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The Changing Role of the Dental School Dean

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B. To encourage qualified persons to consider a career in dentistry so that dental health services will be available to all, and to urge broad preparation for such a career at all educational levels;
C. To encourage graduate studies and continuing educational efforts by dentists and auxiliaries;
D. To encourage, stimulate, and promote research;
E. To improve the public understanding and appreciation of oral health service and its importance to the optimum health of the patient;
F. To encourage the free exchange of ideas and experiences in the interest of better service to the patient;
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The Changing Role of the Dental School Dean

Forum

Departments

Cover image It is hard to lead when folks keep changing the rules of the game.

From the Editor

Ethics Should Fit the Scope of Practice

Questionable procedures justified by good intentions fails the test of ethics.

Which of the following is a definition and which is a characterization?

1. Humans have dignity, individual and collective rights, and may not be harmed
2. Humans are featherless bipeds (Aristotle)

The first is more attractive: it says nice things about humans. It also characterizes seagulls, religious and fraternal organizations, the redwoods, and the U.S. Constitution. But the function of definitions is to sort things into examples and non-examples. Aristotle's rule would pretty accurately get all the humans in one pile and all the nonhumans in another.

Dentistry is evolving, and recently there has been interest in defining oral health or even health generally to accommodate these changes. Consider the following:

World Health Organization (WHO) definition: Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

American Dental Association (ADA) definition: Oral health is a functional, structural, aesthetic, physiologic and psychosocial state of well-being and is essential to an individual's general health and quality of life.

FDI World Dental Federation (FDI) definition: Oral health is multifaceted and includes the ability to speak, smile, smell, taste, touch, chew, swallow and convey a range of emotions through facial expressions with confidence and without pain, discomfort, and disease of the craniofacial complex.

There is a bit of circularity in the WHO definition since one of the dictionary definitions of "wellbeing" is "a state of health." The second part just says that other definitions are incomplete. The ADA "definition" is also circular, but positive in the set of characterizations that are enumerated: "functional, structural, and aesthetic" features are traditional criteria for judging the work of dentists. But it is not traditional to hold dentists responsible for psychosocial thriving. Dentists would not have their licenses disciplined for failure to do so in a "complete" fashion. The FDI definition is a little stronger. It lists a set of operations relative to the oral complex that "healthy" individuals are capable of without undesirable limitations. The trouble here is that health is defined by a standard of disease. It is the old question of whether the patient has a temperature. Yes, everyone does, but is it too low to be consistent with life or so high that it represents a threat?

In a way, these "definitions" are telling us where to look and when to feel satisfied but not whether we have found what we are looking for.

It is as clear as can be that dentistry has succeeded, and beyond anything that could have been imagined even a few years ago. Master clinicians of a hundred, fifty, and perhaps even fewer

years ago lacked the know-how, technology, and delivery systems to accomplish what is now expected of the average recent graduate. Americans expect that long-lasting, painless, beautiful smiles can be had by those who want them. At the same time, school districts across the country are forgoing hundreds of thousands of dollars annually in lost per capita attendance reimbursement because children are absent with oral pain. Rural America is being left behind by the consolidation of dental business and its technology boom that depends on a concentration of paying customers. Dental visits are up slightly for the young and the old, but down for the majority of the population. Dentists are the least trusted of the health professionals while at the same time dentistry is regarded as one of the top "jobs."

The progress of dentistry depends to some extent on how dentistry is defined. We are tangled in confusions over means and ends, individuals and communities, opportunities and obligations, and the assumption that what is legally and economically justified is also ethical.

Many of the exciting recent developments in dentistry, especially those of a highly technical and interdisciplinary nature, serve real needs, but for a small segment of the population. Sometimes the prospect of mastering a new technology skews treatment patterns. The greatest concern among dentists and patients alike now is overtreatment: technically acceptable treatment that is not needed. Both dentistry (the means) and oral health (the outcome) must be ethically sound. Questionable procedures justified by good intentions fails the test of ethics. So does wanting to be a technique star at the expense of patients' health broadly speaking.

The WHO, ADA, and FDI definitions are open on the question of whether oral health is an individual or a general good. Would a community with a basically adequate level of dental functioning be healthier than one with a few "show-off" mouths and many in oral distress? There is much to be said on both sides of this issue. We can hardly fault patients who want the best for themselves or criticize dentists for responding more readily to those who are willing to pay for the best. There are large cohorts of individuals who place low value on oral health, are demanding and difficult to treat (if they even show for scheduled appointments), and detract from the capacity to serve others.

Governments and insurance exist for the very purpose of balancing individual and group needs. Professional organizations have the double responsibility of representing the well-being of members and assuring the public that the profession (in the collective sense) is responding

We are tangled in confusions over means and ends, individuals and communities, opportunities and obligations, and the assumption that what is legally and economically justified is also ethical.

to the needs of the public (in the collective sense). The ethical challenge comes in claiming to be addressing community needs by only responding to individual needs. There is ample evidence in the technology literature that periods of rapid change coincide with and contribute to periods of increasing disparities in income and health.

The category-creating feature of definitions advances claims about who is entitled to do what. As statements about scope of practice, they define markets. Expanding the scope of dentistry has both positive and negative features. Claims on larger markets will lead inevitably to conflicts with other professions and with payers. Scope implies responsibility. Using CBCT images is a market builder. It also represents a liability because the visual area available for review, and thus for which a practitioner is responsible for acting knowledgeably on, is increased. Failure to diagnose, especially relatively low-paying areas of periodontal disease and oral cancer, is one of the leading reasons for malpractice suits and actions against dentists' licenses.

Broadening the scope of practice means increasing the level of training. The tension between expanding the market and expanding the training necessary can be gauged by comparing the profession's budget for lobbying and indemnity programs with its support of education. The ethical issue associated with itching to enlarge scope at the higher end is that in order to be financially sustainable, resources will have to go to fewer patients paying higher fees for more advanced (or different) needs. This is entirely a legal or economic consideration, except in cases where a profession attempts to prevent others from servicing needs that are unattractive to the profession. Then it is an ethical issue.

The tension between expanding the market and expanding the training necessary can be gauged by comparing the profession's budget for lobbying and indemnity programs with its support of education.

Some tentative definitions…

Oral health: Optimal attainable function and appearance and prevention and repair of diseases and damage to the orofacial complex, including conditions that interact with it.

Dentistry: The profession that accepts responsibility for oral health outcomes as its essential and primary reason for existing.

Dental market: Range of activities dentists have an economic and legal right to perform.

Through the Years

A Reflection on the Roles and Responsibilities of Dental Deans

Patricia L. Blanton, DDS, MS, PhD, FACD

Abstract

The role of the dental school dean has changed because of advances in dentistry and changes in the environment around dentistry. Especially prominent in these new forces are declining funding for dentistry, increased calls for integration of all units in universities, and a general move toward collaboration rather than isolation in the way this country addresses problems. The roles of deans are changing from first among faculty, to financial stewards, to capacity builders, and now to "masters of all crises." The skill set required today is long on collaboration, consensus building, and nurturing positive culture.

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I am convinced that if the rate of change within an organization is less than the rate of change outside, the end is near. —Jack Welch, former CEO of General Electric

In today's volatile, uncertain, complex, and ambiguous (VUCA) world, all leaders must adapt to and engage the challenges created by ever-changing circumstances. The need for this adaptability and agility is universal for those in leadership roles and for those who desire those roles. Agile leaders have proven uniquely suited to the challenges of managing in a VUCA world. They possess the enviable ability to connect, adapt, and deliver by building relationships and responsive processes that allow their organizations to balance competing priorities and execute multiple strategies in real time. The need for agile and adaptive leaders is keenly felt in academic healthcare settings. Today's dental school deans are required to execute rapid adaptation to changing external circumstances, without altering the strategic course of their organizations.

Over the years, the dental education system in the United States has been confronted with a number of critical issues. While it is not surprising that the duties and responsibilities of the deans of dental schools have changed considerably, what is surprising is the rate of change. Change has come about not only in response to new challenges but also in an effort to meet the changing needs of dental education, the dental workforce, and our constituent stakeholders. Numerous advisory groups have anticipated the impending age of uncertainty as it relates to dental education and have generated seminal publications to inform the national debate and dialogue. Publications such as: the *Gies Report* of 1926, the *Institute of Medicine Report* of 1995, the *Pew Health Professions Report*, the *Surgeon General's Report*, the *Macy Study Report*, and the more recent call for curricular innovation and change championed by the American Dental Education Association (ADEA) in conjunction with the Commission on Dental Accreditation. All of these landmark efforts and admonitions encourage "change" to ensure the continued viability and respect of academic dentistry among our stakeholders and parent universities. Some problems are immutable laws of human interaction and defy time-line characterization, especially those conflicts that arise over faculty affairs, resource allocation, and equity of staff distribution. These are rather universal and these are faced in all academic environs.

Changing Roles

A look back over the past decades reveals the perceived challenges to our educational system and how they have changed in order of their importance

and in terms of the nature of the challenge. This retrospective is informed by the ADEA publications: *Profile of Dental School Deans, 2002*, *2014*, and more recently the ADEA *Snapshot of Dental Education 2020*. The various deans' perceptions of their duties and responsibilities, as depicted in these reports, were defined by their view of "criticality" and the challenges and opportunities inherent in the management of emerging issues. The deans effectively performed a near daily risk assessment and risk mitigation strategy.

The Dean as First among Faculty

Based on my personal reflections, the focus of dental deans in the 1960s and '70s was primarily "internal," involving issues originating from within the dental school. I was fortunate in my early academic career to have worked with some of the most nationally respected deans in the country—Harry B. McCarthy, Kenneth Randolph, Richard Bradley, and Dom DePaolo. I remember these consummate statesmen (in Bradley parlance) spending the majority of their time within the dental institution, having a brown bag lunch with their department chairs on a regular basis. The frequency and informality of these encounters provided the dean with a pretty good idea of what was going on with his people and gave him the forum to reinforce his position (vision) with his leaders. These opportunities provided much more than the transfer of information; they served to reinforce the "trust" dividend and the mutual respect necessary for collaborative engagement. These deans quite literally walked the halls, laboratories, and lecture rooms and greeted faculty, staff, and students often on a first-name basis. They knew their people and cultivated these relationships. Community leaders and practitioners were on occasion invited into the school for lunch and frank discussions regarding the state of affairs of the school.

