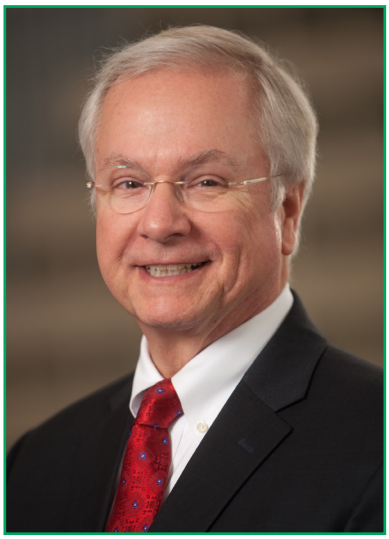
COMMENTARY

Dental Licensure Exams Involving Human Subjects — What Is the Justification?



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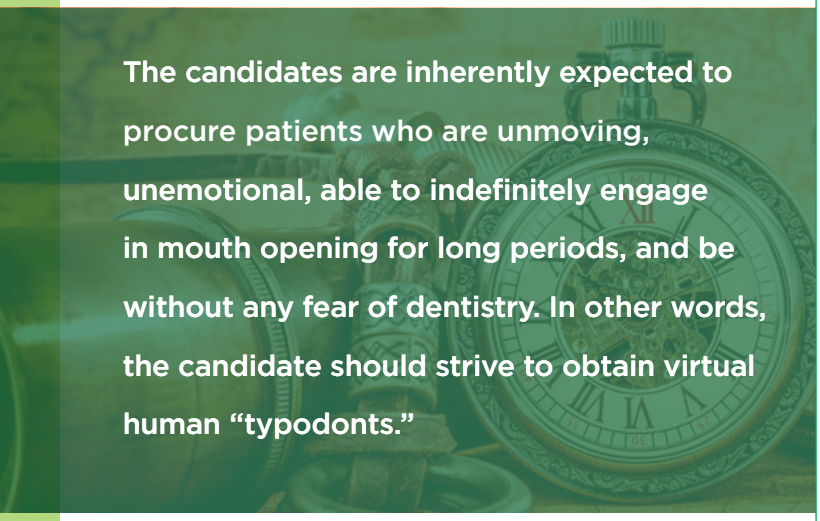
I am initially prompted to modify the question that I have been invited to address, and instead ask, *what is there about licensing exams that could even potentially protect the public?* I will limit my comments to non-ethical issues as they have been thoroughly analyzed by Dr. Schloss. My comments are based upon my personal experiences and observations as a licensed dentist, former dental board member, licensure examiner, and attorney. Let's fast forward.

We have a dental student who has, or will soon, graduate from at least four years of education in a CODA accredited dental school. During that process, the student was closely monitored as he/she performed hundreds of clinical procedures over a number of years. Each step was evaluated and observed by dental faculty familiar with the student's general propensities, academic performance, demeanor, general intelligence and interactions with scores of patients. Each clinical task performed during hundreds of patient encounters was scrutinized, evaluated, critiqued, and documented. Importantly, "one on one" interactional teaching was an inherent part of this process.

Then to the clinical licensing exam. We have a candidate, already assured of graduation from the accredited dental school by its collective faculty, confronted with perhaps the biggest exam of his/her life, overloaded with stress, debt, peer pressure, family expectations, and outside factors having nothing to do with clinical competency. But these extra-

neous factors are of great potential import on the actual demonstration of clinical competency. Of course the student-candidate has performed these clinical examination procedures many, many times in the past and has already been deemed competent by a collective multitude of dental school faculty. But now it's a one-time "high stakes" performance with so much at risk it verges on psychological cruelty. Not to mention the paperwork, specific procedures to follow, patient arrangements, and all the other related non-clinical "risk" factors.



