

THE DENTAL EDUCATION BUBBLE: ARE WE READY FOR A LEED-STYLE RATING?



LEED Certified, LEED Silver, LEED Gold, LEED Platinum. These are all designations made by the U.S. Green Building Council (USGBC) when it established a clear framework for the environmental sustainability of new building construction.

LEED is an acronym for Leadership in Energy and Environmental Design. The terminology will be familiar to anyone who's been involved in major building projects on any university campus in recent years. The ratings reflect the requirements for design, construction, and operation of high-performance, environmentally sound, ecologically sustainable buildings.

What does this have to do with dental education? I bring up the LEED rating system not to discuss the physical construction of new dental school buildings; rather, I'm using a LEED-style rating system as a model that could be adapted to dental education in order to give dental school applicants, faculty members, governmental officials, the media, and the public a more open and honest appraisal of what a given educational program has to offer and what the educational product is really expected to be. This makes sense to me because dental schools have now diverged sufficiently from each other in their ambitions, their educational philosophies, and in the learning experience they offer students beyond the minimum required by accreditation standards to confound interested parties and obscure their significant differences. In fact, the American Dental Association's Commission on Dental Accreditation (CODA) statement assures that accreditation cannot be used to differentiate among dental schools:

The program in dental education is accredited by the Commission on Dental Accreditation [optional: "approved with or without reporting requirements"].

That's it. Even the past practice of giving dental schools commendations for good performance has now been discontinued, probably because dental deans tallied up commendations and used the final number as a public relations tactic to distinguish their own school from the rest. Increasingly, though, different schools have different philosophies, offer different educations, and yield different outcomes. CODA accreditation doesn't tell us much beyond the graduates' being eligible for licensure in a given jurisdiction. This is because the CODA system was never designed to look at how dental schools differ from each other, but rather to look at how they are alike in meeting an agreed-upon core of minimum



Charles N. Bertolami, DDS, DMedSc
Herman Robert Fox Dean
NYU College of Dentistry

"My proposal is not intended as a replacement for the CODA accreditation process, but rather as a supplement to it for interested institutions and individuals. We can think of CODA as similar to a city-issued permit to construct a new building. CODA thereby remains fundamental, but it is only the beginning."

standards. While this is entirely appropriate for an accreditation system, I wonder if a point has been reached where more than the minimum requirements is needed? Perhaps we should be thinking about building upon the CODA system through a strictly voluntary, LEED-style system available to interested dental schools in order to make their specific missions, visions, and values more transparent and relevant to the public, including to prospective students. Accordingly, my proposal is not intended as a replacement for the CODA accreditation process, but rather as a supplement to it for interested institutions and individuals. We can think of CODA as similar to a city-issued permit to construct a new building. CODA thereby remains fundamental, but it is only the beginning.

A Penchant for Rankings

The desire by dental school applicants for comparative information is reflected by the rankings of dental schools found on websites such as <http://studentdoctor.net> or <http://dental-schools.findthebest.com>. They grab whatever data they can, but none of the data are backed by a credible or responsible agency, nor is participation voluntary for the institutions named. Weight is accorded any given attribute based on the interests and idiosyncrasies of the person(s) making up the ranking. A good case in point is the now discontinued *U.S. News and World Report* ranking of dental schools that was formulated on nothing more than asking dental school administrators to rank all schools based on their subjective impressions of the few schools they actually knew about as well as the majority of schools about which they knew precisely nothing.

Despite these defects, however, perhaps the impulse underlying ranking lists and the counting up of commendations ought to be listened to as an expression of a legitimate need. Maybe the penchant for rankings is telling us something important: Insufficient comparative information is available to make informed choices by people who need to know. Maybe some credible method is needed for distinguishing among accredited programs—not with a *ranking* but with a *rating*. Maybe a few categories of ratings—certified, silver, gold, platinum, or something similar with well-defined criteria—would offer applicants and the public more information than they get now and might give institutions a tangible goal to strive for.

A rating system could differentiate programs that offer an education from those offering technical training—a distinction aptly described by R. Bruce Donoff (1), who stated that he favored shifting the balance away from training and toward education. Donoff contrasts the qualities of higher education with those of vocational training and argues persuasively that “... the educator must use different methods from those of the trainer. Education encourages critical thought, whereas training can be based on imitation or parroting.” Recognizing this distinction might be important because the differences between accredited dental education programs and the philosophies that inspire them are becoming as great today as they were in the early 20th century.

