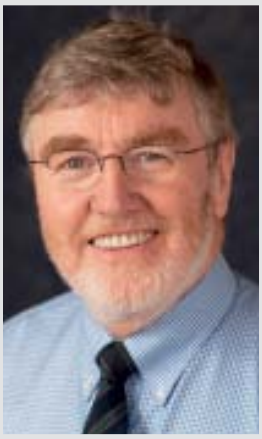
An Interview with Dr Michael MacEntee



What is your current position and role in prosthodontic education?

Ambiguous, to say the least! I am approaching a transition point in my life and career, and I'm not so sure where I'll go from here. If you mean: "what am I doing now?" I can respond with pleasure that I am still an actively teaching, researching, and clinically practicing professor of prosthodontics and dental geriatrics at the University of British Columbia. It's a role that I've played overall since 1975, when I joined the Faculty of Dentistry. I was hired to help teach prosthodontics, although I believe that my colleagues at the time were not altogether clear on what exactly that meant. Prosthodontics as a discipline was undergoing a dramatic identity crisis at the time from a segmented discipline of "C & B, Full and Partial Dentures, and Maxillofacial Prosthetics" to the coherence that we have today. When I arrived at UBC, the C & B course was reasonably strong, but the denture courses were in disarray. My role at the outset—as I interpreted it—was to tackle the disarray. It was an uphill clinical and political struggle, but we came into line eventually with the global movement, and we also possibly contributed a little to it.

How did you get here?

This question has three dimensions for me: physical, intellectual, and emotional. My migration from Ireland through England, Ontario, Trinidad, Manitoba, South Carolina, and, finally, to British Columbia was an unplanned route of dreams! I followed in my father's footsteps. Mind you, I was 15 years old when I drifted into the decision to become a dentist. There was an unspoken assumption at home that I would continue my father's country practice, but he died unexpectedly near the end of my second year of dental studies, and I had my first lesson in the futility of long-term plans.

Following in my father's footsteps, I graduated in 1969 as a dentist from the Royal College of Surgeons in Ireland and went into general practice in Northern Ireland. Sadly "the Troubles" in that part of the world were getting very nasty, so Mary, my wife, and I relocated to the south of England. There was a shortage of dentists everywhere and opportunities were plentiful. I was restless, and a few months after our son was born, we set off again to see the world with all of our worldly possessions in eight suitcases.

From practice possibilities in South Africa, Australia, and the United States, I selected an internship at the Hamilton General Hospital in Ontario, where I extracted more teeth than I care to remember and had my first direct encounter with people who lived near or below the poverty line. The outpatient department of the hospital provided dentistry for people on welfare who, to the consternation of the nurses, frequently arrived in welfare-paid taxis for free dentistry. "Why," the nurses complained, "do they get free dentistry when we pay?" It was a confusing question until I heard the circumstances surrounding the taxi-riders—physical sickness, psychological distress, and a multitude of social disturbances had dealt them sorry blows. The "free-riders" were unhappy and confused despite the provincial welfare they received. None of them chose their poverty or social turmoil, and they needed help. It was clear to me that at very least I could relieve their dental pain. Poverty was beyond my professional mandate, but if I could help to make them a little less uncomfortable and a little more socially integrated, then my own job was more satisfying, and that's where my social and political awakening occurred.

What were the influences that led to your career decision?

After my experiences in the Hamilton General Hospital and a brief cultural adventure as a dentist in Trinidad, I returned to a school service with the government in rural Manitoba and then to a general practice in Winnipeg, where I encountered a group of affluent elderly patients with crowned teeth and rampant caries. I had no idea how to manage their dental disease. I thought of replacing the crowns but fortunately I abandoned this unpredictable approach before I started. Instead, I contacted Aidan Stephens, my prosthodontics teacher in the Dublin Dental Hospital, who had moved to the Medical University of South Carolina as an associate dean. I asked him how I might go about reconstructing the elderly mouths in Winnipeg, and he advised me to become a prosthodontist.

