NATIONAL INSTITUTE FOR HEALTH SPECIALITIES

NIHS Program Requirements for Specialty Education in Oral and Maxillofacial Surgery (Emirati Board in) Oral and Maxillofacial Surgery

The Emirati Board in Oral and Maxillofacial Surgery is expected to define its specific program aims consistent with the overall mission of its Sponsoring Institution, the needs of the community it serves and that its graduates will serve, and the distinctive capabilities of dentists it intends to graduate. The Program must demonstrate substantial compliance with the Common and specialty-specific Program Requirements.

Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophical statements are not program requirements and are therefore not citable.

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Introduction

Int. A. Preamble

Graduate dental education is an important step of professional development between dental school and independent clinical practice. It is in this vital phase of the continuum of dental education that residents learn to provide best patient care under the supervision of faculty members who not only instruct, but also serve as role models of excellence, compassion, professionalism, and scholarship.

Graduate dental education transforms dental graduates into dental scholars who care for the patient, family, and a diverse community; create and integrate new knowledge into practice; and educate future generations of dentists to serve the public.

Graduate dental education has as a core tenet the graded authority and responsibility for patient care. The care of patients is undertaken with appropriate faculty supervision and conditional independence, allowing residents to attain the knowledge, skills, attitudes, and empathy required for independent practice. Graduate dental education develops dentists who focus on excellence in delivery of safe, equitable, affordable, quality care and the oral health of the populations they serve.

Graduate dental education occurs in clinical and academic settings that establish the foundation for practice-based and lifelong learning. The professional development of the dentist, begins in dental school, continues through faculty modelling of the effacement of self-interest in a humanistic environment that emphasizes joy in curiosity, problem-solving, academic rigor, and discovery. This transformation is often physically, emotionally, and intellectually demanding and occurs in a variety of clinical learning environments committed to graduate dental education and the well-being of patients, other residents and fellows, faculty members and all members of the health care team.

Int. B. Definition of Specialty

Oral and Maxillofacial Surgery (OMFS) is a surgical specialty that integrates medicine and dentistry for the diagnosis and management of diseases, injuries, and deformities of the oral and maxillofacial region, including the mouth, jaws, face, and associated structures. The specialty encompasses both functional and aesthetic aspects of patient care and involves interdisciplinary collaboration to restore health, function, and facial harmony.

The scope of Oral and Maxillofacial Surgery includes, but is not limited to, the management of maxillofacial trauma, congenital and acquired deformities, head and neck pathology, temporomandibular joint disorders, dentoalveolar surgery, implantology, and facial aesthetic procedures. The extent of practice is defined by the

competencies acquired through accredited training programs and as outlined within this curriculum (NIHS - Emirati Board in Oral and Maxillofacial Surgery).

Int. C. Length of Educational Program

The duration of an advanced dental education program in oral and maxillofacial surgery must be five (5) years of full-time formal training. (Core)

I. Oversight

I.A. Sponsoring Institution

The Sponsoring Institution is the entity that assumes the ultimate financial and academic responsibility for a program of graduate dental education, consistent with the NIHS Institutional Requirements.

The financial resources must be sufficient to support the program's stated goals and objectives. (Core)

Background and Intent: *The institution should have the financial resources required to develop and sustain the program on a continuing basis. The program should have the ability to employ an adequate number of full-time faculty, purchase and maintain equipment, procure supplies, reference material and teaching aids as reflected in annual budget appropriations. Financial allocations should ensure that the program will be in a competitive position to recruit and retain qualified faculty. Annual appropriations should provide for innovations and changes necessary to reflect current concepts of education in the advanced dental education discipline.*

I.A.1. The Sponsoring Institution must be the primary clinical training site defined as the most utilized rotation site of clinical activity for the program. (Core)

I.A.2. The program must be sponsored by one NIHS-accredited Sponsoring Institution. (Core)

I.B. Participating Sites

A participating site is an entity that provides educational experiences or educational assignments/rotations for residents.

I.B.1. The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)

I.B.2. There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)

I.B.2.a) The PLA must:

I.B.2.a)(1) be renewed at least every 5 years; (Core)

I.B.2.a)(2) be approved by the designated institutional official (DIO); (Core)

I.B.2.a)(3) specify the duration and content of the educational experience; (Core)

I.B.2.a)(4) state the policies and procedures that will govern resident education during the assignment; (Core)

I.B.2.a)(5) identify the faculty members who will assume educational and supervisory responsibility for residents; (Core)

I.B.2.a)(6) specify the responsibilities for teaching, supervision, and formal evaluation of residents. (Core)

I.B.3. The program must monitor the clinical learning and working environment at all participating sites. (Core)

I.B.3.a) At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration with the program director. (Core)

Background and Intent: *While all residency programs must be sponsored by a single NIHS-accredited Sponsoring Institution, many programs will utilize other clinical settings to provide required or elective training experiences. At times it is appropriate to utilize clinical sites that are not owned by or affiliated with the Sponsoring Institution. Some of these sites may be remote for geographic, transportation, or communication issues. When utilizing such sites, the program must ensure the quality of the educational experience.*

I.B.4. The program director must submit any additions or deletions of participating sites routinely providing educational experience, required for all residents, of one-month full time equivalent (FTE) or more through NIHS Accreditation System. (Core)

I.B.5. Resident assignments away from the Sponsoring Institution should not prevent residents' regular participation in required didactics. (Core)

I.B.6. Rotations away from the Sponsoring Institution must not exceed 26 weeks in duration. (Core)

I.C. Recruitment

The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and

retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative staff members, and other relevant members of its academic community. (Core)

I.D. Resources

Clinical facilities must be provided within the sponsoring or affiliated institution to fulfill the educational needs of the program.

I.D.1. The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. (Core)

I.D.1.a) Equipment and supplies for use in managing medical and dental emergencies must be readily accessible and functional. (Core)

Background and Intent: *The facilities and resources (e.g.: support/administrative staff, allied personnel and/or technical staff) should permit the attainment of program goals and objectives. To ensure health and safety for patients, residents, faculty and staff, the physical facilities and equipment should effectively accommodate the clinic and/or laboratory schedule.*

I.D.1.b) The program must document its compliance with the institution's policy and applicable regulations including but not limited to radiation hygiene and protection, ionizing radiation, hazardous materials, and bloodborne and infectious diseases. Policies must be provided to all residents, faculty and appropriate support staff and continuously monitored for compliance. (Core)

I.D.1.b)(1) Additionally, policies on bloodborne and infectious diseases must be made available to applicants for admission and patients. (Core)

Background and Intent*: The program may document compliance by including the applicable program policies. The program demonstrates how the policies are provided to the residents, faculty and appropriate support staff and who is responsible for monitoring compliance. Applicable policy states how it is made available to applicants for admission and patients should a request to review the policy be made.*

I.D.1.c) Residents, faculty and appropriate support staff must be encouraged to be immunized against and/or tested for infectious diseases, such as mumps, measles, rubella, hepatitis B, prior to contact with patients and/or infectious objects or materials, to minimize the risk to patients and dental personnel. (Core)

***Background and Intent**: The program should have a written policy that encourages (e.g., delineates the advantages of) immunization for residents, faculty, and appropriate support staff.*

I.D.1.d) All residents, faculty and support staff involved in the direct provision of patient care must be continuously recognized/certified in basic life support procedures, including cardiopulmonary resuscitation. (Core)

***Background and Intent**: Continuously recognized/certified in basic life support procedures means the appropriate individuals are currently recognized/certified.*

I.D.1.d)(1) Private practitioners who provide training must follow a similar criterion required for the training faculty. (Core)

***Background and Intent**: Private institutions can be used for training and should meet the same facility standards as institutional facilities.*

I.D.1.e) The program must have access to clinical facilities that include:

I.D.1.e)(1) Space designated specifically for the advanced dental education program in oral and maxillofacial surgery. (Core)

***Background and Intent**: Dedicated space is necessary to maintain the autonomy of a program. Sharing the same clinical facilities with other areas of dentistry is not permitted.*

I.D.1.e)(2) Proper equipment for performance of all ambulatory oral and maxillofacial surgery procedures, including administration of general anaesthesia and sedation for ambulatory patients. (Core)

I.D.1.e)(3) Adequate bed availability to provide for the required number of patient admissions and appropriate independent care by the oral and maxillofacial surgery service. (Core)

I.D.1.e)(4) Properly equipped space for monitoring patients' recovery from ambulatory surgery, general anesthesia and sedation. (Core)

