

SOCIAL ORGANIZATION OF THE DENTAL PROFESSION IN A SMALL CITY

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Use of the medical profession as a model for the study of other professions, particularly in the health field, is understandable. Medicine is clearly a profession, is a relatively old one and has been used as a point of reference for codification of a number of fields. Some of these professions, like dentistry, have recently arrived, and others like nursing, are congeries of activities and norms whose professional status is not yet fully settled.

However, because medicine, like any professional system, has a range and an organization of structural and subcultural features that are unique to it, the fact that some of its elements may be shared with other fields can make it a deceptive and unreliable model. This is more than a trivial possibility, inasmuch as the medical profession has been more frequently and more thoughtfully studied by social scientists on both theoretic and empirical levels than is the case for other health professions.

The point is that distinguishing between elements that are specific to a profession and those that are generic to it as a profession is not a logical but an empirical matter. The present paper is a contribution to the empirical problem. Essentially, it is a deliberate effort to parallel for the dental profession Hall's study of the informal organization of the medical profession in a specific community.

Frankly, one would wish for more certain comparability between Hall's study and this one. Hall's community is identified only as an "eastern American city;" the fact that the community used in this

study could be similarly described isn't enough to resolve the question of their comparability. Perhaps even more unfortunately, Hall does not describe the total informal organization of the medical profession in the community; rather, he identifies an "inner fraternity" and limits himself largely to this one stratum and to the processes by which it exercises and perpetuates its overall control. Hall's analysis of the social organization of the profession is an "elitist" one, in which sharp light is cast on the elite segment, and the various residual or nonelite aggregates are left to blend into an obscure and relatively undifferentiated background.¹

The present study, by contrast, attempts a total-system view, depicting the social-structural relations of all the strata and segments, not simply the most influential. This is not a regretful admission of yet another possible source of noncomparability: how can one know whether differences in Hall's report and this one reflect real differences in the social organization of the two professions, or merely result from the different kinds of nets cast over what might be not-so-very-different phenomena?

Spring City (a pseudonym) is a small eastern American city with a population (1960) of about 13,000. It is a county seat and an important trade and service center for a population many times its own size. Located at the outer rim of a huge metropolitan area, Spring City is close enough to a metropolis to enjoy its benefits but distant enough to avoid being transformed into another set of suburban bedrooms for commuters. Most of the employed population of the city works within the immediate county; 55 per cent of dwelling units are owner occupied, and, as of 1960, 56 per cent of residents had lived in the same dwelling for more than five years. Local election majorities are usually Republican.

Spring City was selected as the site for the study on the following grounds: it was a relatively stable community; it had what seemed to be the "right" number of practicing dentists—about 30—to be based primarily on intensive interviewing; and its location was convenient for the senior author, who planned to do the lion's share of interviewing.

The most recent edition of the *American Dental Directory*² lists 30 dentists in Spring City. A careful count revealed that 27 dentists practice within Spring City and seven others have offices just outside it, constituting a total dental community of 34 practitioners. The aim was to interview and administer questionnaires to every dentist in the

Spring City dental community, but this aim was not fully realized. Of the 34 dentists, 27 became respondents, three refused to participate and four—who had offices outside Spring City proper—were simply overlooked.

The age-range of dentists is from 29 to 73 years, with two-thirds in the 30 to 49 age group. One dentist is a Negro, another is a woman; all others are white males. Of the 27 interviewed, 14 are Jewish, seven are Catholic and six are of various Protestant denominations. Eight dentists attended the dental school of a high-status university in a nearby metropolitan area; another eight attended an intermediate-status university in the same metropolis; the remaining dentists were trained in a scattering of other dental schools.

In an era in which professional status and mobility are usually believed to go together, respondents as a whole display remarkable geographic immobility. Of the 27 respondents, 23 are lifelong residents of the state, and of these 23, 20 spent their early years within a 15-mile radius of Spring City. In other words, the dental community of Spring City is largely constituted of "hometown" boys.

THE INFORMAL ORGANIZATION OF PHYSICIANS

As Hall puts it, to test the hypothesis that an "inner circle" of physicians exercises a profound influence over the opportunities and careers of other physicians in the community, he sought answers to five questions; he suggested that affirmative answers to his five questions would confirm the hypothesis. The five were: Is there a group of physicians that (1) is limited to the more important types of specialties, (2) occupies the strategic posts in the major hospitals, (3) maintains offices with a distinctive and contiguous spatial distribution, (4) is homogeneous as to religion and ethnic characteristics, and (5) is integrated into a system in which its members exchange substantial favors?³

As a matter of course, Spring City dentists were confronted with Hall's five questions. The results, however, were anomalous. To recapitulate briefly:

1. The few dental specialists in Spring City—three orthodontists, two oral surgeons, and an endodontist—not only were without power in the local system but also tended to occupy subordinate and vulnerable positions vis-à-vis general practitioners.

