2025 INDEX
COMMITTEE C (DENTAL EDUCATION AND RELATED MATTERS)

**Material Posted July 1

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: None 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.

BOARD COMMENT: The Board of Trustees noted that Resolution 401 has six resolving clauses: three resolving clauses urging the Commission on Dental Accreditation (CODA) to make revisions to the clinical Accreditation Standards; one resolving clause urging CODA to work with ADEA, AGD, and the recognized dental specialties on the proposed revisions to the clinical Accreditation Standards; one resolving clause urging CODA review and revise its Conflict of Interest policy; and one resolving clause urging CODA strengthen its communication and engagement with the American Dental Association through the existing ADA/CODA Workgroup.

In regard to the resolving clauses related to revisions of the clinical Accreditation Standards, the Board of Trustees is aware that the maker of Resolution 401 has not contacted and asked for expert review from the Council on Dental Education and Licensure (CDEL) regarding the proposed revisions. The Council is the ADA agency with responsibility to monitor accreditation and accreditation matters, which includes providing input and feedback to CODA on proposed new and revised accreditation standards. The Council has four direct appointments of full-time faculty and/or administrators from the American Dental Education Association, along with eight ADA appointments that provide general dentistry and specialty private practice perspective on accreditation matters.

In regard to the resolving clause regarding CODA's Conflict of Interest Policy, the Board of Trustees is aware that CODA is in full compliance with United States Department of Education Recognition Criteria § 602.15 Administrative and fiscal responsibilities:

> The agency must have the administrative and fiscal capability to carry out its accreditation activities in light of its requested scope of recognition. The agency meets this requirement if the agency demonstrates that:
>
> (a) The agency has
> (6) Clear and effective controls, including guidelines, to prevent or resolve conflicts of interest, or the appearance of conflicts of interest, by the agency's:
> (i) Board members;
> (ii) Commissioners;
> (iii) Evaluation team members;
> (iv) Consultants;
> (v) Administrative staff; and
> (vi) Other agency representatives

Finally, in regard to the CODA-ADA Relationship Workgroup resolving clause, the Workgroup has been meeting continually on at least an annual basis with appointed members of the Board of Trustees for

approximately fifteen years. Current Board of Trustees members of the Workgroup report that their interactions with CODA members on the Workgroup have been professional, transparent, and engaging.

For the reasons outlined above, the Board of Trustees urges a no vote on resolution 401.

BOARD RECOMMENDATION: Vote No.

Vote: Resolution 401

BERG	No	DOWD	No	KNAPP	No	STUEFEN	No
BOYLE	No	GRAHAM	No	MANN	No	TULAK-GORECKI	No
BROWN	No	HISEL	No	MARKARIAN	No	WANAMAKER	Yes
CAMMARATA	No	HOWARD	No	MERCER	No		
CHOPRA	No	IRANI	No	REAVIS	No		
DEL VALLE-SEPÚLVEDA	No	KAHL	No	ROSATO	Yes		

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.

Resolution No. 402 New

Report: N/A Date Submitted: 4/3/2025

Submitted By: Dr. Steven Saxe, delegate, Nevada

Reference Committee: C (Dental Education and Related Matters)

Total Net Financial Implication: $200,000 Net Dues Impact: $2.00

Amount One-time: Amount On-going:

ADA Strategic Forecast Outcome: Direct to Dentist: Increase interpersonal and digital connections with members, dental students, and future members over the next five years.

DEVELOPMENT OF THE DENTAL SCHOOL EDUCATIONAL VALUE INDEX (DEVI)

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

Background: For decades, the dream of becoming a dentist has inspired countless students—drawn by the independence, respect, and fulfillment historically associated with the profession. However, today's dental landscape is vastly different from what it was even 20 years ago. Dental education has become more expensive, more corporatized (transformed to operate like a corporation, emphasizing profit), and in many cases, less clinically robust, as seen in the continued decline in full-time faculty hiring and reliance on adjunct and volunteer instructors in clinical education. (2, Page 4)

Educational debt now regularly exceeds $500,000 for some graduates, with the average surpassing $300,000. (1) This cost burden, combined with tuition-first financial models, has resulted in many students experiencing food insecurity and relying on campus food pantries to meet basic needs, (2) Mental health concerns are also rising, as academic stress, isolation, and financial pressure converge during a formative period of professional development, and (3) These challenges often persist for years after graduation and are closely tied to decisions made at the pre-dental stage—such as enrolling in high-cost programs with limited clinical training or poor support systems.