I.D.1.e)(5) Adequate onsite computer resources with internet access available to the residents. (Core)

I.D.1.e)(6) Flexibility to allow for changes in equipment location and for additions or deletions to improve operating efficiency and promote efficient use of dental instrumentation and allied personnel. (Core)

I.D.1.e)(6)(a) Facilities must permit the residents to work effectively with trained allied dental personnel. (Core)

Background and Intent: *A program is expected to have auxiliaries available to assist the residents so the program can meet the educational Standards.*

I.D.1.e)(7) Diagnostic imaging and laboratory facilities in close proximity to the patient treatment area. (Core)

I.D.1.e)(8) Inpatient facilities to permit management of general and oral health problems for individuals with special health care needs. (Core)

Background and Intent: *Residents can manage oral health problems of inpatients with serious medical problems. Individuals with special health care needs include those with medical, physical, psychological, or social circumstances that require modification of dental treatment. These individuals include (but are not limited to) people with developmental disabilities, complex medical problems, and significant physical limitations.*

I.D.1.e)(9) Resources such as radiographic, biometric and data collecting facilities must be readily available to document both clinical and research data. (Core)

I.D.1.e)(10) Residents must have access to adequate space, equipment, and physical facilities to do research. (Core)

I.D.2. The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for (Core):

I.D.2.a) access to food while on duty; (Core)

I.D.2.b) clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)

I.D.2.c) security and safety measures appropriate to the participating site; (Core)

I.D.2.d) accommodations for residents with disabilities consistent with the Sponsoring Institution's policy. (Core)

I.D.3. Residents must have ready access to Oral and Maxillofacial Surgery-specific and other appropriate reference material in print or electronic format. This must include access to biomedical textbooks, dental journals, online resources, and other sources pertinent to the area of Oral and Maxillofacial Surgery practice and research, electronic medical and dental literature databases with full text capabilities. (Core)

I.D.4. The program's educational and clinical resources must be adequate to support the number of residents appointed to the program. (Core)

I.D.4.a) Patient Availability:

I.D.4.a)(1) An adequate and diverse pool of patients requiring a sufficient scope, volume and variety of medical and oral health care needs and a delivery system to provide ample opportunity for training must be available, including healthy individuals as well as individuals with special health care needs. (Core)

I.D.4.a)(2) These health care needs must include, but are not limited to, medical, physical, psychological, or social situations that make consideration of a wide range of assessment and care options necessary. (Core)

Background and Intent*: Documentation of the scope, volume and variety of patients and procedures completed by the residents, including those with complex impairment who require substantial functional support and modifications to dental treatment, shall be recorded and are to be available for on-site review.*

I.E. Other Learners and Other Care Providers

The presence of other learners and other care providers, including, but not limited to, students, interns, residents from other programs, fellows, and advanced practice providers, must enrich the appointed residents' education. (Core)

I.E.1. The program must report circumstances when the presence of other learners has interfered with the residents' education to the DIO and to the graduate medical education committee (GMEC). (Core)

Background and Intent: *The clinical learning environment has become increasingly complex and often includes care providers, students, and post-graduate residents and fellows from multiple disciplines. Programs have a responsibility to monitor the learning environment to ensure that residents' education is not compromised by the presence of other providers and learners.*

II. Personnel

II.A. Program Director

II.A.1. There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)

II.A.1.a) The Sponsoring Institution's GMEC must approve a change in program director. (Core)

II.A.1.b) Final approval of the program director resides with the Central Accreditation Committee. (Core)

Background and Intent: *While the NIHS recognizes the value of input from numerous individuals in the management of a residency, a single individual must be designated as program director and made responsible for the program. This individual will have dedicated time for the leadership of the residency, and it is this individual's responsibility to communicate with the residents, faculty members, DIO, GMEC, and the NIHS. The program director's nomination is reviewed and approved by the GMEC. Final approval of program directors resides with the Central Accreditation Committee.*

II.A.1.c) The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability. (Core)

Background and Intent*: The success of residency programs is generally enhanced by continuity in the program director position. The professional activities required of a program director are unique and complex and take time to master. All programs are encouraged to undertake succession planning to facilitate program stability when there is necessary turnover in the program director position.*

II.A.2. At a minimum, the program director must be provided with the salary support required to devote 50 percent FTE of non-clinical time to the administration of the program. (Core)

Background and Intent: *Fifty percent FTE is defined as two-and-a-half (2.5) days per week. "Administrative time" is defined as non-clinical time spent meeting the responsibilities of the program director.*

II.A.3. Qualifications of the program director:

II.A.3.a) must include oral and maxillofacial surgery expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Central Accreditation Committee; (Core)

Background and Intent: *Leading a program requires knowledge and skills that are established during residency and subsequently further developed. The time from completion of residency until assuming the role of program director allows the individual to cultivate leadership abilities while becoming professionally established. The three-year period is intended for the individual's professional maturation.*
The broad allowance for educational and/or administrative experience recognizes that strong leaders arise through diverse pathways. These areas of expertise are important when identifying and appointing a program director. The choice of a program director should be informed by the mission of the program and the needs of the community.
In certain circumstances, the program and Sponsoring Institution may propose and the Central Accreditation Committee may accept a candidate for program director who fulfills these goals but does not meet the three-year minimum.
Successful administration of a Oral and Maxillofacial Surgery residency program requires administrative time. At least half of the required 0.5 FTE should include blocked time to complete administrative requirements of the residency. Time spent in clinics supervising residents, while important, should not be counted in the required 0.5 FTE of administrative time.

II.A.3.b) must be licensed as a consultant and have at least three years' documented post residency experience in oral and maxillofacial surgery, or with a specialty qualification that are acceptable to the Central Accreditation Committee; (Core)

II.A.3.d) must include ongoing clinical activity in oral and maxillofacial surgery; (Core)

Background and Intent*: A program director is a role model for faculty members and residents. The program director must participate in clinical activity consistent with the Oral and Maxillofacial Surgery. This activity will allow the program director to role model the Core Competencies for the faculty members and residents.*

II.A.4. Program Director Responsibilities

The program director must have responsibility, authority, and accountability for administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care. (Core)

II.A.4.a) The program director must:

II.A.4.a)(1) be a role model of professionalism; (Core)

Background and Intent: *The program director, as the leader of the program, must serve as a role model to residents in addition to fulfilling the technical aspects of the role. As residents are expected to demonstrate compassion, integrity, and respect for others, they must be able to look to the program director as an exemplar. It is of utmost importance, therefore, that the program director model outstanding professionalism, high quality patient care, educational excellence, and a scholarly approach to work. The program director creates an environment where respectful discussion is welcome, with the goal of continued improvement of the educational experience.*

II.A.4.a)(2) design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program; (Core)

Background and Intent: *The mission of institutions participating in graduate dental education is to improve the oral health of the public. Each community has health needs that vary based upon location and demographics. Programs must understand the social determinants of oral health of the populations they serve and incorporate them in the design and implementation of the program curriculum, with the ultimate goal of addressing these needs and health disparities.*

II.A.4.a)(3) administer and maintain a learning environment conducive to educating the residents. in each of the Core Competency domains; (Core)

Background and Intent: *The program director may establish a leadership team to assist in the accomplishment of program goals. Residency programs can be highly complex. In a complex organization, the leader typically has the ability to delegate authority to others yet remains accountable. The leadership team may include dental and non-dental personnel with varying levels of education, training, and experience.*

II.A.4.a)(4) develop and oversee a process to evaluate candidates prior to approval as program faculty members for participation in the residency program education and at least annually thereafter; (Core)

II.A.4.a)(5) have the authority to approve and/or remove program faculty members for participation in the residency program education at all sites; (Core)

II.A.4.a)(6) have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program; (Core)

Background and Intent: *The program director has the responsibility to ensure that all who educate residents effectively role model the Core Competencies. Working with a resident is a privilege that is earned through effective teaching and professional role modeling. This privilege may be removed by the program director when the standards of the clinical learning environment are not met.*
There may be faculty in a department who are not part of the educational program, and the program director controls who is teaching the residents.

