An Interview with Professor Sandro Palla

Prior to your retirement, what was your position and role at the University of Zürich? Were you also involved in other related administrative scholarly activities?

I am now a professor emeritus at the University of Zürich, but prior to my retirement, I was the director of the Clinic for Masticatory Disorders (Orofacial Pain and TMD), Removable Prosthodontics, and Special Care Dentistry. The latter responsibility included the management of geriatric patients and those with special needs, such as Alzheimer disease and chronic syndromes, as well as those patients who are physically and mentally handicapped. My clinical responsibilities also included the training of both undergraduate and postgraduate students, with the latter groups' program leading to specialty qualification in the field. In Switzerland, the Swiss Dental Association, through the Swiss Society for Reconstructive Dentistry, recognizes specialist qualifications in reconstructive dentistry within one of four fields—fixed prosthodontics, removable prosthodontics, geriatrics, and orofacial pain.

I was also Director of Curriculum Revision and for 3 years served as the academic director or dean at the Centre for Dental Medicine. At that time, the primary responsibility of this role was to improve the recognition of dentistry within medicine. The curricular role included the need for co-coordinating the restructuring of the undergraduate dental program with a focus on the "medicalization" of the curriculum. This led to a broadening of the medical knowledge, an earlier contact of students with patients and oral medicine topics, as well as a reduction of the previous heavy emphasis on technical requirements and student laboratory work.

Where and when did it all start—influences, role models, etc?

The Gysi tradition strongly influenced the prosthodontic thinking in Zürich. Professor Alfred Gysi was head of what was then the Department of Prosthodontics and Restorative Dentistry, and had very eclectic interests, such as pioneering work on a geometric approach to three-dimensional jaw movement and occlusion, together with tooth histology and dental caries. Prof Gysi introduced the design of anatomically correct artificial tooth rehabilitation, which was a significant step—keeping in mind that at the time, prosthodontics was essentially almost entirely devoted to complete denture rehabilitation.

More direct and personal influence came from my immediate predecessor, head of the then Department of Complete Dentures, Prof Albert Gerber. He also had strong interests in occlusion and the temporomandibular joint and influenced my fascination with the management of temporomandibular disorders (TMD). This quickly expanded to erroneously consider joint imaging as a means of improving the diagnosis of TMD by considering condylar position, but also led to my interest and commitment to TMD research.

This interest also led to my decision to visit the Department of Occlusion at the University of Michigan to further develop knowledge of the etiology and treatment of TMD, recognizing that a varied treatment approach was needed depending on the specific etiology. The head of the Department of Occlusion at that time, Dr Major Ash, was most influential with his questioning of issues. This was a further stimulus for an enquiring young mind, and helped develop a continuing curiosity to explore and consider different research ideas and approaches.

On returning to Zürich with an expanded knowledge base and an opportunity to build on the foundation for treatment that had already been established there, it was opportune to implement change, driven by the recognition that the majority of TMDs could be managed with a variety of techniques, but that not all were successful. This led to the recognition of the need to broaden clinical assessment and for patient management to include general medical management with the involvement of medical specialties. The approach was also strongly influenced by Dr Isler, clinical neurologist from the Medical School, which was the beginning of interdisciplinary treatment for TMD and orofacial pain in the faculty.

What were the most rewarding experiences of your career?

To have had the opportunity to be able to influence dental education so that it developed and grew to include more biologic and medical content in mainstream coursework, to have been able to encourage a broadening of the educational protocol from a primary focus on teeth and periodontal disease to embrace basic science as a foundation for clinical knowledge, and to have been given scope to play a role in enhancing medical course content in the dental curriculum.

Disappointments?

A few, inevitably, given the ups and downs of clinical academic life. I had to come to terms with a couple of observations that continue to concern me. First, that colleagues do not sufficiently recognize the role of dentistry as an integral and important part of general health management, and the often needed integration of medical and dental management in dental treatment; and second, that dentistry is becoming increasingly driven by commercialization, particularly through a focus on esthetics. This appears to be at the expense of an expanding medical focus on diagnosis and on the overall management of oral health.

