Letter to the Editor

Dear Editor:

In his most recent Guest Editorial, Dr. Klein makes a case for the ranking of pediatric dental residency programs in the United States.[1] Dr. Klein makes a compelling argument that if the profession and AAPD are not proactive about generating a ranking, then others will do it for us. The question then becomes not whether we should have programs ranked, rather who will decide upon the ranking criteria. Dr. Klein's point is well taken. If anyone is going to rank pediatric dental residency programs, it ought to be those who know the profession best. Dr. Klein proposes the following as ranking criteria: publications, grant funding, faculty scholarship, and exam scores.

When considering a ranking system, I would propose that we look at the goals of our profession and the purpose of practitioners being generated from the programs. The stated mission of pediatric dentistry is to "advance optimal oral health for all children."[2] If we agree that is the mission of the profession, then the degree to which programs graduate residents who meet that mission would seem to be a better measure for determining rankings.

The core values[3] of pediatric dentistry are:

1. Health and health care equity.
2. An effective dental workforce.
3. Effective public programs.
4. Oral health promotion.
5. Child and adolescent welfare.
6. Science, education, research, and evidence based care.
7. Children with special health care needs.
8. Families and communities.
9. Membership.

Measuring program outcomes based on how successfully graduates of a program meet the core values of the profession would provide a more accurate, ethical, and comprehensive ranking system. Research and scholarship are certainly an important part of the profession, as evidenced by the core values, but they are only a single component. To date, early childhood caries is still pervasive, and access to care remains a significant challenge. To date, research, publication, and grant funding alone have not resolved these problems. Applications to pediatric dental residencies have increased, as have applicant grades and scores.[4] However, even with these increased numbers of qualified candidates, along with their high grades and high test scores, our challenges remain unsolved.

A program's success in generating pediatric dentists who contribute to the core values of the profession would be more appropriate criteria for a ranking system. Factors such as achieving board certification to demonstrate clinical competence, serving children with the greatest needs (i.e., accepting Medicaid or working in Health Professional Shortage Areas), and actively advocating for children and pediatric oral health are examples of measurable outcomes that could and should be factored into a pediatric dental residency program ranking system.

Children do not need dentists who attended programs that are highly ranked, yet who do not perform the challenging and virtuous work that is the profession's true purpose. The values we use to create a ranking system ought to align with the core values to which we say we aspire. A ranking system should benefit the children we exist to serve, and not simply provide bragging rights for ivory towers.

Sincerely,

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3. American Academy of Pediatric Dentistry. American Academy of Pediatric Dentistry Core Values. Pediatr Dent 2016; 38 (special issue):5-6.
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Response to the Letter to the Editor

In her letter, Dr. De Bord expressed concern that "a ranking system should benefit the children we exist to serve and not simply provide bragging rights for ivory towers". Indeed, our profession should engage in a broader discussion on what a future ranking system should measure. Programs need to appreciate the benefits they can derive from measuring core academic and clinical standards on a regular and standardized basis and not only every seven years for their CODA accreditation self-studies, whose results are not publicly available. It would be helpful to create an environment for programs that is conducive to embracing transparency as an opportunity rather than considering it a threat.

This could be an opportunity to learn from medical specialties. In his book *Better*, Dr. Atul Gawande[1] points out so aptly that in the case of the Care Center Data of the Cystic Fibrosis Foundation[2] it is not necessarily the greater knowledge of providers or newer technology that accounts for better treatment outcomes and a center's higher ranking. It is the extra engagement of providers and their intent to leave no stone unturned when caring for patients. For the latter, these publicly accessible quality measures matter, regardless of how they were achieved. He goes on writing that Donald Berwick, MD, a former Administrator of the Centers for Medicare and Medicaid Services[3], believes "that the subtleties of high-performance medical practice can be identified and learned. But the lessons are hidden because no one knows who the high performers really are. Only if we know the results from all can we identify the positive deviants and learn from them. And if we are genuinely curious about how the best achieve their results then the ideas will spread." It is no coincidence that at the heart of the U.S. News rankings are data that include an assessment of a health care facility's structure, processes, and treatment outcomes for delivering high-quality care. Public transparency regarding safety and patient volumes play an important role as well.[4]

There are dental schools with defined teaching and clinical care processes that have evaluated their outcomes regularly. These schools have demonstrated higher implementation rates of evidence-based guidelines – and consequently improved patient care. But, only a small number of schools have formally implemented clinical practice guidelines and an even smaller number collect feedback on whether the implementation is proceeding as planned.[5]

Many pediatric dentistry programs need to change along with revised CODA accreditation standards. Progressive leaders have proposed and already implemented a more contemporary model for postgraduate pediatric dentistry education.[6] Centralized databases where residents log their clinical experiences are already in use in some dental and medical pre- and postdoctoral education venues and could, if universally embraced, provide a reliable source of unbiased data for ranking and accreditation purposes.[7]

A ranking system intent on comprehensively assessing educational programs should therefore include data on a program's structure, processes, treatment outcomes, patient safety, as well as number and variety of procedures performed by residents. The faculty body should be assessed by the number of publications, grant dollars received, h-index, and other unique qualifications, while teaching outcomes would be reflected by the nationally standardized in-service and ABPD examination scores. Programs could leverage their particular strengths to score high. In a rating system espousing the nine AAPD core values, some programs may earn more points through oral health promotion, while others will do better in science, education, research, and evidence-based care. Others would benefit from their large patient pool that provides excellent clinical opportunities for residents, have effective public health programs in place, or excel in training a new generation of academic teachers with advanced degrees. Many programs already have accomplished faculty with the desire and skill to develop new gold standards of care in our field through quality research in the basic and translational sciences as well as other scholarly endeavors.

Through collaboration and commitment to our profession's core values that can be verified by data, we can create widespread and sustained progress that will universally benefit patients, residents, faculty, and the profession as a whole. However, progress will be slow without the transparency and accountability that only data-driven national statistics can provide.

Sincerely,

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