II.A.4.a)(7) submit accurate and complete information required and requested by the DIO, GMEC, and NIHS; (Core)

II.A.4.a)(8) provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s); (Core)

II.A.4.a)(9) provide a learning and working environment in which residents have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; (Core)

II.A.4.a)(10) ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process; (Core)

II.A.4.a)(11) ensure the program's compliance with the Sponsoring Institution's policies and procedures for due process when action is taken to suspend or dismiss, not to promote, or not to renew the appointment of a resident; (Core)

Background and Intent: *A program does not operate independently of its Sponsoring Institution. It is expected that the program director will be aware of the Sponsoring Institution's policies and procedures and will ensure they are followed by the program's leadership, faculty members, support personnel, and residents.*

II.A.4.a)(12) ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)

II.A.4.a)(13) document verification of program completion for all graduating residents; within 30 days; (Core)

II.A.4.a)(14) provide verification of an individual resident's completion upon the residents' request, within 30 days; (Core)

Background and Intent: *Primary verification of graduate dental education is important to credentialing of dentists for further training and practice. Such verification must be accurate and timely. Sponsoring Institution and program policies for record retention are important to facilitate timely documentation of residents who have previously completed the program. Residents who leave the program prior to completion also require timely documentation of their summative evaluation.*

II.A.4.a)(15) obtain review and approval of the Sponsoring Institution's DIO before submitting information, as required in the Institutional Requirements and outlined in the NIHS guidelines to the Common Program Requirements. (Core)

II.A.5. Associate Program Director (APD):

II.A.5.a) For programs with an approved resident complement of more than 15, the sponsoring institution must appoint an Associate Program director to support the PD by actively participating in administrative and educational activities (Core)

II.A.5.b) Sponsoring institution to provide APD with 0.3 FTE (or 12 hrs per week) of protected time for education and program administration, The APD must not work more than 0.7 FTE in a clinical capacity. (Core)

II.A.5.c) APD should assume the role for a duration suitable for ensuring program continuity and stability. (Core)

II.B. Faculty

Faculty members are a foundational element of graduate dental education – faculty members teach residents how to care for patients. Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of dentists by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach. By employing a scholarly approach to patient care and engaging in scholarly activities, faculty members, through the graduate dental education system, improve the oral and overall health of the individual and the population.

Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an

effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.

Background and Intent: *"Faculty" refers to the entire teaching force responsible for educating residents. The term "faculty," including "core faculty," does not imply or require an academic appointment or salary support.*

II.B.1. At each participating site, there must be enough faculty members with competence to instruct and supervise all residents at that location. (Core)

II.B.1.a) The ratio of all faculty to residents must be a minimum of 1:1. (Core).

II.B.1.b) Clinical instruction and supervision in oral and maxillofacial surgery must be provided by faculty who fulfil the qualification requirements stated under paragraph II.B.3.b). (Core)

II.B.2. Faculty members must:

II.B.2.a) be role models of professionalism; (Core)

II.B.2.b) demonstrate commitment to the delivery of safe, quality, cost-effective, patient-centered care; (Core)

Background and Intent: *Patients have the right to expect quality, cost-effective care with patient safety at its core. The foundation for meeting this expectation is formed during residency and fellowship. Faculty members model these goals and continually strive for improvement in care and cost, embracing a commitment to the patient and the community they serve.*

II.B.2.c) demonstrate a strong interest in the education of residents; (Core)

II.B.2.d) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities including timely continuous feedback and assessment; (Core)

II.B.2.e) administer and maintain an educational environment conducive to educating residents; (Core)

II.B.2.f) regularly participate in organized clinical discussions, journal clubs, and conferences; (Core)

II.B.2.g) pursue faculty development designed to enhance their skills at least annually: (Core)

Background and Intent: *Faculty development is intended to describe structured programming developed for the purpose of enhancing transference of knowledge, skill, and behavior from the educator to the learner. Faculty development may occur in a variety of configurations (lecture, workshop, etc.) using internal and/or external resources. Programming is typically needs-based (individual or group) and may be specific to the institution or the program. Faculty development programming is to be reported for the residency program faculty in the aggregate.*

II.B.2.g)(1) as educators; (Core)

II.B.2.g)(2) in quality improvement and patient safety; (Core)

II.B.2.g)(3) in fostering their own and their residents' well-being; (Core)

II.B.2.g)(4) in patient care based on their practice-based learning and improvement efforts. (Core)

Background and Intent: *Practice-based learning serves as the foundation for the practice of medicine. Through a systematic analysis of one's practice and review of the literature, one is able to make adjustments that improve patient outcomes and care. Thoughtful consideration to practice-based analysis improves quality of care, as well as patient safety. This allows faculty members to serve as role models for residents in practice-based learning.*

II.B.3. Faculty Qualifications

II.B.3.a) Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)

II.B.3.b) Faculty members must have a current license in oral and maxillofacial surgery or other specialty as required, or possess qualifications judged acceptable to the Central Accreditation Committee. (Core)

II.B.3.c) Any non-dentist faculty members who participate in residency program education must be approved by the program director. (Core)

Background and Intent*: The provision of optimal and safe patient care requires a team approach. The education of residents by non-dentist educators enables the resident to better manage patient care and provides valuable advancement of the residents' knowledge. Furthermore, other individuals contribute to the education of the resident in the basic science of the specialty or in research methodology. If the program director determines that the contribution of a non-dentist individual is significant to the education of the residents, the program director may designate the individual as a program faculty member or a program core faculty member.*

II.B.4. Core Faculty

Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents. (Core)

***Background and Intent**: Core faculty members are critical to the success of resident education. They support the program leadership in developing, implementing, and assessing curriculum and in assessing residents' progress toward achievement of competence in the specialty. Core faculty members should be selected for their broad knowledge of and involvement in the program, permitting them to effectively evaluate the program, including completion of the annual NIHS Faculty annual survey.*

II.B.4.a) Core faculty members must be designated by the program director. (Core)

II.B.4.b) Core faculty members must complete the annual NIHS Faculty Survey. (Core)

II.B.4.c) Core faculty member-to-resident ratio must be 1:3.5. (Core)

II.C. Program Coordinator

II.C.1. There must be a program coordinator. (Core)

II.C.2. At a minimum, the program coordinator must be provided with adequate time for the administration of the program. (Core)

***Background and Intent:** Each program requires a lead administrative person, frequently referred to as a program coordinator, administrator, or as titled by the institution. This person will frequently manage the day-to-day operations of the program and serve as an important liaison with learners, faculty and other staff members, and the NIHS. Individuals serving in this role are recognized as program coordinators.*
The program coordinator is a member of the leadership team and is critical to the success of the program. As such, the program coordinator must possess skills in leadership and personnel management. Program coordinators are expected to develop unique knowledge of the NIHS and Program Requirements, policies, and procedures. Program coordinators assist the program director in accreditation efforts, educational programming, and support of residents.
Programs, in partnership with their Sponsoring Institutions, should encourage the professional development of their program coordinators and avail them of opportunities for both professional and personal growth. Programs with fewer residents may not require a full-time coordinator; one coordinator may support more than one program.

II.D. Other Program Personnel

The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program. (Core)

II.D.1. Adequate allied dental personnel suitably trained and credentialed, to ensure clinical and laboratory technical support. (Core)

Background and Intent: *Multiple personnel may be required to effectively administer a program. These may include staff members with clerical skills, project managers, education experts, and staff members to maintain electronic communication for the program. These personnel may support more than one program in more than one discipline.*
Allied dental personnel are expected to be available for operating room cases, conscious/deep sedation patients, surgical procedures and behavior management situations. There are instances when a resident assisting another resident may be beneficial as long as the experience does not negatively impact the residents' education. Clinic scheduling and off service rotations will be considered in assessing adequacy of allied dental personnel.