Some DDS/DMD programs seem to be moving toward a profit-generating vocational training model while others are emphasizing—and investing in—their status as mature components of the nation’s finest research universities. Some see themselves as addressing the increasingly apparent and problematic disparity in access to dental care between the rich and the poor, whereas others remain oriented toward the traditional

“Perhaps we should be thinking about building upon the CODA system through a strictly voluntary, LEED-style system available to interested dental schools in order to make their specific missions, visions, and values more transparent and relevant to the public, including to prospective students.”

university values of research, teaching, and service. It’s hard to imagine that the divergence now taking place would be completely irrelevant to the students involved or to the public. An extremely variable and inconsistent educational setting, sometimes driven by proprietary motives, is what necessi-

tated the landmark Gies Report of 1926 with its attendant commitment to making education in the biomedical sciences as central to the study of dentistry as it was to medicine. The result was that innumerable, non-university-affiliated proprietary dental colleges closed.

These closed colleges had names like Barnes Dental College, Central College of Dentistry, German-American Dental College, Homeopathic Hospital College, Interstate Dental College, San Francisco Dental College, Southeastern Dental University, National Medical University of Illinois, and many more. They would be replaced by another category of institution whose members had names like Harvard University, Columbia University, the University of Pennsylvania, the University of Michigan, and the University of California. Not all professions followed the same pattern. For instance, independent chiropractic and osteopathic schools have maintained a model

whose institutional names continue to evoke the proprietary flavor of the dental schools of the 1890s—as do, incidentally, the dental schools now being spun off by the major osteopathic chains. This is not good or bad, but it does reflect aspirations different from those of the founders of modern dental education, who audaciously aimed to incorporate their field into what would subsequently be recognized as the Carnegie classification's highest category of research university. For dentistry, the result has been an enormous increase in the quality and uniformity of the educational product, accompanied by the transformation of a trade into a profession. In the 1950s, when the graduates of these major institutions strongly endorsed the fluoridation of public water supplies and the use of fluoridated dentifrice—becoming in the public's mind the most enthusiastic proponents for putting themselves out of business by eliminating the disease they were educated to treat—the public's confidence in dentistry as a profession increased immensely, as did dentistry's prestige as a learned endeavor.

Alas, nothing is forever. Fearing the early signs of a reversion to an older and a discredited model of dental education, Dr. Peter Polverini, dean of the School of Dentistry at the University of Michigan, called a meeting of about half of the nation's dental school deans in May 2010, in Ann Arbor, Michigan.

Dr. Polverini's (2) concern centered on “the emergence of a tiered system of dental education resulting from the opening over the past decade of a number of dental schools without a clear research mission.” He pointed out that research-intensive universities demand that all of their schools and colleges, “including dental schools, demonstrate certain standards of excellence in terms of research and discovery. Indeed, such schools are looked upon as full partners within the mission of the university.”

What are the options for dental education? As more schools emerge that do not align with the mission of the research university, does dentistry abandon its hard-won status within the mainstream of higher education—newer schools prospering financially while embracing the look of a community college

and the feel of a proprietary enterprise? Not to mention the question posed by Dr. Polverini: “Who is going to lead the profession into the future if all we are doing is training dentists to be technically competent?” (2)

Furthermore, a dichotomy exists not only between newly founded dental schools and long-established ones but also between the diverging educational programs of schools that have been around for years. Many such schools exist within research-intensive universities but without embracing the research mission of the parent university. It was this misalignment between the mission of the university and the actual, if

silent, mission of the dental school that played a big part in the epidemic of dental school closings that began in the 1980s. Polverini's commentary on the outcome of the Ann Arbor meeting states the key facts for dental schools, both new and old (2):

Now, for the first time in nearly a century [the importance of the biomedical sciences in the dental school curriculum and research in the basic biology of oral structure and the pathology of oral-facial disease] is being challenged by this new direction in dental education, which is based on the premise that a shift from an emphasis on research to teaching is required to provide more care for underserved populations.... Financially driven resource issues also play a role in explaining the rise of the non-research-oriented dental schools.... A dental education management model that reduces operating costs by contracting out the basic sciences to



a non-residential basic science faculty and shifting institutional priorities from the traditional clinical education, research, and patient care model to an emphasis on clinical education and care can initially appear attractive. But once you mortgage the responsibility of basic and translational research to someone else, you essentially lose control over the future of the profession.

