

Deans and Prosthodontists

Are deans important to the prosthodontist out on the end of the food chain? You bet! Their decisions affect dentistry and its specialties every day and in every way. We should know what they are thinking concerning our specialty. Above all, we should be included with our influence, suggestions and contributions when deans plan our future.

Deans

What is a dean? Their job descriptions are expansive. In no order of importance, they are involved in budget development, using their abilities to guide budgets through to acceptance. They have to clearly communicate the mission of their school or college to their parent university and to the public they serve. Deans search for and hire faculty and staff. They have ultimate responsibility for filling their schools with students, qualified and quantified as the need is determined. Deans conceptualize the curricula that they think meets their school's needs and their faculty's capabilities; and they delegate the work which molds a final, but ever changing curricula. Deans seek donors and raise moneys beyond those granted by their parent institutions. Deans join a consortium of deans in order to stay in tune with what all deans together envision their most effective actions should be. They communicate with alumni in order to form a past connection with present. Deans project plans for the future and set forth actions to accomplish those plans in a

programmed manner. Deans serve as the spokespersons for dentistry in their academic and public domains. Deans can and should serve as an inspiration for us all, leading us where dentistry can do its best.

With no particular training ground for deanships, we can say that most deans accomplish these tasks reasonably well and with little flak from their many constituencies. Give them credit. They are out there moving snail-paced institutions ahead in order to meet what is determined to be the needs of their communities, their sponsoring universities and those they train and employ. They are always competing for recognition and dollars to do the job well. If American dentistry is any gauge of success, American dental school deans deserve great credit for their many positive accomplishments!

The Past

In order to act in consensus, deans have relied on all sorts of reports and guidelines fed to them from government, foundations, and organized dentistry. Recently they have relied heavily on the Institute of Medicine Future of Dental Education Report* and the Surgeon General's Report on Oral Health**. These two reports spoke to the specialties and private specialty practitioners as parts of dentistry that must be recognized. The Gies Report, published by the Carnegie Foundation for the Advancement of Teaching in 1926 is given credit for taking dental

education away from commercial interests and placing it in academic institutions, giving deans the responsibilities they now enjoy. A lasting framework for dental educators came about with the creation of the American Association of Dental Schools, now the American Dental Education Association. The ADEA and various American Dental Association councils continue to give the deans guidance as to where they should direct their attentions. The dean's consensus use of these and other references has resulted in public statements, published papers and visible courses of action that speak to their "want list" pertaining to dentistry and its specialty of prosthodontics.

I. Deans want to relate dental education more closely with medical education.

Prosthodontic treatment, of all the specialty treatments, cannot be done with a prescription pad. We know that biotechnology may prevent and eliminate many of the complications leading to prosthodontic treatment. Biotechnology has not eliminated disfigurement due to trauma nor tissue loss from the severe disease for which the cause has not been determined. Graduating dentists should be able

*The Institute of Medicine Study of Dental Education: Issues Affecting Prosthodontics. *ProsStars Newsletter*, Vol. 2, No. 4, Oct. 1996 and Vol. 6, No. 2, April 2000.

**The Surgeon General's Report on Oral Health in America. *ProsStars Newsletter*, Vol. 7, No. 1, Jan. 2001

to meet the basic needs of replacing missing hard and soft tissues, and the specialist in prosthodontics should be called upon when the capabilities of general dentists are at their limit.

Subtracting from the trainings that insure total patient restoration in order that we become more like physicians or that we evolve into molecular biologists will only take away from dentistry's strengths. Prosthodontists put people back together, functionally, physiologically and esthetically, after their diseases and traumas have torn them apart. That is what we do! Let's remember also that even deans will seek out the best in a prosthodontist when the need arises in their own oral or facial tissues.

II. Deans want the dental work force to be representative of the general population.

Many studies, especially the Surgeon General's Report, identify population segments with poor oral health. They point out that these people are not be served by dentistry for one reason or another. Coupled with this they see low numbers of minorities, especially Hispanics and African-Americans, applying for and enrolling in dental schools.

Prosthodontists know these population trends lead to untreated diseases. They see individuals from these under served populations with losses so severe that only extreme measures in treatment can correct them. They know too that extensive debilitating diseases and hospitalizations deplete all funds, be they insurance monies or government assistance funds. This always leads to frustration in the specialty of prosthodontics because the more treatment needed, the greater the expense of the end-treatment. Who's to pay for it?

We should remember, however, that

prosthodontists are trained to return the worst that can happen to optimal function. We are not trained to solve social or economic problems, nor should we be. It can be said that if you threw an army of dentists at the under served population, it wouldn't matter what that army's racial makeup was. What would matter would be the numbers and skills of the providers and adequate money to pay them. In addressing the problem let's emphasize that compensation is due to providers at the end of the line of treatment in any population, served or under served; and it seems that the providers at the end of many of dentistry's problems are the prosthodontists.

