

INFORMATIONAL REPORT ON DENTAL ANESTHESIOLOGY PROGRAMS ANNUAL SURVEY CURRICULUM SECTION

Background: At its Winter 2015 meeting, the Commission directed that each Review Committee review a draft of its discipline-specific Annual Survey Curriculum Section during the Winter meeting in the year the Survey will be distributed. The Commission further suggested that each Review Committee review aggregate data of its discipline-specific Annual Survey Curriculum Section, as an informational report, when the materials are available following data collection and analysis. The Commission noted that all survey data is considered confidential at the programmatic level.

The Curriculum Section of the Commission's Annual Survey is conducted for dental anesthesiology programs in alternate years. The next Curriculum Section will be conducted in August/September 2024. The draft Curriculum Section is provided in **Appendix 1** for review by the Dental Anesthesiology Review Committee.

Summary: The Review Committee on Dental Anesthesiology Education is requested to review the draft Curriculum Section of its discipline-specific Annual Survey (**Appendix 1**).

Recommendation:

Part II - Dental Anesthesiology Curriculum Section

Part II of the survey is confidential. Any reports from this section will not identify individual programs by name.

21. What percentage of time did residents spend in each of the following areas during the 2021-22 residency year?

Column must add up to 100%. Do not enter percent signs.

	1st Year	2nd Year	3rd Year
a. Anesthesia for ambulatory dental procedures provided in a dental clinic or in a facility outside the hospital operating rooms including office-based venues (Standards 2-6; 2-7; and 2-9)	<input type="text"/> %	<input type="text"/> %	<input type="text"/> %
b. Rotation/assignments to other services (Standard 2-10)	<input type="text"/> %	<input type="text"/> %	<input type="text"/> %
c. Didactics: conferences/seminars (Standards 2-1, 2-2, 2-3, 2-4)	<input type="text"/> %	<input type="text"/> %	<input type="text"/> %
d. Teaching (Standard 2-15)	<input type="text"/> %	<input type="text"/> %	<input type="text"/> %
e. Investigative work (Standard 6-1)	<input type="text"/> %	<input type="text"/> %	<input type="text"/> %
f. Other, please specify (Standards 2-12 and 2-13)	<input type="text"/> %	<input type="text"/> %	<input type="text"/> %
<input type="text"/>			
Total	<input type="text"/> %	<input type="text"/> %	<input type="text"/> %

22. Please indicate the number of clock hours residents spent in lectures, seminars or formal courses during the 2021-22 residency year.

	1st Year	2nd Year	3rd Year
a. Applied biomedical sciences (Standard 2-4a)	<input type="text"/>	<input type="text"/>	<input type="text"/>
b. Physical diagnosis and evaluation (Standard 2-4b)	<input type="text"/>	<input type="text"/>	<input type="text"/>
c. Behavioral medicine (Standard 2-4c)	<input type="text"/>	<input type="text"/>	<input type="text"/>
d. Techniques of anxiety and pain control (Standard 2-4d)	<input type="text"/>	<input type="text"/>	<input type="text"/>
e. Complications and emergencies (Standard 2-4e)	<input type="text"/>	<input type="text"/>	<input type="text"/>
f. Pain management (Standard 2-4f)	<input type="text"/>	<input type="text"/>	<input type="text"/>
g. Critical evaluation of literature (Standard 2-4g)	<input type="text"/>	<input type="text"/>	<input type="text"/>

23. Please indicate the number of weeks residents spent on the following clinical rotations/assignments during the 2021-22 residency year.

	1st Year	2nd Year	3rd Year
a. Cardiology (Standard 2-10a)	<input type="text"/>	<input type="text"/>	<input type="text"/>
b. Emergency medicine (Standard 2-10b)	<input type="text"/>	<input type="text"/>	<input type="text"/>
c. General/Internal medicine (Standard 2-10c)	<input type="text"/>	<input type="text"/>	<input type="text"/>
d. Intensive care (Standard 2-10d)	<input type="text"/>	<input type="text"/>	<input type="text"/>
e. Pain clinic/service (Standard 2-10e)	<input type="text"/>	<input type="text"/>	<input type="text"/>
f. Pediatrics (Standard 2-10f)	<input type="text"/>	<input type="text"/>	<input type="text"/>
g. Pre-anesthetic assessment clinic (Standard 2-10g)	<input type="text"/>	<input type="text"/>	<input type="text"/>
h. Pulmonary medicine (Standard 2-10h)	<input type="text"/>	<input type="text"/>	<input type="text"/>
i. Other, please specify <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Use this space to enter comments or clarifications for your answers on this page.

