American Board of Orthodontics: Past, present, and future

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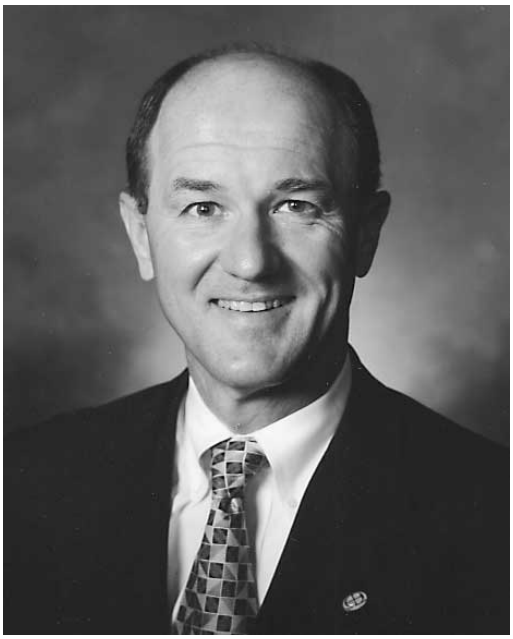
The American Board of Orthodontics was founded in 1929 and is the oldest specialty board in dentistry. It was initiated by Dr Albert Ketcham and several colleagues who believed that the specialty of orthodontics should have a certifying body. The certificate issued by the Board was then and has continued to signify a certification of attainment. It does not confer any legal qualification, privilege, or license to practice orthodontics. It is not a professional or academic degree.

The mission of the American Board of Orthodontics is to establish and maintain the highest standards of clinical excellence. In its mission statement, the Board defines 4 objectives: (1) to evaluate the knowledge and clinical competency of graduates of accredited orthodontic programs; (2) to reevaluate clinical competency throughout a diplomate's career through recertification; (3) to contribute to the development of quality graduate, postgraduate, and continuing education programs in orthodontics; and (4) to contribute to certification expertise throughout the world.



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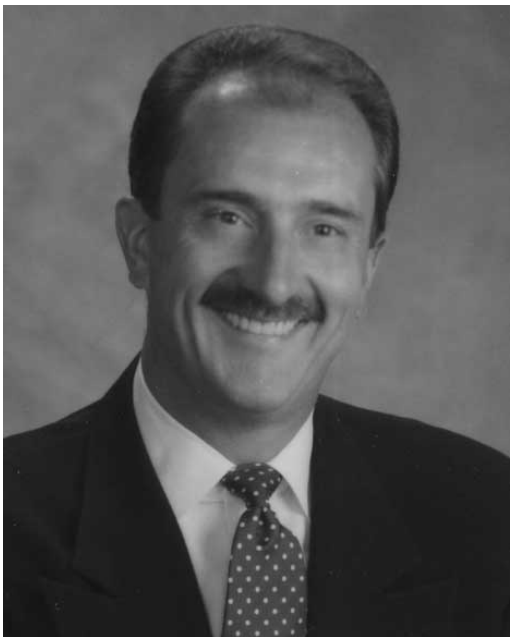

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HISTORY AND EVOLUTION

Since its founding, the Board has continued to evolve. In the beginning, Directors of the Board were chosen because of their contributions to the specialty of orthodontics. At that time, there were no defined criteria for selection of Directors. The outgoing Director usually chose, or greatly influenced, the selection of the succeeding Director from that constituent of the American Association of Orthodontists. In addition, in the early days of the Board, many orthodontists were granted diplomate status by credentialing.

In the early 1950s, the Board was recognized by the American Dental Association as the official certifying Board for orthodontics. After this recognition, the Board gained more prestige, and more orthodontists chose to begin the process of board certification.

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In the 1950s and 1960s, a clinician desiring ABO certification would write a thesis and also present clinical case reports. There was no written examination. As the Board certification process developed, the need for a written examination was discussed. The Phase II written examination was implemented in 1964. During the years from 1964 to 1978, the candidate could either write a thesis or take a written examination. The thesis requirement was eliminated in 1978. From that time on, candidates became certified in much the same way as they are presently, with a written examination along with the presentation of clinical case reports.

DIRECTOR SELECTION (PHASE I)

As the American Board of Orthodontics became more sophisticated in its examination protocol, the Director selection process also became more organized. Russell Greer (AAO President) and O.B. Vaughan (ABO President) developed the current Director selection process; it was approved by the American Board of Orthodontics and by the American Association of Orthodontists, and was fully implemented in 1988.

The selection process for Directors requires that each AAO constituent form an ad hoc committee that nominates 3 to 5 individuals who they feel have sufficient credentials to serve as Director/Examiner.