2. A number of dentists held hospital posts, but they did not thereby exercise more than mild and limited influence. Basically, the center of gravity of dental practice was in the individual offices of dentists, not in organized settings such as hospitals.
3. Several of the dentists who were social isolates had offices that were physically isolated, but no significant linkage was found between the spatial distribution of dentists' offices and the interpersonal or professional relations of dentists.
4. Religion and ethnic characteristics were demonstrated to have meaningful associations with patterns of social organization among dentists. However, these associations were not revealed until the data were intensively cross-examined.
5. As to exchanges of favors among dentists between whom were social bonds, Spring City's dental system displayed an essential asymmetry, a lack of reciprocity. When the exchange system among dentists was finally understood, it bore little resemblance to the reciprocal system described for physicians by Hall.

The social organization of dentists in Spring City then is unlike that of physicians, as described by Hall. Now to turn to the central subject of this paper, only the "bare bones" summary of the investigation will be presented.

Considered as a whole, the social organization of Spring City dentists consists of a loosely knit professional and entrepreneurial system balanced between maximum autonomy and the regulation of competition and conflict. It is structured on the basis more of rotating than of reciprocal exchange-relations between colleagues.

THE DENTAL NETWORKS

It is informally organized into two colleague networks, each consisting of a core of established practitioners and a satellite group of juniors. Each network differs in terms of tightness of cohesion or solidarity, degree of influence and prestige, relative importance of attributes of ascribed status and patterns by which new members are sponsored. The networks were labeled Network A and Network B (see Figure 1).

Essentially, the networks were identified on the basis of responses to two questions: *Which colleagues do you see regularly or feel fairly*

close to? (See Figures 2 and 3). *As far as your own mouth is concerned, which dentist usually provides your dental care?* (See Figure 4.)

Other attempts to establish the stable and recurrent sociometric patterns confused more than they clarified. These attempts included: charting the flow of referrals; determining what dentists "covered" for what colleagues in the latter's absence; learning which colleagues any given dentist would be likely to discuss cases or problems with, to choose as spokesmen for or representatives of the profession and to consider as his most admired colleagues. As Figures 5 through 8 show, these attempts produced no clear patterns.

Network A consists of dentists who are white, either Catholic or of a number of Protestant denominations, of North European ancestry in the main, most of whose personnel are members of local—emphasize *local*—families of orientation identified with Spring City's upper or upper-middle class. Evidence indicates that patterns of association and friendship existed between some of the parents and families of Network A dentists long before the individuals concerned launched their dental careers. Parental occupations included those of judge, physician and manufacturer.

Network B, on the other hand, consists in the main of Jewish dentists. Although over half the members of Network B are, like those of Network A, hometown boys, their families of orientation had lower social origins and were without significant ties of interaction with one another. Parental occupations included unskilled and skilled blue-collar trades and proprietors of small retail businesses.

Similarities Between the Two Networks

In terms of age composition, or even better, number of years in practice, each network tends to be a mirror image of the other. Each has a group of young and novice practitioners, a core of established and middle-aged dentists, and a number of preretirement elderly men. Each resembles the other, also, in having a coterie of specialists to whom general practitioners refer cases requiring special knowledge or techniques. Members of both networks show a high degree of interest and concern in entrepreneurial as well as professional aspects of dentistry and, across the board, high value is placed on autonomy.

Income range is about the same for both networks, the number of operatories is about the same (the range is from one to three per dentist), and every dentist in each network employs at least one auxiliary. Those dental procedures rated as "preferred" by most Spring

FIGURE I. NETWORKS A AND B: PARTS OF THE SYSTEM.