24. Please provide the number of cases/procedures the 2022 graduates completed/performed throughout the entire three-year residency program.

	Highest number	Lowest number
a. Deep sedation/general anesthesia cases (Standard 2-6a)	<input type="text"/>	<input type="text"/>
b. Intubated general anesthetics cases (Standard 2-6a.1)	<input type="text"/>	<input type="text"/>
c. Nasal intubations (Standard 2-6a.1)	<input type="text"/>	<input type="text"/>
d. Advanced airway management techniques (Standard 2-6a.1)	<input type="text"/>	<input type="text"/>
e. Cases of children age 7 and under (Standard 2-6a.2)	<input type="text"/>	<input type="text"/>
f. Patients with special needs (Standard 2-6a.3)	<input type="text"/>	<input type="text"/>
g. Ambulatory patients (Standard 2-6b)	<input type="text"/>	<input type="text"/>
h. Patients over age 65 (Standard 2-6b)	<input type="text"/>	<input type="text"/>
i. Patients with physical status ASA III or greater (Standard 2-6b)	<input type="text"/>	<input type="text"/>
j. Patients requiring moderate sedation (Standard 2-6b)	<input type="text"/>	<input type="text"/>
k. Patients with chronic orofacial pain (Standard 2-6c)	<input type="text"/>	<input type="text"/>

25. How many months, over their entire three-year residency, do the residents devote exclusively to clinical training in anesthesiology?

26. (Standard 2-7)

27. How many months, over their entire three-year residency, are the residents assigned to a hospital anesthesia service that provides trauma and/or emergency surgical care? (Standard 2-8)

Use this space to enter comments or clarifications for your answers on this page.

CONSIDERATION OF PROPOSED REVISIONS TO IMPROVE DIVERSITY IN DENTAL AND DENTAL RELATED EDUCATION PROGRAMS

Background: On December 1, 2023, the Commission on Dental Accreditation (CODA) received a letter from The National Coalition of Dentists for Health Equity (TNCDHE). The request is found in **Appendix 1**. In its letter, TNCDHE provides short-term and long-term suggestions to CODA to improve diversity in all academic dental, allied dental, and advanced dental education programs.

The short-term suggestions from TNCDHE include:

1. Better training of site visit teams on how to assess whether an educational program has implemented a plan to achieve positive results.
2. Ensuring site visit teams are inclusive of educators who represent diversity, such as in race, color, national or ethnic origin, age, disability, sex, gender, gender identity, and/or gender expression, and sexual orientation. Further, when possible, site visit team members should be representative of dental schools with demonstrated success in increasing diversity and assuring a humanistic environment.
3. Redefining the meaning and intent of “diversity” in the Standards, considering the recent Supreme Court decision. While the term diversity can no longer specifically relate to race with respect to admissions other characteristics such as family income, first-in-college-in-family, socioeconomic status, birthplace, gender identity and sexual orientation, and other attributes might be used as hallmarks of diversity.

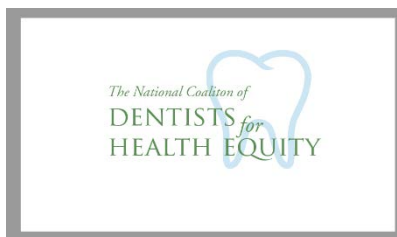
The long-term suggestions from TNCDHE include:

1. Achieving a humanistic environment, addressing discrimination in policies and practice. Suggested revisions to the Accreditation Standards for Predoctoral Dental Education Programs were provided.
2. Review of student admissions related to the underrepresented segments of the population enrolled in dental schools. Suggested revisions and additions to various Accreditation Standards were provided.
3. Considering Standards related to an inclusive environment in dental education. Suggested revisions and additions to various Accreditation Standards were provided.
4. Considering Standards related to access to care among diverse populations. Suggested revisions and additions to various Accreditation Standards were provided.

