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AFRICAN AMERICAN ORTHODONTISTS: How They Have Chosen To Practice Orthodontics

Abstract

by

TASHA WOODSON BOLDEN

The exploration into the professional lives of African American orthodontists was approached to reveal a detailed and in depth look at their individual professional experience as a private practitioner. The initial plan of the study was to conduct as many live interviews as possible with African American orthodontists, who are in private practice within the defined region of: New Jersey to northern Virginia to Illinois.

Qualitative methods were used via open ended interviews to uncover the stories of the participant's professional journey. Qualitative methods were effective in capturing the depth, details, and feelings of each participant's unique professional experience that would not have been revealed using quantitative methods.

A common theme amongst all participants was that race and racism had an impact on their professional lives. The participants concluded, although race and racism are still a factor, the race-based barriers they faced will not be as difficult for their successors to overcome. They encourage African Americans to consider careers in the field of orthodontics.

DEDICATION

I dedicate this project to my family. I thank you for all of your love and support given throughout this long journey. Special thanks to my father-in-law for helping me run that last mile.

With much love,

Tasha

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The advancements of African American orthodontists have been poorly documented throughout history. I would like to express my sincere appreciation and gratitude to the seventeen participants in this study who helped to rectify this void in history. They willingly opened themselves up and shared their professional stories and experiences, and for that I am truly grateful.

I would like to acknowledge and thank the members of my thesis committee Drs. Mark Hans, and Richard Griffith. A special thank you and appreciation is extended to my thesis advisor, Dr. Rhonda Y. Williams, whose wisdom, knowledge and belief in academic excellence, guided, encouraged, and supported me throughout this project.

Tasha W. Bolden D.M.D, M.S.D

INTRODUCTION

History

The practice of dentistry by Africans transported to the New World began upon their arrival on the shores of the North American continent. They brought knowledge of the craft with them from Africa and gained additional skills from dentists in the colonies.[1] According to Clifton Dummett in Afro-Americans in Dentistry: Sequence and Consequence of Events, in 1840 there were 120 African Americans practicing dentistry in the United States.[2] None of these men were formally trained dentists since this was also the founding year of the first dental school in the United States.[3] "One of the early examples of dental practice among Negroes in the United States was the account which appeared in the Pennsylvania Gazette on September 11, 1740, of a Negro named Simon who was able to 'bleed and draw teeth' and 'pretended to be a great doctor among his people."[4]

In 1865, the unforeseen freedom from slavery left most former slaves without dental care. They were unable to afford the care previously provided to them by

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[1] Clifton Orrin Dummett, *Growth and Development of the Negro in Dentistry*, (Chicago, IL: Stanek Press, 1952), 2.

[2] Clifton Orrin Dummett and Lois Doyle Dummett, *Afro-Americans in Dentistry: Sequence and Consequence of Events,* 1978, 3.

[3] Ibid.

[4] Dummett, 3.

plantation dentists and were therefore not welcome by their former oral care providers. The number of African American dentists, who possessed the qualifications and means to obtain a dental education, was minimal due to insufficient incentives and opportunities, such as limited access to training, inequality, and the lure of the more prestigious career of medicine. Regarding this matter Stephen J. Lewis wrote:

> As late as 1880 there were probably fewer than a dozen legal dental practitioners within the colored group. Most of those who had entered the profession at this time had done so largely through the suggestions of white practitioners for whom they had been employed as laboratory mechanics, coupled with the desire of white dentists to dispose of their colored patients. Hence the element of selective choice of a professional career as such played a minor role insofar as the field of dentistry was concerned.[5]

Those who chose to involve themselves with the education of African Americans in dentistry, "did so with a view to caring for the needs of the Negro population."[6] Their goal was to train and release these new black professionals into the African American community. The idea was that, "those who received this training should return to their people as soon as possible to care for their acute needs. Such a conditioning of the minds and ambitions of early African American dentists necessarily limited both their outlook and incentive."[7]

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[4] Ibid.

[6] Ibid

[7] Ibid.

The first African American to receive a formal dental education in the United States was Robert Tanner Freeman. In 1867, just two years after the end of the Civil War and the passing of the 13th Amendment to the Constitution of the United States, Tanner graduated from the Harvard University Dental School, the first non-proprietary dental school in America.[8] When formal education programs in dentistry and medicine were opened to African Americans, a career in medicine was more attractive and popular than a career in dentistry. A dental education was considered inferior to a medical education because the former was generally not a university discipline.[9] In 1882, Howard University, which was established in 1867 to provide college education for African Americans, opened a college of Dentistry as part of the medical school program. The College of Dentistry became an independent entity at Howard in 1929.[10]

Three of the early pioneers in African American dental history were Dr. George Franklin Grant, Dr. William A. Jackson and Dr. Charles Edwin Bentley. Dr. Grant, developer of the oblate palate (cleft palate appliance), graduated from Harvard Dental School in 1870.[11] He was the first African American dentist appointed to Harvard's dental faculty, where he served 19 years. He was a founding member and

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[8] Dummett, 6.

[9] Dummett, 33.

[10] Dummett, 34.

[11] *Quintard Taylor, "Grant, George Franklin (1847-1910)", BlackPast.org: Remembered and Reclaimed, [an on-line reference guide to African American History] available from* http://www.blackpast.org/?q=aah/grant-george-franklin-1847-1910;Internet; *accessed 22 March 2007.*

president of the Harvard Odontological (dental) Society, and he was elected President of the Harvard Dental Association in 1881.[12] Dr. Jackson graduated from the Philadelphia Dental College, where he worked as a janitor before and during his entire period of study, in 1889. He provided financial assistance to struggling African American dental students. Dr. Bentley graduated from Chicago College of Dental Surgery in 1887.[13] He treated both white and African American patients and was the first to suggest dental examinations for school children. Dr. Bentley was also credited for aiding many schools, benevolent societies and other organizations.[14] Dr. Ida Gray Rollins, the first African American woman to earn a degree from a dental school, graduated in 1890 from the University of Michigan. She was the first black female practitioner in Chicago, Illinois.[15] The achievements of these African American pioneers in dentistry and their contributions both to the profession of dentistry and to the growth and development of their people are examples of benefits that can flow from opening professions to all who can qualify to serve.

The specialty of orthodontics welcomed its first African American practitioner, Dr. Earl Wiley Renfroe, in 1942. Dr. Renfroe received his orthodontic certificate and Master's degree from the University of Illinois, Chicago College of

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[12] Ibid.

[13] Dummett, 8.

[14] Ibid.

[15] Elsa Barkley Brown, Darlene Clark Hine, and Rosalyn Terborg-Penn, *Black Women in America: An Historical Encyclopedia*, (Brooklyn, New York: Carlson Publishing, Inc., 1993) 1316.

Dentistry. He earned his Doctor of Dental Surgery degree from the same university in 1931. Dr. Renfroe graduated first in his class of 127 students. He accomplished this achievement while working fulltime outside of the University and carrying a full course load of credits. Dr. Renfroe was promoted to associate professor at the University of Illinois College of Dentistry in 1953, and then to full professor in 1957. According to William Bike, a biographer of Dr. Earl W. Renfroe, "Dr. Renfroe was acknowledged as the best hands-on clinical orthodontic instructor in the world."[16] He is considered, by the Brazilians, as one of the "Fathers of orthodontics in Brazil"[17] because of his commitment and dedication to improving the knowledge of orthodontics in Brazil.[18] Bike continued, "Upon being invited to Brazil the first time, he learned Portuguese so he could teach the course in the Brazilian dentists' native language."[19]

Dr. Renfroe broke down many barriers for African Americans. After he became a member of the University faculty in 1953, he challenged Jim Crow policies by ending the "practice of students being allowed to work only on patients of the same race as themselves" at the College of Dentistry.[20] He was the first African

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[16] William S. Bike, *Dr. Earl Wiley Renfroe, 1907-2000*, [University of Illinois at Chicago website on-line], (Chicago, Il: The Board of Trustees of the University of Illinois, 2004, accessed November 2004); available from http://www.uic.edu/depts/dort/Renfroe.html; Internet.

[17] Ibid.

[18] William S. Bike, *Essays on Earl Renfroe – A man of Firsts*, (Chicago, IL: University of Illinois at Chicago College of Dentistry, 2001), 37-40.

[19] Bike, *Dr. Earl Wiley Renfroe*, http://www.uic.edu/depts/dort/Renfroe.html; Internet.

[20] Ibid.

American to head a department at the University of Illinois' Chicago College of Dentistry where he was named head of the Department of Orthodontics in 1966. In 1957, "Dr. Renfroe and Dr. Thomas Barber, another UIC College of Dentistry faculty member (department of Pediatrics), collaborated on their seminal article entitled "Interceptive Orthodontics for the General Practitioner", which was published in the *Journal of the American Dental Association.*[21] The article which discussed the concepts of preventive and interceptive orthodontics, was republished in many different languages and journals worldwide. A year later, Dr. Renfroe was elected president of the Chicago Association of Orthodontists.[22] Dr. Renfroe also became well known in the dentistry profession for his published textbooks. In 1960 *Technique Training in Orthodontics* was published.[23] The Brazilian army made the book required reading for its dentists in 1964. The text, *Edgewise,* his second textbook, was published in English in 1975 and in Japanese in 1977.[24] Dr. Renfroe was listed in eight published "Who's Whos".[25]

When Dr. Renfroe opened his office in Chicago's downtown loop area, it was the first acknowledged office for an African American professional in any field in Chicago's downtown.[26] In 1934 he was also the first African American in Illinois to

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[21] Ibid.

[22] Ibid.

[23] Earl Renfroe, *Technique Training in Orthodontics* (Ann Arbor, MI: Edwards Bros. Inc., 1960).

[24] Earl Renfro, *Edgewise* (Philadelphia: Lea & Febiger, 1975).

[25] Bike, *Dr. Earl Wiley Renfroe,* http://www.uic.edu/depts/dort/Renfroe.html; Internet.

[26] Ibid.

be licensed as a commercial airline pilot. Dr. Richard P. Perry, former president of the Illinois State Dental Association, stated "Dr. Renfroe was a brilliant dental student, the best hands on clinical instructor of his time, a pilot, a soldier, a leader in the fight for racial equality and a true gentleman."[27] Dr. Earl Wiley Renfroe taught for over 50 years at the University of Illinois at Chicago, College of Dentistry.

During the 1950's, there was a spurt in the growth of dental specialists. African American dentists did not participate in any significant numbers in that growth. There are two acknowledged reasons for the lack of participation of African Americans in the initial growth of dental specialties. One was the financial burden of obtaining the required education and starting a practice. The second was the non-appreciation of specialty standards by "the individuals of the profession and in the community who would form an outlet for specialty services."[28] There is another probable, yet unacknowledged reason as well: the effects of racial discrimination. The "separate but equal" doctrine that barred African Americans from many dental schools in the country was not abolished by the United States Supreme court until 1954. Consequently, a number of the schools that offered the education required to become an orthodontist were not open to black students until after that date. Most African American practitioners, therefore, could only pursue careers in general dentistry.

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[27] Ibid.

[28] Dummett, 54.

