It’s Time to Launch a Counter-Cultural Movement!

David A. Nash, D.M.D., M.S., Ed.D.

Dr. Nash is professor and dean at the College of Dentistry, University of Kentucky. Direct correspondence to Dr. Nash at University of Kentucky, College of Dentistry, Lexington, KY 40536-0084. Internet: danash@pop.uky.edu

The German-American theologian/philosopher Paul Tillich’s writing is rich in its ability to provoke thinking. Professor Tillich probed the meaning of words and reconstructed them in unconventional ways to challenge our thinking regarding their communication of understanding. I call your attention to a distinction he draws between two closely related words, both Greek in origin, “chronos” and “kairos.” Chronos is the Greek word from which we derive our word “time;” thus we have chronology as a way of acknowledging a sequence of events occurring through time. Professor Tillich contrasts “chronos” as time, with “kairos” – a concept for the Greeks that is best understood by us as timing. It is the idea of the opportunities of the moment … the coming together of a number of forces that present a unique opportunity. Tillich frequently refers to “kairos” as the “pregnant moment” – that is, like the time of conception, a particular moment in time filled with extraordinary potential. These moments are Tillich “kairotic” moments.

We all acknowledge that there are special moments in time. All time is not the same. At certain moments in time we reach, as the Institute of Medicine report’s title suggests “crossroads.” Points in time where we are at major decision points regarding how to proceed; “kairotic” moments, for they are moments in time in which the road selected can make a significant difference. As I suggested in a 1994 paper calling for an oral physician curriculum this particular moment in dentistry is a moment filled with great and special opportunity. It is both a moment in time, and a place in time … a “crossroads,” at which we have the potential to transform the nature of dental education and the profession of dentistry. It is to the challenges of this time, as we stand at this crossroads, that I will address myself today on the topic of curricular changes after IOM.

Revisiting the Oral Physician

The paper on the oral physician represents my best judgment of how our curricula in dentistry must change and evolve, given the environmental forces at work. These forces are powerful and significant. I identified five such forces in that paper, and suggested that they are converging in such a manner to suggest the time (there’s that word again) has arrived to address the fragmentation of dentistry from medicine, the separation of the education of dentists from physicians, and to integrate dentistry with medicine in our nation’s health care education and delivery system. Let me briefly recount those forces:

Conceptual reflection forces transformation of dentists in oral physicians. The oral cavity, the stomatognatic system, is a part of the human body. It is not remarkably different than any other functional organ system. There is no reason to believe that the first twenty centimeters of the alimentary canal is, or should be treated as, conceptually different than the rest of the human body. Oral health professionals should be able to consider and evaluate the general health of their patients in caring for them, in ways no different from other specialties of medicine. Dentistry is to medicine as ophthalmology is to medicine. Con-

Journal of Dental Education • Volume 60, No. 5
ceptually, they are equivalent specialties of medicine.

Reflection on the "new biology" forces transformation of dentists into oral physicians. Cellular and molecular approaches to treating disease have revolutionized health care in the past decade. Understanding at this level is dramatically expanding our options for prevention, diagnosis, and treatment. To apply modern science, the contemporary dentist must understand modern science in a way current curricula in dentistry do not permit. Radical changes occurring in molecular biology and genetic engineering are affecting dentistry, both now and for the future.

Epidemiological analyses force transformation of dentists into oral physicians. Millions of Americans who are medically and/or pharmacologically-compromised experience oral health problems. In fact, many individuals are at high risk for oral problems because of systemic disease and disabling conditions. The dentist must be able to manage the oral health care of individuals with a myriad of diseases and processes that require accommodation in oral therapy. Additionally, dentists must understand and adjust to the increasing numbers of medications taken by their patients. Even the profile of oral health problems is changing significantly. Edentulism is a condition gradually disappearing from the American scene. Significant declines in dental caries experience are being seen in our school-aged children. Periodontal health is continuing to improve.

Analysis of the health professions forces transformation of dentists into oral physicians. An appropriate health care delivery system should acknowledge the unique and important role of health for all aspects of the human organism and provide access to care in a cost-effective way. Dentistry must become fully integrated into the nation's health care delivery system for dentistry to receive its justified and equitable share of concern and financing from and for the public.

Finally, economic analyses force transformation of dentists into oral physicians. Colleges of dentistry are being threatened in the current economic environment of higher education. The reduction of public financial support for higher education, coupled with the inability of our students to shoulder increased tuition burdens, demands that we develop educational programs that can be operated in more cost-benefit, effective ways. Reintegrating dental education with medical education offers the potential to effect savings and create greater degrees of efficiency for both.