Today's pre-dental students are part of a generation raised on reviews, ratings, and comparative data. They are accustomed to using objective metrics to guide life decisions—where to live, what to buy, and which careers to pursue. Yet when it comes to dental schools, no scientific, outcomes-based ranking system exists to help applicants evaluate where they are most likely to thrive. Instead, students rely on prestige-based rankings, unverified online forums, or word-of-mouth—resources that are often outdated, incomplete, or inaccurate. In contrast, the Association of American Medical Colleges administers the AAMC Graduation Questionnaire, which provides national outcomes data on U.S. medical education.

A well-designed index would not only empower students with relevant comparative information, it would also help dental schools communicate their strengths and areas of investment through verified, objective data. Institutions with strong support systems, robust clinical programs, and high faculty engagement will be able to highlight their value to prospective students in a credible, accessible way. Transparency can become a shared tool for institutional accountability, public trust, and continuous educational improvement.

Transparency in educational outcomes is also an issue of equity. Students from underrepresented or disadvantaged backgrounds may lack access to professional mentorship and rely more heavily on public-

facing information. A centralized, ADA-supported tool will help level the playing field. It will also provide dental schools with a reliable alternative to speculation and misinformation online.

The most recent ADEA survey showed 76% of graduating students wanted more clinical experience in implant surgery, and 52% said the same about endodontics—despite 92% stating they had the skills to begin practice (1). This mismatch between confidence and experience reflects an urgent need for clearer communication of program strengths and limitations.

Meanwhile, the profession itself is undergoing a structural shift. Private equity and insurance-driven models increasingly shape practice management decisions and clinical autonomy, while many new graduates enter employment with DSOs rather than private practices. Dental education must evolve alongside these realities, but prospective students currently lack the tools to evaluate programs with clarity and confidence.

While ADA administers the Dental Admission Test (DAT) and ADEA administers Associated American Dental Schools Application Service (AADSAS) centralized application system, the ADA remains a key stakeholder in dental education policy and workforce development. With its influence, infrastructure, and public reach, the ADA is well positioned to support the development of a public-facing, outcomes-focused index. This system—referred to here as the Dental School Educational Value Index (DEVI)—will be a collaborative tool to promote transparency, support student wellness, and encourage educational excellence.

Some have raised concerns that a lower ranking could negatively affect a graduate's employment opportunities. However, in today's dental job market, most DSOs and large employers do not publicly use school reputation as a primary hiring criterion, and there is no evidence of national hiring trends favoring prestige over demonstrated skills or licensure. The profession has seen a dramatic 40% increase in annual dental graduates over the past two decades, from roughly 5,000 to over 8,000. Yet despite this growth, shortages persist only in areas where dentists are reluctant to relocate—not due to insufficient supply.

We must focus on strengthening the profession, not lowering the bar. Dental schools are not currently required to publicly report clinical graduation requirements or student support metrics. While CODA sets minimum clinical requirements for accreditation, it does not mandate public disclosure of case-specific graduation data or student-level support metrics. Moreover, there is no centralized system to verify whether those individual requirements were actually completed before a degree is awarded. CODA relies on institutional self-assessment and does not independently confirm case counts or clinical experience at the student level *(*Comprehensive Policy on Dental Licensure (*Trans*.2018:341) section titled *Curriculum Integrated Format Clinical Examination*). As more schools open and class sizes expand, according to ADEA's 2023 applicant data, the number of dental schools and first-year enrollees has grown steadily, even as applicant pools have plateaued. We risk a "race to the bottom" in educational quality while simultaneously inflating the cost of entry into the profession. Pre-dental students deserve transparency before taking on life-altering debt. The public deserves confidence in the competence of future practitioners. DEVI offers a credible, ethical, and legally sound way to promote accountability—without penalizing any school or individual.