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

This serendipitous introduction to the prosthodontics program offered by the Medical University of South Carolina led me as a prosthodontic resident to John J. Sharry, who was the dean, and Stephen Bartlett, who was the director of graduate prosthodontics. Sharry and Bartlett were clinical visionaries. They had a sophisticated sense of the history and need to integrate fixed and removable prosthodontics, but they had no illusions about the intellectual weakness of the evidence supporting the clinical practice of dentistry. As graduate students, my colleagues and I acquired their ways and views. However, despite the compatibility of their clinical visions, they were administrative foes, and I saw first hand the unpleasant aspects of academic politics that served neither of them well. Fortunately, I was unscathed by the battles of sparring academics as I moved through a very intellectually interesting and clinically challenging clinical program. But there were lessons learned there that helped me cope with battles in my own academic life, and now, as a seasoned player of academia, I can attest to Woodrow Wilson's quip that the intensity of academic squabbles reflects indeed the triviality of the issues considered.

The patients I treated at the MUSC offered another cultural awakening. It was the Deep South, and racial tensions were strained. I had seen already in Northern Ireland the distrust and cultural mockery from one community to another. These were not trivial issues. I was part of the privileged community in Ireland and in South Carolina that saw and judged the other community through the distortion of privilege. However, I learned quickly that clinical success, even with plastic or metal, depends as much on my sensitivity to the whys and wherefores of others as it does on the fit of my prostheses. I notice now, even in Canada today, how little significance as a profession we give to these social and psychological differences. We offer our services with the naïve conviction that what is best for me must be best for them, and then we wonder why they do not listen.

Anyway, when I arrived at UBC, my skills were in prosthodontics. I had a solid foundation in my clinical discipline and could set about safely refining my clinical skills. I saw readily how I could contribute to the prosthodontics courses of the faculty, but I was completely adrift from the research activities of the faculty. I had no research experience, and only a vague awareness of the scientific method. I was completely bewildered when asked to dinner by a senior colleague to "talk science." The epidemiology of oral diseases in old age had caught my attention, and I was beginning to talk "about" statistics and other scientific methods, but I had never imagined that people talked science as a language unto itself. This constant reference to science amongst my more established and revered faculty members mystified and threatened me as a clinician.

Still, I persisted to learn the ways of research, and with help from Crispin Scully and Tom Dowell at the University of Bristol, where I spent my first sabbatical leave, I applied scientific principles to discover how little we knew about the distribution or cause of oral disorders in old age. Subsequently, I tried carefully to apply scientific principles and "probability theory" to survey the oral health–related beliefs and behaviors of elderly people. The results were published, and I rose through the academic ranks. However, I had doubtful confidence in my findings beyond the inexplicable rampancy of oral disease among people who customarily attended to their dental needs.

Some years later, I discovered from research collaborators in sociology, social work, and nursing that physical diseases emerge, spread, and disturb people not simply because of their physical aberrations but through a much more complicated and uncertain interplay of physical, psychological, and social phenomena. William Osler, who pioneered medicine in the 19th century, asserted that, "Medicine is a science of uncertainty and an art of probability," yet nobody had explained this to me, nor did I hear it in science or any other language at dinner parties or in the hallway gossip of my dental school. On the contrary and in contrast to my own clinical observations, there was an unsettling air of certainty among my seniors, who, as principal investigators of large research grants, believed zealously in science as the one true way to resolve health problems. My clinical world did not fit into a laboratory. It was saturated with chance and bias, despite my efforts to overcome and eliminate them. At last, I realized that many good clinicians use clinical scripts with more than a smattering of humanistic sensitivity more routinely and effectively than they use the upper hierarchies of scientific evidence. But let me drop this attack on the tyranny science! The readers of this journal have heard it before.

I've been influenced greatly by Jim Bader and Dan Shugars at UNC and by Vibeke Baelum at Aarhus University, who argue that useful management regimens for caries and periodontal disease will emerge more likely at the population or societal level than at the individual or tooth level. Considering the general mismanagement of caries globally and, most particularly, in our own institution, surely we need another more realistic explanation for this perplexingly recurrent disease that demineralizes teeth notwithstanding our technical sophistication with dental restorations.