Since Dr. Renfroe received his credentials to practice orthodontics in 1942, there has been only a modest increase in the number of African American orthodontists. Data on the number of African American orthodontists today and the number of students in training for a degree in orthodontics is very difficult to obtain. According to the American Dental Association ("ADA"), there are currently 117 African American orthodontists practicing in the United States. That number would represent about 1.25 percent of the total number of practicing orthodontists in the country.[29] Dr. Donald M. Russell, clinical director of the Department of Orthodontics at Howard University, organized a directory of "Orthodontists of African Descent" in 1994.[30] This directory which has not been updated listed over 200 names of practicing African American orthodontists as of the date of publication. There are more practicing African American orthodontists graduating every year so the number recorded in the directory most likely has increased. Dr. Mathews, a study participant who will be characterized later, believes the number recorded by the ADA is probably understated by at least fifty percent.[31] Many African American orthodontists are not members of the ADA. This might be the cause of any inaccuracy in the ADA's data base. There are no other sources for the number of African American orthodontists. Nor, as will be discussed in the Literature Review for this study, is there much

[29] Howard M. Landesman, "In a troubled economy, partnerships between corporate America and academic institutions are crucial," The Bridge Online, July 2003[newsletter on-line]; available from http://www.uchsc.edu/news/bridge/2003/July/lazarra.html; Internet; accessed October 2003.

[30] Donald M. Russell, *Orthodontists of African Descent: 1994 Directory*, (non-published document)

[31] Dr. Mathews, [pseud.], interview by author, tape recording, 21 June 2004.

information or data on the achievements, contributions or tribulations of African American orthodontists. This absence in the literature sparked the interest for this thesis. After preliminary study and exploration, the initial question of "Was the small number of African American orthodontists and the absence of a record of the development of African Americans in orthodontics the results of racism?" evolved into how has race affected the experience and professional development of African American orthodontists?

Race

In this study, race refers to a group of people, with similar heritage, background and color[32] such as African Americans whose history in the United States has been recorded under the terms of slaves, "negroes," "colored people," blacks and most recently African Americans. Racism is the feeling of superiority of one group or groups of people over another group or groups and the discrimination based on such belief.[33] This study examines the effects of race and racism on the educational and career paths of African Americans in the practice of orthodontics. The battle to achieve racial equality has been and continues to be one of the biggest challenges of the United States.[34] Both the Civil War, and the Civil Rights struggle have been

[32] Merriam-Webster's desk dictionary Merriam-Webster Inc. 1995, 450.

[33] Ibid.

[34] W.E.B. Dubois, *The Souls of Black Folk 1903*, (New York: Alfred A. Knopf, 1993), 5.

about achieving or securing the legal, social, economic and political rights of African Americans.

Many volumes have been written on various aspects of racism faced by many groups of people throughout recorded history.[35] The discriminatory and pernicious effects of racism on African Americans in most areas of life in the United States, including education[36], housing[37], employment[38], health[39], incarceration[40], and

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[35] Jeff Plunkett, *Is Racism a Serious Problem?*, (Detroit: Greenhouse Press, 2005), 7-18 &109-114; and David K. Shipler, *A Country of Strangers: Blacks and Whites in America*, (New York: Alfred A. Knopf, 1997); and George M. Frederickson, *The Arrogance of Race*, (Connecticut: Wesleyan University Press, 1988); and Harriet A. Washington, *Medical Apartheid,* (New York: Doubleday, 2006).

[36] Michael Winerip, *Discovering Crisis Again and Again*, (New York Times, April 30, 2003), B7.

[37] Thomas J. Lueck, "New York Ranks High in Housing Bias," *New York Times*, 3 November 1991, R1; and John Yu, "Economists Know About Bias in Lending," *New Times*, 4 September 1994, E10.

[38] Walter Fields, "African Americans Marginalized in Job Market," *Black information link*, 23 March 2004 [journal on-line]; available from http://www.blink.org.uk/pdescription.asp?key=3091&grp=18; Internet; accessed 13 March 2007; and D. Johnston and E. Lichtblau, "A critical study minus criticism," *New York Times,* 31 October, 2003, A1.
James E. Turner, "New Millennium Challenges for African Americans, The Legacy of Racism and Social Inequality: ", *The Black Collegian Online;* available from http:// www.black-collegian.com/news/special-reports/millenium1999; Internet; accessed 13 March 2007.

[39] J. L. Webster, Sr. MD, "Harvard Scholars Prove Racism in Healthcare Major Contributor to Health Gap in African Americans", *BlackNews.com;* [journal on-line]; available from http://www.blacknews.com/pr/harvardscholars101.html; Internet; accessed from 13 March 2007; and Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington, D.C.: The National Academies Press 2003) 80-123; and January W. Payne, Dying for basic care: For blacks poor healthcare access caused 900000 lives, Washington Post.com, Washingtonpost.com/ac2/wp-dyn/a13690-2004dec20?lan; accessed 13 March 2007.

[40] "Race and Incarceration in the United States: Human Rights Watch Press Backgrounder,", *Human Rights Watch,* 27 February 2002 [journal on-line]; available from http://www.hrw.org/backgrounder/usa/race/; Internet; accessed 13 March 2007; and Eric E. Sterling, "Racially Disproportionate Outcomes in Processing Drug Cases", *News Briefs* 16 September 1998 [journal on-line]; available from http://www.ndsn.org/sepoct98/outcomes.html; Internet; accessed 24 March 2007.

entertainment[41] are well documented. The progress of the United States in establishing equal opportunity for African Americans and other groups, such as women, who have been excluded from full participation in economic and political areas, have also been recorded in many different sources. However, the effects of racism on the practice of orthodontics by African American practitioners is largely undocumented.

Landmark cases by the United States Supreme Court such as *Plessy vs. Ferguson,* 163 U.S. 537 (1896), which established the "separate but equal" doctrine; *Brown vs. Board of Education,* 347 U.S. 483 (1954), which abolished the "separate but equal" doctrine; *Regents of University of California v. Bakke* 438 U.S. 265 (1978) and the recent University of Michigan discrimination cases, *Gratz v. Bollinger* 539 U.S. 244 (2003) and *Grutter v. Bollinger* 539 U.S. 306 (2003), all of which limited affirmative action for admission into college, have affected the availability of educational opportunities for African Americans.[42] Education is an essential key to the privilege of practicing orthodontics. Discriminatory barriers to education would therefore limit the number of African American orthodontists.

In the United States the percentage of African Americans practicing various professions are usually less than the percentage of African Americans in the working

[41] Holman, "Myths and Matters of Race, Sports like American Society has a Fractured Picture", *New York Times*, 19 June 1998, SP11; and NAACP in Report on Hiring Bias, Criticizes the Recording Industry", *New York Times,* 27 April 1987, C13.

[42] Reginald Wilson, "Affirmative Action – 2003" *New Politics*, vol. 9, no. 4 (new series), whole no. 36, Winter 2004 [journal on-line]; available from http://www.wpunj.edu/newpol/issue36/Wilson36.htm; Internet; accessed 5 May 2007.

population. This is true for law, higher education, medicine, dentistry and others.[43] There are probably different reasons for the discrepancies in these numbers. Some reasons are related to barriers (such as lack of education and work experience, discrimination in hiring, etc.) to entry into professions. Other reasons for the difference in numbers pertain to barriers that had to be overcome by African Americans after entering professions. Ellis Cose in *The Rage of a Privileged Class*, a book-length essay on race in America, focused on several of the barriers that must be overcome by African Americans after entry into specific professions. He wrote, "No other racial group in American history has endured as much rejection on the path to acceptance" as have African Americans. Cose also points out, "For most blacks in America, regardless of status, political persuasions, or accomplishments, the moment never arrives when race can be treated as a total irrelevancy."[44]

Another factor that has to be dealt with continually by African American professionals is the effect of skin color. According to chief justice Earl Warren, who wrote the majority opinion in *Brown v. Board* of Education, an important part of that case for plaintiffs was the work that showed the preference for white skin over black skin in the United States and the potentially inerasable effects that phenomenon together with segregation might have on the hearts and minds of young black children. In the famous footnote 11 to the opinion of *Brown*, Justice Warren cited the

[43] Department of Labor Statistics for 2006 Household Data Annual Averages, According to the Data in 2006 there was an average of 144 427,000 persons over the age of 16 years employed in the United States. African Americans constituted 10.9% of that number, but only 2.9% of lawyers, 5.2% of physicians, 6.7% of post secondary educators, and 3.4% of dentists.

[44] Ellis Cose, *The Rage of a Privileged Class: Why are middle-class blacks angry? Why should America care?* (New York, NY HarperCollins, 1993) 9.

work of Dr. Kenneth Clark and others who demonstrated in the "doll experiment" the preference of African American grade students for white dolls over black dolls.[45] So deeply rooted is the belief that dark-skinned people are inferior, violent, lazy and unable to be trained, even to some extent amongst people with dark complexions, that the behavior resulting from that prejudice has been identified and demonstrated in many different studies in housing, employment, social encounters and other facets of life in America. For instance, Malcolm Gladwell in the recent bestseller *Blink* even documents the negativity associated with dark pigmentation in American society.[46] Gladwell shows how the social reality of race and color are so much a part of the fabric of our society that most people cannot mask the effects of the phenomenon, even when they know they are being tested for it.[47]

This fact serves as a backdrop for every section of this study. All of the participants of the study acknowledged that African Americans have to be prepared to deal with the effects of race and racism all of the time. The question that emanated from that consensus is, "In what ways has race affected the African American orthodontist in private practice?"

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[45] "With an Even Hand, Brown v. Board at Fifty," *The library of Congress: Exhibitions*, 14 October 2004 [journal on-line]; available from http://www.loc.gov/exhibits/brown/brown-brown.html; Internet; accessed 2 May 2007.

[46] Malcom Gladwell, *Blink: The Power of Thinking Without Thinking,* (New York: Little Brown and Company, 2005) 77-88.

[47] Malcom Gladwell, *Blink: The Power of Thinking Without Thinking,* (New York: Little, Brown and Company, 2005) 77-88.

REVIEW OF LITERATURE

A review of the literature on the history of American orthodontists nearly excludes African American orthodontists. There are few written accounts of how race affected the experience, contributions, challenges and triumphs of African American orthodontists. Except for general discussion of the early pioneer in the field, the stories of the professional experience of other African American orthodontists have not been recorded in accessible references. The exploration of data and information from professional organizations regarding African American dentists and orthodontists was not very enlightening. The ADA and the American Association of Orthodontists ("AAO") respectively shed only a little knowledge on the subject. As mentioned earlier, the ADA has reported that approximately 117 African American orthodontists are practicing in the country.[48] However, whether that number is accurate or suspect, such statistics fail to elucidate the experiences of African Americans practicing orthodontics.

Due to the dearth of information regarding African American orthodontists, there is a need for literary contribution to dental, orthodontic, and African American entrepreneurship (as it relates to private practice in orthodontics) history. Previous

[48] Howard M. Landesman, "In a troubled economy, partnerships between corporate America and academic institutions are crucial," The Bridge Online, July 2003 [journal on-line]; available from http://www.uchsc.edu/news/bridge/2003/July/lazarra.html; Internet; accessed October 2003.

historical research on the dental and orthodontic professions as well as African Americans as entrepreneurs, nearly excludes African American orthodontists.

