9 percent in 1890. By 1900, there were 29,665 total dentists or 2.7 percent.

While the number of women in dentistry has increased dramatically in recent times, there were times in the 20th century when the percentage of female dentists actually decreased. According to U.S. Census data, the percentage of female dentists in the U.S. was 2.7 percent in 1900, stabilized at 3.2 percent in 1910 and 1920, but dropped to 1.8 percent in 1930 and to 1.5 percent in 1940. ADA statistics revealed that women represented only 1.2 percent to 1.7 percent of U.S. dentists from 1952 to 1979, respectively. The percentage would increase to 3 percent in 1982, 6 percent in 1987, 9 percent in 1991, 12 percent in 1995, 16 percent in 2000, 20 percent in 2005 and 24 percent in 2010.

The drop in the percentage of female dentists in the U.S. from the 1920s to the mid-1970s has been attributed to the closure of proprietary schools, to economic issues and to discrimination in dental school admissions policies during those years. The increase of women in dentistry that started in the mid-1970s was attributed in part to the feminist movement and nondiscrimination laws.

Women in Early California Dental Colleges

The state of California founded the University of California (UC) in 1869 and resolved, “all advantages enjoyed by men were extended to women on equal terms.” The UC established its Medical Department in 1873 and its Dental Department in 1881, both in the same building in San Francisco’s North Beach. Lucy Wanzer, MD, became its first female medical graduate in 1876. Initially denied admission by the UC, she was told: “Women did not have the intellect or stamina required to be a physician, and in no way were women able to compete with men.” Though the male students were encouraged to harass her, she eventually earned the respect of her class and the faculty.

In 1883, Maria Angelina Burch, DDS, from Pescadero, Calif., became the first woman to graduate from the UC Dental Department, which was the first dental college on the West Coast. Tuition for the full two-year program was $130 per year with an extra $30 for the diploma. At the Dental Department, Dr. Burch was a “favorite with both the faculty and her classmates, while her ambition and intelligence caused her to graduate with the highest honors.” A dental editor of the time commented about her: “It no longer looks strange to see a lady’s name among dental graduates. But we well remember when this was not so.”

This was a good beginning; however, when Dr. Burch died at the age of 27 in 1888, her fitness and stamina for the profession were questioned by some: “She was fast climbing the hill to fame and fortune; the strain, however, was too great for a weak physical frame to bear and she succumbed when all looked bright and prosperous before her.”

In 1896, five of the 52 UC Dental Department graduates were women, including Amy M. Gilbert Bowman, DDS, who stated, “As I look back on
Gilbert would marry her senior class president, Charles H. Bowman, DDS, joining one other married couple in her class. Gilbert-Bowman became the UC Dental Department’s first female staff clinician and the second woman to join the faculty of a California school of dentistry, serving from 1901–1908, as listed in the Dental Department announcements. Established in 1896, the Dental Department of the College of Physicians and Surgeons Dental Department in San Francisco. There were 43 male students in their class. Dr. Richardson joined the P&S faculty by 1905 and founded the college’s “orthodontia clinic” in 1915, the first woman in the U.S. to do so. (Photo courtesy: University of the Pacific, Arthur A. Dugoni School of Dentistry.)

FIGURE 2. Elizabeth Richardson, DDS, (first row, fourth from the right) and Rosa M. Close, DDS, (first row, third from the right). Drs. Richardson and Close were the only female students of the class of 1901 of the College of Physicians and Surgeons Dental Department in San Francisco. There were 43 male students in their class. Dr. Richardson joined the P&S faculty by 1905 and founded the college’s “orthodontia clinic” in 1915, the first woman in the U.S. to do so. (Photo courtesy: University of the Pacific, Arthur A. Dugoni School of Dentistry.)

my college course I must render homage most profound to my alma mater for the way in which her women students were treated. From the first they were received on an equal footing with their brother students and were given the same opportunity for study and work.”14 Gilbert would marry her senior class president, Charles H. Bowman, DDS, joining one other married couple in her class. Gilbert-Bowman became the UC Dental Department’s first female staff clinician and the second woman to join the faculty of a California school of dentistry, serving from 1901–1908, as listed in the Dental Department announcements.

In 1915, she founded the school’s “Orthodontia Clinic” — the first female dentist to do so in the country — and by 1918, it had 10 dental chairs and was one of the world’s largest. The clinic also provided free care to underprivileged children one day a week. Richardson’s title was professor of orthodontia and she was chief of clinic until she passed away in 1936.18

Women Invited to Join the Organized Profession

Lucy Hobbs Taylor, the first woman to graduate from a school of dentistry, joined the Iowa Dental Society by invitation of its president, L.C. Ingersol, in July 1865, and “it is believed that this was the first instance of a woman entering as a member of a state dental society.”21 Hobbs Taylor met “grand, just men” in her dental society, “the bylaws were changed to meet the case, and the woman dentist was made a member of the association.”22

FIGURE 3. San Francisco’s Frances C. Treadwell advertised in publications as “the pioneer lady dentist of the United States.” In 1865, she was the first woman to join a dental society, even before Lucy Hobbs Taylor. (Photo: Master Hands in the Affairs of the Pacific Coast, 1892.)

FIGURE 3. San Francisco’s Frances C. Treadwell advertised in publications as “the pioneer lady dentist of the United States.” In 1865, she was the first woman to join a dental society, even before Lucy Hobbs Taylor. (Photo: Master Hands in the Affairs of the Pacific Coast, 1892.)
Preceding Hobbs Taylor by just a few months, Frances C. Treadwell became the very first woman elected to membership in a dental society just two months earlier (FIGURE 3). The official proceedings of the Delaware Dental Association reported a “Dr. Treadwell of Delaware City” joined on Wednesday, May 10, 1865.22 Another source stated a “Frances Treadwell” joined shortly after the association organized in 1863.23 Treadwell, who practiced in Smyrna, Del., in 1858 and “next went to Delaware City, where she remained until 1868,”23 was not welcomed with open arms. “If a thunderbolt had fallen in their midst it would scarce have caused more excitement,” she recalled, as the members shouted, “Put her out,” and “We want no she-dentists here.” Delaware secretary W .G.A. Bonwill and visiting icon J. Foster Flagg “took it upon themselves to invite the woman in. With two sponsors, the sentiments changed. A few shrugged their shoulders but the majority gave her a cordial welcome. One can hardly believe such a thing possible — that a body of intelligent men who had met together for the interchange of knowledge could have been so prejudiced.”16

Pioneer and Suffragette
Frances Treadwell moved to San Francisco in 1889 for health reasons. In California, she advertised in various publications as the “first woman to enter the profession of dentistry” and as the “Pioneer Lady in Dentistry”24,25,26 Although Connecticut’s Emeline Roberts Jones has been recorded as the first woman to practice the profession of dentistry beginning in 1859,2 Treadwell started practicing no later than 1854 — facts seemingly supporting her claim.27,28,29,30

Treadwell also belonged to a San Francisco suffrage organization. A person not just of courage, but also of wit, she spoke to her group in 1896:

“If a thunderbolt had fallen in their midst it would scarce have caused more excitement,” she recalled, as the members shouted, “Put her out,” and “We want no she-dentists here.”

Early Licensure
The State of California first regulated dentistry with the Act of March 12, 1885, later called the Dental Practice Act. Dentists were required to obtain a certificate to practice their profession from the newly created Board of Dental Examiners. There were three different ways to get a certificate: by presenting a diploma from a reputable dental college; by passing a four-day clinical and written dental board examination; or for a limited time, by the “grandfather clause” — just simply stating under oath that one was an existing “practitioner of dentistry” in California as of March 12, 1885. The registration fee was $1.31

Fuellgraff, DDS, was the first woman to graduate from the University of Michigan Dental College and the 14th woman to graduate from a U.S. dental college.1 Interestingly, only three of these first 14 female dental school graduates were from the U.S.; the rest were from Europe and Russia. It was believed Fuellgraff returned to Germany after graduation. However, based on her diploma from a reputable college, she received a certificate to practice in California in 1889 with Los Angeles as her registered place of practice.4

Early Dental Societies in California
In 1884, Maria A. Burch, DDS, was the first woman elected as an officer of the newly created California State Odontological Society (CSOS). She also was the first woman to give a scientific presentation to the same. This new group required a diploma in dentistry or medicine for full membership and had 49 active members by 1885. The CSOS was established by the first UC Dental Department dean, Samuel W. Dennis, MD, DDS, who served as Burch’s preceptor at the college. Burch’s speech “Development and Growth of the Jaw” was accepted by the society as a “valuable contribution.”4 She served as librarian and curator and was re-elected to the same position in 1885.15

“Two decades ago, the idea of a woman leading a professional life was deemed absurd. A female lawyer, preacher or physician was looked upon as a candidate for the museum. Today she engages in all these branches of higher labor and has conclusively demonstrated to the male element that, although the gray matter of his cerebral organ may excel in quantity, when it comes to quality the weaker sex makes good the deficit.”31

The following week, her group co-hosted an event with guest Susan B. Anthony. California gave women the right to vote in 1911 and the 19th Amendment granted the same across the country in 1920.
The 125-member strong California State Dental Association, CSDA, a precursor to today’s California Dental Association (CDA), welcomed female members for the first time in 1895 at its annual meeting. The year before, the CSDA Board of Trustees granted membership to San Quentin’s Carolyn M. McElroy, DDS, a graduate of the University of Michigan Dental College in 1890.16 Philadelphia Dental College 1887 graduate Marion Ward Craig, DDS, from Oakland, was also elected during the course of this 25th annual meeting held in San Francisco.37 CSDA President Luther A. Teague announced their two names “as the first lady members of the association, and the present meeting the first to enjoy their presence.”38 McElroy gave a scientific presentation to the meeting, the first woman to give a scientific presentation to the CSDA. Her speech was titled “Treatment of Pulpless Teeth.”41 Read served as the first woman president of the San Diego County Dental Society (SDCDS) in 1895 and was subsequently elected component president a record four additional terms in 1897, 1901, 1902 and 1912.42 Read gave the opening address at the first annual meeting of the SCSDA. She was one of the handful of Southern Californians with dual membership, belonging also to the Northern California-centric CSDA. In 1896, she was the second woman to give a scientific presentation to the CSDA. Her speech was titled “Treatment of Pulpless Teeth.”41 Read served as the first female elected officer.40 Read, DDS, as second vice president — CDA’s first female elected officer.40 Read served as the first female president. In 2015, San Diego’s School of Dentistry graduate, as its first female president. In 2015, San Diego’s School of Dentistry graduate, as its first

**Frances Treadwell, the “pioneer lady in dentistry,” appeared in the official group photo. However, she did not become a member and is not even mentioned in the minutes.**

The increased numbers of female dentists in California have been reflected to some degree in their roles in the profession and in the larger community. According to Jay Newton-Small, author of *Broad Influence: How Women Are Changing the Way America Works*, a critical mass of women, usually 20 to 30 percent, can change an institution. Newton-Small states that the differences in many areas of life depend on the percentage of women “at the table.” This ranges from the “token” woman, such as the years when there was often only one woman in a dental school class, to current trends, where a large percentage of women, a critical mass, is present and able to fully participate in decision making.46

