

Beyond the University: Leadership for the Common Good

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Abstract: Leadership in health professions education and the university in general has been the subject of intense scrutiny and observation in recent years. For a variety of reasons, universities and their component schools (including dental schools) are not always perceived to advance goals for the common good. The conclusion of this report is that common good unfolds from effective leadership. The report examined the tenets for why oral health care matters and why it deserves more significant national attention. The failure for oral health issues to reach the national conscience is due, in large part, to ineffective leadership. Effective and apparent leadership styles are described in the paper, including the context of why effective leadership is more important now than ever. In addition, the characteristics of leaders to advance the public good are noted. Leadership necessary to reclaim the public trust in higher education is also discussed. Leadership and “followership” rallying around goals for the common good provide a significant path for dental schools and their parent universities to accomplish great things. The absolute necessary ingredient from which common good develops is effective leadership.

Common good unfolds from effective leadership. The thesis proposed in this paper is that, for a variety of complex reasons, dental schools and universities are not always perceived to advance goals for the common good and, thus, both leaders and followers (in this case, faculty, students, alumni/ae, society) are compromised.

Dental and oral health care continues to be marginalized in the deliberations of health policy makers, the health insurance industry, and the political deal-makers. A consequence of this continued marginalization is the lack of access to and appropriate use of oral health care, especially among some segments of the population, including special needs populations, underrepresented minorities, the working poor, lower socioeconomic groups, and immigrants. Although about 42 million individuals lack medical insurance, nearly 125 million individuals are without dental insurance. The tragedy is that compromise of the “common good”—access to and appropriate use of oral health care—is taking place against a backdrop of unprecedented advancements in science, technology, education, and medicine.

In the past few decades, we have learned that oral diseases are not self-limiting, but are cumulative. They impact not only oral wellness, but also general health; and they affect job and school performance. More recently, data are confirming that oral diseases lead to increased risk of cardiovascular disease and stroke.¹

Exciting studies are being conducted that relate oral diseases to low birth weight infants.² In addition, it is well known that a host of other systemic diseases have a unique relationship with oral tissues, including diabetes, human immunodeficiency viral disease (HIV) developmental disorders, autoimmune diseases, and osteoporosis. We also know that oral cancer is a leading cause of cancer with more than 33,000 cases diagnosed and 8,000 deaths a year.³ Oral diseases can impede an individual’s ability to speak, swallow and/or smile. They can also have a negative impact on an adolescent’s development of self-esteem and one’s employment potential. Oral diseases can result in loss of school and work time; they can disfigure; they can cause pain; they can lead to increased risk for heart disease; they can even kill! So why has this American tragedy happened and why does it continue to happen? This is a particularly vexing question when one realizes that the oral health of millions of people is unnecessarily compromised with disproportionate needs inequitably spread among population groups.⁴ Has this tragedy occurred because oral health is not important, or is it because leaders have not underscored its importance? While the United States purports to have the best oral health care in the world, and that may be true, surely it can be improved. Improvements in oral health, especially oral health care access, will take leadership at every level including politicians, university and health science center presidents, university governing boards,

dental school deans, dentists, caregivers, health care organizations, and even the consumer.

The purpose of this paper is to explore the current leadership dilemma in health professions education and to prompt extension of the role of oral health professionals to serve as leaders who engage a richer “public good” agenda as part of their role as “doctor/teacher.” It is not designed to be a review of the literature on leadership; rather, this paper will attempt to provide fertile discussion to extend the role of dental education to develop in future graduates leadership skills directed toward a more societal mission as a partner with the university and the community it serves. Lack of an identifiable, public good agenda has been responsible, in part, for the loss of public confidence in higher education, and in American institutions in general.⁵ For the university in general and dental school, in particular, to overcome voids in public confidence, higher education leadership must be willing and able to establish goals for the common good. The common good in dentistry includes improving access to and appropriate use of oral health care. Goals for the common good require leadership distinct from that to personal achievement and meeting specific university and dental school goals. How do we define leadership for the common good and how does it differ from present leadership skills?

