An Interview with Professor Ridwaan Omar

Ridwaan Omar has been an invaluable member of this Journal's editorial team for well over a decade. He is the current Head of Prosthodontics at the University of Kuwait and agreed to this interview request a year ago. We started the interview with his brief explanation about the region he is currently in, so as to provide a perspective for the reader.

Saudi Arabia is the largest of several countries located in the Arabian Peninsula; Kuwait, in contrast, is one of the smallest. In a number of ways, the "Gulf countries" are similar (albeit also with some differences). Unparalleled development programs over the past 40 years or so have resulted in a widespread relocation from rural and/or nomadic living to urban areas and, indeed, a shift toward increasingly western lifestyles. The present generation of young adults has more than likely spent their lives in the oil boom period, which started in the late 1960s. A similar pattern applies to the other Gulf countries driven by oil/gas-based economic strength, which has both shaped their development and distinguished their modern history from the other more populous and less prosperous countries of the Middle East. Not surprisingly, the dental profession and dental education in Gulf and non-Gulf countries show different trajectories, too, even though there seem to be some areas of convergence recently with the rapid appearance of private schools in some countries. One needs to qualify this by saying that while this reflects a demand for dental education, accessibility to these schools in the Gulf countries is probably achievable by most; in non-Gulf countries, it would be the preserve of a very small elite in the population.

What is your present position at Kuwait University and role in prosthodontic education?

I came to Kuwait some 6 years ago, seeing the new dental school as an opportunity for encouraging change in the prevailing professional—and more specifically, disciplinary—status quo. This would suggest that one would have felt there was need for a shift. This was indeed so, as I had, by then, had a long time to observe the unfolding regional disciplinary landscape. My appointment at Kuwait University was in the Department of Restorative Sciences, and shortly after, I was asked to take on the academic leadership of prosthodontics, a unit within the department. As in undergraduate curricula elsewhere, prosthodontics forms a large part of our students' program, and the role we play in it is, I feel, one that all academics must resist losing direct contact with—even when the demands from other quarters threatens it. As it happens, the other part of my responsibilities as Vice Dean for Academic and Clinical Affairs is not an altogether uninteresting "business of administration" one, since we are in the process of a significant curriculum re-design toward wider inclusion of the medical sciences, more integrated (as opposed to wholly discipline-based) clinical dental education, and greater student-centered learning.

Before coming to Kuwait, I had lived and worked in Saudi Arabia, mostly in academia, for 20 years. After such a long time, thoughts that a change could be good for one might not be unusual. A perceived need for change can be due to any number of stock reasons. For me, the main ones were a feeling of having done about as much as I could where I happened to be, actually wanting a new challenge, and an anticipation that a new school, without the entrenched teaching formulae likely to be found in older ones, could allow better expression of a long-held educational project. Since the "project" was, to a large extent, incubated in and tailored to the region, remaining within the region itself seemed obvious. Furthermore, the Middle East is a part of the world that I had come to know well and whose unique characteristics I had come to understand and hold dearly. Standing out amongst these special features is a cultural tradition that prides itself on a warmth of spirit, especially to those from the outside, the centrality of family cohesion founded on patriarchal values (benignly so, I believe), loyalties which, once formed, are unshakeable, and a stoic yet spiritual view of life in general. A small prosthodontic reference to what I'm trying to say is a study we did on the emotions felt regarding tooth loss by edentulous Saudis. What we observed in peoples' responses was an unequivocal acceptance of their predicament across the group, a seeming tolerance in the face of hardship, reflecting, we thought, the spiritual view

taken of life's challenges. This contrasted with findings from elsewhere of far lesser willingness to accept their condition.

Returning to our own curricular changes that I mentioned earlier, even though we are still in the transitional phase, there is no denying the educational benefits already seen through a greater inquisitiveness and the broader perspective taken by students in clinical prosthodontics. In such a context, the possibilities for giving greater relevance to what students learn in their undergraduate prosthodontic education are theoretically limitless. Increasingly, I see my role as a "home-straight–entering" academic as using the academic route to reconcile older stances with new knowledge if the discipline's positive development in the region is to be assured. It may be due to the possibilities that a smaller "pond," as well as a better understanding of its particular undercurrents, provides in terms of forging a convergence of positions, but I am more hopeful now than I once was, as we unfold the breadth of prosthodontic management and therapeutic possibilities to our students, that the educational and clinical emphasis is ripe for repositioning. It is no longer a question of whether but rather where that emphasis will be on the continuum between the "technique-passionates" at one end and the "evidence-only stalwarts" at the other.

