SPECIAL ARTICLE

The American Board of Orthodontics: Diplomate recertification

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Although some specialty certifying boards began recommending or requiring recertification of their "boarded" specialists as early as 1986, recertification is a relatively new concept for the specialty of orthodontics. In the mid 1990s, the American Board of Orthodontics (ABO) recognized that many other medical and dental specialty boards had already established voluntary or mandatory recertification policies and decided to establish its own time-limited certifying policy. After a series of field tests involving former directors, council members of the College of Diplomates of the ABO, and volunteer diplomates, the ABO instituted a recertification policy for candidates who applied for initial certification after January 1, 1998. Since then, the total number of diplomates who have been recertified has steadily increased. Surveys of successfully recertified diplomates reflect a positive feeling about the process. When medical and dental specialists are expected to be more accountable, recertification has been shown to be a valid method to help ensure continued competency. The ABO believes that the formulation of educational and certifying processes to document a diplomate's clinical competency throughout his or her career will help to serve the public welfare. The ABO is attempting to make initial certification and periodic recertification attainable for more orthodontists and, in so doing, to provide a standard by which we exist as a specialty. (Am J Orthod Dentofacial Orthop 2004;126:650-4)

Why recertification? This is an interesting and thought-provoking question, and it merits a thoughtful answer. The purpose of this article is to clarify the value of recertification for board-certified orthodontists during the present era of dynamic evolution of our specialty.

In May 2000, an article appeared in the *American Journal of Orthodontics and Dentofacial Orthopedics* entitled "American Board of Orthodontics: Past, present, and future."[1] It presented an overview of the ABO's history and delineated its mission to (1) evaluate the knowledge and clinical competency of graduates of accredited orthodontic programs; (2) reevaluate clinical competency throughout a diplomate's career through recertification; (3) contribute to the development of quality graduate, postgraduate, and continuing education programs in orthodontics; and (4) contribute to the certification expertise throughout the world. Recently, the American Board of Orthodontics (ABO) has focused on the second goal—recertification–and that is the theme of this article.

By 1996, the ABO recognized that many other medical and dental specialties had implemented policies of recertification.[2-4] The ABO enacted its own policy of recertification, issuing time-limited (up to 15 years) certificates to candidates who applied for initial certification after January 1, 1998. In addition, the ABO began exploring the concept of recertifying orthodontists who had been certified before this policy change and decided to award certificates that were not time limited to those diplomates. Current directors and past directors who continued to serve as examiners presented cases for recertification in 1999 and 2000, and, in 2001, the ABO began investigating methods of recertification with assistance from the College of Diplomates of the ABO Councilors. Since then, volunteers from the specialty and orthodontic consultants to the ABO have been recertified. Sixty-five diplomates were examined and recertified in 2002, followed by another 30 in 2003 (Table I).[5] The number of diplomates who have been recertified indicates a growing understanding of the value of recertification and commitment to the process.

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Table I. Total number of recertified diplomates by year

Year	*Number recertified*	*Total recertified*
2004	27	152
2003	30	125
2002	65	95
2001	11	30
2000	10	19
1999	9	9

Table II. Responses (n = 27) of newly (2004) certified diplomates to recertification process

Item	*Average VAS score*
Instructions were clear	4.14
Submission of case report should be component to demonstrate treatment experience	4.29
Preparing 1 case report is reasonable request for examination	4.21
Grading 10 consecutively treated cases should be component of examination	3.93
Website provided easy access for treatment planning portion of examination	4.36
Treatment planning should be component of examination	4.57

VAS, Visual analog scale: 1 = disagree to 5 = agree.

The ABO encourages all diplomates who were certified more than 10 years ago to participate in the recertification process, which currently consists of 3 components:

1. The diplomate presents a recently treated case that meets the specifications of 1 of the first 8 ABO Phase III categories.
2. The diplomate is assigned 2 cases on the ABO secure website for diagnosis and treatment planning (Board Case Record Examination).
3. The diplomate is asked to apply the ABO's Objective Grading Cast Evaluation System to score 10 consecutively finished cases. The ABO furnishes the measurement gauge and instructional CD so that the diplomate can learn the system.

