SCENARIO I: OPPORTUNITY LOST

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Scenario 1 Highlights

In this scenario, academic dentistry is blessed with a strengthened financial position over the next five years, but educational innovation loses momentum after the COVID-19 pandemic. Tradition wins over innovation and prevents growth and sustainability of initiatives precipitated by the pandemic.

As the pandemic gave way to new normals, academic dental institutions were energized around change and innovation. Financial prosperity enabled schools and programs to allocate funds to improve diversity, equity, and inclusion; expand interprofessional education and practice; and increase faculty development, retention, and recruitment, including hiring additional faculty members and assigning faculty protected time for scholarship and innovation. Investments in the physical and technical infrastructure enhanced the teaching and learning environment. Faculty compensation packages were increased, and many retired dentists were hired in adjunct positions, easing the workload of the clinical faculty. Lower student-to-faculty ratios initially increased clinical productivity and faculty research. The commitment to *time in program* accreditation requirements in dental education combined with time-honored traditions was strengthened through increased state and federal funding for higher education and research. Academic dental institutions invested in new technologies for classroom and clinical instruction, and all health professions programs expanded interprofessional education, collaboration, and practice models within

their existing structures. Increased funding from public and private sectors helped train clinical faculty and supported both faculty and student research. Dental schools also increased community engagement through service-learning in community-based clinics, and the commitment to community provided a vehicle to support a healthy work-life balance for students, faculty, and staff.

The sense of well-being generated by financial security led to optimism among many thought leaders that significant educational innovation would follow, and schools directed part of their investments toward measures that would support progress toward that goal. By 2026, however, it has become clear that progress has slowed or halted in most dental schools, without having come near to realizing the promise. The reasons for this disappointment are not fully understood and vary from institution to institution, but it is evident that adherence to traditional academic dental culture by many in both the academic and practice environments has been one powerful factor undermining educational innovations. Early progress in interprofessional education and practice, for example, was ultimately halted when those resistant to change in dentistry, medicine, and other health professions seized the initiative and convinced their colleagues to retreat again to their disciplinary silos. While the advocates of change are pleased with progress made in some aspects of academic dentistry, enabled by its strong financial position, they wonder if future generations will view this period as one in which the conditions for transforming dental education were finally right, but the opportunity was missed.

Life in This Scenario

As Dr. Mika Salazar waited outside her department chair's office in early March 2026, she reviewed her reasons for being there. She remembered well her first meeting with the chair, Dr. Nisa Shah, when she came to the school to interview for her first tenure-track position, full of hope and high expectations.

During that visit three years ago, everything led her to believe this would be the place she would find support for her dreams of being an educational innovator. Previously, as a busy clinical instructor, she had little time for scholarly activities or developing the new educational methods she believed would improve the profession and satisfy her creative drive. Dr. Emma Watson, search committee chair, told Mika the significantly increased financial support for all health professions after the COVID-19 pandemic enabled the school to expand its faculty, build a new clinic, add allied and specialty dental programs, and expand the school's equity and diversity efforts. "We're hiring several new faculty members like you," Dr. Watson said, "with the goal of balancing your teaching with time for your scholarship and work in areas like interprofessional education."

Also on that day, Dr. Shah told Mika about the school's new clinical and translational science research teams, mentoring program, and faculty development activities that would help her become a successful clinician scholar. In addition, Mika had positive conversations with Dr. Kevin Augsberger, who shared his excitement about the new integrated medical and dental clinics; dental hygiene student Hakim Johnson, who told her he had entered the program after participation in the school's pipeline program for disadvantaged youth; and fourth-year dental student Maria Rodriquez, who would soon achieve her goal of becoming a dentist because of tuition credits she received as a first-generation student from an immigrant family. After this campus visit, Mika felt enthusiastic about the possibilities and accepted the school's offer.