I believe these forces drive an integration of dentistry with medicine, and a significant change in our paradigm for educating oral health professionals for the future. I have selected the term "oral physician" to characterize these new oral health professionals. While having a contemporary ring, the term is as old as the advent of modern dental education; for it was the term used by William Gies in 1926 as he deliberated in his report to the Carnegie Foundation on the direction dental education should take.

He finally recommended a curriculum and course of action that would reinforce the separation of dental and medical education that then existed and exists to this day; not because he believed it made the most conceptual sense, but rather because there were significant environmental reasons to do so — just as there are significant environmental reasons to revisit integration today.

Key to this concept of an oral physician is a five-calendar year educational program that integrates the curriculum in dentistry and medicine in such a way that it culminates in the awarding of both the Doctor of Dental Medicine (D.M.D.) degree and the Doctor of Medicine (M.D.) degree. Oral Physician students would participate in the course work of the first three years of the medical curriculum, through the major clerkship year. Courses specific to dentistry would be conducted during weeks when courses in medicine are not scheduled. In the planning done at the University of Kentucky, approximately twelve to sixteen weeks of dentistry could be taught during the first three-calendar years. The final twenty-four months of the curriculum would be devoted primarily to dentistry with an integrated track of preclinical and clinical courses. Projections for this oral physician curriculum indicate that it could provide exposure to dentistry over the five years equivalent to the typical, traditional curriculum in dentistry today. And, it could result in the graduation of oral health professionals with the diagnostic acumen of the physician, and the technical skills of the dentist.

The advantages of an oral physician curriculum for dentistry and dental education are several:

- It results in graduates with a deeper and broader education in science.
- It results in graduates with a better understanding of the human organism, and its pathophysiology.
- It results in graduates with more sophisticated diagnostic abilities, better able to assess and manage the general health and well-being of patients.
- It permits the education and preparation of health
professionals uniquely qualified to treat the oral health of a growing patient population whose management is more complex, because they are medically and/or pharmacologically compromised.

- It attracts highly qualified students to dentistry, and addresses the complaint of some students regarding the lack of intellectual stimulation associated with current curricula in dentistry.
- It results in graduates who are better prepared to participate in interdisciplinary primary health care delivery.
- It permits graduates to be more competitive in the future environment of health care, and more flexible in adjusting to professional changes.
- It responds to increasing national appeals for dentistry to become more fully integrated into the health care professional team and the health care delivery system.
- It provides opportunity for integrating support services for faculty, staff, and students of dentistry and medicine, with resulting efficiencies and economies of scale, and improved cost-benefit effectiveness.
- It is an initial step in dentistry assuming its appropriate position as a specialty of medicine.

Having reviewed what I proposed prior to the Institute of Medicine’s study, I want to consider their report, not solely from the perspective of their recommendations, but as importantly, from the perspective of the assumptions they make about dentistry and its future. If I am to be helpful, I must suggest strategies for transforming our dental curricula. Whether one accepts the oral physician model, or any of the several curricular recommendations of the Institute of Medicine, change, significant change, must occur!

I view effective significant change in curricula as a daunting task — history documents my assessment. Solomon and Brown in 1989 published a fifty-year assessment of the dental curriculum. Through an examination of clock hours by content, they concluded that the curriculum had changed little since 1934. Studies prior to IOM have called for significant changes in dental education, with little effect. We are not alone. Numerous studies of medical education over the past fifty years have called for many of the same changes in medical education to little avail. I have come to believe that our curricula are a deeply embedded, cultural phenomenon. Therefore, if there is any hope for change, it must be through a transformation of our culture by methods appropriate to cultural transformation.

I am going to proceed by exploring briefly the nature of culture and its relevance to change. Then I will examine the assumptions of the Institute of Medicine study relative to curriculum as an expression of the “culture” of the Committee; comparing their cultural assumptions with those I see operative in dental practice and dental education today. An examination of the literature of cultural change offers strategies that could prove helpful to us as we mount, as I believe we must, a counter-cultural movement to effect change. I will conclude by challenging you to join me in calling for and helping lead such movement. Before continuing, I must acknowledge my immense debt to Professor Edgar Schein, of the Sloan School of Management, Massachusetts Institute of Technology. His book, Organizational Culture and Leadership, is indispensable for those seeking to effect change.

Understanding Culture

The concept of culture is hard to define, difficult to analyze, and challenging to manage. Yet it is essential that we pursue the concept, for change can not be effected without considering culture as a primary source of resistance to change. My argument today will be that the changes I have called for and the changes the Institute of Medicine is recommending, run counter to the culture that predominates in dental education and in the profession at large.