Even though our school is still too new to have begun its own postgraduate programs, I am actively involved in residency training programs run by the Ministry of Health, while also being fully engaged in the establishment of the Kuwaiti Board in Prosthodontics. In this regard, the opportunity to define learning outcomes with far greater societal relevance and specificity than has been the practice is probably one of the best means of developing the discipline in the country.

How did you get here?

I consider myself fortunate, in the 1960s, to have been able to go from South Africa to school in England—all through the good grace, generosity, and some sacrifice of my parents. After finishing school, I studied physics at the University of Leeds, and toward the end of my degree, not being too enthralled by the prospect of further study in possibly low-temperature physics, I was literally open to all other options! A friend, who was several years older than I was and who had come into dentistry after having been a school teacher, painted such a sufficiently enticing picture of dentistry that I found myself literally "falling toward" it.

This could not have been the most objective way in which to make a career choice, but I do wonder now, many years on, how the guidance of a "mature" individual, yet new to dentistry, compares with that of the one traditionally called upon to give such guidance, who is generally a senior role model and one already engaged in the profession. Also related to the question of choice of profession, I wonder whether my own somewhat serendipitous landing in dentistry may be seen as an early example of what has become the trend in some countries of admitting graduates in diverse fields into abridged dental programs. If I may, my own experience fully resonates with such a move in dental education, and I applaud it.

I arrived at Guy's Hospital Dental School into what was called 2nd BDS, an entry point at which all the essential scientific building blocks for dentistry are assumed to have been covered. The problem was that I knew almost nothing about the biological sciences, never having taken such courses, so I needed to very quickly "validate" my entry-point assumptions—from learning about what a cell was and how it functions to how it was fundamental to making any progress in understanding dental science. Much of it seemed only mildly curious, I have to say. As always, there are people who can bring light to such dark times, and one who did so for me was Professor Jeff Osborne, who provided the most compelling illustration of the rhythmic undulations of ameloblasts during enamel formation using his own DIY creation of a Perspex smoke chamber with movable internal dividers that had slits cut in them. Professor Osborne seemed, at the time, to be a committed cigarette smoker, and easily filled his chamber with his own exhaled smoke to show, in a darkened laboratory, how primary striations in enamel are formed. I have never since doubted the (single) true benefit of cigarette smoke!

What were the influences that led to your career decision?

From very early on, the uniqueness of a biological system, especially vis a vis the rarity of absolutes, its probabilistic functional nature, and the acceptability of inexactness, ran directly in the face of concepts in the physical sciences. There was, of course, complete denture laboratory techniques in the third year that served as a sort of "second best" in the exactness stakes. But the real disorientation one felt had more to do with needing to come to terms with the wide variations in the natural histories of disease processes. Being in the mind of a junior dental student, I assume that these questions had to have been instinctive (intuitive would be presumptuous) rather than fully rationalized, but they stayed there, and as I later became drawn toward the discipline of prosthodontics,

the need for greater clarity to the pivotal question about clinical judgment grew. Only much later would come the far more challenging matter of how we as clinicians grapple with, and then "grow into," being able to conjoin evidence-based information—whilst acknowledging its varied uncertainty—with experiential knowledge toward achieving that overarching measure that we can term "clinical (managerial) competence."

After graduation in 1975, I worked for about a year in general dental practice, which was at the time somewhat negatively connoted as "NHS dentistry." Although there are those who would say that some patients over-benefitted, a blanket characterization of the era would be unfair. Many benefitted from dental, even oral, healthcare under the National Health Service, according to the 10 yearly UK Adult Oral Health Surveys, with improvements in several outcomes including declining edentulism, with increasing partial edentulism among older adults reported over a 30-year period. As a young NHS dentist, the opportunities that independent practice gave one were, on the one hand, exciting and challenging, but on the other, worrying: One felt capable of providing care to some, but also wholly inadequate to do so for others. Being the NHS, the economic factor was not a big issue, and it was possible to treat adult patients with compromised, depleted, and heavily restored dentitions—of whom there were many. Sometimes their complexities seemed to be beyond one's ability and experience and they could be referred. But the nagging void even then was the inconsistent levels of functional satisfaction with quite varied numbers of remaining teeth. Not having some handle for assessing the level of prosthodontic intervention that was functionally needed gradually became a cause for unexplained anxiety. So, just over a year after graduation, there was an unarticulated but growing realization of the need for the "management of patients' oral rehabilitative needs" more competently—and now, I would add, more inclusively too. To act on this would need a deeper theoretical understanding of the discipline, as well as the accompanying clinical and technical skills. If for me choosing dentistry was possibly by default, choosing my discipline most certainly was deeply considered.

