

The new American Board of Orthodontics certification process: Further clarification

S. Ed Owens, Jr,^a Vance J. Dykhouse,^b Allen H. Moffitt,^c John E. Grubb,^d Peter M. Greco,^d Jeryl D. English,^d Barry S. Briss,^d Scott A. Jamieson,^d and Michael L. Riolo^e

Jackson, Wyo, Blue Springs, Mo, Murray, Ky, Chula Vista, Calif, Philadelphia, Pa, Houston, Tex, Boston, Mass, and Marquette and Grand Haven, Mich

The American Board of Orthodontics (ABO) has welcomed questions about the new process of achieving board certification and recertification since announcing these changes in March 2005. To increase transparency and facilitate an understanding of the board's intent, we provide the following supplemental information.

The ABO is responsible to 3 main interest groups: the public, the dental profession, and the orthodontic specialty. All are integral participants in the board's ultimate purpose of improving the quality of orthodontic specialty care. The ABO's vision is that all educationally qualified orthodontists should demonstrate competency by completing the ABO certification process at the end of their formal orthodontic education and continue to maintain specialty board certification by periodic reexamination. The emphasis in this process is recertification as a means of continuous clinical assessment throughout an orthodontist's career.

The ABO's original 1930 Charter of Incorporation addressed the board's responsibility to the public by apprising the general population of the professional capabilities of an orthodontist. In the past 75 years, the board has publicly represented the specialty as a peer-review organization for determining professional competency. In so doing, the board has hoped to favorably influence the overall quality of orthodontic specialty care. The premier intent of elevating the level of care received by our trusting public is *the* motivational impetus for instituting the new board process.

To the dental profession, the ABO affirms that the orthodontic specialty has an instrument to critically

observe its members. The board also plays a role in the accreditation process as a measure of the clinical competency of academic orthodontic program directors and the efficacy of graduate orthodontic programs.

For the specialty of orthodontics, the directors of the board emerge as a peer-review organization that is recruited from various geographic regions in the United States. Directors serve the public to represent the specialty's concern for the quality of care. The practicing orthodontist voluntarily allows the board to examine his or her knowledge and clinical skills as further testimony of the public's trust in the professional.

How did the ABO determine that a new process of certification was necessary?

The basic premise of the ABO's new process is straightforward. The universal goal of excellence in orthodontic specialty care can be achieved by engaging as many practitioners as possible in the boarding process and then continuously reevaluating them throughout their careers via recertification to verify that their skills are maintained or improved. Some investigators have repeatedly documented that the skills of practicing physicians actually decline rather than improve with increasing years in practice, and it is thought that orthodontists are no exception to this trend.¹⁻³

During the past 75 years, most orthodontists have not become board certified. This problem excludes the possibility of gaining knowledge about care quality by a peer assessment group such as the ABO. Hence, orthodontic treatment quality often remains unevaluated for decades of a practitioner's career. In this scenario, one must question whether the care delivered to our trusting public is optimized.

The public is aware of the value of board certification. Gallup polls have confirmed this in the medical model.¹ The ABO has therefore created a system that educators can support and use to encourage residents to pursue board certification. Once in the system, along with most of their orthodontic colleagues, it is unlikely that the boarded orthodontist will forfeit certification.

^aPresident of the ABO.

^bPresident-elect of the ABO.

^cSecretary-treasurer of the ABO.

^dDirector of the ABO.

^eImmediate past president of the ABO.

Reprint requests to: Dr S. Ed Owens, Jr, 1130 S Highway 89, PO Box 628, Jackson, WY 83001; e-mail,

Am J Orthod Dentofacial Orthop 2005;128:541-4

0889-5406/\$30.00

Copyright © 2005 by the American Association of Orthodontists.

doi:10.1016/j.ajodo.2005.08.027

The board can then impact the standard of specialty care through rigorous recertification requirements.

How does the new process of certification strengthen the specialty of orthodontics?