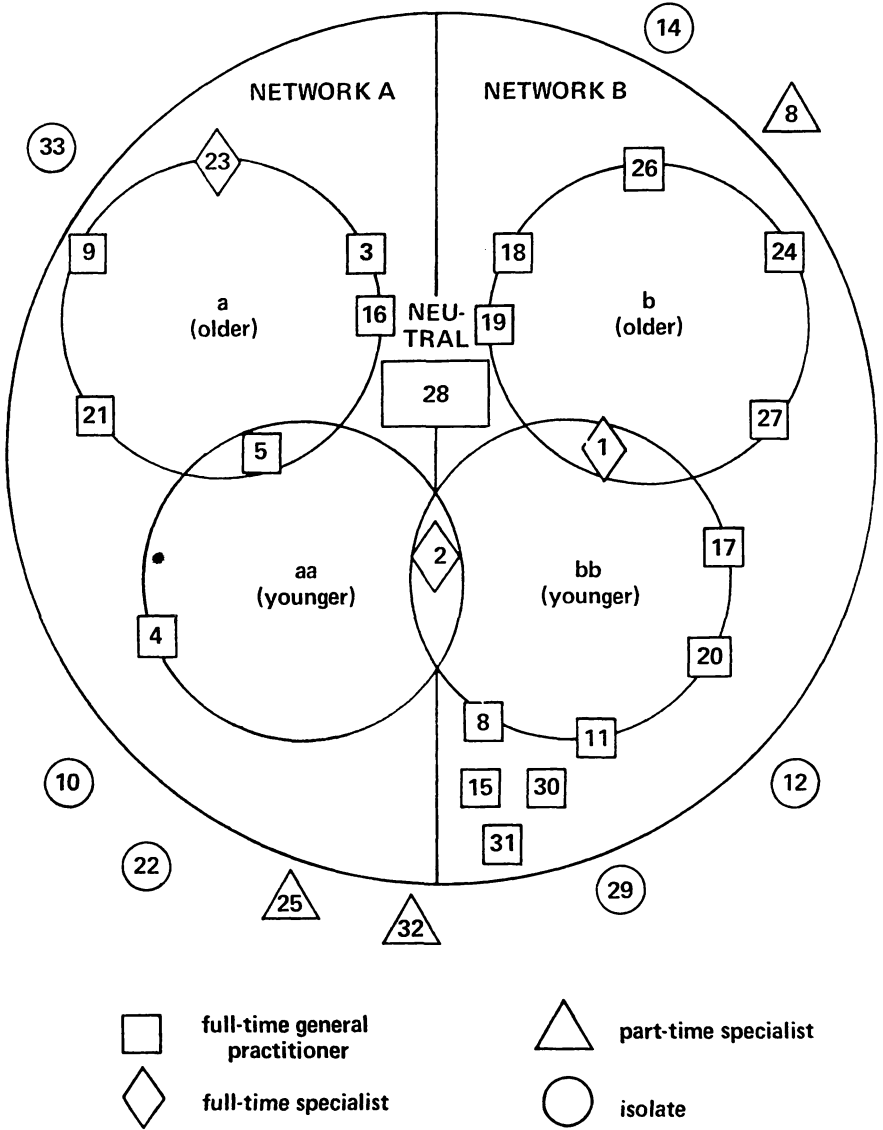


FIGURE 2. FOUR SOCIOMETRIC MATRICES DERIVED FROM THE QUESTION, "WHICH COLLEAGUES DO YOU SEE REGULARLY OR FEEL FAIRLY CLOSE TO?"

OLDER SUB-GROUP OF NETWORK A (a)

Dentist	3	5	9	16	23	21
3		+	+	+	+	+
5	+		+	+	+	-
9	+	+		?	+	?
16	+	+	?		+	+
23	+	+	+	+		+
21	+	-	?	+	+	

OLDER SUB-GROUP OF NETWORK B (b)

Dentist	26	27	18	24	19
26		+	+	+	+
27	+		+	+	+
18	+	+		?	+
24	+	+	?		?
19	+	+	+	?	

YOUNGER SUB-GROUP OF NETWORK A (aa)

Dentist	5	4	2
5		+	+
4	+		+
2	+	+	

YOUNGER SUB-GROUP OF NETWORK B (bb)

Dentist	1	11	20	17	8
1		+	+	+	+
11	+		+	+	+
20	+	+		?	+
17	+	+	?		+
8	+	+	+	+	

FIGURE 3. INTERRELATIONS INDICATED BY ANSWERING THE QUESTION, "TO WHICH DENTAL COLLEAGUE DO YOU FEEL CLOSEST?"