III. Resident Appointments

III.A. Eligibility Requirements

III.A.1. An applicant must meet the following qualifications to be eligible for enrolment to a NIHS-accredited program: (Core)

III.A.1.a) Refer to NIHS criteria included in the Training Bylaw. (Core)

III.A.1.b) Completion of a B.D.S., D.D.S. or D.M.D. degree from a university recognized and accredited by the Ministry of Education of the UAE. (Core)

III.A.1.c) Completion of at least one year of clinical experience after the internship. (Core)

III.A.1.d) Completion of Diploma of Membership of the Faculty of Dental Surgery (MFDS) or its equivalent. (Core)

III.A.2. All prerequisite post-graduate clinical education required for initial entry or transfer into NIHS-accredited residency programs must be completed in a NIHS-accredited residency program, or in residency programs approved by the NIHS. (Core)

III.A.2.a) Residency programs must receive verification of each resident's level of competency in the required clinical field using evaluations from the prior training program upon matriculation. (Core)

III.A.2.b) Prior to enrolment in the program, residents must fulfil the NIHS eligibility criteria. (Core)

III.A.3. A dentist who has completed a residency program that was not accredited by NIHS, may enter a NIHS-accredited residency program in the same specialty at the postgraduate year 1 level and, at the discretion of the program director of the NIHS-accredited program and with approval by the GMEC, may be advanced to the postgraduate year 2 level based on evaluations at the NIHS-accredited program. (Core)

III.B. Number of Residents

III.B.1. The program director must not appoint more residents than approved by the Central Accreditation Committee. (Core)

III.B.2. All complement increases must be approved by the Central Accreditation Committee. (Core)

III.B.3. The number of residents appointed to the program must not exceed the program's educational and clinical resources. (Core)

III.C. Resident Transfers

The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring resident. (Core)

IV. Educational Program

The NIHS accreditation system is designed to encourage excellence and innovation in graduate medical and dental education regardless of the organizational affiliation, size, or location of the program.

The educational program must support the development of knowledgeable, skillful dentists who provide compassionate care.

IV.A. Curriculum Components

The Educational Curriculum must contain the following educational components: (Core)

IV.A.1. A set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates; (Core)

IV.A.2. Competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice. (Core)

IV.A.3. These goals and objectives must be distributed and available to residents and faculty members. (Core)

IV.A.4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision. (Core)

IV.A.4.a) These responsibilities and specified projected progress are described for each PGY level as determined by the Clinical Competency Committee (CCC). (Core)

IV.A.5. A broad range of structured didactic activities; (Core)

IV.A.5.a) Residents must be provided with protected time to participate in structured core didactic activities. (Core)

IV.A.5.a)(1) Didactic activities include, but are not limited to: (Core)

- Formal instruction (a module/lecture materials or course syllabi) in evidence-based practice
- Didactic program course syllabi, course content outlines, or lecture materials that integrate aspects of evidence-based practice
- Literature review seminar(s)
- Multidisciplinary grand rounds to illustrate evidence-based practice
- Projects/portfolios that include critical reviews of the literature using evidence-based practice principles (or "searching publication databases and appraisal of the evidence")
- Assignments that include publication database searches and literature appraisal for best evidence to answer patient-focused clinical questions.

IV.A.6. Advancement of residents' knowledge of ethical principles essential to dental professionalism; (Core)

IV.A.7. Advancement in the residents' knowledge of the basic principles of scientific inquiry, including how to design, conduct, and evaluate clinical research, explanation of it to patients, and applied to patient care. (Core)

IV.B. Defined Core Competencies

IV.B.1. The program must integrate the following Core Competencies into the curriculum: (Core)

IV.B.1.a) Professionalism

Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)

IV.B.1.a)(1) Residents must demonstrate competence in:

IV.B.1.a)(1)(a) compassion, integrity, and respect for others; (Core)

IV.B.1.a)(1)(b) responsiveness to patient needs that supersedes self-interest; (Core)

IV.B.1.a)(1)(c) respect for patient privacy and autonomy; (Core)

IV.B.1.a)(1)(d) accountability to patients, society, and the profession; (Core)

IV.B.1.a)(1)(e) respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation; (Core)

IV.B.1.a)(1)(f) ability to recognize and develop a plan for one's own professional wellbeing; (Core)

IV.B.1.a)(1)(g) appropriately disclosing and addressing conflict or duality of interest (Core)

IV.B.1.a)(2) Residents must practice oral and maxillofacial surgery in full compliance with accepted standards of ethical behavior. (Core)

IV.B.1.b) Patient Care and Procedural Skills

Residents must be able to provide patient care that is appropriate, and effective for the treatment or oral/head and neck health problems and the promotion of health. (Core)

IV.B.1.b)(1) Records related to the educational program, must be documented in the resident clinical logs after completion of specified procedures and/or patient complexity, including: (Core)

- operating room cases,
- clinical procedures (e.g., emergency, trauma, restorative, preventative, cosmetic, multi-disciplinary, etc.),

- patient diversity/complexity (e.g., well-patient, medically complex, special needs, hospital based, etc.).

Background and Intent: *These records are to be available for on-site review: overall program objectives, objectives of resident rotations, specific resident schedules by semester or year, completed resident evaluation forms for current residents and recent alumni, self-assessment process, curricula vitae of faculty responsible for instruction. The resident's Logbook provides programs with data required for program improvement and gives residents and official records of clinical procedures required by regulatory boards and hospitals.*

IV.B.1.b)(2) During training period, residents must perform 175 major oral and maxillofacial surgery procedures on adults and children. (Core)

IV.B.1.b)(2)(a) For the above procedures residents must play a significant role (diagnosis, perioperative care and subsequent follow-up) in the management of the patient. (Core)

IV.B.1.b)(2)(b) For the above 175 procedures there must be at least 20 procedures in each category of surgery defined as: (Core)

- Trauma
- Pathology
- Orthognathic surgery
- Reconstructive surgery
- Cosmetic surgery.

IV.B.1.b)(2)(c) Trauma.

In addition to mandibular fractures, trauma management must include surgical management and treatment of maxillary, nasal, and orbito-zygomatic-maxillary complex injuries: (Core)

- Tracheotomies / cricothyrotomy,
- open and closed reductions of fractures of the mandible, maxilla, zygomatic-maxillary, nose, naso-frontalorbital-ethmoidal and midface region,
- repair of facial, oral, soft tissue injuries and specialized structures.
- management of dentoalveolar trauma.

IV.B.1.b)(2)(d) Pathology

Residents must demonstrate experience in the medical or surgical management of temporomandibular joint pathology and at least three other types of procedures. (Core)

IV.B.1.b)(2)(d)(i) Temporomandibular joint pathology including, but not limited to:

- internal derangement
- arthritis
- post-traumatic dysfunction
- neoplasms.

IV.B.1.b)(2)(d)(ii) Other types of procedures including, but not limited to:

- major maxillary sinus procedures,
- salivary gland/duct surgery,
- management of head and neck infections, (incision and drainage procedures),
- surgical management of benign and malignant neoplasms and cysts.

IV.B.1.b)(2)(e) Orthognathic surgery

Residents must perform orthognathic procedures including correction of deformities in the mandible and the middle third of the facial skeleton: (Core)

IV.B.1.b)(2)(e)(i) surgical correction of functional and cosmetic orofacial and craniofacial deformities of the mandible, maxilla, zygoma and other facial bones

IV.B.1.b)(2)(e)(ii) treatment of obstructive sleep apnea, collaborative care with orthodontist and/or sleep medicine team:

- ramus and body procedures,
- subapical segmental osteotomies,
- Le Fort I, II and III procedures,
- craniofacial operations.

IV.B.1.b)(2)(f) Reconstructive surgery

Residents must perform procedures for both reconstructive and cosmetic indications including: (Core)

- vestibuloplasties,
- augmentation,
- temporomandibular joint reconstruction,
- management of hard and soft tissue maxillofacial defects,
- insertion of craniofacial implants,
- orofacial cleft repair,
- peripheral nerve reconstruction,
- other reconstructive surgery,
- both bone grafting and soft tissue grafting,
- harvesting of bone and soft tissue grafts.
- Harvesting of bone graft from extraoral such as iliac crest, costochondral, calvarial, tibia, fibula and others
- Harvesting of soft tissue graft including skin, fat, muscle and others.

IV.B.1.b)(2)(g) Cosmetic surgery

Residents must perform cosmetic surgical and non-surgical facial aesthetic procedures including but not limited to: (Core)

- injectables,
- threads facial suspension,
- rhinoplasty,
- blepharoplasty,
- rhytidectomy,
- genioplasty,
- lipectomy,
- otoplasty,
- scar revision.

IV.B.1.b)(3) During the training program the residents must perform at least 250 minor oral surgical procedures under local and general anesthesia on adults and pediatric patients. (Core)

IV.B.1.b)(3)(a) For the above procedures residents must handle the management of the case from

diagnosis, preoperative evaluation and postoperative follow-up. (Core)

IV.B.1.b)(3)(b) The resident must perform all minor oral surgical procedure as the main operator -first surgeon- and must demonstrate a systematic approach and be able to manage pre/peri and postoperative complications. (Core)

IV.B.1.b)(3)(c) The resident must demonstrate competency in modifying the treatment plan and perform minor oral surgical procedure in medically compromised patient as well as provision of the necessary pre/postoperative care. (Core)

IV.B.1.b)(3)(d) The resident must be able to perform different procedures in each category of minor oral surgery which defined as: (Core)

- Biopsy procedures in head and neck region,
- Complicated and uncomplicated exodontia,
- Endodontic surgeries,
- Pre-prosthetic surgeries,
- Intraoral soft tissue surgeries,
- Intraoral hard tissue surgeries,
- Orthodontic related surgeries.

