Serving the Public Good: Challenges of Dental Education in the Twenty-First Century


Abstract: The purpose of this study was to explore perceptions of the roles and responsibilities of dental education in serving the public good, and the extent to which they are being met, from the vantage point of leaders at the university and state level. Five questions were developed to gather views on dental education’s success in meeting the expectations and needs of the public. Fifty-one interviews were conducted with leaders at seven institutions and with public officials in six states. Overall, dental education was perceived as fulfilling its public purpose in promoting oral health, providing access to care, and conducting relevant research. However, significant areas for improvement were noted including better communication of accomplishments to key stakeholders, graduating a more socially aware, culturally sensitive, and community-oriented dental practitioner, and being a committed partner with other community leaders in improving access to care for all citizens. Current programs aimed at addressing these gaps (e.g., Pipeline, Profession, and Practice program) are discussed. Dental education can address these perceptions only by producing graduates who desire to fulfill their obligations to society and serve the public good.

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The public expects that higher education will instill its graduates with a strong sense of social responsibility and personal accountability. Etzioni states that a good society depends on agencies of socialization, including its educational institutions, as well as informal social controls to instill shared moral values. Thus, the academy plays an important role in the socialization of its citizens.

Newman et al., in The Future of Higher Education: Rhetoric, Reality and the Risks of the Market, describe an informal compact between higher education and the public that defines higher education’s responsibility to society. This compact states that higher education serves society through its missions of teaching, research, and service and, in return, higher education is afforded special privileges, such as academic freedom and public trust. Newman et al. express concern over what they see as a slow erosion of this compact as well as the special status afforded to educational institutions, caused in large part by institutions’ increasing focus on fiscal exigencies. Yet they argue that “serving the public purposes of higher education has never been more important” (p. 214). Derek Bok, president emeritus of Harvard University, in the 1992 keynote address to the American Association of Higher Education on the topic of reclaiming the public trust, noted that higher education will remain open to criticism by the public, and justly so, until such time as we can convince the public—by our actions—that education is our top priority.

While Newman et al. and Bok focused on the larger realm of higher education, these same concerns may be raised in dental education. Academic dentistry today faces myriad challenges, not the least of which are decreasing financial support, leading
to the need for increased fiscal self-sufficiency; an increasingly older and medically complex patient population; and a shortage of faculty that may soon approach crisis levels. A recent report on the effects of declining state support on state-supported dental schools found an increasing gap in incomes between faculty and dentists in private practice, fewer full-time clinical faculty, higher cost of dental education, and a decrease in the number of underrepresented minority students and those from families with parental incomes of $50,000 or less. Those schools with the lowest increases in total revenue lost one third of their full-time clinical faculty and a disproportionate number of clinical faculty with Ph.D. degrees over the twelve-year period studied. These factors, especially financial burdens including decreased support, differential incomes, and the increasing cost of an education, place constraints on dental education that can have lasting negative consequences. These include diminished capacity to produce an adequate number of qualified oral health care providers and meet the research mission of the university, as well as difficulties in attracting and retaining dental faculty.

It may be argued that dental education has a special obligation to the public because of its responsibility to provide professionals to serve the health care needs of its citizens. Welie, in a three-part series of articles on dentistry as a profession, states that “the ethical foundation of a profession is . . . the voluntary promise to care for those fellow humans who are vulnerable and in need” (p. 532). Further, those entering a profession must “assume a variety of demanding duties and responsibilities” (p. 602). Welie argues that dentistry is at risk of losing its professional status and reverting to its previous position as a business because of an erosion of the social contract requiring dentists to provide their expertise to all those with oral health needs.