The number of female dentists in the U.S. increased more than sevenfold from 1979 to 1995. The public image of the dentist as male was changing. By 2015, women comprised almost three of every 10 practicing dentists. It is predicted that by 2035, women will represent 45 percent of the U.S. dentist workforce.47

**“Critical Mass” — The Image and the Reality**

An article in the 1986 *Journal of the American Dental Association* predicted the percentage of female dental students would stabilize at 25 percent.42 Women made up 28.9 percent of professionally active dentists in 2015, according to the ADA’s Health Policy Institute.9 In 2015, a full 48 percent of dental school graduates were women44 compared to 44.3 percent in 2008.45

The Southern California State Dental Association, the other precursor to today’s CDA, was founded in 1898. (SCSDA and CSDA would unite in 1973 to form CDA). In 1899, the 90-member strong SCSDA elected San Diego’s Emma T. Tredwell (sic), F.C., San Francisco,” appeared in the official group photo. However, she did not become a member and is not even mentioned in the minutes. This may have been due to her “outlaw” status. Although Tredwell worked in plain sight in San Francisco and once had an office located in the San Francisco Supreme Court Building, she never obtained the required certificate to practice dentistry in California. In fact, she was one of 57 “illegal practitioners” listed in the 1896 Board of Dental Examiners report, as “Tredwell (sic), F.C., San Francisco,” and subject to a maximum penalty of up to six months in jail if caught.4

Although the achievements by these female dental leaders at the close of the 19th century looked promising, they did not lead to many leadership opportunities for women in California’s dental societies. A survey found the first woman to have served on the CDA Board of Trustees was Marlene M. Schultz, DDS, from the Western Los Angeles Dental Society in 1977, with only six women serving as president of a component dental society in California between 1895 and 1990.43 That would significantly change, with 108 women serving as local component presidents from 1990 to 2011.

**The Latest Accomplishments in Organized Dentistry**

In 2003, after 133 years of existence, the California Dental Association installed Sacramento’s Debra S. Finney, RDH, MS, DDS, a 1986 University of the Pacific School, Arthur A. Dugoni School of Dentistry graduate, as its first female president. In 2015, San Diego’s
Carol Gomez Summerhays, DDS, a 1978 graduate of the Herman Ostrow School of Dentistry of USC and 2008–2009 CDA president, became the first female ADA president from California.

California’s female dentists have faced challenge and sometimes adversity. They have also captured opportunities and paved the way. We can look back favorably upon the accomplishments of these early practitioners who helped shape today’s dental practice landscape.

Over a century ago, in 1909, Amy Gilbert Bowman, in her remarks to the Los Angeles Dental Society titled “Women in Dentistry,” shared optimism for her place in the world and in her chosen profession. “Personally I feel that it is not only good to be a woman,” she concluded, “but very good to be a woman dentist.”16 Although much has changed in intervening years, the same might be said today by the growing number of women proudly joining our profession.

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THE CORRESPONDING AUTHOR, Brian K. Shue, DDS, CDE, can be reached at brians@cdsdp.org.
Female Leaders Essential to Organized Dentistry

Carol Gomez Summerhays, DDS

There can’t be two female presidents in a row.

That’s something I heard more than a few times during my campaign to become the 152nd president of the American Dental Association, following Maxine Feinberg, DDS, the 151st ADA president. Funny … I never heard this about two men in a row or even 127 in a row (the longest streak). Why would it be so different to have two women in a row?

Geraldine Morrow, DDS, made history in 1991 as the first female ADA president, followed 15 years later by Kathy Roth, DDS, in 2006. Feinberg was elected in 2014, eight years later, and then me the following year. With intervals between the elections of female presidents decreasing, and attitudes toward female leaders in the ADA apparently warming, it might seem to an outsider as though we had overcome our reluctance to elect female leaders. If only it were so simple.

Information and awareness building is key to understanding and ultimately solving this conundrum. The ADA has long collected data about how our membership, House of Delegates, councils, committees and commissions break down by gender. It wasn’t until recently through the work of the ADA Diversity and Inclusion Committee that the ADA set best practice leadership benchmark standards that suggest that the organization’s leadership and governance composition should reflect the members it serves.

This new benchmarking data is useful because it allows the ADA to set targets for leadership diversity on a regular basis based on its member composition. Research advises that member organizations that have reflective leadership are more likely to attract members from broader demographics. Accordingly, and I speak from my own experience, women want to see themselves reflected in the leadership of the member organizations they choose.

This new benchmarking approach can also help state and local dental societies be more cognizant of the pipeline of female leaders coming through at the state and local levels. Are leaders emerging at the state and local level reflective of their respective membership?
Overall, data show that even though the number of female dentists is increasing, these women aren’t moving into leadership positions at the same rate. An analysis of the data also revealed that in some cases, the number of female leaders was decreasing. Here are two examples:

Example 1: The largest number of female trustees to serve concurrently on the 17-member ADA Board of Trustees was five, in 2007. Then there was a sharp drop. In my final year as ADA trustee (2014), I was the only female trustee. I felt like an endangered species. When Dr. Lindsey Robinson, DDS, followed me as 13th District Trustee, making the 13th District the first to elect two female ADA trustees in a row, she, too, was the only female ADA trustee that year. What happened?

Example 2: When I was president-elect of the California Dental Association in 2008, I attended the ADA President-Elect’s Conference in Chicago. That year there were six female presidents-elect. The following year there was one. Again, what happened?

Before I get into ways I believe we can help guide women into leadership positions, I want to take a moment to recognize that we have, in fact, made important progress. I am encouraged by the fact that the face of dentistry is becoming more gender diverse. Today, 29 percent of working dentists are female, compared to only 9 percent when Dr. Morrow became the first female president — a 222 percent increase. Women now make up nearly half of their dental school classes and in some cases are the majority. This is great news! But our association’s mission is to help all members succeed; it won’t succeed if it does not represent the interests of those members. That is why representative leadership is so important, and why it’s absolutely essential that we address the low number of women in leadership positions.

I have heard it argued that the number of women in leadership roles will increase over time in relation to the number of women practicing dentistry. With women making up 29 percent of the dental workforce, why aren’t more districts sending female trustees to the ADA board? Why are we not seeing more female dentists as presidents of their local dental societies and state dental associations? The argument that this will work itself out over time is false.

**With women making up 29 percent of the dental workforce, why aren’t more districts sending female trustees to the ADA board?**

We have to acknowledge that men and women, in many cases, lead differently, and we have to appreciate these differences. “Men are from Mars and women are from Venus,” as the saying goes. There are differences between women and men based on the way we were raised and how we were treated growing up. In some cases, these lead to double standards. Being assertive as a man might be perceived positively while an assertive woman is described as bossy. This manifests itself differently for each woman. In her book *Lean In: Women, Work, and the Will to Lead*, a favorite of mine, author Sheryl Sandberg writes about how women don’t negotiate for higher salaries like many men do because they don’t want to be perceived negatively, or they take back seats in the boardroom to let others have a turn rather than sitting at the table.

These differences extend beyond the office. For example, and I’ve observed this in organized dentistry, women have a harder time networking with others outside the boardroom. Men might build networks while golfing, playing basketball, fishing or hunting. Even though in many cases men and women share responsibilities for children and home equally, most women I meet assume the larger share of this responsibility, making out-of-the-office networking a challenge.

Going forward, it is important that we acknowledge that this problem won’t work itself out, and also that traditional paths to leadership that work for men might not work for women. As a result, it’s time we be more intentional about developing pathways to leadership for women and helping them develop leadership skills and the confidence to assume leadership roles within the profession.

Here are three ways each of us can more intentionally encourage and develop female leaders:

**Mentor young women.** If you ask successful people what they did to get to where they are, they will probably tell you they didn’t get there without the help or mentorship of another person. During my first year out of dental school, 1979, for every 125 dentists in the workforce, two were women. There weren’t many female role models for women interested in dentistry.

My mentor was Clifton Dummett, DDS, and he helped me build confidence to get involved at the local level, then the state level. His guidance and persistence helped me realize I was capable of being a leader. He mentored many young dentists and initiated our mentor-mentee relationship; I’m not sure I would have felt comfortable asking him to be my mentor at the time. It can be difficult for women to find mentors in men.
We have no excuse now, because we have a lot of women in the profession who can mentor other women. If you know a young female dentist, whether you’re a man or woman, offer to mentor her. Encourage her to take on leadership roles. Recommend her for positions for which she is qualified. Help her get involved.

Be aware of your biases. Early in my career, I was told by a female practice management consultant that my practice was successful because I thought like a man. Comments like this reinforce the notion that women don’t belong in leadership roles and that only men have what it takes to be successful at the top. What leadership skills did my colleague perceive in a man that she didn’t think were natural to a woman? That’s gender bias.

Leaders are expected to be strong and decisive. Female leaders face age-old societal notions that they should be nice, caretaking and unselfish. Men are praised when they are assertive, but women are criticized for the same trait. Women who excel in traditionally male roles are viewed as competent, but less likeable than their male counterparts. Skills that are important for leaders to possess, like negotiation, are perceived differently in men and women. To use the salary negotiation example I used before, a 2007 study by researchers at Harvard and Carnegie Mellon found that there’s a “social cost” for women who negotiate their salaries, resulting in a negative perception of women who negotiate versus women who do not. The study found little “social cost” of negotiating for men.3 Women should not be penalized for behaving in ways that for men are “normal.” Consider which biases you harbor and why. Then work to eliminate them.

(Women interested in brushing up on their salary negotiation skills should read Sandberg’s book Lean In. She offers some tips that I have found helpful.)

Take steps to support talented female leaders. In the 1990s, Ernst & Young set out to retain more women in its workforce after recognizing that turnover among females was higher than it was among their male peers. They implemented flexible workdays and job hours, telecommuting policies, flexibility and part-time work in times of life pressure, and mentoring programs. Today, the percentage of female partners at Ernst & Young has tripled.6

As I said previously, it is false to assume that gender inequality in leadership will work itself out. We have to make changes at an organizational level. Programs that provide leadership training to women, work groups that identify bias and plans that promote diversity are essential steps. Biases are embedded in stereotypes and organizational practices that can be hard to detect. When they’re out in the open, there’s possibility for change.

Conclusion

Diversity has to become part of organizational culture. For culture change to take root, each of us has to take steps to enact change. That means changing our behaviors to support diversity. I get the sense that gender equality is becoming less of a box to tick and more an open topic of discussion, and that’s a good thing. With continued investment in talented young women, we can correct the imbalance and ensure that our association truly represents the interests of the members we serve. The responsibility rests with each of us.

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THE AUTHOR, Carol Gomez Summerhays, DDS, can be reached at carolsummerhays@gmail.com.
I’ve got my hands full as it is. How can I keep up on every new change in employment law?