The Dean as Financial Steward

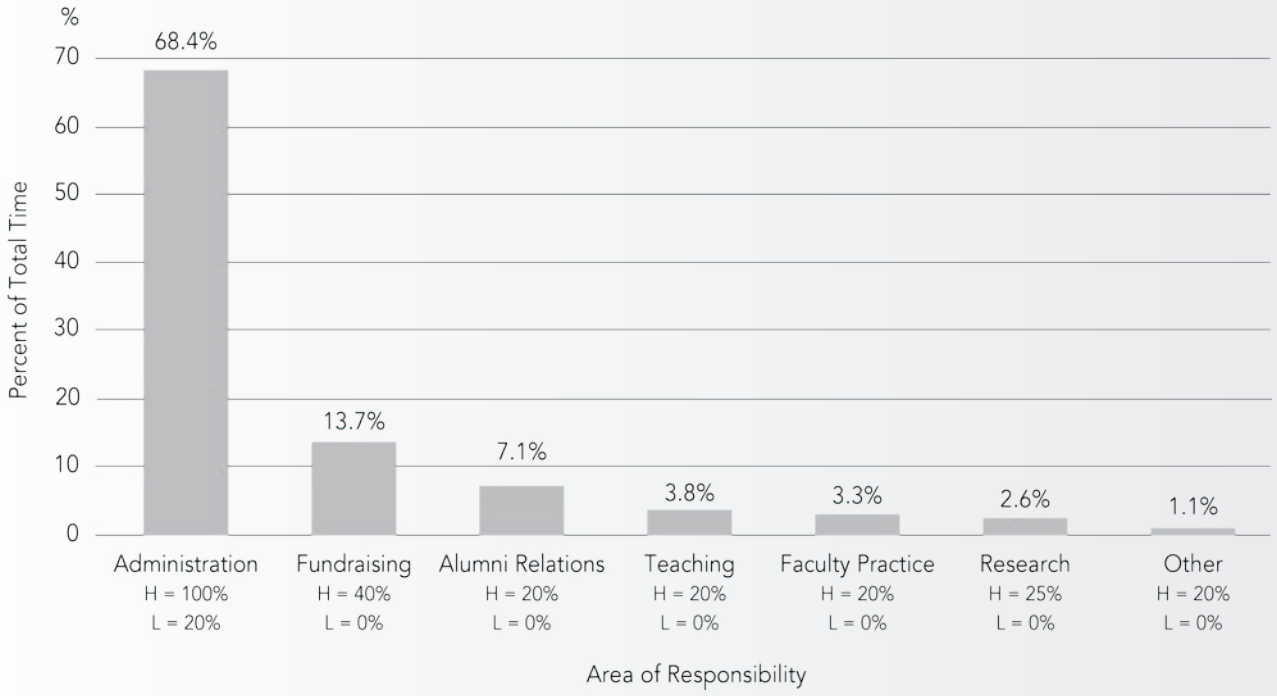
The deans did venture beyond the confines of the dental school to attend the monthly county dental society meetings and the odd Chamber of Commerce luncheon. But their duties and responsibilities were met primarily "on site." This situation began to change during the twilight of Dean Bradley's term and was mandated during Dean DePaolo's tenure. This signaled a changing landscape from a purely academic environment to a more political stage. State appropriations began to decline precipitously, and, with that, finance became more of a concern than ever before. Deans began to actively lobby state legislators and negotiate with community leaders, alumni, and others to address basic financial problems. In 1991 state appropriations made up 80% of the dental school budget. By 2004 state allocations made up only 31% of the budget, and by 2008 state appropriations made up a mere 14.8% of the dental school budget. The percentage of the dental school budget underwritten by state legislators will asymptotically approach zero in the next ten years. These catastrophic budget reductions forced deans to cut services, increase class size, and raise tuition on an annual basis to remain financially solvent. Moreover, the increase in class size did not always convey more faculty authorizations. In short, the same number of faculty were teaching larger student cohorts who were paying meteoritic tuition rates.

The Dean as Builder of Capacity

At the turn of the century the dental deans identified new emerging issues. Future workforce needs and access to care for indigent and vulnerable populations took center stage in 2002. Resource allocation and infrastructure was redirected to provide for populations at risk and revenues were repurposed from infrastructure maintenance, which in all probability was already deferred. Investment in emerging technologies also slowed or was tabled. Interestingly, the previously identified interest in technology was on the wane from 1999-2002. It is suggested that this is due to the fact that the dental deans came to view technologies as emerging in 1999 and a necessity by 2002.The single greatest challenges faced by the deans in 2002 were reported to be: (a) maintaining a balanced budget; and (b) maintaining momentum, morale, and vision in the face of significant decreases in state appropriations.

ADEA's *Deans' Views on Current and Emerging Issues for 2002* proposed that the most time-consuming activities for dental deans included "administration" and "fund-raising," with administration occupying up to two-thirds of their time (Figure 1). The most frequently reported activity with respect to administrative responsibilities was faculty recruitment and development, with a particular emphasis on "high-quality and diversity" of the faculty cohort. This was a significant

FIGURE 1. **Where do deans focus their attention?**



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challenge due to the fact that fewer and fewer individuals were electing to enter traditional academic positions owing primarily to the debt burden they accrued as undergraduate dental students. Put simply: they simply could not service their debt.

Findings represented in the 2014 edition of the *Dean's Views on Current and Emerging Issues* are depicted in Table 1. The most time-consuming activity of our dental deans for that period was seen to be "school administration and management," while the greatest challenges were reported to be "financing, dental education, faculty recruitment, and retention, along with sustaining the research mission." Those challenges consistent over the prior decades included fundraising, finance, and budgeting along with communication, negotiation, and conflict management. The role of the dental dean over this period was seen to be even more multifaceted and challenging than ever before. Deans reported their top six most important knowledge areas with respect to the performance of their duties to be: (a) communication skills; (b) conflict resolution; (c) finance / budget oversight; (d) leadership development; (e) negotiation skills; and (e) public relations.

Master of All Crises

The issues facing the dental dean of 2020 have become even more numerous, more complex and require the dean to travel most often beyond the four walls of the dental college to negotiate with numerous third parties on behalf of the dental college. The number one issue facing today's administration is dental school finance. In 2008, Dean DePaolo stated that "dental education is on the precipice of a crisis" where costs are escalating while revenues are declining. In an effort to check the harmful effects of the decline in state appropriations, dental deans increased standard enrollment—often with no increase in the number of faculty—and raised tuition. In fact, tuition has climbed to unprecedented and perhaps unsustainable levels and student indebtedness is at an all-time high. Interestingly, the IT expense of the dental education institution now overrides the cost of "people," i.e., the hiring of faculty and staff. Tuition and fees are no longer adequate to support the financial needs of the institution.

TABLE 1. **Deans' primary reporting relationships, hours worked per week, and time spent in various areas of job, by number and percentage of total respondents (N=55).**

Variable	*Number (Percentage)*
Primary reporting relationship	
Provost (or equivalent) of university	37 (67.3%)
Vice president (or equivalent) of university	10 (18.2%)
President of university	8 (14.5%)
Average number of hours worked per week	
40–49	3 (5.4%)
50–59	18 (32.1%)
60–69	28 (50.0%)
70–79	5 (8.9%)
80 or more	2 (3.6%)
	Average (SEM)
Average percentage of time spent in	
School administration/management	52% (2.0)
Fundraising	15% (1.3)
University service	10% (0.8)
School patient care/clinical services	6% (1.0)
Alumni relations	8% (0.7)
Research	6% (0.7)
Teaching	6% (0.6)
Other	5% (0.7)

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In the face of these constraints, efforts to increase clinical income and to expand the college's fundraising have become of paramount importance.

The number two issue seen to be facing today's dental dean relates to recruiting and retaining faculty highly qualified in their respective areas and capable of supporting a research effort. A key problem today related to the issue of faculty is the recruitment and retention of individuals with the skills and motivation to support and even lead to change within the institution. Also related to faculty concerns are salary issues—significantly lower than practitioner salaries—as well as the need for developing future educators/scientists in dentistry. Academic programs are only as good as the faculty who lead them, so the future of the profession hinges on our success in managing these faculty issues.

The number three issue facing today's dental dean is "clinical practice." As clinical revenues become increasingly more important in financing dental education and as dental education is more so now expected to serve as a significant safety net provider, it has become more important to pay attention to business practice, billing and collecting for clinical services, technology, infrastructure including effective clinic management systems, attracting increasing numbers of patients, monitoring patient satisfaction, etc.

In addition to these three primary issues facing today's dental deans—all related heavily to financial concerns and constraints—are numerous additional challenges. With enhanced technology in the educational/infrastructure environment, it has become most important to balance technology with the interpersonal aspects of the provision of care. The need for the continuous assessment of the impact of technology on the educational process is acknowledged and requires a commitment on the part of the administration and the faculty.

Modern healthcare delivery systems are complex and rapidly changing and require new skills and knowledge for the faculty and students. It is incumbent upon the administration to ensure their people are grounded in the newly articulated competencies to meet the Commission on Dental Accreditation's required and recommended standards to ensure full accreditation of the respective college. Such articulated competencies include: (a) institutional effectiveness;

(b) evidence-based practice; (c) systems-based care; (d) quality management; (e) information access and management; (f) population medicine; and (g) interprofessional education.

Right-sizing the Research Portfolio

As dental deans appreciate the critical nature of solvency, they are forced to rethink their research efforts and research platforms. Often their internal review reveals the uncomfortable realization that "research costs money." In fact, in many institutions research platforms lose money and in others research is at best revenue neutral. Research efforts are not sustainable at the current funding levels. This often leaves deans wondering "how much research can I afford to engage in?" From a financial perspective, the real costs for conducting research must be accurately identified and recouped so that research activities are not routinely subsidized by other programs. This concern calls for an element of discretion unlike that imposed by most other budget decisions.