What, then, are dental education’s specific responsibilities in instilling in dental students a sense of what it means to be a professional? What is its role in promoting the public good? A recent position paper by an ADEA Presidential Commission recommends seven roles and responsibilities of academic dental institutions in meeting the oral health needs of all Americans:

1) preparing competent graduates with skills and knowledge to meet the needs of all Americans within an integrated health care system;
2) teaching and exhibiting values that prepare the student to enter the profession as a member of a moral community of oral health professionals with a commitment to the dental profession’s societal obligations;
3) guiding the number, type, and education of dental workforce personnel to ensure equitable availability of and access to oral health care;
4) contributing to ensure a workforce that more closely reflects the racial and ethnic diversity of the American public;
5) developing cultural competencies in their graduates and an appreciation for public health issues;
6) serving as effective providers, role models, and innovators in the delivery of oral health care to all populations; and
7) assisting in prevention, public health, and public education efforts to reduce health disparities in vulnerable populations. (p. 780)

These are laudable goals, promulgated by leaders within the dental education community, and may be viewed as guideposts for determining whether, and to what extent, we are meeting our contract with society. However, it is equally important to initiate a dialogue outside of dental education in order to determine current expectations and assess the extent to which we are meeting these expectations.

Consequently, the purpose of this study was to explore perceptions of the roles and responsibilities of dental education in serving the public good, and the extent to which they are being met, from the vantage point of academic leaders within the university and representatives from organized dentistry and public health at the state level. By assessing the viewpoints of opinion leaders who are familiar with dental schools but not directly involved in curriculum implementation, we can begin to understand whether dental education is perceived to be contributing to the profession’s compact with society.

We will argue that if dental education is not fulfilling its obligations to the society that it serves, as reflected in the views of these leaders, then we must determine where we fall short and either change perceptions or begin to make the changes necessary to align ourselves with these expectations.

Methods

The authors represent one of three groups of fellows in the American Dental Education Association Leadership Institute class of 2006. Leadership Institute fellows are faculty in dental education institutions who are competitively selected to par-
participate in a year-long leadership fellowship and charged with investigating an issue of concern to dental education. By consensus, the group chose to investigate the opinions of leaders in higher education, organized dentistry, and public health regarding their perceptions of the roles and responsibilities of dental education in serving the public good and the extent to which they are being met.

We first identified individuals in key roles in higher education and at the state level who, by nature of their positions, interact with dental education and therefore would likely have opinions regarding the chosen topic. We selected comparable leaders at each of our institutions or states for standardization. Although exact titles varied among institutions, individuals held positions commonly referred to as president, provost, vice president for health affairs, vice president for development, vice president for research, and vice president for government relations. State leaders included the executive director of the state dental association and director of the state Department of Community Health. Breakdown of respondents by position is reported in Table 1. All members of the identified sample were interviewed with the exception of one community health director, who could not be contacted due to scheduling conflicts. Three individuals served as both vice president for development and vice president for government affairs, and one vice president for health affairs also served as provost. Two investigators shared the same state and therefore conducted their three state-related interviews (executive director of the state dental society and two community health representatives) together. All remaining interviews were conducted individually. Of the fifty-one respondents, 23.5 percent were female, and 76.5 percent were male; they were primarily Caucasian (94 percent); and the age range was forty to sixty-seven years.

Five open-ended, non-leading interview questions were developed with the objective of determining interviewees’ perceptions of the roles and responsibilities of dental education:

1) From your perspective, how does dental education serve the public good?
2) Do you think dental education is fulfilling its role in meeting this purpose?
3) How can dental and allied dental education better meet the needs of the public?
4) How can dental education align with your office or organization to best serve the public good?
5) As dental education plans for the future, is there an area that you see as a priority?

Study approval was obtained by each author from his or her Institutional Review Board (IRB) or relevant authority prior to conducting the interviews. Data were collected and stored in compliance with IRB standards.

A letter introducing the interviewer and purposes of the interview, as well as a copy of the questionnaire and consent form, was sent to interviewees prior to the interview. An interview was then scheduled at a mutually convenient time. Each interviewee was asked the same five questions.

Data were collected by two means: handwritten notes taken during the interview and, in some cases, audio recording of the interviews in addition to the handwritten notes. Each interviewer also documented the interview date, recording method, length of interview, and interviewee role. Summaries were typed from the handwritten notes and/or audio recordings and sent to one author to be combined for data analysis.