Now, after three years, she is disillusioned and frustrated with the *same old, same old*. Recalling her wonderful interview, tour, and initial experiences makes her think the school presented itself as the educational innovator its leaders hoped it could be, but general inertia and faculty resistance to change prevented much progress. There are positives: she has a good salary and time for scholarship and appreciates the school's diversity and technologically advanced clinic. Plus, her family loves the city, and her children are in good schools. Still, she feels her creative energies have stagnated, and her enthusiasm for

educational innovation has flagged with so little opportunity to flourish. Colleagues who are innovation advocates have already left, and she believes students are suffering from the outdated curriculum though she suspects they will only realize it later. From day to day, she often feels she is simply going through the motions still pleased to be educating the next generation of oral health professionals but always thinking there could and should be better ways of doing so.

Today, after Mika is welcomed into Dr. Shah's office, she tells her department chair about these frustrations and admits she is starting to look at positions at other schools and even considering leaving academia to join a practice. Taking a deep breath, Mika asks, with dwindling hope, "Is there anything you can do to help?"

Scenario 1 Details

With great success and despite some early implementation challenges, effective public health mechanisms and a surprising uptake of vaccines brought the COVID-19 pandemic under control. Significant public awakening led to increased support for public health, healthcare, and health professions education, and financial investments followed from both private and public sectors. Academic dental institutions found themselves suddenly freed from the financial worries of the past and able to allocate new funds to many areas. Advocates of educational innovation hoped the situation would enable transformational change in the structure of dental education. Five years later, academic dentistry has made progress in several areas, but educational innovation is not among them. And even in areas where some progress has been made, the momentum has slowed or halted.

The aftermath of the pandemic saw massive increases in mental health issues throughout society, including academic dental institutions. Challenges of health equity that already existed were exacerbated by COVID-19, and increasing social unrest created stress levels that were overwhelming. A clear need for behavioral health services and well-being

initiatives was recognized in academic health institutions. Health professions programs addressed this need within their communities—seeing mental health and well-being as one part of crisis preparedness efforts and an integral part of the curriculum and faculty development. Unfortunately, over time, the glitz wore off, and the traditional education model in service of the missions of teaching, research, and service returned to old habits and rigid hierarchies.

The teaching mission of dental schools was a primary area for innovation which was boosted by faculty development and recruitment. Internal and external faculty development offerings promoted best practices in effective teaching and provided peer review and training for faculty related to their roles as educators and mentors. Investments in new equipment and other aspects of the physical and technical infrastructure enhanced the teaching and learning environment. Schools increased faculty compensation packages to attract and retain faculty members and were able to offer adjunct positions to retired or retiring dentists with an interest in teaching thereby reducing the workload of the clinical faculty. Schools strengthened pipeline initiatives for developing future educators and recruited some recent graduates as faculty. Lower student-to-faculty ratios initially increased clinical productivity and faculty research engagement. However, faculty recruitment efforts focused on senior practitioners comfortable with and committed to the traditional education model which had consequences for implementation of educational innovations.

Initially, there was momentum and conversation around curricular change, including integration of content pertaining to diversity, equity, and inclusion; however, there was minimal space in the traditional curriculum to make substantial changes. Instead, the compromise often included adding a couple of lecture hours on cultural competence in each educational program or hiring a part-time diversity officer.

In another aspect of the curriculum, parent institutions increased opportunities for faculty and students from multiple programs to collaborate in interprofessional patient care via community-based clinics and didactic courses. Although interprofessional training should

start early in the curriculum, dental schools struggled to provide meaningful interprofessional experiences that encouraged learning from, about, and with multiple professions. A need remained for faculty development to precede and accompany interprofessional education and to cross-train faculty to work with students across the health sciences.

In the research mission, fiscal prosperity saw a renewed commitment to biomedical, clinical, and educational scholarship. Legislators approved substantial additional funding for research, most of which was dedicated to the National Institutes of Health (NIH), including the National Institute of Dental and Craniofacial Research (NIDCR), and other funding agencies. Universities were given additional incentives for training, recruitment, and retention of the NIH-funded faculty. The NIH and other research institutions implemented "boot camps" and research training programs for junior faculty members to improve their competitive grant applications. The NIH allocated additional funding for Early-Stage Investigators, making it possible for faculty to engage in cutting-edge research. The NIDCR's Short-Term Mentored Training Awards supporting early career faculty members were expanded. Universities allocated additional funds for consultants to assist faculty members with their grant applications and other responsibilities related to research administration. Well-funded dual-degree programs led to the recruitment of competitive students to research teams. This, in turn, increased research productivity and resulted in novel preliminary findings and competitive grant applications.