IV.B.1.b)(4) Residents must demonstrate experience in emergency care, including diagnosing and rendering emergency treatment. (Core)

IV.B.1.b)(4)(a) residents must provide care for oral and maxillofacial acute illnesses and injuries including management of oral and maxillofacial lacerations and fractures. (Core)

IV.B.1.b)(5) Residents must demonstrate experience in outpatient non-surgical and surgical management, including preoperative and postoperative evaluation, in a broad range of oral and maxillofacial surgery involving adult and pediatric patients. (Core)

IV.B.1.b)(5)(a) This experience must include: (Core)

- dentoalveolar surgery,
- placement of implant devices,

- management of traumatic injuries and pathologic conditions including temporomandibular disorders,
- facial pain,
- augmentations and other hard and soft tissue surgery, including surgery of the mucogingival tissues.

IV.B.1.b)(5)(b) Residents must be experienced in dental implants including comprehensive preoperative, intraoperative and post-operative management. (Core)

IV.B.1.b)(5)(b)(i) Preoperative management must include interdisciplinary consultation, diagnosis, treatment planning, biomechanics, biomaterials and biological basis. (Detail)

IV.B.1.b)(5)(b)(ii) Intraoperative management must include surgical preparation and surgical placement including hard and soft tissue grafts. (Detail)

IV.B.1.b)(5)(b)(iii) The post-operative management must include the evaluation and management of implant tissues and complications associated with the placement of implants. (Detail)

IV.B.1.b)(6) Residents must be experienced in anesthesia.

The cumulative anesthetic experience of each graduating resident must include administration of general anesthesia/deep sedation for a minimum of 300 cases. (Core)

IV.B.1.b)(6)(a) This experience must involve care for 50 patients younger than 13. (Core)

IV.B.1.b)(6)(b) A minimum of 150 of the 300 cases must be ambulatory anesthetics for oral and maxillofacial surgery outside of the operating room. (Core)

IV.B.1.b)(6)(c) The graduating resident must be competent in the: (Core)

- delivery of general anesthesia/deep sedation to patients of at least 8 years of age and older,
- management of children younger than 8 years of age using techniques such as behavior management, inhalation analgesia, sedation, and general anesthesia,
- anesthetic management of geriatric patients.

IV.B.1.b)(7) Residents must be certified in Advanced Trauma Life Support (ATLS) prior to completion of training. (Core)

IV.B.1.b)(8) Residents must be certified in Pediatric Advanced Life Support (PALS) prior to completion of training. (Core)

IV.B.1.b)(9) Residents must be proficient in the interpretation of diagnostic imaging. (Core)

IV.B.1.c) Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social behavioral sciences, as well as the application of this knowledge to patient care. (Core)

IV.B.1.d) Practice-based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, applying scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning. (Core)

IV.B.1.d)(1) Residents must demonstrate competence in:

IV.B.1.d)(1)(a) identifying strengths, deficiencies, and limits in one's knowledge and expertise; (Core)

IV.B.1.d)(1)(b) setting learning and improvement goals; (Core)

IV.B.1.d)(1)(c) identifying and performing appropriate learning activities; (Core)

IV.B.1.d)(1)(d) systematically analyzing practice using quality improvement methods and implementing changes with the goal of practice improvement; (Core)

IV.B.1.d)(1)(e) incorporating feedback and formative evaluation into daily practice; (Core)

IV.B.1.d)(1)(f) locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems; (Core)

IV.B.1.d)(1)(g) using information technology to optimize learning. (Core)

IV.B.1.e) Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Core)

IV.B.1.e)(1) Residents must demonstrate competence in:

IV.B.1.e)(1)(a) communicating effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; (Core)

IV.B.1.e)(1)(b) communicating effectively with dentists, physicians, other health professionals and health- and oral health-related agencies; (Core)

IV.B.1.e)(1)(c) working effectively as a member or leader of a health care team or other professional group; (Core)

IV.B.1.e)(1)(d) educating patients, families, students, residents, and other health professionals; (Core)

IV.B.1.e)(1)(e) acting in a consultative role to other dentists, physicians and oral health professionals; (Core)

IV.B.1.e)(1)(f) maintaining comprehensive, timely, and legible medical and dental records, if applicable. (Core)

IV.B.1.f) Systems-based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of oral health, as well as the ability to call

effectively on other resources to provide optimal oral health care. (Core)

IV.B.1.f)(1) Residents must demonstrate competence in:

IV.B.1.f)(1)(a) working effectively in various oral health care delivery settings and systems relevant to their clinical specialty; (Core)

IV.B.1.f)(1)(b) coordinating patient oral health care across the health care continuum and beyond as relevant to their clinical specialty; (Core)

IV.B.1.f)(1)(c) advocating for quality patient care and optimal patient care systems; (Core)

IV.B.1.f)(1)(d) working in interprofessional teams to enhance patient safety and improve patient care quality;(Core)

IV.B.1.f)(1)(e) participating in identifying system errors and implementing potential systems solutions; (Core)

IV.B.1.f)(1)(f) incorporating considerations of value, cost awareness, delivery and payment, and risk benefit analysis in patient and/or population-based care as appropriate; (Core)

IV.B.1.f)(1)(g) understanding oral health care finances and its impact on individual patients' health decisions. (Core)

IV.C. Curriculum Organization and Resident Experiences

IV.C.1. The curriculum must be structured to optimize resident educational experiences, the length of these experiences, and supervisory continuity. (Core)

IV.C.1.a) Assignment of rotations must be structured with sufficient length to provide quality educational experience, defined by continuity of patient oral health care, ongoing supervision, relationships with faculty members, and high-quality assessment and feedback. (Core)

IV.C.1.b) Clinical experiences should be structured to facilitate learning in a manner that allows residents to function as part of an effective interprofessional team. (Core)

IV.C.1.c) The program must provide the opportunity to extend the resident's diagnostic ability, basic and advanced clinical knowledge and skills, and critical judgment beyond that provided in undergraduate education. The program must also provide experience in closely related areas to ensure that residents become competent in comprehensive care. (Core)

IV.C.2. The program must provide instruction and experience in pain management if applicable in oral and maxillofacial surgery, including recognition of the signs of addiction. (Core)

IV.C.3. Each resident must devote a minimum of 150 weeks to clinical oral and maxillofacial surgery. (Core)

IV.C.3.a) Fifty-two (52) weeks of the time spent on the oral and maxillofacial surgery service must be at a senior level of responsibility, 26 weeks of which must be in the final year. (Core)

IV.C.3.a)(1) Senior level responsibility means residents serving as first assistant to attending surgeon on major cases. (Detail)

IV.C.3.a)(2) Resident serves as first assistant for the majority of surgical procedures performed during this rotation. (Core)

IV.C.3.a)(3) They are to be present for most pre- and post-operative patient visits. (Core)

IV.C.4. Anesthesia:

IV.C.4.a) The off-service rotation in anesthesia must be supplemented by longitudinal and progressive experience throughout the training program in all aspects of pain and anxiety control. (Core)

IV.C.4.b) The ambulatory oral and maxillofacial anesthetic experience must include the administration of general anesthesia/deep sedation for oral and maxillofacial surgery procedures to pediatric, adult, and geriatric populations, including the demonstration of competency in airway management. (Core)

IV.C.4.c) The combined assignment must be for a minimum of 32 weeks. (Core)

IV.C.4.c)(1) A minimum of 20 weeks must be in the anesthesia service and should be consecutive and include both adult and pediatric anesthesia. (Core)

IV.C.4.c)(1)(a) Four of these 20 weeks should be dedicated to pediatric anesthesia. (Core)

IV.C.4.c)(1)(b) The resident must function as an anesthesia resident with commensurate level of responsibility. (Core)

IV.C.4.c)(2) A minimum of 12 weeks must be organised as longitudinal anesthesia experience during the rotations in oral and maxillofacial surgery, as dedicated day per week. (Core)

IV.C.5. Medical Service

IV.C.5.a) A minimum of 16 weeks must be on medical specialty services. (Core)

