

From Departmental Mergers to School Closings: Lessons in Organizational Change in Dental Education

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Abstract: The available information on the closing of dental schools offers only a partial explanation for those decisions. As consultants to parts and pieces of closings and major restructuring efforts of dental schools, Triangle Associates had the unique opportunity to listen first hand to the dynamics that accompanied closing decisions. This article offers three lessons derived from a case analysis of the closing of six dental schools and significant organizational change in five other dental schools. They are: 1) perceptions of “cost-benefit ratio” of dental education; 2) barriers to developing alternatives; and 3) leadership roles of faculty, chairs, and deans. As reasons for closing go beyond the easily quantifiable financial conditions of the school, trustees and university administrators should ask “Why the dental school?” (or any other program) in comparison to other schools and programs. In that schools closed when budget overexpenditures were only 5 to 10 percent of the total budget, the “cost-benefit ratio” must have to do with the perceptions of the social benefit of dentistry.

Except for the differences in clothing and hair styles in the photographs, the news stories of Emory University dental students protesting the 1985 closing of their school and the 1998 photos of Northwestern University dental students after the announcement of the closure of their school appear amazingly similar. Some of the quotes, separated by a decade, appear both in support and in opposition to the closing but hauntingly echo each other:

- “changes in the mission”
- “contract to educate”
- “no warning”
- “cost to educate a dental student”
- “had few options”
- “uncertain about next steps”
- “national trends”

Following the Emory closing, dental leaders, both within and without dental academic dentistry, rallied to uncover the cause and treat appropriately. Among other outcomes, a \$3 million dental education grant from the Pew Charitable Trusts focused on ways to improve dental education, especially the leadership and management, and thereby prohibit another Emory. Optimism in dental education grew, not just because

of the national efforts to address the future, but also because numbers of applicants began to grow for all dental schools.

Even in the midst of growing enrollments through the 1990s, continued discussion about closing dental schools remained in the background. Privately funded schools in states with a competing publicly supported school worried most. Georgetown University and Fairleigh Dickinson University both closed. Loyola University announced the closing of its dental school claiming that a state the size of Illinois did not need four dental schools. Apparently, by 1998, the state did not need even three dental schools, at least not sufficiently to dissuade Northwestern University from evoking “a change in mission” and closing its dental school.

At first glance, and when dealing with those scientifically trained, there appear to be many “rationales” for the closing of those schools. In some ways, those in health professions education would like to have some assurance that the closing of any school has a clear progression of “diagnosis,” treatment planning, intervention, and then cure. (Or at least morbidity that seems to follow the initial diagnosis.) Failing that, dental education becomes a random roll of the dice when it comes to quality assurance.

Why Dental Schools?

The available information on the closing of three dental schools offers little comfort for those so scientifically inclined. At least, the information offers only a partial explanation. As consultants to parts or pieces of three of the dental school closings and a number of other significant organizational changes in other health professional schools and university programs, staff of Triangle Associates have had the opportunity to watch and listen first hand to the dynamics that accompanied those closings. While we did have abundant examples of thoughtfulness and leadership in the decisions to close, many of the explanations seemed, at best, to be half answers.

“Why dental schools?” we often asked, in hopes that answers to that question would help dental schools and university administrators do a better job of predicting closure.

At times, the rationale has focused on over-supply and dwindling enrollments. But why only dental schools? In the same fifteen-year period in which three dental schools closed, in part because of the “over supply of dentists,” “falling income for dentists,” and other environmental forces, not one college of veterinary medicine, including the small number of privately funded schools, closed when graduates faced similar dynamics of oversupply in small animal veterinary practice and declining incomes. In fact, the number of applicants for small animal programs increased. Nursing went through similar peaks and valleys in projections for practice needs and income during the same period and closed almost no schools, even when nursing has almost three times the number of four-year programs than does dentistry.

Changing needs and perceptions of society were other oft-cited reasons for the closings. Certainly the dental health needs of America have changed dramatically in the last twenty-five years. But why only dental schools? If changing societal needs and perceptions were a predictor in closing dental schools, why have enrollments and numbers of programs in legal education expanded? You would think that a profession that engenders so many jokes would be easy pickings for cost-conscious university administrators.