Where and when did it all start—influences, catalyzing events, etc?

The attraction of the discipline was strengthened by my wish also to teach it. This tied in with the possibility of a faculty appointment at the first dental school (the University of the Western Cape–UWC) in South Africa to admit students other than the "white" racial group, according to the then political system. One recalls viewing such a situation with mixed feelings, but the bottom line was the chance to contribute to the education of a broader group of dental professionals for the country, who to that point could not have had such an opportunity. Some good was surely to come of it, we felt—as it did. On other fronts, the dental profession in South Africa was well established. Prosthodontics, at the University of the Witwatersrand in particular, had a strong tradition of research and clinical excellence. It was here, in the early 1980s, that I recall being introduced to the then revolutionary results from the Brånemark group on osseointegrated dental implants together with the Toronto replication studies.

Working in the NHS was a tough learning environment, but its lessons were invaluable. One of those crucial lessons, I believe, was that I entered my next phase of formal education with a conviction of the importance of accepting how little one really knows at any given time and the hard work and humility it takes to fill those gaps as they appear. Such a stance also accepts that there are, and indeed there have been, moments along the journey that influence the perspective one takes and, thus, where one places one's emphasis. Perspectives and emphases will each have changed at various points—mostly as a gradual process, but occasionally very strongly. No doubt there will be more such pivotal moments. At the Eastman in London, I consider myself privileged to have had, as my mentor, Michael Wise. He had obtained his specialty education at the University of Indiana, and I have no doubt that he helped me benefit from his experience with a system of postgraduate dental education that was arguably amongst the best of its kind at the time. Who can forget that precision in everything was everything then, and precision ensured excellence. The case in point was, of course, clinical (and technical) excellence, even if the extent to which technical precision per se is able to influence clinical outcomes is a lot less clear today than was believed at that time. What cannot be disputed in this regard, however, is the role of precision of process in recognizing and interpreting patterns of events in order to judge likelihoods of clinical outcomes.

When I returned to join the young UWC dental school as a faculty member in late 1978, the excitement of teaching students preclinical crown and bridge and clinical courses was enormous. I was also building a busy extramural practice. At the same time, postgraduate programs were being established, each with their own time demands. The effects of such creeping overload are not difficult to imagine, and as

one saw less and less of one's young family, choices needed to be made. To a young prosthodontic educator whose career pathway seemed chosen, yet not quite fully settled into, and also by now being fully familiar with the large economic disparity between the academic and private practice domains, a cause for serious personal reflection arose. Reducing practice time was a possibility, but leaving academia was not an option. Probably influenced by having lived outside my country of birth for so long, the outcome of it all was that a change of location was felt the best way forward. Although an increasing "brain drain" from the country was happening, I do not believe that this was influential in my own choice.

Faculty vacancies were being advertised at a new school, King Saud University, in Riyadh, and it seemed like a place to go to for a short stint while one nailed down a definite career pathway, where that might best be built, and a timeline for it all. Well, those are probably my most famous last words, because there really was not much looking back, as Riyadh took on a virtually home-away-from-home status.

The call of South Africa would always remain, but for most of the time that I was away and until change actually began to happen, the chances of any change actually happening would for most have been a dream. But as South Africa transformed from its old self into a nonracial democracy, not only the country but the whole world celebrated and applauded the magnanimity with which leaders, both new and old, grasped the opportunity for peaceful, just repositioning—would that such reconciliation could apply to the many intractable divisions elsewhere, including professional ones! Institutional and organizational changes followed suit, including dental education. Some could do so more quickly than others, dependent as change was on the degree of repositioning required of the existent educational models. To illustrate this point, during a spell at the University of Stellenbosch in 1998, it seemed curious to me how undergraduates, albeit senior ones, were called upon to re-restore failed, complex prostheses, most of which would have been provided under insurance cover during earlier times. The educational benefits of such an approach would seem questionable, but perhaps I am commenting on just one of the inevitable consequences of the structural inequities that then existed. Other than this, huge socioeconomic disparities remain, and it is the manner of the discipline's response to the large numbers of patients in need of care that will define its future development in the country.