IV.C.5.a)(1) The experience must be focused on pre-anesthetic risk stratification and perioperative medical assessment of the surgical patient. (Core)

IV.C.5.a)(2) The rotations must include internal medicine 8 weeks and emergency medicine 8 weeks. (Core)

IV.C.6. Surgical Service:

A minimum of 52 weeks of clinical surgical experience must be provided. (Core)

IV.C.6.a) This experience should be achieved by rotation to surgical service departments (not to include oral and maxillofacial surgery) as following: (Core)

IV.C.6.a)(1) ICU 6 weeks. (Core)

IV.C.6.a)(1)(a) This should include management of critically ill patients. (Core)

IV.C.6.a)(2) General surgery 12 weeks. (Core)

IV.C.6.a)(3) Orthopaedics 4 weeks. (Core)

IV.C.6.a)(4) Ophthalmology 4 weeks. (Core)

IV.C.6.a)(5) Neurosurgery 8 weeks. (Core)

IV.C.6.a)(6) Plastic surgery 6 weeks. (Core)

IV.C.6.a)(7) ENT 8 weeks. (Core)

IV.C.6.b) Experience must provide residents with adequate training in pre- and postoperative care, as well as experience in intra-operative techniques. (Core)

IV.C.6.c) Oral and maxillofacial surgery residents must function as a surgery resident with a commensurate level of responsibility, operate at a PGY-1 level of responsibilities or higher and are on the regular night call schedule. (Core)

IV.C.7. Other Rotations (elective):

Eight additional weeks of clinical surgical or medical education must be assigned. (Core)

IV.C.7.a) These must be exclusive to all oral and maxillofacial surgery service assignments and may include dermatology, pediatrics or radiology. (Core)

IV.C.8. The residency program in oral and maxillofacial surgery must include education and training in the basic and clinical sciences, which is integrated into the training program. (Core)

IV.C.8.a) A distinct and specific curriculum must be provided in anesthesia, clinical medicine and surgery. (Core)

IV.C.8.b) The integrated clinical science curriculum must include off-service rotations, lectures and seminars given during the oral and maxillofacial surgery training program by faculty and attending staff. (Core)

IV.C.8.c) When assigned to a required rotation on another service (surgery, medicine, anesthesiology, electives), the oral and maxillofacial surgery resident must devote full-time to the service and participate fully in all the teaching activities of the service, including regular on-call responsibilities. (Core)

IV.C.8.c)(1) Beyond the required rotations, residents may take calls on the oral and maxillofacial surgery service when on additional rotations. (Core)

IV.C.9. Didactics

Didactics seminars and conferences, directed by faculty, must be conducted to augment the biomedical science and clinical program. (Core)

IV.C.9.a) Didactic sessions shall include: (Core)

IV.C.9.a)(1) The broad scope of oral and maxillofacial surgery includes, but is not limited to, trauma,

orthognathic, reconstructive/cosmetic, and pathology including temporomandibular disorders and facial pain. (Core)

IV.C.9.a)(2) Basic Sciences (Core)

- anatomy (including growth and development),
- physiology,
- pharmacology,
- microbiology,
- pathology.

IV.C.9.a)(2)(a) Instruction in anatomy must include surgical approaches used in various oral and maxillofacial surgery procedures. (Core)

IV.C.9.a)(3) Physical Diagnosis (Core)

IV.C.9.a)(4) Clinical Oral and Maxillofacial Surgery (Core)

IV.C.8.a)(3)(a) The scope of oral and maxillofacial surgery includes, but is not limited to, trauma, orthognathic, reconstructive/ cosmetic, and pathology including temporomandibular disorders and facial pain. (Core)

IV.C.9.a)(5) General Anesthesia and Deep Sedation (Core)

IV.C.8.a)(5)(a) Comprehensive didactic program on general anesthesia, deep sedation, moderate sedation, behavior management and other methods of pain and anxiety control. (Core)

IV.C.9.a)(5)(b) The didactic program must include lectures and seminars emphasizing: (Core)

- Perioperative evaluation and optimization of patients of all ages,
- Risk assessment,
- Anesthesia and sedation techniques,
- Monitoring, and
- The diagnosis and management of complications.

IV.C.9.a)(6) Admissions

Didactic experience must ensure adequate training in a broad range of inpatient oral and maxillofacial surgery

care, including admission and management of patients. (Core)

IV.C.9.a)(7) Major Surgery (Core)

IV.D. Scholarship

Dentistry is both an art and a science. The dentist is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through resident participation in scholarly activities. Scholarly activities must include discovery, integration, application and teaching.

IV.D.1. Program Responsibilities

IV.D.1.a) The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)

IV.D.1.b) The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. (Core)

IV.D.1.c) The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)

Background and Intent: *Elements of a scholarly approach to patient care include:*

- *Asking meaningful questions to stimulate residents to utilize learning resources to create a differential diagnosis, a diagnostic algorithm, and treatment plan*
- *Challenging the evidence that the residents use to reach their dental decisions so that they understand the benefits and limits of the dental literature*
- *When appropriate, dissemination of scholarly learning in a peer-reviewed manner (publication or presentation)*
- *Improving resident learning by encouraging them to teach using a scholarly approach.*

IV.D.2. Faculty Scholarly Activity

IV.D.2.a) Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core)

- Research in basic science, education, translational science, patient care, or population health
- Peer-reviewed journal publications, case-presentation publications

- Quality improvement and/or patient safety initiatives
- Systematic reviews, meta-analyses, review articles, chapters in dental textbooks, or case reports
- Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials
- Contribution to professional committees, educational organizations, or editorial boards
- Innovations in education

IV.D.2.b) The program must demonstrate scholarly activity by the following methods: (Core)

IV.D.2.b)(1) faculty participation in posters, workshops, quality improvement presentations, podium presentations, reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor. (Core)

IV.D.2.b)(2) peer-reviewed publication incl. case-discussion and letters to the editor. (Core)

IV.D.3. Resident Scholarly Activity

IV.D.3.a) Residents must participate in scholarship. (Core)

IV.D.3.a)(1) Basic science and clinical investigation must be included in the didactic curriculum for residents. (Core)

IV.D.3.a)(1)(a) All residents should participate or have education regarding both basic sciences and clinical research during the program. (Core)

IV.D.3.b) Residents must participate in research projects. (Core)

IV.D.3.b)(1) Residents must design and complete a clinic-based graduation research project relevant to the specialty which was conducted under direct supervision of a faculty member. (Core)

IV.D.3.b)(2) The project, prepared in a form which can be used for publication, shall be submitted for publication in a specialty specific journal or presented in a national or international specialty conference. (Core)

IV.D.3.b)(3) Resident must present the proof of research project submission, or presentation, to Emirati Board to be eligible for a final examination (Board Certification) in accordance with the NIHS guidelines. (Core)

V. Evaluation

The purposes of evaluation are as follows:

- Enable instructors to make robust (defensible and transparent) high-stakes (promotion/remediation) decisions regarding the candidates' competency.
- Provide trainees with feedback on their learning and longitudinal competency development.
- Include a variety of types of assessment to allow for a valid, reliable, and objective assessment for a range of different learning outcomes.
- Offer learning opportunities.
- Promote reflective and self-directed learning activities.
- Certify the deserving trainees.

V.A. Resident Evaluation

V.A.1. Feedback and Evaluation

Formative and summative evaluation have distinct definitions.

Formative evaluation is monitoring resident learning and providing ongoing feedback that can be used by residents to improve their learning.

More specifically, formative evaluations help:

- residents identify their strengths and weaknesses and target areas that need work
- program directors and faculty members recognize where residents are struggling and address problems immediately.

Summative evaluation is evaluating a resident's learning by comparing the residents against the goals and objectives of the rotation and program, respectively and is utilized to make decisions about promotion to the next level of training, or program completion.

End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when residents or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the residency program.