When it comes to employment practices, there’s one spot where CDA members can get assistance with every nuance of running a practice: CDA Practice Support. Download a customizable employee manual or train your staff with easy-to-use PowerPoint presentations. There are even tips on setting staff rules around piercings and tattoos. What’s more, if you need personalized advice, our employment expert is just a phone call away. CDA Practice Support. It’s where smart dentists get smarter.

800.232.7645 or cda.org/practicesupport
The dental profession would be forever changed when, in 1865, the Ohio College of Dental Surgery became the first recognized dental school in the nation to accept women into its ranks. That first female student, Lucy Beaman Hobbs Taylor, pioneered the way for generations of women to come.1 As with most paradigm shifts, wide-ranging change was slow to follow. Between 1866 and 1893, only 181 women had graduated from the nation’s dental schools and as late as 1905, only 12 of the 25 dental schools in the U.S. accepted women.2 Women entering dental school remained near 1 percent for nearly a century until the 1970s when a new trend emerged, a steep and swift increase in female enrollees.2,3 By 1980, women made up 19.8 percent of the first-year dental class. Their numbers increased sharply to 38 percent by 1990 and, by 2015, women represented 48.8 percent of the incoming class in the country’s 65 dental schools.4,5 As the ethnic makeup of dental schools evolves, data show that women of color represent an increasingly greater ratio in the individual racial-ethnic groups of incoming classes.

As an example, among Caucasians, the ratio of men (55.1 percent) to women (43.9 percent) has remained nearly unchanged from 2008 to 2015; however, among Asians, 42.6 percent were men while 56 percent were women.6 Related data reveals that women demonstrate an increased desire to serve one’s own race-ethnic group. This trait is marked by Hispanic-Latino women, Black-African American women, Native Hawaiian-Pacific Islander women and men and American Indian-Alaska Native men. According to one study, women of all race-ethnic groups were more likely than their male colleagues to place importance on service to vulnerable and low-income patients.7 Women’s prominence in the profession is increasing globally as well. Sixty percent of dental students in India are women, and that number is growing steadily. In the United Kingdom, 50 percent of new entrants to dental undergraduate programs are female and by 2020, more than 50 percent of all practicing dentists there will be female. In Russia, women constitute 48 percent of the dental workforce, and in Finland, 75 percent of practicing dentists are women.8

**ABSTRACT** More than 150 years ago, Lucy Hobbs became the first woman in the country to enter dental school. Today, women represent nearly half of the nation’s entering class, more than a third of the faculty and a growing number of administrative leaders, including deans. Evidence illustrates a developing pipeline toward greater numbers and strength of women in dental education, creating a far-reaching impact on teaching, learning and patient care in academia, practice and the profession.
Graduate Demographics

While dental education continues to be deemed a sound investment,9 students of both genders are concerned about educational debt. Average indebtedness of 2015 graduates was $223,984 for all students and an average of $255,567 for only those students with debt (exclusive of the 12 percent of grads with no debt).10 Some studies show that among those students graduating with debt, women had accumulated slightly less than men. Reasons for these differences are not known, as is how this may influence future practice choices.11 Data from the American Dental Association Health Policy Institute suggests that the effects of demographic characteristics, including race and gender, may actually influence career decisions to a greater extent than does debt load. Their studies demonstrated that women were less likely than men to specialize (by 11.0 percentage points) or to own a practice (22.5 percent less) and that female practitioners worked approximately 20 percent fewer hours per year than did their male colleagues.7 The annual American Dental Education Association (ADEA) survey of graduating 2015 seniors confirms that slightly more men (50.1 percent) than women (48.3 percent) planned to enter private practice7 (TABLE 1).

Beginning with application and admission to school, the concept of a “pipeline” or progressive increase of women at all levels in dental academia has been explored. The overarching concept being that, as increased numbers of women enter and graduate from dental school and postdoctoral programs and enter practice, they may become faculty members and move into increasing levels of leadership positions, including department chairs, directors of postdoctoral programs, assistant and associate deans and deans.12 The primary levels of this pipeline have certainly been realized; an increase in doctoral enrollment has been clearly documented.4 A review of postdoctoral program enrollment indicates overall increases in the past decade and a half and, while the number of male enrollees has increased slightly, programs have seen much more significant increases in the number of female residents (TABLE 2).

### TABLE 1

<table>
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<th>Immediate Plans</th>
<th>Total Number</th>
<th>Total Percentage</th>
<th>Male</th>
<th>Female</th>
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<td>2,272</td>
<td>49.3%</td>
<td>50.1%</td>
<td>48.3%</td>
<td>60.0%</td>
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<tr>
<td>Faculty/staff member at a dental school</td>
<td>22</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0</td>
</tr>
<tr>
<td>Armed forces</td>
<td>242</td>
<td>5.3%</td>
<td>7.0%</td>
<td>3.4%</td>
<td>9.1%</td>
</tr>
<tr>
<td>Other federal service (e.g., VA)</td>
<td>61</td>
<td>1.3%</td>
<td>1.4%</td>
<td>1.2%</td>
<td>3.6%</td>
</tr>
<tr>
<td>State or local government employee</td>
<td>38</td>
<td>0.8%</td>
<td>0.7%</td>
<td>1.0%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Public Health Commissioned Corps</td>
<td>127</td>
<td>2.8%</td>
<td>2.2%</td>
<td>3.3%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Dental graduate students/resident/intern</td>
<td>1,582</td>
<td>34.3%</td>
<td>33.3%</td>
<td>36.3%</td>
<td>12.7%</td>
</tr>
<tr>
<td>Other type of student</td>
<td>41</td>
<td>0.9%</td>
<td>0.7%</td>
<td>1.0%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Other position related to dentistry</td>
<td>114</td>
<td>2.5%</td>
<td>2.8%</td>
<td>2.2%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Unsure</td>
<td>103</td>
<td>2.2%</td>
<td>1.6%</td>
<td>2.8%</td>
<td>5.5%</td>
</tr>
</tbody>
</table>

Note: Percentages may not total 100 percent because of rounding.
Source: American Dental Education Association, 2015-16 Survey of Dental Education: Report 1 – Academic Programs, Enrollment and Graduation.

### TABLE 2

<table>
<thead>
<tr>
<th>U.S. Postdoctoral Enrollment by Gender, Selected Academic Years</th>
<th>Male</th>
<th>Percentage</th>
<th>Female</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2000–01</td>
<td>5,006</td>
<td>67.3%</td>
<td>1,636</td>
<td>32.7%</td>
</tr>
<tr>
<td>2005–06</td>
<td>5,554</td>
<td>63.1%</td>
<td>2,047</td>
<td>36.9%</td>
</tr>
<tr>
<td>2010–11</td>
<td>6,217</td>
<td>59.7%</td>
<td>2,504</td>
<td>40.3%</td>
</tr>
<tr>
<td>2015–16</td>
<td>7,059</td>
<td>56.2%</td>
<td>3,087</td>
<td>43.7%</td>
</tr>
<tr>
<td>Increase from 2000-01 to 2015-16</td>
<td>2,053</td>
<td>600</td>
<td>1,451</td>
<td></td>
</tr>
</tbody>
</table>

Supporting Dental School Faculty

Boyer proposes that the work of the professoriate includes four distinct, intersecting functions: the scholarship of discovery, or research; the scholarship of integration whereby isolated findings are put into perspective, including across disciplines; the scholarship of application, specifically how research discoveries can be applied; and, finally, the scholarship of teaching, inferring that activities become consequential only when understood by others. Men and women alike, the most adept faculty help students develop critical thinking and problem-solving skills, evaluate evidence and translate theory to practice, with growing independence.

The demographics of dental school faculty are changing, though not as rapidly as those of students and residents. Although women made up just 37 percent of full-time dental faculty and 34 percent of total faculty in academic year 2013–2014, it must be noted that a definite shift becomes apparent when age ranges are examined. Among faculty age 39 and younger, women begin to emerge as the larger percentage of faculty, outnumbering their male counterparts (FIGURE 1).

The ADEA supports and participates in the advancement of this growing cadre of women faculty in a variety of ways, including the ADEA/Pfizer/Enid A. Neidle Scholars Program — an annual fellowship opportunity to study gender-related issues; the ADEA International Women’s Leadership Conference, which brings together educators, practitioners and researchers who educate and mentor women; the ADEA Leadership Institute for future leaders of dental and higher education; the ADEA Summer Program for Emerging Academic Leaders; and the Hedwig van Ameringen Executive Leadership in Academic Medicine (ELAM) for women leaders from dental education, academic medicine and public health.

Support for women’s research efforts has also seen progress. Released in 1991, the Report of the National Institutes of Health: Opportunities for Research on Women’s Health established an agenda for research on women’s health and advancement of women in health careers. In 2011, the International Association for Dental Research (IADR) established the Women in Science Network to focus on faculty career development and health research, including mentorship for graduate students and junior faculty. Despite growing numbers of postdoctoral residents and dental faculty, the number of first authors on scientific journal manuscripts has not grown at the same rate. However, 2008 documented three times as many female first authors as 1986.

Women researchers have also seen gains in leadership and role models at the national level; one such notable example is the current director of the National Institute of Dental and Craniofacial Research (NIDCR), Martha Somerman, DDS, PhD. Additionally, from 2000 to 2016, 41 percent of IADR presidents and 24 percent of American Association of Dental Research presidents have been women, a significant increase over the same number of years preceding.

Administrative Leadership

The number of women in academic leadership and administrative positions is developing positively showing consistent growth in assistant and associate dean positions held (TABLE 3). At the most senior leadership post in dental schools, the position of dean, women are ascending in increasing numbers. Jean Sinkford, DDS, PhD, who at the time of her 1966 application to Baylor College of Dentistry was an associate professor of anatomical sciences there, went on to become the first female dental school dean.
at Howard University in 1975.20 Today, female deans lead 14 (22 percent) of the 65 U.S. dental schools. Of the 28 new deans appointed from 2013 to 2015, a full 10 (36 percent) were women.21 A remaining down note: Administrative salary disparities have not yet reached parity, with the largest gender discrepancies displayed at the dean level where female deans earn just 74.5 percent of their male colleagues’ salaries.11

**Mentorship and Role Modeling**

As in all areas of professional life, mentorship is invaluable to career navigation for the striving dental student, postgrad resident, new faculty member or aspiring administrative leader. Mentors reveal opportunities—including stretch assignments, facilitate networking connections, advocate on behalf of protegés, increase visibility, provide feedback, build confidence and encourage and celebrate achievements, among many other forms of support.11,22,23

Mentoring may take a variety of forms and it’s essential to build a cadre of people whose perspectives are respected and valued from whom to seek advice.24 Certainly, mentoring contributes to faculty productivity, satisfaction, retention and advancement throughout one’s professional career, for women and men.24,25 The slightly different action of sponsorship is equally critical. Public recognition and support of someone with emerging talent or untapped potential, especially when this occurs at the leadership table, can enhance opportunities for advancement to positions that stretch, challenge and build new leaders.26

Taken as a whole, history and data appear to support the notion of a developing pipeline toward greater numbers and strength of women in dental education.12 Determination and resilience defined the earliest women in dentistry. With continued intention, female students, residents, scientists, clinicians, faculty, administrators and leaders will realize their full potential and have a far-reaching impact on teaching, learning and patient care in academia and practice.