Summary: The Dental Anesthesiology Review Committee and Commission are requested to consider the letter from The National Coalition of Dentists for Health Equity (**Appendix 1**). If proposed revisions are made to the Accreditation Standards, the Commission may wish to circulate the proposed revisions for a period of public comment.

Recommendation:

Prepared by: Dr. Sherin Took



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December 1, 2023

Dr. Sherin Took, EdD, MS
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Commission on Dental Accreditation
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Dear Dr. Took,

Recommendations to increase diversity in dental education and practice via the Commission on Dental Accreditation Standards

The National Coalition of Dentists for Health Equity's mission is to support and promote evidence informed policy and practices that address inequities in oral health. One of our priorities is to advocate for greater diversity among dental students and faculty to better reflect the diversity of the US population in the oral health workforce.

In November of 2022, we wrote to the Commission on Dental Education (CODA), expressing concerns about the lack of diversity in predoctoral dental education and the apparent lack of enforcement of the CODA standards on diversity (hot link to our letter on our website). We observed that despite these standards, no dental schools (as of 2022) had received a recommendation related to diversity over the ten years that the standards had been in place. Our letter recommended new standards, policies, and procedures that would enhance diversity in predoctoral dental education. We were pleased to learn that CODA accepted our letter and referred it to a committee reviewing potential changes in the predoctoral standards and that the committee's report will be considered in the early 2024 CODA meetings.

Since 2022, we have spent additional time reviewing CODA standards for the other academic dental educational programs including dental hygiene, dental therapy and advanced education programs and realized our recommendations should also apply to these other programs. In this letter, we review our original recommendations, and propose additional ones for all educational programs.

We believe that the dental school accreditation standards utilized by CODA serve a vital role in achieving a diverse oral health workforce. However, we also believe that the current CODA predoctoral education standards do not appear to be encouraging academic dental institutions to recruit a more diverse student body or faculty. CODA adopted the new diversity predoctoral education standards 1-3 and 1-4 about ten years ago. However, recent data from the American Dental Education Association shows that "between 2011 and 2019, the percentage of HURE applicants increased only 2.2% annually on a compounded basis. Additionally, the proportion of all HURE dental school first-year, first-time enrollees for the entering class increased by only 3% between 2011 (13%) to 2019 (16%) (ADEA Report-Slow to Change: HURE Groups in Dental Education, <https://www.adea.org/HURE/>)" The conclusion we draw is that dental schools are not doing enough to recruit more HURE students to meet the intent of the CODA Standards.

We recognize that the recent Supreme Court decision to abolish the use of race in making admission decisions will prevent academic dental institutions from using race as a determining factor in admissions. The recommendations we make below do not suggest or presume that strategy.

In this letter, we are offering several additional suggestions to CODA to improve the diversity of all academic dental education programs, including predoctoral, dental hygiene, advanced educational programs and dental therapy. Three of these are short term recommendations that are not related to changing accreditation standards, with the understanding that CODA appropriately takes considerable time in changing standards which entails seeking input from many individuals, communities, and entities. In addition, we make another set of suggestions that are long term and include modifications to the "Examples of evidence to demonstrate compliance" for some of the standards. Our recommendations are based on papers found in recent Special Editions of The [Journal of Public Health Dentistry](#) and the [Journal of Dental Education](#).

In particular, the longer-term suggestions build on the recommendations of the paper by Smith, PD, Evans CA, Fleming, E, Mays, KAI Rouse, LE and Sinkford, J, 'Establishing an antiracism framework for dental education through critical assessment of accreditation standards, as well as two additional papers in the Special Edition including Swann, BJ, Tawana D. Feimste, TD, Deirdre D. Young, DD and Steffany Chamut, S, 'Perspectives on justice, equity, diversity, and inclusion (JEDI): A call for oral health care policy;' and Formicola, AJ and Evans, C, 'Gies re-visited.' Note that some of these recommendations were included in the previous [letter to CODA](#) sent on November 4, 2022

SHORT-TERM SUGGESTIONS

Suggestion 1: We recommend that site visit teams be better trained on how to assess whether an educational program has implemented a viable plan that achieves positive results. Under the structural diversity section of the Standards, it is stated clearly that the numerical distribution of students, faculty and staff from diverse backgrounds will be assessed. Assessment is appropriate but showing an improvement in the diversity of the dental schools' academic communities based on the school's plans and policies should also be demonstrated.