One definition that is particularly easy to grasp and apply to the dental school/university setting is that put forth by Wills in 1994.⁶ Wills states that “the leader is one who mobilizes others toward a goal shared by leader and follower.” In his provocative book *Certain Trumpets*, Wills postulates that leaders need to understand followers far more than followers need to understand leaders, which is a time-consuming but necessary aspect of leadership. So leadership and “followership” are two ingredients that determine whether leaders can lead. The third critical ingredient is a goal. According to Wills, the goal is the *raison d’être* for the existence of a leader and his or her followers because followers do not necessarily submit to the person of the leader; rather, they join him or her in pursuit of a common and hopefully, worthwhile goal.⁶ Wills further suggests that we do not lack leaders. What we do lack is followers and, by implication, we lack agreement on the process and establishment of common goals that both leaders and followers judge are the right thing to do and are appropriate for the circumstance or specific context of the setting and the times.⁶ Simply stated, various leadership forms are best judged on their goals, rather than their style.

Oral health professionals often fail to achieve improvements in the oral health of the community because they are not provided or lack the skills necessary to share their knowledge and expertise with those beyond the dental office, the dental school, or the university setting. As a result, their oral health knowledge and skills remain within the narrow confines of the “dental operatory” or dental school, rather than dispersed widely to members of the community at large for the purpose of improving the common good. Thus, the ability to establish common good goals is compromised. The net result is dispassionate leadership, frustration, apathy, concern, and differing expectations on the part of the university and its governing board, the dental school, the practitioners, and the community. Under these circumstances, it is very difficult for the dental school to contribute value to a mission disparate among the university, its component school, and the community. The resultant perception that the dental school or any other school is not critical to the university’s mission and is, therefore, expendable is a natural potential outcome of the inability or unwillingness to establish and implement shared, common goals for the public good.

Leadership cannot be conducted in a vacuum, and partnering is necessary for leaders and followers to transcend parochial interests and facilitate the public good.

Apparent Leadership and Effective Leadership

At different temporal times and in historical context, various and sundry forms of leadership have been effective. There are some excellent reviews of leadership that address these issues, including Lucas,⁷ Fisher,⁸ and Bensinon and Neumann.⁹ For example, depending on the state of the institution and the historical context, charismatic leaders are effective and, at other times, transformational or even representative leadership is necessary and effective. A number of forms of leadership bear on this paper. The following list is not meant to be comprehensive, but is designed to illustrate some of the extant forms of leadership in dental education and the university that have varying degrees of effectiveness or ineffectiveness as the case may be:

- **arrogant leadership**—this leadership is characterized by an institution-wide attitude that the goals of the school/institution are what are best for the students, staff and/or community. There is little ex-

ternal input into common goal setting; this is an intrinsically derived form of self-congratulatory and self-aggrandization type of leadership.

- **confrontational leadership**—this leadership is characterized by conflicting goals among schools, the university and/or community. Micromanagement, anxiety, turmoil, and punishment, rather than reward, describe the atmosphere of this type of leadership. Leaders and followers are in constant conflict and fear of failure is evident in the institution. Insecurity thrives.
- **plodding leadership**—this leadership is characterized by common goals aimed at contributing to the institutional “bottom line” and/or is designed to meet community, university, or student “perceived” needs. Plodding along rather than pushing the envelope is observed here. Similar to status quo, but occasional “rocking the boat” occurs.
- **regressive leadership** – this leadership is designed to meet the most basic school or university needs. Any goals are set at a low level; change does not exist; and the environment is characterized as “boring.” Sometimes the leader can be accused of having had a charisma bypass!
- **status quo leadership**—this leadership is characterized by a “do not rock the boat” attitude among leaders and followers. Change is slow if at all and there is little movement toward common good goals.
- **visionary leadership**—this leadership pushes the envelope for the school and the university and exhibits constant movement toward meeting extended common good goals. Shared vision characterizes this form of leadership. Followers are both excited and anxious.