### References
Commentary

A tipping point is approaching where the majority of dental students in the United States will soon be women if enrollment trends continue. Just as in many other health care occupations, the “feminization” of the dental workforce is a source of debate, as it could have important implications on both clinician practice patterns and patient outcomes. For example, in terms of labor supply, one study found that female general practitioner dentists in Washington state worked 10 percent fewer days and treated 10 percent fewer patients than male dentists. However, female dentists performed the same number of procedures per patient as male dentists, suggesting that despite differences in total days worked and patients treated, male and female dentists have similar rates of productivity.1 Similar trends are indicated within dental specialties, as well; female orthodontists are less likely to be in practice ownership positions and are more likely to take leaves of absence, devoting 25 fewer days to practice per year compared to their male counterparts.2

Beyond hours worked, several studies indicate that female dentists have distinctive practice patterns and are more likely to utilize “conservative,” prevention-based clinical measures over invasive procedures. For example, female general practitioner dentists are more likely to report that they recommend at-home use of nonprescription fluoride for caries treatment and are less likely to intervene surgically compared to male dentists.3,4

The supply of dentists in the U.S. is rising. The number of practicing dentists increased from 58.1 per 100,000 population in 2005 to 60.9 in 2015. The supply of dentists is expected to increase further in the coming years. For example, a recent analysis found that under the most probable scenario, there will be 65.7 practicing dentists per 100,000 by 2035.4 In California, by contrast, the supply of dentists increased from 72.8 per 100,000 population in 2003 to 76.6 in 2013,6 but is expected to decrease to 74.7 by 2033 under the most probable scenario.7 The fact that an increasing share of the California dentist labor force will be female could mean that total hours worked by dentists in California will decline

ABSTRACT If trends continue, the majority of U.S. dental students will soon be women. However, there is little empirical analysis examining gender differences in the labor supply of dentists and the potential effects on the dental care sector. We help fill this data void by examining differences in dentists’ hours worked by gender, how this has changed over time and the potential implications for the current and future aggregate labor supply of dentists in California.

AUTHORS

Marko Vujicic, PhD, is the chief economist and vice president of the Health Policy Institute, American Dental Association and visiting assistant professor at Tufts University in Boston. Conflict of Interest Disclosure: None reported.

Bradley Munson, BA, is a senior research analyst of the Health Policy Institute, American Dental Association and former data analyst at Resources Inc. Conflict of Interest Disclosure: None reported.

Brittany Harrison, MA, is the senior project assistant of the Health Policy Institute, American Dental Association. Conflict of Interest Disclosure: None reported.

Does California Project the Future of Dentistry?

Marko Vujicic, PhD; Bradley Munson, BA; and Brittany Harrison, MA

Brittany Harrison, MA, is the senior project assistant of the Health Policy Institute, American Dental Association. Conflict of Interest Disclosure: None reported.
faster than the number of dentists. This would be the case only if female dentists systematically worked fewer hours than their male counterparts. With limited research in this area, it is difficult to assess the extent to which gender composition shifts matter with respect to total aggregate dentist labor supply available for patient care.

In this paper, we help fill this data void by examining differences in hours worked between male and female dentists, how this has changed over time and the potential implications on current and future aggregate dentist labor supply in California. We discuss the policy implications of our findings.

**Study Data and Methods**

**Data**

We relied on data from the ADA Health Policy Institute’s Survey of Dental Practice for information on dentists’ working hours. This annual survey is conducted on a nationally representative random sample of dentists in private practice. According to the most recent data available, 90.4 percent of active dentists in the United States are in private practice.5 Response rates to the Survey of Dental Practice from 2000 to 2014, our period of focus, varied from 14 to 45 percent. The most recent year for which data were available was 2014, and the response rate was 14.0 percent nationally and 12.9 percent in California. Over the 15-year period, there were 36,093 responses nationally and 4,905 in California. During data cleaning, we screened outliers and dropped them from the analysis where appropriate. In addition, we weighted estimates for the years 2000 through 2014 to compensate for survey nonresponse bias with respect to these dentist characteristics: age group, gender, practitioner or specialist status, ADA membership status and county population corresponding to the dentist’s location. Further details on these data set are available elsewhere.8

and they have been used in numerous peer-review journal publications.10,11,12

For information on the gender composition of the dentist workforce, we used the ADA masterfile, the most up-to-date information on dentists in the U.S. The masterfile is a database of all dentists, practicing and non-practicing, in the U.S. and contains rich information, including dentist age and gender. It is updated through a variety of methods including reconciliation with state licensure databases, death records and various surveys and censuses of dentists carried out by the ADA. We used the masterfile’s archived datasets from 2001 through 2015 to gather historical information on the dentist population by gender. Further details on these data are available elsewhere.5

**Methods**

To calculate the female share of the dentist workforce in California and the U.S., we limited the analysis to those dentists in the ADA masterfile who were licensed, not suspended, not retired, were located in one of the 50 states or District of Columbia and whose primary occupation was any of the following: private practice, dental school faculty, armed forces, other federal service (e.g., Veteran’s Affairs, Public Health Service), state or local government, hospital staff, graduate student, intern or resident or other health or dental organization staff member.

We constructed a measure of dentists’ annual hours worked in California from the product of two answers from the Survey of Dental Practice: total weeks worked in a year and hours per week spent in the practice. We analyzed this measure by various age, gender and year breakdowns dependent on sample size. For example, we compared male and female dentists’ average hours worked across three time periods where we pooled data: 2000–2004, 2005–2009 and 2010–2014. We examined differences in average hours worked by age and gender, pooling data for 2000–2014.

To estimate total dentist labor supply in California, we multiplied the number of practicing dentists by average annual hours worked for each age and gender group. This yields a measure of total aggregate labor supply, or total hours worked, by all practicing dentists in California.

**Study Results**

**FIGURE 1** presents the share of the dentist workforce that is female for California as well as the U.S. from 2001 to 2015. The percent of practicing dentists who are female increased from 16.0 percent to 28.9 percent over this timeframe in the U.S. California saw a similar rate of increase, although compared to the national average, California has a higher share of dentists who are female. In 2015, 33.4 percent of practicing dentists in California were female.
Discussion

Our analysis shows that female dentists in California work fewer hours per year than their male counterparts. The gender gap in hours worked varies over time and across age groups. For dentists older than age 55, however, the gap largely disappears. Putting our results together, we find that the aggregate number of hours worked for all dentists in California would be 3.6 percent higher if female dentists worked similar hours as their male counterparts in their age group.

Looking forward, our analysis has several important policy implications. Given that an increasing share of dental school graduates in the U.S. are female, understanding gender differences in labor supply of dentists and how this potentially impacts the total amount of hours available for patients’ dental care is increasingly important. A recent analysis found that the number of practicing dentists per capita in the U.S. is expected to increase by 7.9 percent between 2015 and 2035. However, total hours of care available to patients is expected to increase by 6.5 percent after accounting for the expected shifts in the gender composition of the future dentist workforce. Our results suggest that future gender shifts in the California dentist population would have a similar effect, but a more refined analysis is needed specific to California.
It is important to emphasize what our results imply and what they do not imply for the current and future supply of dentists in California. Our results strongly suggest that while the per capita supply of practicing dentists in California is expected to decrease in the coming years, total aggregate dentist labor supply (per capita) is expected to decrease faster due to shifts in the gender composition of the dentist workforce. But our results do not provide any insights beyond this. For example, our research sheds no light on whether the current or future supply of dentists in California is sufficient to meet patient needs. Some readers might be inclined to infer from our results that “dentist shortages are likely to be exacerbated in California because of the feminization of the dentist workforce.” We wish to be clear that our analysis does not imply this at all. There is, in fact, strong evidence of significant unused capacity in the dental care delivery system in California. More important, in our view, is even if female dentists work fewer hours than their male counterparts, it is unclear how this translates, if at all, to the volume of patient visits, the number of procedures performed, access to dental care or oral health outcomes. It could be that female dentists are more efficient in terms of the amount of care delivered for a fixed number of hours worked. Or, irrespective of the volume of care delivered, similar or even better patient outcomes could be delivered through fewer hours worked. As we noted in the introduction, there is evidence that female dentists tend to provide more “conservative,” prevention-focused care. These are important areas for future study and we realized our research contributes nothing in this area.

We also wish to emphasize that our analysis focused solely on labor supply.

There are, of course, other gender differences that are worth exploring in the practice patterns of dentists. For example, a recent study found that after controlling for other factors, such as age and race, female dentists are more likely than male dentists to accept employment in public health settings and to treat low-income patients. Thus, it is conceivable that the “feminization” of the dentist workforce in California could improve access to dental care for underserved groups. Evidence from other states also indicates that female dentists are more likely than male dentists to treat Medicaid beneficiaries. Recent analysis indicates that female dentists, all else equal, have lower rates of entering private practice, owning a practice, and specializing in higher-paying dental specialties compared with male dentists.

As noted in our introduction, there are also important differences with respect to treatment patterns. In lieu of invasive treatments, female dentists are more likely to use educative techniques to promote at-home preventive measures among their patients. Though some researchers have characterized this tendency as an overall productivity gap between male and female dentists, the dental profession as a whole may be shifting “toward greater use of prevention and more conservative management” of dental conditions, particularly caries.

We want to emphasize that the overall impact of the “feminization” of the dentist workforce in California is still very ambiguous and merits further study. We have focused on analyzing the potential impact on total aggregate labor supply and, in our view, the effects are small. We also think there are much more important areas that are worth investigating, as well. Given that shifts in dentist demographics are expected to continue, such research will prove vital.

REFERENCES
8. ADA Health Policy Institute analysis of ADA masterfile. 2015.
Women in the Boardroom: Reflecting the Changing Gender Demographics of Dentists

Natasha Anne Lee, DDS

ABSTRACT

Even though there are more women in the workplace today than ever before and more women than men are now graduating from college, there are relatively few women who hold leadership positions, be it in government, academics or on corporate boards.

AUTHOR

Natasha Anne Lee, DDS, is assistant professor of practice management at the University of the Pacific, Arthur A. Dugoni School of Dentistry and a fellow of the American College of Dentists, the International College of Dentists and the Pierre Fauchard Academy. She is the CDA president-elect and maintains a private practice in San Francisco. Conflict of Interest Disclosure: None reported.
our professional organizations and the leadership of our organizations. As dentistry shifts toward a more gender-balanced profession, this article serves to investigate the benefits of gender diversification in leadership, barriers to leadership for women today and how organizations can adapt to support and encourage more women to take on leadership roles.