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Since site visit teams are different for each school, there can be no consistency in the assessment process unless site visitors are given explicit expectations of what schools should demonstrate to comply with each of the two standards. CODA should develop a specific detailed orientation for each site visit team on what is acceptable and what is not acceptable for each of these two standards.

Suggestion 2: To be better able to assess whether schools meet diversity and humanistic standards, site visit teams should be inclusive of educators who represent diversity, such as in race, color, national or ethnic origin, age, disability, sex, gender, gender identity, and/or gender expression, and sexual orientation. Wherever possible, site visit team members should also be representative of dental schools that have demonstrated success in increasing diversity and assuring a humanistic environment.

Suggestion 3: Especially in light of the recent Supreme Court decision, CODA should redefine the meaning and intent of the term "diversity" in the Standards documents. While the term diversity can no longer specifically relate to race with respect to admissions other characteristics such as family income, first-in-college-in-family, socioeconomic status, birthplace, gender identity and sexual orientation, and other attributes might be used as hallmarks of diversity.

LONG-TERM SUGGESTIONS

1) Achieving a humanistic environment- Not much is known about how dental schools address discrimination in their humanistic environment policies and practices. Although school policies on anti-discrimination might exist, students, faculty, and staff from underrepresented populations may still experience microaggressions, discrimination, racism, and barriers to socialization and mentorship. It has been suggested that such experiences may be underreported due to numerous factors, including fear of retaliation and/or disbelief that such concerns will be adequately addressed by the dental school. Because there are small numbers of underrepresented students, faculty, and staff in some dental schools, even anonymous humanistic surveys may not reveal these issues.

Suggested new "Examples of evidence to demonstrate compliance with Predoctoral Education Standard 1-3 may include:"

- Policies and procedures (and documentation of their effectiveness) implemented to seek feedback from traditionally underrepresented individuals concerning their experiences with the school's environment.
- Results of feedback that the school has sought from underrepresented students, faculty, and staff about their experiences with the school's environment.
- Documentation of the number and types of problems, complaints, and grievances reported about the school's environment, together with documentation of the school's effectiveness in addressing these issues.

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2) Student Admissions

Despite the historical lack of students and faculty from underrepresented segments of the population enrolled in US dental schools, it appears that dental schools are rarely cited for not meeting Standard 1-4. One reason for this may be that the standard allows dental schools to set their own interpretations and expectations for student and faculty diversity. As a result, diversity at some dental schools may not appropriately emphasize certain specific underrepresented segments of the population and/or entirely represent the diversity of the local and regional population surrounding the schools, and/or reflect the national demographics in which the schools' graduates will practice their profession. Additionally, CODA provides no specificity for the level of engagement, with respect to recruitment, that dental schools should have with underrepresented populations

Suggested new "Examples of evidence to demonstrate compliance may include".

- Documentation that the school has implemented policies, procedures, and strategies to attract and retain students, faculty and staff from diverse backgrounds in order to achieve parity with the diversity profiles of the school's local, regional or national populations
- Documentation of longitudinal improvement in the diversity of the school's students, faculty, and staff. Where improvement is absent or minimal, documentation of the evaluation of strategies to improve diversity and of modifications made to these strategies to improve outcomes.

The intent of Standard 1-4 states that "admissions criteria and procedures should ensure the selection of a diverse student body with the potential of successfully completing the program". A problem is that the interpretation of this intent can vary dramatically from school to school. Admissions decisions are made by committees of people, and although there are trainings and processes to address implicit biases toward traditionally underrepresented applicants, the admissions process is still largely subjective. There are unique social and structural issues that exist for underrepresented applicants that must also be considered when assessing their potential for success. Those issues may influence undergraduate education academic achievements including GPA's and standardized tests. The question to admissions committees shouldn't necessarily be which applicant has the higher score, but rather does an applicant demonstrate appropriate academic achievements, despite a history of significant barriers, to successfully negotiate the curriculum.

Suggested new "Examples of evidence to demonstrate compliance may include:"

- Documentation of policies and procedures used to consider the unique social and structural constructs that affect traditionally underrepresented applicants in the admissions decision-making process.