III. Deans want para-professionals to fill in where training dentists in biomedical sciences and research leaves off.

This idea is filled with problems for prosthodontists.

We have a mutually supportive relationship with the laboratory technology industry. This relationship improves the technologist in every way. In reverse, their expertise in using the latest technologies and their extraordinary skills improves all restoration in dentistry. Prosthodontists simply could not do without the laboratory industry and its technologists.

Two things diminish this historically strong tie. First, when deans see that curriculum time can be taken away from courses directed to manual and mechanical skills and given to physician-like courses, dentistry is weakened. For proof it was observed that a first year resident in a well known advanced education course in prosthodontics had never carved a crown. Laboratory technologists soon realize that their knowledge and skill base is greater than that of this prosthodontist in training. It doesn't take long for them to wonder, "why

the middleman?" Second, when laboratory technologists give courses and use their laboratories as learning centers involving individuals as demonstration patients, they are really thinking it is only a matter of time when the "consumers" demand that they treat directly, allowed by law. Even the influential American Association of Retired Persons strongly supports this concept (denturism), thinking that such treatment is by far less costly than that done by dentists.

One problem leads to another, and the above ideas lead nowhere. Enrollments in laboratory technology schools are precipitously dropping off, coincidentally accompanied by a decrease in the number of schools. Applications to certify as CDTs are decreasing. The reasons are crystal clear! Dental technology is extremely hard, routine, confining and sometimes boring work, much like dentistry. Who wants it when the final product has to fit precisely, function without difficulty, and satisfy a demanding consumer? Their career desires are most probably like those considering a career in dentistry. Find something easier, like counting bugs and running pipettes and centrifuges; go into computer training or head for Wall Street. Don't develop the skills that no one else has. That process is much too demanding!

IV. Deans want to take us where "emerging science" can lead us.

Just where is it that emerging science has led us? Dental caries is still seen. Periodontal disease is endemic in humans. Oral cancers occur with some frequency with the etiology of most unknown. After all of these years we have heard with great wisdom from the past Surgeon General himself that dental disease might be an exacerbating factor in heart disease, diabetes and complications in pregnancies. Just

what have the bug counters given us to eradicate the need for dental skills?

Are the deans blind? Looking at the past, the great advancements in dentistry have not been physician or biotechnology related, with the significant exception of fluoride therapies. Let's be honest about fluorides: the successes of fluoride use were totally serendipity, and they were not due to any pointed scientific investigation. Our other great strides: the air turbine handpiece with its accompanying carbide burs and diamond cutting instruments; casting technics that improved inlays, onlays, crowns and removable partial dentures; plastics and ceramics and composite materials; bonding chemicals; even amalgam itself; metals formed as implants; luting materials; whitening agents; and the manufacture of artificial teeth all have advanced dentistry and prosthodontics to where they are today. These many contributions have literally become contemporary dentistry!

"Emerging science?" It's very well needed, but let's relegate to its proper place. Its proper place is not to lead but to contribute, if possible!

V. Deans want and are trapped by available government money.

Deans come with all sorts of qualifications. They must satisfy academic requirements, bring certain levels of experience to the job, and carry a particular personality fit for the institution. A search committee predetermines the needs for the school as they see them at the time of the search and usually for seven or more years into the future. But when the short list is finally put together the final selection will be based on the candidate who can keep the institution financially solvent. That's the name of the game!

In meeting the obligation of financial solvency deans can be forced into a corner. The money is where the money is. It will come from the parent institution, perhaps some state aid, alumni donors, maybe even some from the commercial dental firms and finally grants. Ah, grants! The dean can readily see that if there is a choice between amassing faculty with clinical qualifications, or faculty who are researching in their own minuscule, closely held niches, but coming with a grant or with the potential of obtaining a sizable grant, they will most assuredly hire the researcher.

Has any dental student ever seen one of these researchers out where they can learn something from them, be it skills or applicable knowledge? It's doubtful! The dean doesn't pay the faculty member who will have daily contact with the student, and we wonder why there is a dearth of highly qualified dental school faculty.

VI. Deans want to condense the dental school curriculum to three years.

Deans have implied, many times and in many ways, that too much time and faculty effort is spent on teaching dental students to become laboratory technicians. With that said they look to the University of the Pacific School of Dentistry model as the success story that uses a three year curriculum. Such a model reduces student debt, cuts out unnecessary laboratory instruction time and creates the opportunity to train dentists clinically in advanced general dentistry programs (GPRs) during a fourth year elsewhere.

