ADEA AMERICAN DENTAL EDUCATION ASSOCIATION
Charting Progress
MAY 2008

A Monthly Newsletter from ADEA Executive Director Richard W. Valachovic, D.M.D., M.P.H.

In this month's letter, Dr. Rick Valachovic, Executive Director of the American Dental Education Association, reviews efforts to expand health professions education in considering the current expansion of the number of dental schools.

New Dental Schools: Proceed, But Appreciate That They Are Only One of Many Answers to Our New Challenges

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I've had some interesting conversations in recent months around the topic of new dental schools. There's no denying the enthusiasm that surrounds their creation. The atmosphere is rife with promise. There's an openness to experimentation, a willingness to try new models. Whether it's a more cost effective financing structure or a curriculum that's more in tune with how contemporary students learn, new schools are fostering innovation—something we all agree would benefit all of our institutions.

In the past six years, five new dental schools have been established, another five are in the works, and there's talk in some quarters of expanding even further. What is the rationale for this expansion? The U.S. Department of Health & Human Services
Health Resources and Services Administration estimates that 46 million Americans are living in Dental Health Profession Shortage Areas and that 9,000 additional dentists will be needed to fill this gap in care.

Notably, many of the new dental schools (including those in the planning stages) are affiliated with universities that also have colleges of osteopathic medicine. This comes as no surprise to my counterpart at the American Association of Colleges of Osteopathic Medicine, Dr. Steven Shannon. "The majority of colleges of osteopathic medicine have a mission to train doctors to provide primary care, and they see oral health as a major part of preventive care," he says. "These institutions are also somewhat better positioned to start new schools. They're frequently located in rural areas where the need for dentists is acute, and two thirds of them are used to operating without state support, so they're more entrepreneurial, more creative in their thinking."
A.T. Still University (ATSU) is one such institution. A component of ATSU is the Kirksville College of Osteopathic Medicine, and it also is the parent institution for Arizona's first dental school, which graduated its first class in 2007. Arizona ranks 44th in the nation in the ratio of dentists to population, with most of its dentists clustered in urban areas, so ATSU has ample opportunity to contribute to solving the state's problem with access to oral health care. According to Dr. Jack Dillenberg, Dean of ATSU's Arizona School of Dentistry and Oral Health, "Greater than 30 percent of our graduates will provide oral health care in community health center settings in Arizona and around the country." The university also plans to open a state-of-the-art dental facility where fourth year students will provide faculty-supervised dental and oral health care to underserved seniors and adults with special needs.

There's no doubt that ATSU's Arizona School of Dentistry and Oral Health is starting to have an impact in meeting the needs of the underserved, but will this hold true for new dental schools generally? Is the creation of new dental schools the best or the only way to address access to care issues?

Similar concerns about workforce shortages, and generous government funding, propelled the expansion of new medical and dental schools in the

late 1960s. This expansion succeeded in bringing huge numbers of people into our profession, but it failed to achieve its ultimate goal. New dentists and physicians did not go into underserved areas and, two decades later, access to care was as restricted as it had been at the start of the expansion. When applications to dental schools began to plummet in the late 1980s, access to care was in many ways even more imperiled, as we had only 1.3 applicants for every dental school slot. At the same time, seven dental schools closed in the 1980s and 1990s.

Today's applicant numbers—more than three applicants for each first year dental school slot—would seem to indicate that there are enough qualified students out there to fill new schools. And the dental profession is not alone. Throughout the health professions, there is a perceived need to increase educational opportunities. The Association of American Medical Colleges (AAMC) has set a goal of graduating 35% more students, but it isn't planning to open new schools. Would this work for dentistry?

There are some notable differences between our professions that make this appear doubtful. Dental students need to begin developing their technical skills before they enter the clinical arena. It may be easy to squeeze a few more bodies into a medical school lecture hall, but dental schools would also need more simulation and preclinical lab space and clinical operatories to accommodate new students. As always, there's the financing problem. Building and equipping these facilities takes substantial sums of money.

Perhaps we can learn something from the experience of our colleagues in pharmacy. For 35 years the number of U.S. pharmacy schools held steady at 72, but starting in the mid 1980s new schools began to appear. By 2002, the United States had 84 pharmacy schools. Today, a mere six years later, the number stands at 105 with another five schools expected to open by June 2008 and about a dozen more schools in the planning stage.