The objective of the Ann Arbor meeting was to prevent such a change from occurring in the foundational premise of dental education. While I agree fully with the motives of the Ann Arbor meeting, I believe the change has already taken place—a tiered dental education has become a reality. This paper advocates being more transparent about it—a goal that a criteria-driven rating system could help to achieve. If a “dental education management model that reduces operating costs by contracting out the basic sciences to a non-residential basic science faculty and shifting institutional priorities from the traditional clinical education, research, and patient care model to an emphasis on clinical education” has taken place, shouldn’t everybody know about it? Not every school can be categorized as research-intensive, and, more important, maybe that’s fine. It’s a choice. A rating system could make the choices that have already occurred more transparent to everyone.

Why Emphasize Research?

Maybe I’m placing too much emphasis on the significance of research in dental education as a way of classifying or rating dental schools. After all, research is supposed to be about discovering new treatments, cures, and diagnostic methods, not necessarily about teaching students. Isn’t this why even research-intensive universities draw a distinction within their threefold mission of research, teaching, and service? Indeed, whether new or old, dental schools today legitimately differ among themselves on the importance of research and scholarship. Schools that give lip service to the importance of research may not, in fact, act in accordance with professed beliefs—not even when their parent universities genuinely do have research as an important mission.

But research within an educational institution is not only about new discoveries; it’s also about a prevailing environment congenial to intellectual activity: The kinds of faculty members

a research-intensive institution attracts and the influences *those* kinds of faculty exert on the education of dental students are very different from a setting in which faculty members are completely unengaged in research. Henry Rosovsky’s classic book, *The University: An Owner’s Manual* (3), argues that it makes a difference when the person behind the podium is also the person who wrote the textbook; that university-level teaching is difficult without the new ideas and inspiration provided by research. “A combination of teaching and research is part of the university faculty identity. The university professor is not a teacher who is expected to confine him- or herself to the transmission of received knowledge to generations of students. He or she is assumed to be a producer of new knowledge, ...who transmits state-of-the art knowledge to students at all levels.” Similar arguments can be made about whether a school’s faculty will include tenured full-time academics and basic scientists, or whether it will consist exclusively of superannuated dentists who have left private practice and are willing to undertake a part-time or voluntary teaching position as a retirement diversion?

Does a dental school integrated within a major research university offer something different—does it contribute something more to the education of students? If so, how is such a difference acknowledged? Rosovsky (3) reflects on the impact of research universities in society at large. There are slightly over three thousand institutions of higher education in the United States. At the top, in his view, are the best research universities, numbering about 50, both public and private. He considers

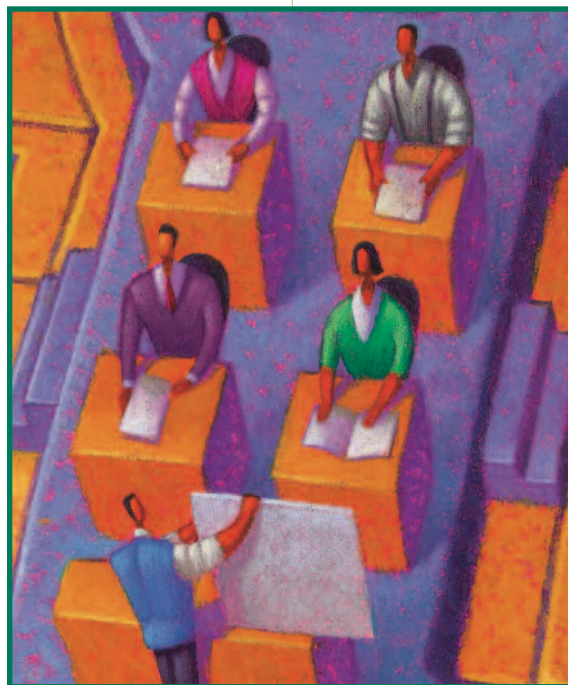
“A high level of success in incorporating dental schools into research universities of the highest stature could be one index of dentistry’s success over the past century in reinventing itself not only as a discipline and vocation, but as a learned profession.”

these institutions to be “the cutting edge of our national life of the mind. They determine the intellectual agenda of higher education. They set the trends.” (3) In this way, they also establish the priorities. Is this something we in dental education are willing to give up? How will it

be decided who has a seat at the table of higher education leadership if all dental schools are considered equivalent in name but not in substance? How have (or have not) the nation’s dental schools become distributed among these elite research universities, or, to put it another way, among the nation’s finest universities, how many have opted to have dental schools?