In dentistry, many leadership positions are voluntary within our professional organizations and not only compete for time and attention with practice life, but also with family life. Even though generational attitudes are changing toward domestic balance in the home, women typically are still the primary family caretakers and often take pause in their careers to have and raise a family. Forty-two percent of working mothers say they had reduced their hours in order to care for a child or other family member and 39 percent say they had taken a significant amount of time off of work for family reasons. About one-third of women who reduced their work hours or took a significant amount of time off of work to care for a child or family member felt that the pause was detrimental to their career.

Mothers don’t regret taking these steps, however. More than 90 percent of working moms who have reduced their hours or taken a significant amount of time off from work say they are glad they did so. This means that organizations will need to accept the fact that some women will choose to take a break or reduce their commitment level for a period of time and will prioritize these family duties over opportunities for career advancement or association leadership roles. Organizations need to create a culture that is accepting of such decisions and remove stigmas that are associated with women in leadership choosing to take a career pause. Additionally, organizations should develop methods of maintaining even the most simple touch points with leaders of either gender who are taking a break from their roles in order to keep that person connected to leadership so they may be more aware that the organization is happily awaiting a time when the leader may choose to take a step back in.

Additionally, organizations should assess their governance and leadership structures and pathways and consider making it easier for women to participate in ways other than the traditional committee or board where a volunteer is expected to serve six years or even longer. Many professional associations are moving toward a task force structure and away from standing committees. Task forces typically have a shorter duration with a specific end and a more defined purpose. While a task force structure has many benefits to the organization, these more bite-sized commitments may, in fact, be more appealing to women who are planning to have a family and who are hesitant to take on a longer-term board or committee leadership role.
Some have described the “flattening” of organizations that have purposefully created horizontal leadership opportunities or even broken down the leadership ladder into more of a “lattice.” Cathleen Benko and Molly Anderson, authors of a multitude of books and articles on organizational leadership, explain, “Lattice career paths move up, down, diagonally and across. They provide options to align career aspirations and personal needs with corporate objectives and operational requirements.”

“Globalization and technology are creating organizations with fewer rungs and more options for how, when and where work gets done,” according to Benko and Anderson. Besides considering flatter organizations that allow movement in directions other than up the ladder and more bite-sized leadership roles, organizations must consider utilization of technology to connect leaders and teams in ways other than face-to-face meetings or conference calls. Alternative means of participation are not just helpful for dentist moms wishing to contribute, but will most likely be the way that future generations demand to participate in leadership.

Besides family commitments, there are other reasons why women are not equally represented in top leadership roles. Nationally, an important and diverse demographic is emerging. Not only are the number of female dentists increasing, cultural diversity is on the rise as well, although dentists do not yet mirror population demographics.

Meeting the needs of the 21st century graduate is critical to the strength of the American Dental Association (ADA). I am a recent graduate, a wife, a mother of young children and a business owner. A commitment to be part of the organized profession, to help shape the future of our profession, was the driving force for my decision to seek national office in the ADA. As the youngest elected vice president of the American Dental Association, I’m able to voice the concerns of thousands of new member dentists and bring a new perspective to the board. Going forward, it’s important that the governing body of the ADA, the House of Delegates, reflects the changing demographic of the profession at large.

The ADA Institute for Diversity in Leadership is designed to enhance the leadership skills of dentists who belong to racial, ethnic and gender backgrounds that have been traditionally underrepresented in leadership roles.

— Irene Marron-Tarrazzi, DMD, MS
underestimate their capabilities.6
on the other hand, are more likely to
as significantly less effective. Women,
when, actually, they were rated by others
more effective leaders than women did
38
in many leadership contexts, even though
may see themselves as incongruent with
social dominance leads to overconfidence
Berkeley, found that “men may see themselves as
overconfident.7 Another study
capable than other individuals who do not
status when they are actually no more
often achieving positions of influence and
leadership roles to women in a way that is
business and education organizations.”8
Other studies have shown that when
female students do not feel their grades
are meeting their own expectations, they
are more likely to drop the course than
their male counterparts.6 This tendency to
hold themselves to higher-than-necessary
expectations may limit their willingness to
place themselves into positions where they
feel that others too may be critical of their
capabilities, especially in light of findings
that 43 percent of respondents (male and
female) in a 2014 U.S. poll reported that
they felt women were held back from
top executive business positions because
women were held to higher standards.9

This perception, along with a
female tendency to downplay and
underestimate one’s own capabilities,
may be one of the reasons we find fewer
women in top leadership positions.

While women may sometimes perceive
themselves as less capable than they
really are, studies have found that men
and women exhibit similar leadership
traits, and surveys of subordinates
rank men and women leaders the
same when it comes to meeting goals,
accomplishing tasks, effectiveness and
meeting the needs of the group.8,10

These findings point to a need for
building the confidence of potential
women leaders, marketing leadership
roles to women in a way that is
more likely to get them to apply and
having more women role models in
leadership who can help other women
envision themselves as leaders.

Companies and organizations are
starting to value gender diversity as a
competitive advantage. There is a breadth
of research investigating the benefits of
gender diversity in leadership and whether
increasing the number of women in
leadership is beneficial to corporations
and associations. These studies and
discussions have certainly led to gender
diversity in leadership being recognized
more as a matter of importance.

One study of U.S. firms from 2001
to 2007 showed a positive relationship
between gender diversity among directors
and the earnings quality, measured by
across quality and earnings benchmark
measures of the companies.11 Another
2010 study evaluated accounting, stock
market and corporate governance data
from 3,876 listed companies in 47
countries. It concluded that firms with a
greater balance of independent and female
directors were associated with superior
financial performance as measured by
higher firm performance by market and
accounting return on assets and further
found that “a gender diverse board is more
important to firm performance than is
a board with independent directors.”12
The results of this study further
suggested “that female directors send a
positive signal to the public regarding
a firm’s ethical behavior” and that “the
positive firm performance effect of many
independent directors is only positive if
that board is also gender diversified.”12

Inclusion of women leaders may
serve to moderate an organization’s risk
tolerance because research shows that the
genders tend to tolerate risk differently.
One such study at Ohio State University
analyzed 2001 mathematics scores on
the SAT tests. Prior to 2016, the test was
designed to penalize students for making

![FIGURE 5. Percent saying they would like to be a boss or top manager someday.](http://example.com/figure5.jpg)

<table>
<thead>
<tr>
<th>Generations</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Millennials (ages 18 to 32)</td>
<td>61%</td>
<td>70%</td>
</tr>
<tr>
<td>Gen X (ages 33 to 48)</td>
<td>41%</td>
<td>58%</td>
</tr>
<tr>
<td>Boomers (ages 49 to 67)</td>
<td>21%</td>
<td>32%</td>
</tr>
</tbody>
</table>

Note: Based on those who are not retired and are currently not the boss/top manager (n=1,539).
incorrect guesses rather than skipping a question when they were unsure of the answer. This study found that “among equally able test takers, male students are more likely to guess, while female students are more likely to skip questions, fearing the penalty and thus ending up with lower scores.” The study revealed that “gender differences in willingness to take risk account for about half of the gender gap in guessing.” The SAT test was changed in 2016 and no longer penalizes students for incorrect guesses, thus removing the risk-taking aspect from students’ SAT scores.13

Studies also show that inclusion of female leaders may improve an organization’s reputation. Corporate social responsibility is defined as “a discretionary allocation of corporate resources toward improving social welfare that serves as a means of enhancing relationships with key stakeholders.” One study found a positive correlation between the percentage of women on a board and corporate social responsibility institutional strength ratings that measure an organization’s “ability to meet expectations of the community and diversity stakeholders through philanthropy, community support and hiring practices.” The study concluded that inclusion of women on boards was positively correlated with a corporation’s reputation, supporting the findings of other studies that have indicated that women bring an increased sensitivity to corporate social responsibility.14

Even male and female dental students report different motives for pursuing a dental career that also point to women being more sensitive to social responsibility. A survey of first-year dental students in 2001 at publicly funded dental schools in the U.S. indicated that female dental students rated people-oriented motives more highly than male dental students while male students were more likely to rate self-employment motives as important.15

I think that it would be very powerful if the organized profession could support our young and diverse members with tools to strengthen their practices and improve their lives. These might include:

**Guidance in Selecting a Practice Model That Fits** — In one to three years, five to 10 years and 10+ years, whether the new graduate prefers a career as an associate, practice owner, researcher, educator or public health dentist, seminars, online tools and resources to help the new dentist determine the model of practice that fits best would be a valued service.

**Negotiation Skills** — In 2013, on average, women dentists made 66 cents on the dollar compared to male dentists, similar to gender pay inequality well known in the corporate world. Studies have shown that women, in general, are better advocates for others than for themselves. However, when offered the job, women only negotiate their salary 7 percent of the time (versus men at 57 percent). Improved negotiation skills would be valuable when interviewing for an associateship position, purchasing a practice or advocating on behalf of others.

**Development of Business Understanding and Acumen** — New graduates must have the tools to manage personal debt, scan the practice environment to identify risks and opportunities and make sound, strategic business decisions.

**Building Strong Teams** — Mentoring or coaching to help navigate gender bias and become better leaders of their practice teams would be advantageous. How does the young associate cultivate an atmosphere of respect and cooperation among existing long-term team members and create a call to action behind which their teams can rally?

**Leadership, Professionalism and Communication Skills** — Leadership opportunities arise in your personal and professional life. How you conduct yourself in your practice will be mirrored by your team, perceived by your patients and, ultimately, become the image of your practice. This includes social media and online presence.

**Time Management** — Achieving work-life balance is challenging. Strategies to help practitioners, women and men, analyze how they use their time would be useful. Reorganizing and prioritizing can help new dentists dedicate more time to the things that are most important to them, with broad implications for family, career and personal growth.

**Creation of Support Networks at Home and at Work** — Managing family and professional life requires a strong network of behind-the-scenes supporters … it takes a village. Encouraging our young colleagues to build and maintain strong networks of men and women whose opinion and support they value is essential. Coming together to exchange ideas and information should not be thought of as “support groups” but, instead, as platforms for accelerating one’s acquisition of skills and knowledge. These connections create opportunities. — Irene Marron-Tarrazzi, DMD, MS

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and business-related motives as more important in their reasons for becoming dentists. Changes in motive for those entering dentistry will influence the value of professional associations for members, and those who lead will have to shape the organization to meet the needs of a growing number of female dentists who in fact may have pursued a career as a dentist for different reasons than dentists of the past. Additionally, increasing numbers of female dentists and women having less of a business motive when entering the profession may have further implications for future practice models as more women are working in group practices. Increasing gender diversity in leadership in professional dental associations will be necessary to gain a broader perspective on emerging practice models and dentists’ motivations to choose different models.