Culture is a useful concept for it enables us to understand the complex and often hidden aspects of organizational, that is, professional and/or academic, life. As we attempt to lead in effecting substantive curricular change, we will become amazed (if you have not become already) at the resistance we will encounter – resistance that seems to be both beyond reason and unreasonable. We will come to understand that we are challenging basic assumptions regarding the nature of dental education and the profession, assumptions that are deeply embedded in the thinking of many of our colleagues.

Critical to the concept of culture is the notion that groups share or hold ideas in common. These are cognitive constructs, and include such dimensions of thinking as: norms, values, assumptions, beliefs, standards, and attitudes. It is these collective, mutually-shaping patterns of thinking that guide the behavior of individuals and groups. When we use the expression “cultural,” we are also implying two other elements. One is structural stability. Not only are the constructs shared, but they are deeply held, therefore
stable. By this, I mean they are constructs that are seldom brought to a level of consciousness for reflection or critique. The other is integration. Culture integrates these cognitive constructs into a larger paradigm or gestalt, and ties them together into a coherent whole. The stability and integration of these norms, values, assumptions, beliefs, standards, and attitudes is what we mean by culture. Once a culture is established, as culture is at a macro-level in dental practice and dental education, and at a micro-level in each of our colleges; culture determines the nature and challenge of the leadership required to lead evolution and change.

While we could explore each of the cognitive constructs of culture, I am going to focus on only one—that is, assumptions. These unconscious, taken-for-granted perceptions, thoughts, intentions, and feelings ultimately predict the source of our values and our actions. I choose assumptions because the other cognitive constructs can be assimilated by assumptions. In fact, many anthropologists or social psychologists would agree that assumptions are primary. Culture as a set of assumptions defines us what to pay attention to, what things mean, how to react emotionally to what is going on, and what actions to take in various situations.

Basic assumptions in a culture are rarely brought to a level of consciousness; therefore neither confronted nor denied and, hence they are very difficult to change. To learn something new relative to our basic assumptions requires us to resurrect, re-examine, and possibly change some stable position of our cognitive structure. Such learning is intrinsically difficult because a re-examination of basic assumptions temporarily destabilizes our cognitive and interpersonal world, releasing large quantities of basic anxiety. The human mind needs cognitive stability. Therefore, any challenge to or questioning of a basic assumption will release anxiety and defensiveness. The key to leading in changes that challenge basic assumptions, cultural change, is managing the significant anxiety that accompanies any relearning of basic assumptions.

Both the power and problem of culture comes through the fact that basic assumptions are shared, and therefore mutually reinforced. It is when these basic assumptions are no longer proving functional—most likely due to significant environmental shifts, that the power of culture become the problem of culture. The central problem for leaders of change is how to challenge this dysfunctionality in such a way as to allow those who hold unwarranted assumptions to maintain a sense of integrity while moving through the anxiety that comes from having to part with an assumption that is no longer valid, and move to one that is functional and valid in the new environment.

**Saber-Tooth Curriculum**

Thinking about curriculum, curricular change, functionality, and culture in the context of the changing environment, invariably reminds me of J. Abner Peddlwell’s *Saber-Tooth Curriculum.* Those of you familiar with this satirical classic may recall that in the early Paleolithic Age an ingenious man named New Fist devised a system of education to teach the activities that would provide the children with food, clothing, and security. In arriving at this system, he asked himself, “what things must we tribesmen know how to do in order to live with full bellies, warm backs, and minds free from fear?” To answer this question, he ran over various activities in his mind. “We have to catch fish with our bare hands for food; we club the little woolly horses and use their skins for clothing, and we drive away the saber-tooth tigers with fire.” Thus New Fist’s curriculum included three subjects: fish-grabbing, horse-clubbing, and tiger-scaring. Over the years the schools that evolved became very efficient at teaching these relevant subjects and all of their children were systematically trained in the fundamentals. The tribe prospered and was happy in the possession of food, clothing, and security.

After many years the Ice Age approached. With it came environmental changes that dramatically altered the tribe’s lifestyle. The waters became muddy so you could no longer see the fish to grab them; the forest became so wet that the horses went east to the dry plains and were replaced by antelope too fast and agile to club; the air became damp and the saber-tooth tigers developed pneumonia and died. They were replaced by black bears not afraid of fire. Now there were no fish for food, no hides for clothing, and no security from hairy death.

