More Emphasis Is Needed on Patient Well-Being in the Dental Curriculum

David Precious, *CM, DDS, MSc, FRCD(C), FRCS;* **Reginald Goodday,** *DDS, MSc, FRCD(C);* **Archie Morrison,** *DDS, MSc, FRCD(C);* **Ben Davis,** *DDS, FRCD(C);* **Chad Robertson,** *DDS, MSc, MD, FRCD(C)*

Contact Author

Dr. Precious
Email: *d.s.precious@dal.ca*

Cite this article as: *J Can Dent Assoc* 2010;76:a29

As dental educators, we are concerned that the teaching of core oral health services is losing its relative importance within the undergraduate dental curriculum in Canada. From our perspective, when we speak about core oral health care, we are referring to essential health services such as treatment of cleft lip and palate, obstructive sleep apnea, ankylosis of the temporomandibular joint, squamous cell carcinoma of the lip and serious traumatic injuries. If dental students can experience being a team member in the provision of such core health services, we believe that as professionals they will have a greater depth of understanding and compassion for the patient.

A Flawed Evaluation System...

Any discussion about the decreased prominence of core oral health services in our dental schools must also address the overall teaching and evaluation philosophies that seem to have taken root. It is our position that the increased use of quantitative evaluations of teachers, along with a decreased emphasis on patient well-being, requires further attention.

The first area to examine is the prevalence and unintended outcomes of employing quantitative evaluation methods. It is becoming common for faculty and administrators at dental schools to make personnel and program decisions based on systematically collected information. This information is often obtained by student ratings of instruction, peer evaluation and faculty self-evaluations.

These 3 evaluation methods are popular because written evidence of teaching evaluation is often necessary for defending job promotions or for legal and university procedural reasons. However, we believe these conventional methods of evaluation are fundamentally flawed because they try to apply the methods of science to the study of social phenomena.

The goals of these evaluation methods are more concerned with the measurement of performance and certifying competency then with improving teaching. The most serious shortcoming is that these evaluations have little bearing on the well-being of the patient. Information about teaching performance rarely leads to recommendations and future improvements either in patient care or core oral health care. In essence, teachers, students and administrators are engaged in evaluation exercises that do not attempt to directly test whether the condition of the patient is substantially improved.

...Leads to a Flawed Teaching Approach

In dental schools, the norm is for teachers to give dental students clear objectives, lecture material, appropriate references and practical demonstrations of a particular subject. We then assign tasks or pseudo-problems to students and ask them to employ skills we have

already taught them to "solve" these mock scenarios. Tasks become problems only when the students do not have the skills to deal with them. Otherwise, a given task simply becomes an exercise or practise in the use of skills that have already been acquired.

What we seldom provide the student is the opportunity to formulate problems, an exercise of considerably greater intellectual importance than problem solving. In depriving the student of this valuable educational opportunity, we falsely separate conception from execution, and in the process, stress vocational training over professional education. In stressing a vocational approach, the relevance of the needs of the patient is lost and our long-term goal to encourage dentists to be creative, innovative and caring health care professionals is undermined.

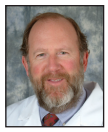
How can we overcome these apparent shortcomings? The clinician-teacher must have a genuine passion for his or her subject area. As well, teachers of dentistry must demonstrate behaviour which proves to students that the patient truly comes first. This requires a teacher to be necessarily eclectic. However, there are few supporters (or accurate measures) of eclecticism in dental education today. Reliance on current teacher evaluations has led to uniformity, predictability, precision and control. We should always remember that teaching is, in large part, an art that isn't always easily captured in a quantitative evaluation.

Our educators must also celebrate thinking in our students, and the best way to achieve this is by demonstrating behaviour that students can emulate. For the clinician-teacher this means conducting clinical investigations that seek to improve the condition of the patient by either verifying or refuting the appropriateness of a treatment. The teacher should then seek to write about these investigations in a peer-reviewed publication. Dental students are remarkably receptive to this kind of teaching by example.

The guiding philosophy of today's dental education, which is driven by the development of statements of educational goals, course objectives and methods of teaching evaluation, must also demonstrate to students that administrators and faculty have the general well-being of the patient as their uppermost concern. If we fail to do this, there is a real danger in graduating new dentists who have been through the education system without having been convinced that the patient truly comes first.

THE AUTHORS

Dr. Precious *is dean emeritus of dentistry and professor in the department of oral and maxillofacial sciences, division of surgery, Dalhousie University, Halifax, Nova Scotia.*



Dr. Goodday *is associate professor and chair of the department of oral and maxillofacial sciences, division of surgery, Dalhousie University, Halifax, Nova Scotia.*

Dr. Morrison *is associate professor in the department of oral and maxillofacial sciences, division of surgery, Dalhousie University, Halifax, Nova Scotia.*

Dr. Davis *is associate professor in the department of oral and maxillofacial sciences and head of the division of surgery, Dalhousie University, Halifax, Nova Scotia.*

Dr. Robertson *is assistant professor in the department of oral and maxillofacial sciences, division of surgery, at Dalhousie University, Halifax, Nova Scotia.*

Correspondence to: *Dr. David Precious CM, 5981 University Ave., Dalhousie University, Halifax, NS C3H 1W2.*

The views expressed are those of the authors and do not necessarily reflect the opinions or official policies of the Canadian Dental Association.

This article has been peer reviewed.