

Afterword

From the Honored Past to the Anxious Future

Messages from the 75th Anniversary Summit

Lisa A. Tedesco, Ph.D.

Dr. Tedesco is Vice President and Secretary of the University and Professor of Dentistry at The University of Michigan. Direct correspondence and reprint requests to her at The University of Michigan, 503 Thompson Street, Ann Arbor, MI 48109-1340; ltedesco@umich.edu.

President James B. Angell was introduced and made congratulatory and greeting remarks, thanking the Association for its action and influence in securing the establishment [in 1875] of the [Department of Dentistry] of [The University of Michigan]. He spoke very encouragingly of the school and prophesied for it a very useful career. His remarks were received with warm approbation.

—from the Transactions of the Michigan Dental Association, 22nd Annual Meeting, October 10, 1877

The law of evolution operates both ways—it lops off the useless, and survives the fittest—so I have no fears as to the final result. Now, if some of us whose heads are white stick to the things of the past and belong to the carboniferous period, perhaps we may be useful in our profession, as the coal fields are today to this great moving world—to burn up—but while we are doing that, the more scientific and learned may have the light and warmth of our enthusiasm that has kept the profession alive in its days of obscurity and weakness.

—J.A. Robinson, in the Transactions of the Michigan Dental Association, 22nd Annual Meeting, October 10, 1877

A lady came into the office one day and stated that she made up her mind to go east, in accordance with the recommendation of her physician, and that she was going to have her teeth treated, or fixed up, as she said, before she

went. She was in ill health, and her physician had recommended her to spend the summer at the seashore. Before she left the office finally we extracted nine teeth, the roots of which were too far gone to be saved. My preceptor inquired what medicine she was taking. She said her physician had told her it was not necessary for her to take anything excepting a blue pill. He told her he thought she had better abandon that. It proved that the whole difficulty came from the teeth, and in two weeks from the time of the removal of those teeth she was able to do a great deal of work . . . abandoned her trip, and in less than a month reported that she was as well as she ever had been.

H. Benedict, “Discussion on the Relation of Dentistry to Medicine,” in the Transactions of the Michigan Dental Society, 27th Annual Session, March 30, 1882

President Angell’s remarks were delivered at a dental society meeting, two years after The University of Michigan Regents approved the establishment of a Department of Dentistry and the state legislature approved the designation of funds for its support.¹ Words like these from a university president in 1877 no doubt engendered confidence, pride, and a sense of usefulness for the department’s place in the university.

Dr. Robinson’s words were delivered at the same meeting during a discussion session on matters related to curriculum emphasis and its impact on the profes-

sion.² The emotion and intensity of these words are much more captivating than either the subject of the debate or the side of the issues that Dr. Robinson represented.

The remarks of Dr. Benedict⁴ place our contemporary conversations on the opportunities for cooperation between medicine and dentistry as re-statements of the increasingly present theme, albeit a theme with a century and a quarter of scientific discovery in its wake.

Many others in many other states no doubt spoke the views represented by these individuals, during this period of history when dentistry as an academic and professional course of study established its roots at the university. Then and now, a profession's enthusiasm, alone, for any discipline cannot sustain its place in the academy. Almost 125 years later, at the Summit we find ourselves in similar conversations on usefulness and value, and obscurity and weakness. What are the core messages from this Summit about assuring our usefulness and value, and preventing obscurity and weakness?

Centrality of Mission

From the lessons of closed schools and challenged programs, to the tensions and choices of vital and thriving schools, there is a strong, clear, perhaps even singular message about mission that is repeatedly provided for all to hear. This message is about the centrality of mission. While the general mission of the university will not stray far from research, teaching, and service, specific emphases and identifiable initiatives will vary over time. Understanding the values and philosophy that more broadly define campus initiatives and the timeline they are placed on can provide an awareness of place and opportunity for academic dentistry.

Our dental schools and colleges find themselves in comprehensive universities, each with articulated goals for teaching, research, and service. Many of our schools and colleges are part of academic health centers, as well. For some institutions, the resources are not identifiable or attainable to revitalize, infuse, or extend research productivity. For the schools who do not find themselves in the top fifteen institutions for research productivity, other avenues to “centrality of mission” must be found.

Through design, this other avenue is also a core mission of health professions schools—clinical care and serving the health needs of the public. The mission of

the research university and the academic health center is extended and enhanced, fundamentally, by clinical outreach, clinical care, and all related services that can be provided to the public through the dental school. There are growing numbers of persons in the population who are patients of no one, yet in need of care. By region and by state, there are creative ways waiting to be identified to acquire funding for care needed by the unserved and underserved people in our society. Some states and regions have identified and designed such programs for clinical outreach and reimbursement and these models should be explored widely and urgently.