Women make up a greater portion of patients seeking dental care and are more often the decision makers when it comes to their families receiving dental care. With more women becoming dentists, encouraging more women to serve in leadership roles may help an organization be more astute when it comes to understanding both dental patients as consumers and dentists as consumers when it comes to membership in our professional associations. Studies have actually shown that consumers look favorably upon companies that have women on their boards in sectors that operate close to their final consumers and argue, “the nature of this effect reflects an imperative for equality of representation that highlights the need to reflect gender diversity among customers.”

Many organizations and companies are now accepting that gender diversification in their boardrooms and in executive positions is of benefit. But the pool from which to select dentist leaders has been heavily weighted toward men because there have been more male dentists than female dentists. Now that 50 percent of dental school enrollees are women, over the next several decades we will see the number of women in the leadership pool increase and the relative number of men decrease. This means that an organization must address recruitment and retention of female dentists as leaders if it wishes to maintain a large pool of capable and willing candidates.

Some organizations and companies have instituted diversity committees and programs but found minimal measurable success in gaining more female leaders. It turns out that it is harder to change the behaviors of an organization than it is to create a diversity program. Leadership expert Ronald Riggio of Claremont McKenna College writes, “Leadership development programs need to fit the requirements of both the organizations and the leaders undergoing development. They need to be theory driven, use proven methods, be integrated into ongoing organizational processes, evaluated for effectiveness and substantial. It is quite likely that the success of organizations will depend on their ability to nurture and develop leadership capacity for success in the new millennium.” The good news is that surveys show that women of the millennial generation are almost three times more likely to report an interest in being the boss or serving in a top management position compared women of the baby boomer generation which may help organizations in future recruiting efforts (FIGURE 5).

Some companies and organizations make the mistake of adding a token woman to a board or executive committee in order to feel like they have addressed the gender diversity issue. However, one token woman in a leadership position will not lead to the benefits a company is seeking. A study found that “the mere presence of a single female director may not be sufficient, because minority group members, often considered tokens, may find it more difficult to voice their opinions and be heard. As the number of women on a board increases, communication barriers come down and the minority voice becomes more assertive while, at the same time, the majority is more likely to heed attention to it.” The author further writes that contributions women bring to the board “are more likely to be considered by the board when the group diversity dynamics move away from tokenism to normality.”

Secondly, instituting quotas when a leadership development plan and pipeline has not been established to find or create a pool of talented and capable female leaders can backfire. Placing individuals in leadership positions just because of their gender when they have not gained the experience and expertise necessary to serve in that leadership role can be detrimental to an organization and can demoralize the leaders as well as create discontent for those who do not believe that gender diversity is a positive thing. “In 2003, a new law required that 40 percent of Norwegian firms’ directors be women — at the time only 9 percent of directors were women. We find that the constraint imposed by the quota caused a significant drop in the stock price at the announcement of the law” and that findings were “consistent with the idea that firms choose boards to maximize value.” In this case, the imposed quota and severe constraint on the choice of directors due to an undeveloped gender diverse talent pool led to deterioration in operating performance and economic declines when unqualified board members were placed in leadership positions simply to meet the gender diversity requirements of the new law.
Once an organization recognizes the benefits of gender diversity, creates a qualified talent pool, empowers and recruits women, provides them with support they need as leaders and attains a truly gender-diverse leadership, they must then go one step further. That next step is to move beyond diversity and to a level of inclusiveness.

According to a Deloitte study, more millennials were actively engaged, empowered and reported higher levels of authenticity when they felt that the organization fostered an inclusive culture. Millennials were more likely to define inclusion as teamwork and connectivity rather than older generations who think of inclusion more in terms of integration, acceptance, and ethnic, racial and gender tolerance. And to millennials, diversity is more about respecting identities, focusing on unique experiences, ideas, opinions and thoughts compared to nonmillennials who were more likely to define diversity based on representation, equality and demographics.21

The California Dental Association has increased its number of female dentists in leadership roles in the past decade, and currently the ratio of women who hold leadership positions in the organization is 33 percent, mirroring the 33 percent of practicing dentists in California who are women. While this ratio of female leaders exceeds leadership ratios on corporate boards, elected government office and in many other organizations, dentistry must look ahead because those 50 percent of women in dental school now will represent 50 percent of our members and 50 percent of our leaders in the future. I'm proud to serve as a female leader and role model in dentistry and am grateful that my path to leadership was made easier by female dentist leaders who came before me who I know faced greater barriers than I have ever experienced. I’m pleased to see an increased number of women applying to leadership positions and willing to take the time and effort to serve in leadership in our professional dental associations. I’m pleased as well to hear my colleagues report that they feel that the California Dental Association is a good example of an organization that provides a supportive and inclusive environment for them as women and even as new moms holding leadership roles. And while there are certainly biological benefits to not having to wait to use the facilities, I really do look forward to a future of having to wait in line for the women’s bathroom. ■

REFERENCES
1. www.pewsocialtrends.org/2015/01/14/chapter-1-women-in-leadership
2. ADA Health Policy Institute, unpublished 2014 findings from the Survey of Dental Practice

THE AUTHOR, Natasha Anne Lee, DDS, can be reached at natashadds2000@gmail.com.
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**ONTARIO (GP)**—Established in 1992 w/ 5 eq ops in busy single story shopping center. Has some Dental cal and HMO. Proj. approx. $418k Buyer’s $140K. Property ID #5134.


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Second Chances: Accepting a Dismissed Patient Back Into Your Practice

TDIC Risk Management Staff

We’ve all been faced with the dilemma of giving second chances. Whether an old flame or a disloyal friend, choosing to accept someone back into your life can be a difficult decision. But what about accepting dismissed patients back into your practice? Do they deserve a second chance?

The answer is: It depends. According to The Dentists Insurance Company, in some cases, such as noncompliance, accepting a dismissed patient back to your practice can lay the groundwork for a liability claim. But in other cases, the answer isn’t so clear.

TDIC Senior Risk Management Analyst Carla Christensen reports cases in which patients claim they never received dismissal letters, so the dentists are unsure as to whether to take them back. In these situations, the practice is generally not required to provide care as long as they have documentation that they followed the proper dismissal protocol.

When notifying patients of the intent to dismiss, dentists should send two letters: one by regular first-class mail and the other by a tracked delivery service that requires a signature upon receipt, such as FedEx. This method of delivery provides evidence of notification should a patient claim he or she was not informed of the dismissal. Confirming each patient’s mailing address and contact information at every appointment can also protect dentists should a letter be returned.

“That way, a dentist has evidence a good faith effort was made to inform the dismissed patient via the last known address on file,” Christensen said. “It serves as documentation of the dentist’s efforts to provide formal notification of discharge from care.”

Another consideration concerns patients who were dismissed for noncompliance. It is common practice to send a failed appointment letter, advising the patient of the need to return and the importance of maintaining dental health. But if these letters go unanswered, dentists often have no choice but to dismiss the patient from care.

“A dentist should document attempts to educate patients regarding related risks and to provide a specific date for the patient to appoint or take the recommended treatment actions,” Christensen said. “Failed appointment letters reduce the likelihood a patient would hold the dentist responsible for failure to treat or refer, because the provider warned them of the urgency and risks related to the treatment concern.”

In one case reported to TDIC, a dentist provided a temporary restoration and scheduled the patient to return in a week for cementation of the final crown. The patient failed to appear for the cementation appointment and the office sent a failed appointment letter. The patient did not respond or reschedule the final cementation appointment, so the office sent the patient a noncompliance dismissal letter. Six months passed before the patient finally contacted the office...
to request completion of treatment. “Because the dentist had fully documented the patient’s noncompliance with treatment recommendations and termination of the treatment relationship, TDIC advised her that she was not required to reappoint the patient,” Christensen said.

Failing to document treatment options and communication with patients can lead to serious problems. In one case, a patient was only coming in for emergency care. She was diagnosed with a deep cavity and the dentist recommended a filling. But she failed multiple follow-up appointments and the dentist eventually dismissed her from the practice. Three months later, she called and begged the dentist to take her back. The dentist agreed, placing an amalgam filling in the tooth. He advised her that the filling was very large and depending on how the tooth responded, a root canal could be necessary. A few weeks later, the patient showed up to the practice unannounced, upset because the tooth had fractured at the gumline. She demanded that the dentist pay for her implant and a crown.

Unfortunately, the dentist did not have thorough documentation in the patient’s chart. Although the patient was only coming in for emergency care, the dentist allowed her to do so and failed to discuss the importance of regular care, including exams, radiographs and cleanings. He did not inform her that failing these routine maintenance appointments could result in her dismissal.

There are many reasons why a dentist chooses to take a patient back. Sometimes, it’s purely financial — driven by a desire to maintain his or her patient base. Other times, it’s out of sympathy — a desire to help a patient in need. In some cases, the patient manipulates the situation by appealing emotionally or complimenting the dentist and the dentist’s judgment becomes clouded. But none of these reasons offset the risk to the practice of bringing back a dismissed patient.

Generally speaking, TDIC recommends dentists do not accept patients who have been dismissed for noncompliance or nonpayment. But there are specific situations when accepting a patient back could be considered. For example, some patients do not fully understand the gravity of failing routine hygiene appointments until they receive the dismissal letter in the mail, and they call right away to be seen. Still others are dismissed simply because they moved away or changed insurance; in these cases, it is acceptable to allow them to return as patients.

Choosing to give a patient a second chance is a personal decision that demands thorough consideration on a case-by-case basis. There is risk associated with accepting a patient back into your practice, but it is possible to lessen the risk and protect yourself from liability by following a few guidelines.

TDIC’s Risk Management Advice Line at 800.733.0634 is staffed with trained analysts who can answer patient dismissals and other questions related to a dental practice.
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Under HIPAA, any impermissible use or disclosure of unsecured patient information, whether on paper, film or electronic format, is presumed to be a breach requiring notification. Notification must be done unless the covered entity or business associate can either demonstrate low probability that patient information has been compromised based on a risk assessment or show the use or disclosure is one of the four exceptions to the notification requirements. This flowchart will help guide a HIPAA-covered entity through the breach assessment and notification process and comply with both HIPAA and California law. Dental practices that are not HIPAA-covered entities are required to follow the state’s data breach notification rules, which do not include a breach risk assessment. The chart should be used in conjunction with “Data Breach Notification Requirements,” a resource that has detailed information on the process and is available on cda.org/practicesupport.