A few practical men of the “New Fist breed” soon learned to cope with the problem and developed nets for fishing, snares for the antelopes, and pits for the bears. Thus it became necessary for the people to learn net-making, snare-setting, and pit-digging as these become essential for existence. The schools, however, continued teaching fish-grabbing, horse-clubbing, and tiger-scaring. “Why aren’t the new skills we need to survive taught in our schools?” a few radicals asked. The wise old educators responded “if you had any education yourself, you would know that the
true essence of education is timeless. It is something that endures through changing conditions like a solid rock standing squarely and firmly in the middle of a raging torrent. You must know that there are some eternal verities, and the saber-tooth curriculum is one of them.” Those of you who have read this little gem of education know that as the instructional content became less and less relevant, economic, social, and political problems beset the tribe and they were ultimately overrun and destroyed by an adjoining tribe whose education was much more pragmatic.

The parallels between this story from the Saber-Tooth Curriculum and our situation in dental education today are so striking that I need not draw them. The basic assumptions that undergird our current curriculum are rapidly losing their functionality in a radically changing environment. Today we need “a few young radicals of the New Fist breed” to challenge the functionality of these old assumptions and to lead in introducing a new curriculum, a new culture if you will, in order to assure that our oral health professionals of the future have the knowledge, skills, and attitudes that are and will be essential for our profession to meet the oral health needs of the society it serves.

Contrasting Assumptions

The Institute of Medicine Study Committee makes basic assumptions about dentistry and dental education – thus reflecting a cultural orientation. I make basic assumptions about dentistry and dental education in my call for an oral physician curriculum – thus reflecting a cultural orientation. And, dental education currently operates with basic assumptions that have stood the test of time, at least seventy years ... again reflecting a cultural orientation. Let me share with you my understanding of the basic assumptions of the Institute of Medicine Study Committee as I see them reflected in their report and recommendations. And, at the same time, contrast these assumptions with parallel ones that I believe currently characterize the culture of dental education, as powerfully reinforced and influenced by the practicing profession. I readily acknowledge that these characterizations of the current culture: 1) are mine, 2) are generalizations, 3) do not apply to any college specifically or to all colleges generally, 4) do not characterize significant numbers of faculty members and practicing dentists who do not share these assumptions, and 5) may be exaggerated (though not excessively) to draw contrasts. I will not attempt, nor would I be able, to document the accuracy of my judgment relative to these cultural ass-
sumptions. I will depend on you to judge their accuracy and relevance to our discussion based on your own experience.

A. Curriculum is to educate, rather than just train, student dentists to serve their patients and communities well. (IOM)
Curriculum is to train students to perform the procedures they will need in private practice to eradicate disease, and to repair and replace teeth, thus rehabilitating the dental arches. (Current Culture)

B. Curriculum is to prepare student dentists to continue the development of their knowledge, skills, and attitudes over a life-time of practice. (IOM)
Curriculum is intensive and extensive enough to provide student dentists with the knowledge and skills they will need for several years in practice. (Current Culture)

C. Curriculum is to ground student dentists in basic biopsychosocial sciences; their relevance to the clinical practice of dentistry; including how to think scientifically. (IOM)
Curriculum in the basic biopsychosocial sciences is necessary to maintain the credibility of dentistry as a profession and justify the awarding of a doctoral degree, but has limited clinical relevance. (Current Culture)

D. Curriculum in basic biopsychosocial sciences for student dentists is equivalent to that of student physicians; is integrated with that of student physicians, and is taught by the same basic biopsychosocial sciences faculty. (IOM)
Curriculum in the basic biopsychosocial sciences for student dentists need not be equivalent to that of student physicians. Dentists (are not physicians of the mouth and) do not need the same understanding of human science as physicians. (Current Culture)

E. Curriculum is to provide student dentists with basic understanding of systemic disease and clinical medicine in order that they can safely and effectively manage the oral health care of medically and/or pharmacologically-compromised patients, particularly the elderly who are becoming a larger segment of dental practice. (IOM)
Curriculum is to teach student dentists basic pathophysiology of disease and pharmacological therapeutics that may complicate dental care; and when and how to refer to appropriate specialists when patients present with complicated medical conditions, or are receiving therapeutics that require accommodation in providing care. (Current Culture)

F. Curriculum is to provide appropriate clinical experience in medicine to help dentists practice comfortably in large, multi-specialty group health care practices. Oral health is an integrated part of total health, and oral health care is an integral part of comprehensive health care. (IOM)

Curriculum for student dentists need not be integrated with, or in the same environment, as the curriculum for student physicians. Dentistry is not health care, at least in the traditional understanding of the system. Dentistry is not medicine. Dentists will continue to practice in solo, private practice settings outside the context of an integrated health care delivery system. (Current Culture)

G. Curriculum in clinical dentistry is to enable students to develop the competencies necessary to care for patients in a setting and manner found in an optimally structured and functioning community-based practice. (IOM)