Contributions of Service

Service within the context of mission should not be underestimated for opportunities to contribute to the university. There are a number of higher education issues to which academic dentistry can contribute. For example, from the challenges and experiences we have faced to improve and sustain our programs, we can contribute to identifying and resolving cross-cutting future faculty issues in higher education and health professions education. We have had to address issues of appointment flexibility in professional employment agreements. We have already begun to explore alternative tenure practices and tenure and nontenure tracks, while assuring appropriate compensation and recognition standards that provide pathways for promotion across tracks.

Over the last several years, universities have recognized the growing importance of their value to the community, state, or region. Whether public or private, our comprehensive research universities are no longer relating to the community, state, or region as a silent, or distant, partner. Service through clinical care beyond the confines of the dental school can be a very visible and valuable contribution. Service relationships can be arranged to address the needs of people who would not otherwise have care as described above. Service relationships can be designed to reduce the cost of clinical educational arrangements within the dental school. And, to add to the potential positives of this type of educational outreach, state healthcare funding may be available or may already exist in communities without adequate numbers of care providers so that the school is reimbursed for the care provided at an appropriate level. There are a small number of schools engaged already in community practice-based education, with approaches that benefit the public, the dental school, and

the university. While this model for clinical education requires a philosophical shift among faculty, staff, and students, its value and need are high, and its feasibility is established.⁵⁻⁷

The fourth report of the Pew Health Professions Commission, published in 1998, emphasized the importance of similar movement for medical education.⁸ Whether the model is applied to dental education or medical education, however, three basic elements are essential to the creation of community-based clinical education. These elements are: identifying the unserved and underserved communities and their clinical care needs; advocating and arranging for compensation for care through state-based funding; and moving the sites and preparing the instructional systems for clinical education outside the school clinic and hospital walls. Efforts like these represent service that fundamentally contributes to the public good. Contributions to the public good, like those found in community-based clinical education, are inarguably valuable for all partners, university, dental school, and community.

While there are examples possible from each of our schools, one example from Michigan on academic values further underscores how mission, service, and the initiatives of university leadership can align. Provost Nancy E. Cantor conceptualizes the connection of the university to the larger community through the notion of permeable boundaries.⁹ She observes that our universities are “grand societal experiments” where we engage in activities that benefit society that might not otherwise be accomplished. In order to engage these activities and experiments of program and service, the boundaries between university and community must become permeable, while respected. Taken together, the challenge is ours in academic dentistry to accept the invitation to engage, indeed to permit, permeability.

Dentistry and Medicine’s Collaborations: Evidence and Experience

Discipline boundaries have served the discovery and communication of new knowledge in clear and important ways for a very long time. The future of science and the future of clinical practice across a number of professions call for a new interdisciplinarity, however, if we are to continue apace with progress. Work within the traditional disciplines has become limited by discipline-bound approaches and methods. Ad-

vances from breakthroughs and creative understandings are found at the edge of the discipline, at its intersection with related fields of study. Cross-discipline study represents new collaborations in unimagined relationships until this time.

Since the publication of the IOM report, there has been renewed discussion about directed and meaningful collaboration with medicine. During this same period of time, new findings have emerged that once again demonstrate the connections between oral health and disease and other systemic conditions. A conscious reorientation of language has occurred in all our conversations, or so it seems. New research relationships for oral and craniofacial science have been well described at this conference.¹⁰⁻¹² Researchers are engaged in conversation across core knowledge areas represented by molecular biology, biomedical engineering, epidemiology, and behavioral sciences.

Yet, are we beyond intoning that the “mouth is a part of the rest of the body”? Are we ready to act on evidence and experience and create in our students and in our clinics the dentistry-medicine connections that will better serve our patients? Are we ready to go a further step forward and include the social, psychological, and economic aspects of care in clinical education and patient care?

In all of these conversations, there is a thematic line that creates a strong voice for a new view of oral medicine. It is a view that does not discount the surgical and restorative treatments, but rather extends the place and value for dentistry in general.

In terms of direction, it is difficult to improve on the language suggested in the recommendation for dentistry from the fourth Pew report⁸—to “promote and develop opportunities for cooperation between dentistry and medicine that will integrate oral medicine into comprehensive patient management.” Suggestions offered for providing these opportunities include integrated training for dental and medical students and clerkships for dental students in areas of medicine related to oral health, such as pediatrics, geriatrics, and emergency medicine. Another important, visible, and valuable contribution recommended by the Pew group is to provide training in oral health for physicians who are preparing to be generalists, with a part of this training targeted at teaching physicians how to work with dentists effectively.