One author assembled the interview summaries into one comprehensive file for data analysis. This file identified institutions only by code and respondents within institution only by role. Two authors (ED, MG) then performed a qualitative analysis of the data using this comprehensive file. The interview text was first examined independently to identify, code, categorize, classify, and label the primary patterns in the data. These two authors then met to reach consensus by confirming patterns, examining any competing explanations, and ensuring that no pattern had been

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1Two others covered Government Relations as well.
2One combined this function with being Provost.
3Two investigators from the same state completed joint interview(s).
4One health official could not schedule.
overlooked. After summarizing their findings and checking this summary against the original interview text, the summary was reviewed by the five remaining authors, who also checked the summary against the interview text to corroborate/legitimize the findings. It should be noted that, as a qualitative study, the goal was to summarize general themes rather than to quantify the number of times a theme was reported.

Results

A total of fifty-one interviews were conducted (Table 1). Most interviews (n=44; 86 percent) were conducted in person. The remaining seven interviews were conducted by telephone. Responses to the five questions are summarized below, with illustrative statements made by the interviewees. Italics in the text are used to represent phrases and sentences taken from interview notes (i.e., paraphrases); quotation marks are reserved for direct quotes from the individuals based on audio recordings.

Question 1. From your perspective, how does dental education serve the public good?

Answers to this question fell into three broad categories. Nearly all respondents indicated that dental education serves the public good by training professionals who will promote oral health and educate the public about the importance of oral health. In addition, the majority indicated that dental education also serves the public good by addressing the needs of the underserved, and several listed research as another means by which it serves the public good, for example, “by expanding the frontiers in knowledge in dentistry and disseminating it to the public.”

Question 2. Do you think dental education is fulfilling its role in meeting this purpose?

Over one-third of the respondents provided an unqualified “yes” in response to this question (seventeen of forty-seven respondents). However, the majority (64 percent) offered a qualified yes, but more can be done. Areas of perceived need included maldistribution of the workforce, and in particular a shortage in rural and inner city areas, and access issues related to outreach to the community. Some respondents mentioned manpower (n=6) and diversity (n=4) concerns in the profession, and several (n=8) cited a need to better educate the public on policy because “we’re not getting that message out effectively.” Four individuals, representing different roles both within and outside academic institutions, expressed the opinion that dentists do not seem to understand the role of a health professional in the community. These comments illustrate this perception: “dentistry is more business minded than socialist; dentistry should be more socially responsible”; “[dentists are] one point of contact in the health care system, but don’t seem to realize their role”; and “the issue is whether graduates understand where they fit in with the community as a whole and that they have a responsibility for health care for the public in a larger perspective.”

Question 3. How can dental and allied dental education better meet the needs of the public?

Many of the interviewees’ suggestions mirrored the concerns noted in response to Question 2. These included improving access to care for the underserved (n=10), especially through outreach, and increasing public awareness of the importance of oral health (n=6). As one interview subject stated: through outreach, dental schools have to find a better way of serving the dentally underserved, especially those who cannot afford dental treatment. Eleven respondents commented on the need for curriculum change to address diversity, language and cultural barriers, and the needs of geriatric and medically compromised patients. Three respondents mentioned the importance of increasing workforce diversity, and one stated: a negative effect will occur for future populations if medical and dental professions do not reflect the community that we are serving. In addition, four subjects described the importance of oral health research. One suggested that more research should be done from the public health perspective, determining what programs work best and helping people to adopt behaviors that promote oral health. Another commented that the future of research depends on multidisciplinary cooperation among the health care professions, and one respondent felt that it was important to continue to create and integrate new knowledge into the dental curriculum to promote lifelong learning among students. Four respondents commented on the importance of partnering with K-12 and/or higher education programs to promote public health initiatives, and two respondents mentioned the value of developing partnerships with public health, health centers, and/or organized dentistry.

Question 4. How can dental education align with your office or organization to best serve the public interest?