Curriculum in clinical dentistry is to prepare students to deliver dental procedures to patients efficiently in a solo, private practice setting. (Current Culture)

H. Curriculum in clinical dentistry is patient-centered and emphasizes comprehensive care. (IOM)

Curriculum in clinical dentistry should focus on student dentists and their learning. Clinics are teaching clinics and patients serve as the means to student learning. Procedures required by departmental disciplines are the focus of care. (Current Culture)

I. Curriculum in clinical dentistry emphasizes teamwork and cost-effective use of well-trained allied personnel. (IOM)

Curriculum in clinical dentistry must avoid excessive delegation of duties to dental assistants, dental hygienists, and dental laboratory technicians. Student dentists must learn to perform all the procedures of dentistry for themselves for how else will they be able to know if they are being completed correctly. (Current Culture)

J. Curriculum in clinical dentistry is scientifically-based, and emphasizes critical thinking and decision-making; that is, it is grounded in biopsychosocial sciences and in practice guidelines that have been developed based on clinical outcomes research. (IOM)

Curriculum in clinical dentistry is based on what works in practice. Student dentists should be taught to treat dental disease through use of tried and true procedures in order to have an armamentarium of technical skills to establish a successful practice. (Current Culture)

K. Curriculum in clinical dentistry is to provide student dentists with an understanding of biological technology that will increasingly be used to diagnose and treat disease. (IOM)

While there have been some changes over the past, dentistry continues to be a two disease profession. Prophylaxis, amalgam and composite restorations, gold and porcelain fused to metal restoration, extractions, partial and full dentures, and root canals will continue to be the mainstay of professional practice. (Current Culture)

L. Curriculum is taught by faculty members who are appropriate role models characterized by the following qualities: scientifically-based, clinically-competent, medically-informed, progressive, critical-thinking, socially responsible dentists; dentists who are recognized in the university community for their scholarship. (IOM)

Curriculum is taught by individuals who are dentists, understand dentistry, and are conservative, emphasizing the development of high quality technical skills. Faculty in dentistry, because of the unique nature of the profession, cannot be expected to manifest the same level of scholarship as other professors in the university. (Current Culture)

M. Curriculum is presented using active, stimulating teaching methodologies that enable student dentists to become self-directed, critical-thinking problem-solvers. (IOM)

Curriculum is taught by faculty members who understand their role as training dentists through
lecture, recitation, frequent written examinations, laboratory drills, practical examinations, and clinical repetition to ensure that student dentists are skilled technicians in dentistry. (Current Culture)

N. Curriculum is taught by faculty members who understand their role as humane, empathetic, sensitive facilitators of student learning; faculty who strive to build a spirit of community and collegiality between student dentists and themselves. (IOM)

The role of a faculty member is to disseminate information, assign work, administer and grade examinations, supervise and monitor clinical care – checking progress on procedures at frequent intervals to be sure they are being properly completed; and to require student dentists to complete a specified number of technical tasks prior to graduation from the curriculum. (Current Culture)

O. Curriculum does not contain marginally useful and redundant course content, unnecessary pre-clinical and clinical laboratory exercises, and does provide adequate time for serious individual study, research, and reflection. (IOM)

Curriculum in dentistry is long, arduous, demanding. Students are too busy through the four years. During the first two years, evening and weekends are to be spent in library study, and in completing pre-clinical laboratory exercises. During the final two clinical years, time outside of the clinic is to be spent doing laboratory work in support of completing clinical requirements. (Current Culture)

Summarized, the assumptions of the Institute of Medicine report are that “dental education should be scientifically-based, clinically relevant, medically informed, and socially responsible.” By contrast the assumptions of the current culture suggest that: Dental education should be based on current professionally-accepted standards, should be practical, should focus on students being trained to eradicate dental disease and repair and replace teeth; and prepare students to open and successfully manage a private practice of dentistry.

**Effecting Cultural Change**

The Institute of Medicine has strongly endorsed the need for major change – change that I believe challenges the basic assumptions of dental education – cultural change. The report says, “attempts to preserve that status quo is, in effect, a path toward stagnation and eventual decline.” If dental education is to survive and thrive in our rapidly and radically changing world, we must find a way to change our culture. That requires leadership, strong leadership; leadership that can break the tyranny of the old culture; leadership that can effectively break the frame of old dysfunctional assumptions, while providing stability, security, and integrity for those holding old beliefs while they transition to newer, more functional, assumptions.