In all of the closings, the one common denominator has been the cost of educating dental students. Either implicitly or explicitly, the cost of running a dental school came up during discussions on closing. On average, the dental schools that closed had budgets of

around \$5 million and deficits of around \$400,000. Most had gone through attempts to reduce costs. While not all universities involved went so far as to say that cost was the only factor, none denied that it was a major consideration. But why only dental schools? Medical education costs were also rising in the late 1980s and early 1990s at the same time that medical reimbursements were falling. While all leaders of academic health centers were worried about the costs of maintaining the teaching hospitals, closure has not been attempted. Even where policy makers have forced closure of residency programs, it could only be done with compensation for lost income and services of residents. Most dental school clinics similarly rely on an underserved or low-income population for clinical education, and there have been few plans to replace the services of the clinics of the closed schools. The response to the Pew commission’s recommendations for closing 10 percent of the medical education programs has not led to one closing.

Asking the question of “why dental schools?” is not a lament over past decisions and an attempt to transfer questions of closure to other health professions or other professions in hopes of protecting dental schools. Instead, the question of “why dental schools?” rather than other schools offers some insight into the dynamics that accompany organizational change in health professions education.

Lessons in Organizational Change

This section offers four lessons derived from a case analysis of the closing of six dental schools and significant organizational change in five other dental schools. Much of what has been learned has application to other health professional schools and to higher education in general. In that Triangle Associates has also worked with other health professional schools, academic health centers, and universities, I have tried to identify what pieces of the lessons go beyond dental education. I have also tried to move beyond the easier answers of interpreting these cases as isolated and idiosyncratic examples. Most students of organizational behavior assume that when members of two different organizations talk with each other, read the same things, and attend the same meetings, they tend to subconsciously pattern similar organizational dynamics.

We also learned something about the myths concerning school closings and major organizational

change. We did not find strong evidence that legal issues related to tenure were strong dynamics in the closings. Neither were actions of the state legislature or reactions from alumni.

This section covers the following three lessons: 1) perceptions of “cost-benefit ratio” of dental education; 2) barriers to developing alternatives; and 3) leadership roles of faculty, chairs, and deans. These lessons appear in no intentional order and without any implied rating of frequency or impact. The quotes that appear, unless otherwise indicated, came from individuals involved in the closing of dental schools or other significant organizational changes affecting dental education. I have chosen to preserve the confidential nature of the consulting relationship by not attributing names or organizations.

Perceptions of “Cost-Benefit Ratio”

One of the most frequent appraisals of dental education by those involved in the closing of the dental schools and of university administrators in general has been the cost of dental education. Cost alone has never been the deciding measure. Even though all those involved in the closing of the dental schools used the single word “cost,” they actually meant either “cost-benefit ratio” or “cost-income ratio.” The first measure appears to have been more influential in most of the decisions to close programs, but the second ratio is also influential.

In the 1950s and 60s, this university, and other universities had the luxury to develop many different programs, support many disciplines, and create new professional schools. I guess we needed them then. We just don’t need them now. Given the financial pressures, we need to focus on those programs that provide the greatest benefit to society for the cost expended.

University vice president for administration.

In that “cost-benefit ratio” significantly influences decisions about organizational structure in all of higher education, it makes sense to find it influencing changes in dental education. All of higher education, except for a small—but growing—segment of for-profit organizations, has always been viewed as a mediating institution. Society is filled with mediating institutions: churches, synagogues, foundations, colleges, libraries, and the like. They are not, in the strict sense, government services, but neither are they organizations that

produce goods and services or wealth. Instead, they serve to support and facilitate the development of members of the society. America is big on mediating institutions, as witnessed by the number of voluntary organizations and societies. For mediating institutions, the “benefit” in cost-benefit ratios extends to social as well as personal benefit.

