The New York State Postgraduate Fifth-Year Dental Residency as a New Licensure Path: Concerns for Public Protection

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Abstract: The recently enacted law creating an alternative pathway to dental licensure in New York state is benchmark legislation. Along with the positive effects of dental education that may ensue, the author has serious concerns that the strongly emotional and political debate occurring during the bill’s consideration obscured important considerations for public safety and the erosion of standards for licensure in New York. In addition, this pathway has potential to negatively affect freedom of movement and licensure by credentials for practice in other jurisdictions.

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On July 23, 2002, Governor George E. Pataki signed into law Senate 4503b/Assembly 9229a, a bill that allows for voluntary substitution of the successful completion of an American Dental Association, Commission on Dental Accreditation-approved dental residency in lieu of the New York State Education Department’s clinical licensing examination.

Educators, along with the New York State Dental Association and the American Student Dental Association, fostered a coalition that vigorously criticized the New York State Board for Dentistry, as well as the entire examining community including the testing body engaged to administer the clinical examination requirement for licensure in New York, the North East Regional Board of Dental Examiners Inc. Although examiner support for clinical licensure examinations was solidified nationally, considerable conflicting posturing occurred between the examiners and the proponents of this legislation. It became clear that much of the justification proffered for this change was based on student and educator disappointment with the present licensure pathway. Numerous reasons were cited including high failure rates, allegations of inhumane and unethical patient treatment, the necessity of the participation of patients in the testing process, complaints of perceived examination unfairness, perceived examiner incompetence, alleged lack of relevance and validity of the test, redundancy, alleged irregularities in scoring, excessive pressure on the candidate during the exam itself, the “snapshot” assessment nature of the exam, cost, and failure of the entire process to be congruent with licensure pathways for other professions such as medicine. Additionally, the dental education community perceived a need to address an increasing lack of applicants for dental residency programs through incentive programs offering higher salaries, varying degrees of debt forgiveness, and the elimination of the requirement to participate in a clinical licensure examination.

This new law, which took effect January 1, 2003, allows program directors and their attending faculty to proclaim a resident’s competency based on the completion of a one-year general dentistry residency, circumventing and eliminating any further clinical licensure examination or any competency assessment by an independent third party, solely representing the public.

Importance of a Fifth Year

It is clear that students learn at very different rates. Didactic information can be assimilated, in most cases, in a predictable range of time, whereas technomechanical psychomotor skills often require unpredictable numbers of repetitions for a beginner to establish a basic skill level. There is reason to assume that, in basic dental clinical training, more practice time for some is necessary to reach the competence required for the independent practice of
dentistry. An ever-more filled curriculum, crowded with new science, new technology, new patient needs, and a burgeoning array of new dental restorative materials, dictates that a fifth-year voluntary residency be available. There is no doubt that this additional educational opportunity would and does allow for less practiced learners to gain confidence and competence. Those new dentists, who are more advanced, will use these additional experiences to grow from their initial competence to greater proficiency, as well as to explore more complex treatment regimens.

Students in need of supervised learning to gain critical competence can mature with a less hectic and daunting schedule than was necessary to graduate from dental school. One-on-one mentoring would allow, conceptually, these underachievers to rise to the next level in a protected environment. Providing this type of learning environment is extremely valuable to the dental profession.

There is no intent in this discussion to diminish the huge contribution to the educational process that faculty provide, but rather to point out the need to continue the partnership among accreditor, educator, and examiner.

Concern arises not over what fifth-year programs will provide, but how that mission of further education relates to a fair, unbiased assessment of critical competencies required for licensure.

Residencies, up to now, have been generally competitively awarded. One can envision, under this new law, that some of the positions will have to be reserved for those who truly need a fifth year, rather than being filled by those dentists seeking to enhance their armamentarium and build upon their achieved competencies. Some graduates who are well trained and have achieved satisfactory competency levels may elect not to sit for the licensing examination while in dental school and opt for licensure by way of this new pathway. However, several important considerations enter into the decision. First, a new format of the North East Regional Board of Dental Examiners Inc. (NERB), the Curriculum Integrated Format (CIF), is being successfully pilot-tested with very favorable reaction from the students and faculty. This new format spreads the observation of skills during the senior year over an extended period of time, both diffusing the high anxiety and allowing for multiple attempts to succeed before graduation. Treatment can be rendered within a more normal sequence in the school clinic, with school patients, than in the traditional board exam format. The immediate proximity and opportunity for remediation within the dental school curriculum are huge benefits to the patient and the treating student.