What sort of changes have you personally undergone in the process of tackling career, family, and shifting academic realities?

The family's move to Riyadh in 1984 was for two reasons: to establish a career as the best prosthodontic educator I could be, while at the same time providing an environment that was conducive to raising a young family. Quite early in this "experiment," my wife and I had no doubt that, to a large extent, these expectations were met. To date, this remains not only our view, but also our sons', then aged 5 and 3 and now 31 and 28.

My new department chair was Professor George Mumford, formerly (and formally) from Connecticut and Indiana, but in so many ways always a true Australian. Working with George and other colleagues there at the time corroborated some of my own ideas on the engineering exactness of prostheses. Mechanical imperatives dominated our educational direction, as they did and indeed still do in many other programs throughout the world. Still, one cannot deny the rumblings within as one became more and more aware of another prosthodontic management approach that clearly differed from the one we swore by: Fixed restorations seemed to be surviving well, and even if the extent to which patients' needs were satisfied was not entirely clear, there were relatively few complaints—and was this important anyway if technical standards had been met? Even today, it remains axiomatic that the best possible mechanistic solution is the only one, all else being even improper. On the other hand, one was regularly faced with hugely imprecise swaged gold crowns and retainers, many with "tagged" acrylic facings often with distorted pontic spans due to the softness of the metal framework, and as a result, often heavily impinging on the underlying ridge, and yet, when these were sliced off in readiness for metal-ceramic replacements, there was not a lot to be seen in the way of disease under them. Regrettably, swaged gold restorations are still widely applied in countries to our north and east, but do we really know enough about them to denigrate them? Not that minimalism ever became teaching practice then, but I found myself gradually moving from a 100% replacement strategy on sight to far fewer replacements. After much reflection and fruitless enquiry from published sources (as existed), one found oneself gradually being steered from an outright ideological stance of "if you don't see a problem while examining a patient, you aren't looking hard enough" toward a far more uncomfortable one, specifically about the veracity of our hallowed formula. In any event, academic realities being what

they are, it was too early for a shift in our educational approach given the absence of any scientific explanations for what was empirically observed. It is sad to admit that this lack of evidence persists to this day.

There was quite a cosmopolitan mix of faculty members, then almost exclusively expatriates, with its many influences: Educational and cultural variation would seem self-evident, which, in some way, must have had its role in one's own changing position. In another sense, if the stereotypical image of the region is one of a slow pace, I would instead characterize it as unhurried, maybe even introspective. In this regard, I have to confess to wondering at the time whether this was partly the reason for a seeming lack of urgency in the area of scientific enquiry because research was not a high priority. Insofar as direct (positive) personal effects, I do wonder whether my own impatience, even intolerance, about things in general was transformed or at least tempered in such an atmosphere of serenity! Students were both bright and enthusiastic, representing the top echelon of school-leavers. Upon graduation, many who were eligible had prosthodontics high on their list of preferred disciplines. Unlike graduate students in most other countries, ours were fully funded by the Saudi government (as they are in Kuwait, too), and most chose to go to the US (as they do in Kuwait, too), and a smaller number to the UK and Scandinavia.

Later, I assumed the administrative role of Director of Research. At the time, postgraduate programs in the clinical specialties were being developed, and, for the purpose, I was involved in setting up core facilities for physical, biological, and microbiological research. All I can say is that it was scientifically and educationally rewarding, but the administrative minefield was at times traumatic (probably because of the differences from what one was accustomed). Soon after this, I also became chair of our department. The "business of administration" multiplied, but thankfully, there was soon to be a meaningful reprieve.

What has made you happiest in your career? Disappointments and regrets?

Any number of influences can potentially alter the course one happens to be on. Most of these are people: There are those with whom we briefly cross paths, and then again, there are those who have re-directional impacts on the course we are on. A number of people, too many to mention, have left their positive marks; one or two have done the opposite, but one gains little by dwelling on them. Among those who I count as pivotal is Gunnar E. Carlsson for the maturational influence he has had on my academic development.