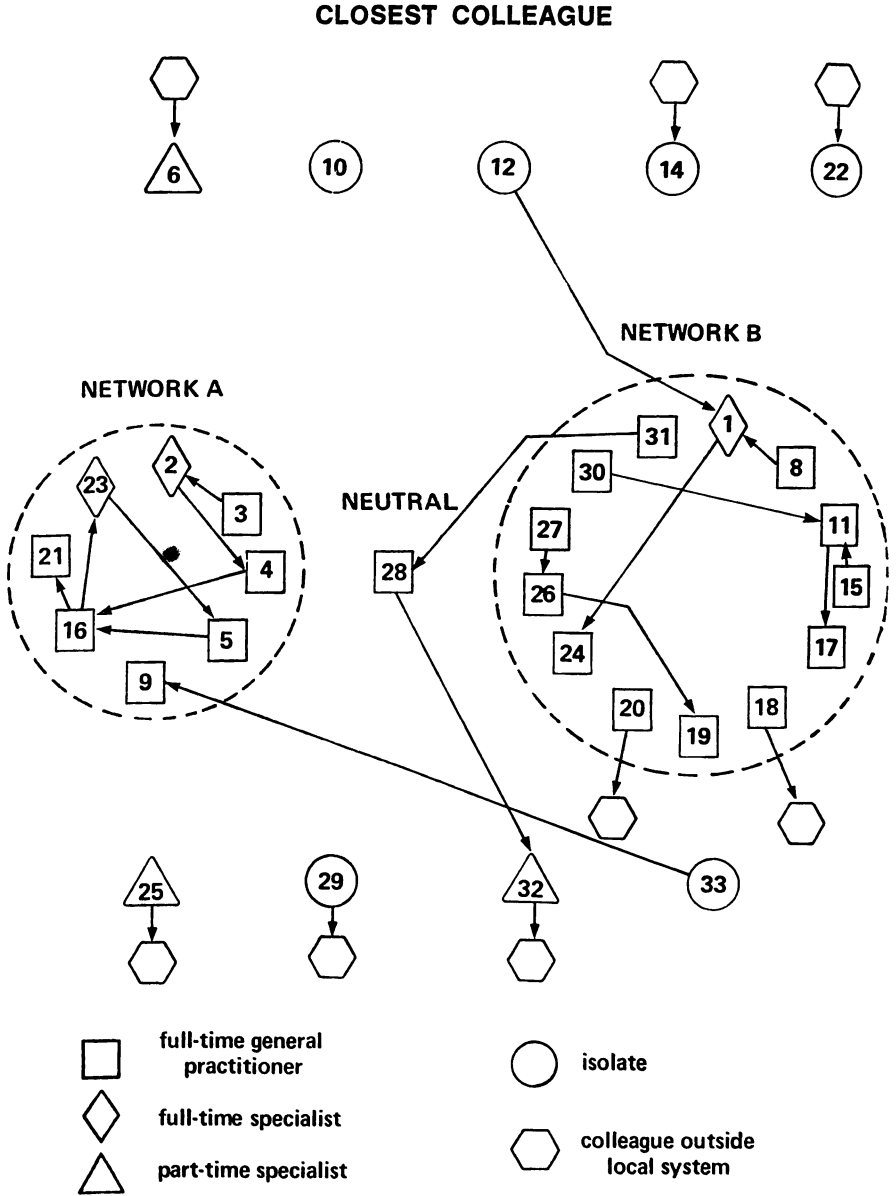
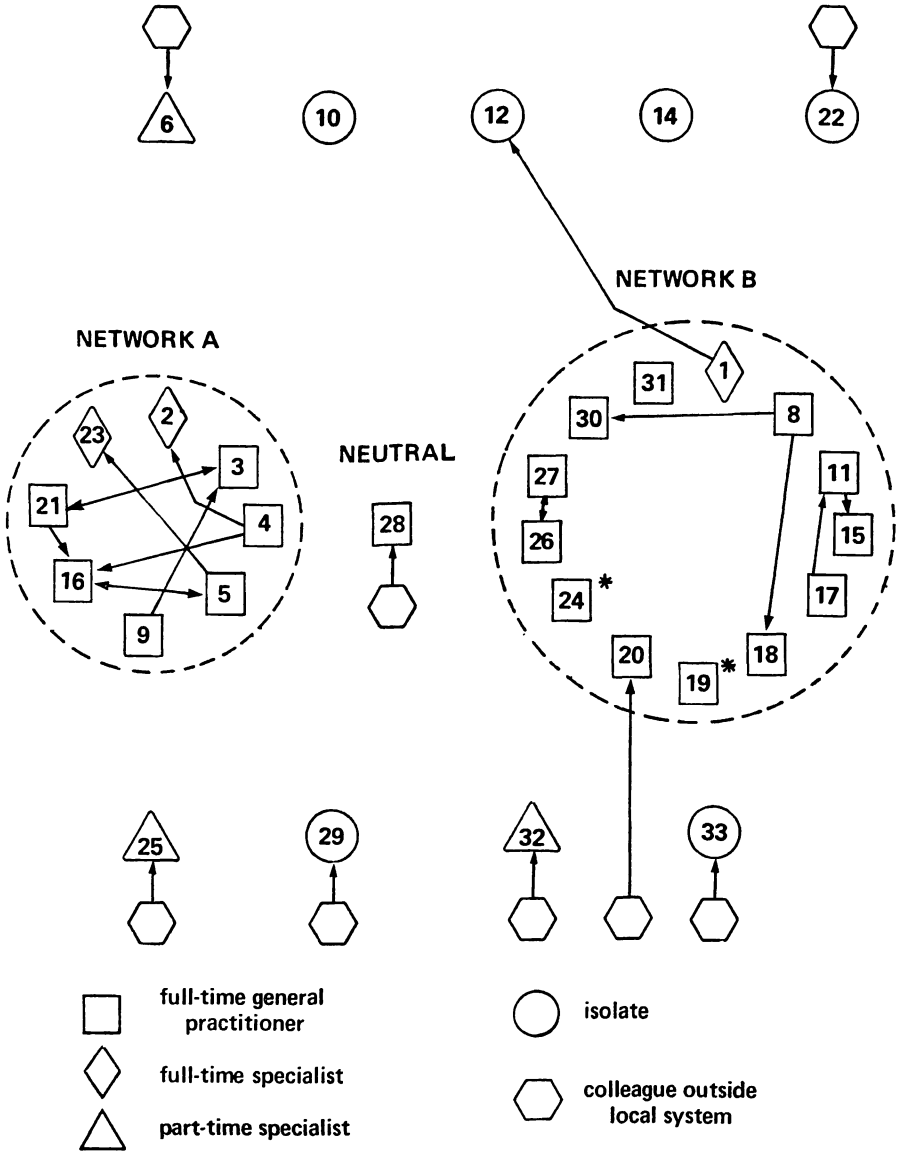