Most seniors would rather have a license before graduation whether or not they seek additional training. The license granted by the residency route is not yet acceptable in any other licensing jurisdiction. Credentialing to another state requires, among other things, the completion of a clinical licensure exam. Acquiring licensure by completion of a residency not only restricts the new dentist to practice only in New York, but when all is said and done, when life’s vicissitudes compel a dentist to move to another geographic area at a later time, a clinical licensure exam will have to be taken. The desire to move may occur many years later, when the acceptability of National Board results have expired and the difficulties inherent in repreparing for both didactic and clinical assessment examinations becomes an issue. Supporters of this new licensure pathway expect other states to follow with similar legislation. Perhaps some will, but it is likely that some other states will want to review data from the New York experience before making similar changes.

On the eve of these sweeping changes, there are many questions to be answered. For example, will qualified residency seekers be denied positions to make room for remediation of the slower learner? Will the top candidates be disadvantaged by diminution of faculty contact time as a result of the need for the faculty to spend more time with remediation? Are more faculty positions needed? Where will additional qualified teachers come from? Will these residencies become a “dumping ground,” allowing schools to absolve themselves of what to do with the bottom of the class?

Accreditation

The assertion that graduates and residents who have completed CODA-accredited programs successfully do not need further competency assessment is open to question. Believing that program completion ensures individual competence to work unsupervised is naïve.

Successful program completion is a loosely defined concept. Finishing a program is dictated by regular attendance, adherence to rules, and lack of any adverse discipline and task completion for pa-
tients assigned for treatment. Under the condition of anonymity, a number of program directors and faculty anecdotaly reveal that they cannot remember any resident in their program being held back from completion due to quality of care issues.

Accreditation is a peer-reviewed process controlled by educators in which a self-assessment program analysis is fully scrutinized as to compliance with set program standards in a multitude of areas. One of these areas is outcome assessment. CODA program acceptability in part depends on independent competency measurements. Postgraduate programs submit to this audit for compliance every seven years, with recommendations cited for improvement when indicated. This exercise is a sporadic report card, a validation of the process, not a certification that its graduates are competent to independently treat patients. Unfortunately the licensure community has only a token role in this educator-dominated realm.

When programs adhere to their own standards, which vary from program to program, the teaching tools are deemed in place for quality education. Many programs are excellent; some are not. Deviation in level of teaching quality, shortage of faculty, lack of uniform instructor calibration and training, program variation as to standards and criteria, differences in available kinds of caseload, patient availability for selection of varied dental needs, and limited supervision all can contribute to some mistrust of a program director’s authority, essentially, to grant licenses. Satellite sites associated with many residencies are rarely visited by accreditation site visit teams, and there are anecdotal reports that some of these remote clinics occasionally utilize less than adequately trained and screened faculty and that sometimes treatment is carried out by residents with no supervision at all. Some applicants for employment positions as dental associates in my practice have revealed during their interview sessions that their residency experience often was carried out with little or no supervision, regardless of whether they were previously licensed or not. This inadequate supervision has been corroborated by unprompted comments from some dental residents at dental association meetings.

Faculty who teach, assist, and supervise residents and are familiar with individual patient case development may have difficulty providing objective evaluations for purposes of ascertaining independent practice ability because of the halo and proximity effects, which often lead to skewed ratings. Educators may grade their own students for teaching purposes, but to grade for high-stakes licensure purposes is a conflict of interest. In response to an American Dental Association House of Delegates’ resolution, the American Association of Dental Examiners in concert with the American Dental Association produced Guidelines for Valid and Reliable Dental Licensure Clinical Examinations in May 1992. Among a multitude of caveats for fair, valid, and reliable testing, anonymity in grading was highly suggested. All testing agencies adhere to this concept. Any assessment of resident quality of care is not anonymously graded, nor is the grade corroborated by agreement of additional examiners.

Likewise, critical review of treatment that might potentially impact negatively on an individual’s program success opens up fears of litigation against the program from the criticized provider. In addition, detrimental long-term effects on recruitment of future residents could ensue from the reputation of “tough standards” in the licensure path of the program. This program “image” concern raises the possibility of biased, easy grading.