Participating schools will have the opportunity to publicly highlight their strengths, build applicant trust, and demonstrate their commitment to educational excellence. Ultimately, DEVI is not just about protecting students—it's about protecting patients. Public trust in the dental profession depends on transparency, consistency, and competence in clinical education.

To reduce legal risk, DEVI will rely only on voluntarily submitted, verifiable data directly from dental schools. Institutions that choose not to participate will be listed as non-reporting. This protects the ADA from antitrust and defamation concerns by maintaining objectivity, respecting institutional autonomy, and aligning with legal principles enforced by the Federal Trade Commission (4). Comparable systems in law

(U.S. News rankings), consumer reporting (BBB), and medicine (AAMC Graduation Questionnaire, AMA Residency Navigator) have shown that transparent, factual systems can survive legal scrutiny when properly constructed and voluntarily adopted.

References:

1. *Dentists of Tomorrow 2023: An Analysis of the Results of the ADEA 2023 Survey of U.S. Dental School Seniors* – Istrate, ADEA, 2023
2. *Trends in Dental School Faculty* – Istrate, Journal of Dental Education, 2024
3. *Dental Student Well-Being: A National Survey of Psychological Distress, Coping, and Access to Support* – Journal of Dental Education, 2014
4. *FTC Guide to Antitrust Laws* – Federal Trade Commission, 2024
5. *Correlation Between Students' Dental Admission Test Scores and Performance on a Dental School's Competency Exam* – Carroll, Journal of Dental Education, 2015 https://pubmed.ncbi.nlm.nih.gov/26522638
6. *Relationship Between Performance in Dental School and Performance on a Dental Licensure Examination* – Stewart, Journal of Dental Education, 2005 https://pubmed.ncbi.nlm.nih.gov/16081568

Resolution

402. Resolved, that the American Dental Association, through appropriate agencies and in collaboration with ADEA, AGD, Specialty Associations) and ASDA) stakeholders, shall develop and publish the Dental School Educational Value Index (DEVI) as a public-facing, outcomes-based transparency system, and be it further

Resolved, that DEVI shall include voluntarily reported and verifiable metrics such as:

- Average number of procedures completed across core disciplines
- Student-to-faculty ratios (general and specialty)
- Total educational cost and sources of funding
- Access to wellness resources, food assistance programs, and mental health services
- Reported levels of graduate confidence, satisfaction, and support for diversity and inclusion

and be if further

Resolved, that the ADA shall encourage all accredited dental schools to adopt standardized, outcomes-based reporting on an annual basis and ensure these findings are made publicly accessible through DEVI to help students make informed, equitable, and future-ready choices, and be it further

Resolved, that DEVI shall be promoted as a voluntary, collaborative transparency initiative, and participating schools shall be recognized for their leadership in educational excellence, and be it further

Resolved, that the ADA explore collaboration with the Commission on Dental Accreditation (CODA) to identify which outcome metrics may be appropriate for inclusion in the accreditation self-study process, while maintaining DEVI as a separate, ADA-supported tool to improve institutional accountability and public trust.

BOARD COMMENT: The Board of Trustees thanks the maker for forwarding Resolution 402 and agrees that serious questions exist concerning competency training disparities that appear to exist in dental education. However, the Board believes that these questions are better investigated by other entities,

including ADEA and CODA, through a mechanism other than a ranking system. The Board also questions whether dental schools would participate in such an index, significantly reducing its usefulness, and whether the ADA's involvement in this type of index would have a negative impact on the ADA's relationship with dental schools.

BOARD RECOMMENDATION: Vote No.

Vote: Resolution 402

BERG	No	DOWD	No	KNAPP	No	STUEFEN	No
BOYLE	No	GRAHAM	No	MANN	No	TULAK-GORECKI	No
BROWN	No	HISEL	No	MARKARIAN	No	WANAMAKER	No
CAMMARATA	No	HOWARD	No	MERCER	No		
CHOPRA	No	IRANI	No	REAVIS	No		
DEL VALLE-SEPÚLVEDA	No	KAHL	Absent	ROSATO	Abstain		