The recertified diplomates have been surveyed each year to obtain their opinions of the recertification process. Recently compiled statistics and trends accumulated from a 2004 survey of newly recertified diplomates are summarized in Table II.[5] The survey consisted of questions that the respondents answered using a visual analog scale of 1 to 5. Most respondents thought that both the design of the examination and the experience itself were positive.

In a world in which change occurs at an accelerating rate, the ABO remains responsive to the needs of society. We live in an age of consumerism; Consumer Reports is often used to reference qualifications, and doctors must document their competencies.[6-10] The ABO is the only ADA-recognized and AAO-sponsored certifying body for the orthodontic specialty. If the ABO is to fulfill its mission to ensure the highest standards and competency, then completion of the initial certification process is insufficient to ensure that a specialist remains competent throughout his or her career. Periodic reevaluation of the diplomate is, therefore, appropriate and imperative.

It is worth exploring the recertification policies and processes of the other 8 ADA-recognized dental specialties by referencing the report from the ADA Council on Dental Education and Licensure (Table III).[11] With the exception of the American Board of Oral and Maxillofacial Pathologists, which is currently investigating its own policies, all other specialties have established policies of time-limited certification for new diplomates. The time frames for recertification vary from 7 to 15 years between reexaminations. In general, once the policy of mandatory, time-limited certificates has been established for new diplomates in these specialty areas, more senior diplomates have been asked to voluntarily become recertified. Recertification is generally granted by some combination of ongoing continuing education credits, regular attendance at meetings, publication of articles in refereed journals, teaching, written examinations, lectures, presentations, and clinical case presentations.

As in medicine (Table IV), recertification has been the subject of debate and policy revision.[12] Because hospital privileges are directly linked to certification, it is understandable that medical specialists must attain board status. Although the path to dental specialization and certification is not identical to that of medicine, there are similarities. Our medical colleagues struggle with many of the same issues we do, particularly with regard to early specialty programs as adopted in January 2003 by the American Board of Surgery. The purpose of these programs is to allow program directors in vascular, pediatric, and general surgery to pursue combined training programs granting dual certification.[13]

There is sentiment, at least among some in the medical community, that health providers should control their destinies and formulate the educational and certifying processes to reduce the likelihood of untoward outside influences.[14] The American College of

Table III. ADA dental specialty certification and examination data

	Dental public health	*Endodontics*	*Oral maxillofacial pathology*	*Oral maxillofacial radiology*
Founding date	1951	1956	1948	1979
Date of ADA recognition	1951	1964	1950	2000
Number certified without examination from founding through 12/31/03	12	34	7	74
Number certified by examination through 12/31/03	271	1194	383	81
Total certified through 12/31/03	283	1228	390	155
Number deceased, dropped, or placed on inactive roll through 12/31/03	132	489	118	62
Number of active diplomates as of 12/31/03	152	739	276	93
Number certified in 2003	10	41	10	5
Number of diplomates recertified in 2003*				3
Number of diplomates certified by August of 2004	3	11		
Number of diplomates recertified in 2004 as of 8/1/2004				5
Total number diplomates recertified since inception of recertification*				18

Data from Report of the ADA-Recognized Dental Specialty Certifying Board; Council on Dental Education and Licensure American Dental Association, p 3.

*Complete only if board has process for recertification.

†First recertification cycle will end December 31, 2004.

‡Includes both diplomates and board-eligible candidates, including 758 retired, 821 deceased, and 25 inactive due to failure to pay yearly fees, and 1716 candidates in process of certification.

Physicians, the American Society of Internal Medicine, and the American Board of Internal Medicine, whose fellows all have time-limited certificates, have worked to improve and upgrade their recertification methods.[15] The American Board of Medical Specialties determined that it would be more appropriate to adopt the term "maintenance of certification" rather than "recertification" as it moved toward computerized testing.[16]

There has been a paradigm shift and a sense of urgency by the ABO with regard to certification. The ABO perceives its role, relevance, and credibility to be critical to the survival of our specialty. The ABO also believes that, to fulfill its mission, it must not only certify diplomates, but also periodically recertify them.