V.A.1.a) Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)

V.A.1.a)(1) This feedback will allow for the development of the learner. More frequent feedback is strongly

encouraged for residents who have deficiencies that may result in a poor final rotation evaluation. (Outcome)

V.A.1.b) Evaluation must be documented at the completion of the assignment. (Core)

V.A.1.b)(1) For block rotations of greater than three months in duration, evaluation must be documented at least every three months. (Core)

V.A.1.b)(2) For block rotations of any duration, a written evaluation must be provided at the end of the rotation. (Core)

V.A.1.c) The program must provide an objective performance evaluation based on the Competencies, and must: (Core)

V.A.1.c)(1) use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members) (Core)

V.A.1.c)(2) provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)

V.A.1.d) The program director or their designee, with input from the Clinical Competency Committee, must:

V.A.1.d)(1) Meet with and review with each resident their documented semi-annual evaluation of performance (Core)

V.A.1.d)(1)(a) Review of resident Case-Logs must be a part of the semi-annual review. (Detail)

V.A.1.d)(2) assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; (Core)

V.A.1.d)(3) develop plans for residents failing to progress, following both the NIHS Emirati Board and institutional policies and procedures. (Core)

Residents who are experiencing difficulties with achieving progress may require intervention to address specific deficiencies. Such intervention, documented in an individual remediation plan developed by the program director or a faculty mentor and the resident, will take a variety of forms based on the specific learning needs of the

resident. However, the NIHS recognizes that there are situations which require more significant intervention that may alter the time course of resident progression. To ensure due process, it is essential that the program director follow NIHS and institutional policies and procedures.

V.A.1.e) At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable. (Core)

V.A.1.f) The evaluations of a resident's performance must be accessible for review by the resident. (Core)

V.A.1.g) Assessment should specifically monitor the resident's knowledge by use of a formal In-Training Examination or other cognitive exams. Tests results should not be the sole criterion of resident knowledge and should not be used as the sole criterion for promotion to a subsequent PG level. (Detail)

V.A.1.h) Resident Promotion:

Residents' promotion from PGY-1 to PGY-2 and PGY-3 will be decided by the program director after taking in consideration all evaluation tools and portfolios. Each promotion must be discussed in the dedicated Clinical Competency Committee (CCC) meeting(s). (Core)

V.A.2. Final Evaluation

V.A.2.a) The program director must provide a final evaluation for each resident upon completion of the program. (Core)

V.A.2.a)(1) The Oral and Maxillofacial Surgery-specific objectives, and the specialty-specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program, and once he/she obtains the license to practice in his/her Oral and Maxillofacial Surgery. (Core)

V.A.2.a)(2) The final evaluation must:

V.A.2.a)(2)(a) become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy; (Core)

V.A.2.a)(2)(b) verify that the resident has demonstrated the knowledge, skills, and behaviours necessary to enter autonomous practice; (Core)

V.A.2.a)(2)(c) consider recommendations from the Clinical Competency Committee; (Core)

V.A.2.a)(2)(d) be shared with the resident upon completion of the program. (Core)

V.A.3. A Clinical Competency Committee must be appointed by the program director. (Core)

V.A.3.a) The Clinical Competency Committee must include at least three members of the program faculty, at least one of whom is a core faculty member. (Core)

V.A.3.a)(1) Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents. (Core)

V.A.3.a)(2) The Program Director has final responsibility for resident evaluation and promotion decisions. (Core)

V.A.3.b) The Clinical Competency Committee must:

V.A.3.b)(1) Review all residents evaluation at least semi-annually; (Core)

V.A.3.b)(2) determine each resident's progress on achievement of the specialty-specific objectives; (Core)

V.A.3.b)(3) meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress. (Core)

V.B. Faculty Evaluation

V.B.1. The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)

V.B.1.a) This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, review of patient outcomes, professionalism, research, and scholarly activities. (Core)

V.B.1.b) This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core)

V.B.2. Faculty members must receive feedback on their evaluations at least annually. (Core)

V.B.3. Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)

The program has the responsibility to evaluate and improve the program faculty members' teaching, scholarship, professionalism, and quality care. Therefore, the annual review of the program's faculty members is mandatory and can be used as input into the Annual Program Evaluation.

V.C. Program Evaluation and Improvement

V.C.1. The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)

The performance of residents and faculty members reflects the program quality and will use metrics to reflect the program's goals.

The Program Evaluation Committee must present the Annual Program Evaluation Report in a written form to be discussed with all program faculty and residents as a part of continuous improvement plans.

V.C.1.a) The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident. (Core)

V.C.1.b) Program Evaluation Committee responsibilities must include:

V.C.1.b)(1) acting as an advisor to the program director, through program oversight; (Core)

V.C.1.b)(2) review of the program's requirements, both NIHS Emirati Board required and program self-determined goals, and the progress toward meeting them; (Core)

V.C.1.b)(3) guiding ongoing program improvement, including developing new goals based upon outcomes. (Core)

V.C.1.b)(4) review of the current operating environment to identify strengths, challenges, opportunities, and threats related to the program's mission and aims. (Core)

V.C.1.c) The Program Evaluation Committee should consider the following elements in its assessment of the program:

V.C.1.c)(1) program curriculum; (Core)

V.C.1.c)(2) outcomes from prior Annual Program Evaluation(s); (Core)

V.C.1.c)(3) NIHS letters of notification including citations, areas for improvement, and comments; (Core)

V.C.1.c)(4) the quality and safety of patient care; (Core)

V.C.1.c)(5) Aggregate residents and the faculty:

V.C.1.c)(5)(a) well-being; (Core)

V.C.1.c)(5)(b) recruitment and retention following institutional policies; (Core)

V.C.1.c)(5)(c) workforce diversity following institutional policies; (Core)

V.C.1.c)(5)(d) engagement in quality improvement and patient safety; (Core)

V.C.1.c)(5)(e) scholarly activity; (Core)

V.C.1.c)(5)(f) Resident and Faculty Surveys; (Core)

V.C.1.c)(5)(g) written evaluations of the program (see above). (Core)

V.C.1.c)(6) Aggregate resident:

V.C.1.c)(6)(a) in-training examination results ; (Core)

V.C.1.c)(6)(b) board pass and certification rates (Core)

V.C.1.c)(6)(c) graduates' performance. (Core)

V.C.1.c)(7) Aggregate faculty:

V.C.1.c)(7)(a) faculty evaluation; (Core)

V.C.1.c)(7)(b) professional development. (Core)

V.C.1.d) The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)

V.C.1.e) The Annual Program Evaluation review, including the action plan, must:

V.C.1.e)(1) be distributed to and discussed with the members of the teaching faculty and the residents (Core)

V.C.2. The program will be accredited and reaccredited by the NIHS in accordance with NIHS Accreditation Bylaws. (Core)

V.C.2.a) The program must complete a Self-Study before its reaccreditation Site Visit. (Core)

V.C.2.b) The Self-Study is an objective, comprehensive evaluation of the residency program with the aim to improve it. (Detail)

V.C.3. The goal of NIHS-accredited education is to train physicians who seek and achieve a board certification. One measure of the effectiveness of the educational program is the ultimate pass rate. (Outcome)

V.C.3.a) Under the guidance of the Program Director all eligible program graduates should take the certifying examination conducted by the NIHS to obtain the Certification. (Outcome)

V.C.3.b) Graduates are eligible to sit for the Certification examination for up to three years from the date of completion of residency training. (Core)

V.C.4. During the residency, the residents are strongly encouraged to sit for an organized Annual In-Training Examination. (Core)

VI. The Learning and Working Environment

Residency education must occur in the context of a learning and working environment that emphasizes the following principles:

- Excellence in the safety and quality of care rendered to patients by residents today
- Excellence in the safety and quality of care rendered to patients by today's residents in their future practice
- Excellence in professionalism through faculty modeling of:
    - the effacement of self-interest in a humanistic environment that supports the professional development of dentists
    - the joy of curiosity, problem-solving, intellectual rigor, and discovery
- Commitment to the well-being of the students, residents, faculty members, and all members of the health care team

VI.A. Patient Safety, Quality Improvement, Supervision and Accountability

VI.A.1. Patient Safety and Quality Improvement

All dentists share responsibility for promoting patient safety and enhancing the quality of patient care. Graduate dental education must prepare residents to provide the highest level of clinical care with

continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by residents who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.

Residents must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

It is necessary for residents and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.

VI.A.1.a) Patient Safety

VI.A.1.a)(1) Culture of Safety

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.

VI.A.1.a)(1)(a) The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)

VI.A.1.a)(1)(b) The program must have a structure that promotes safe, inter-professional, team-based care. (Core)

VI.A.1.a)(2) Education on Patient Safety

Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)

Background and Intent: *Optimal patient safety occurs in the setting of a coordinated inter-professional learning and working environment.*

VI.A.1.a)(3) Patient Safety Events

Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety and are essential for the

success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

VI.A.1.a)(3)(a) Residents, fellows, faculty members, and other clinical staff members must:

- know their responsibilities in reporting patient safety events at the clinical site; (Core)
- know how to report patient safety events, including near misses, at the clinical site; (Core)
- be provided with summary information of their institution's patient safety reports. (Core)

VI.A.1.a)(3)(b) Residents must participate as team members in real and/or simulated inter-professional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)

VI.A.1.a)(4) Resident Education and Experience in Disclosure of Adverse Events

Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty dentists to model, and for residents to develop and apply.