Educational Completeness from Diversity

Over the last several years, higher education has learned a great deal about the value and importance of diversity. Most of our discussion has focused on preparing students to work with diverse patient groups and the development of cultural competence among the students, faculty, and staff in our schools. But a fuller appreciation for the compelling need for diversity, whether in higher education or in our professional schools, comes when we understand the impact of a diverse student body.¹³ Data show that students educated in diverse environments are more active citizens, participate more in democracy, and are more likely to interact with persons of different races and cultures after their schooling has ended. Thus, an education becomes fundamentally different and enriched when it is experienced with persons of different races, ethnicities, and capabilities.¹³⁻¹⁵ As one university president has observed, there is no substitute for the day-to-day interactions that occur as part of the learning environment for understanding how persons who differ along the critical dimensions of race and ethnicity experience the world, think about problems, and explore solutions.¹⁶

A recent compelling study¹⁷ briefly reviewed the differential treatment received by racial and ethnic minorities in the United States when compared to whites and provided new evidence on how gender, race, and ethnicity of patients and physicians are related to physicians' style of participation during clinical care. When physician and patient's race or ethnicity was the same, patients reported having more interaction/participation with the physician. This study emphasizes the importance of understanding all the conditions that create barriers between patients and health care providers. Such barriers can have a cascading effect, and secondary barriers are placed in action—for example, miscommunication, noncompliance with a regimen, and missed appointments.

In sum, experiencing diversity in the classroom and the clinics and including cultural competence in the curriculum are critical elements to a full and complete education. Anything less is short-changing students, patients, and society.

A Final Comment on Engagement: It's Beyond the Front Porch

During one conversation at this conference a view of the dental school as a “front porch to the university,” a portal for public contact with great potential for public service, was suggested. This image for academic dentistry, while vivid, evokes a passive role rather than an active engagement that pushes the school itself out toward the contiguous and distant communities it endeavors to serve. Academic dentistry's future will require great engagement with all the issues discussed at this Summit. Academic dentistry's future will require jumping off the porch, searching for partners, and creating the conditions that will secure relationships that benefit partnerships, whether the partnerships are for research, patient care, or education.

Acknowledgment

Appreciation is expressed to Patricia F. Anderson, senior associate librarian, University of Michigan School of Dentistry for her extraordinary research skills and the generous gift of time she gave to locating the historical texts consulted during the preparation of this paper.

References

1. Transactions of the Michigan Dental Association, 22nd Annual Meeting, October 10, 1877:9. University of Michigan, School of Dentistry Library
2. Robinson JA. Transactions of the Michigan Dental Association, 22nd Annual Meeting, October 10, 1877:64. University of Michigan, School of Dentistry Library
3. Holmes ES. Discussion on dental education. Transactions of the Michigan Dental Association, 22nd Annual Meeting, October 10, 1877:64. University of Michigan, School of Dentistry Library
4. Benedict H. Discussion on the relation of dentistry to medicine. Transactions of the Michigan Dental Association, 27th Annual Meeting, March 30, 1882:87. University of Michigan, School of Dentistry Library
5. Kotowicz WE, Tedesco LA, Jacobson JJ, Burgett F, Bagramian R. Advancing community practice based education: curriculum aspects and issues. The Macy Project, unpublished manuscript, University of Michigan, School of Dentistry, Nov. 1998.
6. Jacobson JJ, Kotowicz WE. Macy Report on Community-Based Dental Education. University of Michigan School of Dentistry's Community Practice 857. Unpublished manuscript, Nov. 1998

7. Formicola AJ, McIntosh J, Marshall S, Albert D, Mitchell-Lewis D, Zalos GP, Garfield R. Population-based primary care and dental education: a new role for dental schools. *J Dent Educ* 1999;63:331-8.
8. O'Neil EH and the Pew Health Professions Commission. Re-creating health professional practice for a new century, the fourth report of the Pew Health Professions Commission. San Francisco, CA: Pew Health Professions Commission, December 1998.
9. Cantor NE. The university and American values. Address to the University Community, Rackham Series on American Values. University of Michigan, unpublished manuscript, Sept. 1998.
10. Slavkin H. Dental and craniofacial science and education in 2020; in this volume.
11. Genco RJ. Building partnerships and interdisciplinary collaborations in oral health research; in this volume.
12. The oral-systemic connection: spectrum series. National Institute for Dental Research, National Institutes of Health, Bethesda, MD, September 1997.
13. The compelling need for diversity in higher education. Office of the Vice President and General Counsel, University of Michigan, January 1999.
14. Chambers DL, Lempert RO, Adams TK. Doing well and doing good. *Law Quadrangle Notes*, University of Michigan Law School, Summer 1999:61-71.
15. Bowen WG, Bok D. *The shape of the river*. Princeton: Princeton University Press, 1998.
16. The myths about affirmative action, a conversation with Lee Bollinger. *Detroit Free Press*, August 2, 1999.
17. Cooper-Patrick L, Gallo JJ, Gonzales JJ, Vu HT, Powe NR, Nelson C, Ford DE. Race, gender, and partnership in the patient-physician relationship. *JAMA* 1999;282(6):583-9.