In 1990 Richard Glenner et al. published a "historical-sociological account" of The American Dentists. This pictorial account "is intended to introduce the reader to major components of a dentist's career and how it grew out of American society, as well as contributing to this society over the past century and a half."[49] In this monograph, the author dedicates a chapter to "Who became dentists in America." According to this chapter, approximately 120 African Americans were practicing dentistry by 1840. African American dentists of that time acquired their skills and techniques from their apprenticeships with white, more prominent dentists. The chapter also provides a very brief chronology of African American dental history from 1867 – 1930 documenting the first African American dentists (male and female), the founding of Howard University, the founding of the Robert Freeman Dental Society, and a chronology of the number of African American dentists in 1910, 478 to 1,773 in 1930. For the most part this book focuses on the practice of white dentists and the development of dental equipment and offices from the eighteenth century to post World War II.

In 1952 Clifton Orrin Dummett Published the Growth and Development of the Negro in Dentistry in which he gave a historical perspective of the pathways of the African American dentist. Dummett's historical coverage begins with the earliest

[49] Richard A. Glenner, Audrey B. Davis, and Stanley B. Burns, *American Dentist: A Pictorial History With a Presentation of Early Dental Photography in America*, (Missoula, Montana: Pictorial Histories Publishing Co, 1990).

African civilization and their tribal dental habits. He continues the history with accounts of African Americans who practiced prior to the end of slavery and the nature in which they practiced, only treating African American patients sent to them by white dentists who did not want to treat them. Some of these African American dentists were foreign trained or were lab technicians for white dentists who no longer wanted to provide care to African American patients. Dummett included accounts of African Americans, trained to be technicians to treat "their own people", who experienced much ridicule for competing with white practitioners. White practitioners, distressed by the competition demanded legal action be taken to abate the practice of dentistry by African Americans.[50] Dummett further develops the history of African American dentists after slavery with several accounts of formally trained African American dentists and their individual accomplishments. The book documents the beginning of the first African American Dental Society, the National Dental Association, a study on inter-professional relationships, dental education and specialization. Although dental specialties were researched within this book, orthodontics was not included except for the mention of the State of Board of Dental Examiners in Illinois listing Dr. Earl W. Renfroe as holding a specialty license in Orthodontics.[51]

Except for this book, the majority of the texts and articles reviewed, published between 1926 and 1990, regarding the history of dentistry and orthodontics, excluded

[50] Dummett, 4.

[51] Dummett, 52-58.

African Americans as part of dental history. The objectives of these books were quite broad. They covered different eras of dentistry including ancient times, the fall of Rome, the modern era, and the history of the specialties.[52] However, despite this breadth of experience, there is no mention of the contributions or development of African American dentists or specialists. Herman Prinz also develops in Dental Chronology, a timeline of important historic events in the evolution of dentistry from antiquity through modern times. He too overlooks the experiences, roles and contributions of African Americans to the profession.[53]

An interesting quote from Milton Asbell's book, Dentistry states, "Dental history contains the story of the professions' entire culture and the related components of knowledge. The dentist who shows a lack of interest in the historical data of his professional fathers, demonstrates both a deprecation and depreciation of ancestral values, those solid values upon which mankind has perpetually registered its pride and affection."[54] Given the fact that Asbell makes such a profound statement regarding the importance of knowing and acknowledging one's entire professional

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[52] Wilbur Morse Shankland, *The American Association of Orthodontists: the biography of a specialty organization,* (St. Louis: American Association of Orthodontists, 1971).
Robert W McCluggage, *A history of the American Dental Association; a century of health service,* (Chicago: American Dental Association, 1959).
M.D.K Bremner, *The story of Dentistry from the dawn of civilization to the present, with special emphasis on the American scene*, (Brooklyn, New York: Dental Items of Interest Pub. Co., 1954).
Arthur Ward Lufkin, *A History of Dentistry*, (Philadelphia: Lea & Febiger, 1948).
J. Ben Robinson, *Foundations of Professional Dentistry*, Baltimore, MD: Waverly Press, Inc., 1940).
Alfred J. Asgis, *Professional Dentistry in American Society, A Historical and Professional Approach to Dental Progress,* (New York: Clinical Press, 1941).
Bernhard Wolf Weinberger, *Orthodontists: An Historical review of its Origin and Evolution, Including an Extensive Bibliography of Orthodontic Literature Up to the Time of Specialization*, (St Lois: The C.V. Mosby, 1926).
[53] Herman Prinz , *Dental Chronology: a record of the more important historic events in the evolution of dentistry*, (Philadelphia, Pa: Lea & Febiger, 1945).

[54]Milton B. Asbell, *Dentistry: A historical perspective*, (Bryn Mawr, Pa, Darrace & Co. Inc, 1988).

history and culture, it is remarkable that he makes no reference to African Americans in dental history. Is one to interpret this to mean there are no "solid values" from which "pride and affection" can be developed from the dental history of African Americans? This book follows the tradition of the majority of dental history literature. It highlights the accomplishments of whites and disregards the contributions of African Americans in dental history.

THESIS STATEMENT

African American orthodontists in private practice, located in the Northeastern and Midwestern parts of the United States, during the last forty years, believe that race and racism have adversely affected their practice in orthodontics. In such areas as the preparation for entry into the profession, the location and financing of their business, the perception of their practices and the referrals of patients to them by their white peers, African American orthodontists maintained that they have faced and have had to overcome obstacles and barriers that were different from ones faced by their white peers.

METHODOLOGY

Given the paucity of information available on the subject of this study, a qualitative research approach was adopted. Qualitative research approaches are especially effective in studies where little empirical research exists.[55] The decision was made to conduct face-to-face interviews with African American orthodontists in private practice. The goal was to learn as much as possible about the experiences and role of race and racism on African American orthodontists from the men and women in the profession who are the focus of this study. This type of information is better suited for a qualitative approach because personal experience, motivation and feelings about race and racism are not easily unveiled from numbers. A qualitative research approach protects the participants experiences from generalizations often concluded from quantitative studies. The initial plan of the study provided for the interviews of as many African American orthodontists as possible from New Jersey to northern Virginia to Illinois. The number of potential participants in the geographical region selected for the study is upward of sixty doctors. There are more than thirty African American orthodontists known to be practicing in Washington, D.C. metropolitan area alone. In fact, the number of potential participants in Washington D.C. was very impressive and maybe sufficient to warrant a separate study for just that group. Using

[55] Michael Quinn Patton, *Qualitative evaluation and research methods*, 3d ed., (Thousand Oaks, CA: Sage Publications 1990) 10-14.

the 117 estimate provided by the ADA, the doctors in the nation's capitol represented almost a third of the practicing African American orthodontists in the country. As it turned out, only one orthodontist (out of approximately 20 contacted) from Washington, D.C. was able to participate in the study. A number of those contacted chose not to participate. Most of those who did agree to be interviewed were never able to schedule a convenient time to do so.

Seventeen African American orthodontists, 16 men and one woman, from six states, New Jersey, Maryland, Virginia, Pennsylvania, Ohio, Illinois and Washington D.C. participated in this study. I conducted the interviews between May and September 2004 in the offices of the participants. Holding the interviews at the participants' place of business gave them the ability to speak candidly in a comfortable setting. That method also presented the opportunity to observe the locations and environments of the offices as well as patient populations, the participants' people skills, and other pertinent information.

The participants presented a rich tapestry of diversity in terms of backgrounds, education, and experience. It was therefore remarkable that they were in agreement on most of the findings of the study pertaining to race. The participant with the longest tenure opened an office in an urban area with a large affluent African American community in the 1960's. The one with the least tenure began practicing in an office in a suburban all white community in the 1990's. The participants have all been in private practice for at least 10 years.

Participant Demographics

- Five participants came from a family where one parent or close family member was doctor or dentist. Only one of the participants took over the practice of a parent.
- Three participants were born and raised in the South; six in the North; six in the Midwest; and two in the Caribbean.
- Two participants attended white institutions for all their higher education. Two attended predominantly African American institutions for all of their higher education. The remaining 14 participants attended both white and African American institutions for various parts of their higher education.
- Four participants had offices in predominantly white communities and eight had offices in predominantly African American communities. The rest (5) had practices in diverse communities.

With permission of the participants, the interviews were all recorded, except for two. The format of the interview consisted of an informal warm-up period of general conversation, followed by a more formal discussion during which each participant answered a series of similar open-ended questions. The purpose of the interview was to have the participants tell their stories in their own words. The interview questions were only used as a guide. Each participant completed a demographic sheet regarding themselves and their practice. The interviews were analyzed to derive the observations and conclusions presented herein. The participants were also told that their identities would remain confidential. To keep

that assurance, a code name has been assigned to each participant for use in this study. Each participant is referred to by the same name throughout the study. In some cases the use of demographic information, such as the name of the city in which a practice is located, is not disclosed in order to preserve the covenant of confidentiality with the interviewees.

BOUNDARIES OF THE STUDY

This study is an initial probe into the practices and experiences of African American orthodontists in the United States. The practice of orthodontics in other regions of the country may be different enough from those in the geographic area of this study to warrant different reports about those regions. This study did not delve deeply into the financial success of the participants. That subject and other aspects of the experience of African American orthodontists, such as their involvement in professional associations and the barriers that still must be overcome in funding their practices are left to further studies.

The small number of women in the participant group also leaves unexplored any differences that may exist from the effects of gender and racism in the experience of African American orthodontists in this study.

EDUCATION

"I think it is awfully sad that the state of Illinois has not trained a black orthodontist since the seventies." Dr. Carter[56]

Completion of dental school and orthodontic training programs are keys to the privilege of practicing orthodontics. Those keys also act as barriers to practice for those who are denied entry into such institutions. The captioned quote was made by an administrator at a dental school in Illinois in 1992, indicating, for two decades no African American was trained to be an orthodontist in that state. To be sure, there are probably a number of reasons for this result; but despite any stated reasons, the effect is still devastating to African Americans who might have wanted to learn orthodontics in that state. This is an example of how education, or as in this case the lack of access to required training, can be a barrier to entry into the field of orthodontics.[57]

Dr. Carter, an African American orthodontist, who has practiced in a Midwestern city with a predominantly African American patient population since 1993, was sought after by the administrator to whom the quote is attributed, to end the long drought of no African American orthodontists being trained in that state for

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[56] Statement made by University of Illinois orthodontic department administrator, quoted by: Dr. Carter [pseud.], interview by author, tape recording, 15 May 2004.

[57] Richard G. Weaver et al., "Applicants to U.S. Dental Schools: An Analysis of the 2002 Entering Class," *Journal of Dental Education* 68 (8): 880 – 900, August 2004 [journal on-line]; available from http://www.jdentaled.org/cgi/content/full/68/8/880; Internet; accessed 5 May 2007.

20 years.[58] It is ironic that this long period during which no African American was trained to become an orthodontist occurred in the state where the first African American orthodontist in the country was trained.[59] The drought also took place while Dr. Renfroe was being heralded as the best hands on instructor of orthodontics in the country and the father of orthodontics in Brazil.

Obtaining a professional education is a challenging process within itself. When coupled with the burdens of race, the effects can be overwhelming. This is especially true for African Americans who attended white dental schools and or orthodontic training programs. Most of the doctors in the study who attended predominantly white schools were the only African Americans in their classes and in many cases their schools.