Clearly, there are many forms of leadership. Effective leadership in whatever form it manifests itself must be derived from a legitimate base, such as that provided to a president or dean by a governing board. Unfortunately, at times, boards and administrators limit the authority of a legitimate leader, making it impossible for the leader to lead while making board wonder why the leader can't lead.⁸ Thus, the effective leader needs legitimacy as well as expertise, persuasion, and charisma to take advantage of the leadership position.⁸ Indeed, some of the external forms of leadership described above are derived from the ability or inability of the institution to sustain and support legitimate leadership. In considering the characteristics of providing effective, common good leadership for the dental education enterprise and the university into the next century, it is important to understand the current environment in higher and health professions education.

The Context

In spite of documented excellence in research, education, community service, and patient care in various universities, as well as medical and dental schools, the public is skeptical of higher education and medicine.¹⁰ Increased external accountability has been the subject of much consternation and debate in the academy. In their essay “Accountability of Colleges and Universities,” Graham, Lyman, and Trow bring important insight into the problem, which has a direct bearing on the dental school/university relationship.¹¹ A paradox of public esteem is apparent in the American higher education community.^{12,13} On the one hand, American higher education receives international praise, but is routinely criticized in the nation.¹¹ Reconciling this public paradox is problematic. The Harris Poll has been tracking the confidence that American people have in the nation's leading institutions since 1966. The long-term trend has been a substantial decline in major institutions, including higher education and medicine.¹⁰ Although there has been an improvement in confidence in 1998, the relative level is still low. The perception is that the public believes that these institutions fail to serve the public need and the professionals who lead them may be placing career interests above public interests.¹² Graham, Lyman, and Trow argue that higher education needs to be more responsive to the public's needs.¹¹ The American public feels it has less control over higher education and that it is impotent to deal with that realm's bureaucracies and political structuring.¹¹ The public is also concerned about an apparent inadequate devotion to teaching, does not understand tenure, and is unable to understand why change is so difficult among a faculty who are supposed to be on the cutting edge of change.¹¹ The public is also unable to evaluate educational quality and is seriously concerned about admissions, tuition costs, and unavailability of financial aid.¹¹

Thus, there is an accountability dilemma in higher education, which takes on both internal and external dimensions. The university and dental school must understand, cope, and deal with both. Internally, it is necessary for the schools within the university setting to provide data to the parent university and its governing boards regarding their effectiveness, their “shared” goals, and their levels of performance, as well as the identification of necessary program improvements and how they will make those improvements.¹¹ In short, internally, the school must justify to the university how it is carrying out its mission. Externally, it is necessary

for schools and universities to demonstrate to society and their constituents that they are carrying out their mission, are using their resources appropriately and with integrity, and are meeting the expectations of the governing boards and the community who provide fiscal support and are the reservoir for students.¹¹ The legitimacy of leadership on behalf of the university and dental school is threatened by these growing accountabilities and the governing boards' response to them.

Leadership is one critical ingredient necessary to reconcile these issues. Leadership is fundamentally necessary for the dental school and university to gain the confidence of the community they serve, by actively working toward a shared vision aimed at the common good. This work requires leaders who are willing and able to engage societal issues in the context of the overall mission of the school and the university. Additionally, this work requires that the university understand both community needs and the capacity of the community to help address its own needs with the assistance of the university, its schools, and the community itself. Communities have been burned by the arrogant leadership of some universities in the past. To be effective, this leadership work must not try to impose its beliefs or will on the community, but must partner with the community to establish a shared set of goals, expectations, and implementation strategies.

An interesting case in point for dental education that could result in erosion of public confidence is that of oral cancer. Recent data have demonstrated that oral cancer, one of the worst cancers in terms of morbidity, mortality, and survival, is not routinely a part of the oral and craniofacial examination by the practicing medical and dental health community.^{3,14} This apparent failure raises questions about the legitimacy of the dental school's educational mission. At the same time, this continuing problem with oral cancer almost defines the necessity for the dental school, the university, the practicing community, and the consumer to address this issue as a common good.