A high level of success in incorporating dental schools into research universities of the highest stature could be one index

of dentistry's success over the past century in reinventing itself not only as a discipline and vocation, but as a *learned* profession. Answering this question requires knowing which universities qualify as the nation's best. Rosovsky never actually enumerated his list of the top 50 or 100 US universities. But he did make clear the kinds of places he had in mind: universities that "lead the world in basic science research; provide a significant share of the most competitive graduate programs; [and] are generally at the cutting edge..." Such universities are competitive. "Institutions of the same class compete for faculty, research funds, students, public attention—and much else." Rosovsky says that at top American universities, "faculties are assembled largely on the basis of individual quality without the constraint of considering where they received their education." Quality and competitiveness dictate. At such places there are no reservations about the beneficial effects of competition, seeing it as a strategy to prevent complacency or indolence, and prompting the drive for excellence and change. Such universities assume that the quality of their faculty plays the single most important role in maintaining reputation and position. "The best faculty attracts the finest students, produces the highest-quality research, [and] gains the most outside support." (3) Few would argue that dentistry should not have a seat at the table—but increasingly, dental education institutions are not willing to commit themselves financially or psychologically to making this happen. In fact, the trends that impelled the convening of the Ann Arbor meeting suggest that dental schools are working to reverse the gains of the last century.



A Slippery Slope

Contemplate this statistic: Between 1982 and 2000, seven dental schools closed—none of them having a significant research portfolio. Forget the dental schools themselves. Look, instead, at the parent universities of the dental schools that closed. Five of the seven parent universities are the kinds of institutions that today have in aggregate almost a billion dollars of research funding and qualify as research-intensive

universities. Lacking a significant research portfolio, those particular dental schools didn't really fit within the parent universities that housed them.

Now look at the parent universities of the first five dental schools that have opened since 2000: The NIH research funding of the *parent* universities amounts to only \$3.5 *million*.

Remember, we're talking about the parent universities, not the dental schools. This means that the aggregate NIH funding of these five parent universities equates to about the same amount as the research funding of the single dental school ranking 21st among dental schools in NIDCR funding today.

What this means is that the parent universities of these institutions themselves do not see research as part of their mission; will not attract research-oriented faculty; and that the dental schools they host—statements to the contrary notwithstanding—will have little orientation toward research. This has to mean something about the environment within which students in these schools will be educated, yet we pretend that all dental schools are the same because they are all accredited. Should anyone care? It's not for me to say, but it should at least be known. Some system for making such a difference more transparent would be a more honest way to go.

Ratings in higher education are nothing new, with perhaps the most well-known being the Carnegie Classification of Institutions of Higher Education. (4) The interesting thing is that it appears that dental schools are no longer being established within the highest Carnegie classification of "doctorate-granting universities with very high research activity" (RU/VH) or "high research activity" (RU/H). Today, with one possible exception, new dental schools are mainly associated with parent universities identified as "special focus institutions." This Carnegie category includes theological seminaries, Bible colleges, other faith-related institutions, freestanding medical schools and medical centers, other health professions schools, and other special-focus institutions. This is not necessarily a bad thing, but it may signal a shift in the public's perception of the dental profession, and, more than that, it may predict

something about dentistry's stature in the future. I do think that having dental schools at the most prestigious universities in the country has made a difference in how the dental profession has been viewed as a whole. I do worry that the richness and diversity of health sciences education within a major research university is at risk of being lost.

Elements of a Rating System Going Beyond Research

Research, of course, is only part of the story. For instance, consider those schools that sacrifice a research agenda in the name of educating dentists to help redress the disparity in access to care between the affluent and the indigent. Do such schools offer a markedly reduced tuition and/or a greatly enhanced financial aid package? Do the graduates of such schools bear significantly lower debt burdens, making it more likely that they can enter the public service sector? If this is not the case, is there some logical resolution to the inconsistency between a stated mission to serve the broader public health while at the same time burdening students with a debt level that almost assures traditional private practice as the only financially viable option available to them?