Dr. Hamilton, the only woman participant in the study, shared an example of dealing with the burdens of race and gender in the educational cycle. In the first week of her orthodontic residency program, a faculty member stated matter-of-factly: "I do not like blacks and I do not like women so good luck."[60] The faculty member knew nothing about Dr. Hamilton except for what he could physically see before his eyes – an African American woman. Dr. Hamilton took the comment in stride, stayed in the class, performed well academically and graduated from the program. The results of abusive, race-based and gender based statements like the one made by

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[58] Dr. Carter

[59] See page 4-6

[60] Dr. Hamilton [pseud.], interview with author, 05 Jun 2004.

the faculty member are extremely disruptive for African American students. Such comments interfere with the educational and learning process by shattering the innocence of a fresh new mind which should be focusing on exploring the mysteries of new knowledge, but instead have to adopt a defense mode to deal with the burdens of racism. African American students spend much energy overcoming experiences like that – energy their white colleagues can devote to their studies.[61]

Dr. Dean, has been practicing for 32 years in the northeast. He attended an all white dental school and revealed a common assumption held by some whites about the educational experiences of African American students who obtained their undergraduate degrees at historically black colleges or universities. He shared, "There was some prejudice against the fact that I went to a black school [college]."[62] An administrator told him: "We only want the top students from around the country." He continues, "But I kept pursuing it. I was working in the histology department and I was working in one of the labs and a white guy, who was confident in my success kept encouraging me [to reapply] and I went to back to apply. They asked that I take some of the larger [white] university courses. They asked me to take English and then Anatomy."[63] This type of institutional bias, based upon a false prejudgment of the African American student's ability to do the work at the white institution because of the preparation learned at a black institution, is another example of racial burdens

[61] Ethan Bronner, "Colleges Look for Answers to Racial Gap in Testing, *New York Times*, 8 November 1997, A1.

[62] Dr. Dean [pseud.], interview by author, tape recording, 28 May 2004.

[63] Ibid.

to which African American students must focus time and energy. Their white colleagues are often spared the necessity of proving they really belong in the institution. Since the white students graduated from predominately white institutions, there is an assumption they can do the work in graduate school. This is an energy draining process that can affect the performance of those subjected to racism on a daily basis.[64]

The doctors in the study who attended white institutions often encountered other incidences of racism. These occurrences made the African American students feel unwanted and had harmful effects on their ability to thrive at those institutions. These encounters quite often took the form of false prejudgments of the African American students at those institutions. Dr. Dean shared this experience,

> I remember in dental school it was kind of tough. I used to hang with the white guys and drink beer. They got to talking and they came out and said they did not know what to think of me when I first got there. 'We thought that you must have been a straight A student and you would come in and make straight A's. We thought you were exceptional. Then we thought that you would come in and flunk out and the university would get all kinds of government money and then you would be gone, but then we realized you were just like us, you get an A here a B there a C here, you're just a regular person, and drink beer with us.[65]

Dr. Dean used these socializing opportunities to overcome the inaccurate prejudgments of his white peers. He also was able to demonstrate his ability to satisfy the academic requirements of the program. He was so successful at

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[64] Tara Mark, "Racial Article Angers Many at George Mason", *Washington Post,* 13 November 1996, B1.

[65] Dr. Dean.

confronting and changing the initial bias against him, that upon graduation his white peers and faculty members voted him most likely to succeed.[66]

The sentiment from African Americans who attended white schools is summed up by Dr. Dean, who said, "Racism was rampant."[67] As students, the participants had to overcome these obstacles in order to move to the next stage of their development. Even obtaining references for admission into professional programs was affected by racism. Dr. Ioni, a study participant who graduated from a large white dental school and has been in practice in an urban center for fourteen years, said he felt "A woman (white faculty advisor) who is really hard on African Americans did not write a letter of recommendation for me."[68] He had to find another source of reference

The educational experience for the participants who attended predominantly African American institutions differed from their cohorts who graduated from white institutions. The former group found support, nurturing and camaraderie in their schools. Typical of their experience is a story relayed by Dr. Boyd, a Midwestern orthodontist, who has practiced in an urban setting for nineteen years. He attended a predominantly African American institution for all of his professional education. Dr. Boyd said,

> In high school I knew I wanted to be a dentist but messed around and did not study. I chose Knoxville College because of my poor grades I got in high school... While I was at Knoxville College I was exposed

[66] Ibid.

[67] Ibid.

[68] Dr. Ioni [pseud.], interview by author, tape recording,, 08 June 2004.

> to dentistry ... at Meharry. Through a summer program there [Meharry] I took some science classes. I then applied to [University of] Illinois, Howard [University] and Meharry [Medical College]. I never heard from Illinois, but got a conditional acceptance at Howard.[69]

Dr. Boyd was exposed to orthodontics at Howard where the white director/chair of the department "shook me up and reinforced the importance of school. That is the kind of experience (the extent of support and mentorship) you get from going to a black school."[70] The participants who attended black professional schools also took pride in their institutions and the achievements of other African American students and faculty. Dr Boyd said,

> Going into the hospital cafeteria and seeing so many black physicians, surgeons, oral surgeons.... To see these guys it was like WOW, it kind of just made you swell up. We had some of the brightest minds in medicine I have always gone to predominantly black schools and I would not change anything... At Howard, half of the class was white and it was awesome to see the top students in our class were black.[71]

Perhaps that is why none of the participants in the study who graduated from a predominantly African American orthodontic training program are practicing in predominantly white communities.

Education is the key to the practice of orthodontics. The members of this study encountered racism at various levels of their educational journeys. Those who attended predominantly white institutions had to deal with more incidents of racism than their peers who attended predominantly African American institutions. In both

[69] Dr. Boyd [pseud.], interview by author, tape recording,, 15 May 2004.

[70] Ibid.

[71] Ibid.

cases the members of the study were able to overcome the burdens of race to accomplish their professional goals.

LOCATION

"The good ole adage for business is location, location, location." Dr. Mathews[72]

Selecting a location is one of the most important decisions in the establishment of an orthodontic practice. Many factors must be considered to find the best location, such as the demographics of the community, the accessibility of the site, the number of general practitioners (GPs), and the number of other orthodontists already in the area. For most of the black orthodontists in this study, however, there was also another factor – the racial composition of the community and the race of GPs in the area.

Sixty five percent of the doctors in this study established their initial practice in an African American community. Although the participants in the study had their unique reasons for selecting specific locations, one rationale they had in common was trying to reduce the level of risk they might incur by trying to cross the color line. Comments like, "I wanted to go someplace where I knew I could get referrals," surfaced numerous times.[73] The response of Dr. Edwards, an orthodontist who has been in practice for thirteen years in an urban community with a predominantly African American population, exemplifies this recurring concern:

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[72] Dr. Mathews.

[73] Dr. Olsen [pseud.], interview by author, tape recording, 22 June 2004.

> It is a referral based business and if you have to cross the color line it is a little more difficult to make the connection. I think I could have done it, but it may be more difficult for others. I think it could be done but it is something we would have to deal with uniquely.[74]

These orthodontists expressed an awareness of the social and political ramifications of navigating a society where race still structured economic and business practices. Therefore, they chose to practice in areas where they believed they would be easily accepted as African Americans and their race would not be viewed as a negative or cautionary factor.

In African American or diverse communities, the African American orthodontists interviewed in this study also took comfort in knowing that they had support and the ability to use established contacts. That comfort was based upon a sense of familiarity with the area. Dr. Jacobs' story reflects many of these characteristics. He has been practicing in northeastern communities with predominantly African American patients for thirty-four years. Dr. Jacobs describes his experience in selecting his office locations as such:

> "I was practicing with another orthodontist and I was new to the area, and when I went on my own I had immediate support for the GPs. [My second location] is in the town where I was born and raised. I always wanted to practice here and I had an opportunity to buy a building. I opened a practice on the first floor and rented the second floor as office space. I opened [my third location] because a group of black GPs asked me to consider the area and there happened to be an orthodontist who owned a building and was looking to retire. So I stepped into that situation. He was a white orthodontist [in a predominantly African American community] with a limited practice. But once again I had immediate support of local GPs. [My fourth location] I was looking at a practice that was in one of the poorest

[74] Dr. Edwards [pseud.], interview by author, tape recording, 28 May 2004.

> sections and was owned by a white orthodontist in a Hispanic neighborhood. The office was over a drug store but there were a lot patients just there [waiting]. There was no need for GP support, the patients were standing at the door. I practiced there for a few years and then purchased a very beautiful house in one of the better sections of [town] in a residential area near a park and converted the first floor into an orthodontic office. My patients just followed me from that area [the previous location in that same town].[75]

The success Dr. Jacobs experienced is a direct result of support and familiarity. At no time did he venture into true unknown territory, where he would be at a greater risk. The relevance of support from GPs and the comfort afforded from establishing an office in known community areas are readily apparent from Dr Jacobs' comments. The desire to return to the town in which he was raised is understandable, but surprisingly, only showed up in two of the seventeen interviews. The request he received from black GPs to open an office in his third location helps verify a belief held by many of the participants of the study that GPs prefer to make referrals to people like themselves.[76]

The belief that racial identity structured the referral process of GPs – or that white GPs refer patients to white orthodontists and African American GPs to African American orthodontists – also influenced where some African American orthodontists decided to establish their practices. Dr. Olsen, who practices in a diverse community in Maryland said, "Most of my referrals are minority. Not all but most. In a predominantly white area I don't feel that you could survive because of

[75] Dr. Jacobs [pseud.], interview by author, tape recording, 11 June 2004.

[76] Dr. Olsen.

[the lack of] referrals."[77] As a result, many African American orthodontists who viewed this referral practice as an obstacle chose to avoid it. Overall, the answers to the question – "Why did you choose to not locate your practice in a predominantly white area?" – ranged from a preconceived notion of not being able to do as well economically in such a community;[78] a desire to be in an area with the least amount of personal hassle;[79] the need to give back to their people and community;[80] and the desire to avoid racially oppressive or intimidating environments.[81]

Already burdened by the pressure of establishing a successful practice, some African American orthodontists preferred to open their offices in neighborhoods where they felt a greater level of cultural ease, familiarity, and pleasantness. Dr. Boyd maintained:

> One of the beauties of being in a practice in an African American community is they understand me. I can joke with them about my humble beginnings and they understand. I can show them that I was just like YOU! When I can reach them. That is why I am here. It is a position that allows me to reach out. I know that is why I am here.[82]

It is a matter of choice, not a lack of one. Several African American orthodontists would not dream of operating their business anywhere else other than in an African American community. The fact that they have the opportunity to have a positive

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[77] Ibid.

[78] Dr. Olsen.

[79] Dr. Lewis [pseud.], interview by author, tape recording, 21 June 2004.

[80] Dr. Boyd; and Dr. Grant [pseud.], interview by author, tape recording, 4 June 2004.

[81] Dr. Edwards.

[82] Dr. Boyd.

influence on young African American minds during formidable teenage years helps define a good location for some participants of the study. The fact that the youth in African American communities can look to their orthodontist and say, "He is just like me," is unique to this situation. The lack of positive African American role models young people can relate to can lead to destructive voids in the lives of African American children. The desire to give back to their communities by filling those voids is very satisfying to some of the participants of the study.[83]

There are a few African American orthodontists in this study who established their practices in predominantly white communities. They learned to work with race to help shape their practices. Dr. Arrington, is an African American orthodontist, who took over an established practice from his father, in the white suburban community in which he was raised. Dr. Harris, worked independently out of a general practitioner's office. Dr. Franklin, who has been in private practice for 31 years, currently practices in a predominantly white community. He relocated to this area after practicing for over 20 years prior in a nearby predominantly African American community. Even though his present practice is in a predominantly white community, he still maintains a patient base where 50% of his patients are African Americans and only 25% of his patients are white. All of the above arrangements came with an established referral base. There was a built-in level of acceptance and commitment already established. So these three orthodontists did not have to incur as much risk as their cohorts in establishing their practices.