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TABLE

Breach Notification Requirements Apply

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<th>Non HIPAA-CE &gt;500 CA residents</th>
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<td>Notify law enforcement of suspected illegal activity, such as theft of computers, boxes of charts, etc., as soon as possible.</td>
<td>Notify affected residents “in the most expedient time possible and without unreasonable delay.” The written notice must have specific content and be sent via first-class mail or by email, as long as the individual has consented to receive communications via email.</td>
<td>Notify affected individuals, or next of kin if individual is deceased, within 60 calendar days after discovery of the breach and without unreasonable delay. The written notice must have specific content and be sent via first-class mail or by email, as long as the individual has consented to receive communications via email. Substitute notice (website or print or broadcast posting) with toll-free telephone number active for 90 days must be used if contact information for 10 or more individuals is insufficient.</td>
<td>Substitute notice allowed if less than 10 individuals are affected.</td>
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<tr>
<td>Substitute notice is allowed under state law if the cost of providing individual notice is more than $250,000, more than 500,000 people would have to be notified or the organization does not have sufficient contact information for those affected.</td>
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<td>Within 60 calendar days after discovery of the breach, file a report on the Office for Civil Rights website. No later than 60 days after the end of the year in which the breach or breaches occurred, file a breach report or breach log on the Office for Civil Rights website. Within 60 calendar days after discovery of the breach, notify prominent media outlets of the breach.</td>
<td>Within 60 calendar days after discovery of the breach, notify prominent media outlets of the breach.</td>
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<td>Upon notifying affected residents, upload a copy of the notification to the state attorney general’s website.i</td>
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i. oag.ca.gov/ecrime/databreach/report-a-breach.  

Regulatory Compliance appears monthly and features resources about laws that impact dental practices. Visit cda.org/practicesupport for more than 600 practice support resources, including practice management, employment practices, dental benefits plans and regulatory compliance.
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6117 MODESTO – TURLOCK AREA  2016 shall collect $675,000 with $375,000 in Profits. PPO practice. Full Price $275,000.

6115 SAN FRANCISCO’S RUSSIAN HILL – CHINESE PRACTICE  2016 shall collect $300,000 with Profits of $145,000. Has been a $400,000 year performer. Full Price $120,000.

6114 AUBURN – ROSEVILLE AREA  2016 is trending another $1.1+ Million year. Profits tracking $425,000+. Beautiful and extensive facility leases for $1.60 sq.ft. Not a Premier Practice.

6113 FRESNO  Consistently collecting $600,000+ per year. Shopping center location with fixed rent. Profits topped $365,000 in 2015.

6112 HEALDSBURG  Ideal as part-time practice in desirable locale or foundation to grow. 100% out-of-network. Trending $200,000 in collections, Profits of $100,000+. Full Price $30,000.

6111 SANTA ROSA  Perfectly positioned for next Owner. Best equipment, networked and digital including Pano. 3-days of Hygiene. 2016 trending $520,000+ with profits exceeding $250,000. Conservative Owner. Best location.


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6106 SACRAMENTO’S EL DORADO HILLS  2015 collected $640,000. UCR Fees. Best price. Very solid opportunity.

6105 MODESTO  Collected $430,000+ on 3-day week. 3-days of Hygiene. 5-ops. Central location. Successor should open 4th day.

6104 SANTA CLARA – CUPERTINO AREA  Restorative practice. 2015 collected $1.55 Million with Profits of $694,000. Paperless and digital. Beautiful office. UCR Fees!

6103 SAN FRANCISCO’S UNION SQUARE  Opportunity to acquire highly regarded practice in condo. Beautiful 5-ops, digital and paperless. 6th op available. 2015 collected $658,000.

6100 SANTA CLARA  Phenomenal launching pad for next Owner. Fantastic location, 5-op facility. Management not taking advantage of what is possible even though 2015 collected $725,000 with Profits of $323,000. Perfectly positioned to be a $1 Million+ year performer immediately! Needs young DDS.

6098 WEST PETALUMA  THE business center of the North Bay! Business parks are growing and young families are drawn to this great family community per the unique amenities of this historic river city. Collected $468,000 with Profits of $212,500. 4-days of Hygiene.

6097 MOUNT SHASTA  Small town living renowned for outdoor lifestyle. 3-day week collected $881,000. Available Profits totaled $485,000. Digital including Pano. Full Price $350,000.

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BAKERSFIELD  Established 55 years. 5-ops in 3,000 sq. ft. Will do $1 Million. Full Price $300,000. Building available for $350,000.

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EAST LOS ANGELES  One million Latinos in service area. PPS sold to Seller in 1985. Will do $1 Million in 18 months. Full Price $300,000.

EAST SAN FERNANDO VALLEY  Absentee Owner. $8,000/month Cap Check. 4-ops. Do a Million within a year.

INDIO  4,000 sq.ft. dental building. Full Price $650,000.

LADERA RANCH  Grossing $650,000. Shopping center location.

LAGUNA NIGUEL  Location, location, location! 4-ops with Panorex. Full Price $185,000.

LA JOLLA  Established 20-years. 3-ops. Grossed $150,000. Super opportunity with immediate growth. Full Price $150,000.

LAWNDALE  Hi identity. 2 ops. Full price $125,000.

LOS ANGELES HMO  Grossing $1.2 Million. 5-ops. Full Price $1.2 Million.

LOS ANGELES HMO  Does $4 Million.

NORCO – CORONA  Will do $1.5 Million. 8-ops. Exquisite. Full Price $1.2 Million.

NORWALK  Fantastic high identity location. 5 ops. Full Price $250,000.

ORAL SURGERY PRACTICE – LOS ANGELES  Established 40 years.

ORANGE  Beautiful 10 operatory office ready for merger.

PASADENA  Established 60 years. 7-ops. Always $1 Million. Full Price $600,000.

REDLANDS  Shopping center. Grosses $350,000. Full Price $250,000.

RIVERSIDE  Facility only. 4 ops. Full Price $50,000.

SOUTH ORANGE COUNTY BEACH CITY  Grosses $650,000. 4 ops. Beautiful!

PERIO PRACTICE - PRESTIGIOUS BEACH CITY  Established 40 years.

TORRANCE  Established 12 years. 5 star building. 3-ops. Grossing $250,000. Full Price $195,000.

TUSTIN  Dental building. Full Price $1.5 Million.

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Proper Utilization of Auxiliaries

Volkmar Felahy, DDS

After graduating from dental school 16 years ago, I faced many quandaries at the beginning of my professional journey. Some of these professional dilemmas were procedural, while others were administrative. In time, and with experience, most of them have been resolved; but a few still lend themselves to great conversation with my dental colleagues.

One of the administrative dilemmas involves dental auxiliaries and what they can and cannot do. For example, some dentists knowingly, or unknowingly, ask their auxiliaries to do too much. They may expect them to perform duties outside their scope of practice, such as asking an RDA to take a final impression for an occlusal guard or adjust a temporary crown with a handpiece while it is cemented in the patient’s mouth. In an extreme case, a dentist hired a dental assistant simply for the purpose of holding his dominant arm steady to prevent it from shaking as he provided treatment. Alternatively, some dentists chronically underutilize the abilities of dental auxiliaries by not allowing them to perform duties they are skilled and licensed to provide, such as crown and bridge temporaries, drying endodontic canals and other tasks that fully utilize their skillsets. A possible reason for the inappropriate utilization of auxiliaries is confusion regarding what they can do. For example, a DA can assist chairside and take X-rays; an RDAEF can legally take a final crown and bridge impression, make a temporary and place the final restoration. In addition, there are different specialty certifications in oral surgery, anesthesia and orthodontics. Regardless of the possible reasons, dentists have an ethical obligation to educate and abide by the proper utilization of our chairside assistants.
Ethical principles guide dentists in the CDA Code of Ethics regarding the utilization of dental assistants. The first principle is integrity. A dentist should act with honor and constantly strive for the highest professional standards. A good rule of thumb is to always strive for the level of care that you would expect to be given to your loved ones. Allowing assistants to work outside their scope of practice is a violation of the CDA Code of Ethics, including the ethical principle of integrity, which is to behave with honor and decency.

The next principle to consider is beneficence. Truly, the cornerstone ethical principle is to do no harm. We must weigh the risks and benefits and always do what is best for the patient. It’s not a far stretch to say that having an assistant work outside his or her scope could create a harmful situation or that not fully utilizing an assistant could be a detriment to the greater good of the patient. We must always consider the patient’s welfare in clinical and practice decisions. Finally, veracity, or honesty, is the foundation of a patient-doctor relationship. We need to be truthful with our patients, but also truthful with ourselves regarding our limitations.

Section 1C of the CDA Code of Ethics states, “It is unethical for a dentist to render, or cause to be rendered, substandard care.” Allowing assistants to work outside their allowable duties, even if we do not realize it, is by definition allowing substandard care. In addition, Section 4 of the code addresses the ethical obligation to comply with state and federal laws. It seems self-evident, but breaking the law or not complying with the California Dental Practice Act is considered unethical behavior. This could lead to action being taken against your dental license and your tripartite membership.

As dentists and CEOs of our careers, it’s imperative that we educate ourselves regularly about the ever-changing laws and regulations that govern the way we practice. Just as dental materials continue to evolve, so do the rules and certifications governing dental assisting. As with all changes within the field of dentistry, the main goals motivating these revisions are to increase patient safety and increase the quality of services we provide. The bottom line is this: We should not ask our assistants to do tasks that they are not permitted to do. Furthermore, we should allow them to do the tasks in which they are trained and skilled and can legally perform. Proper utilization of dental assistants will add predictability, decrease stress on the dentist and increase efficiencies within the practice.

Volkmar Felahy, DDS, is a general dentist in Rocklin, Calif. He is a member of the CDA Judicial Council.

For more information on the proper utilization of auxiliaries, refer to the table of permitted duties on cda.org. For further guidance, contact your local ethics committee, or Brittney Ryan, CDA Judicial Council manager, at 800.232.7645.
AC-566 SAN FRANCISCO: Spectacular views of Washington Square. 3ops +2 add’l, 1400 sf $225k
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AN-642 SAN BRUNO: Don’t miss this one! FFS, 5 ops 1950 sf $740k (Real Estate $1.2M)
BC-361 OAKLAND: Estab 23+ years! 2200 sf w/ 7 ops. Seller retiring $330k
BC-432 PITTSBURG: Family-oriented Practice! 1640 sf w/ 6 ops. Seller retiring $350k
BC-520 HAYWARD Facility: Located in Downtown, 1500 sf, 4 equipped ops, X-Rays in 3 ops. $65k
BC-614 SAN LEANDRO Patient Charts: Increase your Production & continue TX to this stable patient base $150k
BC-646 ORINDA: well-established, family-oriented Practice, Word-of-Mouth Refs, 4ops in 1080sf $825k
BG-622 PLEASANT HILL: Unlimited growth potential by increasing office hours 2700 sf w 6 ops $575k