From the institution's perspective, does charging a high tuition while at the same time not investing in faculty, preclinical and clinical facilities, and research programs accomplish anything beyond generating significant financial surpluses for the owners of the dental school?

The approach taken by some of the newer schools is not the only one worth discussion: Consider long-established public dental schools offering a modest tuition for in-state residents. Are the residents in those states that are subsidizing the education of dental students getting their money's worth? Do tuition-subsidized graduates of public dental schools give a sufficient return on the state's investment in them? For instance, absent the debt burden carried by private dental school graduates, do dentists who graduate from public dental schools charge their patients less on average? Are they more likely to participate in Medicaid reimbursement programs? Are they

more likely to accept patients who are on public assistance or are completely indigent? Are they more likely to practice in underserved areas? Are graduates who benefited from heavily state-subsidized educations even likely to remain in the state that paid for a big chunk of their education?

Such a critique can be tailored to any dental school: Are the high-tuition, research-intensive dental schools really delivering on what the students are paying for? As important as I think an education colored by research may be—one taught by the highest-quality faculty at the best universities—maybe that's *not* what a lot of students are really interested in. Maybe the best students go to the cheapest schools because their academic records are the most competitive and they have the choice of

attending any dental school they want. Maybe what's left are the less academically gifted who are the least likely to benefit from the kind of education a first-rate faculty and a first-rate university can offer. If a high-tuition, research-intensive dental school really is offering a better educational product, it ought to be able to prove it.

It is precisely because each of these viewpoints is credibly defensible that I think a rating system is a good idea. Let everyone know exactly what they're getting into.



The Difficulties of Devising a Rating System

Inevitably, a rating system is values-driven. For instance, the ad-containing website <http://dental-schools.findthebest.com> offers rankings based on what it claims are “unbiased, data-driven comparisons.” However, the data has to be evaluated by someone—and whoever that anonymous person is, he or she will have a value system that decides what will be included, what will be excluded, and what the weight accorded each category will be. The ranking is based on the “schools’ programs and statistics, including average DAT scores, mean GPA admitted, class size, NIDCR funding, and more.” The website states that “FindTheBest gathers ratings from the most respected experts in each category.” Who exactly are these experts and how do the chosen input data make a difference in the eventual educational outcome—the thing we’re really interested in? I wonder why mean college GPA, DAT scores, tuition, location,

percentage of the applicant pool admitted, or class size would be factored into a rating system. These are all things that have some interest to an applicant seeking admission to a particular school, but distilling such data into a ranking doesn't make much sense because the data are so easily available to applicants through public sources. A much more important and impressive metric for a rating system might be one based on what a dental school actually achieves with the students they do admit.

When excellent students enter a school and equally excellent students exit it four years later, it doesn't really say much about the educational program—whether transformative change attributable specifically to the school, its programs, and its faculty is a realistic expectation. Good students in a bad environment typically make the best of it and still learn a lot even when the system, in effect, works against them. On the other hand, when students with marginal backgrounds go on to brilliant careers, it says something about the educational program itself, as opposed to the qualifications the students came in with. Rather than focus on admission numbers—easy though they are to secure—it might make more sense to look at the pass rate on Part I and Part II of the National Board Examination and on regional licensing examinations.

This all distills to a simple fact: Data-driven rankings are not that useful when the institutions being ranked are not voluntary participants in the rating system because the quantity and quality of data are often only whatever is publicly available. The elements of a rating system would need to go far beyond this—what the educational program *actually* produces, especially in terms of outcome measures that are not publicly evident. I don't think it would take long for well-intentioned educators, practitioners, a highly qualified think tank such as the Santa Fe Group, and members of the public to define the appropriate parameters—parameters based on outputs, not inputs. It would require that the voluntarily participating institution be willing to invest time, money, and effort in securing follow-up data reflecting the real impact of its educational programs. Examples were mentioned earlier:

- Some schools purport to educate public service-oriented graduates who will disproportionately seek employed positions in the public sector rather than in higher-income

private practice. Does such a school credibly deliver on that claim over the long term? Such information could be factored into a rating.

- Schools accepting major subsidies from state governments could account for a disproportionate benefit to the citizens of the state that paid the bill if such a benefit actually exists.
- High-tuition schools that claim outstanding faculty and strong research programs ought to be able to differentiate the performance of their students on objective external measures of achievement in comparison to other schools.