FIGURE 4. ANSWERS TO QUESTION, "AS FAR AS YOUR OWN MOUTH IS CONCERNED, WHICH DENTIST USUALLY PROVIDES YOUR DENTAL CARE?"

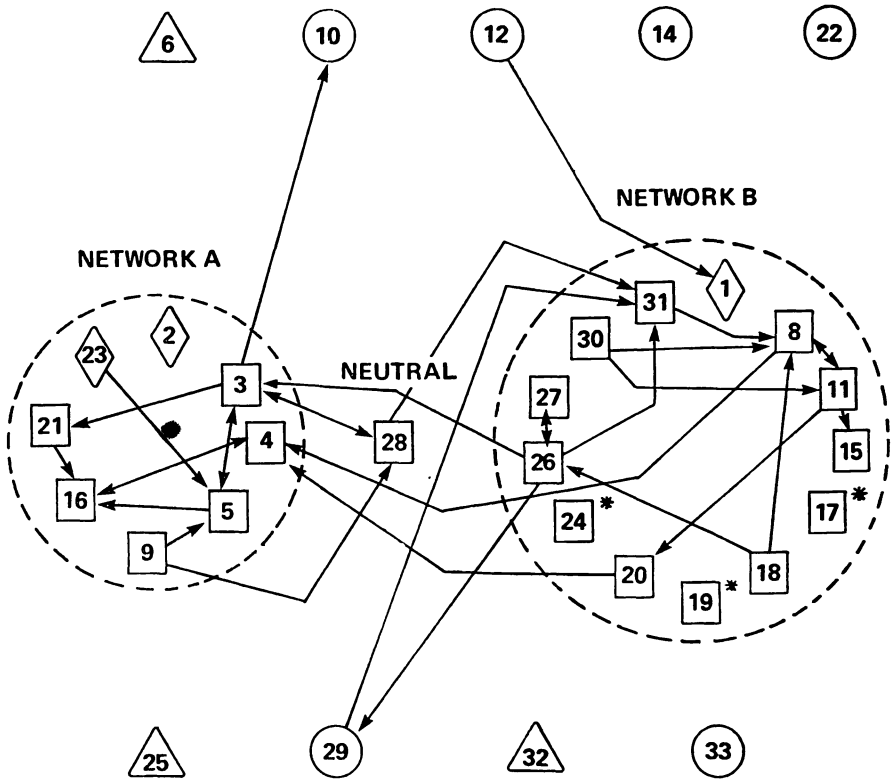
PERSONAL DENTAL CARE



* Information not known.

FIGURE 5. ANSWERS TO QUESTION, "ON OCCASION, A DENTIST MAY ASK ANOTHER DENTIST(S) TO COVER FOR HIM IN HIS ABSENCE. WHICH DENTIST(S) ARE YOU LIKELY TO ASK TO COVER FOR YOU?"

