Resolution No. 401 New

Report: N/A Date Submitted: 04/03/2025

Submitted By: Dr. Steven Saxe, delegate, Nevada

Reference Committee: C (Dental Education and Related Matters)

Total Net Financial Implication: [Total Net Financial Impl.] Net Dues Impact:

Amount One-time: Amount On-going:

ADA Strategic Forecast Outcome: Public Profession: Drive evidence-based, ethical quality care.

MINIMUM HANDS-ON STANDARDS FOR SAFE DENTAL PRACTICE AND CODA GOVERNANCE

The following resolution was submitted on Thursday, April 3, 2025, by Dr. Stephen Saxe, delegate, Nevada.

Background: This resolution urges CODA to adopt enforceable national standards requiring patient-based procedural training for graduation—clarifying that observation or conceptual instruction alone is insufficient for competency. It seeks to ensure CODA-accredited dental schools provide a minimum national standard of patient-based procedural training; and to strengthen CODA governance, transparency, and accountability, including collaboration with ADEA on educational capacity and student well-being. It calls for conflict of interest reform and accountability, and addresses the link between inadequate clinical education, overwhelming debt, and early professional burnout in students, with implications for patient safety, licensure portability, and the long-term health of the profession.

The Commission on Dental Accreditation (CODA) is responsible for establishing accreditation standards for U.S. dental education programs. Concerns have been raised by educators, students, and professional stakeholders regarding variability in clinical graduation requirements, particularly as institutions shift from structured, patient-based procedural requirements to more broadly interpreted competency-based assessments. This change has created inconsistencies in graduate preparedness and educational quality, with significant variation in clinical experiences among CODA-accredited programs. CODA standards state that “graduates must be competent in providing oral health care within the scope of general dentistry,” including procedures in restorative dentistry, fixed and removable prosthodontics, endodontics, periodontics, oral surgery, and operative care **(Commission on Dental Accreditation Predoctoral Standards, 2023, pp. 29–30; https://coda.ada.org/standards).**

A dentist’s competence cannot be fully assessed without direct patient-based procedural experience. Competency assessments cannot substitute for verifiable, hands-on clinical education. While some institutions cite limited patient availability as justification for reduced patient care requirements, this raises concern about consistency, accountability, and public safety—especially as tuition continues to rise and new programs are opened without sufficient clinical infrastructure.

Reports from dental graduates and educators confirm that some institutions now set **extremely low procedural thresholds** in core disciplines such as **operative dentistry, restorative dentistry,**

endodontics, periodontics, oral surgery, and fixed and removable prosthodontics. In some cases, even those minimal requirements are waived in favor of **passive observation** rather than direct performance. This practice undermines the ethical obligation of dental schools and accrediting bodies to ensure that every graduate is competent to perform essential clinical procedures across the full scope of general dentistry.

CODA's own standards clearly define these competencies. "Graduates must be competent in providing oral health care within the scope of general dentistry," including procedures in restorative dentistry, fixed and removable prosthodontics, endodontics, periodontics, oral surgery, and operative care (CODA Predoctoral Accreditation Standards, Commission on Dental Accreditation, 2023, p. 29). Furthermore, CODA explicitly states in its Mission Statement that the Commission "serves the public and dental professions" and that its accreditation standards for dental education programs are designed to "protect the public welfare" by ensuring quality educational programs. (CODA Predoctoral Accreditation Standards, 2023, p. 5)

Dentistry is a surgical discipline, and the safe and effective practice of dentistry requires not only cognitive understanding but also **repeated psychomotor engagement**. Clinical competency cannot be achieved through observation alone. In a widely cited study, Duvivier et al. (2011) found that **deliberate, repetitive practice combined with feedback significantly improved clinical skill acquisition** in medical students, especially during early stages of training (Duvivier RJ, van Dalen J, Muijtjens AM, Moulaert VRMP, van der Vleuten CPM, Scherpbier AJJA; "The Role of Deliberate Practice in the Acquisition of Clinical Skills," BMC Medical Education, 2011, 11:101, pp. 1–7).

Similarly, Chambers (2012) found that dental students showed no significant improvement from repetition alone unless it was part of a structured, feedback-driven model—highlighting the importance of deliberate practice frameworks. (Chambers DW, "What Do Dental Students Learn from Repeated Practice of Clinical Procedures?", *Journal of Dental Education*, 76(3), 331–337; available at https://onlinelibrary.wiley.com/doi/full/10.1002/j.0022-0337.2012.76.3.tb05258.x). These findings reinforce the view that conceptual-only instruction, without procedural repetition and feedback, is insufficient—and potentially harmful—when preparing clinicians to treat the public.