Due to the directed nature of this question, responses were examined by each individual office separately, and are reported as such.

Executive Directors, State Dental Associations. The major theme among state dental directors was
working together on common goals: legislative initiatives, community programs, and communication with practicing dentists. As one respondent stated, we must recognize that we all need each other.

State Departments of Community Health Directors. The common theme among community health directors was the need for dental education to get out into the community. One respondent stated that dental education must be at the table with key committees and legislative initiatives. This individual also recommended more involvement in local and statewide coalitions so that dental education is part of the planning process. Another indicated that community-based programs should be enhanced, possibly by the development of internships and residency programs to better serve the community. One suggested that dental education coordinate efforts with the state community health office to speak to communities, using faculty for technical support of community-based issues. Finally, one respondent indicated that there must be better collaboration on curriculum related to public health, stating that our chief of oral health only provides a single lecture to the first-year dental students. That seems to be the extent of our involvement with each other, and that needs to be improved.

Presidents and Provosts. Responses by presidents and provosts followed a similar pattern and are reported together. Five respondents felt that the dental schools were already aligned with the mission of the university, and one encouraged the school to continue to promote service, teaching, and research. Three subjects reported that dental education must work harder to collaborate with other units, through research and/or interdisciplinary education programs involving both faculty and students and by integrating research and service into the broader mission of the university.

Vice Presidents for Research. These responses were similar to those of presidents and provosts, but directed mainly at the research mission of the university. Three respondents cited the need for collaboration with other health care or clinical areas and with basic sciences and better integration with the rest of the university. One research vice president stated: dentistry should be at the table and be active and proactive in participating in these activities. Work together on data gathering: program reviews, graduates' perceptions, success rates.

Vice Presidents for Government Affairs. Five of the seven government affairs officers said that dental education must promote itself, get the word out about what dental educators do, and educate the government affairs office so that it can advocate for us, for the greater good of both the university and the state. One respondent mentioned the importance of tying oral health to the health of the rest of the body.

Vice Presidents for Development. The common theme among development officers was that they could help dental education. Respondents recommended partnerships to identify a mission and a vision, as well as potential donors. They also suggested that they could help dental education develop impact statements and disseminate information in language that the lay public will understand.

Vice Presidents for Health Affairs. Five of the six health affairs personnel suggested improving integration and cooperation with other dental programs and/or health care professions to better solve mutual challenges. One recommended listening to advisory committees as a means of providing checks and balances on program initiatives, and one suggested that dental education make a greater commitment to research in specialty programs and increase funding for those programs.

Question 5. As dental education plans for the future, is there an area that you see as a priority?

The general themes that emerged from these responses were access to care (n=19); public health, particularly prevention versus treatment of disease (n=11); educating the public about the importance of oral health (n=9); and training of dental students in certain content areas (n=4). Access to care issues focused especially on addressing disparities in oral health care and improving access for vulnerable populations. Two respondents indicated that dental education should ensure that graduates are culturally competent, and two others said that graduates should be able to communicate with a diverse patient population and to show empathy and compassion toward their patients. Three respondents stated that an effort should be made to increase the diversity of the student body, and two individuals mentioned the need to ensure that students become lifelong learners.

Two of the six executive directors of state dental societies emphasized the need for a new licensing process to allow greater mobility for practitioners. One called for efforts to recruit and retain quality faculty to guarantee the future of dental education.

Nine respondents noted that the public should be better educated about the importance of oral health and its impact on general health. Outreach and community-based initiatives were cited as examples of how this education could be delivered. Public health
was also mentioned by three respondents as being a priority for the future. In particular, these interviewees stated that prevention and wellness versus disease should be stressed, especially for children. As one respondent put it, “Dentistry is not just about toothaches; it is about diseases that concern the entire body. Selling health is an important part of the process.”

Three individuals stated that it is important for dental schools to see themselves as part of the overall institution and not islands unto themselves. Two respondents indicated that dental education must remain affordable for all of society, and two stressed the importance of identifying alternative sources of funding as state funding decreases.