VI.A.1.a)(4)(a) All residents must receive training in how to disclose adverse events to patients and families. (Core)

VI.A.1.a)(4)(b) Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated. (Detail)

VI.A.1.b) Quality Improvement

VI.A.1.b)(1) Education in Quality Improvement

A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary for health care professionals to achieve quality improvement goals.

Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities. (Core)

VI.A.1.b)(2) Quality Metrics

Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.

Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)

VI.A.1.b)(3) Engagement in Quality Improvement Activities

Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.

Residents must have the opportunity to participate in inter-professional quality improvement activities. (Core)

VI.A.2. Supervision and Accountability

VI.A.2.a) Although the attending dentist is ultimately responsible for the care of the patient, every dentist shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.

Supervision in the setting of graduate dental education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

VI.A.2.a)(1) Each patient must have an identifiable and appropriately-credentialed and privileged attending dentist who is responsible and accountable for the patient's care. (Core)

VI.A.2.a)(1)(a) This information must be available to residents, faculty members, other members of the health care team, and patients. (Core)

VI.A.2.a)(1)(b) Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core)

VI.A.2.b) Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising dentist may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the appropriate availability of the supervising faculty member, fellow, or senior resident, either on site or by means of telecommunication technology. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.

VI.A.2.b)(1) The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)

VI.A.2.b)(2) The program must define when physical presence of a supervising dentist is required. (Core)

VI.A.2.c) Levels of Supervision

To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: (Core)

VI.A.2.c)(1) Direct Supervision: the supervising dentist is physically present with the resident during the key portions of the patient interaction. (Core)

PGY-1 residents must initially be supervised directly. (Core)

VI.A.2.c)(1)(a) The program must have clear guidelines that delineate which competencies must be demonstrated to determine when a resident can progress to indirect supervision. (Core)

VI.A.2.c)(1)(b) The program director must ensure that clear expectations exist and are communicated to the residents, and that these expectations outline

specific situations in which a resident would still require direct supervision. (Core)

VI.A.2.c)(2) Indirect Supervision: the supervising dentist is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision. (Core)

VI.A.2.c)(2)(a) Clinical faculty must be immediately available to provide direct supervision to residents for all clinical sessions. (Core)

Background and *Intent:* *Clinical faculty are physically in the treatment area for clinical sessions with scheduled patients and, immediately available within one minute, for all patients. Indirect supervision should only be used after careful consideration of the competence of the resident and also based on the delineation of privileges and procedure types. Clinical faculty are held accountable for responsibilities and attendance. Certain funding sources require specific faculty to resident ratios which should be observed.*

VI.A.2.c)(3) Oversight: the supervising dentist is available to provide review of procedures/encounters with feedback provided after care is delivered. (Core)

VI.A.2.d) The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. (Core)

VI.A.2.d)(1) The program director must evaluate each resident's abilities based on specific criteria, guided by specific evaluations. (Core)

VI.A.2.d)(2) Faculty members functioning as supervising dentists must delegate portions of care to residents based on the needs of the patient and the skills of each resident. (Core)

VI.A.2.d)(3) Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)

VI.A.2.e) Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). (Core)

Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. (Outcome)

VI.A.2.f) Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. (Core)

VI.B. Professionalism

VI.B.1. Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional responsibilities of dentists, including their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)

VI.B.2. The learning objectives of the program must:

VI.B.2.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; (Core)

VI.B.2.b) be accomplished without excessive reliance on residents to fulfill non-dentist obligations; (Core)

VI.B.2.c) ensure manageable patient care responsibilities. (Core)

VI.B.3. The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)

VI.B.4. Residents and faculty members must demonstrate an understanding of their personal role in the:

VI.B.4.a) provision of patient- and family-centered care; (Outcome)

VI.B.4.b) safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; (Outcome)

Background and Intent: *This requirement emphasizes that responsibility for reporting unsafe conditions and adverse events is shared by all members of the team and is not solely the responsibility of the resident.*

VI.B.4.c) assurance of their fitness for work, including: (Outcome)

VI.B.4.c)(1) management of their time before, during, and after clinical assignments; (Outcome)

VI.B.4.c)(2) recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team. (Outcome)

VI.B.4.d) commitment to lifelong learning; (Outcome)

VI.B.4.e) monitoring of their patient care performance improvement indicators; (Outcome)

VI.B.4.f) accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data. (Outcome)

VI.B.5. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider. (Outcome)

VI.B.6. Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff. (Core)

VI.B.7. Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)

VI.C. Well-Being

Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient dentist and require proactive attention to life inside and outside of dentistry. Well-being requires that dentists retain the joy in dentistry while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of residency training.

Residents and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Dentists and all members of the oral health care team share responsibility for the well-being of each other. For example, a culture which encourages covering for colleagues after an illness without the expectation of reciprocity reflects the ideal of professionalism. A positive culture, in a clinical learning environment,

models constructive behaviors and prepares residents with the skills and attitudes needed to thrive throughout their careers.

VI.C.1. The responsibility of the program, in partnership with the Sponsoring Institution, to address well-being must include:

VI.C.1.a) efforts to enhance the meaning that each resident finds in the experience of being a dentist, including protecting time with patients, minimizing non-dentist obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; (Core)

VI.C.1.b) attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core)

VI.C.1.c) evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)

VI.C.1.d) policies and programs that encourage optimal resident and faculty member well-being; (Core)

VI.C.1.e) attention to resident and faculty member burnout, depression, and substance use disorders. The program, in partnership with its Sponsoring Institution, must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance use disorders, including means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must: (Core)

VI.C.1.e)(1) encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, a substance use disorder, suicidal ideation, or potential for violence; (Core)

VI.C.1.e)(2) provide access to appropriate tools for self-screening; (Core)

VI.C.1.e)(3) provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)

VI.C.2. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family

emergencies, and parental leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities. (Core)

VI.C.2.a) The program must have policies and procedures in place to ensure coverage of patient care. (Core)

VI.C.2.b) These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work. (Core)

Background and Intent: *Residents may need to extend their training depending on the length of absence and specialty board eligibility requirements. Teammates should assist colleagues in need and equitably reintegrate them upon return.*

VI.D. Fatigue Mitigation

VI.D.1. Programs must:

VI.D.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation; (Core)

VI.D.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; (Core)

VI.D.1.c) encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. (Detail)

VI.D.2. Each program must ensure continuity of patient care, consistent with the program's policies and procedures, if a resident may be unable to perform their patient care responsibilities due to excessive fatigue. (Core)

VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care

VI.E.1. Clinical Responsibilities

The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. (Core)

VI.E.2. Teamwork

Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system. (Core)

VI.E.3. Transitions of Care

VI.E.3.a) Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)

VI.E.3.b) Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. (Core)

VI.E.3.c) Programs must ensure that residents are competent in communicating with team members in the hand-over process. (Outcome)

VI.E.3.d) Programs and clinical sites must maintain and communicate schedules of attending faculty and residents currently responsible for care. (Core)

VI.E.3.e) Each program must ensure continuity of patient care, consistent with the program's policies and procedures, if a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency. (Core)

VI.F. Clinical Experience and Education

Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.

VI.F.1. Maximum Hours of Clinical and Educational Work per Week

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities and clinical work done from home. (Core)

VI.F.2. Mandatory Time Free of Clinical Work and Education

VI.F.2.a) The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being. (Core)

VI.F.2.b) Residents should have eight hours off between scheduled clinical work and education periods. (Detail)

There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than

eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. (Detail)

VI.F.2.c) Residents must be scheduled for a minimum of one day in seven free of clinical work and required education. (Core)

VI.F.3. Maximum Clinical Work and Education Period Length

VI.F.3.a) Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)

VI.F.3.a)(1) Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. (Core)

VI.F.3.a)(1)(a) Additional patient care responsibilities must not be assigned to a resident during this time. (Core)

VI.F.5. Moonlight

Residents are not permitted to moonlight. (Core)

*Core Requirements: Statements that define structure, resource, or process elements essential to every graduate dental educational program.

†Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

‡Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate dental education.

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