BN-504 RICHMOND: Established Practice & Real Estate! 1450 sf w/ 2 ops + 2 add’l $100k RE $700k
BN-608 SAN LEANDRO: Ideally located & a must see! 1700 sf w/ 4 ops $485k
CC-552 SAN RAFAEL: 3ops, 800 sf. Practice & Lease Concession: $225,000 / Charts Only: $175,000 + an add’l amt for EQ
CC-567 ST. HELENA: Live & Practice in beautiful Wine Country, 5 ops 1842 sf single-story bldg $790k
CC-599 SANTA ROSA: Stable pts base, well-respected Practice, 3 ops in 1040 sf $250k
CG-611 S. MARIN CO: Desirable, well-established neighborhood, 20pts/mo 3ops, 1100 sf $650k
CG-632 SAN RAFAEL: Small town life, vibrant-growing city, 6-8 pts/day, 3ops in 800sf office in beautiful bldg $165k
CG-583 SEBASTOPOL: Seller willing to consider all reasonable offers. Health Forces Sale $50K & Real Estate also available!
CN-616 NAPA: State of the Art Practice - Seller moving out of state! Call for Details!
DC-480 SILICON VALLEY: Multi-Specialty Practice, 14+ops in 7500 sf, Owner Financing avail-Terms $1.075M
DC-604 LIVERMORE Facility: Turn Key Facility, fast growing city, 3ops +3 add’l plumbed in 2380 sf modern office $110k
DC-623 MENLO PARK: LOTS of room for GROWTH w/ close proximity to Facebook, Stanford, Google & Tesla $380k
DN-497 PLEASANTON Facility: Great Location! 870 sf w/ 3 ops + 1 add’l. Owner Financing w/10% Down! $95k
DN-631 CAMPBELL: Rare Opportunity! 1100 sf w/ 3 ops, busy retail shopping center $249k
DG-519 SANTA CLARA Facility: Move In Ready! 2240 sf w 6 fully equipped ops $225k
DG-530 SAN JOSE: Dentrix JUST installed! Highly respected quality practice! 2015 collections $1M+ $795k
DG-635 CASTRO VALLEY: Excellent Location & Stellar Reputation! Solo Group Practice $690k
DG-643 SAN JOSE: Seller Motivated! 3,300 sf w/ 4 ops + 2 add’l available! Call for Details! Only $65k

800.641.4179 WPS@SUCCEED.NET
BAY AREA CONTINUED

DN-557 SALINAS: 3000 sf w/ 7 ops & collecting over $2.225M. $1.4M
DG-619 SAN JOSE: One of the most unique practices you will ever see! 1450 sf w/ 5 ops $1.1M

NORTHERN CALIFORNIA

EC-525 SACRAMENTO: Great Location! Excellent Visibility! 1500 sf w/ 3ops, 10-15 new pts/mo. Motivated Seller $195k
EC-551 GREATER SACRAMENTO: Practice & Real Estate 1750 sf w/ 4ops + 1 add'l, 8npts/mo $800k
EN-464 ROCKLIN Facility: Don’t miss out on this remarkable opportunity! 2150 sf w/ 4 ops $100k
EG-589 SACRAMENTO: Perfect Downtown Location near Capitol. 2300 sf w/ 6 ops $475k
EG-638 CITRUS HEIGHTS: Focus on Crown & Bridge. 1,680 sf w/ 2 ops. Plumbed for 1 add'l & Room to expand. (Real Estate also Available) CALL for DETAILS!
EG-639 CITRUS HEIGHTS: Real Estate for Sale – Call for Details!
EN-609 SACRAMENTO: Remarkable, well-established, grosses $1.7mil+ /yr 3700 sf w/ 10 ops $1.7M
EN-625 SACRAMENTO: Looking for a HMO practice in a great Location? 2,500 sf w/5 ops $450k
EN-621 ELK GROVE: This opportunity comes loaded with goodwill galore! 1400 sf w/3 ops + 2 add'l! $195k
EN-626 CARMICHAEL: Lifestyle you just can’t be beat! HMO 1,250 sf w/ 3 ops $350k
EN-628 ORANGEVALE: Great place to work, play & live. HMO 1,310 sf w/ 4 ops + 1 add'l! $375k
EN-627 CARMICHAEL: Remarkable HMO opp. awaits your talent & skill! 1,200 sf w/3 ops + 1 add'l! $268k
EN-634 ROSEVILLE: Beautifully designed, well-appointed and fully digital! 2352 sf w/4 ops + 2 add'l $235k
FC-489 CLEARLAKE: Great lifestyle. 2015 Gross $915k on 3 day week, 4ops. Real Estate 3600 sf shared, interest “Pride Institute” designed office $470k
FN-527 TRINITY COUNTY: Be the only dentist in town! “Pride Institute” designed! 2350sf w/5 ops +1 add'l. $250k
GC-472 ORLAND: Live & Practice in charming small town community. 1000 sf w/2ops, Seller Retiring. $160k
GG-453 CHICO: 5000 sf w/ 7 ops Perfect for 1 or more dentists! $325k
GG-454 PARADISE: 2550 sf w/ 9 ops, 40 yrs goodwill! Amazing Opportunity! $525k
GG-517 YUBA CITY: Rare Opportunity to purchase Dental Facility with REAL ESTATE! $325k
GN-244 OROVILLE: Must See! Gorgeous, Spacious 2500 sf w/5 ops! $315k

NORTHERN CALIFORNIA CONTINUED

GN-399 REDDING: Loyal patient base & relaxed workweek schedule, 1440 sf w/3 ops $150k
GN-546 CHICO AREA: Catering to fearful patients, offering quality sedation dentistry, 2600 sf w/ 4 ops $350k
GN-606 BUTTE COUNTY: Hesitate & you’ll miss out on this one-of-a-kind opportunity! 1700 sf w/ 4 ops Only $245k
GN-641 YUBA CITY: Fantastic signage & visibility. Building available for purchase! 2,400 sf w/ 5 ops $475k
HN-213 ALTURAS: Well managed, consistent revenues! 2200 sf w/ 3 ops + 1 add'l! $115k
HN-280 NO EAST CA: Only Practice in Town 900 sf w/ 2 ops $60k
HN-618 SIERRA FOOTHILLS: Seller Retiring! Much room for growth by increasing office hours! 750 sf w/ 2 ops $95k
HN-633 AUBURN VICINITY: Loaded w/ warmth, charm & goodwill galore! 1,430 sf w/ 4 ops $525k

CENTRAL VALLEY

IC-468 SAN JOAQUIN VALLEY: High-End Restore Practice! 6 ops in 2500+ sf office. Call for Details! $425k
IN-569 MADERA: Stellar reputation and load with goodwill! 2,900 sf w/ 7 ops $634k
JC-541 FRESNO Facility: 1210 sf & consists of 2 fully equipped ops & plumbed for add'l op Call for Details!
JN-551 COALINGA AREA: Serving community of working families! Paperless Practice. 1200 sf w/3 ops $395k
JN-593 FRESNO: Change smiles in this quality family-oriented practice! 2430 sf, 6 ops $375k

SPECIALTY PRACTICES

AC-601 SAN FRANCISCO Perio: High quality practice, 30npts/mo, 3ops, Seller workback for smooth transition $800k
BC-600 CONCORD Ortho/Pedo Charts Only: Continue treatment to these Ortho/Pedo patients Call for Details! $400k
BC-612 CONTRA COSTA COUNTY Ortho: Just of the I-80 commuter corridor! Call for Details! Only $40k
CG-424 NAPA Prosthodontist: Digital X-ray & NEW 3D Imaging Unit! On track to collect just under $1m $690k
EG-637 CITRUS HEIGHTS (Prosthodontist): 1,680 sf w/ 2 ops. Plumbed for 1 add'l & Room to expand. $390k (Real Estate Also Available)
FN-536 LAKE COUNTY Perio: Focusing on Prevent dental problems before they begin! 1750 sf w/ 3ops $225k
IC-543 CENTRAL VALLEY Ortho: 1650 sf w/ 5 chair bays & plumbed for 2 add'l!, Strong Refs & Satisfied Pts Base $125k
IC-540 FRESNO Sleep Apnea: Motivated Seller retiring! Step right in & make it yours! Call for Details!

“ASK THE BROKER” CAN NOW BE FOUND AT WWW.WESTERNPRACTICESALES.COM
Round Health (Circadian Design, Free)

Patients around the globe benefit from widely available medications and supplements that work to improve health and quality of life. For select patients who have daily regimens that include multiple dosages of a vast array of drugs, it can be difficult to remember what or when something has been taken. The Round Health app seeks to assist patients with this challenging task by helping to keep track and send reminders to follow their medication schedule.

The premise of Round Health is simple. Users enter medications individually along with dosages and when they are expected to be taken. The app sends notification reminders to the user at specified times, similar to an alarm clock. When a medication is taken, a simple check mark is selected next to its name, which subsequently logs the time. A green “All Taken” message is displayed when patients complete their daily regimen. Users can see an entire history of when they took their medications through daily or monthly views and the data can be exported to other iOS apps as a CSV file. Users can select from not only prescription drugs but also over-the-counter drugs and supplements along with their available dosages. Refill reminders can also be entered so patients can be notified when its time to reorder. Users must register for a free account in order to sync their information across multiple devices. Otherwise, users can keep their information on the single device without an account. Round Health offers an Apple Watch app for additional convenience.

— Hubert Chan, DDS

Charging Your Cell Phones With Solar-Powered Battery Jackets?

You know how it goes: Right when you need to make a call or send an email on the go, your cell phone battery decides to run out of juice. Scientists at the University of Central Florida (UCF) may have a wearable solution. Jayan Thomas, a nanotechnology scientist who was recently acknowledged for developing a cable that transmits and stores energy like a battery, has created a filaments concept that can be woven into clothing to collect and store energy from the sun. You read that right, this could mean a solar-powered battery jacket is coming soon. Here’s more from UCF News: “The breakthrough would essentially turn jackets and other clothing into wearable, solar-powered batteries that never need to be plugged in. It could one day revolutionize wearable technology, helping everyone from soldiers who now carry heavy loads of batteries to a texting-addicted teen who could charge his smartphone by simply slipping it in a pocket.”

Thomas said the concept was inspired by the movie “Back to the Future Part II.” “That movie was the motivation,” he said. “If you can develop self-charging clothes or textiles, you can realize those cinematic fantasies — that’s the cool thing.”

For more information, visit today.ucf.edu.

— Blake Ellington, Tech Trends editor

Study Says Social Media Sways Consumer Spending

Businesses that utilize social media and have a high level of engagement on their posts may see a direct correlation with sales, according to a study at the University of Buffalo. The study, published in the Journal of Marketing, analyzed the sentiment and popularity of posts and how active users were on social media. The study found that the more popular posts were on social media, the larger impact it had on purchases.

The researchers looked at data from a large retail store with various locations, the customer activity on that company’s social media pages and its in-store purchases. Ram Bezawada is an associate professor of marketing and co-author of the study.

“The clear message here is that social media marketing matters and managers should embrace it to build relationships with customers,” Bezawada said. “Developing a community with a dedicated fan base can lead to a definitive impact on revenues and profits.”

For more information, visit buffal.edu.

— Blake Ellington, Tech Trends editor

Would you like to write about technology?

Dentists interested in contributing to this section should contact Tech Trends Editor Blake Ellington at blake.ellington@cda.org
Discover your inspiration.

Get your heart racing. Fuel your professional passion through fired-up lectures from industry leaders. See your talent, tools, inspiration and community in a new light at CDA Presents.
Opalescence offers a complete whitening menu to meet every patient’s needs and lifestyle. Each product can be used individually or combined with another product for quicker and more dramatic results.