Inside the American Board of Orthodontics

The 2007 Directors of the American Board of Orthodontics. Front row, from left: Joseph A. Groth (Southeastern Society), Kristina H. Ackerman (Pacific Coast Society), Barry S. Briss (Northeastern Society), Scott A. Jamieson (Great Lakes Association) and S. Ed Owens (former RMDO Director). (Photo: ABO)

Each constituency selects a new ABO director for an eight-year rotation tenure.

The selection process functions as follows: The elected leadership of a constituency appoints five-person committee. This committee reviews resumes and has the prerogative to interview prospective candidates. The president of the constituency submits a minimum of three and a maximum of seven nominees to the ABO. The ABO directors thoroughly evaluate the recommended candidates, then convene and identify one person from the constituency’s list for final approval confirmation by the ABO Trustees and the House of Delegates.

The ABO directors consider director selection to be one of their most critical decisions of the year. The directors wish to select the most appropriate individual from the very capable and talented candidates that are offered by the constituency. The choice of the individual from the constituency’s list reflects the skill and attributes the ABO needs at that particular time. I can tell you that it is always a very difficult task to identify one individual from a list of such worthy candidates.

What are the objectives and purposes of the ABO?

In essence, the ABO is our specialty’s statement to the profession of dentistry and the general public that the specialty conducts peer review and self-evaluation. All health care specialties have developed certifying boards for examination of their membership. These boards provide the orthodontic specialty with the guidance and support they need to be used by the profession and/or specialty, as well as the general public, to verify a practitioner’s competency in the area of health care.

Therefore, the objective of the American Board of Orthodontics, as quoted from our bylaws, “… is the pursuit of excellence in orthodontics for the betterment of the public for whom the specialty of orthodontics serves.” The ABO accomplishes the objective by 1) stimulating and promoting the spirit of self-improvement, 2) elevating the standards of orthodontic education and treatment and 3) conducting examinations to evaluate the knowledge and skills of practicing orthodontists.

This principle objective has been the intention of the American Board of Orthodontics since its inception and organization in 1930 as evidenced in the original Articles of Incorporation developed by Dr. Victor W. Van Vliet.

The Board’s ultimate vision is that all educationally-qualified orthodontists demonstrate their competency by completing the ABO certification process, attaining a level of their orthodontic training and continuing to maintain their specialty board certification by periodic re-examination.

Do you believe that the ABO is accomplishing its objectives?

Well, I believe that the Board is on course and moving in the right direction to eventually accomplish its declared objective. I had the opportunity to speak with Dr. Frank Boywer before he passed away. He was an ABO director in the 1990s, and at that time, the primary concern and focus of the Board was to stimulate a greater participation of orthodontists in certification. Little has changed in the last 50-plus years, and the ABO is still fighting that battle. You see, the only way the Board can accomplish its objectives is to have the vast majority of orthodontists participating in the voluntary process of certification.

The Board has made many changes over the years, and I am hopeful that we will encourage more orthodontists to become a part of the voluntary system. In fact, the College of Diplomates of the ABO was formed in 1979 to serve as an organization that would promote ABO certification. Unfortunately, the extensive efforts of so many dedicated individuals never raised the percentage of boarded, active AAO orthodontists any higher than 29 percent. The percentage has historically hovered in the 20 to 25 percent range.

So the Board, following considerable discussion among the directors, past directors and other leaders in CDABO and the AAO, made the significant decision to alter the certification process, which was announced in March 2005. The paradigm shift in the certification process was met with praise from many, criticism from some and, perhaps, passive acceptance by most. The two-fold approach was to first re-invigorate interest of the many practicing orthodontists who were never able to take the Boards for an infinite array of reasons. The limited Gateway Option was directed at those individuals and has been successful with many of the 2,900 orthodontists receiving the five-year certification.

Secondly, the early certification following orthodontic residencies was to mirror the medical model – to certify orthodontists very early in their careers, followed by recertification throughout their practice lifetime. The first group of graduates will be examined in February 2008.

In direct answer to your question, “Is the Board accomplishing its objectives?,” here is my response: We currently have more than 5,000 board certified orthodontists. That is nearly 51 percent of all active AAO membership. In historical terms of percentages, the ABO has been very successful in stimulating orthodontists to enter the certification process. But it will be five to seven years before the Board will begin to see if the early certification option has made an impact. We will take as long to determine if those that were boarded by the Gateway Option will truly follow through and recertify. Until that time, we can only make suppositions, and most of those are usually based on personal biases.

Would you explain the new ABO clinical examinations?

The Board has two newly defined clinical examinations: the Initial Certification Exam and the First Recertification Exam. Both of these have essentially the same criteria, except for one very important aspect. Each exam requires a total of six case reports to be presented. Three cases need to have a minimum Discrepancy Index (DI) of 10 points or more, and three cases need to have DI of 20 points or more. Only one orthognathic surgical case may be presented. One case must have extractions in all four quadrants and demonstrate effective space closure. The area of difference involves the Class II malocclusion requirement. The Initial Certification Exam that is taken within three years following residency requires one case of the six to begin with a bilateral end-to-end Class II first molar relationship and treated to a Class I occlusion. On the other hand, in the First Recertification Exam, one case must have a full step Class II first molar relationship at least on one side treated to a Class I occlusion. That is a critical difference between the two examinations. This distinction was necessary, as many full step Class II malocclusions cannot be effectively managed within the timeliness of an orthodontic residency. I would think most orthodontists realize the difficulties in correcting a full step Class II to a Class I regardless of the treatment plan.