Dental education has had a history of success with our basic assumptions in our previous environments. Such a circumstance has helped strengthen our shared assumptions, and leaves us unlikely, and in many instances unwilling, to challenge or to re-examine these assumptions. And, in an environment that is changing and changing, these assumption become a liability precisely because of their strength. Even if we can bring these basic assumptions to a level of consciousness, many faculty members want to hold on to them because they justify the past, and are the source of much of our current pride and self esteem.

How do we effect cultural change in such a circumstance? I mention four strategies identified by Schein:

**Leading change through infusion of outsiders.** Basic assumptions can be changed by changing the composition of the organization, particularly in key leadership positions. Typically in organizational change in the business community, a new chief executive officer brings in his or her own people and dismisses individuals who are perceived to represent the old, ineffective way of doing things. This in effect destroys the culture that existed and initiates the process of new culture formation.

This strategy has limited value for use in dental education because of the stability that exists in our faculties. We have less mobility today than previously … and we have “tenure.” Those seeking to lead cultural change in dental education must lead in the context of the individuals existing in their organizations. Few, if any, of our colleges of dentistry have the opportunity to remove major leaders and replace them with new individuals who reflect the cultural assumptions that are most functional and appropriate for our
colleges' current reality. However, our requirements for cultural change can be enhanced by recruiting a few people to key and influential positions. Additionally, it may be helpful to recruit "external change agents" to visit our colleges to help educate faculty, members regarding the imperative for changing assumptions based on the changing environment; individuals who may have a clearer ability to assess the environment than those within our colleges; individuals who because of their standing and credibility can influence cultural change.

**Leading change through coercive persuasion.**

Based on studies of prisoners of war who had undergone major belief and attitudinal change during captivity, Schein suggests that coercive persuasion is a way to change culture. He indicates that elements of culture that are dysfunctional, but strongly adhered to, are comparable to what the captor was up against with prisoners who asserted their innocence. The key to producing changes in such situations is first to prevent exit and then to escalate the disconforming forces while providing psychological safety. Although this is difficult to execute, it is precisely what effective change managers do. By using the right incentives, they make sure the people who they wish to retain in the organization find it difficult to leave. By consistently rejecting old behavior patterns and mandating new behavior patterns, they make it difficult for people to sustain old assumptions. By being supportive, and rewarding any evidence of moving in the direction of new assumptions, effective leaders provide some psychological safety.

While we can envision such a strategy of coercive persuasion could have merit, again we are significantly constrained in using this strategy for change in dental education. Not infrequently our academic health centers and our universities mandate reward patterns, or have in place policies and procedures that are barriers or impediments to challenging old behavior patterns. Additionally, any hint of coercion draws rapid criticism from our higher education communities, and appropriately so. We place a high value on respecting individual autonomy as reflected in our tradition of academic freedom.

**Leading change through "turn-arounds.**

Schein suggests that a first condition for change is always that the organization must be "unfrozen." Our dental schools must come to realize that some of our past ways of thinking and doing are increasingly obsolete and dysfunctional in the current environment. And we must realize that new external realities threaten our colleges' survival. Leadership must "turn-around" the program if it is going to survive. In effecting a "turn-around" the leader must have a clear sense of where the organization needs to go; a model of how to change the culture to get there; and the power to implement the model. If any of these elements is absent the process will fail. In any case, the anxieties that arrive from the implied change must be actively managed.

Schein identifies two fundamentally different leadership models that have been promulgated for leading "turn-around," or as they have become more popularly known "transformations." One is the strong vision model. In this model the leader has a clear vision of where the organization should end up, specifies the means by which to get there, and consistently rewards efforts to move in that direction. The model works particularly well if the future is reasonably predictable, and if a visionary leader is available. If neither of these conditions can be met, organizations can use the so-called "fuzzy vision model," where the leader states forcefully that the present is intolerable and that the performance must improve within a certain time frame, but then relies on the organization to develop a vision of how actually to get there. The "we need to change" message is presented forcefully, repeatedly, and to all levels of the organization. Transformations must usually be supplemented by long-range development programs to aid in new learning and to help imbed new assumptions. It is not enough to have strong leaders unfreeze the system and get change started because change must be managed in all of the organization's subcultures, a process that takes a great deal of time.

The Pew Dental Education Project was, in essence, a $9 million project to unfreeze dental education. Focused on strategic planning, it was an effort to help dental educators see that the world in which we live and work is changing—changing dramatically. Did it unfreeze us? You form your own opinion—my assessment is that generally it did not. But since Pew, I have been in numerous meetings of deans where the discussion revolved around our lack of an over-arching, coherent vision for dental education. We have had no clear and consistent vision for professional education. If cultural change has been occurring over the past ten to fifteen years, it has followed a "fuzzy vision model." We dental educators have been a lot like Alice in Lewis Carroll's classic. You'll remember her encounter with the Cheshire Cat.