[83] Ibid.

Dr. Lewis, who has been in practice for over 20 years, is the fourth African American orthodontist in the study who opened an office in a predominantly white community. He had the same concerns as the African American orthodontists who opened their practices in African American, minority, or racially diverse communities. Dr. Lewis's rationale for settling in a predominantly white community was,

> As an African American I knew there would be a slight problem because of color [in a white community], but at the same time I settled in a place with a liberal attitude where they would see me first as an orthodontist and not as a black person.[84]

While perceived liberalness of the neighborhood shaped his initial decision, once there he actually experienced some of the expected problems regarding the lack of referrals – that is, until a white practitioner, who did not like the other orthodontists in town, intervened and gave him an opportunity to prove his skills. Dr. Lewis maintained:

> It is only because of one liberal Jewish person that I am successful today. He said, 'I think you are pretty good I am going to send my patients to you.' That is why I am sitting here now, because of the Jewish pediatric dentist. I went around and talked to [white GPs] like I was supposed to. They sent me a smattering of patients but not a lot. But as soon as one of their own kind [a white orthodontist] came in here then they basically did not refer to me, even though I am good. If it had not been for this Jewish guy here, it is very possible that I would have done ok but I would not have done as well as I am doing now. He gave me the foundation for me to grow on.[85]

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[84] Dr. Lewis.

[85] Ibid.

In Dr. Lewis' case, the liberal political milieu did not automatically trump race when it came to patients making personal health decisions. However, the liberality of a white, Jewish GP led to a lifeline of referrals that enabled Dr. Lewis to succeed in a predominately white community.

Even where the establishment of an office in a predominately white community by an experienced African American orthodontist was accomplished with no problems, maintaining that office with increasing competition from new white orthodontists proved very difficult. After establishing a very successful practice in a predominantly African American community, Dr. Peterson, the participant with the longest tenure in the study (38 years in urban communities) opened and operated a second successful practice in a predominantly white community for a number of years. He said that he experienced no difficulties establishing or operating that office. The interview with him took place at his original office in the predominantly African American community. Dr. Peterson shared his story, "I chose this area because there was a big concentration of affluent black people. I wanted to do something for the people. I then opened in [a white community] because I thought it was a nice area. I did pretty good there..."[86]

When asked why he closed his second office in the white community, he stated:

> Because they got more and more orthodontists there, white ones, and it is hard to get the referrals from them [white GPs] unless you socialize with them. If I had also been active in the societies ... I was very

[86] Dr. Peterson [pseud.], interview by author, tape recording, 24 June 2004.

> successful. I was chairman of Children's Dental Health Week. It got to be too many meetings so I slowed down and closed that office.[87]

Dr. Peterson was a very light-skinned African American man; in fact, his race to some might have been indistinguishable. He experienced no problems establishing a practice in a predominantly white community. It was not until he stopped socializing with the white general practitioners and reduced his community involvement, that referrals dwindled and he closed the second office. Even after practicing orthodontics for over thirty years he felt as an African American he could not compete with new white competition without a lot of extra work.[88] (See section on referrals.)

Numerous participants in the study believed that an African American who is confident, competent and able to establish good relationships with white GPs and get involved in community activities can be successful in white neighborhoods. Dr. Kelly who has been an orthodontist for fourteen years practices in a diverse community very similar to where he grew up. He says, "I have noticed certain business personalities and traits in certain individuals. They are going to be successful no matter where they go."[89] Dr. Kelly also believes that the problem is one of personality and not race. He says, "I have proven that whites can feel comfortable with your skills, philosophy, persona, and level of service."[90] Personality may indeed

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[87] Ibid.

[88] Ibid.

[89] Dr. Kelly [pseud.], interview by author, tape recording, 11 June 2004.

[90] Ibid.

be a factor, but personality and race are not mutually exclusive. Moreover, the weight of available information suggests that race for various reasons definitely affected the selection of location for African American orthodontists.

Most of the participants in the study believe that today they or new members of the profession can establish a successful practice in predominantly white communities. They still believe, however, that an African American orthodontist has to work twice as hard as his or her white counterpart, but with hard work, perseverance and the proper attitude, the "obstacle" of race in interracial communities can potentially be overcome. As one participant put it: "I think today you could [be successful]. Would you be one of the big dogs? Maybe not."[91]

[91] Dr. Mathews.

FINANCE

"African Americans have a hard time getting money from banks." Dr Carter [92]

Like other business ventures, one of the requirements of establishing an orthodontic practice is sufficient capital to fund the purchase/lease of an office, office equipment and supplies, and the overhead of a new operation. The doctors in this study report that African Americans in general and they specifically had trouble obtaining support from the usual source – banks

Dr. Dean, who is an older orthodontist in his early sixties, shared his personal experiences of when he was first trying to begin his practice in Philadelphia:

> I went to a bank to borrow $25,000 to buy this practice. The [banker] said 'No way.' ...I wanted to punch him. 'You know we would probably be more willing to lend this money to a lady who was setting up a wig store on the corner than to you because we know she is going to fail in year one and this money is going to be insured. A guy like you will play around and we will have a tough time collecting.' I happened to know a guy who was a football player (white) who helped me out and offered to co-sign and they accepted it. But they did not trust me. I think the climate is a little bit different now.[93]

Most of the doctors in the study believe it is common knowledge that African Americans in this country have more difficulty obtaining funding for business than whites. Dr. Edwards, one of the younger doctors in the group, age 44, said, "Anyone who does not see the reality that it is more difficult for the African Americans is just

[92] Dr. Carter.

[93] Dr. Dean.

blind."[94] Dr. Edwards shared his frustrating tale about obtaining financing when he opened his first practice in a predominantly African American neighborhood. He was top in his class, attended prestigious [white] universities, was very attractive and articulate, but still had difficulties overcoming the barriers of race.

> Obtaining a loan is an extremely subjective process. Funding is based on location. It may have been easier if I were going into the suburbs. I went to the bank to get money and I was declined, because I did not have any collateral. I was not used to rejection. But how am I supposed to have collateral when my father did not finish high school. That takes you back to the good ole boy story. I actually knew someone on the board of the bank, an African American doctor, and he could not even change their minds. So that really hurt. I ended up getting the money from dental suppliers and I made it work, but that could have been an obstacle for some people. If the suppliers didn't help and the bank would not... I can see why some people go with (management companies) because they are experiencing this level of frustration. If I were to give anyone advice I would say go out on your own.[95]

These actual stories of rejection reflect the ways that race has had an effect on the establishment of African American orthodontic practices. Dr. Edwards believes, "That is changing every decade but it is still true [today]."[96]

Most of the doctors in the study believe they were denied funding from banks because of their race. Even the loan requests that were rejected because of a lack of collateral by the borrower can be classified as a result of racism because as Dr. Mathews, who has been in practice in an urban setting in Maryland for 34 years,

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[94] Dr. Edwards.

[95] Dr. Dean.

[96] Dr. Edwards.

stated: "Most black professionals are not coming from families of great economic means and don't have collateral."[97] This may be an example of institutional racism in which the standards (requirements for collateral for a loan) have been set for a valid purpose; but the effect of application of the standard bars a group of people (African American) from ever meeting the standard. The fact that the orthodontists who were refused the loans managed to obtain the financing for their business through other means indicates they were good risks for the banks to take. The other question that has to be answered before a definite conclusion can be substantiated on this point is how many white orthodontists in similar circumstances were granted loans by banks without the type of collateral demanded of the African Americans in this study.

As with other aspects of the effect of race, the members of this study did not allow the inability to obtain funding from banks to deter them from their dreams of having their own orthodontic practice. They utilized creative means to bypass the financial hurdle. Dr. Dean had a friend who was a star athlete who cosigned the loan with him. Dr Edwards obtained the funding to establish his practice from a dental supply company. A few of the doctors in the group with the least tenure escaped the funding problem by entering into a partnership with a management company.[98] As with other limiting effects of race on the practice of orthodontics for African Americans, the doctors in the study believe they had to work harder than their white peers to establish their own practices.

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[97] Dr. Dean. Although the economic level of the participants is not well defined, over 50% come from families where at least one parent had a college degree.

[98] Dr. Edwards.

Several of the members of the study experienced no difficulty obtaining funding from banks. Dr. Peterson said that when he "came out of [an Ivy League program] he went to the bank, got a loan and opened up a practice just like that."[99] This was atypical of the experiences of the vast majority of the doctors in the study.

Most of the participants in the study believe that today some of the barriers such as the difficult bank funding practices for African American orthodontists are being lowered and even removed. Dr. Dean commented that today "African Americans should not be fearful that they will not make it on their own."[100]

[99] Dr. Peterson.

[100] Dr. Dean.

REFERRALS

"I did not want to buy a practice from Dr. Cohen because people who refer to Dr. Cohen are not going to want to refer to Dr. [Black]." Dr. Olsen[101]

The practice of orthodontics is regarded as a referral-based business. To be successful a practitioner must have a steady stream of patients from external sources. Whether the referrals are from dentists in general practice, insurance companies, other patients, or advertising, a large patient base is a must in this volume based business. Traditionally, new orthodontic practitioners relied on the referrals made by GPs to establish a patient base. In the last 20 years or so, that method has been augmented by insurance companies and mass advertising from management companies. (Management companies refers to practice management organizations that enter into partnerships with private practice orthodontists. Part of the services provided by them are patient referrals obtained through advertising in various media as well as on the internet. See discussion beginning on page 59.) Each of these sources of new patients can greatly affect the financial viability of orthodontic practices. There is no longer a sole reliance on GPs for referrals.

Gaining the confidence of GPs is a key skill for orthodontists. This is especially true for new practitioners until they have time to build an effective internal referral system through word of mouth or other means. The orthodontists in the study

[101] Dr. Olsen.

stated unequivocally that for African American orthodontists in predominantly white communities, race is a big factor.[102] More than half of the doctors in this study chose not to locate their practice in white communities because of the extra effort which would be required to negate the effects of race on their practice. "I chose to stay [in the black community] because I was intimidated for reasons we discussed [lack of referrals and patient acceptance]"[103] This was the attitude of Dr. Edwards. When Dr. Kelly was asked if he could be successful in a predominantly white environment he stated,

> "It depends on the area, I never really thought about going to an area like that, I am not sure why, for fear that I would not be successful. For some reason, I may have had some preconceived notion that I would not do as well as I would in a mixed setting."[104]

There is an additional level of risk when crossing the color line that may not be encountered by the white orthodontists because there are no effects of race that must be negotiated, "It is a referral based business and if you have to cross the color line it is a little more difficult to make the connection."[105] The orthodontists in the study reported, "Referral relationships that cross the color line are usually weak."[106] They spoke of promised referrals that never materialized.[107] Most stated they received few referrals from white GPs.

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[102] Dr. Lewis.

[103] Dr. Edwards.

[104] Dr. Kelly.

[105] Dr. Edwards.

[106] Dr. Jacobs.