A bonafide question that can be asked by the public is: where is the dental education and university leadership in trying to deal with oral cancer as a life or death issue? Has the leadership not been willing to challenge the public and embrace the consumer on this issue of oral cancer? Is it because resources are diverted to some other non-public good purpose? Examples from other forms of cancer may be instructive. For example, malignant melanoma and cervical cancer are two terrible cancers that have lower morbidity and prevalence than oral cancer. Yet the manner in which these cancers have gained national visibility are ster-

ling examples of how leadership in the academic community, the private sector, and the consumer have worked together to increase consumer and health professional awareness to prevent and treat these cancers.¹⁴ Interestingly, Oral Health America has moved oral cancer to the forefront of consumerism, through its National Spit Tobacco Program (NSTEP). The NSTEP program is a fine example of how partnerships between the private sector, foundations, organized sports, and the consumer can be an effective tool in promoting health. Are not all etiologies of oral cancer a common good that can be addressed in the same way? Does oral cancer require a shared goal of curricula reform and continued competency standards for the practitioner? Where and what is the common good here and does the dental school have anything to offer to such a shared goal? Where is the outrage and leadership over the fact that oral cancer continues to be a major death threat with no apparent solution in sight? What have dental education and the university done to galvanize consumer focus, as they have with the case of other forms of cancer? What type of leadership is necessary to deal with this seemingly intractable problem? While the continuing oral cancer dilemma illustrates ineffective leadership, other similar ineffective leadership examples exist that are related to oral health, including aging, the oral and systemic health connection, and funding for oral health care for the underserved.

In fact, a recent editorial in *The Nation's Health* by the President of the American Public Health Association stated that oral diseases continue to be one of the most prevalent and untreated diseases in the United States. The consequences of oral disease were further characterized in the editorial as extensive, leading the author to conclude that we are experiencing an "neglected epidemic."¹⁵

Conflicting missions could also lead to erosion of public confidence in both the university and the dental school. For example, if the mission of the university is defined as a research-intensive institution while the dental school is more concerned with its education role, how does one resolve the issue? Does the university fire the dental school dean? Or does the university encourage the dental school leadership to develop a shared vision with common good goals, in which all cohorts contribute in an equitable manner? Can the university and the dental school resolve the conflicts that occur between the university and dental school mission, the bottom line, and the public need? Can various components of the university contribute in ways that build on the comparative advantage of each? Indeed, what are

the necessary characteristics for the leaders of the next millennium to deal with these issues?

Requirements of Leaders for the Public Good

Considering the conflicting internal and external accountability expectations that currently exist, coupled with other conflicts within the academy, dental school/university leadership will be continuously challenged, perhaps even more intensively, in the next century. Thus, the next generation of leaders will need to have the skills to deal with the expectations and paradoxes that are already apparent and may accelerate in the future. Before embarking on this topic, some people may argue that defining skills of the next generation of leaders is not necessary because leaders do emerge; we do have university presidents, dental school deans, presidents of corporations, and community leaders, many of whom are effective by “rising to the occasion.” While that may be a somewhat accurate observation, it is also clear that the half-life of a university president, dental school dean, law school dean, and academic leader in general is considerably less now than it was a decade ago. The intense scrutiny, the constant tugging between constituent groups, the demands for fiscal and programmatic accountability, the external influences on the positions, the necessity to raise funds and begin the job after 7:00 p.m, the necessity to secure resources and support from state, federal, or university sources, the “town and gown” conflicts, and the constant threat of closure all require a rethinking of the necessity for understanding what it will take to lead these institutions into the next century.

Although this paper lists some characteristics of leaders for the next millennium, it is important to keep in mind the original postulate, that it will take three ingredients: a leader, a followership (working toward a shared goal for the common good to move and institution or school forward in such manner to captivate, excite, and gain support from its constituents), and society. Thus, the first requirement of an effective leader is someone who cares and has passion and compassion about the common good. Without those characteristics of caring, passion, and compassion and the will to engage in a shared vision, all else will ultimately fail. It is necessary for the leader to be a risk-taker and have the ability to move multiple constituencies and to be prudent, thoughtful, but willing to push the envelope. The ability to communicate a shared vision is fundamental

to establishing an agenda for the common good. It is also necessary that future leadership be willing to challenge the university, the governing board, the profession, the private sector, and the consumer in a constructive manner. Also, it is vital that future leadership be comprised of independent, critical thinkers who have creative, innovative ideas, are politically savvy, and can provide the strategic vision, based on the common good, to create coalitions, partnerships, and collaborations and thus attract human capital and fiscal resources to realize the shared vision. Finally, the new leadership must be ready to engage the consumer in an advocacy role, and must be willing to stand up to intense, sometimes unfair and invasive public scrutiny.