"The Cat only grinned when it saw Alice. It looked good natured she thought: still it had very
long claws and a great many teeth (confirming
the relevance of this story for dentistry) so she
felt that it ought to be treated with respect.
Cheshire-Puss, she began, rather timidly, as she
did not at all know whether it would like the
name: However, it only grinned a little wider.
Come, it's pleased so far, thought Alice, and she
went on. Would you tell me, please, which way I
ought to go from here? (Alice, like us, was at a
crossroads.) That depends a good deal on where
you want to get to, said the Cat. I don't much
care where - said Alice. Then it doesn't much
matter which way you go, said the Cat. — so
long as I get somewhere. Alice added as an ex-
clamation. Oh, you're sure to do that, said the
Cat, if you only walk long enough."

Now for vision, you have the Institute of Med-
cine report, and I have the oral physician² While not
prescriptive, the Institute of Medicine report does of-
er a strong vision of which road dental education
needs to take as we stand at this crossroads. While
not offering specific models or strategies to get there,
the lilac and forest green colors (the academic colors
of dentistry and medicine) of the published document
symbolically reinforce that dentistry needs to move
toward integration (or reintegration if you prefer) with
medicine.

We need a “turn-around” — we need transfor-
mation! The message needs to be resoundingly heard
from every dean’s office, every academic dean’s of-

cice, every student affairs office, and from every lab-

oratory, clinic, and corridor of every college of den-
tistry in America. I believe we now have a vision for
dental education and for a new culture; the IOM has
given us such a vision. But as the subtitle of the IOM
report...Challenges and Changes³ suggests, we will
encounter significant challenges as we seek to
change...as we attempt to transform the culture of
dental education and our profession.

Leading change through reorganization and
rebirth. Schein suggests that little is known about
the process of reorganization and rebirth. But, if one
destroys the organization — the carrier of the culture,
by definition that culture is destroyed; and whatever
organization replaces it will begin to build its own
new culture. Obviously, it is difficult to imagine this
as a deliberate strategy, but it may be relevant if basic
survival of the organization is at stake. Cultural
changes of this type sometime result from mergers or
acquisition, with a resulting restructuring of the or-
ganization. Certainly we are seeing a major trend in
American business in this direction. The huge new
financial institution resulting from the merger of
Chemical and Chase Banks will be a reorganized and
reborn bank, with no doubt a new culture that is ei-
ther a composite of the two previously existing banks,
or that may reflect a new vision of a new chief execu-
tive officer.

Maybe this strategy for cultural change is to-
tally inapplicable to dental education. However, in
the past, it has been suggested that my College at the
University of Kentucky merge with our sister institu-
tion, the University of Louisville. And — the sugges-
tion was made by a well-known dental educator. It
was also suggested that the resulting institution be in
a new and different location from the current colleges.
The resultant of such a merger and move would no
doubt result in a new culture — though it would be
difficult to predict whether better or worse than the
two existing previously. And, I might indicate that I
have been involved indirectly in a progressive en-
deavor underway at the University of Alberta,
Edmonton, Canada. There, as a component of Uni-
versity President Frazier’s plan to maintain dental edu-
cation rather than close the school, the Faculty of
Dentistry is becoming a Department of Oral Health
Sciences in the Faculty of Medicine, with plans for a
major initiative to integrate the curriculum in den-
tistry more closely with that in medicine⁴. This en-
deavor certainly would qualify as leading cultural
change through reorganization and rebirth. In the
emphasis on downsizing and economic account-
ability in the world today, it is not unimaginable that
cultural change may come to some colleges as a result of
mergers, not only with one another, but as at Alberta,
with colleges of medicine.

Launching A Counter-
Cultural Movement

I would like to spark a real counter-cultural
movement with a rallying cry reminiscent of: “Give
me liberty, or give me death;” “I have not yet begun
to fight;” “I only regret that I have but one life to give
for my country;” “Remember the Alamo;” or “Storm
the Bastille.” However, I am not sure what emotion-
ally laden words would provide sufficient spark. It
is tempting to capitulate to the significant challenges
we face and conclude on a pessimistic note. How-
ever, I am an indomitable optimist and while I am

Going to acknowledge, in passing, reasons for some
pessimism and skepticism, I conclude with a strong
sense of optimism!

In many ways it is precisely because the chal-
Challenges are so great, the barriers so high, and the forces to overcome so mighty and many, that we can be optimistic. The history of civilization is replete with stories of minority cultures who have, not only preserved, but actually overcome and thrived, specifically because of the adversity they faced. We must reference these groups — you choose whichever one is spiritually closest to you — and draw from them courage and strength to sustain us as we engage the challenges to change at this crossroads.

