

Oral and Maxillofacial Pathology— Its Future in Doubt?

After its inception in 1948, the American Academy of Oral Pathology (AAOP) served as the parent organization of an emerging specialty of dentistry and was approved as such by the American Dental Association in 1950. The official name change to oral and maxillofacial pathology occurred in 1995. Since its founding, this specialty has grown to nearly 700 members, which include 265 Diplomates. But despite the leadership's attempt at long-range analysis and planning, there has been a 23 percent decline in membership since 1990 and a 3 percent decline in the number of Diplomates during this same time span.

To address this significant and worrisome trend, the leadership of the organization has quite appropriately begun to analyze the possible reasons for this decline. Reasons include the closure of seven dental schools over the last decade and a reorganization of the administrative structure in many of the remaining fifty-four schools. In addition, combining smaller departments such as radiology, oral and maxillofacial pathology, and oral medicine has led to loss of the specialty's identity within many schools. Also of note is the recent closure of an additional advanced education program in the specialty, leaving the United States and Canada with only fifteen fully accredited programs, most of which graduate one to two board-eligible individuals per year. This statistic must be weighed against the annual retirement or attrition of formerly active individuals within the specialty. In some cases, absorption of the specialty into medical school pathology departments has further diminished the role of oral and maxillofacial pathology in dental schools, resulting in a further loss of identity of the specialty. On the other hand, some oral and maxillofacial pathology departments have survived because of the associated tissue diagnostic services (so-called biopsy services) that serve university and community practices, often with a contribution to the dental school from its earnings.

Complicating the problem is the fact that many trained oral and maxillofacial pathologists teach in general pathology, oral pathology, oral biology, den-

tal hygiene, postgraduate, and undergraduate courses. Because there are fewer oral pathology teachers in dental schools, the teaching burden has been shifted to younger faculty who are already facing a heavy burden of teaching commitments. Dental schools desire to attract entry-level faculty who already have or are capable of achieving Diplomate status. Entry-level faculty are expected to serve as clinical faculty, perform diagnostic duties, conduct externally funded research, and pursue other scholarly activities appropriate to a tenure-track position. But while some individuals are capable of performing successfully in most of these roles, it is rare when any one individual can accomplish all of them, given the constraints of time, research funding, and overall commitment to the university.

Although we continue to work within the same set of constraints provided by the product of our current educational and training programs, in oral and maxillofacial pathology it is time to reconsider the product of our current training programs and what may be required for sustained growth in the specialty. A component of the answer may lie in eliminating the traditional, though often unspoken, exclusionary behavior of organized oral and maxillofacial pathology, resulting in fragmentation of diagnostic and therapeutic disciplines among similarly small segments of recognized and unrecognized specialty groups within our profession. Considerations in the past for increasing the representative base of diagnostically and therapeutically related disciplines have included amalgamating oral pathology, oral medicine, and oral radiology, with specific subset Diplomate status, under the rubric of an overarching oral and maxillofacial science-based discipline. Inclusion of a hospital dentistry component in affiliated university hospitals further offers the oral pathologist with the appropriate background and training additional professional opportunities.

We must also give thought to innovation within advanced education programs, which would build on the traditional strengths of surgical oral and maxillofacial pathology, and to a greater emphasis on sci-

ence and academic accomplishment in the form of laboratory-based research at a nationally competitive level. Such programs and their graduates would be attractive not only to dental schools but to hospital-based pathology departments as well. The potential overall contributions of the well-rounded oral and maxillofacial pathologist to the health care delivery system must be emphasized. Contributions could include active participation in direct patient care for those with oral disease within both the hospital environment and dental school setting. Management of oral and maxillofacial diseases and conditions by the oral and maxillofacial pathologist must also assume a greater level of importance, not just in dentistry but within the health care delivery system as well.

Ph.D. programs for the oral and maxillofacial pathologist should be redesigned so that students receive the necessary training to begin a research-based career in oral disease upon graduation. Alternatively, an M.D.-based program with postdoctoral education in head and neck pathology and molecular-based methodologies would create individuals capable of functioning in the diagnostic or laboratory-based side of surgical oral pathology within a hospital or free-standing oral pathology laboratory or as a member of the reference laboratory industry. Such individuals with expertise in head and neck pathology with

specific oral and maxillofacial pathology training would better establish the role of our specialty in a broader-based diagnostic environment.

The preservation and growth of oral and maxillofacial pathology require greater emphasis on our role and value within the educational community, the health care delivery system, and the research community. We must remove barriers that serve to isolate us from other components of the health care system, while reinforcing the importance of oral and maxillofacial pathology to members of our own profession, most notably our colleagues in the oral and maxillofacial surgery community. We must embrace new ideas in a healthy, constructive manner in an effort to expand our scope by blending diagnostic and therapeutic components, as has been the case in dermatology. Oral and maxillofacial pathology is in a position to lead our profession, but educational programs must be redesigned to allow innovative growth and the development of skills in our graduates that will be valued by the research community on one hand and the health care delivery system in the twenty-first century on the other. To be successful in this endeavor, we must obtain the support and assistance of the American Dental Association, the American Dental Education Association, and the Academy of Oral and Maxillofacial Pathology.

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