Indeed, my work over the past decade has been influenced even more broadly by the debate on the contributions of science and art to research and inquiry in general. This debate has been carried notably by the biologists Edward O. Wilson, who favors the reductionism of science, and the late Stephen J. Gould, who argued that only a broader mix of science and the humanities can explain the contingencies of complex systems. I see health, diseases, and health care as very complicated human phenomena, and I feel much more comfortable as a clinician combining scientific and humanistic methods for my research.

What has made you happiest in your career?

When that eight-unit implant-supported maxillary prosthesis fell into place and the patient smiled! I assume your question relates to my work rather than to my domestic life. Either way, it is a difficult question to answer because my Irish temperament tends to scoff at temperamental or emotional extremes—at least when we are sober. We fear extremes because they are fleeting, yet neither are we a perpetually dour race; I do have happy moments! Reaching far back, I probably felt most satisfied, relieved, and happy on my graduation from dental school. Then, I had the exciting sense of freedom and personal independence that comes with entry to a useful profession. I do continue to feel elated when a patient smiles gratefully, when a student sees the light, when an editor accepts my paper, and when an audience claps appreciatively. As professors, we spend a lot of time as public performers, and like other performing artists, we crave recognition and acclamation!

It has been a privilege to serve our professional organizations. The Association of Prosthodontists of Canada brought me to the national stage in a minor political role. Then, the International College of Prosthodontists provided a forum for me to see how other countries accommodate prosthodontists. I learned from these experiences that our profession needs organizations such as these; they need our attention and sustenance, and we need the knowledge and camaraderie they offer. My time with the Royal College of Dentists of Canada, both as an examiner in prosthodontics and as president, was particularly rewarding to me as a Canadian because in my time, it saw the beginning of a formal process of examining dental specialists for clinical credentialing across the country, and I am sure that dentistry in Canada is the better for this process. In all, my experiences in organized dentistry gave me challenges and very many rewards.

On the other hand, my most enduring satisfaction comes from the achievements of my graduate students. I have had the good fortune to supervise five PhD students and three MSc students. Three of the PhD students and one MSc student came from abroad with English as a second language, and I learned much more than I taught during their time with me. All of my graduate students came with a serious interest in an academic career, and it is immensely satisfying to see that the three doctoral students who have graduated are now assistant professors, one Master's student is an associate dean for clinical affairs, and the other completed his PhD elsewhere and is now an assistant professor with us at UBC. Currently, I have two PhD students and one MSc student nearing the end of their studies, and hopefully they too will remain in academia. At a time when dental faculties everywhere need new blood, it is pleasant to know that I have made some useful contribution to this need by sparking the imaginations and sustaining the intellectual curiosity of at least a few others.

Disappointments and regrets?

The usual disappointment in academic life is realizing that an argument does not work—typically because I have presented it ineptly. The collegiality of academic life can be very disappointing when a colleague is misjudged or fails to live up to expectations. We are a competitive community, and the competition is not always kind. There is much talk about interprofessional teamwork and collegiality, especially in the clinical context, so our expectations are constantly raised but not often rewarded. We live in a realm where new ideas are valued highly and innovations seen rarely. We are paid to be critical, and self-criticism comes with the job—even when we experience success. It's disappointing to see how little we celebrate our achievements, probably because there is always another beckoning peak. Perhaps this beckoning lessens with age—I haven't noticed yet.

Your thoughts about different approaches to a graduate education?