The requirements or characteristics of leaders for the common good can be seen in Table 1. Although many of these characteristics are the same as those necessary for effective leadership in other eras, the increasing complexity of today’s society has created new challenges for today’s leaders. The increased demands for accountability and technological revolution that have accelerated the growth of a global society and accentuated the visibility of the public’s needs require that current leaders possess a broader and more sharply honed set of skills than in the past. The apparent introversion of some members of the academy demands a broader mix of leadership skills to overcome the insularity and reach out to the community.

This is not the time to select a person for the leadership position in either a university or dental school because he or she is the one to whom no one involved in the search process strongly objects.¹⁶ As Fisher aptly points out, to do so is a sad commentary about the manner in which people are selected to lead our institu-

Table 1. Requirements of Leaders for the Public Good

Caring
Passion
Compassion
Resolve
Risk-Taking
Ability to Move Multiple Constituencies
Thoughtful
Visionary
Communicator
Willingness to Change
Creativity
Innovation
Politically Savvy
Ability to Create Coalitions and Partnerships
Ability to Attract Resources
Consumer Advocate

tions and reflects, in some ways, the reduced legitimacy of the leadership who are held responsible but not empowered.⁸ Fisher also states that “it is now well established that presidential leadership is the main imperative for the revitalization of higher education.”⁸ This is also true for dental education. The nation’s dental schools and the citizens served by them cannot afford a compromised and compromise candidate. Why is all this necessary? The leadership for the dental school and the university must be synchronous, because the problems that must be addressed are multi-dimensional and complex and require shared goals, partnerships, and resolve, such as:

- poor image of the dental school and the profession in dealing with oral health issues in a non-parochial manner
- change that is much too slow and a faculty much too defensive of their own “turf”
- public advocacy for access and reimbursement issues
- reconciling university, bottom line, dental school, and public needs
- necessity to take dental education into community-based settings
- creating resources to reduce the cost of education and resultant indebtedness level of the graduate
- expanding diversity
- recruiting and retraining faculty for the next century
- breaking down the artificial separation of medicine and dentistry
- contributing to societal expectations in a more meaningful manner

The problems confronting the American higher education and dental education system demand a new set of expertise requiring integrated, cross-disciplinary, and cross-cultural approaches. Mandel eloquently articulated the necessity for dental schools and their universities to respond to their roles and responsibilities in the communities that surround them.¹⁷ Indeed, if the future of the nation depends on education and on a healthy public, dental education, the university, and the consumer must work together toward this common good as a paradigm for social justice and responsibility.¹⁷ It is necessary for leadership and creativity in dental education and the university to flourish in a partnership aimed at doing great things together with the community.

Of course, all of this will take not only leadership, but also a faculty capable of participating in and supporting shared goals for the common good. Herein

lies another problem specific to dental education and the university: there is a tremendous dearth of qualified faculty to staff the nation’s dental schools. For a number of reasons, with salary discrepancies being a particularly obvious one, it is becoming terribly difficult to recruit graduate dentists to join the faculty. The American Association of Dental Schools estimates that there are currently four hundred unfilled positions in dental education. This is a critical matter that requires serious partnerships with the university and the community for reconciliation. For example, some dental schools are reluctant to establish community-based clinical education programs and faculty practices, which could reduce the economic discrepancy between dental education and private practice, for fear of “town and gown” repercussions. This is where shared vision for the common good is necessary. How else can the university and the dental school best carry out their social mission? Is the university willing to address this fundamental faculty need with the community of practitioners? Or will the university give only passive support to community-based education and practice? The area of faculty recruitment also requires a partnership between the dental school and the university. For example, the dental school needs to be creative in recruiting faculty with other departments and schools throughout the university or academic health center, but this recruitment cannot be accomplished unilaterally. The university must be willing to step up to the plate and support these dental school recruitment initiatives actively with philosophical and fiscal support. Faculty recruitment, only one of many complex issues, but one critical to the future of dental education and its place in the university, will flourish or fail based on the willingness of leadership to lead by placing the common good at the fore.