When referrals were made by white GPs, they were often for patients white orthodontists were not interested in treating. Dr. Dean told of a referral of a young African American girl with a large bimaxillary protrusion (a pronounced protrusion of the upper and lower jaws more commonly found in African Americans) that was referred to him by a white GP who told the patient. The African American orthodontist "probably would be more interested [in treating her] because he treats patients like that a lot better." Dr. Dean said the white orthodontist "just did not want to treat her."[108] Another incident of race referrals experienced by Dr. Dean was an invitation to join in a group practice, with white orthodontists, but remain in his same location:

> "I was approached by an organized group of orthodontists and asked if I would like to join their group and practice where I am." The purpose of the relationship was described as such by the white orthodontist extending the offer, "I have a certain segment of clients, particularly young white females that don't want to sit in the waiting room around black men and I have been getting [negative] feed back from them. So I was wondering if you would let me refer them [black males] over to you." Dr. Dean replied, "No I am not interested, I have black males and white women who all sit together in my office and they have no problems.[109]

Comments from the participants in the study reflected the belief that "Like refers to like." One participant summarized the concept thusly, "Black orthodontists need the support of black GPs because in my opinion you are not going to get the

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[107] Dr. Lewis.

[108] Dr. Dean.

[109] Ibid.

business from the good ole boy network. Why? Because that is the history of this country. Which is just the way things are."[110]

Dr. Lewis experienced the same lack of support from white GPs when he opened his practice in a diverse community. He said "I went around and talked to [white GPs] like I was supposed to. They sent a smattering of patients, but not a lot." He had a very difficult time establishing his practice until a Jewish GP said to him, "I think you are pretty good. I am going to send my patients to you."[111] Dr. Lewis states that, "It is only because of [that] white liberal Jewish person, that I am successful today." (See page 37.)

Dr. Peterson had no difficulty establishing a practice in a predominantly white community. He believes his good fortune resulted from the fact that he was very active with local GPs and community events when he opened the practice. He was even the chairmen of the Children's Health Week. He closed that office because he found that once he stopped being active with the local GPs and reduced his involvement in community activities, the referrals dwindled to an unsustainable level. There are several factors that may have contributed to the declining business in that office. One was the increase in the number of white orthodontist in the community.[112] Many of the orthodontists in the study stated their belief that given the choice between a white orthodontist and an African American orthodontist, most white GPs would make referrals to the white orthodontist. Most of the orthodontists

[110] Dr. Jacobs.

[111] Dr. Lewis.

[112] Dr. Peterson.

in the study believe that today the "Like referring to like" phenomenon can be overcome by extra effort by African American orthodontists. Such extra effort would entail cultivating ongoing social and professional relationships with white GPs, a strong and creative marketing approach, and much community involvement similar to the type Dr. Peterson did when he established his practice. Another possible reason for the original success of Dr. Peterson's practice, in a predominantly white community, may be because it is difficult to determine his race at first glance. He possesses stereotypically white characteristics; he has a very fair complexion, is very articulate and engaging. He is also a graduate of predominantly white and Ivy League institutions for dental and orthodontic credentials. It is possible that the white GPs who made the referrals to help establish his practice did not know he is an African American.

Today for established African American orthodontists, referrals from white GPs, although important are not as critical as in the past. The established practitioners within the study relied heavily upon word of mouth and sibling business that come to successful orthodontists as well as other sources for referrals. Today insurance companies that have patients in dental plans can direct patients to doctors who accept their plans. Several of the orthodontists in the study obtain most of their referrals from this source. This may have changed over the lifetime of their practice, but it was a significant starting point in the establishment of their businesses. Some felt they had to accept Medicaid type plans longer than their white counterparts would have. The other large source of referrals is from the mass advertising conducted by

management companies. This advertising directs patients through television, news paper ads and internet websites to orthodontists who are in their networks. Several of the orthodontists in the study have such arrangements. Referrals are the lifeline of the orthodontic business. This is especially true in establishing a new practice. Most of the orthodontists in the study report that race is a big factor in obtaining referrals because of the culture of the United States pertaining to race. So prevalent is this belief among the group that sixty five percent of the group chose not to practice in predominantly white communities because they did not wish to deal with the extra burdens required of African American orthodontists to overcome the problem of race. Most of the doctors in the study believe that the like referring to like phenomenon can be overcome with a lot of extra effort by African American orthodontists.

PERCEPTIONS

"They basically feel we are inferior." Dr. Lewis[113]

Most of the doctors in this study share the opinion that their white peers believe African American orthodontists are inferior as stated by Dr. Lewis. This opinion is derived from professional experience, i.e. lack of promised referrals and other interactions with white GPs instead of from mere assumptions. The members of the study believe that white GPs mislead African American orthodontists with pledges of support that are never made. Dr. Lewis said, "They don't want to admit it to your face but behind your back is a different story."[114] In his case, he received promises of referrals that never materialized. This duplicity can be dangerous for the unwary African American orthodontist.

The perception of inferiority by their peers keeps some of the doctors in the study, from participating in professional activities that could help their practices. Dr. Dean says, "We are not part of their [white orthodontists] group. We are not active in their circles – maybe because we feel we are not wanted there or because we just don't want to be there."[115] He further states, "We are not as active in their community. We don't participate in their events. Like right now I am not a member

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[113] Dr. Lewis.

[114] Ibid.

[115] Dr. Dean.

of the Pennsylvania dental society. I dropped out partly because of financial reasons." This is a classic catch 22 situation. Dr. Dean's decision to drop out of the dental society because he does not feel a part of a group and because of financial concerns could adversely affect his practice because developing a good relationship with GPs and becoming more involved in community activities are proven methods of obtaining referrals and increasing business for orthodontists.

The participants in the study generally attributed the negative perception of African American orthodontists by their peers to cultural norms of American society. Dr. Lewis said, "America is a racist society. When they see you, the first thing they see is an African American person. And I don't care which year it is."[116]

A number of the members of the study believe that white patients also share some of the negative perceptions of African American orthodontists held by their white peers. Dr. Kelly reports that he has "...had white patients walk in – see me – see my staff and walk out."[117]

Other members of the group have overcome this problem. Two of the doctors in the group have patient bases that are over 90% white. One of the two was born and raised within the predominantly white community in which he practices. He reports that he does not "think about it [race] as much as some people do because he kind of grew up in some what of a bubble."[118] He was never made to feel like he was the only African American kid in his graduating class in high school.

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[116] Dr. Lewis.

[117] Dr. Kelly.

Most of the doctors in the study feel that the negative perceptions of them based solely on their race limits their practice. They accept that as a fact and move on. They do not feel inferior. They are very proud of their accomplishments and contributions to their communities. They measure their success in the smiles of their satisfied patients. They believe the perception of inferiority of them by white colleagues and patients is the problem of those colleagues and patients. The participants do not allow that perception to drive them out of business. In the words of Dr. Lewis "Until you can change the mindset that white is right, the problem will exist."[119] He further states that, "We [African American orthodontists] have to work harder- dress better- speak a little better."[120] Those tactics have enabled the African American orthodontists in the study to effectively deal with the race-based negative perception from peers and patients.

[118] Dr. Arrington [pseud.], interview by author, tape recording, 13 May 2004.

[119] Dr. Lewis.

[120] Ibid.

MARKETING

"My referrals have increased 4-5 times just because I got out there." Dr. Olsen[121]

The participants of the study acknowledge the positive effects that marketing (defined as measures to generate a larger patient base) can have on their business. For new orthodontists, this translates into activities designed to cultivate good relationships with GPs, and community involvement such as dental screenings, oral health fairs, speaking at schools and church functions. Today with the growth of management companies and insurance companies these activities may not be as heavily relied upon as they were in the past.

For participants who established practices prior to the mid nineties, external marketing returned mixed results. For those in practice in predominantly African American communities marketing consisted of "word of mouth, internal office marketing and raffling a kids bike."[122] Radio ads were also part of their marketing strategy designed to develop the relationships which gained them referrals from mostly African American GPs. In the words of one of the participants, "African

[121] Dr. Olsen.

[122] Dr. Arrington.

American population and African American GPs go hand in hand."[123] Those activities were helpful in establishing the practices.

For offices that were located in predominantly white communities similar activities were required with more emphasis placed on developing relationships with white GPs.[124] These activities were less successful than activities to influence African American GPs. The reason for the difference in success rates was not apparent from the interviews. The inference is that race was the most important factor for the difference, but there could have been other causes such as different cultural norms. There were exceptions. There are two locations in which marketing activities generated sufficient referrals to enable the growth of the practices. One of the two had initial success until new white orthodontists established offices in the same community. This African American orthodontist who had been practicing orthodontics for over 30 years, decreased his marketing activities and eventually closed that office. The other office in a predominantly white community, in which marketing activities were sufficient to generate continual growth was that of Dr. Arrington. He inherited the practice from his father and maintained an active level of involvement with the community and his peers.

The effectiveness of marketing for African American orthodontists is best explained by the story of Dr. Olsen. He has a partnership with the largest dental management company in the country. Therefore he was able to take advantage of

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[123] Ibid.

[124] Dr. Arrington.

that company's mass advertising through television, radio, and the internet. On the company's web site Dr. Olsen is listed as the orthodontist to contact for services in the city in which his office is located. The management company has provided a good source of referrals. Dr. Olsen combined that source with other marketing activity to increase his business four to five times as cited in the captioned quote at the heading for this section. But most importantly he feels, "You have to treat people with respect and be on time. I am on my staff all of the time about that. People talk and [therefore] most of my referrals come from internal marketing which has been the biggest source of new patients."[125] The two other doctors in the study who have agreements with the same management company also report that mass marketing has worked well for growing their businesses especially in the initial stages. "All of my phones lit up after the commercials ran. People were outside waiting to get in after a month or two."[126]The participants of the study who have contracted with a management company all feel that race can be a barrier when it comes to referrals. One stated, "The management company allows you to market orthodontics, not the orthodontist."[127]

The effectiveness of marketing in the generation of referrals would lead one to think that marketing is a permanent part of orthodontic practices. That however is not the case. For the participants in this study, generally, the older the practice the less

[125] Dr. Kelly.

[126] Dr. Norman [pseud.], interview with author, 21 Jun 2004.

[127] Dr. Queen [pseudo.], interview by author, tape recording, 1 September 2004.

time they devoted to marketing. Older practices relied more on business from word of mouth, from siblings of satisfied patients, from internal marketing and other sources such as insurance companies. There was also a tendency of this group of participants to do what they wanted to rather than what they had to do. Dr. Norman, who is happy with his relationship with a practice management group said, "I don't want to market dentists period. I want to go to work and go home."[128] This frame of mind is also typical of those members of the study who are in partnerships with management companies. They are not interested in the entire business of orthodontics. They just want to practice the technical aspects of the business.

The answer to the question – "What is your marketing strategy?" – was often "Hardly anything"; and "Nothing." When the African American orthodontists were asked why they were not more active in marketing, Dr. Dean replied, "We are not as active in the [white] community. We don't participate in their events."[129] There seems to be some reluctance, perhaps based on a feeling of discomfort for members of the study to get too involved in the white community. This is true even where it is known that the interaction could lead to business opportunities. Dr. Jacobs, who operates several offices in northern New Jersey said, "I think it is a personality thing. I think that I am basically an introvert. I would rather go fly fishing than attend some of the meetings."[130]

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[128] Dr. Norman.

[129] Dr. Dean.

[130] Dr. Jacobs.

There seems to be a level of contentment with the status of the longer established practices in the study. The participants acknowledged that marketing can potentially increase the size of their business, but they are proud of the standard of quality in their practices and[131] the contributions they are making to their communities.[132] At this point of their careers they seek more balanced lives, and do not find value in the extra effort that would be required for more robust marketing programs. They all would advise new African American practitioners to pay careful attention to marketing as a way to develop and grow their business.