I became acquainted with Gunnar through one of his PhD students, Anders Johansson, who joined my department in Riyadh in 1988. From about this time, research became a much stronger focus for me than it had ever been. My experiences with the group have shown me that synergy, in all respects, is the key, and all successful collaborations will have sought this out before going to the next step. I would suggest that a tendency for individual rather than joint efforts, which seems to be a tendency in the region, may also be an explanation for the relatively smaller research productivity—and this in spite of the availability of enviable resources for research.

Events, too, can play a part, so a turning point came in 1990 with the Iraqi invasion of Kuwait, just north of us in Riyadh. The net result, with many uncertainties facing one's family, was that they relocated to South Africa (which was by then itself undergoing the first moves toward political change), while I moved to the large military hospital in the same city, Riyadh. Here, clinical practice was the mainstay, and this was rewarding after a more limited amount of it at the dental school. During this time, I organized and prepared candidates for postgraduate clinical examinations of the Royal College of Surgeons of Edinburgh, for which the hospital was accredited. In many ways, this rounded my exposure to the full spectrum of professional activities in Saudi Arabia. Our research group continued its work, and during this time, I was privileged to be asked by its then new Editor-in-Chief to join the IJP's review board, a role I have since thoroughly enjoyed and benefitted from academically, including, of course, during the tenure of the current Editor-in-Chief.

By 1998, the possibility of returning to a new South Africa arose. As I indicated, it had been my hope to do so at some stage, so I felt I owed this to myself. However, having been away from that academic environment for what was then 15 years was probably too long a time to re-adapt—at least it felt that way to me. My stay at Stellenbosch as Chair of Prosthodontics was thus short, and it was with much disappointment that I had to concede that what I had anticipated was not to be. On the other hand, it was with renewed anticipation that I returned to the region in which I had spent the bulk of my career, and whose many characteristics I felt I understood, perhaps better than I did my own country's.

During the 9 years that I had been away from the dental school in Riyadh, there had been a steady shift in the faculty complement toward Saudis. Most were gradates of the school who then went abroad for postgraduate education, mostly for specialty training and a Master's degree and mostly in the US. Not

unexpectedly, the educational approaches of the schools they attended would, in turn, be reflected in their own teaching stances—at least in the immediate to medium terms—until individual scholarly inquiry and interaction with colleagues from different backgrounds begin to push the learnt boundaries.

There is no doubt that the policy of "indigenizing" the work force in all sectors is proper for all Gulf countries, whose dependence on expatriates had for long been excessive. One of the positive outcomes is the stability of staff, compared to the relative mobility of expatriates. It has the potential of organically growing and consolidating local skills and for the incumbents to become role models for ongoing recruitment into academia. Ultimately, this can and should positively impact on the quality of undergraduate and postgraduate dental education in the region, although the length of time it will take for the benefits to filter through should not become open-ended. In countries as young as the Gulf states (both in stages of development and in population age distribution), yet growing as fast as they are (both in economic size and in population), the time dimension could be problematic. A case can be made for a mechanism whereby the indigenous academic growth, for which the potential undoubtedly exists, might be optimized. This should involve supporting the process more purposefully with clearer guidance on the academic method—indeed beyond the mechanics of prosthodontic treatment, execution, and delivery. The possession of skills and an information base should be accepted as the mere tools that they are and by no means the full repertoire of an academic.

However, what seems not to be in short supply and seems almost to be the prevailing disciplinary method is the vast, almost scary, array of "high-tech" available to "technologize" prosthodontic practice, although many times of questionable therapeutic utility. Conversely, "low-tech" represents regression. Added to an almost unshakeable belief in technology is the view of some that any other approach to solving patients' functional problems belongs in the realm of philosophy, which is simply construed as nondental and, therefore, irrelevant to practical clinical pursuits. Certainly, there is probably a large proportion of patients in this region with the economic means to have "the best that is on offer" (on a cost-determined basis), but there is also a large segment of society that remains in the other, less fortunate camp. The lack of baseline data, particularly relating to adult oral health and prosthodontic treatment need in particular, seriously constrains much-needed scholarly debate.

Advice to a younger colleague who is agonizing over career paths—academia or practice?