Regrettably, over the past decade, there have been significant reductions in the total amount of funding dollars available through the grant process. The competition is keen and this trend continues unabated. From 2005 to 2014, the total National Institute for Dental and Craniofacial Research (NIDCR) budget for extramural research decreased by roughly 4%, which represents a decrease of $20 million to dental institutions. After adjusting for inflation, the decline in funding to dental institutions from the NIDCR and the National Institutes of Health (NIH) was approximately 30%. With declining revenues and predictable inflationary increases related to the costs of conducting research, this will continue to be a problem for the foreseeable future. As of this writing, the NIH invests about $41.7 billion annually in medical research for the American people, $477 million of which is earmarked for dental research. Quite frankly, the real value of a research program cannot be reliably measured in dollars generated but rather in the stature that a robust research program brings to the reputation of the parent institution.

The Contemporary Skill Set

In consideration of the dental deans' greatly enhanced responsibilities, they must maintain open communication and good relations with external constituents such as alumni, donors, community leaders, practitioners, as well as with internal constituents such as faculty, staff, and students. As we saw in the 2014 ADEA *Deans' Report*, negotiating skills, conflict resolution, and communications skills were identified as very important. One of the most critical relationships of the deans today is the successful integration of the dental school into the university system. The dental school is an integral part of an integrated healthcare system. Some of the leading dental educational institutions in the United States were shut down just a couple of decades ago because the mother institution failed to see the value of the dental component to the university system. Finally, over the decades, leaders have appreciated the need to clearly state a vision, define objectives, and establish mutually acceptable timelines to achieve specific goals while always considering and monitoring the budget to ensure solvency.

In today's environment, serving as a dean of a dental school is a daunting task given the current challenges in health care, educational models, research, funding, and the need for community engagement. It is incumbent upon contemporary deans to recall the time-honored tradition among "leaders"—the acknowledgement of the importance of people. It has been said that durable teams nurture their faculty and students while simultaneously focusing on fulfilling the school's mission. Nothing facilitates progress and change more than having the right people in the right place, people who are both capable and committed. This starts with the effectiveness, the efficiency, and the loyalty of the people in the dean's office and in the leader (chair) positions in the school. The wrong culture can never institute the right strategic plan. Thus the old saying "culture eats strategy." Not all leaders facilitate change. Deans universally agree that the biggest obstacle to change as well as the greatest opportunity is "people." This is so important that the deans must get on the phone and do the time-honored thing of personally checking the key references before finally making the offer.

Over the decades, our deans have not only respected the fact of "people to be the key to success of the mission of the school" but the necessity of ensuring solvency of the school. Deans and their leaders must know the budget and all its nuances. That is their ultimate responsibility.

For many years the "ideal" leadership style of a dean was team-oriented, displaying high levels of both "task" and "relationship" orientation; task orientation was "getting the job

One of the most critical relationships of the deans today is the successful integration of the dental school into the university system.

done" versus relationship orientation or "relating to people." The time-honored way of our early deans involved external as well as internal consensus built over time as collaboration. These were the days when most issues, if not all, were of an internal nature. As we see, today's dean faces numerous challenges from outside the four walls of the dental school. The ability to address both internal and external changes emanating from today's environment calls for a flexibility not seen with the traditional leadership style of the dental dean historically. One must be prepared to push schools to evolve. This is done by inspiring a vision, motivating the faculty, transforming the curriculum, managing resources, and raising funds.

Accordingly, some leaders in dental education are advocating for an "adaptive" leadership style to recognize and manage change in a more expeditious manner. The question is: can deans exercise this kind of adaptability amidst the realities of the typical and long-existent authority structure present today? There are inherent complications that will require ingenuity and foresight on the part of the leader—the dean. Inspirational leadership is called for to impart a vision for the future in the face of the "turmoil amidst all the change." Deans will need to support their people to support the vision and mission of the college. Ultimately, it will take audacious leadership to accomplish the culture change necessary in this age of uncertainty.

We need leaders who can not only envision the needs and direction of their programs, but who can inspire the administration, faculty, and staff to change the way they think and act. Norman Vincent Peale said, "Change your thoughts and you can change the world." The deans of today have this responsibility to lead in an informed, thoughtful, and courageous way to ensure the continued viability of academic dentistry.

Change is not easy and our deans will need to be strong in supporting and encouraging their faculty as they lead the change efforts. The duties and responsibilities of a dental dean have not only changed over the decades, but have expanded in response to numerous challenges from outside the institution, as well as those emanating from the everyday activities within. It is said that emerging leaders must be skilled in negotiating their way through three key factors: context, complexity, and connectivity. The challenge for leader development programs in the twenty-first century is to make sure we are equipping future leaders with these capacities rather than simply developing them in the leadership mold of the past. A recent article in *Deloitte Insights* highlights this need and offers this advice: "putting different performance measures in place for leaders can go a long way toward establishing a culture that supports competencies such as the ability to manage uncertainty and lead through change." Leadership demands are changing and we need to develop the critical capabilities and reward the attainment of these competencies for this century's leaders. ■

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The Changing (Expanding) Role of Dental Deans

Henry Gremillion, DDS, FACD

Abstract

The dental school dean connects the present with the future, the faculty with the university, and students with the profession. Among the roles he or she juggles are fundraiser, advocate, politician, ambassador for change, team builder, and coach.

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The trite phrase "the winds of change are blowing" certainly comes to mind when I reflect on the future of dental education and the historical perspectives on the changing role of dental deans. There has never been a time in the history of dentistry when so many positive developments are occurring simultaneously. There has been an explosion of scientific, technological, and procedural advances. The amalgamation of the science with the art of dentistry has resulted from an enhanced appreciation for evidence-based diagnosis and care. Importantly, the oral health team is now taking its rightful place as a critical member at the primary care table. However, with all of these changes it may also be said that with changes come new challenges, expectations, and growing expansion of roles.

The basis of my comments are demonstrative of the changes that I have observed and experienced since my matriculation through dental school in the mid-1970s. My perspective is deeply rooted as a result of my path from small town rural Louisiana practice to return to the health sciences center setting for post-doctoral training, then accepting my first faculty position at age 38. By contrast most of my faculty colleagues in those early years of my academic career had spent the majority of their careers in the academic setting. Certainly that was common for administrators at the time. Now, 31 years later, my tenure in academia has provided me the opportunity to witness and experience many changes in the landscape and the various paths that have been followed to positions of leadership.

My recollection of and perspective on the role of the dean 40 years ago is tempered by the old adage "if you have seen one dental school, you have seen one dental school." Just as dental schools are different, it must be appreciated that every leader's style and institutional circumstances are different. However, at that time deans were typically male and many were retired military or well-respected longtime faculty members who had risen through the ranks. A prime responsibility of the dean was to keep the ship on the straight and narrow. A strong political connection through personal contacts provided for support and security in a time of dental education funding plenty that was bolstered by capitation funds related to the identified dental workforce shortage. Human resources issues, compliance mandates, and regulatory controls (local, state, and federal) were minimal. The demographics of the faculty and student body were largely Caucasian males. These comments are not intended to be disparaging. My observation and personal experience

validate, in my limited sphere of reference, that the deans were visionary and doers who met the demands of the time.

The sobering truth is that today we as healthcare professionals, educators, clinicians, researchers, and administrators face tremendous challenges. This statement should not be misconstrued as negative. Quite the contrary. Oral health professionals are leading the way in clinical and basic science research in many areas. Our profession is at the forefront in the establishment of a new and expanded mindset reflected in the clinician/scientist model. Because of this healthy perspective the profession is moving away from being viewed as a "cottage industry" by other health care disciplines and assuming its role as leaders in the field of diagnosis and management of pain, dysfunction, and diseases associated with the most complexly innervated area of the human body, the stomatognathic system and its contiguous structures.

Without question I as dean and our leadership team face challenges far beyond didactic and clinical training, and engaging in internal relationships with students, faculty, and staff. It is of critical importance that we gain and maintain a firm understanding of the constantly shifting sands of many areas. The scope of reference has expanded to include: economics (finance and budget); rising student debt; political volatility; social media influences; importance of diversity and inclusion; consideration of a broad array of "stakeholders" locally, statewide, nationally, and internationally; generational differences; demographics (patients, students, staff, and faculty); and evolving practice models to name a few. In addition to being keenly aware of the aforementioned factors it is critical that dental deans and their leadership team develop strategies that will address future trends that will affect healthcare education in the realms of health equity and disparity, social justice, oral health literacy, and person-centered care in an environment that is increasingly becoming more interconnected figuratively and literally.

Fundraiser

As I reflect on how my time is parsed out over a month's period, it is glaringly evident that fundraising and identification of additional funding sources on many levels and in many environments is a major part of my role. It is well-recognized that for the majority of public dental schools there has been a dramatic reduction in state funding. Therefore, this mandates that as dean I engage in strategic thought and effort toward development of new sources of revenue to augment clinical, grant, and contract revenues in order to ensure sustainability. This decrease in funding cannot be overcome by raising tuition alone. As dean I recognize the numerous issues surrounding rising student debt. Student debt has been a major concern that we as deans discuss at the state and national levels. Adding to this challenge is the evolving issue revolving around student loans and the uncertainty regarding potential legislatively driven changes that may have profound impact. Importantly, it is highly likely that a complex group of factors to include student debt, generational differences in practice perspective, and our increasing mobile society is strongly influencing the expansion of oral health practice models. Without doubt, this further challenges recent graduates and dissuades consideration of a career in academics as a career path. I find much of my time engaged in contemplation and strategizing how to best adapt our longstanding model of education to meet these challenges. Thus the role of *dean as strategist* is evident.

Advocate

Therefore as dean it is incumbent on me to advocate. To best advocate I must *educate, promote, and communicate* our cause, providing detailed and valid information to all stakeholders to include higher-level administration, alumni, corporate entities, and legislative bodies. Only through this ongoing process can funding to support the enormous cost of providing dental education be garnered.