Health professions education, in general, and dental education, in particular, occupy a unique place in higher education. For many, the professional schools seem to have a more immediate tie to social well-being than do basic science or general liberal arts programs. Beginning with the Flexner report, health professions schools were viewed as so important to society that they were slowly moved, encouraged in part by tighter accrediting and licensure standards, from proprietary and free-standing training programs into universities.

Any review of literature on social policy on higher education or on the configuration of health professional schools demonstrates the social benefit of effective and well-run health professions schools. On the other hand, health professional schools both gained and lost in the move to a university setting. Proprietary and free-standing training schools for physicians, dentists, and nurses were highly efficient in the method of training, even if preparation for continued professional learning, teaching of only research-based methods with proven outcomes, and other attributes were underemphasized.

Not all health professions and not all aspects of any one health profession benefited equally from the modern university academic health center setting. Most dental educators have experienced that truth as they have struggled with the best educational setting for dental hygiene programs. Whatever the intended benefits of the post-Flexner movement toward improving health professions education, one unanticipated benefit was the public’s perception of the status of health professionals. The medical profession has enjoyed a significant increase in public perception, mostly built upon real advances in health technology based upon research, but also in more closely affiliating with a mediating institution such as higher education. (Science, mathematics, physics, and astronomy, in particular, enjoyed a similar increase in public perception in pre-Copernican times based upon its affiliation with organized religion, another mediating organization.)

Dentistry enjoyed similar gains in both quality of practice and public perceptions of practice through the early twentieth century. It did not, however, build the relationship with the public that medicine and nursing enjoyed. When asked what her late husband would

think about the closing, the widow of one of Emory University Dental Schools largest benefactors said she thought he would agree with the decision.

Let's face it, the general public sees the worth in a medical school. Our fund raising successes for the (teaching) hospital often involve patients or their families with significant medical problems. It's harder for dental schools to cultivate the depth of relationship when most of their clinical patients can not afford to make significant gifts and, even if they did, (they) would not see the importance of new dental research."

Medical school dean

Dentistry, in general, produces mixed signals about its place in society. On the one hand, it has always remained predominantly in the fee-for-service sector of health care financing. Most health plans do not cover dental benefits, except as an option or for special populations such as young children or the disabled. Strangely, more Americans will visit a dentist in a year than will visit most of the sub-specialties in medicine. Few, if any, dentists have appeared in heroic roles in the popular media, yet films are filled comic visits to the dentist.

It was not the reality of workforce issues or changes in health care that influenced the final decision. It was the court of public opinion. The image of nurses is almost mythical. Nursing touches lots of people in very personal ways. Their supporters came in every shape and size and in large numbers. And then someone raised the question of gender equity. We were talking about closing one of the few health professional schools that is predominantly female. We ultimately withdrew the proposal.

University provost

I have never had a medical doctor write me or call me and tell me that we have too many doctors and we should close down the medical school. Sure, they worry about the quality of admissions and want some limits there. On the other hand, I have had local dentists tell me there were too many dentists in the state and we should dramatically reduce the size of the entering class or even close the school.

University president

The concept of social benefit ties to the mission

of higher education. In at least two of the dental school closings, the university referred to "a change in mission" as instrumental in the decision. In both cases, the changes in mission were more implicit than explicit. We could find little evidence of the thought process that changed the mission, but lots of evidence that it had changed. More accurately put, as the thinking about mission had changed, it did not filter evenly throughout the university. Harvey Mintzberg's review of strategic planning cautions that the mission of an institution is strongly rooted in history. Changing that mission takes inordinate effort.

None of the decisions to close a dental school resulted from a popularity contest among the health professions. Every one of the dental schools closed had evidence of quality teaching and competent graduates. Their clinics treated, at no or reduced cost, a population that often had few alternatives for dental care. They had all attracted external support from both alumni and others. In short, they had demonstrated social benefit.

The costs, however, of dental education are significant. Comparisons between cost of education for the different health professions have always been difficult to compute, primarily because of the different methods of cross-subsidization. Suffice it to say, for the purposes of this discussion, that the cost is high and the opportunities for significant clinical revenues remain low, in part because teaching dental clinics have never been configured in the same way as teaching hospitals. Medical teaching hospitals have no problem "competing" with other hospitals. Dental deans remain cautious about competing with local dentists. When they have, even for underserved populations, dental associations typically complain. Again, university presidents and trustees receive mixed signals about the benefits of dental schools.