Discussion

Major Findings

Many of our study findings were anticipated. Overall, respondents indicated that dental education is serving the public good by promoting oral health, including educating the public on its importance; providing access to dental care for all populations by educating skillful clinicians to provide care; and conducting research into oral disease processes.

Other findings indicate that there is work to be done to ensure the fulfillment of our social compact. For example, interviewees consistently discussed the need for greater workforce diversity to reflect the communities we serve and better outreach efforts to improve access to care. They indicated that it was important to prevent dentistry from becoming a profession for the wealthy as a result of the high cost of dental education and that more efforts are needed to address shortage areas.

The concept of diversity extended to the curriculum, with recommendations that we train dentists to be more knowledgeable about cultural diversity and potential language barriers, as well as working with medically complex and elderly patients. One suggested that the means of accomplishing this was through community outreach programs. They also advised that new knowledge be integrated into the curriculum and that we strive to create lifelong learners.

Respondents advocated multidisciplinary cooperation among health care professionals and better integration with the overall institution, and all constituencies provided suggestions for collaborations and partnerships that would allow dental education to better serve the public.

Many felt that dental education should develop community-based initiatives to better educate the public on the importance of oral health, with an emphasis on prevention, and one suggested engaging in public health research to determine what public education programs might work best in this regard.

Perhaps most unsettling is the view, expressed by four respondents, that dental education is not producing socially responsible graduates who fully understand their responsibilities to the community as members of the profession.

Taken collectively, the characteristics of public good cited by our respondents—promoting oral health, access to care, diversity, cultural competency, and social responsibility—provide a working definition of the social contract between the profession and the public. There is the expectation that dental professionals will exhibit socially responsible behavior as evidenced by the attributes of providing good care in a culturally competent manner to members of the public in need of dental services.

Is Dental Education Addressing These Concerns?

Many of the concerns voiced by the subjects in this study, notably workforce diversity, access to care and community outreach, curriculum change, and partnership development, are shared by many leaders in dental education. Are we adequately addressing these concerns?

Workforce diversity and access to care are long-standing issues within academic dentistry, and broad-based initiatives have been developed to address them. For example, the Area Health Education Centers (AHEC) program was developed by Congress in 1971 to recruit, train, and retain a health professions workforce, including dentists, committed to underserved populations. In a typical year, AHECs provide training to 37,000 health professional students, including approximately 1,300 dental students, in community-based sites. Research has indicated that students who have participated in these experiences have a better understanding of the complex needs of the underserved and are more likely to provide additional community service and to establish practices in underserved areas after graduation.

More recently, the Robert Wood Johnson Foundation, together with The California Endowment, launched the Pipeline, Profession, and Practice...
Program, aimed at increasing access to dental care for underserved populations. This initiative, begun in 2001, has provided funding to fifteen U.S. dental schools to 1) implement programs to increase recruitment and retention of underrepresented minority and low-income students; 2) revise didactic and clinical curricula to integrate community-based practice experiences into their educational programs; and 3) establish community-based clinical education programs for dental students and residents.

The fact that our interviewees were not aware of, or at least did not discuss, these nationally visible programs suggests that this is an area in which dental education falls short in communicating its efforts to the public. Failure to communicate its successes within the community is a shortcoming noted in a recent survey of perceptions of dental education from within and outside the university.

The American Dental Hygienists’ Association is addressing disparities in access to care through a proposal to create an advanced dental hygiene practitioner, modeled after the profession of nurse practitioner. This is a developing project worth following. However, the impact of expansion of services by dental hygienists and dental auxiliaries in providing better access to care may not be realized due to concerns from organized dentistry and the practicing community about appropriateness of nondentists providing such care.