Politician

Inherently, the interaction with such a diverse group of stakeholders necessitates that a dean must also be a *politician* of sorts. I firmly believe that it is of utmost importance for higher-level administration in health sciences centers and universities as well as legislative bodies be made aware that education of the oral health workforce is time and faculty intensive. In truth, dental education basically includes a clinical residency, as we educate practice-ready health professionals in a period of four years, that is not funded under the Graduate Medical Education (GME) system. This is in stark contrast to the medical school education model, which is rigorous but not faculty intensive, and thus is less costly. Importantly,

it is through medical residencies that physicians obtain their primary clinical education and skills. These residencies are supported by GME funding, which ensures sustainability.

The dean of today must recognize and contend with generational differences to include the learning styles of our students, which are driving change to small-group and team-based learning. The dean of today at times has to be a *psychologist and mediator* due to the sometimes difficult-to-deal-with meteoric rise of social media and challenging change in communication styles of our students. Additionally we must face the harsh reality that we are living in an era where "everybody expects a trophy," and this is made even more complex by the impact of "helicopter parents."

Ambassador for Change

I have witnessed the benefit resulting from the significant investment in basic science; translational and clinical research dental education is focused on educating critical thinkers who can apply diagnostic and treatment procedures based on the most up-to-date scientific evidence. Importantly, recent scientific discovery has enhanced our and the general public's understanding and appreciation of the fact that quality oral health is a significant component of quality overall health and well-being. Examples of this include the recognized relationship between periodontal disease and conditions such as heart disease, diabetes, stroke, and some neurodegenerative diseases. Also known is that chronic oral inflammation during pregnancy can result in low birthweight babies. Much of my time is spent sharing this important information, as an educator beyond the walls of the school of dentistry. This necessitates interaction with various media sources to share the message of the importance of oral health in an effort to increase public awareness and engagement. In a sense, it is important that as dean I have the role of promoter/spokesperson of the oral health professions in many different venues and environments.

The learning environment is also changing as there is a major focus across all healthcare education disciplines for interprofessional education and collaborative care. This has been prompted by the recognition that overall patient care outcomes (population health) can be improved through open communication across disciplines as we learn with, from, and about one another. Technology, transfer of information, and the changing demographics of our patient population will likely drive expansion of the scope of practice of the oral health professionals of the future… our current students. The long-term benefit for our patients will be tremendously enhanced through an educational environment that engenders the concept of lifelong learning. I feel that it is most important that as dean I place strong emphasis on fostering this important perspective.

The tremendous acquisition of new knowledge and the expansion of the scope of practice has provided a broadened and deepened understanding of the underlying mechanisms of diseases. It is also understood that orofacial pain and dysfunction is common in the general and patient populations. Our enhanced understanding of pain pathways and mechanisms have provided for expansion of dentistry far beyond

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It is glaringly evident that fundraising and identification of additional funding sources on many levels and in many environments is a major part of my role.

previous boundaries. This has promulgated the development of areas of subspecialty and much-needed development of additional areas of specialty/special interests within the field of dentistry. Dentistry has also become involved in significant roles in areas of sleep medicine/dentistry. This begs the question "Where do you find the time in the four-year curriculum to teach the basics and include the appropriate amount of additional curriculum content to educate future-ready oral health professionals?" It is most important that the dean, leadership team, and curriculum committee carefully analyze, strategize, and answer this important question. I find a significant aspect of my role as dean is as an *analyst of population health and knowledgeable about public health*.

What has become readily apparent is the fact that oral health education demands that dental school administrators provide leadership on issues that impact education of the entire oral healthcare team and beyond. The expectation is that dental school deans and leadership teams serve as the *authority on the education of the dental, allied dental, and advanced dental workforce in addition to members of the interprofessional team. As dean I must be engaged in strong advocacy and political engagement* to further the mission and goals for dental education. A major area of focus of our efforts must be on preparing "future-ready" oral health professionals who are socially and culturally aware. Concomitantly, the academic health education institution must play a role in improving the oral and overall health of the community.

Team Builder

Whether real or perceived, there exists the belief that dental schools are a primary safety net for the underserved and vulnerable populations. As dean I recognize that there is great need to continually strive to develop programs that will facilitate expansion of and access to services; it is critical that communities, local, state, and federal entities engage in shouldering their share of the load. This in and of itself leads to the obvious reality that efforts to increase oral health literacy be expanded. I am convinced that will be best accomplished by engagement of and collaboration with numerous outside stakeholders in an interprofessional and crossprofessional manner. In this sense, the role of the dean is a team builder *beyond the confines of the school of dentistry*.

It is obvious that we function in an increasingly diverse environment. It is important for the dean and leadership team of dental education institutions to focus on *expanding the cultural and social awareness*. As dean I feel responsible for fostering development of an inclusive environment in which faculty, students, and administrators work together to create the future of dental education and, hopefully, dental practice. The demographics of our student population as well as our faculty has changed dramatically over the past several decades. This is true not only related to gender difference, but from an ethnic perspective as well. I recognize that, as an extension of the aforementioned factors, globalization of our efforts far beyond the confines of our individual institutions is an important aspect of our ever-evolving sphere of activity and engagement. Therefore, it is important that dental deans and administrators develop and sustain an inclusive culture within the institution that will serve to facilitate

development and sustain an environment that will promote the future of dental education in an increasingly interconnected world.

Coach

My personal experience brings to the forefront that as dean, I must also be a recruiter and a coach. Another aspect of the changing demographics in dental education is related to faculty make-up. We have gradually approached a critical point where the number of our faculty over the age of 60 is substantial. Who will be our faculty of the future? Where will the critical mass come from? There appears to be a trend in the pathway to academic dentistry as more entering faculty come from private practice backgrounds. There is great benefit to having this indispensable cohort who provide a wealth of experience and wisdom. However, it is evident that this resource must be complemented by enhancing the pipeline of recent graduates who choose academia as a career path. While significant effort has been put forth to accomplish this goal, it has been a difficult task likely due to a multiplicity of factors.

I feel very strongly that it is my responsibility in conjunction with our leadership team to instill an understanding of the importance of innovation and creativity in the culture of the institution. This will best prepare graduates to become lifelong learners. Looking forward this will be best facilitated by providing resources that support intraprofessional (oral health team) and interprofessional education and collaborative care. To that end it is important that the faculty be given opportunities to grow and further mature as educators with exposure to current pedagogical practices and principles with and appreciation for generationally varied learning styles. Additionally, the importance of providing guidance and support for lifelong learning and scholarly activity cannot be overstated as this will solidify the foundation of our purpose for being. In essence, as dean I must serve as a *stepping stone for individual and team growth*.

> I find a significant aspect of my role as dean is as an analyst of population health and knowledgeable about public health.

Importantly, the oral health team is becoming increasingly more integrated with the primary health care team, thereby driving change in practice models and structure with an increasing focus on collaborative (interprofessional) practices. I envision a continuum of health education and practice developing that will be best able to serve the public as we gain new knowledge across and throughout the healthcare team on which the oral health profession is a critical component. This will occur and be best served as we strive to work with our students to develop an even stronger culturally competent, well-prepared biomedical workforce that leads to improved population health.

Conclusion

The future of the oral health professions is bright, varied, and rewarding. The science and art of the dental field is evolving rapidly in the areas of technologic advances, research, esthetics, pain relief, and helping others to feel better and function better. Dental educators have opportunities to significantly impact the lives of so many in our communities vicariously through those whom we teach in a strategically, forward-thinking environment. It is clear that the expectations and demands on today's dental dean have dramatically expanded over the past several decades. ■

Sea Changes for Dental Deans

Ronnie Myers, DDS, FACD

Abstract

The roles of today's dental dean can be identified under seven heads, all beginning with the letter C: compliance, communication, cash/cost, congeniality, cohort, competence, and community. The individual who takes on that responsibility is a real person, complete with skills, vision, a personality, and a personal history.

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I am not sure of anyone who began their academic career saying, "I want to be dean." If so it must have been a curious few. Certainly, since the coronavirus pandemic began in March 2020, many deans are saying, "This is not what I expected."

To put in perspective the answer to the question, "What is different about today's dean's responsibilities versus the job of two to three decades ago?" I believe the background and road map of the protagonist telling the story is important. I was raised in a small town in Westchester County in New York State, just 30 miles north of mid-town Manhattan. A town on the Hudson River of about 15,000 people, it was more famous for the prison that still resides there, known as Sing Sing, and the phrase "send him up the river" than the Native American Sink Sink Indians, which is where it got its current name "Ossining." My father's father ran a pool hall/cigar store on Main Street in a building that he owned, and where my father was raised. My father became a general dentist and his first practice location was on the second floor of that building. Eventually, the practice moved a few blocks when my parents built a home/office across the street from the high school, and that is where I grew up. My mother was an elementary school teacher and so there existed this combination of dentistry and education in my DNA. In fact, when I was interviewed for dental school, I can still remember the question, "Would you ever consider teaching in dental school?" My answer still resonates, "I would, because the only person who can teach a dentist to be a dentist is another dentist."

Was I truly thinking, dean? I do not think so. This was 1975, the height of the applicant pool of over 15,000 for a little more than 6,000 first-year positions. I finished dental school, received my certificate in pediatric dentistry, and did a fellowship in special needs. We all have mentors in dental school, individuals whom we emulate, look up to, consider their career something of a model, and who provide guidance and a path. Dr. Martin Davis was one of my mentors who guided me toward pediatric dentistry and my fellowship. In 1982 I was teaching part time for Dr. Davis, working in my father's practice, and working for my next mentor, Dr. Harold Diner who ran the fellowship program, when I was approached and asked to consider a position teaching full time at my alma mater, Columbia University School of Dental and Oral Surgery (SDOS), as program director of the General Practice Residency (GPR) of Columbia Presbyterian Hospital. Dr. Steven Roser, then the division director of oral surgery and the director of the Oral and Maxillofacial Surgery program at Columbia, interviewed me and Dr. Alan Formicola, dean at Columbia, offered me the position. I then spent the next 34 years at Columbia serving in many capacities, from the original

position of GPR director to clinical dean, vice dean and interim dean between Drs. Ira Lamster and Christian Stohler. In 2016, a new dental school was opening in Westchester County, the Touro College of Dental Medicine. I was approached, recruited, and have become the first dean following the founding dean Dr. Jay Goldsmith.