Even within dental schools, much of the organizational change in recent years has been in response to changing social needs and the science of dentistry. Merger or elimination of departments has often mirrored the rise and fall of different dental competencies. Yet deans are often unable to see the corollary for university officials. In some ways, both for changes within dental schools and for the closing of dental schools, the most bitter pill to swallow for faculty has been the perception of not being needed any longer.

If the university was in financial trouble and had to close schools in order to stay afloat, I would understand. But that's not the case. All schools but a few lose money. They are saying that dentistry alone is not worthy of the sup-

port from the university. In some ways that means they are saying that I am not worth anything to the university.

Dental school faculty member

There is no objective criteria for assessing social value of an educational program. If the “cost” side of the equation is difficult to figure, the “benefit” side is impossible. In interviews and public statements around dental school closings and significant organizational changes within dental schools, academic leadership finds it very difficult to explain the “cost-benefit ratio.” However imprecise, the concept remains powerful. Future decisions in the health professions will continue to use the concept. As mediating institutions, public perceptions about the benefit of schools and programs remain key in decisions to change health professional schools.

Unfortunately, public perception about health and science is not usually formed scientifically.

Failure to Develop Alternatives

As university president Clark Kerr pointed out almost three decades ago, higher education is slow to change and offers very few alternatives in terms of structure and methods. He goes on to point out that the stability of higher education remains both a strength and a weakness. In all three cases of the closing of dental schools, there appear to have been few alternatives considered.

I had this wild thought one day during all the conflict.. What if there had been a College of Proctology? Would they have closed it before they closed dentistry? Everyone in dental education is fearful of becoming a department in the College of Medicine, but I wonder if we would still be educating dental students if we had been a department? It makes you wonder about the alternatives.

Dental school faculty member

I choose that quote not because I think it offers the answer, but because it underscores the dynamics of universities and dental schools trying to manage change without choices. Lenny Marcus points out the need for more options to lessen the rising amount of conflict among the principal parties in health care. The lack of options for organizational change in dental education stems from three common attributes related to change: experience with other models, environment for deci-

sion making, and attitudes toward conflict.

Those with whom we talked about the closure of dental schools or other significant organizational changes refer to their lack of experience with other models. Obviously, if almost all dental schools appear to be carbon copies, then it must be the best model. Frequency of replication, either in nature or organizational life, has never been tied directly to some ultimate measure of quality. In fact, replication or frequency often replaces a needed quality or strength. The similarity of educational models reflects more the isolated history and culture of higher education than some competitive evolutionary process.

What if, for argument sake only, one dental school in America volunteered to become the department of a medical school or that some mean-spirited university president or vice president for health affairs actually moved a dental school into the medical school? Would dental education, the actual teaching and training of dental students, and the competencies of graduating practitioners be all that different? McMaster University in Canada has such a merged model for nursing, some allied health professions, and medicine called the Faculty of Health Sciences.

My sense is that if dental schools and their deans thought they had a 50-50 chance either merging the dental school into medicine or medicine into dental schools, more of them would consider the possibilities. Based upon size alone, medical schools will always dominate the merger and dental schools will always oppose that loss of control, no matter what the alternative.

University vice president

I am not advocating a merger. There is so little data out there on comparative organizational structure in higher education that even merging departments under the banner of “better organizational structure” is, at best, pseudo-science.

Speculation (with a dose of fantasy) leads to lots of different models: a dental teaching clinic that actually attracts patients like a teaching hospital and to which area dentists refer frequently; a proprietary dental school that meets all of the accreditation standards and does almost no research except inquire about the quality of its teaching and its graduates; a successful department of dentistry in a medical school in which dental faculty are well distributed across the faculty pecking order in the school; or a funding mechanism for dental education from either state or federal sources

that recognizes the difference in costs of education among different health professions and adjusts support accordingly.

