Clinical Curriculum for the Twenty-First Century


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In the 1995 Institute of Medicine (IOM) report, Dental Education at the Crossroads: Challenges and Change, the Committee on the Future of Dental Education recommended that “dental students and faculty participate in efficiently managed clinics and faculty practices in which patient-centered, comprehensive care is the norm.”1 This language is echoed in the Commission on Dental Accreditation’s most recent Accreditation Standards for Dental Education Programs, which state that “Administration, faculty, staff and students are expected to develop and implement definitions, practices, operations and evaluation methods so that patient-centered comprehensive care is the norm.”

Standard 2-25 of the Accreditation Standards for Dental Education Programs stipulates that “At a minimum, graduates must be competent in providing oral health care within the scope of general dentistry, as defined by the school, for the child, adolescent, adult, geriatric and medically compromised patient,” including fourteen specific competency areas. On August 1, 2002, the Commission on Dental Accreditation clarified Standard 2-25 by adopting and implementing the following Intent Statement:

Intent:

Graduates possess the basic knowledge, skills, and values to practice dentistry, independently, at the time of graduation. The school identifies the competencies that will be included in the curriculum based on the school’s goals, resources, accepted general practitioner responsibilities and other influencing factors. The comprehensive care experiences provided for patients by students should be adequate to ensure competency in all components of general dentistry practice.

While the Accreditation Standards for Dental Education Programs constitutes the criteria by which the Commission on Dental Accreditation evaluates dental education programs for accreditation purposes, it also acknowledges that methods of achieving standards may vary according to the size, type, and resources of sponsoring institutions. Notwithstanding each school’s unique goals, resources, accepted general practitioner responsibilities, and other influencing factors, the commission prescribes that “The comprehensive care experiences provided for patients by students should be adequate to ensure competency in all components of general dentistry practice.”

Therein lies an ongoing challenge in the mission of dental education: the struggle to balance the learning needs of the student with the comprehensive dental care needs of the patient. Dental schools must design and implement clinical curriculum models in which patient-centered, comprehensive care is the norm, but at the same time, ensure that each student has an appropriate mix of patient care experiences that are part of general dental practice.

Previous investigations of the issues in dental school clinical curriculum development have dem-
onstrated that schools have taken various approaches to the design of the predoctoral clinical curriculum. Baughan and Hagan reported in 1991 that comprehensive care programs in U.S. dental schools are varied with respect to such factors as faculty supervision, types of patient care provided, and student requirements and evaluation. In 1994, Kilgore and Casada found that more schools were adopting a comprehensive care model, but that wide variations in the approaches to clinic patient management, requirements for graduation, and system effectiveness existed. In 2002, Hook et al. reported that while most dental educators surveyed favored a comprehensive care environment, unit requirements systems were maintained for reasons of tradition, appropriateness, necessity, and/or administrative preference. The conclusions from these articles are consistent with the observation of the Committee on the Future of Dental Education in the IOM report that “In general, differences in the way schools implement comprehensive care involve both practical realities and pedagogical concerns. . . . Most of the schools visited by the committee acknowledged that their implementation of comprehensive care involved less-than-ideal compromises, political, logistical, and financial.”

The comprehensive care model of clinical education, according to the IOM report, is characterized by the following attributes:

- A generalist role model rather than a specialist role model,
- Patient-centered education rather than a student-centered education,
- Continuity of patient care rather than segmented patient care,
- A focus on evaluation and management rather than a procedure focus, and
- Competency criteria rather than numerical requirements.

Some have suggested that comprehensive care implies that each individual student is responsible to provide care for all of the patient’s oral health needs (e.g., single provider), and/or that clinical education is not accomplished in geographically separate areas based on discipline, and/or that schools must have a separate department of general dentistry.

We subscribe to a somewhat less prescriptive definition of the term “comprehensive care.” We have generally adopted the philosophy that a comprehensive care model is one in which students participate in the complete management of patients’ oral health needs in an appropriate sequence. We believe that the continuum of care learned by predoctoral students should be that provided by a general dentist and that it should include patient examination, diagnosis and treatment planning, and direct treatment or management of all of a patient’s oral health needs.

As we have reviewed the literature, visited other dental schools, and communicated with colleagues from other institutions, it has become obvious to us that what one school calls comprehensive care may be dramatically different from the way the concept is implemented at other schools. This observation of the variation in approaches to achieving “patient-centered comprehensive care” was the impetus for the ADEA Section on Comprehensive Care and General Dentistry Program at the Association’s 80th Annual Session and for this series of articles.

The Section on Comprehensive Care and General Dentistry Program at the ADEA 80th Annual Session (March 11, 2003, San Antonio, Texas) was entitled “Clinical Curriculum for the Twenty-First Century.” The program focused on the structure and management of the clinical curriculum in patient-centered competency-based dental education. Presentations included an overview of the predoctoral clinical education models currently in use at ADEA member dental schools, the perspective of an established school that has recently had a major revision to the structure of its clinical curriculum, and the perspective of a new school planning a “blank-slate” clinical curriculum. The following three articles in this series are based on the presentations from that program:

- In “Predoctoral Clinical Curriculum Models at U.S. and Canadian Dental Schools,” Drs. Holmes, Boston, Budenz, and Licari present the results of a recent survey of predoctoral clinical education models currently in use at ADEA member dental schools, the perspective of an established school that has recently had a major revision to the structure of its clinical curriculum, and the perspective of a new school planning a “blank-slate” clinical curriculum. The following three articles in this series are based on the presentations from that program:
- In “Developing a Group Practice Comprehensive Care Education Curriculum,” Drs. Licari and Knight discuss the development and implementation of a new clinical curriculum at the University of Illinois at Chicago.
- In “A New School’s Perspective on Clinical Curriculum,” Drs. Sanders and Ferrillo describe the evolving curriculum at the University of Nevada, Las Vegas.
REFERENCES