For the candidate, there are never-ending concerns: *Will my patient show up? Will the patient's dentition/condition be approved for the required procedures? Can these unknown examiners consider the potential negative effects from my patient's inability to open wide, or tendency to move around in the chair, or extreme fear of pain?* Of course any patient-related behavior that results in clinical imperfections are the candidate's responsibility, because the candidates are inherently expected to procure patients who are unmoving, unemotional, able to indefinitely engage in mouth opening for long periods, and be without any fear of dentistry. In other words, the candidate should strive to obtain virtual human "typodonts." Indeed, wide variations in patient selection are a reality that every candidate must deal with.

In this environment that is obviously fraught with physical and emotional stress and anxiety, the aspiring licensee will perform very regimented and routine dental procedures that he/she has successfully performed many times in the past, while in an accredited dental school. But none of those successes are relevant now. They were simply required to allow the candidate to graduate, only to then risk it all during this one time roll of the dice.

So how does this scenario potentially "protect the public," or "insure the health and safety of the public?" In my opinion, there is absolutely no correlation. More than likely, the patient volunteer receives dental treatment in a licensing exam which is within the standard of care, but which takes hours, is performed by a profusely nervous and highly stressed dental graduate/candidate, and only after opening their mouths an incessant number of times of unknown duration. From the patient's perspective, the entire experience is anything but enjoyable. Let's face it. The patient is only the necessary "guinea pig." And at best, after hours of sitting patiently in the dental chair, the patient leaves intact. At worst, a slip of the hand, a sudden movement by the patient, or a margin deemed "open," will require the patient to obtain follow up treatment from a licensed practitioner at unknown cost.

A dental licensing exam on a human subject is, in my view, wholly unjustified and primitive. We are no longer barbers. It degrades the value of a 4 year dental education in a CODA accredited dental school, dismisses or at best minimizes the collective wisdom and judgment of dental school faculty, and places the entire outcome on a one time review by dental examiners. The dental licensure examiners are not themselves evaluated

as to their own clinical competency, past malpractice suits, or past licensure issues. So how do these "pieces" of the licensure exam process fit together to "protect the public?" In my judgment, they do not.

Justification for such a patient exam boils down to the dental profession's blind adherence to the past, resistance to change, "we all had to do it," and the millions of dollars received by the regional testing agencies. On what basis can we believe that a clinical licensure exam on a human subject benefits anyone? Statistically, virtually 100% of the candidates will eventually pass the exam. If not the first time, it will just require more money, complicated logistical and procedural hurdles, and a replay of all the stress factors. And the eventual passage occurs in the absence of any clinical remediation. But they will pass, if only they continue to retake the exam. And, if by chance a candidate never passes, what have we established? And is that worth the millions of dollars paid to regional testing agencies and the potential harm to a patient volunteer?

Dentistry is the only healthcare profession that requires its professional school graduates to run the clinical, patient-based, licensure exam gauntlet. I am unaware of any empirical study that in any way connects such an exam with protecting the public. Clearly, the ADA's OSCE exam is far more likely to measure competency and clinical ability, but without subjecting patients to duress and the potential risk of injury emanating from an environment replete with stress, duress, uncertainty, strict protocols, and financial pressures. And OSCE would provide licensure candidates a purely objective exam and a level playing field for comparative evaluation purposes.

After 40 years of involvement, I still can't comprehend any justification for a clinical licensure exam involving human subjects. I believe it has more to do with the millions of dollars received by (competitive) regional licensing entities with sparse accountability to any person or entity, and the profession's inherent resistance to change. It really has little or nothing to do with protecting the public from "incompetent" graduates of a CODA accredited 4-year dental school.

Perhaps a candidate fails the clinical exam because of a 1–2 mm overextended preparation, or imperfectly tapered walls, or an arguably "open" margin, or because he/she allowed calculus to remain on a tooth that was difficult to access. Never mind that every dentist who has practiced for any length of time has cemented a crown that was later determined to have an "open" margin, or prepared a less than ideal class II, or encountered an inappropriate "undercut." This is the nature of dentistry. It happens to the best of practitioners and is simply a reality in the clinical practice of dentistry. It just isn't "allowed" to happen on the clinical licensure exam.

Hopefully, my opinion will encourage more candor and a more objective and unbiased discussion about the ADA/OSCE exam. Our profession and its future licensees deserve our doing so. ■