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- Documentation of procedures used to educate admissions committee members to implicit biases that may exist with respect to the potential of underrepresented applicants to excel in the academic program.
- Documentation of admissions criteria intended to assess not only academic achievements, but also the interest, desire, and commitment of applicants to learn about issues such as cultural competency, community-based practice, and addressing inequities in oral health within the population.

Standards 4-4 for Predoctoral Dental Education programs and Standard 4-2 for Dental Therapy programs state "Admission policies and procedures must be designed to include recruitment and admission of a diverse student population". There are no accreditation standards for Dental Hygiene or Advanced Educational programs that mandate that these programs have policies and practices to achieve a diverse student population. It is recommended that CODA add these standards with appropriate intent statements and examples of evidence to document compliance.

Generally, with respect to Standards 1-3, 1-4, and 4-4, we recommend that CODA strengthen the accountability that should undergird the standards. There must be accountability around these standards. Accountability must be built into the process of reviewing the standards, supporting site visitors in their work, and making sure that dental schools who fail to meet the standards are required to improve their practices and those dental schools who are exceeding the standards should be encouraged to continue to grow.

3) Inclusive Environments in Dental Education

Underrepresented students have a more difficult time achieving both success and a feeling of belonging in dental educational programs for a myriad of reasons.

To improve retention of students in dental education programs facing academic, social or emotional challenge, it is recommended that CODA strengthen the intent statement for student services (Standard 4-7 for predoctoral programs and Standard 4-12 for the dental therapy programs).

The intent statement should state "programs should have policies and procedures which promote early identification and subsequent mentoring/counseling of students having academic and/or personal issues which have the potential of affecting academic success or the personal well-being of students".

Dental Hygiene and Advanced Education programs have no accreditation standards that address academic or personal support for students having difficulties. It is recommended standards be added.

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4) Access to Care among Diverse Populations

Access to dental care, and therefore oral and systemic health, is significantly compromised by a number of factors including race, gender, sexual orientation, economic status, education, and neighborhood environment, among other factors.

CODA should strengthen the intent statements with respect to graduates being competent in treating patients in all life stages (predoctoral standard 2-22, dental hygiene standard 2-12 and dental therapy standard 2-20) to assure that foundational knowledge is taught and clinical competence is assessed with respect to changes in oral physiology, the management of the various chronic diseases and associated therapeutics associated with aging, as well as psychological, nutritional and functional challenges manifested in many of these patients.

The intent statement of predoctoral standard 2-17, which addresses student's competence in managing a diverse population, is vague. It is recommended CODA strengthen predoctoral standard 2-17 by stating that "graduates MUST (currently reads should) learn about factors and practices associated with disparities in health status among vulnerable populations, including structural barriers, and must display competency in understanding how these barriers, including prejudices and policies regarding, but not limited to race, gender, sexual preferences, economic status, education and neighborhood environment, affect health and disease and access to care".

There are no standards for dental hygiene or advanced education programs that mandate that graduates be competent in treating a diverse population. CODA should add such standards to these programs.

According to the intent statement of predoctoral Standard 2-26, students working in community health care or service-learning settings are essential to the development of a culturally sensitive workforce. However, the standard merely states that the program makes available such learning environments and that students be urged to avail themselves of such opportunities. CODA should mandate the student's participation in service-learning and/or community-based health centers clinics.

We are pleased to submit these suggestions to CODA and we hope they will be considered by CODA in our mutual efforts to increase the diversity of the dental workforce.

Sincerely,
Dr. Lawrence Hill DDS MPH
President, National Coalition of Dentists for Health Equity

cc:
American Dental Education Association - Dr. Karen West, President; Sonya Smith, Chief Diversity Officer,
American Dental Education Officer

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National Dental Association - Tammy Dillard-Steels, MPH, MBA, CAE, Executive Director; Dr. Marlon D. Henderson, President; Dr. Kim Perry, Chairman of the Board

Diverse Dental Society – Dr. Tamana Begay, President

American Dental Therapy Association – Cristina Bowerman MNM, CAE, Executive Director

Hispanic Dental Association - Dr. Christina Meiners, 2023 President; Juan Carlos Pierotti, Operations Manager

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