Over the last decade, many dental schools have increased tuition, expanded class sizes, and opened new programs while struggling to provide adequate patient cases for student training. Students are expected to assume **mortgage-sized debt**, often without reliable assurance of receiving calibrated clinical experience. The ADA, ADEA, CODA, and U.S. Department of Education (USDE) have not implemented effective mechanisms to **test, evaluate, or calibrate educational quality** across institutions. This disconnect places undue burden on students and raises concerns about consistent clinical readiness and patient safety.

This gap in clinical exposure—combined with insurmountable debt—is contributing to psychological strain, stress, and early professional burnout among dental students and new graduates. The ADA recognizes that chronic stress and anxiety, when left unaddressed during dental education, can lead to functional impairment, depression, burnout, and poor quality of care. ADA policies urge dental schools to integrate wellness and emotional health resources, and constituent/component societies to assist their members with wellness efforts and resources. (See ADA Policies: Statement on Dentist Health and Wellness (*Trans.*2005:321; 2017:264) and Dental Schools to Provide Education to Dental Students on Drug and Alcohol Use and Misuse (*Trans.*2014:453) provided in Appendix 1)

Many institutions also struggle to maintain an adequate number of qualified faculty members to supervise students, further compromising clinical education quality and straining faculty-to-student ratios. CODA requires that "faculty must be sufficient in number and qualification to

meet program goals" (CODA Predoctoral Accreditation Standards, Commission on Dental Accreditation, 2023, p. 31; available at https://coda.ada.org/standards).

CODA's *Evaluation and Operational Policies and Procedures Manual* also states that "an increase in enrollment must be accompanied by appropriate increases in program resources," reinforcing that program expansion must be supported by adequate infrastructure to avoid compromising educational quality (Evaluation and Operational Policies and Procedures Manual, January 2025, p. 90; available at https://coda.ada.org/policies-and-guidelines).

If these resources are not available, institutions should not expand class sizes. Inconsistent training and standards also undermine **licensure portability** and **national workforce readiness**, as state boards and employers cannot rely on a consistent baseline of graduate competence.

As the sole accrediting body for predoctoral dental education in the U.S., CODA is a steward of the public's trust in the profession. The conferral of a dental degree represents more than completion of coursework; it signals to society that the graduate is competent to deliver care independently. CODA's decisions directly affect the integrity of the profession and the reputation of every dentist educated in a U.S. dental school. That trust must be upheld with rigorous, consistent, and transparent standards.

Ensuring patient-based procedural experience is not only an academic concern but a **public health imperative**. CODA must uphold its duty to protect the public by ensuring accredited institutions produce **competent, practice-ready graduates**.

CODA operates independently in accreditation decisions, and while it remains a **commission within the ADA**, it pays the ADA for administrative, professional, and organizational support. CODA's continued credibility depends not only on its federal recognition but also on its ability to work collaboratively with ADA governance.

As a U.S. Department of Education–recognized accrediting body, **CODA must comply with** 34 CFR § 602, which mandates **conflict-of-interest safeguards, transparency, and public accountability**. Federal law states that accrediting bodies must have and apply policies to prevent conflicts of interest (*Code of Federal Regulations*, Title 34, § 602.15(a)(6), 2023). **Many CODA Commissioners, Review Committee Members, and Site Evaluators are directly affiliated with the institutions they accredit**, raising structural concerns about impartiality and integrity. CODA's *Evaluation and Operational Policies and Procedures Manual* states that "Commissioners must avoid actual and perceived conflicts of interest."(Jan. 2025, pp. 36–39).

Additionally, the U.S. Supreme Court in North Carolina State Board of Dental Examiners v. FTC, 574 U.S. 494 (2015), held that licensing boards composed of active market participants must be subject to independent oversight to avoid anti-competitive behavior. While not a licensing board, CODA must maintain its impartiality and avoid even the appearance of self-regulation that undermines competition or education quality. Recent CODA decisions—such as the 2015 adoption of dental therapy accreditation standards before ADA policy alignment—highlight the need for improved communication and transparency between CODA and ADA governance bodies. While CODA maintains independent authority

to establish accreditation policies and standards, greater information-sharing and engagement would strengthen mutual understanding and ensure the accreditation process remains aligned with the evolving needs of the profession. CODA's policies require the Commission to notify communities of interest and the U.S. Department of Education of proposed and final changes to accreditation standards and policies (*Evaluation and Operational Policies and Procedures Manual, Jan. 2025, pp. 24, 31*). Previous House of Delegates sessions have discussed alternative accreditation approaches due to concerns about CODA's direction. This resolution builds upon those discussions by calling for responsible, evidence-based, and transparent engagement in accreditation matters.