My perspective of the last four decades in dental education and what the position of being a dean does or must do is grounded in two entirely different institutions: one steeped in history, embedded in the rocks of traditional Ivy League education and one with an unwritten path of excitement, innovation, and new unchartered waters. However, even with these contrasting and opposite ends of the spectrum, there is still the need to have the foundational building blocks and operational issues well grounded.

So, how have the demands and challenges changed over the past three decades? I will call them the seas, or Cs, of change: compliance, communication, cash/cost, congeniality, cohort, competence, and community.

Compliance

I believe a major change in all aspects of the dental education landscape is the continued increase in compliance requirements placed upon all aspects of what we do, who we answer to, and where we need to invest in order to limit liability. We have seen major changes in how we provide care as protocols for infection prevention changed, billing compliance programs evolved, and the Centers for Medicare and Medicaid Services (CMS) imparted requirements of compliance for their funding.

Communication

How difficult was it to communicate information to the faculty, students, and staff in the '80s? Physical memos, typed on a typewriter, copied and sent by interdepartmental mail or, even worse, snail mail. The drastic change to instantaneous messaging through text, e-mail, social media, and more has created many challenges for management in time spent reading, responding, and especially reconciling matters when messaging becomes fast and sloppy. The age of instantaneous interaction through electronic means has been both a blessing and a curse. It is a blessing in the rapidity at which things can be accomplished and a curse being available to all people at all times. Nothing has been more important than opening and continuing the lines of communication between faculty, students, staff, and the university.

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There is probably no one more important aspect of what a dean does than to develop a budget that maximizes revenue and decreases cost, while at the same time creating programs that are innovative, educationally sound, and recognized by peers as exceptional.

Cash/Cost

The complexity of budgeting and costs within each institution varies but the bottom line for all deans is accountability. There is probably no one more important aspect of what a dean does than to develop a budget that maximizes revenue and decreases cost, while at the same time creating programs that are innovative, educationally sound, and recognized by peers as exceptional. This, over the past three decades, has become even more important as state subsidies have decreased, student expectations and demands have risen, the cost of clinical operations has dramatically increased, and state-supported reimbursements for care have decreased. The rising financial pressures over the past three decades have demanded many more hours of a dean's time and have resulted in greater expectations for fundraising.

Congeniality

For many of my generation, dental school felt like a rite of passage. What should dental school be like? Should it be taught the same way everywhere? Should students be thought of today as they were yesterday? Should they be treated today as they were decades ago? I believe the answers to be unequivocally no. The change in the past 10-20 years has been remarkable and in many cases, students are now treated as colleagues. My impression comes from those of us who have embraced the White Coat Ceremony. Initially adopted in medical schools in 1989 but taking full effect through the next two decades expanding to schools of dentistry, osteopathy, pharmacy, and others, this event unto itself projects an image of welcoming, respect, and recognition of taking the step into the profession, a milestone event at which students begin to gain the trust of others in their well-being by taking the oath in which they are recognized for their new role in society. The event, with faculty next to, alongside of, and welcoming students with care, compassion, and understanding by placing the white coat on them, has changed this paradigm from one of subservient to colleague status. There is mutual recognition in oath that, when repeated together, student and faculty pledge with "utmost effort to acquire the knowledge, skills, attitudes, and behavior required for the practice of dentistry, embracing opportunities to learn from patients, teachers, and colleagues." Students have become our colleagues in this embracing moment. In my experience this change has brought remarkable rewards to the educational process, the faculty, alumni development and in most cases an overall improvement to the schools and colleges of dental medicine.

Cohort

The remarkable change in the students we teach has been well documented in many articles, books, journals, and presentations. They are labeled as Generation X, Millennials, and Generation Z. They have been categorized in these groupings based on generalizations of what those born within these periods desire. It has been said that Gen X, those born from 1965 to 1979, expect freedom from campus rules. That the Millennials, born 1980-1994, are consumers and want amenities, convenience, accessibility. These are many of our students. Lastly

the Generation Zs born 1995-2015, the other half of our students, focus on value, relevancy, and importance and they favor support services, technology, and the speed of the Internet. Of course, most of the current deans are the boomers (myself included) born 1944-1964. We must navigate these current student feelings by supplying these consumers with what they need, most of which is expensive. We must recognize the changes in the personalities and be able to deliver the premium education that we are asking them to pay for. The technology, the support services, the value for which they are paying, and the educational relevance of the programs we deliver must match the needs of those we teach.

Competence

Evolution of clinical education and accreditation standards has created programs that are more patient-centered, recognizing comprehensive oral health care as the paradigm shift. No longer is the emphasis on counting procedures as the required milestones for graduation. Instead, the focus has transitioned to overall health care, biomedical foundational knowledge and its incorporation into evidence-based dental care, case completion with improved oral health, and the determination of a graduate's competence in providing unsupervised general dentistry as defined by the school. These changes have resulted in the need for improved supervision with credentialed faculty, better quality assurance programs to ensure the best possible care recognizing deficiencies and correcting them, and identified standards of care that must be defined, attained and measured, along with better clinical infrastructures to ensure better patient tracking and student accountability. It was easier when we just counted completed procedures; but it wasn't right.

Community

The word community embraces multiple concepts: the community of the university; the community of the students, faculty, and staff; the community to which the dental school provides care. The changes that have occurred in these three and what deans must take into consideration in comparison to days gone by are important. The community of the university is paramount on this list. Dental schools for the most part are part of larger wholes. Their value to the institution at large is important and it is incumbent upon the dean to make the parent institution understand the value that the college of dental medicine brings, that the whole is truly the sum of its parts, and that the interprofessional programs, research, and education can only benefit the entire organization. In my opinion the students, faculty, and staff have changed insofar as the intimacy within which they work has provided an atmosphere much more conducive to success. In the past it appeared that the students were separated from the faculty, and this schism was fraught with a "we vs. they" mentality. As previously outlined, I think this has decreased significantly, signaling a marked improvement. Deans, I believe, have recognized the increased importance of outreach to the professional and local communities by partnering with local and state units of professional organizations, as well as lobbying with states for assistance on funding, reimbursement, and licensure regulations. Deans, in general, have taken a much more active role in these outside communities.

It was easier when we just counted completed procedures; but it wasn't right.

Returning to the Future

You might say I am a townie because I still live in Ossining, half a mile from that home/office that my father built, and that I lack the broad overview of the entire landscape of dental education. However, my experiences from one of tradition to one of new innovation have provided me with a unique perspective of the changes that have come in the dean's position.

These Cs of change, I believe, have resulted in enormous benefits for the dental educational community. No doubt they have led to rocky situations, with none being rockier than the tide we try to stem today. But on the other side comes benefit. Benefit for the future of the many dental students we will educate, faculty we will guide, and patients we will treat. Undoubtedly deans need to take chances when trying to make these things happen, while at the same time always trying to keep the balance of risk and benefit in their sights.

At the beginning I mentioned Steven Roser and Allan Formicola, two of my mentors. They took a risk, a chance on me, and for that I will forever be grateful. ■

The Fundamentals of the Dean's Job

David C. Johnsen, DDS, MS, FACD

Abstract

The circumstances change, local pressures favor unique responses, and we want something different because the last big push did not deliver everything we had hoped for. But in the end, the basics of managing a dental school, and many similar organizations, remain the same: (a) leadership and vision; (b) managing emerging opportunities; (c) being accessible and taking care of business; and (d) making sure the structure helps get the job done rather than getting in the way.

Dr. Johnsen is the dean at the University of Iowa dental school; david-johnsen @uiowa.edu.

The role of the dean has stayed the same in many ways and changed in just as many, maybe more ways. The fundamental responsibilities include: leadership, management, administration, and governance. Here are some thoughts on how each of these has stayed the same and changed.

Leadership

Setting the direction for the school is still a first function of a dean. That has not changed. One thing that is different now is that universities have become more formal in their strategic planning processes and expect all schools will tie their strategies to resource use decisions.

Fully engaged strategic planning is always more difficult in times of cuts than in times of increases. With tightening state resources, strategic planning is more difficult for state schools because of the pattern of steadily declining resources. In severe crises, one idea is to get through it, pick up the pieces, and begin more formal strategic planning. And to be sure, any dean in a position for any length of time will be faced with crises that are not in the leadership manual; that will not change. What has changed is that crises are no longer occasional; they are becoming the norm.

Management/ Entrepreneurship

This area has seen as much change as any in the role of the dean. One indicator is the proliferation of books and webinars telling us the newest moves in the management game. One problem is that there are so many alternative perspectives. Another is that those deans are expected to work closely with others who may have read different books.

There are many examples of a rapidly changing environment that call for new approaches to management. These include: technology, creative research, teaching methodology, and generational differences in how we are supposed to relate to each other. While no dean is expected to be an expert in any and certainly not all of these evolving movements, he or she is responsible for keeping the school in a healthy position amid the evolution. Staying on top of trends in research, for example, will be the role of the dean even if the dean is not an NIH researcher. The role of the dean in creating a culture of teaching and learning has changed with the shift from an authoritative teaching style to one of inquiry and respect.

The dean is not the pioneer in all new fields, but is responsible for the culture in which schools adapt to change. With the culture of education and respect, education methodology has opportunities to go beyond knowledge and technical to include things like critical thinking, applied

ethics, social responsibilities, and interprofessional education. Beyond knowledge and technical, the methodologies and accreditation lag behind the culture of inquiry and inclusion. The reverse is the case in technology.

One big trend is the centrality of teamwork in research, patient care, and teaching and learning. In each case isolation will come up short. As excellence in the various parts of dental education becomes increasingly collaborative, deans no longer lead individuals, they lead teams.

Administration

As dental schools have become more complex, the role of the dean to manage the school has become more complex. A growing number of deans have MBAs or law degrees. One thing that has not changed is for the dean to deal with day-to-day problems, and lots of them. The number of constituencies who want 50% of the dean's time has increased. The role of the dean has grown in managing faculty practices, fundraising operations, facilities improvements, legislative engagement, and university politics, among other concerns. The number and complexity of interests essential to dental education has forced deans to develop strong administrative teams with delegated areas of authority.