Frankly, when observing the dilemmas and problematic areas regarding recruitment of the next generation of faculty and the necessity to retrain the faculty of today to meet tomorrow’s needs, the task becomes daunting indeed. It does not appear that dental education has great bench strength, especially in terms of identifying the leaders for the next century. For reasons related to salary, work conditions, job security, and conflicting expectations on the part of administration and faculty regarding teaching and research, faculty role models are diminishing, and the opportunity to work directly with mentors, in a proactive sense, is extraordinarily limited in dental education. There is a lot at stake regarding social expectations and the role of the dental school in the university setting. Leadership for the common good is at the crux

of resolving these problematic issues and the development of future leaders is as necessary as is leadership itself.

Reclaiming Leadership and the Public Trust and Confidence

Bok in 1992 noted that presidents and deans are held accountable for improving the prestige of their institutions and the prestige largely derives from the research reputation of the faculty.⁵ The net result is relative inattention to the education of students at the undergraduate level and the relative lack of effort on the part of the schools and the university to examine the effectiveness of their educational programs.⁵ Moving courses around like a game of checkers does little to solve the curriculum dilemma, and the constant competition for the brightest students has resulted in universities embracing poorly designed, ineffective methods for ranking the quality of their institutions. Indeed, even though it is widely acknowledged that rankings, such as those that appear in national newsmagazines, are based on flawed premises, some allege that universities are manipulating admissions and enrollment data to look favorable in those rankings. This exemplifies how the consumer gets mixed signals from the education community with resultant erosion of public confidence. Dental schools, to their credit, have singularly refused to be engaged in this nonsense and have been willing to stand up and be heard on the folly of dental school rankings. Where is the university leadership in dealing honestly with this issue? It may be perceived, by some, that failure to participate in the national ranking frenzy takes dental education further from the mainstream of university life. Uninformed university leaders may also believe that dental schools are not ranked because they are not academically or scientifically important enough. In truth, publicity by itself is not always valuable to the university, and the dental schools, by their action, confirm this position. Thus, this situation could present a great opportunity for dental school leadership to educate the uninformed, to reach out to the public, and to demonstrate the resolve necessary to effect change. In short, it is a wonderful leadership opportunity.

In order to reclaim leadership and public confidence, dental schools and the university must establish new ways to serve the public. In fact, universities and dental schools do not embrace, routinely, shared goals around which partnerships and alliances with the private and public sectors can be formed. Two of the pos-

sibilities offered by Bok regarding shared goals for the university and community, applicable to dental education, include:

1. **improvement of public schools**, which is critical to the economy, to democracy, and to reducing crime, poverty, and thus to the nation. Although there are examples of some universities and health professions that are engaged in this issue, by and large few universities and even fewer dental schools have participated in the great debates to improve the nation's public schools. Isn't this a common good in which the university, dental school, and society can share and which can lead to doing great things together?
2. **improvement of the health care system**, which is a critical national issue. Access, cost, and quality of health care are very much on the public's mind. But where are the universities and the dental schools on these issues? Indeed, there was a deafening silence regarding the dental schools and the universities in the health care debate that raged in President Clinton's first term. Importantly, the American Association of Dental Schools (AADS) did manage a leadership effort in the health care reform debate, but it was not universally endorsed or advocated by the nation's dental schools. In fact, dental schools and academic health centers may be perceived to be part of the problem, rather than the solution. Isn't this a common goal in which we could all share?