PROVIDING COVERAGE



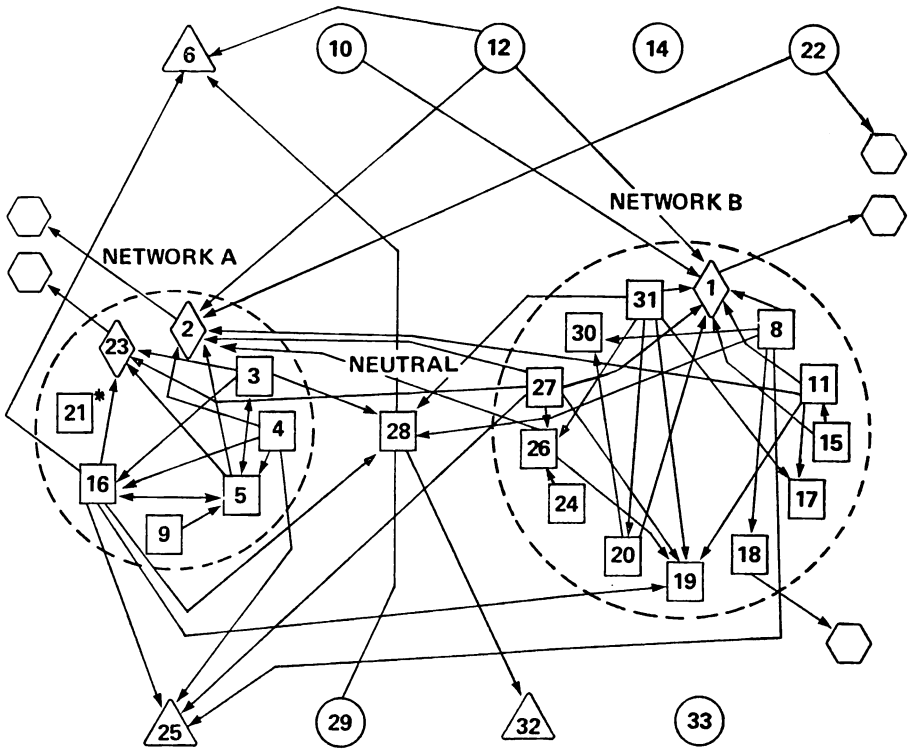
- full-time general practitioner
- ◇ full-time specialist
- △ part-time specialist



- isolate
- ⬡ colleague outside local system

* Information not known.

FIGURE 6. ANSWERS TO QUESTION, "IN REGARD TO DENTAL PROBLEMS, WHICH COLLEAGUE(S) ARE YOU MOST LIKELY TO DISCUSS SUCH PROBLEMS WITH?"

SOLICITING INFORMATION AND OPINION

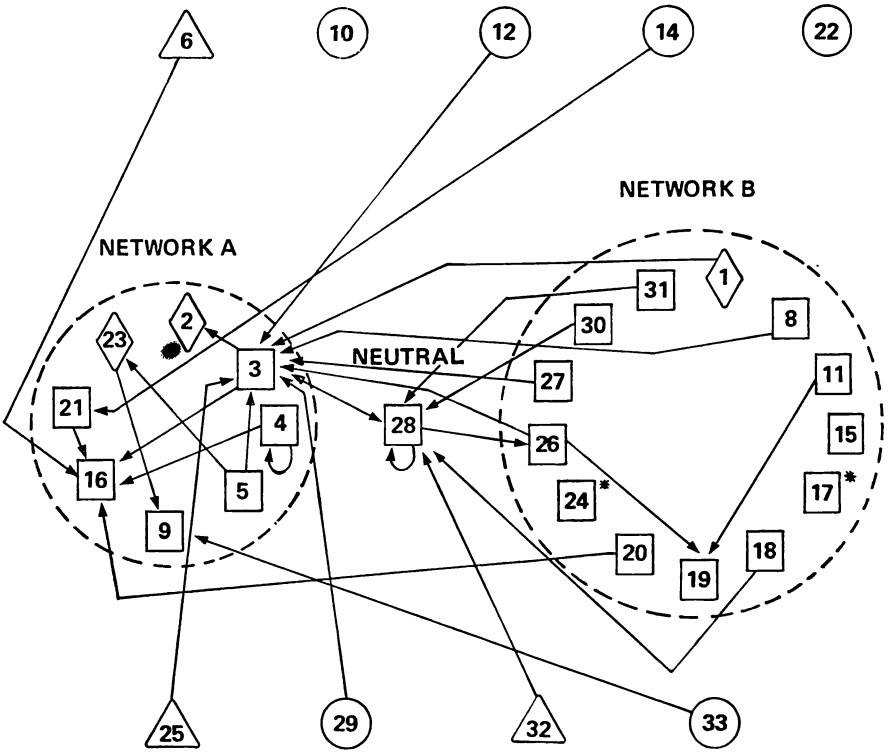


- | | | | |
|---|--------------------------------|---|--------------------------------|
|  | full-time general practitioner |  | isolate |
|  | full-time specialist |  | colleague outside local system |
|  | part-time specialist | | |

* Information not known.

FIGURE 7. ANSWERS TO QUESTION, "IF YOU WERE TO NAME ONE DENTIST IN YOUR LOCALITY TO SERVE AS THE SPOKESMAN FOR, OR REPRESENTATIVE OF, THE PROFESSION ON MATTERS OF CONCERN TO DENTISTS IN YOUR AREA, WHO WOULD YOU CHOOSE?"