The new process is a fresh attempt to engage as many orthodontists as possible in the board-certification process and then motivate them to remain board certified. In turn, quality will be monitored, and thus the strength of the profession as a whole will be increased. Service to the public will be enhanced in a true win-win situation. When application for the Gateway Offer has been made and accepted, the fees cover the immediate administrative costs and the future examination fees for the candidate's first recertification examination. It is expected that the orthodontist will matriculate for recertification without hesitation. This fee arrangement should be another incentive for each orthodontist to proceed with the first recertification examination.

How will the board protect orthodontists who maintain certification from those who do not?

Failure to recertify will mean that the ABO certificate and all references to board certification status will be revoked. The ABO has hired expert legal counsel proactively to develop essential legal support to enforce this rule. The certification-recertification concept has been proven to be extremely effective in health-care professions, and the ABO's legal professionals have had experience in enforcing these rules while providing counsel to many other health-care specialties.

Careful review of the new Gateway Application on the ABO's website will disclose that 3 signatures of commitment to abide by the rules of the contract are required. The board has been advised by legal counsel that the application is fully enforceable.

If recertification is necessary to maintain board certification, how will those who do not recertify be identified?

Practicing orthodontists will be the board's primary eyes and ears. If a local colleague is suspected of misrepresenting his or her board status, ABO attorneys suggest the following procedure:

1. Consult the ABO's website and locate the orthodontist's name. If the name is not listed, the orthodontist is not board certified.
2. Notify the ABO's central office of the alleged noncertified orthodontist's specific actions. Substantiation of the offense might be requested. For example, the caller might be asked to send a copy of the telephone book advertisement or a sample of

the orthodontist's letterhead or an office brochure. The board must have verification before it makes an accusation, but the reporting orthodontist's name will be held in strictest confidence.

3. The ABO will contact the offending orthodontist to inform him or her that the board is aware of his or her actions. The orthodontist will be requested to provide proof that the fraudulent actions have been discontinued.
4. If the orthodontist denies the accusations, refuses to desist, or simply does not respond, proceedings will be immediately initiated to take firm action to legally require that the misrepresentation cease. The proceedings will be fair and approached with due process for the accused orthodontist.
5. After an adverse ruling by the board, the ABO will notify the offending orthodontist's state licensing board, the American Association of Orthodontists, and the American Dental Association of the ruling and the details of the offense.

The ABO is not a punitive organization. It is a voluntary, peer-review organization that is charged by its specialty and the profession to examine its orthodontic colleagues and to elevate clinical care levels to board-established standards. Maintenance of these standards signifies to the public, the orthodontic specialty, and the dental profession that the orthodontist has met current levels of clinical proficiency. The board is obligated to protect the designation of board certification from those who would misrepresent their certification status and proficiency levels.

Should those who were traditionally certified be differentiated from those who are certified by the new process?

As the previous board-certification system becomes extinct, there will be less differentiation between those certified by the traditional system and those certified by the new process. This phenomenon historically occurred when certification by means other than the system of a 15-case display was implemented in the 1980s. Through the years, the ABO has made numerous changes in the certification process that created concern for previously certified orthodontists. In the future, all ABO-certified orthodontists will be considered of equal status, with no tier or class distinction to signify different methods of achieving certification. This unity augments the public's trust in the care level we deliver. All will be involved in a continuous quest to provide excellence in orthodontic specialty care as they are evaluated and reevaluated throughout their careers.

Whether a current diplomate was certified via 15

cases with 2 years of posttreatment records or 10 cases with final records only, board surveys of diplomates have indicated that they appreciate the tremendous value of the continued assessment of his or her treatment ability. The distinct advantage to the traditionally certified orthodontist is that he or she will not be mandated to recertify in the future or will recertify less frequently than those certified by the new process.⁴

Newly certified orthodontists will most likely present 6 cases after their residencies, another 6 cases from their practices within 10 years, 1 or 2 cases and a web-site examination within another decade, and perhaps 1 or 2 cases 10 years later. Given this consideration, the more rigorous and consistent pathway is clearly evident.