The Initial Certification Examination uses cases treated by the orthodontist while in his or her orthodontic training programs under instructor supervision. The First Recertification Examination requires cases that have been treated solely by the orthodontist in his or her own private practices. Both of the examinations include an oral discussion of two cases that the Board presents to the examinee. After review of the cases, the examinee determines which one best matches his or her treatment objectives and then defends his/her treatment plan to the examiners.

The Board believes the examinations are a fair, thorough and an authentic measure of an orthodontist’s clinical acumen.

I know that the ABO has made changes in the written exam. Could you explain the current written examination?

Yes, you are correct. The written examination has had some significant changes in the last few years. For many years, it has been taken by most orthodontists at the end of their graduate orthodontics residencies. Most orthodontic programs have used the results of this examination as one of their outcomes assessment measures. Well meaning health care organizations have heightened security features, completely computer-based test presentations and are conveniently located near most students. We have received extremely positive feedback from those that have taken the examination in this new venue.

The written examination has major sections with 250 multiple-choice questions on both the basic sciences and clinical subjects. The examination takes four hours to complete rather than the previous eight. The computerized testing centers allow the questions to be continuously "shuffled" within an examination section, which reduces the ability of examinees to leave the center and “compare questions.” The exam results are psychometrically analyzed annually by a firm hired by the ABO to accomplish that task. In other words, the ABO written examination is a current, statistically valid test of the orthodontic knowledge base of the examinee, administered in a secure and modern testing facility.
Interview

What other innovations has the Board implemented?
The ABO’s Web site, www.americanboardortho.com, was completely revamped and updated for its June 2006 introduction. We continuously refine and improve the site. The site is divided into two major components, the first being the public side, which lists all currently active Diplomates by name and ZIP code. It also provides a listing of all satellite offices. The other component is the professional area containing the information, applications, rules and regulations that currently apply to the board certification process.

An exciting project on which the Board is currently working involves the development by which an examinee can submit case reports in a totally electronic format. In other words, all the images, digital casts and written materials will be ultimately submitted to the Board in this manner. We hope that it will be ready for either the 2009 or the 2010 clinical examinations.

Our final exciting change is the move of the clinical exam from the St. Louis Airport Marriott to a specifically-designed facility for the administration of clinical examinations in Dallas. We are renting this facility from the American Board of Obstetrics and Gynecology. Our first examination at the new location will be in February. The venue is extremely impressive, with individual examination rooms that contain computers, modern furnishings and sound proofing.

Please tell us about your personal journey as an ABO director?
In a word – unbelievable! I would think all my colleagues on the Board, both past and present, would express a similar response. The humbling sensation that occurs when your orthodontic colleagues ask you to administer a system that judges their knowledge and clinical skills is a remarkable experience. I have, as have all orthodontists, the privilege to improve my patients’ oral health and appearance. That has been my life’s work, and what a satisfying journey it has been. But to have the opportunity to impact the quality of care for all patients of our boarded orthodontists is a thought that seems mind-boggling. I truly believe that all ABO directors take the monumental responsibility with which they are presented and hold it with careful hands.

I would take this opportunity to encourage all board certified orthodontists to seriously consider the possibility of serving. The feeling of accomplishment, the development of long-lasting relationships with fellow directors and the ability to work with our highly professional and capable central office staff all culminate in an extremely satisfying eight years of service.

What closing remarks do you have?
Again, I express my appreciation for the Ortho Tribune giving the ABO an opportunity to inform your readers.

I hope this article may encourage some of our non-boarded colleagues to consider pursuing the rewarding certifying process that encourages each of us to be the best that we can.

Or tho Tribune would like to thank Dr. Moffitt for donating his time and effort, and for sharing his expertise with us!

About the doctor

Dr. Allen H. Moffitt was born and raised in Paducah, Ky. He graduated Magna Cum Laude from the University of Kentucky College of Dentistry in 1970 and served two years in the U.S. Navy. In 1974, he attained a certificate and master’s of science in dentistry from the University of Washington Dental School and subsequently began his clinical practice of orthodontics in Murray, Ky.

Dr. Moffitt has served dentistry as a state delegate and 12 years as Program Chairman for the Purchase Dental Society. He has served the orthodontic specialty as President of the Kentucky Association of Orthodontists and six years as Director to the Southern Association of Orthodontists. He is a member of the Midwest Component of the Edward H. Angle Society, a Fellow of the American College of Dentists, a Fellow of the International College of Dentists, and the College of Diplomates of the ABO. For the past seven years he has been the ABO Director from the Southern Association of Orthodontists. Dr. Moffitt has provided presentations to many organizations and orthodontic graduate programs and has authored several published papers.

Dr. Moffitt has participated in the affairs of his local community as a director of the Chamber of Commerce, a director of the Murray/Calloway County Economic Development Corporation and a trustee for the Murray/Calloway County Hospital Board. Dr. Moffitt and his wife of 59 years have one son, who is an endocrinologist, a daughter-in-law and two young grandsons.

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