

Chapter Nine

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Advanced Specialty Education Programs in Prosthodontics

As the discipline evolved, the need to establish prosthodontics as a specialty became self-evident. In 1947, the first four specialties—oral surgery, pedodontia, periodontia, and prosthodontia—were recognized by the American Dental Association House of Delegates (ADA HOD). While orthodontics had an examining board in 1930, it was not officially recognized as a specialty until 1950. The ADA Council on Dental Education (CDE) formally approved the American Board of Prosthodontics (ABP) at the 1948 ADA HOD, along with boards for oral surgery, pedodontia, and periodontia. The Academy of Prosthodontics (Academy/AP) sponsored the American Board of Prosthodontics (ABP) from its beginning in 1947.^{1,2} When the American Dental Association (ADA) revised its policies regulating the specialty certifying boards in 1959, requirements relating to the qualification of candidates for examination by the Board were adopted.³ However, these requirements created several preliminary difficulties for the specialty that the Academy fellowship addressed through educational workshops held in Chicago.^{4,6}

The ABP developed and administered the specialty certification examination. In 1965, the ADA HOD accepted the eligibility requirement that all individuals taking the Board examination must complete a two-year advanced prosthodontic training program. This began the era of formal educational specialty programs and the changes that have led to the current status of the specialty. In those early years, a national commission for dental education did not exist; as such, the individual specialty certifying Boards established the requirements that set the standards for specialty education programs.

The Academy continued to sponsor the ABP until 1972, when the Federation of Prosthodontic Organizations (FPO) assumed responsibility.^{7,8} Guidelines for advanced prosthodontic education were then developed and published in 1970 by the FPO. These were the result of conferences and workshops conducted by the ADA, the American Association of Dental Schools (AADS), the Veterans Administration, the Academy, and the FPO.⁹⁻¹¹ The Academy served as a valuable leadership resource for the FPO with the efforts of Academy Fellows Carl and Louis Boucher, Martone, Block, Wood, Steffel, Gehl, Klein, Wendt, Lytle, Bell, Laney, Lepley, Atwood, Payne, Brewer, Trapozzano, McGivney, Rudd, Rhoads, Koper, Lord, and others.

**THE SPECIALTIES IN DENTISTRY: PRESENT STATUS
AND RECOMMENDATIONS FOR THE FUTURE**

BEFORE the war, the Council on Dental Education of the American Dental Association had a committee at work on the problem of the specialties in dentistry. The Committee on Dental Specialties was giving consideration to the areas of dental practice which had developed specialties, the training of the specialist beyond the undergraduate course in dentistry and the nature of the recognition of the specialist by the public. The work of the Committee was interrupted by the war but has been resumed in the past two years. At the Miami meeting of the House of Delegates of the American Dental Association the Council was authorized to formulate requirements for the approval of the American Board of Oral Surgery.

At the meeting of the Council on February 7, the Committee submitted a series of recommendations together with proposed requirements for the approval of specialty examining boards in dentistry with a view to the consideration of all such boards which seek approval. The recommendations and requirements were approved, and the application of the American Board of Oral Surgery for approval under the requirements as adopted is now pending before the Council.

The Committee consists of James R.

Blayney, chairman; Bert L. Hooper; Frank J. Houghton; Carl O. Flagstad, and Harold J. Leonard. The following report, which was approved and adopted in its entirety by the Council on February 7, was prepared for the Committee by Harlan H. Horner, secretary of the Council.

Action to Date

Consideration was first given by the Council on Dental Education to the status of dental specialties at a meeting held on December 1, 1940. The following extract from the minutes of that meeting indicates the action taken at that time:

The secretary called the attention of the Council to the fact that "the accreditation of specialists in dental practice" had been announced as one of its functions and asked when and how the Council proposed to deal with that question. After discussion, it was voted that the chairman be requested to appoint a committee of three, one from each of the groups represented on the Council, to inquire into the existing situation touching the development of the specialties in dentistry and to report upon what obligations the Council should assume with reference thereto.

Whereupon Chairman Terry announced the appointment of the following committee for this purpose: Robert P. Thomas, chairman;

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Beginning in 1963, the Commission for Dental Education (CDE) adopted general educational requirements for Advanced Specialty Education Programs. The CDE was the forerunner of two agencies now known as the Commission on Dental Accreditation (CODA), created in 1975, and the ADA Council on Dental Education and Licensure (CDEL). The formal process was initiated for all specialties in 1966. These early guidelines consisted of general program requirements, approved by the CDE, and were applicable to all advanced specialty programs as well as a discipline-specific document. The early documents were a series of guidelines, and not standards. The guidelines contained only "should" statements and no "must" statements. The discipline-specific guidelines were developed and maintained by the individual specialty boards. Prosthodontics identified three distinct tracks: clinical practice, full-time academics, and full-time research were specified. This was the origin of the 60 percent rule for the required time that students must spend treating patients in specialty prosthodontic programs.

The Commission on Dental Accreditation (CODA) was formed in 1975. The mission of CODA is to serve the public and the profession by developing and implementing accreditation standards that promote and monitor the continuous quality and improvement of dental education programs. CODA policies and evaluation guidelines provide the framework for all formal dental education programs. This program and

▲ "The Specialties in Dentistry: Present Status and Recommendations for the Future" (*JADA* 1947)

institutional oral health accreditation procedure is a seven-year process that includes a self-study and peer review of the educational programs as specified by the adopted accreditation standards, policies, and procedures.