Another issue that concerns me is that clinical decision making is often mediated by the dental practitioner's own concept of oral health needs, rather than by what is best for the patient. The latter approach must focus on prevention, with treatment invariably based on the best available clinical evidence. I regret having to say this, but I regard this predicament as essentially a failure of dental education, which appears to still be driven by the provision of items of service and how this is achieved instead of prevention.

Any thoughts about different approaches to graduate clinical education in dentistry (eg, the generally perceived European "paper-heavy" route versus the strongly technical North American one) or about similar differences (if any) in your own fields of interest?

Several paths can lead to a desired educational goal, and methodologic differences are not so important as long as that goal is reached. I must reiterate: The goal of graduate clinical education is to teach a concept that is founded on prevention. Prosthodontic therapy is generally necessary as a result of a failure of the dental community to promote and maintain oral health. Given the fact that most of the time spent in dental education is actually spent undertaking restorative procedures, it is understandable that all too often, students and dentists become fascinated by the quality of the work. They tend to forget that the "best dentist" is the one who succeeds in maintaining his or her patients free of caries and periodontitis indefinitely. Dental education must be taught within the context of promoting and maintaining oral health. There is a need for a teaching paradigm change: Education must be biologically evidence-based and not exclusively skills-oriented. It must succeed in making graduate students remember, throughout their careers, that skills are important only if supported by prevention. This remains the greatest challenge of dental education.

What advice can you give to a younger colleague who is agonizing over career paths—academia versus practice versus industry or government?

Young colleagues who wish to consider an academic career need primarily to be driven by curiosity. They need to be prepared to question knowledge in general and not just accept what is written or stated, and they also need to question themselves. In general, it appears that colleagues regard a title as the mark of success. But to be a success in reality, it is necessary to be a scholar and to recognize that the need to improve oneself as well as their discipline—this is what is needed of professionals to guarantee progress.

Is there a worthwhile future in scholarship that seeks to reconcile the sort of research you did with dental treatment outcomes? Or is the presumed association an inflated or even an underappreciated one?

Clinical practice must evolve through research-based information, and particularly clinical trials and outcome studies on the long-term effectiveness of clinical procedures. Dentists often provide treatment that they believe would be best for themselves with similar conditions, although this is not an acceptable argument anymore. In today's variety of treatment modalities,

there is an even greater need to increase the patient's participation in the goal-setting process, in making him or her share control of the treatment and management decisions that take into account individual preferences within psychosocial contexts.

Too often dental treatment is based on expediency and the success of particular procedures and techniques that the clinician provides without considering other treatment options (ie, minimal intervention based on data from outcome studies on the shortened dental arch concept). In addition, there is an increasing need to acknowledge the implications of medical conditions and their impact on dental care.

For clinical practice to advance, dental practitioners need to become more critical in general, and especially of themselves, of industry pressures, of what is written, and of speakers at meetings. It is important for clinicians to not be passive recipients of information, and this needs to be emphasized and embraced comprehensively during the educational process, where research-based teaching can be an important stimulus to engage interests in life-long learning.

You are regarded as one very high profile academic who was slow off the starting blocks in the post-1982 Osseointegration Conference era. Any reason for this? Were you surprised by the universal impact of the technique on the entire area of oral rehabilitation?

This arose because of a priority interest on orofacial pain rather than a lack of interest in implant rehabilitation.

Implants are continuing to change patients' lives with improved rehabilitation, but in general, prosthodontists continue to deal with what has been poorly managed by our colleagues. In Switzerland, there is an excellent public oral health program that has progressively improved community oral health and is beginning to change the priorities of dental practice. This is encouraging.

Where do you go from here?

To continue to be involved in patient care with a continuing special interest in orofacial pain. In addition, and particularly in the immediate future, to maintain a commitment to teaching, as well as continued research involvement with colleagues with whom I have worked over the years.