How does the ABO's new certification process compare with that of other boards?

Most certifying boards in health-care professions require a written examination as a requirement for application. Some combine the examination with continuing education requirements.^{5,6}

The new Gateway Offer requires passing the ABO's written examination to apply. Therefore, orthodontists who become board certified by taking the Gateway Offer have met requirements that parallel boards of almost all other health professions.

The ABO exceeds this requirement by mandating a clinical examination. Those who accept the Gateway Offer must take a clinical examination within 5 years. The nature of orthodontic practice including documentation with diagnostic and final records lends itself to the requirement of a clinical examination involving case displays. This is in contrast to many other areas of dentistry and medicine in which a clinical examination by means of displaying pretreatment and posttreatment results has been deemed impractical.

Is it significant that the cases presented by new graduates were supervised by orthodontic faculty?

There are a number of reasons that certification early in an orthodontist's career makes good sense:

1. If students and instructors realize that the patients treated in their orthodontic clinics will be held to board standards, it is hoped that they will be especially diligent in treating them. The new orthodontist will be exposed to the amount of effort needed to produce ABO-standard results—a valuable lesson for the neophyte clinician. As the newly graduated orthodontist enters

private practice, he or she must make the ethical decision of how to deliver orthodontic care. Does he or she want to treat to board-quality levels or provide lower-quality treatment? These decisions might have a direct effect of elevating the standard of orthodontic care.

2. Currently, 95% of graduating orthodontists avail themselves of the ABO's written examination. Most are strongly encouraged by their program directors to take it. The ABO expects that the orthodontic programs will likewise encourage and prepare the new orthodontist to take the clinical examination, leading to board certification. The orthodontist should then strive to remain certified throughout his or her career as a routine endeavor. In the future, board certification will become the culture of the specialty.
3. The written examination has become an outcomes measure for orthodontic programs in evaluating their resident education. The initial clinical examination should also become an outcomes measure for the clinical education of the orthodontist, thus fulfilling the ABO's mission to improve orthodontic graduate education.
4. The transition from resident to unsupervised practitioner is abrupt. When a graduate orthodontist obtains a degree and, in some states, a specialty license, he or she opens a practice and begins treating vulnerable patients without faculty supervision. The level of the orthodontic care the patient receives depends on the skill level and diligence of that practitioner alone, usually without additional influence. It is therefore sensible to maintain a national, standardized expectation of clinical competency. The public would be better served if the new orthodontist has successfully passed the Initial Board Certification Examination and later demonstrates a continued level of clinical competency and, ultimately, proficiency through recertification. This process will remain a testimony of the board's sincere effort to assure at least a minimal level of knowledge and skill in orthodontic specialty care spanning a practitioner's lifetime of clinical practice.

CONCLUSIONS

The board hopes that its efforts in the development of the new process of certification and recertification will benefit the public, the specialty, and the entire profession of dentistry. The goal of consistent and enduring excellence in professional care remains

as treasured today as during the birth of our beloved specialty over a century ago.

REFERENCES

1. Brennan TA, Horwitz RI, Duffy FD, Cassel CK, Goode LD, Lipner RS. The role of physician specialty board certification status in the quality movement. *J Am Med Assoc.* 2004;292:1038-43.
2. Duffy FD, Goode LD, Langdon LO. Why we should enhance subspecialty training: indicators of areas for program improvement. *Am J Med* 2002;112:431-5.
3. Choudhry NK, Fletcher RH, Soumerai SB. Systematic review: the relationship between clinical experience and quality of health care. *Ann Intern Med* 2005;142:260-73.
4. The American Board of Orthodontics: guidelines for certification/recertification 2005. ABO website: www.americanboard-ortho.com.
5. Council on Dental Education and Licensure of the ADA. Report of the ADA Recognized Dental Specialty Certifying Board, 2005.
6. ABO staff. Certification by medical and dental certifying boards, 2004 (on file at American Board of Orthodontics, Saint Louis, Mo).