Guest Editorial

Moving Toward 21st-Century Clinical Licensure Examinations in Dentistry

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During the time frame in which this editorial was being written, most of the 2016 predoctoral dental and dental hygiene graduates of U.S. academic dental institutions were completing their studies and preparing to become full-fledged oral health care providers. One of their final hurdles is successful completion of a clinical licensure examination (CLE)—a principal component of which typically has included the use of patients in a one-time, high-stakes test that determines graduates’ readiness to practice.

There is no peer-reviewed scientific evidence that correlates CLE outcomes with other validated assessments of clinical competence. Nevertheless, the exams consume vast resources in the form of time as well as direct and indirect costs to the candidates, their dental schools, and the examining community. Furthermore, the patient-based design of a CLE poses challenges to the candidates’ ethics when ideal treatment plans for the patients involved are not followed or when students must pay patients to participate. The potential complications mean that, “for generations, dentists have been ‘birthed’ into their profession in the most brutal way possible,” in the words of Dean Charles Bertolami of New York University College of Dentistry.1 In spite of these tangible and intangible costs, the process yields no verifiable value in its ultimate objective of providing for the protection of the public.

The American Dental Association (ADA), American Dental Education Association (ADEA), and American Student Dental Association (ASDA) have issued statements, passed resolutions, and launched initiatives that seek to eliminate the use of humans in CLEs. Even with these efforts, alternatives have not been available until recently, and the exams have remained relatively static because responsibility for change lies outside those organizations.

There are 53 licensing jurisdictions (50 states, District of Columbia, Puerto Rico, and U.S. Virgin Islands) in the United States, each of which has statutory responsibility for dental licensure. Ultimately, steps to change licensure exam requirements must be taken in each of those jurisdictions and the legislative bodies that empower the licensing bodies. The various regional testing agencies that administer CLEs are charged by state boards of dentistry to provide an independent third-party assessment of the competence of graduates for initial licensure. The exams given by these testing agencies are meant to replicate the fidelity of the technical components of clinical practice.

For several decades, there has been a divide between the responsibilities and viewpoints of the licensure and education communities. The divide is not about the goal: both communities want a well-prepared and competent oral health workforce. Rather, the schism involves differences on the best mechanism for determining the competence of the licensee.

In 2014, the ADEA House of Delegates passed Resolution 5-H 2014, recommending “the elimination of the human subject/patient-based components” of CLEs and calling for a task force to “develop an action plan to transition to” an alternative licensure exam process.2 In its report, the task force noted significant movement in the clinical licensure arena that merits the attention of dental education and emphasized that there are alternative pathways and pilots of models that grant initial licensure without completion of a traditional clinical exam.3 The task force reported that almost one-quarter of graduating dental students currently have the availability of one or more alternative mechanisms leading to initial licensure.

Dental graduates in California, Colorado, Delaware, Minnesota, New York, Ohio, and Washington can obtain dental licensure via successful completion of all or part of an advanced education program. In Minnesota, a modified version of the National Dental Examining Board of Canada’s licensure exam centers on an objective structured clinical exam (OSCE)
in lieu of the traditional exam involving patients. In California, dental students who successfully complete a Hybrid Portfolio can obtain licensure as soon as they graduate from a California dental school. Most recently, a number of dental schools have adopted a curriculum integrated format (CIF) that was started at the University of Buffalo and is designed to address some of the logistical challenges of the traditional exam while retaining the fidelity of assessing restorative and periodontal procedures.

This issue of the Journal of Dental Education contains two articles describing alternatives to the typical one-time, live patient exam process. The CIF model piloted at the University of Buffalo represents transactional change, while the Canadian-based model used by the University of Minnesota represents a transformational change. In both models, the authors emphasize the collaboration and cooperation that are necessary elements in moving to an alternate approach.

It is notable that both the transactional change in Buffalo and the transformational change in Minnesota involved building communication and collaboration across the divide between the education and licensure communities. In the Buffalo process, the Commission on Dental Competency Assessments (CDCA) and educators and students at the University at Buffalo School of Dental Medicine worked together to develop the CIF described in the Gambacorta et al. article. These innovators used an advisory board comprised of faculty, students, clinical staff, organized dentistry, and licensing exam administrators to address the challenges and engender the change. In Minnesota, the state Board of Dentistry and the School of Dentistry worked collaboratively to introduce the first non-patient-based CLE and to integrate representatives from the Minnesota Board of Dentistry into the key processes of “admissions, scholastic standing, education and policy, and competency review board” at the school. In both cases, the approach of working together to resolve challenges resulted in a less “traumatic birthing” for not only the latest generation to enter the profession but for needed change and movement away from the traditional approach to clinical licensure.

Although dental education is seeing notable progress in the licensure process, there is much yet to do. We must take advantage of the season of change that is upon us to support the movement away from the use of patients and a traditional exam process that does not really reflect the competence of 21st-century dental professionals. Dental educators can support this process by looking to the outcomes of innovative licensure practices in the United States and internationally.

REFERENCES

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