What has changed is that crises are no longer occasional; they are becoming the norm.

Governance

The enterprise that is dental education has become so rich that there are multiple ways of sorting it into units that work well together. Views on governance are all over the board. Schools once had departments aligned along clinical disciplines. Some schools have gone to fewer departments with umbrella names. Others have kept the departments but added administrative layers with vice-chairs and program directors. I am not convinced that has saved much money since each discipline will have a leader by whatever title. The case has been made that condensing departments brings a "critical mass" of faculty together for research. Now there are arrangements along functional lines such as prevention and diagnosis or even cross-cutting themes such as "personal and professional development," "professionalism," and "critical thinking." Some schools have no departments—a theoretical advantage for teaching beyond knowledge and technical with interdisciplinary. Also, shared governance has grown as part of university culture. The dean's ability to direct policy is more limited without extensive input.

Dentistry has become more complex, as has society in general. It should not come as a surprise that the role of the dental school dean should be changing from the good old days when a former well-respected faculty member was chosen to be the spokesperson for the group and many problems were solved in a conversation while strolling through the technique lab and a little growling at a student who did not seem to get it. ■

What is the Role of a Dental School Dean?

Charles F. Shuler, DMD, PhD, FACD

Abstract

In rapidly changing environments such as academics, and medicine and oral health in particular, the way deans manage their programs is apt to be described in a range of terms reflecting the currently fashionable leadership trends and the momentary pressures on various campuses. There is, however, a core of responsibilities that has been stable across time and location. All dental school deans are fundamentally the chief executive officer and the force for articulating an ever-current mission and strategy and ensuring that this animates every part of the institution. Our attention is drawn now to this trend and now to another, but in the end, dental schools are fundamentally evaluated on how well they execute on the triple challenge of teaching, research, and community service. Naturally the best expression of these goals must be tailored to the challenges and strengths unique to each program. Often this core job responsibility of the dean is obscured by the fact that many of the vast range of individuals deans interact with bring personal and narrow concerns.

Dr. Schuler recently retired following two terms as dean of the Faculty of Dentistry at the University of British Columbia; cshuler@dentistry.ubc.ca.

Have you ever posed the question, *What does the dental school dean do?* Everyone associated with a dental school has interacted with the dean at some point. But these are likely to have been focused on personal needs, quite different from exchanges others have had. Some have been counterfactual acquaintances: *Why didn't the dean take care of this or that?* At each of those instances the likely inciting event was different yet the individual seen as responsible for either causing or solving the issue is typically identified as the dental school dean.

The truth is, despite what some imagine, a dental school dean does not know everything that happens in the dental school and does not have the ability to instantly solve every issue or establish conditions that prevent them from arising. A dental school is a complex environment with multiple stakeholder groups that include students, staff, full-time faculty, part-time faculty, clinical faculty, research faculty, alumni, university administration, regulatory/licensing organizations, the profession, dental supply companies, dental manufacturers, patients, and government. Each stakeholder has a specific perspective on the activities in the dental school and often a vested interest in those activities. Many of these various perspectives have inherent contradictions. The different priorities that constitute the dental school mission further add to the complexity of the organizational environment. A dean does play a role in the management of the conflicting priorities with the overall responsibility to achieve the dental school mission.

When I learned of the initiative to focus an issue of the *Journal of the American College of Dentists* on the topic "Changing Roles of a Dental School Dean," I was flattered by the request to contribute an article and intrigued by the goal for the issue. Having recently completed two terms as a dental school dean, to reach the two-term limit of our university, I felt that experience could serve as the basis for the article. Having been a dental school faculty member for 36 years at three different dental schools, both public and private in both the United States and Canada, provided additional experiences relevant to the goal of this issue.

A dental school dean has multiple roles defined by the different responsibilities of the position, the stakeholder constituencies of a dental school, and changes influencing the oral health professions. This complexity of a dean's position is magnified by the large number of and variation in perspectives of those decanal roles held by the numerous individual stakeholders. That wide variation in responsibility means that this article is quite different from others I have published based on my laboratory research. Not only are there multiple roles and responsibilities that

impact on decanal activity but there is considerable dynamic change in those activities. Both internal and external events occur on different timeframes, some quite rapidly such as minutes to hours and others over much longer times such as months to years. In more than ten years as a dental school dean, I was involved in a wide range of different experiences associated with the responsibilities of the position. Those experiences serve as the basis for discussing the changing role of a dental school dean. There are two commonly known roles for a dental school dean: CEO and academic unit leader.

The Role of Chief Executive Officer

A dental school dean is the chief executive officer of the dentistry academic unit and is assessed by the university administration in that regard. That assessment also is importantly based on how the university defines itself, which can be variable and is unique to each institution. There are both public and private universities with dental schools. There are universities defined as "research intensive" with dental schools. The distinction between public and private institutions has important implications with respect to the budget, however; currently the level of public funding for dental schools has greatly diminished. The result is that all dental school deans function in an environment with increasing reliance on student funding

A dental school dean is the chief executive officer of the dentistry academic unit and is assessed by the university administration in that regard.

of the dental school budget and external fundraising. Maintaining a balanced budget, avoiding deficits and ensuring adequate financial resources to support activities represent dominant responsibilities for a dean. This focus on the budget is also a source of considerable internal and external pressure.

The student educational debt levels have increased dramatically in the last decade and the career decisions graduates make are often linked to that accumulated debt and the repayment required. The student debt burden has a direct effect on student attitudes and expectations while in school. A student once told me exactly how much he had paid for a one-hour lecture and that he felt he didn't get his money's worth. Many senior faculty members are uncomfortable with these types of student feedback and the transition of students to a more consumer-oriented approach to their dental school experience.

The topic of student debt has further highlighted the role of the dean managing the dental school budget and ensuring that funds are allocated sufficiently to achieve all the dental school activities. The reality is that currently there are insufficient funds available to achieve all the outcomes desired by all the stakeholders and there is no potential that this reality will change in the future. Balancing the resources available and the activities that must be supported is a major role of the dean. Thus a primary focus of a dental school dean is finances and the effective management of the dental school budget. President Harry Truman had a sign on his desk that read, The Buck Stops Here! The dental school dean is in the same position and held responsible by the university for everything that happens in the dental school, and school finances with a balanced budget is essential.

The Role of a Mission-Focused Leader

The direction for a dental school and the mechanism for establishing a common purpose for all the stakeholders is embedded in the stated mission of the school. While the

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mission and associated strategic plan may appear to be broadly based, they provide a critical framework. It is important that each stakeholder in the dental school be able to identify their specific role in this framework and the ways that the individual can contribute to achieve the goals. The dean has a critical role in facilitating the activities required to achieve the mission and goals of the institution.

First of all, the goals for the dental school are contained in the mission statement. That statement from the University of British Columbia Faculty of Dentistry 2017 DMD accreditation document was: *Goals for the DMD program; integrates the basic biomedical, behavioural and clinical sciences to ultimately develop DMD graduates with the knowledge, skills and values that underlie competence.* This is a quite broadly based statement that encompasses a very large amount of specific content and specifically addresses only the DMD program. Similar mission statements are linked to all the different educational programs. They reflect the current competency-based approach to education and accreditation.

The mission must be translated into action, which occurs through a strategic plan that helps all the stakeholders understand their specific roles to achieve the mission. The UBC Dentistry Strategic Plan that was paired with the mission statement had three thematic areas: (a) enhance the student experience; (b) amplify research productivity; and (c) increase community involvement. This emphasis on research, teaching, and service is common to all dental schools. This primary role, to focus on the mission, must be balanced with the changes that occur in the profession and with the people who are stakeholders in the school. The dean must both manage change and ensure continuity, two responsibilities that may often appear to be mutually exclusive. The dean provides leadership for the dental school and facilitates decision making in the best interests of the entire school. This process of balancing school-wide decisions with individual-specific impact involves a considerable time commitment and is frequently the source of considerable critique.

Unpacking the Two Identified Roles and Beyond

I spoke to several friends and colleagues who have been dental school deans and asked them to define the role of a dental school dean hoping that this would provide a starting point for this article. Interestingly, a very common response received was, *Well it depends…* This further reinforced the very dynamic nature of the role of a dean and an important situational dependence of the role.

A dental school dean is a university position and consequently a job description exists. That job description is a component of every accreditation self-study (see sidebar). That job description sets out the multiple expectations for a dental school dean. Interestingly the job description contains the phrase *basic roles* of the dean, which means that the actual, practical breadth of the roles is much more extensive and subject to considerable variation at different times. Furthermore, this job description does not reflect the changes that have occurred in dentistry and education. It is assumed that those will be incorporated into the program through the broadly based role.

Dean's Job Description, University of British Columbia

Dean of the Faculty of Dentistry
The Role of the Dean

The Dean of the Faculty of Dentistry is the Executive Officer of the Faculty, reporting to the Vice-president, Academic and Provost, and is a member of the University's senior administration. The Dean is supported by Associate Deans and Department Heads. In addition, a Dean's Advisory Council was established in 2004 to help guide the Faculty in fulfilling the expectations of the University and the community-at-large. Council members bring broad skills from diverse backgrounds.

The basic roles of the Dean include:

- Providing leadership and administrative management, and a strong vision for the Faculty of Dentistry, articulating that vision to faculty, staff, and students within the Faculty of Dentistry, other faculty across the University, and the broader community;
- Providing leadership within B.C.'s dental community;
- Developing a strong and credible presence in the Faculty;
- Forging strong links to and between all departments;
- Fostering interdisciplinary;
- Promoting research and the crucial role it plays at UBC and in the Faculty of Dentistry, including the development of a Faculty research agenda and the integration of research into teaching;
- Providing leadership in the evaluation and reshaping of student experiences within the Faculty, including expanded laboratory and research exposure and curriculum renewal;
- Fostering relationships with the private sector, encouraging technology transfer, and promoting the value and relevance of the Faculty's scholarly research and teaching agenda;
- Engaging actively in fundraising on behalf of the Faculty;
- Maintaining and enhancing productive and collaborative relationships with other Faculties;
- Facilitating the recruitment and retention of outstanding faculty, staff, and students, showing a commitment to educational and employment equity and sensitivity to cultural diversity;
- Maintaining a working environment dedicated to excellence, equity and mutual respect.

