Opening Remarks

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How is it that all of us have come together in Washington, D.C., for these couple of days? Well, like all conferences, the story of the evolution of this leadership summit is long and complicated, but it can be told in relatively simple terms. This, as you know, is the 75th anniversary of the American Association of Dental Schools, and in preparation for our celebration of this historic event, we wanted to have an opportunity to review our progress as dental educators and to look forward to what we might face ahead. All the dental schools in the United States are affiliated in some way with a parent university, and this linkage has been the source of so much of our success as a profession and yet the linkage also provides a key set of challenges as we face the future. It was a bold step with an uncertain future when our then-president Mike Reed, dean of the University of Missouri-Kansas City School of Dentistry, first floated the idea of a summit conference with the anniversary committee. But Mike persevered, and here we are today. It is almost difficult to believe that we've assembled forty-six dental school deans from a total of fifty-five U.S. schools and forty-one university administrators. But we've done it, and we're very pleased and honored that you're here to partake in this unique event.

In conversations last night with many of you who are university administrators it became clear to me that not only is this type of meeting bringing together deans and senior administrators unique to dentistry; it seems that we're among the first to do this with any of the professional schools. So we are doubly grateful that you're here.

Before I became executive director in early 1997, I had spent twenty years as a full-time academician, serving in both a private institution, the Harvard School of Dental Medicine, and a public one, the University of Connecticut. The relationship between the dental school and its parent institution was one that had intrigued me, and I was able to carry this interest with me to my new position. Shortly after I started here last year, I met with Stan Ikenberry, president of the American Council on Education (ACE), to discuss this issue and how we as an association of dental schools could become more closely involved with other higher education associations in the Washington, D.C., area. Much resulted from that first discussion, including the election of AADS into the Washington Higher Education Secretariat. But I'd like to relate to you how that first meeting with Stan Ikenberry went.

As many of you know, Stan was president of the University of Illinois-Chicago before he became president of ACE. Since one of our dental schools is at the University of Illinois-Chicago, I asked Stan how he had interacted with the dental school when he was president there. He told me that, as president of a large university with multiple campuses, there was a triage system in the president's office to deal with issues that might come up to his level of involvement and so he didn't really have a lot to do with the dental school. But as he was reminiscing, he remembered that he had visited the dental school shortly after he became president and became convinced that it was time to do some things about the physical plant, so he got involved with the capital campaign to change the physical plant. And then he said, well, of course, budget issues always rise up to the level of the president, so I was involved with the dental school budget and where funds were being allocated. And, of course, the dental school alumni were an important component of the alumni association in general, and he had a lot to do with the alumni association. And of course there was a leadership transition and he had to select a new dean, so he got very much involved with the dental school in that regard. So I asked him what involvement he had with the *other* units of the university, and he went through physical plant, budget, alumni, leadership, and transition of deans. It drove home to both of us how much the dental school, like other units, is an integral part of the university.

To begin this day with some common background for our discussions, I'd like to briefly look at a timeline

of the last thirty years or so to relate some key developments that have had significant impact on our enterprise. The first slide shows United States dental schools number by type from 1950 to 1997. The blue represents public, the yellow private, and the red private but state-related. With this slide, we can see the growth that occurred in health professions education with funding from the federal government in terms of construction as well as capitation grants.

But there are a couple of things to remember about this period. First of all, we certainly benefited as did medical schools and other health professional schools from the growth of federal funding, but then we suffered in a more demonstrable way when that funding was cut off. Another thing to remember in here is that this period saw a dramatic change in disease patterns. Very often when you talk to people in universities as well as the public, they think that we're still dealing only with dental caries, also called cavities, along with the sequelae of that and periodontal disease. But in the early 1980s, 40 percent of the American population over sixty-five was edentulous; that has changed dramatically. Fluoridation and other factors have given us a very dramatic change in what we are now able to do. Instead of "drilling, filling, and billing" as it used to be, we're now able to move far beyond that with new technologies that are available. This development has significantly changed the opportunities we have to provide care to the public.

One of the other things is that we were worried about oral manifestations of a variety of systemic diseases. Now there's a body of literature growing over the past few years which suggests there is a direct relationship between periodontal disease and other oral conditions and systemic health itself—potentially as a very dramatic factor in certain conditions. One of the other things that happened is the effect of the loss of some of the funding through cross-subsidization in the academic health center; that has been another dramatic factor.

From the second slide, "U.S. Dental Schools: Trends of Applicants and First-Year Enrollments from 1950 to 1996," we can see the dramatic rise in the number of applicants in the mid-'70s. This cohort is not only a result of the baby boomers, but also the Vietnam War effect in that there were a number of people who came into dental schools after serving in the service. The average age of my entering class in 1973 was twenty-seven years of age—a little bit different than it is now. Enrollments rose as schools opened and class size was expanded, but subsequently not only did we close schools, but we also consolidated a lot of schools and reduced class size, so we basically turned back to the number we were putting out in the '60s. Part of this dip in applicants in the late '80s-early '90s was the effect of the recession and the perception within the dental profession that there wasn't a need for more dentists. Also there was the introduction of information technology as a profession and a lot of students were going into that instead of health professions. Subsequently, though, we have seen this significant rise in the number of applicants to dental schools. While the number of open slots remains about the same at 4,000, the number of applicants continues to rise. We expect about 8,500 this year.

One of the other factors important to note is that dentistry has become a much more desirable profession to college students as medicine has been enveloped by managed care. Three things are necessary to have managed care really impact significantly on your market: you need to have an excess of providers (medicine has that, and we in dentistry have not); you have to have a population covered by an insurance product (in medicine, although there is a large uninsured population, most Americans have access to some form of insurance, whereas less than half of the U.S. population has access to dental insurance and those who do usually have an annual cap of $1000 or $2000); and you have to have some waste within the system so that you can squeeze out some profits. Most of dentistry is practiced in small private practices where the dentist took home what was left over after the bills had been paid, so the waste had already been squeezed out. Although there are some niches like California and Florida where dentistry has been affected, in most of the United States dentistry has been relatively exempt from the effects of managed care.

One other thing that I also wanted the senior administrators to know is that about five years ago the dental deans decided that they would not participate in the *U.S.News & World Report* survey. So we have not been in that business that has been a de facto accreditation almost of universities and other professional schools. We have been relatively exempt from that.

Today should be an opportunity for all of us to share our ideas, our hopes and dreams, and our concerns as well. But as we begin these discussions I'd like to repeat an old adage that I often think about when I'm sure the entire weight of the world is on my shoulders. It goes something like this: "Do not feel totally, irrevocably responsible for everything. That is my job. Sincerely, God."