Perhaps dental schools would benefit by an understanding that, as part of the higher education community, they have an obligation not to plod or tinker, but to create thinking leaders and leading thinkers.¹⁸ Dental schools and universities have a responsibility to bring together scholars, students, and the community and to nurture a laboratory of inquiry. Gee recently suggested that a university and, by implication, a dental school can lead only when it understands that its role in society is to create a place for leadership, consistent with its mission of education and scholarship.¹⁸ The university needs to be a safe place where trial and error of new ideas and concepts can be nurtured for faculty, students, and the benefit of society. In this regard, in order to be accepted as a societal leader and to be perceived as contributing to the common good, dental schools and universities must speak out on issues that go beyond the walls of the university. The dental school itself and the university in which it resides can and should establish education and research programs that are beacons of social responsibility.¹⁷ There are some that believe that the nation has lost its public intellectuals and that universities must demonstrate they are

important to the intellectual, cultural, and economic life of this nation to regain the public trust.¹⁸ Clearly, this must also be the case for dental schools, who need leadership to look outward and crumble the walls some of them have built around themselves based on perceived past successes.

The greatest challenge the dental schools and universities face is to convince the consumer, a.k.a. the public, that the academy is willing, has the capacity, and is able to facilitate reforms aimed at engaging societal, common good agendas. Leadership is vital here! The question remains: are dental school administrators, faculty, and students able and willing to engage these societal issues and is the university willing to share in this rich public agenda? What is at stake if things remain the same or even improve somewhat? Are the consequences of inaction acceptable?

The Stakes

The higher education system in this nation is arguably the finest in the world and is the envy of a great part of the world as well. Notwithstanding the comments in this paper, U.S. dental education is also probably the best in the world, resulting in a skillful practitioner and the reduction of the levels of oral disease among many segments of the population. However, there is much to be done. In spite of these wonderful accomplishments, six dental schools have closed in the past two decades, one is in the process of closing, and others are threatened. The real question remains as to why these closings occurred. Is it because they did not meet a societal need and thus costs of education and numbers of applications became an easy excuse for their closure? An interesting counterpoint is the recent emergence of two new dental schools designed to meet specific societal needs. Is there a broad lesson for the dental and university community here? At the same time as these closings have occurred, significant segments of the public continue to lack reasonable access to oral health care. If nothing is done, this problem is likely to increase significantly, since the dentist/population ratio is declining rapidly, with the dental schools producing about 4,000 graduates per year. At the same time, the emergence of health conscious elderly consumers who still have their teeth will put more pressure on oral health care access and utilization issues. Additionally, although dental practices seem efficient, the dental supply capacity has decreased.^{19,20} For example, in addition

to fewer dentists, dentists are reportedly working fewer days per week, and women dentists are not working to capacity.^{19,20}

It would appear that the challenges to higher education and dental education will continue and may even escalate in the future as more and more pressure is placed on accountability, the bottom line, educational reform, research productivity, efficiency of operations, and consumer demands. This seems to be a critical juncture, when the leadership of dental schools and their parent universities can continue on their merry way. If this is the case, more schools will close and society will be even more poorly served in terms of access, cost, and quality of oral health care. On the other hand, if the dental schools and the university are willing to engage in a richer public agenda, which is aimed at addressing core societal needs, the dental schools and the universities will continue to be indispensable to each other and to the communities they serve.

What are some of the “common good” goals that universities, dental schools, and the community can rally around and that can result in a new type of leadership and partnering for the next century? These may include

- engaging the community in expanding the community capacity for enhancing its wellness
- expanding community-based education and clinical care
- improvement of public schools
- improving science education and functional literacy in the population
- taking dental education into the community, beyond the boundaries of the dental school
- engaging in health care reform debate, including appropriate reimbursement models
- partnering with community leaders, the private sector, and state and city government to attack socioeconomic-psychological-environmental determinants of health and assist in empowering the community to self-actualization
- conducting education and research programs that model social responsibility

While considering these common goals, the dental school can take some degree of comfort in the contributions it already makes to the university, including:

- education of citizens in a discrete field of study, dental medicine
- providing a community of scholars
- engaging in research collaborations