Resolution

401. Resolved, that the American Dental Association (ADA) strongly encourages the Commission on Dental Accreditation (CODA) to establish and enforce a reasonable minimum national standard for patient-based clinical procedures required for graduation—emphasizing that competency must be demonstrated through direct performance, not observation, and be it further

Resolved, that CODA be encouraged to revise accreditation standards to ensure all graduates receive verifiable, patient-centered procedural experience essential for safe, independent practice, recognizing that as a surgical discipline, dentistry demands repetition of clinical procedures across all major disciplines, including but not limited to operative dentistry, restorative dentistry, endodontics, periodontics, oral surgery, and fixed and removable prosthodontics, in accordance with the ethical obligation to protect patients and the public, and be it further

Resolved, that the ADA strongly encourages CODA to strengthen its governance and accountability by reviewing conflict of interest policies for Commissioners, Review Committee Members, and Site Evaluators affiliated with accredited institutions, and be it further

Resolved, that the American Dental Association (ADA) strongly encourages the Commission on Dental Accreditation (CODA) to strengthen its communication and engagement with the American Dental Association through the existing ADA/CODA Workgroup; and be it further

Resolved, that the ADA strongly encourages CODA to consult with the American Dental Education Association (ADEA), the Academy of General Dentistry (AGD), and appropriate specialty organizations in dentistry to establish clear minimum requirements for clinical competency, including specific patient-based procedural experiences necessary for safe, independent dental practice.

DRAFT BOARD RECOMMENDATION:

PLEASE NOTE YOUR COMMENTS/CHANGES TO THIS DRAFT BOARD RECOMMENDATION BELOW.

Appendix 1

Statement on Dentist Health and Wellness (*Trans.*2005:321; 2017:264)

To preserve the quality of their performance and advance the welfare of patients, dentists are encouraged to maintain their health and wellness, construed broadly as preventing or treating acute or chronic diseases, including mental illness, addictive disorders, disabilities and occupational stress. When health or wellness is compromised, so may be the safety and effectiveness of the dental care provided. When failing physical or mental health reaches the point of interfering with a dentist's ability to engage safely in professional activities, the dentist is said to be impaired.

In addition to maintaining healthy lifestyle habits, every dentist is encouraged to have a personal physician whose objectivity is not compromised. Impaired dentists whose health or wellness is compromised are urged to take measures to mitigate the problem, seek appropriate help as necessary and engage in an honest self-assessment of their ability to continue practicing.

Dentists are strongly encouraged to have adequate disability and overhead protection insurance coverage which they review on a regular basis.

The ADA and/or its constituent and component societies, as appropriate, are encouraged to assist their members in being able to provide safe and effective care by:

- promoting health and wellness among dentists
- supporting peers in identifying dentists in need of help
- intervening promptly when the health or wellness of a colleague appears to have become compromised, including the offer of encouragement, coverage or referral to a dentist well-being program
- encouraging the development of mutual aid agreements among dentists, for practice coverage in the event of serious illness
- establishing or cooperating with dentist (or multidisciplinary) well-being programs that provide a supportive environment to maintain and restore health and wellness
- establishing mechanisms to assure that impaired dentists promptly cease practice
- reporting impaired dentists who continue to practice, despite reasonable offers of assistance, to appropriate bodies as required by law and/or ethical obligations
- supporting recovered colleagues when they resume patient care

Dental Schools to Provide Education to Dental Students on Drug and Alcohol Use and Misuse (*Trans.*2014:453)

Resolved, that U.S. dental schools are urged to incorporate the American Dental Association Dentist Health and Wellness Program's complimentary resources on emotional health and drug and alcohol abuse into the dental education curriculum to help minimize risks to dental students' health, professional status and patient safety, and be it further

Resolved, that state and/or constituent dental societies be urged to support this effort through their current or future well-being programs.