Other efforts to increase access to care through community outreach fall under the umbrella of service-learning. Yoder poses an important question, echoed by our respondents—“Do dental graduates internalize an appropriate vision of their role as a health professional in the context of community?”—and suggests that “integrating service-learning into the dental curriculum will create a deeper understanding of the dynamics, the assets, and the challenges of the community and its relationship to oral and general health” (p. 115). A key component of service-learning is reciprocity; both the student and the recipient(s) of the program determine what will be learned, and both benefit. Service-learning provides a link between academic coursework and community service, supported by the general public’s interest in observing more relevant and meaningful experiences for students and the government’s willingness to sponsor activities that promote civic engagement. There is a growing body of research that validates the positive effects of service-learning and community service, supported by the general public’s willingness to sponsor activities that promote civic engagement.

The commission, formed in April 2005, currently provides oversight of a task force charged with developing a new set of competencies for the entry-level general dentist that reflect the contemporary oral health care needs of the public. The commission is also publishing perspectives and position papers by noted dental educators to explore the case for change and, ultimately, to help dental schools reform their curricula in the face of...
challenging financial environments, the entrenched nature of today’s curricula, and, most daunting, “the profession’s apparent loss of vision for taking care of the oral health needs of society” (p. 922). The commission’s “Case for Change” article published in the September 2006 issue of the Journal of Dental Education states that

> the profession is evolving toward promotion of high-end specialized clinical services to the individuals who can afford them, while the complexity of disease across all populations continues to grow. This type of professional isolation disregards demographic trends in the population, diminishes dentistry’s role in primary care, allows for marginalization of the profession, and hinders incorporation of dental care models into other health professions. The risk of isolation and marginalization is becoming a reality. (p. 922)

These are the same concerns voiced by Welie8 when he argued that dentistry is in real danger of losing its professional status, and echoed by Beemsterboer, when she laments that “what is often missing [among health care providers] is the ethical commitment to access to care.” This view is given greater credence when one notes that, in the ADEA survey of the class of 2005 dental school seniors, the curricular areas students most often reported as being excessive included ethics and public health. In addition, data from the same class of 2005 senior survey reveals that 22 percent of these soon-to-be-practicing dentists do not believe that access to oral health care is a societal good or right, and 27 percent do not believe that access to oral health care is a major problem in the United States. From the perspective of the authors of this article, the students who hold these views do not represent the culturally competent, compassionate practitioner we would like to create for society. It appears that dental education may be failing these students, and the public, on many levels.

Consideration must be given to the possibility that there are generational differences in values or beliefs related to social responsibility and professionalism. Generational differences may result in a gap between what current leaders in higher education and public health (e.g., our interviewees) and the current generation of dental students or even future generations believe are the social responsibilities of dentistry and dental education. This “conceptual mismatch,” as identified by Ozar in relation to access to care, may apply to other aspects of social responsibility or public good as well. Ethical views and social mores change over time. The authors of this article, the interviewees, and indeed a significant percentage of dental educators fall into an age group that may have differing ideas of the social contract between dentistry and the public. How do the beliefs of different generations impact professionalism from the viewpoint of the professional and of society? Crall notes that “the determination of what it means to be a professional and the extent to which dentists and dentistry meet society’s expectations for that designation are open questions—the answers to which can vary over time.” A recent study of fifty-four physicians and residents suggested significant generational and gender shift in physicians’ attitudes. Baby boomer faculty viewed Gen X physicians as less committed to their careers; however, an analysis of work hours and attitudes toward patient care revealed no significant differences among generations. As educators, we must be willing to objectively evaluate other points of view and assess their impact on the educational process.

Finally, many respondents recommended better integration with parent institutions and partnerships/interdisciplinary collaborations as means to better serve the needs of the public. The recommendations of participants in this study for better integration of the dental school with the parent institution echo those of the IOM report, which noted that it is critical to strengthen the position of the dental school within the larger university if dental education is to not only survive but to flourish. The IOM report called for a commitment to partnership from many sources: from within the dental school and from the university and/or academic health center, as well as in state and federal support both financially and in favorable public policy. The IOM report also encouraged the private sector, organized dentistry, alumni, and community practitioners to partner with dental education on shared goals of improved oral health and quality professional education. More recently, Mouradian et al. have argued that oral health disparities cannot be addressed without collaborative efforts with other health professions. They cite public health as a “natural partner in dental and medical efforts to address disparities in oral health” (p. 510). In addition, Mouradian et al. point to the need for dental as well as medical and other health professional students to take part in interprofessional experiences in order to build critical partnerships for the future.
Limitations