[131] Dr. Arrington.

[132] Dr. Boyd.

MANAGEMENT COMPANIES

"Why are you more successful with them?" Dr. Olsen

In 1994, the leading provider of practice management services to orthodontic practices in the United States became incorporated, with a goal to change the practice of orthodontics nation wide. Using Pearl Vision Centers as a model, the plan for consolidation of the orthodontic industry had begun. The goal was to bring a significant portion of the thousands of offices in operation under the banner of one management company. The vision was based on the theory that if one central organization provided a full range of management services to a host of satellite offices, then the individual offices would realize increased operational efficiency and greater profits, achieving results better than would be achieved as separate businesses.[133]

The emergence of management companies has surfaced as an alternative structure for managing orthodontic practices. Orthodontists interested in this type of relationship agree to operate under a standard structure. The structured format is a partnership where the profits and expenses of an orthodontic business are split on a fixed percentage between the orthodontist, who by law in states in which this form of business is permissible, must own the majority share, and the management

[133] "OCA, Inc."Company Profile. Hoover's, Inc., 2007. *Answers.com* 23 Feb. 2007. http://www.answers.com/topic/oca-inc, accessed December 2006.

company.[134] There is also a management fee paid to the management company. The arrangement provides for an immediate salary for the orthodontist, referrals through mass advertising, access to capital and other business services that make this an attractive option for new and struggling solo practitioners. Dr. Mathews shares his experience with residents who decide to join management companies, "All residents who join (management companies) are happy because they have an instant $100,000 salary."[135] He further states, "Blacks have a great deal of difficulty getting financing. Several have joined marketing companies because of this, even though they did not want to, but they could not get financing."[136] The type of services management companies provide make it easier for African American orthodontists to overcome some of the race-related barriers cited in this study. The question becomes at what cost?

Management companies recognize the reality of race-related barriers and reach out to minorities, not only during the practice recruitment stage, but during the educational process as well. Referring to a new orthodontic residency program, the management company CEO states, "I hope to use the program to attract a number of well-qualified under-represented minorities into the orthodontic profession."[137] A representative of a management company shared some of that company's statistics

[134] Partnerships with management companies are not permitted by law in the state of New Jersey.

[135] Dr. Mathews.

[136] Ibid.

[137] Howard M. Landesman, "In a troubled economy, partnerships between corporate America and academic institutions are crucial," *The Bridge, online*, July 2003 [journal on-line]; available from http://www.uchsc.edu/news/bridge/2003/July/lazarra.html; accessed April 2004.

about African Americans in their program. They claim, "African Americans do ten percent better within our organization than on their own. They also do ten percent better than any other race within the organization."[138] This is used as a major selling point to attract African Americans into their organization. Because of known racial barriers by African Americans management companies may seem like the safe option for new entrants to avoid the barriers known to affect African Americans' entry into orthodontics. Management companies offer a heightened sense of security for new entrants into the profession.

There have been concerns expressed by the participants in the study regarding the recruitment tactics of management companies. Dr. Olsen who has an agreement with a management company and has been in practice for 12 years, believes as altruistic as the management company's education goal for minorities may seem, their ultimate goal is one of self fulfillment rather than true goodwill, he states,

> "I would not go to one of their schools if I had to sell my soul."[139] "The value of [the management company], if you are starting a practice, is a good idea because they take the risk, and they fund your practice, salary, debt etc. But they are doing it [reaching out] for a reason because they know what they are getting out of it. It is short sighted to look at it like that [a good long term opportunity] in my opinion[140].

[138] A representative of the management company, phone interview by author, October 2003.

[139] Dr. Olsen.

[140] Ibid.

Dr. Olsen believes in order to be happy with a relationship with management companies one must settle for contentment, therefore he believes, "It really depends on you and your personality."[141]

Dr. Mathews does not believe the "10% better" hook is worth the value of the share of profits allocated to management companies,

> "I do feel that even though you [the resident] were doing ten percent better [with a management company], with their share of 40% I don't feel that you would be much better off. Some of our graduates in these organizations are in the top income bracket, in part because of (the management company) and in part because of that individual. Those individuals [who are at the top] will do well with or without (the management company)."[142]

Dr. Mathews believes the reason African American orthodontists in management companies do so well is because the companies recruit gifted residents who would do well on there own if they could overcome the race-based barriers faced by new African American entrants into the profession. Dr. Mathews final view on this matter is, "If you build [your own practice], you can do just as well, but maybe just not as fast. Over time you will be just as successful."[143]

Dr. Norman shares his beliefs on the motivation behind management companies goal. He believes management organizations hone in on African American orthodontists because, "They go for blue collar populations [for patients],

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[141] Ibid.

[142] Dr. Mathew.

[143] Ibid.

therefore you find a lot of blacks there, and therefore they like to recruit blacks for those populations. It could be just good business."[144]

"I am sorry I did not join them [management company], sooner. That is my only regret." Dr. Norman[145]

Three participants of this study had agreements with the same management company Drs. Norman, Olsen, and Queen. Dr. Norman had been in private practice on his own for well over 20 years prior to his current 4 year relationship with the management company. Dr. Norman is extremely happy with his agreement with the management company.[146] Drs. Olsen and Queen are no longer enamored with their contracts.[147]

Dr. Norman cites access to capital, generation of referrals through mass advertising, continuing education through an annual convention and management assistance as benefits of his commitment with the management company.[148] He said, "Anytime I have a problem, I just pickup the phone call and they have the answers – employees, air conditioners, anything."[149] Because he is able to rely on the management company to help resolve business concerns, Dr. Norman, is free to focus

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[144] Dr. Norman.

[145] Ibid.

[146] Ibid.

[147] Dr. Olsen and Dr. Queen.

[148] Dr. Norman.

[149] Ibid.

on satisfying patients. He said, "The only thing I have to worry about is just waiting on those patients."[150] He believes he is much more successful with the management company because, "you have access to money. Anything you want to do, you have access."[151] He is planning a long term relationship with the company.

Dr. Norman knows that the management company receives a good percentage of the profits from his business. He feels they are worth it because they help increase the volume of patients he services. He emphasized that his only regret is that he did not enter into an agreement with the company sooner.[152]

"I am not happy with (the management company). It is not worth it"[153] Dr. Olsen

Drs. Olsen and Queen question the value of the services provided by the management company. They acknowledge that the service provided by the management company is good, but they believe the cost is too high. Dr. Olsen says,

> "I am not happy with (the management company) because it is not worth it. In my opinion, people who love it have no idea what the real world is like out there. If I had just graduated and got into a relationship with (the management company), I would be happy because I would not know any better because they [new graduates] have nothing to compare it to. Sure they think it makes their life easier. Because I came from a private practice outside ...I know that the type of services that we get from (the management company) in no way shape or form does it relate to the type of compensation they [the management company] get."

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[150] Ibid.

[151] Ibid.

[152] Ibid.

[153] Dr. Olsen.

The independent go getter mentality of Dr. Olsen would not allow him to settle for contentment.[154] Dr. Olsen describes the tenuous legal battle that must occur to severe ties with the management company,

> "To get out it is not so much that a contract is up but my indebtedness is up and then you start with the technicalities and legal stuff to severe ties. You leave with nothing and can't open up around the block."[155]

He feels the benefits are short lived based upon their value,

> "They help you to hit the ground running, and now I don't see them doing enough to be worth their price. If I were to hire someone to do all that they do for me it [the price] would not compare."[156]

Dr. Olsen believes he is a good judge of the value of the services provided by the management company because he was in private practice prior to entering into an agreement with the company. He is contemplating ending his contract with the management company. Dr. Olsen is an aggressive forward thinking professional who values what the company offered him as a new practitioner, but feels stifled and financially drained by the organization now that he has some experience under his belt. Dr. Olsen argued that his personality and "go get them" attitude made that type of arrangement no longer effective financially for him. He shares this story regarding the previous owner of his practice (who was also in agreement with the management company) and tells why he feels their experience may have been different.

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[154] Dr. Norman.

[155] Dr. Olsen.

[156] Dr. Norman.

> The practice "was already a management company practice. Eighty percent of his [the previous owner's] referrals were from the management company. You look at that and say that is great. No, I did not think so. [The management company] advertising was doing that much better than everything because he was not doing 'everything else'. He was content with what advertising brought in. My referrals from general dentists increased four or five times just because I got out there."[157]

Dr. Queen, who has been in practice for 13 years, has a diverse patient population. His sentiments regarding management companies are very similar to those of Dr. Olsen with the exception of an advantage he believes helped him as a new practitioner. He believes the racially-blind mass advertising is a positive factor that helps to distract the consumer from emphasizing on the race of the orthodontists and focus on orthodontics. He partially credits this blind form advertisement for his cross-over success.

The opinions of most other members of this study who manage their practices independent of management companies range from not knowing enough about such companies to have an opinion, to being vehemently opposed to management companies. They understand the appeal of such companies, but they believe having no limits on their freedom to practice as they choose is more valuable than the benefits derived from an association with a management company. They believe it is better to tough it out at first rather than to sell out to a management company that will not be worth their hefty price in the end. Dr. Edwards shares his story,

> "I never joined a management company. They were kind of on my heels. I kind of just missed that wave, and I would have had to shut

[157] Dr. Norman.

> down my practice to join up. I am glad I didn't, because I feel I created this practice and built it myself. That kind of franchising doesn't give you a sense of individuality in my opinion. I don't want to say it is a crutch, but it is kind of the American way [franchising]. I just feel this [his own practice] is something more that I created and most importantly I hope to sell or pass it on to someone like myself who is willing to work a little harder to get started but can see the forest for the trees."[158]

Dr. Edwards is also against the aggressive behavior management companies exhibit towards African American orthodontic residents and believes management company's access to orthodontic residents should be restrained similarly to the way agents are restrained from contacting college athletes until they leave school.[159]

Dr. Boyd believes that rather than joining a management company and being bound to their production requirements, new orthodontists should start with a small number of patients and increase their base as the skill of the practitioner increases.[160]

This group of participants also believes that race-based barriers to entering into orthodontics can be more easily overcome today than when they started their practices. They advised new African American orthodontists to first try it on your own.

Regardless of the views of the participants of the study on management companies and orthodontists, management companies are having an impact on the practice of orthodontics in the United States today. With the ability to provide financing, mass advertising, management assistance, and other services they are an

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[158] Dr. Edwards.

[159] Ibid.

[160] Dr. Boyd.

alternative option for minority orthodontist who in the past had to and in the present may still have to overcome the barriers to entering into the profession cited in this study. It will be worth further study to see if the cost of the services provided by management companies is worth the impact such companies can have in helping to eliminate the effects of race on the African American orthodontist.

CONCLUSION

African American orthodontists in the geographical area covered by this study, mainly the northeastern part of the United States, are practicing their profession in a variety of ways including choice of locations, source of referrals, methods of financing their practice start ups and form of business organizations. They also bring to their businesses a diversity of backgrounds, educational experience, social and economic outlooks.

They practice in predominantly white communities, predominantly African American communities as well as racially diverse communities. Some have offices in urban areas others in suburban communities. Some received their higher education and professional training at all white institutions, others graduated from predominantly African American institutions. Some are in private practice. Others are in partnership with management companies. Some are from modest backgrounds, others have middle class roots. Still others are descendants of healthcare professionals. Some were born and raised in the South; others in the North or Northern Midwest; and a few are first generation immigrants. With such diversity, and the fact that they have never met as a group, it is remarkable how closely aligned are their experiences and beliefs on the effects of race and racism endured by them as African American orthodontists.