Beyond the necessity of participation by the school being rated, protracted preparation time would be required, as would a site visit by a knowledgeable review team. This would be a worthwhile investment for an institution if there's a platinum rating in the offing. None of this is easy, but it's important and worthwhile.

As with the U.S. Green Building Council's LEED rating, the founding premise has to be stated unambiguously so that institutions can know the criteria they need to aim for in each rating category. As with the LEED system, it would be important for an institution to target the rating it is seeking; that is, not every institution should aim for platinum, and, failing that, be granted gold or silver as a consolation prize. Criteria for categories would need to be defined in

sufficient detail so that an institution can pretty much know that it qualifies ahead of time. Of course, the designations platinum, gold, silver, and certified do convey an implicit statement of quality—but they are all good. The designations for a rating system could be non-hierarchical, resembling the Carnegie classifications mentioned earlier rather than the LEED-style rating.



Is Ethics a Legitimate Outcome?

Just about everybody knows that the dental profession has gotten itself in a terrible fix. The death of a 12-year-old from dental disease brought to public attention an egregious disparity in access to dental care between rich and poor. Today, when the dental profession is mentioned in the media, the news is too often bad—a real public relations disaster. I do believe that when considering dentists as a whole, a significant segment of the population thinks that dentists are more interested in their

own financial well-being than in the health of the public. This is true not only for dentists but for almost anyone in any profession. (5)

Even the American Dental Association (ADA) has sometimes been seen as much an advocacy group for dentists as for the public. Nevertheless, excellent and trusting relationships continue to be lived day-by-day between patients and their own dentists. But the negative perception of dentistry organizationally is leading to legislative initiatives to improve access based on the belief that dentists cannot be trusted to help those in need without the coercive hand of the state. Thus, entirely new categories of dentists are being formulated—dental therapists—that move past the American Dental Association and the existing dental profession as a whole. Will this new secondary tier of dentists actually improve access to care? I doubt it—especially as lower-paid dentist-therapists make fully corporatized dental care more profitable to corporations that hitherto have been unable to enter this marketplace successfully. But my point here is that maybe dental schools have to

bear some share of the blame for the access-to-care problem if viewed as an ethical issue. Have we lost sight of the eleemosynary responsibility of every professional person? Dentists denying care to patients in need or declining to participate in public assistance reimbursement programs might be interpreted as a failing in the way we teach ethics. Maybe a rating system of the type I am proposing could in-

corporate not what is taught in our ethics curricula—a simple input—but rather how *effectively* what we teach actually plays out in dental practice, especially for patients unable to pay. Again, such a schema would require that the rated institution participate, establish systems to track such information, and incentivize their own graduates to be forthcoming.

Whether creation of new categories of dentists will or will not improve access to care is beyond the scope of this paper. I bring up the matter only to underscore the importance of a rating system for schools that confer the DDS or DMD degree. Doctoral-granting institutions will need to differentiate themselves from new dentist-therapy schools because the public is not going to make such fine distinctions despite significant dif-

ferences in the comprehensiveness of education. This point resonated powerfully for me in a statement made in a PBS documentary, *Frontline*, broadcast on June 26, 2012. A newly trained Minnesota dental therapist, speaking on behalf of a newly created discipline, argued confidently:

We are trained to the level of a dentist. How I'm taught to do a filling, how I'm taught to do a root canal on a baby tooth, how I'm taught to extract a baby tooth is identical to the type of education dentists receive. I am trained to that level. I'm just trained in fewer things than a dentist is trained to do...I don't know why anyone would want to oppose a very well-trained professional treating someone who otherwise would not get treated.

The opening statement is the most worrisome: “We are trained to the level of a dentist.” But is this really true? The most dangerous people are those who don't know what they don't know. The therapist is talking about a specific number of

very limited technical procedures—but what about the complications from those procedures? It echoes the distinction Donoff makes when talking about the difference between receiving an education versus receiving training or parroting. The therapist's self-description as a “very well-trained professional” is precisely the point. Who's to say? Who is impartial enough to prevent self-interest from intruding into the

equation? Subsequently in the broadcast, the president of the American Dental Association expressed the view that “Our concern is the idea of a lesser-trained individual doing surgical procedures.” It seems a very reasonable concern; however, those with the highest qualifications as experts are increasingly being delegitimized because they are seen as having a vested interest in a particular self-serving outcome.