Further, to allow graduation from CODA-accredited programs whose actual accreditation process is itself subsidized by the residency program and the future potential members of the dental association, resulting in what is tantamount to automatic licensure, is a major conflict of interest with public protection and trust. Such authority to license and its control should be under the auspices of the New York State Education Department’s Board of Regents, not individuals administering programs rife with conflict of interest.

The Medical Model Pathway to Licensure

The background information offered by the sponsors prior to passage of the bill claimed among other things that this would conform to the pathway physicians take for licensure. The alternative pathway for licensure in New York consists of one postgraduate residency year in a CODA-approved residency program. During final development of the bill, language was added to require some sort of outcome assessment, which was not spelled out in the final bill itself.

At first glance, this pathway does seem to resemble the pathway for licensure required by most
states for physicians. However, upon close examination there is actually very little in common with the pathway for medical licensure. One cannot separate statutory requirements in most states to obtain a medical license from the overall environment of medical education, postgraduate medical education, and the clinical practice environment in which physicians must practice. In other words, one cannot look at the pathway alone, isolated from the other factors. In developing licensing requirements for physicians, state medical boards have integrated licensing requirements and examination requirements.

The requirements for medical licensure in most states generally follow a similar scheme. Although some states have additional examination and testing requirements, this description will be confined to the generally accepted requirements that are common to most states. The discussion will pertain to graduates of accredited medical and osteopathic schools seeking general medical licensure. Most states require that a candidate for licensure meets at least the following requirements: 1) hold a degree of doctor of medicine from an accredited medical or osteopathic school; 2) submit evidence of successful completion of at least one year of training in a postgraduate medical training program accredited by the Accreditation Council for Graduate Medical Education (ACGME);11 and 3) successfully complete all parts of the United States Medical Licensing Examination (USMLE). Some states have training and examination requirements in addition to the above.

Most state medical boards define successful completion of this postgraduate residency-training year as: 1) twelve months of accredited postgraduate training in an integrated program in which the applicant completes all the requirements of the program; 2) the program director rates the applicant’s performance as satisfactory; and 3) the applicant’s performance was such that the applicant would qualify for advancement without academic or clinical probationary conditions to the next year and next progressive level of responsibility in a designated specialty program.

The integrated program in which the first residency year is contained must fulfill the common program requirements published by the ACGME in its 2002 eleven-page document “Common Program Requirements.” These requirements are comprehensive and cover requirements of the sponsoring institutions, qualifications and responsibilities of the program director, resident selection, the educational program itself, resident evaluation requirements that are written and must be maintained, faculty evaluation, and specific competency evaluation and certification requirements in six specific clinical practice areas for each resident.

The United States Medical Licensing Examination (USMLE) is currently delivered in three parts. Step one assesses the understanding and application of important concepts of the sciences basic to the practice of medicine. Step two assesses the application of medical knowledge and understanding of clinical signs to patient care under supervision. Steps one and two are completed during the four years of medical school, usually years two and four. Step three assesses the application of medical knowledge and understanding of biomedical and clinical sciences to the unsupervised practice of medicine. To be eligible for step three, the applicant must meet the licensing requirements set by the state licensing board, hold an M.D. degree or its equivalent, and have attained passing scores in steps one and two. The USMLE has remediation and retake timing requirements to address failures.

The USMLE is in the process of adding an additional examination called the Clinical Skills Examination (CSE). This examination is a live patient-based examination to be implemented for use by the 2005 graduating class. The recommendation for implementation was made due to superior clinical skills performance by foreign medical graduates who are already required to complete this kind of exam prior to entrance into their residency. The USMLE exam measures how well the candidate applies knowledge in the context of actual patient encounters. In each of ten to twelve clinical scenarios, the candidate spends approximately fifteen minutes gathering the history, conducting a focused physical exam, and providing feedback and patient counseling. At the completion of each encounter, the candidate has ten minutes to record the findings before advancing to the next patient. Critical assessment is made on the candidate’s ability to: 1) gather an appropriate history, 2) perform the required physical examination, 3) reach the appropriate diagnostic conclusion, 4) communicate appropriately with the patient, and 5) record the findings and impressions clearly. The introduction of this live examination is based on the realization that supervised assessments in medical school, alone, are not sufficient for measuring clinical competency.
Integral to this licensing and examination scheme is the understanding of the postgraduate medical educational process, hospital credentialing process, and medical peer review system. The physician-licensing requirement for completion of at least one year of postgraduate residency training is based on two important principles. First, because all states require this year and successful completion of the USMLE step three as a minimal requirement for licensure, the first-year integrated residency has been tailored to fit that need. The first-year residency was developed with licensure and the USMLE step three examinations in mind.