Said with tongue in cheek, this would be a blessing for trained prosthodontists. Few general dentists would be able to manage the problems of missing tissues, especially complicated problems. Of course one thing to say about a

three year curriculum; if it is such a great idea why is there only one school using the three plus one model?

VII. The Deans' new dilemma.

After a decade or two of reorganizing dental school departments by making bigger ones out of smaller out-of-date ones, the deans have a new dilemma.

In short, the American Dental Association's Commission on Dental Accreditation (CODA) has decided to accredit programs at least one academic year in length in what they call New Dental Education Disciplines. CODA has set forth and published eight eligibility criteria that would qualify such programs for accreditation.*

They justify this new process for accreditation by declaring that dentistry is an "ever-evolving profession." Such an evolution will be built around new disciplines, for example: esthetics, occlusion, perio-prosth, implant technology. Those who complete the newly evolved and accredited programs possibly can announce that they have finished accredited extra training and imply that they are now specialists.

How are the deans going to address this one? Will they favor the old-line disciplines, the existing and known specialties and/or the new disciplines? Will they evolve new curricula, new clinics and teaching spaces and new faculty as well?

The specialty of prosthodontics awaits the decisions of the deans and their schools. But we await well established and well founded; and thankful that our specialty has had strong support from our deans in the past. We ask for continuance.

Stay tuned, and stay strong, prosthodontists! □

* ADA News August 19, 2002

THE APPRAISAL OF ART and THE ART OF APPRAISAL

The January 1997 (Volume III, Number 1) issue of *the ProsStars Newsletter* discussed esthetics. In particular we asked, "Is esthetics in dentistry art?" We pointed out that most of the emphasis given esthetics in dentistry probably is not esthetics at all.

Clinicians in the forthcoming 2002 Joint Meeting of the American Academy of Esthetic Dentistry and the International Federation of Esthetic Dentistry who talk about restoration design, soft tissue esthetics, improvements in materials and technologies and the analysis of tooth shades will really be stressing **disguise**. (*ProsStars* pointed out that a replacement of a broken picket in a fence is not an achievement in good esthetics.) Further we stated that the use of veneers, orthodontic movement of teeth, bleaching techniques and crowns that alter shapes and positions of teeth are **enhancements**, more than esthetic statements. (Tammy Faye Baker's cosmetics may enhance her appearance, but they don't make a statement related to good esthetics.)

We did conclude, somewhat esoterically, that if the following statements are valid, then esthetics in prosthodontics is art.

- ▶ Perceptions created should give the artist and the viewer pleasure. Art must have a maker and a viewer.
- ▶ It is the artist's sense that controls the work, and the viewers sense that accepts it or rejects it.
- ▶ We create something of beauty, dignity, and naturalness of character. That defines a work of art.

But further we are now concluding that:

- ▶ The rules, guidelines, directions, trainings, managements, objectives and formations of things that lead to "good" esthetics are not, were not and can not be determined by evidence based research. One of the finest dissertations on esthetics ever heard was given by Dr. John Frush at the Academy of Prosthodontics Annual Meeting in Portland, Oregon in the spring of 2002. In describing his "*Fifty Years of Dentogenics*" concept Dr. Frush led his listeners through his visualization of naturalness of tooth form and arrangement as he sees it in the patient's sex, personality and age. He developed this very practical and valid concept with an artist's eye, not by evidence based research.
- ▶ Appearance enhancements, the patient's esthetic desires, esthetic judgments, "bioesthetic" principles, or any of the other precepts commonly advocated in current meetings and journal writings cannot be quantified through measurement.
- ▶ True art has value. The value of any work of art, be it architecture, music, paintings, sculpture, pottery or any other true art form can be determined.

Appraisals. The common way to determine the value of art is to get an appraisal of it. Appraisals are carried out by appraisers. These individuals must be entirely familiar with the particular art form, its market and the market values of similar pieces. There is no such determination of value connected with the dental treatment that we call esthetic treatment. No matter its cost and no matter the fee, the esthetic treatment once delivered has no value. It cannot be appraised and a value of it cannot be determined. The only criteria now available for successful esthetic treatment is that the provider is satisfied, the patient is satisfied, the treatment is not detectable to viewers or at least is acceptable to them, and that the fee seems worth the result. Does it have value? Can it be sold, retaining its value? Can it be insured with a determined value? No, no, and no.

Therefore, let's be careful in our teaching, in our lecturing, and at our meetings not to strut around acting like we have created wonderful works of art, things that stand on their own with no other worth to the patient, and something the patient can't live without because of its great value. The most we can say is that the beauties of our treatments are found in "the eyes of the beholder." That's as close to an appraisal as we'll ever get. □ NDW