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Editorial

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Evolution of Board Certification in Pediatric Dentistry: Changing Patterns Between Enhancing Quality vs Expanding Numbers of Qualifying Members and its Implications for Future Training

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Editorial

The last decade or so has taken notice of dramatic changes in the board certification process within both medical and dental disciplines, and in particular for pediatric dentistry specialists. Changes in format have altered the process from what was once an exclusive, exhaustive, and elite accomplishment for approximately ten percent of the members of the American Academy of Pediatric Dentistry.

Becoming a Diplomate of the American Board of Pediatric Dentistry was once a distinction that undeniably identified the "best of the best," in the field. By virtue of such, this status giving recognition of the most learned, well-read and talented of academics and clinicians, appearances implied that the remainder of its membership fell seriously short of fulfilling optimal if not desirable or even acceptable standards. In efforts to address this discrepancy, significant modification in requirements and testing demands have successfully opened channels for the vast majority of pediatric specialists to pursue and secure board certification. In contrast to earlier times, approximately 500 candidates annually sit for the clinical examination with a 95% success rate. At present, opinions differ as to whether the newest format elevates (or lowers) the bar of quality for its membership. In any event, forces which motivated change to make board certification more attractive and attainable arose from both internal and external origins.

The exam process has essentially been cut in half. It remains an expensive endeavor, particularly for those in academic centers or those without resources having freshly completed training while beginning initial practice activities. The preparatory phase, or Written Exam (Part One) which originated with an extensive and broad topic list of references spanning all aspects of pediatric dentistry from textbook to evidence based literature over a full-day, has been reduced to 200 question multiple choice exam from textbook/clinical impression sources in a half-day session.

Part 2 previously comprised a one hour "no holds-barred" oral examination giving applicants opportunity to demonstrate their knowledge of factual information, problem-solving skills and best judgment on a broad range of topics. This session might have been considered

intrusive if not intimidating for some, but also enriching and informative to allow candidates to self-assess their knowledge and adequacy of their own preparation. Part 3 required detailed documentation and presentation of 4-5 defined cases they treated, beginning to end with follow-up in areas of behavior management, pulpal and restorative care, traumatic injury, and management of medically compromised and/or neurologically challenged patient. Part 4 served as a day-long site visit with specific expectations for demonstration of care with opportunity for explanation and discussion of rationale and office philosophies toward any aspect of care. The new format, Part two takes place in two hours; several vignettes of clinical simulations, represent significantly abbreviated sections of Parts 2, 3 and 4 of the old format. For a limited period (2001-03) candidates had the option of participating in either the old or the reduced format.

Regardless of the format being followed, the hopes and expectations of the American Board has remained that prospective candidates find each and every part invigorating, informative, and invaluable tools to self-assess one's strengths and weaknesses. Those weak in testing or intimidated by the process, while unfortunate, may not readily share this interpretation of the merit of the process.

From an external vantage, hospital bylaws shifting in the mid 80's on a nationwide basis determined that for all specialties in which an American Board existed, clinicians would then be required to secure American Board certification by their time of re-appointment. One's ability to bring and treat cases under general anesthesia thus became contingent upon satisfying its certification requirement. On an internal basis, disciplines on a nationwide basis felt pressure to increase the percentage of their membership which could demonstrate this credential of success amongst their respective peers and colleagues. Structurally, a trend which became obvious was that few specialties if any conducted as comprehensive a format as pediatric dentistry; as result, need suggested that pediatric dentistry condense its format more in line with other disciplines.

Within pediatric dentistry, divergent schools of thought will continue to exist. The American Board has, nevertheless, committed to reducing testing demand/standards to increase membership pursuit with enormous success; old vs new school diplomates will likely continue to clash in moot debate. The question of whether standards for board certification should remain so highly elevated that certification be attainable by but a few, or should it become an expected credential for the masses is no longer on the table for debate. For "old school" Diplomates (those having secured certification under the four-part format prior to 2003) these changes may be a hard pill to swallow. What is an appropriate target with respect to what constitutes the pursuit of excellence? From an ideal perspective, continued efforts to improve the quality and validity of the exam, be it lengthy or abbreviated, can be expected to ultimately erode reservations from either point of view. Resolution of what constitutes a balance between reasonable expectations for qualifying certification and beyond ultimately will be shaped by the program curriculum changes that are forged by accreditation bodies and those faculty responsible for advanced training guideline development. The American Board of Pediatric Dentistry has acknowledged qualification differences between candidates who have passed the four part exam format over the two part process. While subtle, it has nevertheless acknowledged that re-certification is periodically needed and required for those granted certification from having passed the two part format, while those having passed the more comprehensive four part exam are exempt from recertification testing. Distinction, while a footnote to old school diplomates between these two categorical levels of Diplomate status is not well published or disseminated to the public.

As teaching circles and private practice of pediatric dentistry evolve in the coming decades, recognition for changes which likely include extending the length of advanced training might be contemplated.

When exploring the larger picture, the process of advancing education curriculum to strengthen the quality of its training programs is a dynamic and ongoing endeavor. Having been in private practice and academics for nearly forty years, this author envisions several areas where expansion will naturally occur. As pediatric dentistry expands its knowledge base across medical pediatrics, advanced strategies and skills of pharmacological management of challenging child behaviors, orthodontics, and surgical interventions, a fundamental challenge relates to the continued ability to accomplish such within twenty four month periods. Variability of training programs in pediatric dentistry, with regard to faculty and respective program directors contributes to limitations on a program's ability to fulfill

its mission of providing comprehensive exposure and competence across its diverse areas of instruction. This author is a product of an expanded 36 month training program completed in 1979. An additional 12 months enabled a broad experience in clinical pediatric dentistry, greater exposure to anesthesiology and proficiency in airway management, orthodontic diagnosis, mechanics and treatment. It might be hypothesized that the three year residency program better prepared this candidate for completion of the four part board certification process. The addition of a research level component, be it at a preliminary, master's degree or PhD level, might be further hypothesized to serve as a necessary basis for expansion of program length. To successfully prepare postgraduate students for proficiency across all areas within a 24 month time frame is a daunting task. If expansion lies ahead, no doubt these will include re-assessment, not the least of which may impact on board certification changes.

This editorial sought to identify the climate for change and its potential sequelae. The impact, positive or negative, is not easily defined, implied, or resolved other than to focus on the need to make revisions in certification process to accommodate increased numbers while maintaining the highest standards possible. Current format dismisses the notion that board certification serves notice as the height of knowledge. Elevation of the vast majority to the level of minimally qualified appears now to be the rule rather than the exception. It is a sign of the times and should not likely be construed as an undesirable achievement, rather a gesture that elevates individuals to continue to enhance their knowledge and pursue excellence. It becomes noteworthy for those who view certification as a starting point rather than a final destination.