The absence of alternative models does not reflect the absence of creative intelligence in dental education. For those involved in closings and other organizational changes, the absence of alternative models reflects more the limitations of the decision making process.

The interviews from different schools reflect a similar environment for decision making: academic leaders think they have a problem. If they state the problem publicly, they sound accusatory and everyone involved gets defensive. So they talk around the problem euphemistically in public and try to solve it in private. The private process limits the number of people involved, especially those associated with the problem. They limit the type of information they gather because if they ask the questions or present future scenarios, it implies the problem. Then a board gets involved and many of its meetings are public, so they limit how many controversial alternatives they consider. Each scenario suggested in public sets off a firestorm of concern among the affected parties. Some good, but imperfect options, get withdrawn immediately because of intense public pressure. Then when it comes close to decision time, consultants, accrediting bodies, lawyers, and AAUP representatives step in with almost Biblical pronouncements of what can and can not be done. Every step seems destined to prevent the type of discussion that the experts suggest to resolve conflict.

Academic leaders find that, after months of “process,” they still have to choose between the two unpopular options they had in the beginning, thereby reducing the average time in office of academic leaders to months, not years.

Everyone thinks they ‘own’ higher education, but few of them want to pay the ‘maintenance costs.’

University vice president

In all three of the closings, conflict escalated but remained unmanaged through the course of decision making. In two of three cases, we also have some information on the emotional context for the private meetings. In all cases, the emotions related to conflict and an inability to manage the conflict seemed to have provided additional impediments to problem solving and decision making. In all of our experiences in organizational change, participants tend to remember the other party as more recalcitrant than what observations by a

third party reflect. It is obvious that the clash of values, the perceived threat to self-esteem and employment, the public name-calling, and the attempts to rally third-party supporters reduced opportunities for problem solving.

While much has been written on the root causes and ultimate effects of conflict in organizations, higher education presents a set of unique issues. Many organizations espouse values for competition (hence conflict). Without a lengthy debate of the pros and cons of those types of organizations, it makes sense that they attract people who like competition and conflict. Conversely, there are organizations that espouse the value of consensus and collegiality. Again, without debating the relative pros and cons of those organizations, suffice it to say that they attract people with similar values. Regardless of the actual frequency of those values in action, over time the organizations will drift closer and closer to viewing themselves as acting only on the espoused values.

If higher education tends to espouse values of consensus and collegiality (a notion our experience confirms), then institutions in conflict tend to see that their only course of action is to seek consensus and collegiality. A failure to derive consensus was viewed by many we interviewed as tantamount to making a bad decision.

There was never an attempt to build consensus among the faculty at the school. Without consensus, the faculty will not support the decision. In fact they should not support a decision for which they had no input.

Dental school faculty member

Most of those who study decision making would disagree. The evidence appears strong that while consensus-building or involvement in decision making increases commitment to the decision, it does not necessarily lead to the best decision or the right decision. The environment for decision making usually did not include any form of outside arbitration or the mutual acceptance of external decision rules (such as a national standard for cost-of-education, performance on national boards, or clinic revenue per student) to help resolve some of the differences inherent in the discussion.

The role of the faculty looms large in any of the significant organizational changes in dental education. I can find little evidence that dental school faculty behave in ways different from faculty in general. Any reasonable person would expect resistance from the faculty if the programs in which they teach were subject

to reduction or closure. The dental school faculty of the schools that closed generally reflected the profile of other dental schools. In fact, in two of the schools, the profiles of dental schools, when adjusted for differences in academic discipline, look very similar to faculty across the university.

Faculty played a wide range of roles in the process leading up to the decision to close a dental school or other significant organizational change. While there were individual variations among faculty in all the schools, each school seemed to have dominant characteristics. In some, the faculty appeared relatively resigned to the closing. In others, the faculty came out swinging, even before the final decision had been made. What caused the difference? Interviews with those involved in the closings and our observations suggest a couple of reasons for the difference: 1) how long the school had been under threat of closing; 2) type of faculty governance; and 3) role of department chairs.