In addition, the influx of clinical faculty allowed those with research training and interests to initially dedicate significant amounts of time to their research and scholarly work. Universities also allocated funding for interdisciplinary projects and implemented various national and international collaborative research programs. Eventually, however, the traditional educational model prevailed, and only the institutions with research in their core missions were able to continue these initiatives. Non-research-intensive oral health programs returned to their clinical enterprise and continued their emphasis on teaching and

service. They adopted the attitude “We are happy we tried it, but these research programs are just not sustainable!”

To fulfill academic dental institutions’ service mission, faculty service and advocacy efforts increased through greater involvement with local, state, and national associations and alumni groups, although sustaining this change and involvement proved difficult. Alumni and faculty had increasingly different ideas about the future of dentistry which led to policy conflicts, even though schools’ relationships with professional associations were somewhat strengthened. By 2026, some strategic collaborations were moving through several legislatures. In general, faculty, staff, and students initially showed more interest in policy and advocacy and participated at higher levels than before but saw mixed, mostly disappointing, results from their efforts. This led to a decrease in involvement in advocacy and policy-making as faculty, staff, and students became frustrated.

Related to the service mission, the COVID-19 pandemic and its aftermath brought issues of health disparities along with racial and social injustices to the public consciousness. Health professions programs, faculty, and clinics further appreciated the importance of addressing these problems, and these attitudes stimulated funding to address inequities. Academic dental institutions were able to support and promote diversity, equity, and inclusion initiatives. Community engagement was of increased importance to institutions’ service missions. Pipelines to dental education grew gradually in number and reached historically underrepresented students in both urban and rural areas over time. Financial support for community-engaged scholarship focused on population health, access to care, and access to health professions education, which moved dental education a step closer to its equity goals. This looked great to the public eye; however, addressing a striking diversity shortfall would take persistent commitment over time.

In another aspect of service, some faculty members embraced interprofessional practice as one way to improve access to care in underserved communities. Following a public health approach, school-owned and -managed community-based clinics added

significant and sustainable interprofessional components including community service with integrated health records and increased telehealth. Health promotion and disease prevention activities were popular among students as was interprofessional engagement. Interprofessional student groups helped co-create learning and service experiences. Unfortunately, within the ivory tower of traditional dental schools, this type of innovation failed to inspire similar efforts on campus. Conflicts began to increase between students, faculty, and administrators and between various faculty groups which pitted the pro-community/interprofessional practice faction against the only-within-our-walls faction. Time-in-program accreditation standards further contributed to this discord. Oral health integration faded as schools retreated to their silos.

Early on, the attention given to service initiatives led to an improved sense of well-being among students, faculty, and staff. Giving to others and seeing one's positive contribution to the greater community created an environment conducive to meaningful work for all. However, by 2026 growing frustrations within the institutions led to decreased faculty and staff engagement and increased cynicism. Eventually this frustration would transfer to students, decrease morale, and perpetuate the cycle.

For dental education, the five years from 2021 to 2026 were marked by a return to tradition and stability. Strengthened finances yielded some positive changes in strategic priorities related to diversity, equity, and inclusion; faculty development, recruitment, and retention; and interprofessional education, practice, and collaboration. At the same time, factions within schools resisted meaningful innovation or sustainable change.

In the end, the culture within academic dentistry proved resistant to change. Traditional systems based on competition, hierarchies, and self-promotion evidenced by image over action and department-focused care over patient-centered and population-based care held sway after the initial excitement for and movement toward change. Despite making some progress, dental education ultimately entered a period of great somnolence. It was an opportunity lost.

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