There is no doubt that a large financial disparity exists between those in the two domains of prosthodontic activity. I have personally experienced both, albeit not totally separated from each other. Clearly, academia will never make you rich, while there is in most of us a natural desire for human comfort, if not prosperity itself. The advantage for young, aspiring academics in this region is that unlike those in much of the rest of the world, the onus of financial debt upon entering academia is largely absent.

If we are to make a theoretical comparison between the two domains, one way may be to consider the risk and reward of each. For practice, when viewed essentially as an entrepreneurial venture, the analogy could be seen as fairly straightforward. It is more difficult to make such an analogy for academia. One approach may be to assign value to the risk pertaining to scholarship: In this way, the future of the discipline, and coupled with it, society's advancement, would be the "risk" (burden) carried. Assigning value to the reward is more blurred since it lies in the future and the beneficiaries are not personally known to us—contrast this with the likely immediacy and clarity of reward in the practice domain. I would cautiously submit that if a young colleague can see the assumption of such "risk" as appropriate "reward" as fulfilling in the scenario just outlined, then he/she could well consider themselves as being a potential candidate for academia. In addition, although the dividends are not measurable in financial ways, they are perhaps more lasting and probably more sustainable.

At the practical level, it remains a challenge to attract young professionals who want to teach and do research. This, in turn, requires an environment that promotes and can facilitate the development of these skills. Most would agree that this is where the role of postgraduate prosthodontic education and mentorship are crucial.

Where do you go from here?

The answer here has two parts to it. One is general and relates to the need for change in the prevailing trends in the discipline, and although this may be the case in much of the world, I refer now particularly to the region.

Affluence has, quite reasonably, caused a part of society to emulate all that it perceives as best elsewhere in the world. Whether the whole of society is ready for this is unclear, but speaking for our discipline,

there is a disconnect between expensive (yet nevertheless affordable) prosthodontic solutions on the one hand and broader adult oral health concerns at the population level on the other. The seeming preference of the discipline and patients for a technology-driven path at times seems to be its raison d'être. At the same time, education lags behind, seemingly unresponsive, or at best, only slowly responsive, to mounting research evidence that runs counter to many existing paradigms. Repositioning the traditional, one-size-fits-all, all-or-nothing prosthodontic treatment formula to a more inclusive one in which patient-perceived functional needs take on a more significant role in clinical decisions must start with data. In this regard, little is known about prosthodontic epidemiology and even less about its social dimensions, including outcomes of therapy. The relevance of a sociodental approach to needs assessment has not been explored in the regional context. The evaluation of treatment strategies, not exclusively through the absoluteness of prospective RCTs but perhaps in a case series fashion, needs consideration. Yet, the view that scientific data is of necessity the sole arbiter in clinical decision making should be tempered. There seems to me little reason why such essential research questions cannot be posed in Kuwait, with its small, fairly homogenous indigenous population coupled with a well-funded healthcare system. It is only documented outcomes, in the regional context, that have the potential to stimulate more rigorous debate about the still idiosyncratic subject of clinical decision making.

The other part of the answer is more personal. I am between 5 and 10 years from formal retirement (the retirement rules here permit such flexibility), which is why I described myself earlier as one who is "home-straight–entering." If we stick to the analogy of a hurdle track event, throughout the laps that have passed, I consider myself fortunate to have had a good kick off the blocks, a steady maintenance of tempo without flagging too soon, few difficult obstacles to clear, one or two timely stretches of being carried forward by the wind on the sometimes lonely back-straight, and a few good bursts of second wind when they were most needed. Coming into the home-straight now, there is a chance to look over one's shoulder and see that one is at least in the middle of the field, not that being last would have been any disgrace. Although winning is always going to be a special feeling, as sportspeople say, having fully participated is what makes it all worthwhile.

From my perspective, the academic journey has been more than worthwhile so far. Finishing seems still some way off, but resting on one's laurels is hardly a means for progress. Much remains to be done in educational program development, research, and teaching—but probably most important of all is a wish to foster a greater level of humility in our professional interactions, be they amongst ourselves, with our students in whose education we share and to whom we owe our best, or the privilege of attending to our patients' oral functional needs. Conversely, we must resist the arrogance that lingers amongst us of not recognizing how much of what there is to know that we do not know.