Graduate education, and particularly clinical education, has been a work in progress during my lifetime. Dental faculties have adopted, modified, discarded, or otherwise questioned educational schemes that are "knowledge-based," "competency-based," or "goal-orientated," and now we are working our way through "problem-based" and "community service learning"—all worthy theories, but all lacking the reality of clinical practice. Moreover, we know so little about how clinicians reason their way through clinical problems. Almost certainly, it is not in the simplistic

"hypothetico-deductive" approach that dominated medical and dental education through much of the last century. As Shiva Khatami concluded in her PhD dissertation, we still seek "the conceptual framework for clinical reasoning in dentistry grounded on empirical evidence to direct the future evolution of dental education." Perhaps this is a tall order, but it would be good if more clinical teachers joined the search.

Prosthodontics has been dogged by the debate over theory versus technical competence. We still argue about the need for prosthodontists to have the technical skills of a dental technician, yet we don't ask architects to build houses or orthopedic surgeons to cast metal joints. We study in minute detail, and with good reason, the properties of ceramics, resin, and metal; however, we overlook the pathogenesis and management of caries. We replace teeth competently but overlook the psychosocial determinants of tooth loss. We design our dental practices and our university clinics to accommodate the interests of young adults but ignore the needs of people who are disabled. I feel very strongly that our residents should be the champions of dental geriatrics, and they should be equipped to understand and manage the oral health care needs of our aging and frail populations. But this is a battle for another day!

Our graduate students would find it more interesting and rewarding to know how to account for the bias in a clinical study rather than eliminate it from laboratory experiments. Students refine their clinical judgment in the reality of clinical practice, but they are discouraged from studying clinical phenomena, presumably because clinical research is too "messy" and usually falls short of the highest evidence.

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

This is another difficult question because we all have different goals, ambitions, skills, and obligations. I can speak only from my experiences and observations in an ivory tower that many believe produces more chatter than pragmatism. My life in the tower has been intriguing, rewarding, challenging, frustrating, and humbling, but above all, stimulating. It has never been static or dull, and more often than not, it has been disconcertingly chaotic! The privilege of academic freedom within a community of scholars in the university as a whole can be immensely satisfying.

On the other hand, the adoration from patients is very addictive, and I believe there can be immense euphoria and financial reward from an efficiently run clinical practice—and there is much to be said for being your own boss. But I will leave it to others to explain full-time prosthodontics practice.

Is there a real future in prosthodontic scholarship, or is it stuck in a technique-related rut?

There is an immensely productive future in prosthodontic scholarship. We have only begun to scratch the surface of our clinical realm. On the grand scale, we effectively service a very small proportion of the global population. We limit our services almost exclusively to affluent communities and, more recently, to people who we have persuaded to have implants. But as Peter Owen wrote in an editorial for this journal, our responsibility is to "provide treatment for the many, cost-effective conventional treatment . . . with adequate quality control." I am concerned that our current fascination with high-tech, costly, and essentially experimental treatments is threatening our professional integrity, and more pragmatically, it is impeding our ability to provide the conventional treatments that have been tested by time. Anyone seeking clinical instructors for a course in removable prosthodontics should recognize this concern. Dentists and many prosthodontists today can construct an implant denture much more easily than they can seal the periphery of a maxillary complete denture. The options that we present to patients are in effect decreasing as our fees increase, and we become even more inaccessible to the majority of the global population. My father in rural Ireland did not offer implants to his patients, but they appreciated his dentures and care with smiles that were no less enthusiastic than the smiles we receive today for providing implant-retained prostheses. The future is very bright and satisfying for prosthodontic scholars willing to explore and address the needs of the less-advantaged communities in our midst. Currently, this is wide-open territory.

You have just completed a marvelous book, and you are close to a retirement age. Where do you go from here? Any more books in the planning stage?

I have no plans other than the plan to keep it that way. Retirement is no longer required in my educated part of the world, although my own requirements constantly change. Whether or not I will seek that change from within or without the hallowed halls and clinics of UBC will depend on my options. I am fortunate to have a group of prosthodontic colleagues at UBC who can function very well—indeed much better—without me. So, in this regard, I feel content. Yes, there are always books in the planning stage, but alas, "The best-laid schemes o' mice an' men, Gang aft agley."

Thank you for this opportunity to rant and unfold—it has been a joyful privilege!