The current prevailing culture in dental education is deeply embedded and strong — and it is echoed in the profession. One only needs to read Eads’ “President’s Message” in this month’s Texas Dental Journal[1] deriding the Institute of Medicine report, to realize how emotionally committed the current culture is to maintaining the current culture. I quote excerpts from his message:

These recommendations (I.O.M.) will, unless challenged by you and me, drastically change the way dentistry is practiced in the near future. You do not have to be a member of Mensa to see what the educators want to do.

Recommendations 2, 19, and 21 want to increase the training and duties of the dental assistants and hygienists, to train them how to do your job.

People, we have no one to blame but ourselves. In the early 1980s, we pushed for expanded duties and now they are here to haunt us.

As one of my dear friends said (referencing I.O.M.), “this is a scary piece of work.”

The same dear friend was told during a discussion that dentists are too procedure-oriented! This statement borders on stupidity!

People are still trying to compare the practice of dentistry to medicine. The two will never be the same. The only thing dentistry has in common with medicine is we have employees and we have patients.

Dr. Eads states that he has appointed a five-person ad hoc committee of “sharp individuals, excellent thinkers, well-spoken, and not afraid to speak their minds. I have directed them to review the 345-page report and then meet with each of the three Texas deans and hopefully have positive, open, and frank discussions about the TDA’s concerns for the future of Texas dental education as recommended in the I.O.M. report.

I hope I have conveyed to you the seriousness of this matter. For us not to respond to this report is to give tacit approval. We cannot afford to do this!

As another example of the challenges we face, not only in the near-term, but over the long-term, I use my own College. The University of Kentucky was established just after the last major report on dental education, the so-called Hollinshead Report of 1961,[2] commissioned by the American Council on Education. Our Vice President of the Medical Center at the University of Kentucky at the time had a vision of health professions education that had been clearly articulated[3] — it was reinforced by the Hollingshead Report. These visions, amazingly similar to the vision of dental education that I read in the Institute of Medicine report, provided the basis for launching a highly innovative college and curriculum. Thirty years later that vision has largely been lost, and our College has returned to many of the old assumptions — the traditional culture. I have come to understand in new and powerful ways the elasticity of culture — you can stretch it ... but it seemingly springs back.

Not only do we have to counter the culture within our profession, we have to counter the culture in medicine and medical education as well. Many of our colleagues in medicine, in their ignorance of dentistry, are skeptical of why dentistry needs curricular changes that more closely integrate dental education with medical education. The resistance to dentistry that forced physicians Chapin Harris and Horace Hayden to establish a separate and autonomous system of dental education in 1840; and that forced William Gies to reaffirm that decision in 1926, still exists!

My topic — the implications of the Institute of Medicine report for curriculum. Maybe the reality of the future is that there will be none. Maybe the forces of the current culture are too pervasive, too influential, too strong for us to overcome. But I choose to believe otherwise. We need transformative change in dental education! And it will come! I believe the Institute of Medicine report helps show the way; the road that we must take. It is thoughtful, creative, and filled with wisdom. It offers us who want to be a part of a counter-cultural movement a document, a manifesto, if you will, and from America’s most distinguished body in health science policy, the Institute of Medicine of the National Academy of Sciences. It is
a document we can use as a vision for guiding a movement. I am optimistic. History teaches us that a few people of mighty will, battling for a cause they believe right and just, can effect major transformative change. Philosopher-author Ayn Rand reminds us of this in Rourke’s defense at the conclusion of her classic novel, The Fountainhead.¹¹

Throughout the centuries there were men who took first steps down new roads armed with nothing but their own vision. Their goals differed, but they all had this in common: that the step was first, the road new, the vision unborrowed, and the response they received — hatred. The great creators — the thinkers, the artist, the scientist, the innovators — stood alone against the men of their time. Every great new thought was opposed. Every great new invention was denounced. The first motor was considered foolish. The airplane was considered impossible. The power loom was considered vicious. Anesthesia was considered sinful. But the men of unborrowed vision went ahead. They fought, they suffered, and they paid. But they won.

Now is the time. The timing is right. Our profession is at a crossroads — and the Institute of Medicine has delineated our options: embrace the “challenge of change” or take “a path toward stagnation and decay.” To appropriate Tillich’s terminology, it is a “kairotic moment.”

I invite you to stand with me in affirming and advocating for assumptions that counter our current culture — and for us to initiate major curriculum revisions in all of our nation’s colleges of dentistry — thus responding to the challenges of change with the launching of a successful counter-cultural movement!

References