Two major pathways of postgraduate medical training can be followed: surgical and nonsurgical. The first year of either the general surgery residency or internal medicine residency is an integrated resident year in which the training experience conforms to the ACGME common requirements. In this way, all applicants for step three of the USMLE will receive the required core experiences and training. This process has been developed over many years, so that the residency training is specifically accomplished to satisfy the requirements for the USMLE step three and thus the licensing requirement. In addition, it is understood that the first postgraduate year (PGY-1) is not the end point, but that the applicant will continue with several more years of training to reach his or her specialty end point. Furthermore, many residency programs in medicine are a “pyramid” process in which not all starting residents will complete the program, and it is understood that program directors and faculty will eliminate and redirect residents based on their clinical and academic capabilities.

A second safeguard for the public is the hospital credentialing process. Because the overwhelming majority of physicians hold hospital appointments as part of their practices, the hospital credentialing process for privileges safeguards that physicians will only be allowed to practice in those areas in which they received satisfactory training and experience and in which they are competent. Many credentialing processes require proctoring for some procedures before they can be done without supervision. Finally, all procedures and admissions in the hospital are reviewed, and as a result, individual physicians’ credentials can be altered and practice limited based on outcomes of treatment seen in their patients.

Dentistry’s current pathway to licensure also varies by state; however, most contain core requirements. Among other things, most states require that applicants for initial licensure: 1) hold a D.D.S. or D.M.D. degree from an accredited dental school in the United States or Canada; 2) pass Parts I and II of the Joint Commission on National Dental Examinations; and 3) complete a clinical licensing examination prescribed by the state designed to measure critical levels of clinical competency. Currently, in all states but New York, the clinical licensing examination is a requirement.

New York’s alternative of completing one postgraduate year in a CODA-approved residency falls far short of the medical model described above. First, postgraduate dental residencies were not designed to satisfy licensing requirements. They do not contain a unified integrated curriculum prescribed by an independent agency such as the ACGME, ensuring that there is a uniform core experience and educational process leading to an additional independent examination for licensure. There are many dental residencies that have only a twelve-month duration, and therefore the assumption of continued training implicit in the medical model does not exist. The evaluation examination in medicine, the USMLE step three, has been developed by an independent examination board and was in existence prior to the postgraduate training requirement developed many years ago. There is no examination process present in New York to evaluate outcomes and the applicant’s ability to integrate clinical knowledge obtained from the dental postgraduate year to clinical practice in New York. The only psychometrically evaluated and tested process today is a clinical licensing examination.

Because dental residencies were not developed to meet the requirements of a uniform licensing examination process, it is unknown whether the faculty, institutions, outcome assessments, and residency evaluations conform to established standards such as in the first residency year in medicine. Finally, the general and specialty residencies that exist in dentistry do not have an integrated first year in which all include a common core curricula and clinical experience. Therefore, the first-year residency experiences are quite different across the general and specialty practice area residencies. This is a perfectly acceptable situation if the goal of the postgraduate education is training in the specified area described in that residency. However, this is unacceptable if one of the goals of the first year of residency training is to obtain licensure.

Finally, the peer review process and credentialing process, which exist in medicine, do
not exist for dentistry except for those dentists who also hold hospital privileges. What is commonly referred to as peer review in dentistry in effect functions as a patient mediation process or complaint bureau. It is not the mandatory peer review process that exists in hospitals in which outcomes and morbidity are evaluated and steps taken when required. If one eliminates the only independent, postgraduate, peer-review clinical evaluation—the clinical licensing exam—no real peer-review process will exist in dentistry.

**Integrity**

The professional education leading to the dental degree, along with attainment of licensure, depends on the joint integrity of both faculty and student. If fair and accurate grading gives way to liberalized inaccurate assessments, the integrity of the entire process is lost. Academic dishonesty is a problem, as faculty and student alike are being cited. Beemsterboer et al. found that underreporting of incidents of dishonesty lies at the hands of the student body and the faculty who both are reluctant to, voluntarily, get involved. While honor codes and pledges of honesty are widely in use, several administrators claim that the positive influence of these codes appears limited. Over 75 percent of undergraduate school students admit to academic dishonesty. Within the dental school, data is less extensive; however, the seeds for such behavior have been sown.