SPOKESMAN

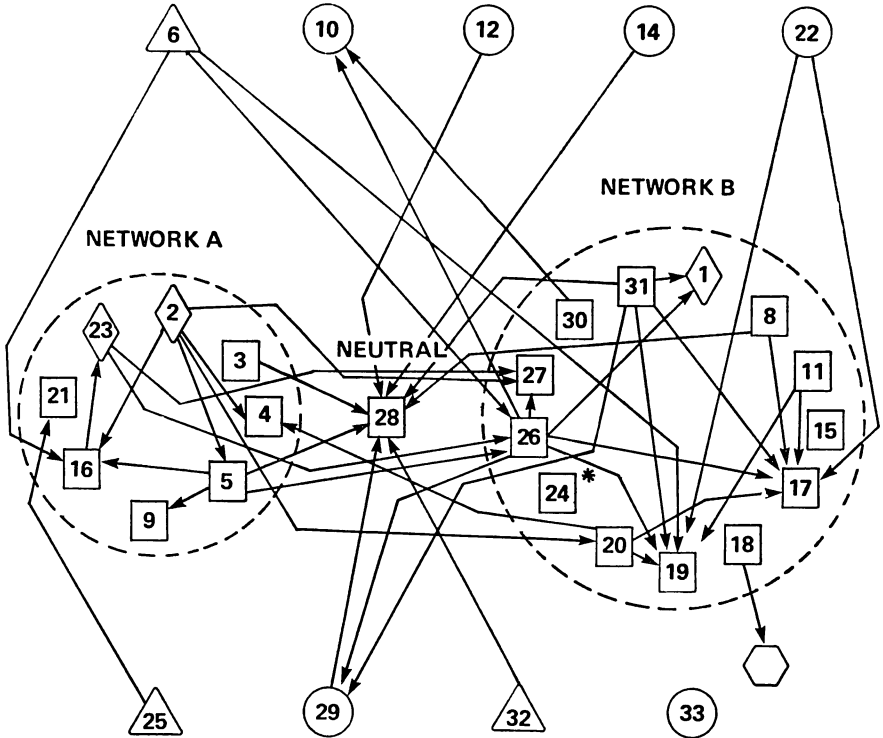






- | | | | |
|---|--------------------------------|---|--------------------------------|
| □ | full-time general practitioner | ○ | isolate |
| ◇ | full-time specialist | ⬡ | colleague outside local system |
| △ | part-time specialist | | |

* Information not known.

FIGURE 8. ANSWERS TO QUESTION, "AMONG YOUR COLLEAGUES, WHICH ONE OR TWO DO YOU MOST ADMIRE?"

MOST ADMIRED



- | | | | |
|---|--------------------------------|---|--------------------------------|
|  | full-time general practitioner |  | isolate |
|  | full-time specialist |  | colleague outside local system |
|  | part-time specialist | | |

* Information not known.

City respondents are performed about equally by members of both networks. (The same procedures—involving gold work, new dentures, crown and bridge work and mouth rehabilitation—were similarly ranked by a national sample of dentists.)⁴

Differences Between the Two Networks

Network A is more cohesive—its members interact somewhat more intensely and exclusively with one another—than is true of Network B. Also, members of Network A occupy superior positions of influence and prestige within the dental community as a whole. Network A dentists are more likely than those of Network B to be named as good sources of information, are more likely to designate themselves as “opinion leaders,” and are the occupants of the few positions held by local dentists in hospitals and in the county dental program. Each network also differs in respect to prevailing patterns of entry, incorporation, sponsorship and socialization of new members.

The crucial factor in the entry and total career of Network A dentists is one extraneous to the practice of dentistry, that is, their *ascribed status*. As not only native sons but also sons of families known to and accepted by other Network A dentists, it is unnecessary for them to demonstrate their entrepreneurial competence; it is taken for granted. Sponsorship is facilitated in many ways for new Network A dentists and, indeed, is often begun even before the individual has graduated from dental school. Finding and financing an office, building a practice, gaining the good graces of all members of the network—all crucial to a new dentist’s career—are characteristically expedited and smoothed by a senior dentist from Network A who lets it be known that he has taken the novice “under his wing.”

The functional nature of the nonreciprocal exchanges between dentists is brought out clearly when the sponsorship of new members is examined. Dr. Smith, say, has been aided by Dr. Jones in a number of ways; Jones referred patients to Smith when the latter was establishing himself, provided advice and information, sponsored him at the Dental Society and so forth. These are essentially asymmetric favors, in that Smith cannot simply repay in kind. However, when a novice known to Dr. Jones enters the dental community, the expectation is that Smith will repay Jones’ favors by extending assistance and sponsorship to the novice. The exchange of favors is not reciprocated but rotated: Smith repays Jones by helping Brown.

Entry patterns for Network B dentists differ. The usual case is that

the incoming dentist is already known to at least one established practitioner of Network B; unlike Network A, however, any number of bases may exist, some of them tenuous and fortuitous, for the prior relation. Also, whereas the senior dentist of Network A will take the initiative in undertaking the sponsorship of a junior dentist, the expectation and usual practice in Network B is that the junior will be the initiator. Characteristically, senior dentists in Network B provide less assistance to proteges and for a shorter time than do dentists in Network A; they limit their aid to the interval when the junior in Network B is beginning to build his practice.