In 1970, guidelines for advanced prosthodontic education were initially developed by the FPO, allowing the ADA to recognize prosthodontics as a specialty of dentistry. The Commission issued the first standards specific to each specialty in 1975. These included the general boilerplate guidelines applicable to all specialties and the specific educational guidelines adopted by each of the specialty boards. The prosthodontic-specific guidelines were developed jointly by the FPO and the ABP. In 1975, CODA initiated the concept of proficiency at the specialty level, the use of "must" statements, the program length specification of at least two years, and the process of measurement and evaluation of student learning. In 1982, the prosthodontic accreditation guidelines were updated to include the adoption of definitions for levels of knowledge (in-depth, understanding, and familiarity) and clinical skills (proficiency, competency, and exposure) and the specification of dental laboratory technology skills. Lists of clinical procedures were added, and dental implants were mentioned for the first time.

The FPO held a workshop in 1982 to further revise the accreditation standards so that all programs would provide instruction and experiences in the full scope of the specialty.¹² After review and discussion at all levels from the programs, dental schools, and the ADA, it was approved that two-year programs would no longer be designated as fixed, removable, or combined. The concept of prosthodontics as a unified specialty was adopted under a single, overarching designation of “prosthodontics,” effective July 1, 1986. Prior to the 1982 updates, the guidelines specified, “The major emphasis of the program should be placed on one of the prosthodontic disciplines” (complete and removable partial prosthodontics, fixed prosthodontics, and maxillofacial prosthetics). As a result, programs had a specific focus, and individuals graduated from either fixed or removable programs. This specification limited the scope of prosthodontic education.

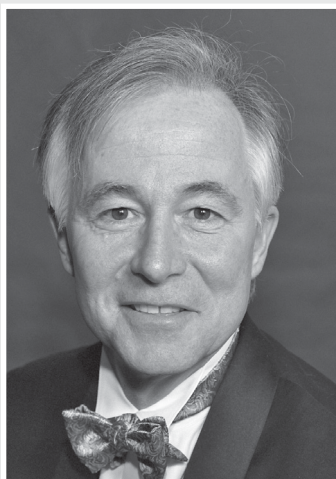
For the first time, the December 1982 proposed requirements for advanced education programs in prosthodontics included a combined specialty that mandated students have in-depth knowledge and a broad range of clinical experience in fixed, removable partial, and complete denture prosthodontics as well as occlusion. These changes were adopted in 1984, when CODA began to implement guidelines specific to each specialty in its own right and independent of the certifying and sponsoring groups. This began the era of iterative accreditation standards development that continually engaged all of the communities of interest.

The next significant update occurred in 1992, when the concept of “standards” as a core accreditation principle was adopted across all dental education. Prosthodontics added more extensive and detailed lists of clinical procedures and outcome standards for both programs and students. The FPO was dissolved on December 31, 1994, and responsibility was transferred to the American College of Prosthodontists (ACP).^{13, 14} The current CODA Review Committee structure was established, and the ACP was named as the sponsoring organization for the purposes of appointing review committee members. The ABP was also identified as a CODA appointee organization.

In 1996, the program length was increased from twenty-four to thirty-three months to accommodate the expansion of prosthodontic therapies and the areas of temporomandibular disorders (TMDs), orofacial pain, and geriatrics. The requirement that the program director be Board certified was also introduced. Graduating students were now expected to be proficient in a large number of clinical areas, distinguishing them from the four-year pre-doctoral (DDS/DMD) curriculum. Changes in 2008 brought the first dental implant placement standard at the participation level. In 2012, the CODA adopted global changes to the core specialty definitions of didactic knowledge and clinical skills, mandating principles consistent with the pre-doctoral concept of “competence.”¹⁵ This modification had a broad effect, as it reduced the levels of didactic knowledge for all nine recognized specialties from three (in-depth, understanding, and exposure) to a single level of in-depth. Areas outside of in-depth knowledge were to be dropped or raised to that level. Likewise, the definitions for clinical skills were reduced from proficiency, competency, and observation to just competency and observation. This change in core definitions required all specialties to make their standards consistent with the new boilerplate guidelines. It led to a comprehensive rewrite of the prosthodontic accreditation standards, which were ultimately implemented on July 1, 2016. These new standards are reflective of the contemporary and forward-looking practice of specialty prosthodontics and include a more diagnostically driven specialty. A broad range of



▲ Kent L. Knoernschild, CODA Prosthodontic Commissioner, 2009–2013



▲ Stephen D. Campbell, CODA Prosthodontic Commissioner, 2013–2017

new program standards was introduced, including implant placement at the level of competence. This accomplishment began in 2009 with the efforts of Academy Fellow Kent Knoernschild and was finally achieved in 2017 by Academy Fellow Stephen Campbell.

Although the CODA Review Committee process was established in 1982, prosthodontics did not have a formal review committee until 1998. The Prosthodontics Review Committee (PRC) is one of the standing committees of the CODA and reports directly to the CODA. As such, they consider all matters related to prosthodontic specialty accreditation, program review, and the process of managing the specialty accreditation standards for the CODA. The chair of the PRC serves as one of the thirty CODA commissioners who oversee all dental education. There have been five prosthodontic commissioners whose leadership advanced the specialty of prosthodontics:

Dr. Stephen F. Bergen, 1998–2001

Dr. Arthur Nimmo, 2001–2005

Dr. Ronald D. Woody, 2005–2009

Dr. Kent Knoernschild, 2009–2013

Dr. Stephen Campbell, 2013–2017

The rich history of the Academy of Prosthodontics demonstrates its role in establishing the specialty of prosthodontics, including the guidelines for specialty education and accreditation as they evolved throughout the twentieth century. This vision and involvement resulted in our modern educational processes and specialty. The Academy of Prosthodontics continues to play a critical role in ensuring that specialty prosthodontics serves the public and future generation of graduates and practitioners.

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