That society has gotten to the point that it has lost its trust in its own experts is tragic (5), and reminiscent of Livy's first-century lament that “we can endure neither our vices nor their cure.” (6) Maybe a more apt analogy would be that we can endure neither our problems nor their solutions.



The Bubble: The Market for Dental Services vs. the Market for Dental Education

A key point made by Polverini at the Ann Arbor Dental Deans Forum (2) was that a motivation for the founding of new dental schools is that “a shift from an emphasis on research to teaching is required to provide more care for underserved populations.” It is important for dental educators to understand that there are two separate but interrelated markets. One is the market for dental services; that is, the public’s demand for direct dental care. At the moment, this market is problematic because given the supply of dentists and the demand for services, some people are being left out—those who can’t pay and therefore are unable even to enter the market for services. Public health dentists, the government, and the media advocate for such individuals to be cared for outside the market system. But the dental services market is not really the market that the newer dental schools are entering. Rather, they are entering the market of people seeking a dental education. Over the long term, it may be true that as the supply of dentists increases, the cost of services could decline, and the public’s interest would be served. But markets are complex, and the way the market for dental services and the market for dental education are related may not conform to expectations. As long as there are more people seeking admission to dental school than there are available seats, the market for dental education can be very profitable. The problem is that the tuition and fee structure of new schools is very high; thus, the graduates of these schools are not likely to be in a position to provide for the needs of the underserved, who require services outside the existing market system. In reality, new dentists are being added for those patients who can already pay for care and for whom there’s not much of a shortage of dental services.

Add to this the emergence of dental therapists who, over time, may radically change the market for dental services. If a relationship emerges between dentists and dental therapists that is comparable to the one that now exists between dentists and dental hygienists, it could make dental practice even more profitable. Alternatively, if dental therapists become the basis for a fully corporatized model of dental care, as has happened in pharmacy with the large chains, it’s more difficult to guess what the impact on independent dental practice will be.

It’s no exaggeration to say that today’s dental students are really speculators willing to pay a high price for an education that may or may not yield the return on their investment that

they expect. Should the bubble burst for dental education, evidenced by a smaller number of applicants than available positions, schools will need to compete for students more intensely. Driven strictly by economics, the most successful schools will be those that offer the fewest services, have the lowest expenses, at the highest possible tuition. Under those circumstances—all things being equal—the most successful and sustainable schools will be the newest ones with the most robust financial plans. But maybe all things are not equal. Maybe some schools will offer services that will continue to be valued by applicants beyond acquiring basic technical skills leading to dental licensure. Perhaps some applicants will see the differentiating value of an education that conforms to the highest standards of the best universities. Maybe those contemplating specialization will gravitate to those places they think will help them gain access to the best postgraduate programs. I’m not really sure that this is true; however, I do think that a rating system of the sort I am proposing could be a step in the right direction.

The purpose of the Ann Arbor Dental Deans Forum was to frame a way of leading the profession into the future. Quite possibly the historical moment for that opportunity had passed before the forum ever took place. The worry at that time was that we were on the verge of “making a dangerous mistake about the standing of the dental profession going forward ... [and that] we will begin to look more like a trade than a profession, a posture that jeopardizes the long-term prestige and progress of the dental profession.” (3) I believe that we are beyond that point. The least we can do is to be honest about it. A rating system might help us do so.

References

1. Donoff RB. Commentary on Bertolami article. *J Dent Educ.* 2001;65(8):739-741.
2. Polverini P. The Ann Arbor Dental Deans Forum: crafting a response to the emerging tiered system of dental education. *Global Health Nexus.* 2010;12(2):24-27.
3. Rosovsky H. *The university: an owner’s manual.* New York: Norton; 1990.
4. The Carnegie Foundation for the Advancement of Teaching. *The Carnegie classification of institutions of higher education* [Internet]. Available from: <http://classifications.carnegiefoundation.org>
5. Yankelovich D. *Profit with honor: the new stage of market capitalism.* New Haven (CT): Yale University Press; 2006.
6. Livy. *Ab urbe condita.* Foster BO, translator; Goold GP, editor. Loeb Classical Library. Cambridge (MA): Harvard; 1919 (reprinted 1978).