- providing community services, through continuing education, consultation, and patient specialty referral and clinical care
- engaging in community, private sector, and professional coalitions
- identifying oral risk factors for systemic disease
- providing for the oral health needs of large segments of the community where the dental school resides
- engaging in integrative learning
- engaging in strategic planning
- leveraging of resources to contribute to the local economy
- repository of bright, inquisitive students
- alumni/ae base of support
- providing a forum for technological innovation and technology transfer
- providing community and professional continuing education

Leadership that has failed to excite followers around the common good must be considered as one reason why dental schools are sometimes considered drains on the budget, rather than vigorous, vibrant components of the higher education enterprise. There is no doubt that dental education has come a long way, but for it to flourish in the future it must continuously be woven into the fabric, philosophy, culture, and nature of the university, and, in turn, it must embrace societal values and needs.²¹

The primary way for this to happen is through leadership for the common good! Clearly, dental education and the higher education community must use each other's talents and resources to address crucial societal dilemmas. The extent to which dental education and the university can connect their education, research, and service missions to each other and to a richer societal agenda will define their future. At stake are the viability of dental education and the revitalization of public confidence in higher education as a primary vehicle for positive societal change. For the sake of the public, it is critical that the leadership of dental education and the university convince the policy makers that a higher value must be placed on oral health. Leadership and followership rallying around goals for the common good are the keys to the future and will determine the possibilities and paths for dental schools and their parent universities to expand their ability to do great things together. At this critical juncture in our evolution, dental education and the universities would do well to keep in mind the lesson of Dante: there is a special place in hell reserved for the morally indifferent and the safely neutral.²²

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References

1. Genco RJ, Gulrich I, Harazthy V, Zambon J, DeNardin E. Overview of risk factors for periodontal disease and implications for diabetes and cardiovascular disease. *Compend Cont Educ Dent* 1998;19(1):40-5.
2. Offenbacher S, Beck JD. Periodontitis: a potential risk for spontaneous preterm birth. *Compend Cont Educ Dent* 1998;19(1):32-9.
3. Horowitz AM, Nourjah PA. Factors associated with having oral cancer examinations among U.S. adults 40 years of age or older. *J Pub Health Dent* 1996;56(6):331-5.
4. Jones RB. Savage inequities: can public/private partnership impact oral health access in the United States? *J Pub Health Dent* 1998;58(1):2-6.
5. Bok D. Reclaiming the public trust. *Change*, July/August 1992.
6. Wills G. *Certain trumpets: the call of leaders*. New York: Simon & Schuster, 1994.
7. Lucas AF. *Strengthening departmental leadership*. San Francisco: Jossey-Bass, 1994.
8. Fisher JC. *The board and the president*. New York: Ace-Macmillan, 1991.
9. Bensinon EM, Neumann A. *Redesigning collegiate leadership*. Baltimore: Johns Hopkins University Press, 1993.
10. Louis Harris and Associates. *The Harris Poll #8*, February 11, 1998.
11. Graham PA, Lyman RW, Trow M. *Accountability of colleges and universities: an essay*. New York: Columbia University, 1995.
12. Bok D. A matter of accountability. *Bulletin of the American Academy of Arts and Sciences*, January 1995.
13. Yankelovich D. *Restoring the public trust*, 1995. Available online: http://mojones.com/mother_jones/ND98/yankle.html.
14. Meskin L. Do it or lose it. *J Amer Dental Assoc* 1997;128:1058.
15. Gotsch AR. The Neglected Epidemic. *The Nation's Health*, 1999, September 2.
16. Kerr C. *Presidents can make a difference*. New York: Carnegie Corporation, 1984.
17. Mandel IB. Oral health research and social justice: the role and responsibility of the university and dental school. *J Pub Health Dent* 1997;57(3):133-5.
18. Gee GE. Gee's view. *Connection* 1998;13(2):32.
19. Brown LJ, Lazer V. Dentists and their practices. *J Amer Dent Assoc* 1998;129(12):1692.
20. Brown LJ, Lazer V. Dental workforce and educational pipeline. *J Amer Dent Assoc* 1992;129(12):1700.
21. Institute of Medicine. *Dental education at the crossroads*. Washington, DC: National Academy Press, 1995.
22. Dobell ES. Easy days are over. *Connection* 1998;13(2):34.