There are several potential limitations to this study. Inconsistency among IRB requirements created challenges among the institutions for uniformity in data collection methods. Slight variations in these methods (tape recording versus individual note-taking) and interview structure (in person versus by phone) may have had some impact on data consistency. In addition, due to the nature of this study, the number of interview subjects was relatively small, which necessarily limits generalizability.

By design, interviews were limited to leaders in higher education and community health. Since members of the public were not included, their expectations of dentistry are expressed through the perceptions of the interviewees. Ozar \(^4\) argues that the perspective of health professionals is profoundly different from that of society in regard to access to care. Additional studies are needed to gather the views of the public and other stakeholders on these issues.

The format of open-ended questions to elicit the respondents’ perceptions did not provide a mechanism to use a priori definitions of key concepts that emerged, such as social contract and responsibility, professionalism, cultural competence, and access to care. Although these concepts can be defined after the fact, the ways in which each interviewee personally defined these concepts is not known.

Conclusions

Despite these limitations, this study provides a broad perspective from the point of view of university, organized dentistry, and community health leaders on how well dental education is meeting its public purpose. These critical allies see much good in what dental education is doing; however, their recommendations on how to better fulfill our public purposes reveal the perception that we can do better. Specifically, the dental education community must

- better communicate our successes to the university and other key stakeholders;
- graduate a more socially aware, culturally sensitive, and community-oriented dental practitioner; and
- be a committed partner with other community leaders in improving access to health care for all Americans.

The conclusion we reach is that there is more to be done to create reflective, socially responsible professionals who recognize and are willing to fulfill their contract with society. Darrell Kirch \(^44\) noted the following in his 2006 presidential address to the Association of American Medical Colleges:

As professionals, we all come to work every day committed to the highest level of individual accountability. If we intend to recapture the public good, we must bring that same sense of purpose, intensity of will, and core values to our shared social accountability. As leaders, we must be willing to be the first to step up to the challenge of reaffirming the public good... sometimes you just have to make a leap of faith. The time is here to take the risk and leap together into a new national discussion...[a] reaffirmation of the public good and a serious rethinking of how we can best support it.

Future Directions

It is no easy task to ensure that dental graduates are socially aware, culturally sensitive, and public health-oriented practitioners who are leaders in their communities and committed to improving access to health care. Instilling these attributes in our graduates is challenging and, as with access to care, the barriers are multifaceted and require the collaboration of many people and organizations at many levels of society.

As the interviewees in this study and others have pointed out, dental education needs to be “at the table” with organized dentistry, higher education, public health, government agencies, and others in a concerted effort. This call for collaborative solutions does not negate or replace but rather embraces recent and ongoing efforts of dental schools, public and private agencies, institutions, and organizations. However, challenges remain. For example, no representatives of dental education were invited to participate in two recent national conferences on health professions education.\(^45,46\)

There are many projects under way within dental education at both local and national levels to address the challenges discussed herein. We propose three actions to ensure that we learn from and build on the successes of recent and current programs:

1. Identify recent and ongoing projects in the areas of outreach, cultural sensitivity, community partnership, service-learning, and the like that include goals to ensure that dentistry is serving
the public good and that dental education is graduating socially aware, culturally sensitive, and community-oriented practitioners.

2. Organize a national symposium of opinion leaders to review findings from these projects, disseminate information, and make recommendations for future action.

3. Conduct additional studies as needed to provide information on how dental education is performing in this arena from the perspective of all stakeholders, as well as how well information is being disseminated, and to identify areas for curricular improvement.

It is our responsibility as dental educators to continually strive to equip our graduates with skills, training, and experiences and instill a commitment to fulfill the expectations of society and leaders in the communities they serve.

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REFERENCES