The ABO reviews the nominees and chooses the individual who they feel best fits the needs of the Board at that particular time. The name of this person is placed before the AAO Board of Trustees for approval. If approved, the individual is proposed to the AAO House of Delegates for final confirmation. This process has worked well, because it allows the Director selection process to be free of political influence.

WRITTEN EXAMINATION (PHASE II)

The written examination has evolved into a well-respected testing instrument that is now used by many graduate orthodontic programs as a method for evaluating not only the academic qualifications of their students, but also the educational effectiveness of their graduate curricula. However, this testing process went through a tremendous metamorphosis during the 1990s.

Before 1992, the written examination was generally a "collection" of questions that were submitted to the Board from a variety of sources. In 1993, feeling the need to strengthen the examination and make it more reliable and valid, an examination committee was formed to oversee the establishment of a new process for constructing the written examination. Dr Richard Diemer, educational consultant to the Board, deserves a tremendous amount of credit for steering the examination committee during this process.

Presently the examination committee begins by identifying specific topic areas to be tested. These topic areas mimic the didactic and clinical criteria that are used to accredit graduate orthodontic programs. The committee then constructs an examination that will carefully and accurately measure the knowledge base of the candidate.

After each examination the responses to questions are scrutinized to determine if they are effective. Each year, about one third of the questions are new, but in most cases the data or performance of these questions are known. The examination committee intends to construct an examination that will produce a predictable level of performance from the candidates.

CLINICAL EXAMINATION (PHASE III)

The clinical examination has a specific purpose. It intends to determine the candidate's knowledge of clinical orthodontics and the quality of the candidate's clinical abilities. Over the past 20 years, the numbers and types of case reports have varied. Before the 1990s, candidates were required to display 15 case reports with records made before treatment, immediately after treatment, and at least 2 years after removal of orthodontic appliances. However, these requirements were modified to encourage greater participation.

As we enter the new millennium, the candidate is now required to display 10 case reports from specific categories of malocclusions. In addition, the candidate is only required to exhibit records made before and immediately after orthodontic treatment.

Probably the greatest recent change in the Phase III examination process has been the development of an objective grading system for assessing the quality of the candidate's treatment results. In November 1998, the American Board of Orthodontics published its grading system for dental casts and panoramic radiographs in the *American Journal of Orthodontics and Dentofacial Orthopedics*. This system is used by Directors and examiners to accurately and objectively assess the quality of treatment of cases presented during the Phase III clinical examination.

In 1999, measuring gauges and instructions for their use were also sent to candidates so they could grade their own treatment results before presenting them to the Board. In this way, the candidates would know whether the quality of the result could meet the standard established by the Board. At present the Board is still developing the cephalometric portion of the objective grading system.

The Board has created a Calibration Committee that will oversee the implementation and modification of this objective grading system in the future. The

Board realizes that the method of assessing candidates will change in the future, and this committee will continue to review assessment systems and make modifications appropriate to the delivery and assessment of orthodontic treatment in the future.

THE FUTURE

The future of the American Board of Orthodontics is bright. The College of Diplomates of the American Board of Orthodontics (CDABO) was established in the 1980s as a vehicle for promoting Board certification. This group of dedicated clinicians is highly supportive of the Board and its mission. The CDABO has established seeker seminars and a mentoring program that will have an impact on the specialty of orthodontics by encouraging more orthodontists to become Board certified.

Hand-in-hand with CDABO's effort is the "practitioner relations" campaign of the American Board of Orthodontics. In 1999, the Board completed a massive public relations initiative by sending computer disks containing the Examination Information Booklet information on the objective grading system, and a description of the benefits of certification to all Board-eligible candidates, orthodontic residents, and the chairpersons of all AAO-approved specialty programs. The measuring gauge used by the Directors and examiners to grade the dental casts was also included in the mailing. This effort should enable all potential Board candidates to begin grading their final patient records, and, hopefully, improve the quality of their orthodontic treatment. This "user friendly" practitioner relations effort will continue.

As the examination process becomes more and more objective, the Board is turning its attention to recertification of orthodontists who have previously earned diplomate certification. Recertification will also be "user friendly" and easy to accomplish. As the Board field tests this new process, more and more certified orthodontists will be given the opportunity to become recertified on a voluntary basis.

The American Board of Orthodontics looks forward to the next millennium with great anticipation. On the horizon, the Board can envision computerized testing and even computerized dental cast evaluation.

Although the adoption of new technologies and methods of testing presents new opportunities that a proactive and innovative Board must consider, the Board will retain focus on its mission established in 1929. At inception, the American Board of Orthodontics sought to evaluate clinical competence; that goal is unwavering. Resolve, however, continues to increase.