Both faculty and dental students, one on one, off the record, recount considerable instances of dishonesty. Over the last four years, I have had the opportunity to meet with both dental students and postgraduate dental residents in school settings, as well as at national and local scientific dental meetings. Under the promise of anonymity, twenty-two different oral (anecdotal) responses from present and recent students, representing thirteen different dental schools, identified a widespread incidence of various forms of academic dishonesty. They also corroborate the extreme reluctance of classmates to report each other’s cheating behavior. Intervention is seriously hampered by fear of recriminations for reporting incidents. Students relate that rarely is anyone ever “turned in” and that a very large percent of the class is guilty at some level. Queries to these students, only after assurances of anonymity and confidentiality of person and school, anecdotally reveal an alarming rate of infractions that include copying during didactic exams, helping others during didactic exams, forging and writing untrue treatment records, signing faculty names on records, falsifying attendance records or having a friend falsely attendence records, taking credit for another’s clinical work, obtaining and/or disseminating test questions obtained from friends, stealing, and helping others to use improper credit for clinical work. These, in addition to other infractions, are well documented in the literature.

Schools are reportedly requiring students to perform fewer exercises and treatments to demonstrate competence. It is particularly troubling to see the reduced numbers of trials being further compromised by forged faculty sign-offs and the taking of credit for work not done by the student involved. All of these infractions are immoral, unethical, and unprofessional. Worse of course is that candidates come to a clinical licensing exam often with very rudimentary skill levels and an inflated opinion of their skill level. Reported instances of these kinds of aberrant behavior may be small, but it is incumbent upon interested parties to understand that these problems are underreported. The fifth-year experience hopefully will provide repetitive trials resulting in competency.

However, certification by the school’s faculty and dean is required prior to a dental student’s admission to the licensing exam. Candidates allowed to take the board are listed by their school as ready to graduate with the D.D.S./D.M.D. degree in forty-five days or less. There are a number of reasons why candidates are unsuccessful on the exam, but evidence of gross incompetence appears in some candidates’ work, as demonstrated by Figures 1-6. These seriously flawed efforts represent not just mistakes, but evidence of serious conceptual deficit and also tear at the credibility of faculty oversight of competency trials and mock boards in school. Examples of gross incompetence such as these illustrations show appear too often on licensing exams. Will it be different when residency faculty are empowered to certify a candidate’s readiness for licensure?

Licensure is a process. The “portfolio” of a student’s growth and credentials includes documentation of the four years of satisfactory study and practice in the university, affirmed by in-school records and assessments, as well as standardized didactic exercises of the ADA Joint Commission on National Dental Examinations, that is, the National Board Part
I and Part II. Further clinical simulations are offered as part of the clinical examination in the form of bench tests, objective structured clinical examinations (OSCEs), and computer-simulated clinical exercises. No license is granted without these credentials, as well as the other patient and simulated patient care test sections.

The so-called one-shot exam (often erroneously referred to as one-day) is a careful examination of the candidate’s clinical skills. Candidates spend up to three days demonstrating their ability to perform relevant basic clinical tasks based on the successful absorption of didactic course material. This is only a portion of the evidence that makes up the entire picture of the candidate’s level of achievement and skill. The selection of tasks is based on extensive surveys of clinical practice. The ability of the new dentist to know what to do is augmented by the proof that he or she can perform those tasks competently. The entire dossier of credentials leads to granting of the privilege of licensure, not a one-day examination.

The New York state government is granted the right to protect the health, welfare, and safety of its citizenry by nature of a licensure process. This state, as other jurisdictions, appoints state board members based on rigorous qualification review to serve the
state in specific professional areas. These sworn state officials have taken an oath to have as their only mission the protection of the public. As examiners, they undergo comprehensive and continued training and are tested in their ability to calibrate according to specific published criteria. Any examiner who cannot calibrate cannot examine.