When compared to faculty in schools that did not close or suffer threat of closure, the demographics suggest that faculty in most dental schools that close are in a “weakened condition.” For example, when Washington University closed its dental school in 1989, there were thirty-seven full-time faculty, only seventeen of whom were tenured. The school had already been through threat of closing for several years. Faculty positions had been reduced. Morale appeared very low. The same was true of most of the other schools.

Once the administration restructured the school to save money and then later appointed a review committee, most of us knew that after a long and protracted process they would close the school. People left and it became almost impossible to recruit faculty. This went on for almost five years. We were all negative. We knew they would not listen to the faculty. I hung on to the last possible day and then retired.

Dental school faculty

While most university administrators probably have recurring fantasies about complacent faculty willing to go along with most any decision, the actual behavior of those faculty in at least two of the dental schools that closed frustrated even administrators.

It’s like they have given up, not only on us as administrators, but on education in general. I can understand why they feel that way, but at the very time we need faculty to help students through a difficult period, the faculty have

withdrawn. I would actually prefer a good shouting match than this passive anger. Maybe if they could cuss me out, then they would get back some of the energy to get on to new academic careers. I worry that many of them will be unattractive to other schools because they seemed to have stopped doing the very things that would impress another school.

Dental school associate dean

Faculty often withdrew when the first criticism or concern about the future of the school appeared in public. In schools where several years of budget cuts or administrative changes occurred before the school actually closed, faculty reported that they stopped trying after the first round of cuts did not lead to more positive perceptions of the school. Administrators’ attempts to involve faculty in decision making did not lead to greater involvement, but rather greater cynicism. In most cases the cynicism appears justified in that the school ultimately closed. But the cynicism may also have contributed to the closing.

It’s all hindsight. The faculty say we had decided to close the school and kept that decision secret for years. We say we really were open to rebuilding the school. Frankly, when a significant number of the faculty simply gave up and grew cynical of every proposal we considered, I began to give up on them.

University Trustee

Dental school faculty (and other health professional schools faculty) generally reflect different attitudes about faculty governance than do their peers across campus. That might be explained in part by the percentage of clinical faculty who often come into academic settings after careers in military, private practice, and the like. It also may reflect the sense of personal autonomy generally displayed by dental school faculty (and dentists in general). Whatever the reason, in the schools that closed, the relative age and strength of faculty governance determined the role of faculty. The stronger the traditions of faculty governance, the more likely that faculty were more active in the decision making, including having direct links to trustees or central university administration.

Contrary to our initial assumptions, strong faculty governance did not lead necessarily to more protracted legal and public disagreements over the closing. In two cases, faculty committees had been active in examination of options for the school and had even involved peer institutions in the discussion. In both

cases, those involved point to long histories of active faculty governance.

On some campuses, faculty governance and faculty unions are assumed to be synonymous. That's not the case here. We have a strong AAUP chapter, but it has a different role from the university senate. We defer to AAUP for most individual cases and the university senate tries to focus on campus or school-wide issues. The more active our committees are in gathering information and addressing the pros and cons of issues early on, the more likely the university administration will listen to us.

President, university senate

Perhaps even more different than faculty in the range of roles they played were the roles played by department chairs. This long-suffering middle manager of educational organizations has, in recent years, gone from being the single most powerful person in the academic hierarchies to little more than a referee and class scheduler. (This sweeping generalization probably applies to all health professional schools but medicine.) Only a few dental schools have sought to reverse this trend through decentralization of resources as well as problems.

Needless to say, most of the chairs with whom we talked at the time of closing appeared confused over what others expected of them.

In one day the dean appealed to me to support his decision, my two most influential alums called to ask me to join them in opposing the dean, three of my most vocal faculty accused me of straddling the fence and remaining silent, and my secretary said I was late on financial reports and promotion packets. That's where the title "chair" came from: everyone wants to sit on you.

Dental school department chair

In a few of the closings, mostly marked by a decline in leadership by the dean (real or perceived), the chairs became the most outspoken critics. Chairs were meeting with university presidents to negotiate aspects of the closing without the knowledge of the deans. They sent out form letters for alumni to use to lobby the president and trustees. They threatened to lead legal battles over contracts, tenure and outplacement support.