In various sections of this study anecdotes the participants have shared highlight some of the race-based barriers they have had to overcome in order to establish and operate orthodontic practices. The participants believe these racial-based barriers exist in such areas as, obtaining the education requirements to practice orthodontics, securing funds to establish an office, selecting a location for an office, earning referrals to grow and develop a business, and marketing their businesses. They believe they had to work harder than their white colleagues to overcome these effects.

This study may be helpful to the leaders, policy makers, educators and others responsible for eliminating the disparity in health outcomes based on race and ethnicity. This goal which was first announced in the Surgeon General's Report on Oral Health in 1995 and finally established in the Department of Health and Human Services healthcare agenda in "Healthy People 2010"[161] focuses attention on the gap in dental care between white and black Americans.

One of the ways to attack this serious national health problem is to create a pool of healthcare workers, including dentists and orthodontists to tend to the "growing chasm between the practice of dentistry in the United States and the oral health care needs of the nation."[162] According to a report from The Center For The Health Professions at the University of California, San Francisco, "The gender, age and racial composition of the dental workforce in the United States does not match

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[161] U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health.* 2nd ed. Washington, DC: U.S. Government Printing Office, November 2000.

[162] Ibid.

that for the general population," and "the racial ethnic distribution of the dental workforce is among the least diverse of healthcare populations."[163] As of 2002 only 6.8 percent of the dentists in the United States were African American, Hispanic or Native American. Also as of 2002, eleven of the fifty-five dental schools in the nation had no African American students in the entering class and twelve of the dental schools only had one African American in the entering class."[164] There is a target for improvement.

Addressing the issues identified in this study can help create environments conducive to attracting the African American talent required to increase the number of professionals needed to help close the disparity in dental care. Educators can take measures to help alleviate or eliminate the race-based burdens participants of this study had to overcome in order to become orthodontists. Such measures could include processes to enable students to challenge and deal with discriminatory practices that unfairly and in some cases illegally hamper their pursuit of their professional goals. Professional associations can institute outreach programs to help African American orthodontists become members of their organizations to help improve the availability of dental care for all Americans.

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[163] Elizabeth Mertz, "UCSF Report Finds Dental Practice Patterns Add To Oral Health Disparity In The United States," *The Center for Health Professions, University of California, San Francisco*, 27 September 2002 [press release on-line]; available from http://www.futurehealth.ucsf.edu/press_releases/haoralhealth.htm; Internet; accessed 5 May 2007

[164] Richard G. Weaver et al., "Applicants to U.S. Dental Schools: An Analysis of the 2002 Entering Class," *Journal of Dental Education* 68 (8): 880 – 900, August 2004 [journal on-line]; available from http://www.jdentaled.org/content/vol68/issue8/images/large/Weaver_Table9.jpeg; Internet; accessed 5 May 2007.

The orthodontists in the study take great pride for their accomplishments and contributions to their communities. They are pioneers, survivors and great role models for the orthodontists who follow in their footsteps. To a person they believe that a great number of the race-based barriers they faced will not be as difficult for their successors to overcome and they encourage African Americans to consider careers in the field of orthodontics. Hopefully their stories as presented in this study will inspire further exploration of their place in the history of the profession and motivate other African Americans to enter the field of orthodontics.

SOURCES CONSULTED

Text

"OCA. Inc." Company Profile. Hoover's. Inc. 2007. *Answers.com,* Website on-line, Available from http://www.answers.com/topic/oca-inc.

"Race and Incarceration in the United States: Human Rights Watch Press Backgrounder." *Human Rights Watch.* Journal on-line. Available from http://www.hrw.org/backgrounder/usa/race/.

"With an Even Hand. Brown v. Board at Fifty." *The library of Congress: Exhibitions.* Website on-line. Available from http://www.loc.gov/exhibits/brown/brown-brown.html.

Asbell, Milton B. *Dentistry: A historical perspective.* Bryn Mawr, Pa.: Darrace & Co. Inc., 1988.

Asgis, Alfred J. *Professional Dentistry in American Society: A Historical and Professional Approach to Dental Progress.* New York: Clinical Press, 1941.

Bike, William S., ed. *Dr. Earl Wiley Renfroe. 1907-2000.* University of Illinois at Chicago. website on-line. Chicago: The Board of Trustees of the University of Illinois, 2004. Available from http://www.uic.edu/depts/dort/Renfroe.html.

_____. *Essays on Earl Renfroe – A man of Firsts.* Chicago. IL: University of Illinois at Chicago College of Dentistry, 2001.

Bremner, M.D.K. *The story of Dentistry from the dawn of civilization to the present. with special emphasis on the American scene.* Brooklyn: Dental Items of Interest Pub. Co. 1954.

Brown, Elsa Barkley, Darlene Clark Hine, and Rosalyn Terborg-Penn. *Black Women in America: An Historical Encyclopedia.* Brooklyn. New York: Carlson Publishing Inc,. 1993.

Dubois, W.E.B. *The Souls of Black Folk 1903.* New York: Alfred A. Knopf. 1993.

Dummett, Cliffton Orrin. *Growth and Development of the Negro in Dentistry.* Chicago: Stanek Press, 1952.

_____, and Lois Doyle Dummett. *Afro-Americans in Dentistry: Sequence and Consequence of Events,* 1978.

Ellis Cose. *The Rage of a Privileged Class: Why are middle-class blacks angry? Why should America care?* . New York: NY HarperCollins, 1993.

Fields, Walter. "African Americans Marginalized in Job Market." *Black information link.* Journal on-line. Available from http://www.blink.org.uk/pdescription.asp?key=3091&grp=18.

Frederickson, George M. *The Arrogance of Race.* Connecticut: Wesleyan University Press, 1988.

Gladwell, Malcom. *Blink: The Power of Thinking Without Thinking.* New York: Little Brown and Company. 2005.

Glenner, Richard A., Audrey B. Davis, and Stanley B. Burns. *American Dentist: A Pictorial History With a Presentation of Early Dental Photography in America.* Missoula. MT: Pictorial Histories Publishing Co.,1991.

Landesman, Howard M. "In a troubled economy, partnerships between corporate America and academic institutions are crucial." The Bridge Online, 2003. Journal on-line. Available from http://www.uchsc.edu/news/bridge/2003/July/lazarra.html.

Lufkin, Arthur Ward. *A History of Dentistry.* Philadelphia: Lea & Febiger, 1948.

McCluggage, Robert W. *A history of the American Dental Association: A Century of Health Service.* Chicago: American Dental Association. 1959.

Mertz, Elizabeth. "UCSF Report Finds Dental Practice Patterns Add To Oral Health Disparity In The United States," *The Center for Health Professions, University of California, San Francisco,* 27 September 2002. Press release on-line. Available from http://www.futurehealth.ucsf.edu/press_releases/haoralhealth.htm.

Merriam-Webster's desk dictionary. Merriam-Webster Inc. 1995.

Patton, Michael Quinn. *Qualitative evaluation and research methods.* 3d ed. Thousand Oaks, CA: Sage Publications 1990.

Plunkett, Jeff. *Is Racism a Serious Problem?*. Detroit: Greenhouse Press, 2005.

Prinz, Herman. *Dental Chronology: A Record of the More Important Historic Events In the Evolution of Dentistry*. Philadelphia: Lea & Febiger, 1945.

Renfro, Earl. *Edgewise*. Philadelphia: Lea & Febiger, 1975.

Robinson, J. Ben. *Foundations of Professional Dentistry*. Baltimore: Waverly Press. Inc.,1940.

Shankland, Wilbur Morse. *The American Association of Orthodontists: The Biography of a Specialty Organization,* St. Louis: American Association of Orthodontists, 1971.

Shipler, David K. *A Country of Strangers: Blacks and Whites in America*. New York: Alfred A. Knopf, 1997.

Smedley, Brian D., Adrienne Y. Stith, and Alan R. Nelson. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington. D.C.: The National Academies Press 2003.

Sterling, Eric E. "Racially Disproportionate Outcomes in Processing Drug Cases". *News Briefs,* 16 September 1998. Journal on-line. Available from http://www.ndsn.org/sepoct98/outcomes.html; Internet.

Taylor, Quintard. "Grant. George Franklin (1847-1910)". *BlackPast.org: Remembered and Reclaimed.* Website on-line. Available from http://www.blackpast.org/?q=aah/grant-george-franklin-1847-1910.

Turner, James E. "New Millennium Challenges for African Americans. The Legacy of Racism and Social Inequality:" *The Black Collegian Online.* Available from http:// www.black-collegian.com/news/special-reports/millenium1999.

U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*, 2nd ed. Washington. DC: U.S. Government Printing Office. November 2000.

Washington, Harriet A. Medical Apartheid. New York: Doubleday. 2006.

Weaver, Richard G., Satyan Ramanna, N. Karl Haden, and Richard W. Valachovic, "Applicants to U.S. Dental Schools: An Analysis of the 2002 Entering Class." *Journal of Dental Education*, 2004. Journal on-line. Available from http://www.jdentaled.org/content/vol68/issue8/images/large/Weaver_Table9.jpeg.

Webster, J. L. Sr. MD. "Harvard Scholars Prove Racism in Healthcare Major Contributor to Health Gap in African Americans". *BlackNews.com.* Journal on-line. Available from http://www.blacknews.com/pr/harvardscholars101.html.

Weinberger, Bernhard Wolf. Orthodontists: An Historical review of its Origin and Evolution. Including an Extensive Bibliography of Orthodontic Literature Up to the Time of Specialization. St Lois: The C.V. Mosby, 1926.

Wilson, Reginald. "Affirmative Action – 2003" *New Politics*, vol. 9, no. 4 (new series), whole no. 36, Winter 2004. Journal on-line available from http://www.wpunj.edu/newpol/issue36/Wilson36.htm.

Interviews

Dr. Arrington [pseud.], interview by author, tape recording, 13 May 2004

Dr. Boyd [pseud.], interview by author, tape recording, 15 May 2004.

Dr. Carter [pseud.], interview by author, tape recording, 15 May 2004.

Dr. Dean [pseud.], interview by author, tape recording, 28 May 2004.

Dr. Edwards [pseud.], interview by author, tape recording, 28 May 2004.

Dr. Franklin [pseud.], interview by author, tape recording, 28 May 2004.

Dr. Grant [pseud.], interview by author, tape recording, 04 Jun 2004.

Dr. Hamilton [pseud.], interview by author, 05 Jun 2004.

Dr. Ioni [pseud.], interview by author, tape recording,, 08 June 2004.

Dr. Jacobs [pseud.], interview by author, tape recording, 11 June 2004.

Dr. Kelly [pseud.], interview by author, tape recording, 11 June 2004.

Dr. Lewis [pseud.], interview by author, tape recording, 21 June 2004.

Dr. Mathews, [pseud.], interview by author, tape recording, 21 June 2004.

Dr. Norman [pseud.], interview by author, tape recording, 21 Jun 2004.

Dr. Olsen [pseud.], interview by author, tape recording, 22 June 2004.

Dr. Peterson [pseud.], interview by author, tape recording, 24 June 2004.

Dr. Queen [pseud.], interview by author, 01 September 2004.

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