In that regard, evaluating the role of a dental school dean has important implications with respect to the specific perspective of the evaluator. Inevitably, deans are most often evaluated based on the impact that a specific decision had on individuals and groups. It is much rarer for a decanal decision to be evaluated with respect to the impact on the dental school as a whole. Evaluating the changing roles of a dental school dean is inherently linked to the purpose of a dental school in a university. This linkage of dental school and university has gone through considerable change in the past 100 years and has been the subject of several publications (Field, 1995; Gies, 1929).

Expectations of Contemporary Dental Education and Meeting the Individual Stakeholder Expectations

Health professions education has only been generally integrated into universities for a little more than 100 years. Following the publication of the *Flexner Report* (1910) on medical education and the *Gies Report* (1926) on dental education major changes occurred. These included formalizing dental education in a university environment. This transition of dental education to a university-based structure meant that the historical apprenticeship-based pattern of training to be a dentist was replaced by an education-based model of learning to be a dentist. The differentiation between training and learning may not be completely resolved even today and continues to

be a topic of great discussion among all the dental school stakeholders.

Every stakeholder in a dental school has opinions about the purpose of the dental school that are most often reflective of the nature of that individual's own position. Thus, the identified purposes are often reflective of different areas of specialized focus in the dental school. All of those different purposes are contained in the list of responsibilities, either stated explicitly or implied, for the dean. Unfortunately each stakeholder is inherently focused on a single activity, typically directly reflective of their own area of interest.

Some stakeholders believe that a dental school exists to produce dentists who go into private practice and provide oral health care to the population. However, every dental school has multiple educational tracks that lead to different professional outcomes. The role of the dean is to ensure that all students in all these educational tracks receive the optimal education to achieve their career objectives. Thus the role of the dean changes with respect to every different educational outcome and depending on the perspective of the observer and the time of the observation. In the eye of the beholder, it may seem that the dean is emphasizing one program more than another. All education programs have a common core set of content areas expressed as knowledge, skills, and values. Interestingly, those three educational domains are continually changing and one requirement of the educational programs in the dental school is to prepare graduates of all the programs to provide patient care at the leading edge of knowledge, not just at the time of graduation but throughout their careers. The term *evidence-based care* has become a common standard and means that the healthcare provider integrates the best scientific evidence with the patient's diagnosis and treatment needs and the provider's clinical expertise; this standard is integrated in all the educational programs. The graduates of the different programs need to develop the skills to find and assess new information and decide how to implement the latest advances into their practice to the benefit of their patients. Consequently educational programs in addition to conveying a foundational set of knowledge, skills, and values need to prepare the graduates to continue to expand on those content areas in the future through a commitment to lifelong learning.

In speaking recently with new dental students the case was made that although they will graduate in 2023 they will likely still be in practice in 2063. Thus their education needs to prepare them to remain at the leading edge of the profession for more than 40 years. Imagine how a 22-year-old first-year dental student reacts when hearing that reality. That lifelong learning objective often leads to one of the most common concerns raised by external stakeholders of the dental school: Are your graduates ready to treat patients? Frequently stakeholders of the dental school comment, *Your students are not learning the current practices in oral health care*. This is an important observation and one that has direct impact on the role of a dental school dean. How are advances in knowledge, skills, and values implemented in a curriculum? The introduction of the latest advances in the profession is directly impacted by one of the key outcomes expectations in accreditation, the graduation of a safe beginner. This means that a curriculum should be focused on principles rather than on specific techniques and materials. The learning of those principles is typically connected to specific patient care practices that have been shown to provide predictable outcomes and have associated rubrics for assessment that provide students with a framework for educational progress. Developing the core principles provides graduates with a foundation for evaluating changes in techniques and materials throughout their career and the ability to identify the limits of their knowledge to engage in continued professional education to advance their knowledge, skills, and values.

Running a Dental School amidst All These Expectations

All dental schools have a defined budget and all universities expect the dental schools to conduct all the research, teaching, and service activities within the budgetary parameters. This reinforces the primary importance of the financial management role of the dean.

That budget reality has led to many conversations and often I have heard, *Why can't the dental school run more like a business?* This is an especially interesting question since a decanal role does have many aspects in common with a CEO. An important

difference that represents a potential response to the question is, *What product does a dental school produce?* and *Who is the consumer of that product?* For a business CEO the production of the product can be analyzed with respect to costs and efficiencies and the entire operation optimized to maximize the profit. That type of analysis is not possible with an educational program. A similar concern about budgetary efficiency has been leveled on all education programs but how is knowledge creation, transmission, and enhancement measured? The *product* is not easily quantified and economically analyzed. Similar types of comments/criticisms are leveled on all educational institutions and the public schools are often the most severely criticized with comments: *Why do we need music in the schools? Why do we need art in the schools? Why do we need sports in the schools?* In every case a stakeholder with a specific perspective raises a question that often reflects personal interest/bias. In critiques of dental school activities and budgets a similar concern is often raised: *Why do you need to have those basic science faculty members?* What position does that type of question reflect? Especially for dental schools that are in universities that are categorized as research intensive, the generation of new knowledge that can lead to advances in health are essential aims of the university and a metric of assessment of individual faculty members and the dental school. Perhaps that question suggests that the school should get rid of the basic science-focused faculty members and strictly focus on the clinical disciplines. This conclusion could be seen as a return to the situations that Flexner and Gies investigated and published more than 100 years ago: Are health profession schools educational institutions or training centers?

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Dentistry is a profession rather than a trade and thus educating our students to be critical thinkers is an important objective. The basic science faculty integrate critical thinking into their research projects and analysis of their research results. Thus critical thinking is a required component of their faculty member profile and these research-intensive faculty members model the critical thinking behavior that is a dental school curricular objective. However, a disconnect appears from the student perspective with respect to the practice of the basic scientists and the educational program for the dental students. In fact the basic sciences are critical in the evaluation and treatment of every patient. Any sign or symptom presented by a patient is the result of an alteration in a basic science mechanism and any treatment or therapy provided aims to restore the healthy basic science status. The basic sciences are the foundation of health care and the reason that both Flexner and Gies believed it was so important to move from a Training model to an Education model in health professional schools. An alternative position might be to ask, *Have basic science research advances impacted oral health?* The answer is a resounding Yes!

The past 40 years have seen dramatic changes in the delivery of oral health care. The changes are all the result of research advances that have been translated into clinical procedures and transitioned into routine clinical practice. I recall that as a dental student I asked a faculty member, *Would it be possible to make a thin layer of porcelain and glue it to the surface of a tooth to improve the appearance?* I still recall the horrified look I received from that faculty member and the suggestion that such heretical ideas were not really consistent with a graduate from our school. Yet now porcelain veneers are a routine part of dental practice; this could only have been achieved through extensive basic science and clinical research led by dental school and dental industry scientists. The linkages between basic science knowledge/investigation and clinical practice can be demonstrated by the outstanding advances made with bonded composite restorations.

Over the years as I have spoken to many dental groups I have frequently heard that *posterior composites don't work,* and from endodontists that *posterior composites were great for their*

practices, they all leak and lead to pulpal infections. So a new material and clinical application was developed through remarkable research advances by Bounocore and others, yet when the application advanced from the controlled settings of clinical trials to the routine clinical use in private practice the clinical procedure was judged to be substandard. Why did that happen? Was it the basic science research that led to clinical failures? The clinical trials did not have these failures so what happened in the transition of the technique to routine clinical use? Perhaps it was that the basic science principles were not appropriately considered. If the basic science properties of the materials were appropriately considered the restoration would not leak and fail, but the basic science properties need to be considered and consequently the importance of learning the basic sciences is essential. Who can help a dental student understand how the basic science properties are related to clinical practice and, even more importantly, how those basic science principles continue to be relevant for dentists in practice as new generations of materials reach the market and enter clinical practice?

The budget is the key and the dean's role in managing the financial resources of the dental school is essential and always of highest priority. This is where the rubber hits the road in the changing role for a dean.

Concluding Remarks

The core aspects of every dental school mission are teaching, research, and service. These remain rather broad and open to multiple interpretations and each dental school can choose to define them in its own ways and subsequently develop programs and activities to achieve the strategic goals. One major role of a dean is to facilitate the development of a strategic plan for the school and, once there is a consensus on the strategic plan, facilitate the school moving towards those goals. To achieve a strategic goal requires people, places, and things and critically all three of these elements essential for the strategic plan require funding. The budget is the key and the dean's role in managing the financial resources of the dental school is essential and always of highest priority. This is where the rubber hits the road in the changing role for a dean. Where should dental school resources, which will always be limited, be focused? This closes the loop between the reality of the school budget and the much less defined school mission/vision. The "safe beginner" has purchased an educational product from the school that provides the knowledge, skills, and values that are consistent with an oral healthcare provider and will sustain that oral healthcare professional throughout his or her career. ■

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The Changing Role of Dental School Deans

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Abstract

Two deans, one with more than a decade of experience and the other in her first year, find that they share a common understanding of their role. In a changing and challenging world, it is the people who are the ultimate concern of leaders. Creating shared vision that empowers those in schools, regardless of their responsibilities, is what is now required of dental school deans.

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In the past two decades, significant changes have occurred in dental education that have influenced the role of a dental school dean. Among these changes, 12 new dental schools opened since 2000, the nationwide enrollment of first-year dental students increased by approximately 30% as a result of the "new" dental school classes and from class-size increases at existing dental schools, while demographic shifts in students and faculty have occurred. Our student cohorts and faculties have a higher percentage of women than ever before and are more diverse in other ways. Students are coming to dental school with greater familiarity with technology in their lives, with different needs, and with high expectations of a learning environment.