At present, new pharmacy graduates are being absorbed into the economy, but the rapid proliferation of schools has posed unforeseen challenges that trouble some observers. Adjustments have been made to the accrediting process to accommodate this unprecedented expansion, and several schools have delayed opening as they struggle to put resources in place, especially faculty. The problem has been particularly acute where several new schools have sprung up in the same geographic area in rapid succession.

At the same time, pharmacy now offers a diverse array of campuses that constitute a living laboratory of educational alternatives. Pharmacy schools are found at public and private institutions, including growing numbers on religiously affiliated campuses. They are traditional, satellite, and standalone institutions. Pharmacy has seen its first for-profit schools since the early 20th century. And for the first time ever, one school has increased enrollment by offering its didactic curriculum online.

Creighton University, a 130-year-old Jesuit institution in Omaha, Nebraska, began providing a distance-learning pathway to the Pharm.D. degree in 2001. Students complete laboratory courses in a condensed manner during the summers, and clinical rotations take place in a variety of locations throughout the country and at some international sites.

Creighton's experiment is now a fully accredited program that has proven very attractive to older students. The average age of those enrolled in the class of 2007 was 31. They lived in 33 states, and 73% of them were women.

Despite the success of this innovative program and the addition of many new schools, some leaders in pharmacy education believe pharmacy's expansion and newfound diversity are increasingly problematic. They want to know why leading research universities with highly regarded academic health centers are not among those choosing to start pharmacy schools.

I've heard a number of our colleagues express similar concerns. They point out that dentistry needs its research portfolio to remain a learned profession, and they fear that a proliferation of dental schools that can operate with lower cost structures may ultimately challenge the stability and contribution to the profession of more established institutions that carry the additional financial burdens associated with research.

One of these colleagues, Dr. Jerry Goldberg, Dean at the Case School of Dental Medicine and Interim Provost at Case Western Reserve University shares this concern, noting that none of the new dental schools is located at a

traditional research intensive university as based on classifications by the Carnegie Foundation. He has consistently expressed skepticism about the need for new schools. For starters, he disagrees with estimates that purport to know how many dentists will be needed. These projections can't account for forthcoming changes to health care financing or for the influence that the availability of dental benefits (or lack thereof) will have on the number of people seeking dental care.

"Opening a dental school every time some legislator or university administrator wants to serve an underserved group is the least efficient way of providing care to poor people that I can think of," Dr. Goldberg says. He acknowledges that the three new dental schools already in place may well be warranted, but he fears that plans for an additional four to six schools may overshoot the mark. "It might be worth it if this resulted in increased access to care, but there's no evidence to suggest that dentists will move to rural areas or seek out clients who can't pay just because there are more of us." He argues that if we produce more dentists than the market can absorb, dentists will work more hours or raise prices to maintain their lifestyles. An overcrowded field will make the profession less attractive, and over time it will no longer make sense for students to invest in an expensive dental education.

Nevertheless, he does see a role for dental schools in addressing access to care. "Dental schools can acculturate students with an understanding that caring for the underserved is part of their professional responsibility. At Case we do this by having first-year dental students provide sealants to all 6- and 12-year-olds in Cleveland's public school system."

Ultimately, Dr. Goldberg believes that we can create more care for those who need it by training dentists in how to work with allied dental professionals and make use of technologies that allow them to provide treatments more efficiently.

Looking at dentistry from a business model perspective, I can see the merit of positioning the dentist in a role of collaboration with a variety of mid level providers, and how each profession's scope of practice must be delineated with care. I can tell you from my 20 years as a dental school clinical director that even what at first seems to be a simple restoration or extraction requires careful attention and the type of care that an integrated team of dental professionals can provide efficiently and cost effectively.

Nevertheless, we should proceed with caution as we move ahead with dental school expansion. Let's not lose sight of equally pressing concerns. Curriculum reform must remain paramount and will have a bearing on the length of dental education and the settings in which it occurs. New models of dental education may emerge in response to market forces. The availability of new technologies will also change the landscape, as will evolving notions of how best to engage dentists and allied dental practitioners to increase access to care. It may be hard to keep all these factors in mind as we increase our capacity to educate new dentists, but only by doing so will our community make the best decisions for the long-term health of our profession.

Richard W. Valachovic, D.M.D., M.P.H.
Executive Director
valachovicr@adea.org

American Dental Education Association

1400 K Street, NW, Suite 1100, Washington, DC 20005
For member service questions, call toll free 888-ADEA OPEN (888-233-2673)
Phone: 202-289-7201 Fax: 202-289-7204