Forays into licensure pathways devoid of appropriate study, without reliability data, without calibrated and anonymous scoring mechanisms, and without freedom from conflict of interest of faculty take a chance that plays with another kind of human experimentation. By allowing practice without valid, reliable, defensible, psychometrically sound skill measurements, a new pathway for potentially substandard second-class care will be established.

Proof of Efficacy

The three-year sunset clause to allow for monitoring of the success/failure of this new licensure mechanism is totally inadequate. The effectiveness or safety for the public by this alternate pathway will not and cannot be known in such a short period of time. It is unlikely that, inadequately screened, incompetent new licensees will immediately commit acts that trigger quality of care or misconduct complaints. They could become a subject of an inquiry or civil malpractice action only after discovery at a later time. Most complaint resolution scenarios, or civil court proceedings, engender long fact-finding and investigatory periods before pretrial evidentiary depositions. Further time elapses before the actual adjudication process takes place. Up to five years is not an unusual period of time for final closing of the case. This, of course, does not take into account that individuals practicing below the standard of care must be discovered, that complaints will be registered in a timely fashion, that existing evidence is sufficiently documentable, that the patient/complainant will testify, or even that the patient is aware of his or her options.

Complaints to state boards do not provide monetary return to the patient in New York, and therefore, convictions for professional misconduct result in punitive and remedial action only. Without the possibility of financial return, the desire for a patient to level a complaint is greatly reduced. Only after multiple years of civil malpractice history can statistics reflecting a dentist’s substandard care begin to be of value. Therefore, review of a provider’s practice history for adverse actions in no way could be germane to the
assessment of this alternative licensure pathway's evidence of safe licensure in three years.

New Horizons

The examining community is sensitive to problems faced by today's student. Moreover, there is an equal understanding of the concerns of the educator. More change has occurred, as a result of the publicizing of genuine valid criticisms in licensure testing in the last five years than in the previous one hundred. The new Curriculum Integrated Format (CIF) being offered by the NERB may not be the last word in change, but it offers a track to licensure within the educational environment that eliminates many of the concerns.

It still is a test. As professionals, we must understand the immense responsibility placed in the practitioner's hands when that shingle is hung. The public trust is there: it will always be there as long as we prove that we are worthy of that respect. The public demands credible proof before granting that trust.

Ongoing efforts between the American Dental Education Association (ADEA) and the American Association of Dental Examiners (AADE) continue. The search for innovative testing and educational modalities (ITEM committee) is in progress, and the participants are committed to hard work in pursuit of alternative competency assessments. Dental deans, practicing dentists, examiners, and educators want to modernize the licensure process without introducing new problems. There is no stalling, but patience is a must in order to properly document fairness, reliability, validity, and fidelity. Open communication and dialog among the ASDA officers, AADE officers, deans, and ADEA under the auspices of the ADA have helped to identify critical issues.4

Conclusions

The use of a fifth-year, postgraduate residency in General Dentistry as a tool to better train dentists to meet the challenges of a rapidly changing and overwhelmingly complex techno-mechanical biomedical career is essential. The help and advice, the teaching and the guidance of dedicated faculty to solidify one's skills and enhance competency are the mark of truly professional education.

In New York state, the Education Department, which has jurisdiction over the licensure of forty-four professions, states in its Office of the Professions policy: “the public gains not only in consistency of policy across the professions, but also in accountability.” This is the key issue. The licensure process is no longer consistent by allowing for circumvention of the state board-accepted outcome assessment by valid and reliable examination in dentistry. Accountability is compromised. The Board of Regents is now faced with accepting credentials that are not credible as to supporting data for veracity, freedom of conflict of interest, and arbitrary, randomly documented, variable standards.

Outcomes assessment is a necessary and integral part of program review and its accreditation. By the very nature of critical input, educational standards are upheld and when indicated, fine-tuned to ensure compliance with established levels of program effectiveness. The duty to train professionals to the highest standards is enhanced. Outcomes generated by well-meaning and honest insiders nevertheless leave, at the very least, the perception of bias.

There is no doubt as to the value of postgraduate training. There is also no intent to denigrate the herculean effort of teachers to educate and raise the standards of professional care. Just as the overwhelming majority of graduating senior dental students have attained the competencies required, most fifth-year programs are excellent and above any criticism. They indeed are an extension of the dental school experience, affording the new dentist continued professional growth.

Educators and examiners must work together to uphold the high standards of the profession. They also should not do each other’s job.

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REFERENCES