Depending upon the type of university a dental school is affiliated with, there may be expectations for a dean to create school programming to address these changes or to integrate the activities of the dental school into those of the parent university and, in some cases, into the activities of a campus with hospital affiliates. So in addition to the expectation that a dean serve as the leader of the academic, research, and patient care enterprises, the chief fundraiser, and a key partner to the dental community and the dental alumni, many deans must also be collaborative campus business partners on an academic health center campus. Additionally for most, regardless of the university structure, there is an expectation that the dean strategize how to identify resources that drive faculty productivity and innovation, all the while serving as the chief goodwill officer who can deploy school and campus resources to support those in need. It is these last two roles—the increasing role of supporting change and innovation while maintaining ongoing program strength and the essential role that a dental dean must play in supporting the community of their individual dental school, to encourage a sense of belonging, resilience, and wellness for each member of dental school family during times of institutional change, growth, and loss—that our individual dean reflections will focus on.

Reflections from Denise Kassebaum

Having had the privilege of serving as a dean for over a decade, I feel that there has been an increased importance in the role I play to catalyze and drive innovation and change in the last few years. The University of Colorado School of Dental Medicine is located on the Anschutz Medical Campus in Aurora, Colorado, a suburb of Denver. As the campus has grown in its focus on innovation, there is an expectation that the dental school will do the same. We have created an innovation agenda and a change management structure that has guided our work for the past three years as part of our

strategic plan. The faculty identified three destinations: educate future-ready graduates, perform person-centered care, and conduct transformative team science. The dental faculty have selected areas of interest and expertise in seven faculty expertise teams that have included: (a) iPads in classroom, preclinic, and clinic; (b) virtual reality, augmented reality, and haptics; (c) person-centered care; (d) digital dentistry; (e) clinical research; (f) biobanking; and (g) precision biomaterials. By creating an Innovation Committee, an Innovation Seed Grant Program, and a faculty development initiative to support presenting project successes at national and international meetings, new innovations and change have been encouraged and supported.

The other area that I feel has increased in my responsibilities as a dean has been the focus I have given to encourage a sense of belonging, resilience, and wellness for each member of the dental school family. To provide a perspective about this, I will demonstrate program changes and increases in this important area.

Creating a sense of belonging in all community members

In the past decade the University of Colorado School of Dental Medicine has made intentional efforts to increase experiences both within and outside the curriculum that emphasize the importance of recognizing the social determinants of health. We have focused on understanding student colleagues as well as on caring for patients. One exercise that we implemented in the last few years and continue to refine is called the "poverty simulation." These discussions are a start in bringing attention to the unique stories that a cohort of dental students bring to their dental school experience. This exercise revealed that a number of our students had either experienced poverty themselves or had family members who had. Important, and a work in progress, these activities are intended to inform students about life experiences that may be new to them.

Resilience

In addition to embracing an increasingly dense predoctoral curriculum, increasing tuitions, and at times personal life challenges, our students today are requesting different levels of institutional support than in the past.

On the Anschutz Campus, we have established Care Teams, provided access to a team of case workers who can help with student issues outside the curriculum, and increased access to student mental health services. There has been a campus-wide initiative to destigmatize accessing behavioral health support.

We have also created joint leadership activities with the fighter pilot cadets at the U.S. Air Force Academy in Colorado Springs to teach resilience principles. We have increased student-led support for new students in the form of tutoring by the American Dental Education Association (ADEA) Student Chapter. We have more faculty assigned not just to supervise academic and clinical procedures, but to check in on how students are managing their patients and how they are personally navigating the challenges of their own curriculum.

Wellness

In addition to behavioral health support services that we continue to increase for students, faculty, and staff, the Anschutz Campus has a Wellness Center that provides a physical location for exercising and nutrition programs. It is a site for a number of national weight-loss shows. Additionally students are encouraged to use the outdoor campus spaces to participate in physical activities at select times during the day. We also created a Virtual Reality Immersive Learning Suite for students, not just to better embrace anatomic structures in different planes, but to experience several resilience packages like "walking with the dinosaurs," "spending time in a meadow," and "walking on a beach" to name a few. Additionally we have a new therapy dog named Lucy, our comfort ambassador who is a golden retriever, who expects nothing from a stressed student but a hug. Lucy is a magnet in our clinics and student lounge areas for individuals needing quick comfort.

Reflections from Lily García

These remarks reflect the eye-opening and humbling experience of my first year as dean at the University of Nevada, Las Vegas, School of Dental Medicine. UNLV Dental Medicine is co-located with a new medical school whose first cohort of medical students are just now matriculating through their third year. UNLV Medicine is about to experience exponential growth both in class size and in facilities. The schools of dental medicine, medicine, and a portion of the nursing program are located in the Las Vegas Medical District, separate

from the parent campus approximately seven miles away. This is the beginning of an academic health center, which lends to the excitement of being a new dean.

The professional opportunities I experienced prior to my arrival at UNLV Dental Medicine allowed me to learn many skill sets when serving in various capacities and administrative roles, including as chair of committees and task forces, division head, department chair at two institutions, and associate dean level positions. The same key aspects articulated by Dean Kassebaum—*a sense of belonging, resilience, and wellness*—are magnified in the roles of a new dean. The skill sets learned through previous experiences are meaningful when they can be used to move initiatives forward that also move forward the people of an institution.

> There is an expectation that the dean strategize how to identify resources that drive faculty productivity and innovation, all the while serving as the chief goodwill officer who can deploy school and campus resources to support those in need.

Listening to learn to lead

In the past six months, I dedicated time to learn the unique nuances of an existing culture while attempting to prioritize initiatives intended to advance the academic dental institution.

With a "people first" perspective, listening to as many voices is critical in support of creating resilience and building respect. Our leadership team is committed to accountability in a time of transition. This mirrors the concept of Kouzes and Pozner in their *The Leadership Challenge*. They urge that leaders must "model the way" to help build a sense of respect within our work environment.

While focusing on our students, staff, and faculty to leverage our strength and institutional capacity, a balance is needed to engage stakeholders for external support. Ultimately, time management in order to be able to have meaningful connections with the various individuals and groups is critical. I find the concept of "flexibility" helpful.

It is my hope that learning about the culture and getting to know the people who are dedicated to UNLV Dental Medicine is my way of demonstrating respect and professionalism for all constituents and evidence of my commitment to our collective success. I see my professional experience as a series of skill sets that I can use but only when applicable and only when useful in the new environment. As much as one believes he or she can prepare for an academic leadership role, each new day presents a facet of the environment that requires intellectual capacity and patience to listen, to engage, and to develop processes and protocols that enable others to address a challenge and seek solutions with a strong sense of trust. Each challenge or opportunity is nuanced within an academic culture whether within a 100+ year-old or a 20-year-old institution.

Deans help each other

The expertise among deans varies as do leadership styles, yet I feel confident that if I were to reach out to any one of my colleagues, my call would be answered, response to my e-mail received, and an offer to convey insights forthcoming. The role of dean is one immersed within the context of academics, yet growing to ensure relevance and impact to benefit the community. Continuous learning is the constant and the wherewithal to use any combination of skill sets to address an issue is an exciting proposition that intrigues many to seek this type of position.

Summary

Whether serving as a dean for over a decade or under 12 months, we conclude that the most important asset of our complex dental schools is our people. The dean's role to create resources and an environment to address the evolving needs of current and future faculty, students, and staff is one of the most important we must assume. It is the people who are behind any institution's ability to innovate, educate, discover, serve, and treat in order to reach the dental school's mission to impact the future. ■

Redemption

Sharhram Shekib, DDS, FACD

Mark Bauman passed away too suddenly last fall. He was a light to many like myself. He always looked for and found the best in us. He once told me, "An organized, informed, and progressive effort by dentists can bring about an improved oral healthcare system and help to achieve a true redemption." He encouraged us to look for that. This little essay, which he saw and encouraged me on, is offered in his memory.

Redemption is defined in the dictionary as the willing act of serving to offset or compensate for a defect, one's own or others. In order to enhance and protect the integrity of our dental profession, it is my belief that we are required to not only function in our primary role as dentists, but also to effectively organize and use all of the resources available to us to cure systemic defects and to bring about the fundamental changes necessary to create an improved oral healthcare system for all. This is our "true redemption" as professionals—and as human beings responsible for one another.

An understanding of substantive law and legal process is also a prerequisite to being able to best organize as a professional community to effectively respond to inequity and inefficiency and to the power of special interest groups that distort the oral healthcare systems. For example, undue political influence, rigid antitrust laws, the outsized influence of insurance companies on the outcome of bills, and a pervasive lack of accountability all have adversely influenced our profession and the quality of the care we are able to provide.

It is quite surprising that there are people who believe we cannot bring about critical changes because we do not have the necessary influence or the required human power. This false and fatalistic way of thinking has infiltrated the core beliefs of many of us, creating a lack of unity and purpose—and, unfortunately, in this way, becoming a self-fulfilling prophecy.

Properly educating and organizing ourselves and using all the tools available, we can certainly bring about real-world transformation. There are a host of ways to begin this essential work: joining professional organizations; creating web and social blogs; reaching out to our councilmen/women, senators, and other well-placed decision makers; voicing our opinion through various channels; and educating ourselves using a variety of dental and legal pathways. Through all of these venues and more, we can create a united and powerful voice that optimizes our impact. Each of us can find a way to add our special talents and passions to this effort. Each of us can simply and wholeheartedly commit to doing what needs to be done for all.

In this united effort, each of us needs to be a leader. A leader is one who is able to sense the needs and concerns of peers, connecting and responding to them with sincerity, staying firm and consistent in pursuit of the group's objectives. A leader must also be committed to change and be both strategic and tactical in approach, taking appropriate and necessary risks, willing to engage in self-sacrifice, to suffer personal attack and even loss when necessary for the greater good, all the while assessing and preparing for future challenges. And, certainly, a leader must maintain great integrity in the face of the constant temptations of power. Each of us, then, may take on these overarching roles and attitudes. Doing so, there is so much that we may accomplish together.

A forward-thinking, informed, and effective coalition of caring professionals of great integrity seeking to institute the changes necessary to create the most equitable and beneficial oral healthcare system possible for all: this is the vehicle of true redemption. Mark Bauman did it. So can we. ■

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