Isolates

In addition to the eight or so dentists in Network A, and the dozen or more in Network B, six dentists may be characterized as "isolates." These practitioners are apparently not incorporated into either network. Although their biographic and situational details present considerable variation, the isolates share the following characteristics and attributes:

Prior to locating themselves in Spring City, isolates had no relations with established practitioners in town. Following entry, they received only minimal support, such as patient referrals, from senior dentists and made no serious effort to be accepted by one of the networks. At present, they are characterized by: minimal interaction with colleagues; lack of prestige and influence; low degree of entrepreneurial achievement; dissatisfaction with the field of dentistry; and difficulty in the area of interpersonal relations.

Specialists

In respect to ascribed characteristics, the only feature that distinguishes specialists from general practitioners is that not a single specialist is a "hometown" product. Four are Catholic and two are Jewish. Parental occupations include skilled and unskilled employment, retail business and professional work.

Specialists engage in much "courting" of general practitioners, especially during the early years of practice-building. New specialists usually make it a point to call on every practitioner in the area, invite them to lunch and entertain them socially. One specialist reported that during his first two months in Spring City he visited and took to lunch every practitioner in the community; subsequently, he and his wife entertained many practitioners at their home. Specialists express

distaste for the need to curry favor with general practitioners, a distaste often deepened by the specialist's conviction that he is the other's superior in technical competence. Specialists take pains to avoid antagonizing general practitioners; for instance, when specialists deal with patients who do not have a regular dentist, specialists deliberately refer such patients to general practitioners on what is hoped others will acknowledge to be an impartial basis. Although specialists are in a position to inspect and assess the quality of dental work of general practitioners, they avoid passing overt judgment even on patently inferior work for fear of losing sources of patients.

Relations between general practitioners and specialists consist of exchanges of mutually beneficial objects. The specialist starts the cycle by ingratiating himself with the general practitioner, but it is the latter who holds the initiative in transactions involving the flow of patients. The general practitioner directs a patient to the specialist; the latter provides specialized treatment and redirects the patient to the first practitioner. Sometimes, however, the general practitioner keeps the patient but directs a request for specialized advice and information to the specialist; the specialist responds to the request and thereby keeps the channel open and viable for more of the first type of exchange.

Each of the full-time specialists is integrated into one of the networks, thus providing network members with ready access to competent specialists and consultants. The specialist, by establishing a close and somewhat diffuse set of relations with a group of general practitioners, assures himself of a stable and regular flow of patients, thereby reducing—sometimes even eliminating—the need to continue “wooing” of general practitioners.

The Dental Supply Man

Dentistry's counterpart to the so-called “detail man” in medicine (a representative of a pharmaceutical house) is the “dental supply man.” This role is what is appears to describe—the representative of a dental supply firm. The dental supply man performs a range of functions in addition to those listed in his job description. He disseminates diffuse information between the networks and also serves as an important “broker” between dental school graduates and on-going dental communities. In the biographies of a large minority of practitioners, mention occurs of the role of the dental supply man in assisting new dentists to canvass possible communities in which to practice, locating

desirable buildings in which to establish an office, introducing novice practitioners to the "right" senior dentists, serving as consultants in the renovation and outfitting of offices and so forth.

Particularistic and Kinship Factors

Whether or not it should have done so, it came as a surprise to the authors to learn of the extent to which particularistic and kinship factors are involved in the career patterns of dentists, especially but not exclusively in early stages. As has been seen, the status of members of Network A depends on ascribed considerations, related to family membership and a whole series of particularistic connections. Members of Network B, also native sons in the main, also rely heavily on material and intangible support from relatives and family connections.

Curiously, the one sector of the Spring City dental community that embodies the cultural ideal of "making it" entrepreneurially and professionally "on one's own," that is, without particularistic or kinship resources, is the group termed the isolates; their divorce from the support of kin may be in line with the free-enterprise value system, but it may also be partly responsible for their dismal entrepreneurial achievement and low professional standing with colleagues.

REFERENCES

¹ Hall's elitist treatment of social organization is neither unique nor out-of-date. In what is essentially, like Hall's, an excellent study, Coleman's *ADOLESCENT SOCIETY* (1961) takes for granted that an adequate understanding of social structure among high school students can be gained by limiting one's attention to the "leading crowd."

² *American Dental Directory*, Chicago, American Dental Association, 1964.

³ Hall, O., The Informal Organization of the Medical Profession, *Canadian Journal of Economics and Political Science*, 12, 41, February, 1946.

⁴ Commission on the Survey of Dentistry in the United States, *SURVEY OF DENTISTRY IN THE UNITED STATES*, American Council on Education, 1961, p. 110.