Despite the changing times, the ABO's mission is as important today as when it was first established. What is different, however, is the environment in which the ABO functions. In the early days, for example, an orthodontist seeking certification had only to present his or her credentials. Then, an orthodontist could become certified by submitting a thesis and a number of cases. The process later evolved to include written (Phase II) and oral (Phase III) examinations in conjunction with case presentations. With the advent of computer technology, these examinations have metamorphosed into their present format. New computerized testing systems, the Objective Grading System for posttreatment occlusal evaluation, the new Discrepancy Index for measuring case complexity, and a web-based clinical testing system have all enhanced the process of certification and made it more objective, valid, reliable, and user-friendly. Again, this approach of designing objective testing methods has been explored and implemented by our medical colleagues. The American Board of Medical Specialties, for example, has endorsed computerized testing, and the American Board of Family Practice field-tested such a system in 2003 and 2004.[17] But is it valid to assume that, once certified, there is no need to further assess a diplomate's competency? Other specialty boards in medicine and dentistry have been asking this same question and have replied by recertifying their diplomates.[18-20] This seems to further validate that the ABO is on the right course.

The ABO's commitment is to assure society that standards exist to maintain credible levels of competency and proficiency. This is best accomplished via continual self-evaluation of the specialty to ensure ongoing education and maintenance of competency. The certification and recertification processes are valid ways to accomplish those goals. Recertification may

Table III. Continued

Oral maxillofacial surgery	*Orthodontics*	*Pediatric dentistry*	*Periodontology*	*Prosthodontics*
1946	1939	1940	1940	1946
1947	1950	1948	1940	1948
15	98	15	38	69
6024	3472	1440	1769	1511
6039	3570	1455	1809	1580
1691	3320‡	118	240	184
4399	2008	1337	1569	724
157	56	63	77	18
0	30	4		†
179	52			
150 registered	27	5	372 need to recertify by 12/31/04	Exam in November 2004
2003 total 527	152	20	Not available	†

Table IV. Recognized specialty boards having recertification

Board	*Year recertification started*
American Board of Dental Public Health	2000; time-limited certificates issued
American Board of Endodontics	1997; time-limited certificates issued
American Board of Oral and Maxillofacial Pathology	2004; time-limited certificates issued
American Board of Oral and Maxillofacial Radiology	2001; review CE points to keep certification
American Board of Oral and Maxillofacial Surgery	1990; time-limited certificates issued
American Board of Orthodontics	1999; time-limited certificates issued
American Board of Pediatric Dentistry	1991; time-limited certificates issued
American Board of Periodontology	Must submit proof of 15 CE credits to retain diplomate status. No one grandfathered 2004; beginning development of self-study examination
American Board of Prosthodontics	1996; must complete 40 CE credits and 1 self-assessment during 8-year period
American Board of Surgery	1997; voluntary 2000; mandatory to have CE credits to keep certificate
American Board of Internal Medicine	1990; time-limited certificates issued
American Board of Psychiatry and Neurology	1994; time-limited certificates issued
American Board of Dermatology	1991; time-limited certificates issued
American Board of Ophthalmology	1992; time-limited certificates issued
American Board of Obstetrics and Gynecology	1986; limited primary certificate 1987; subspecialty limited certificate 2001; switched from 10-year to 6-year certificates
American Board of General Pediatrics	1988; time-limited certificate issued
American Board of Pathology	2006; time-limited certificates will be issued 2000; CME evidence required 150 credits for a 3-year period

one day emerge as a more valued measure of quality care rather than certification, because it assesses the maturing orthodontist's knowledge and abilities.

Board certification is not a guarantee of competency. However, a reasonable person would know that a specialist who has graduated from an accredited program, satisfied all mandated credentialing requirements, voluntarily completed the certifying process, and rose to the challenge of recertification should be capable of providing competent specialty care. In an era

of accountability, we must assume the lead in assuring our own competencies.

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1915 to 1931 Martin Dewey
1931 to 1968 H. C. Pollock
1968 to 1978 B. F. Dewel
1978 to 1985 Wayne G. Watson
1985 to 2000 Thomas M. Graber
2000 to present David L. Turpin