Our chairs did more harm than good. Some of them got very quiet and did nothing. Others of them tried to become the heroes by rallying

faculty against the dean, university president and trustees. Others used public forums when the trustees asked for comment on the closing to bring forth influential alumni to speak highly of the department, but not the school. I was disgusted, primarily because I was one of them and I could not offer an acceptable alternative.

Dental school department chair

In other schools, the chairs were critical positive forces during the actual closure. Many deans and associate deans found that their connection to the decision to close the school rendered them less than effective in implementing the closing. That role fell to chairs, and many of them did it admirably, with little or no training, experience, or outside resources. To them fell the task of managing the emotions of faculty and students in a difficult personal transition. They also developed or called upon the informal networks throughout dental education to place students and faculty in new schools.

No dean wants to be remembered as the "last dean" or the "dean that had to close the school." In fairness to all those involved in dental school closings, the closing of a school does not represent, de facto, a failure of leadership. Those we interviewed or worked with as part of dental school closing had specific criticisms of leadership but it went beyond single individuals. At the same time that some dental schools closed, others with similar profiles stayed open. Obviously, the differences in decisions by different academic leaders explains at least part of the variation.

Similar to the range of roles for faculty and chairs, deans also seem to run the gamut from highly active to more passive roles in the closing.

The single most telling characteristic that seems to have determined the role of deans in the closing was the relationship of the dean to the university president. Personal relationships seem to be a fairly frivolous way to measure leadership, but leadership is a series of relationships. No followers, no leader. In several of the school closings, it appeared as if the dean were often the last person to know what trustees and the university president were thinking and planning.

I watched the relationship of the president and the (dental school) dean deteriorate. I don't think it was ever a great relationship. They seemed to come from different philosophies and styles of leadership. But early on, when the president confided in the dean some of his concerns about the dental school, the dean

went public. Maybe for good reasons, but it seemed to diminish the president's ability to trust him.

University vice president

Personal heroics provides another common theme for the dean's role when faced with closings. In that other schools have been threatened with closing or are private schools that have managed to avoid even coming close to the financial maelstrom that sucked others down, we looked at the role of the dean in some other settings. Clearly, while many of the survivors point to "good management practices," "high quality programs," and other differences, there have also been significant occasions when deans have used strength of personality and personal performance to keep schools afloat. While that seems to fit our mythical stereotypes of leadership, it also places some schools only "one heartbeat away" from any list of probably school closings.

Other deans did what Hillary Rodham Clinton has described in her definition of leadership as "rising above current events." For them, they were able to shift gears from focusing on saving the school to focusing on closing the school in the least painful and most constructive manner.

There was a day when the dean decided that if he put any more energy into fighting the closure, he could not be effective in closing the schools. He told me he expected the same from me. He also said that he knew some alumni, faculty and students would criticize him for not fighting harder and giving up too soon.

Dental school associate dean

Conclusion

The experience of the closing of six dental schools and major reorganization of six others suggests to me that there are schools more susceptible than others to closing for the reasons discussed in this article. In that those reasons go beyond the easily quantifiable financial conditions of the school, trustees and university administrators should ask "Why the dental school?" (or any other program) in comparison to other schools

and programs. In that schools closed when budget overruns were only 5 to 10 percent of the total budget, the "cost-benefit ratio" must have a lot to do with the perceptions of social benefit of dentistry.

I have also watched trustees and university leaders grow increasingly frustrated with the moralistic rhetoric of faculty and the self-promotion of alumni when faced with closing decisions (or other major organizational change). The experiences discussed in this article suggest that those personal dynamics tend to limit the discussions and polarize different views. Few schools used outside mediators, even when faced with significant legal review.

Finally, the experiences of six schools clearly indicates that, regardless of how sound the decision to close a school, there are good ways and bad ways in which to close.

While this article focuses on dental school closings, I think the lessons learned would be helpful in times of any significant organizational change in higher education, especially among health professional schools.

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